THE INSTITUTE FOR CONNECTED COMMUNITIES

University of East London

Evaluation of the integrated social prescribing model in Redbridge

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Dr Marcello Bertotti, Reader in Community Health
Dr Ainul Hanafiah, Research Fellow
David Canitrot, Research Assistant

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1 Executive Summary

Background

In April 2022, London Borough of Redbridge (LBR) and North East London Clinical Commissioning Group (NELCCG) commissioned the Institute for Connected Communities (ICC) based at University of East London (UEL) to carry out an evaluation of social prescribing in Redbridge.

This focussed on three main parts:

(i) Examining the experience of the integrated social prescribing service in Redbridge as delivered by both Primary Care Networks (PCNs) and Redbridge CVS. The main aim of this part of the evaluation was to understand how social prescribing is currently working in the borough and make useful recommendations that could help stakeholders to plan the future of social prescribing in the borough.

(ii) Analyse health and social outcome data made available by Redbridge CVS

(iii) Review the social prescribing for young people model and provide some good practice lessons from a social prescribing for families intervention.

Methods

Qualitative interviews: we conducted 17 online interviews between May and Aug 2022 with a range of stakeholders including four link workers, three PCN managers, one clinical director, as well as council, CCG, Redbridge CVS staff and other stakeholders involved in the strategy or delivery of social prescribing in the borough or surrounding areas.

Quantitative analysis: we carried out an analysis of baseline and six months follow up data from 182 social prescribing clients (Nov 2019-May 2022). We conducted statistical tests (where possible) on a range of variables: socio-demographic profile, general health, personal wellbeing (ONS4), mental wellbeing (SWEMWBS), social capital (social capital harmonized questionnaire set) and health service use (GP visits, A&E attendance and in-patient stays).

Key Findings

Social prescribing is implemented in very different ways across PCNs. 'Buy-in' from GP practices varies widely and takes time and continuous investment. The level of support PCN link workers were able to provide clients varied widely across the PCNs from extremely light touch (15 minutes) to in-depth support involving six sessions over a 3-month period and, in some circumstances, accompaniment of clients to VCSE sector activities. Overall, pressure to deliver a 'light touch' rather than an 'in-depth' and flexible service is very high and is not likely to change.

Overall, PCN link workers were unhappy about their current working conditions primarily in relation to their excessive caseload, lack of clarity about their role, poor working environment, and extremely limited clinical supervision.

All respondents agreed that there is a considerable number of complex cases requiring a multiple and coordinated response.

Despite these, there were also some very good examples of 'networking' within PCNs (e.g. MDTs) and between PCNs and Redbridge CVS which show that integration could be developed further. In the discussion

section (sec.5.2, p.38), we summarised strengths and weaknesses of PCNs and Redbridge CVS to stimulate thinking between stakeholders on how social prescribing could be adjusted.

The recent and not so recent experience of social prescribing in Redbridge shows overall positive statistically significant changes in health outcomes for clients in terms of personal wellbeing and reduction in health care resource use, despite some methodological limitations. Furthermore, respondents emphasise the raising level of complexity of cases in terms of their vulnerability and the need for a 'networked' response to it, which brings together a wide range of expertise in health and beyond and makes use of all the available assets. In section 5.1 (p. 35) we consider the macro trend in complexity such as an ageing population, health inequalities, the impact of the pandemic, and the increase in long term conditions. All these factors make the argument for a stronger social prescribing more compelling.

Key recommendations

Below we discuss some key recommendations. A full list of recommendations is available in sec. 6, p.41 structured upon the key stakeholders involved in the delivery of social prescribing.

Recommendation 1: The joint creation of a *standard operating procedure* which all stakeholders would commit to. One of the key stages of this would be to clarify criteria for assessing 'complexity'. Once the level of complexity is identified, PCNs need to commit to referring clients to Redbridge CVS when complexity is high and requiring individuals to be supported for a long period of time. It is important to recognise that if this does not happen many clients will go back to primary care and contribute to the 'revolving door' mentioned by one clinical director.

Recommendation 2: Some PCNs need to find greater balance between quantity of clients supported and quality of support provided. Some of the reported targets of over 800 clients per year are not achievable. Some GP practices need to provide PCN link workers with suitable working conditions to operate from.

Recommendation 3: Due consideration for the Network Contract Directed Enhanced Service (NHS 2022) which discusses the introduction of 'proactive social prescribing'. This encourages PCN, commissioners, local authorities, VCSE and local clinical leaders to proactively offer social prescribing to an identified cohort with unmet needs. This appears to provide an opportunity for further integration of social prescribing within the borough (see more detail in sec. 6.3, p.42).

2 Introduction

The main aims and objectives of the evaluation are as follows:

Aim 1: Examine the experience of an integrated social prescribing service in Redbridge

Objectives:

1a. Mapping the PCN link workers pathway including roles, how they collect monitoring data, referral routes and other key aspects such as their experience with clients, training, and work.

1b. Understanding the strengths and weaknesses of an integrated social prescribing service in Redbridge

1c. Understanding the health and wellbeing of social prescribing adult users by analysing 6 months follow up evaluation data from Redbridge CVS. Caution in analysing these data is needed as services to clients was affected by the pandemic but this would provide some important findings to determine if the current service is able to maintain health and wellbeing changes over time.

Aim 2: Assess the feasibility of introducing a whole family and young social prescribing approach in Redbridge

Objectives:

2a. Review other social prescribing for young people service

2b. Review good practice lessons from other social prescribing for families services

3 Methods

In order to address objectives **1a and 1b** above, we completed the following:

- Reviewed Redbridge Social prescribing documents

- Conducted 17 online interviews between May and Aug 2022 with a range of stakeholders including four link workers, three PCN managers, one clinical director, as well as council, CCG, Redbridge CVS staff and other stakeholders involved in the strategy or delivery of social prescribing in the borough or surrounding areas. In order to analyse qualitative interviews, we adopted Framework Method data analysis as this allows exploration of diversities within a given population by providing detailed and extensive in-depth information (Ritchie et al., 2013). Interviews with link workers were structured around the link worker competencies framework developed by the NHS (NHS, 2022) to account for the different aspects of link workers' roles. Feedback from interviews with stakeholders have been broadly organised into five analytical frameworks or 'themes'.

In order to examine health and wellbeing outcomes (**obj. 1c**), we analysed data collected from Redbridge CVS on their clients. We accessed baseline and six months follow up data from 182 social prescribing clients (Nov 2019-May 2022) but for some of these we only had either baseline or follow up data but not both. We had both baseline and follow-up data from 86 clients and analysed client data on their socio-demographic profile, general health, personal wellbeing (ONS4), mental wellbeing (SWEMWBS), social capital (social capital harmonized questionnaire set) and health service use (GP visits, A&E attendance and in-patient stays).

In relation to **obj 2a**, we reviewed Redbridge CVS proposal in light of research conducted by ICC (Bertotti et al., 2020), a consultation on social prescribing for young people we conducted two years ago for NHS England and work carried out with the Social Prescribing Youth Network (SPYN).

In relation to **obj.2b**, we carried out an interview with Hackney social prescribing for family service to inform the current Redbridge proposal.

Below, we present the results of our qualitative investigation, quantitative data analysis of adult social prescribing in Redbridge as well as the review of Redbridge CVS model for social prescribing for young and families. Following that, the discussion section will summarise the key results and the recommendation section will put forward some suggestions for stakeholder consideration.

4 Results

This section describes the results from qualitative interviews with stakeholders in relation the integrated adult social prescribing in Redbridge; it analyses quantitative data from Redbridge CVS implementation of social prescribing and reviews the Redbridge CVS models for young people and family social prescribing.

4.1 Results from qualitative interviews with stakeholders in Redbridge

One of the main aims of this evaluation is to identify and discuss the main challenges and opportunities for integration of social prescribing in Redbridge in order to put forward recommendations for action. We first examine how the current social prescribing pathway looks like and the role PCN link workers and Redbridge CVS advisors played in it. We then describe responses about the opportunities and challenges for integration of the services as well as the future of social prescribing in Redbridge.

4.1.1 The social prescribing pathway in Redbridge

This section examines how PCN link workers operated the social prescribing service in Redbridge. It is structured around the journey of each client from when their first approach to their GP practice, to their engagement and connection with the link worker, and finally their onward referral to delivery organisations, both VCSE (Voluntary, Community and Social Enterprise) and statutory sector (e.g. housing). A description of the responses about the level of integration with Redbridge CVS is provided further down in section 4.1.3.

4.1.1.1 Relationship between PCN link workers and associated GP practices

We examined the origin of clients' referral, how relationships with their referral source are created and maintained and potential challenges encountered. The GP practice was the main referring organisation. Within that, nurses, physiotherapists or receptionists alongside General Practitioners referred clients. Some referrals also took place via pharmacists who conducted Structured Medication Reviews. These reviews identified clients with specific multiple drug and social needs and were referred to PCN link workers via MDTs meetings. Although MDTs were seen as important by most PCN link workers to identify patients' needs and to increase GPs referrals, their use varied widely across PCNs.

Most PCN link workers (except one) spent **significant time building relationships with GP practices** in order to persuade them to refer patients to them. Various strategies were used primarily quick presentations to GPs as part of surgeries' weekly meetings, posters, leaflets and continuing provision of feedback about clients that had been referred. One link worker also emphasised the need to spread the message to practice managers and admin staff as they were also involved in referrals.

Overall respondents reported that it **takes time to persuade GPs**, it is a slow process, and it needs to be done routinely to keep reminding new and old practice staff about social prescribing. One of the reasons for the need to continuously reminding GP practices was due to the fact that GPs had other priorities:

> *"It's very difficult to find time with them because they will, you know sort of try and put you at the bottom of the list you know because they've got major priorities" (RSP01; PCN link worker)*

Furthermore, link workers felt there was **a wide variation in terms of referral numbers** across GP practices. Despite investment in speaking about social prescribing across many surgeries, some never really engaged, even after one-year continuous effort to engage them. Although most PCN link workers did communicate with their GPs, one PCN link worker reported that despite being in the same GP practice, they did not communicate with their GP at all.

Types of referrals varied across the PCNs and included referrals for welfare issues. One PCN link workers reported that when clients mentioned any issue connected to welfare, GPs and other healthcare professionals would refer clients to them.

One PCN clinical director emphasised the importance to personalise the relationship with the patient/client at the beginning of the GP consultation by, for instance, using first names rather than mentioning the term 'PCN link workers'.

4.1.1.2 The interaction between link workers and clients

In this section we examined how PCN link workers developed their structured support with the client in relation to co-producing a personalised care plan/assessment, setting goals, and exploring options to meet set goals.

PCN link workers would first contact clients with a **telephone call** to introduce themselves and start assessing needs and aspirations, sometimes called 'personalised care plan'. One PCN link worker reported that it was clear from the very first phone call that clients did not know many of the services available in their local area that could support them.

Co-production of the solution: PCN link workers mentioned terms such as motivational interviewing, person-centredness, empathy, listening, use of non-medical language and identification of assets (not just needs) as key principles of their work with clients.

> *"I'm very open with my clients, I will never say erm, 'Okay tell me about your problem.' I would never use the word problem, I would always say erm, 'How may I help? Or do you want to tell me you know your story or what's going on? Or off load, you know I'll listen." (RSP01; PCN link worker)*

> *"You really have to listen erm[…], they haven't had someone to talk to for God knows how long, some of these people.[..] you really have to kind of animate yourself, make them feel important, you know make them feel that you know they're not at a loss, they're an asset to society. A lot of the time these people have been forgotten even by services." (RSP01; PCN link worker)*

Balancing expectations: One PCN link worker talked about the need to find a balance between clients' expectations and what is effectively available (especially free of charge) and the need to be creative to find a solution that satisfied the client.

> *"The provision of services is low, so that, its there where you have to be creative and say, 'What can we do with what we have?' "(RSP03; PCN link worker)*

Alongside this, one of the issues associated with supporting the client was also the risk of 'over-reliance' on the PCN link worker, the need to strike a balance between number of sessions and support offered with the need of the client to self-manage.

Level of support offered varied widely: The length of support offered to clients varied widely across the PCNs. Some were able to offer up to six sessions (one hour each) over a three-month period and accompany clients to different activities or places.

> *"Just say that they don't feel confident to go to a group or you know, a person that has been a couple of times referred and she is still not picking up, you know low in mood, okay I might meet them at the library and have a cup of tea together and check what is around or maybe walk to the person to that temple and find out what is there for them, that sort of thing" (RSP03; PCN link worker)*

On the other hand, some link workers were engaged in **light touch support** (signposting) which involved minimal interaction between link worker and client, practically between 10 minutes to one hour session. This session involved the immediate identification of a suitable activity or service and a follow up conversation post-referral.

> *"You know what they're saying, giving time, so that's a mantra of social prescribing because a GP can only spend 7 to 10 minutes you would spend however much you can manage. Ideally an hour, half an hour, I mean I was told to do only 10-minute consultations, and 15-minute consultations." (RSP01; PCN link worker).*

One link worker mentioned that they were initially told about a 'flexible' amount of time be spent with clients but then once the service was set up, they were instructed to instead do 'signposting' by their clinical director. As one PCN link worker reported:

> "*And it's not just about signposting and referring, initially I was told when I was erm, you know even erm I actually set the service up at that point, my clinical director goes, 'All we want is signposting.' And I go, 'Right okay'." (RSP01; PCN link worker)*

The same PCN link worker highlighted a **gap of vision between signposting and referral** with the PCN manager:

> *That's not really what I had in mind and it's not really gonna work erm, and that's not wanna do. So my service is about advice, information, a bit of case work, yes sometimes about sign posting but more about referral, advocacy but all client led and all co-produced.*" *(RSP01; PCN link worker)*

In line with this comment, other link workers also emphasised that in most cases they needed more than one session as clients would not open up in the first meeting, although they were trying to be as effective as possible to pick up needs and aspirations in the first meeting.

4.1.1.3 Onward referrals to VCSE sector or other statutory sector organisations

PCN link workers referred to a wide range of services including welfare services (e.g. housing). PCN link workers often booked a follow up phone call with clients to assess whether other services had made contact after referral.

One PCN link worker mentioned that their role was also one of challenging services if they did not respond promptly, acting on behalf of their client to access statutory services. In relation to accessing VCSE sector activities, one PCN link worker lamented that overall, there is scarcity of free service provision within the borough:

> *"Here are not free things for everyone you know, for every particular age group, for every particular culture group, for every particular long term condition. We don't have that in Redbridge, the provision of services is low" (RSP03; PCN link worker)*

4.1.2 Experience of providing social prescribing: Link workers' perspective

This section predominantly reports on feedback from the PCN link workers involved in the delivery of social prescribing in the borough. We discovered that there is a wide variation of experiences across PCN link workers with various ways of working including different pathways, referring sources, depths of relationships with service users and other dimensions. The differences between the NHS-described social prescribing model and the current practices that are implemented in the PCNs are discussed below.

One of the most discernible aspects of the link workers experience is the **substantial disparities of role expectations** between the PCNs. For example, a link worker reported being given the task to identify social prescribing users from a list of overweight people from the GP management system whilst others from different PCNs were receiving referrals after being appropriately triaged at the respective GP surgeries. This is perhaps a reflection of a structured guidance or leadership to implement social prescribing in Redbridge.

> *"We're literally, we just get print offs from the GPs of patients that are on the obese list and you might have I don't know, 300 patients and they just say, 'Work your way through them." (RSP02; PCN link worker)*

Furthermore, the link workers have to provide services over a fairly **large geography**. Respondents mentioned that this could vary between five and eight GP surgeries, encompassing up to 82,000 GP patients thus potentially having up to 1,000 social prescribing patients. As a consequence, capacity of link workers can be stretched, leading to the service being less personalised and/or limited. Burnout and feeling of overwhelm are risks too.

> *"I have lowered my expectations as I went, but the referral numbers, the numbers of referrals I'm happy, they keep coming up and I keep working. However, but the new best contract has gone from, last year it was 250, to this year for my network the lower threshold is 636. And they took, and the upper threshold 840. So, I mean…yeah. It's overwhelming." (RSP03; PCN link worker)*

The respondents have also remarked on the **difficulties and pressures of performing their roles**. Link workers reported that they have been made to go beyond the remit of their job and find it difficult to identify the boundary between their role and that of a therapist, for example.

> *"And you know eventually like, I've, you know me just for starters, I've supported people to improve their blood sugar level, their weight, their cholesterol so that's all the dietary stuff to lose weight. To lose people's homelessness and get them in to housing and off the street. To get people jobs, to get people erm, someone's erm, a tumble dryer blew up and I got them a tumble dryer and a washing machine for free. Tables and chairs with their partners who I know, foodbank vouchers like over 20 times to the same family." (RSP01; PCN link worker)*

> *"I was concerned about the safety of someone, and I just go back to the person that refer and discuss, have a discussion around you know about safeguarding maybe. Could be, you know appropriate in this case, maybe not? Maybe I need to go back to the patient, to be honest, you know at the moment fingers crossed, touchwood there's no, there's been no complaints so far so I'm happy. I'm happy but I know that there can be problems where you know a lot of pressure is put into us and we're trying to manage things that are above our remit really." (RSP03; PCN link worker)*

> *"I try not to go too much into it because I have to remind myself that I'm not a therapist, I'm not like going to solve their problems by just talking to them like a therapist would. So would just kind of try*

my best to be kind of like a friend but not go across the boundary of like maybe touching on too much sensitive information." (RSP08; PCN link worker)

Link workers are also facing challenges around the working environment including but not limited to physical space and lack of support.

> "*You get sat upstairs on a chair that's got no filling and I mean last Thursday I sat on the floor in the end, because it was more comfortable, it's ridiculous. There's no consideration for us, really*." (RSP02; PCN link worker)

> "*One PCN link worker was off on mental health leave and when she re-entered the workplace, she was given a case with 50 patients experiencing bereavement*." (RSP05; Redbridge CVS).

Despite facing extreme challenges and supporting a wide range of people with very different levels of vulnerability, link workers reported of receiving **none to limited clinical supervision and support.** The interpretation and understanding of clinical supervision, such as who is it expected from, in what form, and what frequency was unclear. Excerpts below illustrate the current experience:

> *"I had to fight for it it took me over a year, because I was told that if, what was the words? Maybe I'm not resilient enough if I need clinical supervision so maybe the jobs not for me, that's what I was told. And eventually we got clinical supervision by someone called [] she was really good actually. And we was told we could have three months with her. Well then I went off sick with stress, and so then they said we could have another three months but that's finished, so no, no longer." (RSP02; PCN link worker)*

> *"No there's no like supervision from him it's more like I would email him and get permission, or I tell my manager and my manager tells him, other than that its normally we're more in a referrer service level like he would, its normally like I'm talking to him about a patient or the service like, I need to update on something that's happening in the social prescribing service but that's about it." (RSP08; PCN link worker)*

4.1.2.1 Competencies to engage and connect with people

In this section, competencies that necessitated the roles of link workers are discussed. Amongst those most raised by respondents are the skills **to engage and connect** with clients. In establishing a good rapport, link workers cited providing explanation of social prescribing at the start of session and its role and benefits within the wider health service as crucial. This provides better understanding and clarity of the service and enables clients to manage expectations.

> *"So, once I get the referral, I first give them a call just to acknowledge that I got the referral and I explain, I introduce myself, my role and, a little bit about social prescribing because I think it's very good to manage expectations. It's just a normal introduction, isn't it? Everybody will do it. And I explain what the intervention looks like, so it goes along the lines of, you know erm, I received your referral, your doctor believes that you need some sort of advice or support around this topic, and I just wanted to let you know that this is a brief intervention non-medical, non-clinical, I try to give you time to talk about what matters most to you and that in most cases is something different from what the referral says, which is funny, but you know I think that is, you give people the time to speak you really, you can get under the skin of what is happening and what they want help with." (RSP03; PCN link worker)*

"I would start off with kind of introducing myself and that I work for the surgery and who they were referred by so they're not like, 'Who the hell is this?' And then I would kind of say what social prescribing is and what was kind of on their referral form and then I would kind of tell them to elaborate on what's going on and ask them, you know, 'Now that I've explained these criteria to you how do you think you can benefit from social prescribing? Do you think, this is something you're interested in pursuing?' And then they would most likely say yes, I've got some patients that decline." (RSP08; PCN link worker)

"And in terms of communicating, really listening to those clients especially those with mental health. You know it says low level mental health, it's never just low-level mental health, they've been failed by mental health services certainly in this borough and we have to carry the burden of it often." (RSP01; PCN link worker)

Active listening and having open discussion with clients were also key aspects of a good service. Respondents repeatedly raised that clients were generally coming through the social prescribing service with built up frustrations and disappointments with the wider public health and social services. As such, it is essential to enable and allow the clients to feel heard and be understood to progress into the interventions.

However, one PCN link worker raised that time constraint often posed as a challenge to her and many of her colleagues.

"You really do have to convey the message to GPs and your clinical director that no, the whole point of this is supporting the client holistically and the only way that can happen is if you have half an hour to an hour and sometimes even longer. You own your work, it's very much about self-managing and also project management." (RSP01; PCN link worker)

Although a barrier, respondent insisted that time allocated for clients is a factor that can be negotiated and determined by link workers with the management team. It becomes part of an essential skill in managing expectations of not just externally (clients) but also internally.

4.1.2.2 Competencies to enable and support people

Success in **enabling and supporting clients** is also a key milestone for link workers. Ability to truly engage and delve deep down to understand the needs and ways to help clients were highlighted as an expectation of the respondents' roles. To illustrate:

"A lot of the time these people have been forgotten even by services, and you have to remind them they're a human being like anyone else. They're as much as important to them as any other human being." (RSP01; PCN link worker)

"So, what I done was at the time, erm, I was working with someone else, a guy and I said, 'Look I've called this patient, he doesn't want to speak to me because of my name etc.' So I handed it over and my colleague took it and he did link him up with services, and support groups and stuff like that and talking therapies. So that was how we dealt with that, because my surname was as problem." (RSP02; PCN link worker)

"Oooh so many difficult situations because they seem, I know people still erm, expect a medical model so when they see you they expect, their approach is what are you going to do for me? I'm trying to teach them to tap in to their inner assets, in to their strengths and in to their community, so but you know it is more the other way around so challenges are many." (RSP03; PCN link worker)

Creating awareness of the sources of difficulties or challenges of clients and identifying the strengths and abilities within them were amongst the strategies often implemented by the link workers. These contributed to enabling clients to establish independent reflection of and belief in themselves when in need for help to avoid creating any dependency on anyone. This could in return alleviate frustrations and disappointments.

4.1.2.3 Competencies for safe and effective practice

Abilities to **practice safely and effectively** were also highlighted as an important factor in the delivery of social prescribing. This is expected, if not necessary, as link workers continuously face clients from various walks of life with different sets of challenges. As described below:

> *"I had a lady that, she wasn't low level mental health either, she said she was going to kill herself because her children were better off without her. She was given medication for pain, if she took the medication, her child that was 6 I think at the time had to look after the two-year-old and she was just a burden and they'd be better off without her, and she was going to kill herself. So yeah, that was a challenge, so we went back to the GP and said to the GP, 'This patient's suicidal something needs to happen now.' And there response really was a bit, sort of, 'Oh she's always like that.' So erm, but we handed it over and they did see her and that was how it went."*

> *"Erm, this being as well moments where you know I was concerned about the safety of someone, and I just go back to the person that refer and discuss, have a discussion around you know about safeguarding maybe. Could be, you know appropriate in this case, maybe not? Maybe I need to go back to the patient, to be honest, you know at the moment fingers crossed, touchwood there's no, there's been no complaints so far so I'm happy. I'm happy but I know that there can be problems where you know a lot of pressure is put into us and we're trying to manage things that are above our remit really." (RSP03; PCN link worker)*

> *"I would erm, if I'm speaking to them and something's come up that's quite complicated, let's say I don't know where to refer them or maybe I can't help them because it's out of my remit, I would kind of make them aware of that in a direct way, and then just, maybe consult with someone that is important, no that can help me with this, so it literally could be any one, because the PCN is like got a bit of everyone in there." (RSP08; PCN link worker)*

When faced with complex or challenging cases, link workers often reached out to colleagues, other members of their team, GPs, or even Redbridge CVS to consult and assist in supporting clients. This demonstrates their agility and quick thinking in addressing issues for the benefit of clients. With more complexity comes more need for link workers to be supported and able to interact with other parts of the local ecosystem, including multidisciplinary team.

4.1.3 The integration of social prescribing in Redbridge

Following the description of the SP pathway and the role and activities of PCN link workers, this section examines the historical and current role of Redbridge CVS in the implementation of social prescribing, the relationship between PCNs and Redbridge CVS as well as strengths and weaknesses of the current model. The aim is to provide an account of the level of integration of social prescribing in Redbridge as perceived by the stakeholders involved in its implementation.

4.1.3.1 The Role of Redbridge CVS and its relationship with the PCNs

Redbridge CVS has delivered social prescribing across the borough since 2017, particularly targeted to specific groups e.g., socially isolated and lonely, carers. It has also traditionally provided support through a specific and in-depth delivery model which included 'home visits' and – when required – accompaniment of clients to activities in order to facilitate onward referrals. The publication of the NHS Long Term Plan with the recruitment of PCN link workers across England and Redbridge in 2020/2021 led to new opportunities in relation to social prescribing in the borough but also increased complexity, given the established role of Redbridge CVS and the need to consider their role within the new model delivered by PCN link workers.

Respondents from Redbridge CVS mentioned that they see their role as supporting clients with more **complex needs** as referred from each PCN link worker. Redbridge CVS felt that their role is useful in a number of ways: first, to support PCN link workers with their experience; second, help with accessing specific community services (e.g. foodbanks); third, accessing other welfare services due to their close working relationship with the council; and fourth, their ability to provide in-depth support to clients 'hand holding'. Fourth, acting as a bridge between social prescribing and VCSE sector services. This role is important to strengthen working relationships between primary care and the voluntary sector, but also crucially for CVS to act as a 'single point of access' form PCN link workers to other voluntary sector organisations. This single point of access is important as some voluntary sector organisations providers would find it extremely difficult to have enough capacity to deal directly with queries from 12 PCN link workers. It is important to note that many VCSE organisations in the borough provide important services but are small and sometimes informal, with limited capacity. In such cases, CVS provides a filter that is necessary in order to protect such organisations.

As an example:

> *"And I think it's been an opportunity for them to talk to people who have been in the job, who have been doing social prescribing for quite some time. Redbridge CVS have been running a social prescribing service long before that system came into place, so I think it gave them, I know a couple of them have said they found it really useful the training they received from the service manager about what social prescribing is, because I think they came in to the job not really, not really knowing what social prescribing was. You know having somebody tell you in theory is very different to building up that practice of carrying out the job itself. So I know they found that quite erm, quite useful and I know that our coordinator she has spent a lot of time building up links with the, with the link workers themselves and she's always said to them, 'Look I'm here if you need to come to us.'" (RSP32; CVS)*

CVS respondents reported that referral levels from PCNs to CVS varied substantially by area. More than 50% of CVS referrals came from one of the five PCN, but other areas were referring much less. It was also pointed out that recently referrals have become extremely complex (e.g. refugees, homeless people) particularly around housing issues which cannot be easily addressed as they are rooted in more structural issues of housing shortages across Redbridge and beyond. This situation leads Redbridge CVS to slow down the rate of referrals they receive as they cannot cope with the complexity of those that they receive.

> *"So, some of our limitations can come from, the type of work that we're getting, referrals that we're getting sent through, because the referrals are so complex now. The complexity has grown massively you know, I was sonly just speaking to one of my team and I was saying to them, 'I need to give you some more referrals.' And she said, 'My referrals are so complex at the moment, that I cannot say to you at the moment give me more referrals because of the complexity of the work that they're doing.' So as long as they're trying to meet their goal and make sure the clients are getting what they need, you know we're getting a lot of refugees, a lot of people with housing issues, and there aren't the organisations out there, you know we can sign post, but we can't actually do anything about housing. So that's what stops us from meeting their need sometimes." (RSP29; CVS)*

PCN link workers and managers revealed a **wide range of opinions about the role of CVS**. The majority of PCNs **recognised the importance** of Redbridge CVS, particularly in relation to their ability to support **'complex'** cases. One respondent highlighted that Redbridge CVS is involved in supporting the most 'complex' cases not just in terms of their vulnerability but also in terms of facilitating access to specific services, in particular council services which CVS had a greater historical connection with.

Two PCN link workers were very positive about the role of Redbridge CVS:

"The CVS has really taught us everything we know, because the PCN didn't have any knowledge. Erm, and they, I mean the, Redbridge CVS have supported me and educated me on how I now support the care coordinators and how I deliver support [..] They know what's acceptable, what works, what doesn't. They've trialled it well before us, erm, I think that that would benefit." (RSP02; PCN link worker)

> *"They used to find these unknown services that were actually really good and like bring them and then they would talk to us and, so that was helpful." (RSP08; PCN link worker).*

Reasons for referral to Redbridge CVS varied. Some PCNs link worker would refer on the basis of perceived **number of sessions** needed to support a specific client.

> *"So, for us, the other aspect is to drive an effective service, [?] complex and requires a bit more hand holding than what we can initially provide." (RSP23; PCN manager)*

Other PCN link workers based their decision on **type of activity** or whether clients live on the border to another borough and want to be supported to access services in surrounding areas outside Redbridge. In these cases, the link worker would refer to CVS as they were seen as having additional capacity and knowledge of community services.

Another PCN link worker decided referrals to CVS on the basis of their own **current workload**. If they were not able to manage, they would refer elderly people who needed a more intensive contact than other groups as they were victims of digital exclusion. Other PCN link worker would refer to CVS if clients did not have an urgent need. For example, if they needed to find a cookery class:

> *"So say someone wants a cookery class, now I haven't got a team, and I haven't got those classes but they [CVS] have the capacity and the team to find out which community groups do do cookery classes, I can't look microscopically in depth." (RSP01; PCN link worker)*

With one exception, other respondents including PCN link workers and managers argued that CVS has more capacity. Two PCN link workers also felt that CVS provides a different service from what they can provide, particularly if they feel that clients would benefit from a longer intervention (about 12 weeks) which CVS is well positioned to deliver.

Most PCN link workers agreed that Redbridge CVS has **considerable experience** of delivering social prescribing. However, one PCN manager found that, over time, PCN link workers will acquire sufficient knowledge and contacts to be able to deal with all clients including those who are more 'complex' cases. In such situation, the respondent felt that a future role for Redbridge CVS will not be guaranteed:

> *"I'm thinking probably long term, our girl will be as experienced as what they've [CVS] got because she's quite keen and quite actively goes out looking for resources and support and things like that. She doesn't sit and wait for work to be given to her, she will go out and look for it. Erm, so, I think erm, yeah…I think I don't know, in the future, if there's going to be a place for both [PCN and CVS]." (RSP25; PCN manager).*

CVS was also funded by HealthBridge (GP Federation) to support PCNs with their induction of link workers, some specific training provision, and the hosting of regular monthly meetings. PCN link workers found this training useful in the early stages but later could not attend as they were too busy.

Moreover, PCN link workers, managers and one clinical director also provided some **negative feedback about the work of Redbridge CVS**, particularly in relation to the time it would take to healthcare professionals in the GP practice and/or PCN link workers to refer clients to Redbridge CVS and the level of rejections due to the unsuitability of some clients.

One PCN link worker pointed out that referrals to Redbridge CVS would take a **'lot of input'** (RSP02; PCN link worker) which created a problem due to time pressure on PCN referrals. So, for instance, if they referred directly to a bereavement service and that run appropriately, they would then refer directly to this service from then on, without consulting Redbridge CVS.

Another area became more confident at supporting complex cases, so decided to support these directly.

> *"And just see, kind of go through the patients myself and then because I was becoming more and more experienced at it, I was like alright by myself and so I kind of just forgot to refer to CVS, like it wasn't in my head anymore to refer to CVS." (RSP08; PCN link worker)*

One clinical director highlighted that CVS would **regularly reject clients** referred as they do not meet their inclusion criteria.

> *So you would refer in, 'Oh this does not meet our criteria reject.' 'This does not meet our criteria reject.' (RSP16; PCN clinical director)*

Some respondents stressed that Redbridge CVS is **not recognised as equal partner** by primary care. Some healthcare professionals working in Primary Care Networks do not understand the role of the VCSE sector and Redbridge CVS within that and how this could be of benefit to residents with complex needs.

On the other hand, Redbridge **CVS was also seen as protective of their own communities**. One of the issues highlighted is that PCN link workers have benefitted from accessing GP practice management systems as they can check the background of each client prior to talking to them and thus provide a more effective service.

4.1.3.2 Strengths and weaknesses of the current social prescribing model in Redbridge

Respondents explored a wide range of strengths and weaknesses in relation to the current social prescribing system in Redbridge. This section deals with these strengths and weaknesses in relation to the model. Other aspects related to the experience of link workers is examined in sec. 4.1.2.

One of the most important **strengths of SP** was '**knowledge sharing**' about clients in a networked ecosystem.

The presence of PCN link workers has enabled better connection between different types of expertise in primary care (e.g. mental health nurse, pharmacists) and other services such as Citizen's Advice or the drug and alcohol teams. PCN meetings facilitate the coming together of different roles and PCN link workers are more integrated as a result. Multi-disciplinary teams (MDTs), PCN link workers, Redbridge CVS and the VCSE sector together to benefit residents of the borough. MDTs were particularly seen by most respondents as an important part of delivering social prescribing as bring together different skills. Within MDTs, the status of social prescribing has developed over time from a slow start to a growing acceptance, at least according to one PCN link worker.

However, a 'blended' and networked system is apparent in some PCNs. One PCN manager highlighted that alongside MDTs, healthcare workers and link workers cross-refer people. This happens primarily because link workers are available to do that work.

> *"And then there's individuals who are coming in with issues around mental health. Social prescribers are not mental health therapists [..] they will then refer out to the mental health professionals, 'I have this patient, and they've got this need, what do you advice?' Is the first question and its fantastic because we've got that cross way, so yes we do a multi-disciplinary team and the way we do it is rather than stack a case up and discuss it, if it's a hot topic deal with it there and then with the individual, and then move it along much faster rather than going [through the MDT]." (RSP21; PCN manager)*

> *"So it's very like blended, and the mental health practitioner calls me and we have like MDTs together about a patient. He's going to help with the mental health side, I'm going to help with the social side. So its become yeah, its become quite effectively er, blend- I would say the patient is receiving the most because we do try our best to try and hit all parts of what's going on and with the help of the other MDT colleagues." (RSP08; PCN link worker)*

Knowledge sharing within the **'networked' ecosystem** also included Redbridge CVS which was seen as providing mentorship, general support particularly with complex cases and become aware of additional services across the borough through regular meetings. Some PCN link workers also emphasised the added value of CVS in building capacity within the system and help with the most difficult cases (see sec. 4.1.3.1 for more details). Reflecting on the experience with CVS, one representative from the CCG highlighted that

> *"the CVS service has been a great service and has shown real collaboration across the Borough. So no I wouldn't necessarily change it, I think, it definitely brought social prescribing to the forefront of the PCNs minds when they were in the, establishing themselves and yeah. So no I wouldn't necessarily change anything now" (RSP27; CCG)*

More generally, social prescribing was also seen as **adding capacity to the prior care pathway**. One clinical director stressed that the presence of social prescribing enables them to be much more effective particularly in relation to social issues clients may experience including benefits and housing:

> *"And when you're trying to sort out somebody's benefits etc, and it's not being sorted you know and then suddenly your social prescriber manages to, not just sort out their housing needs, but their benefits, their appointments for the hospital, their transport systems etc, you know that's a, the amount of time that it frees up it's just amazing" (RSP16; clinical director)*

Despite the significant strengths, the current social prescribing model also suffers from several weaknesses. One of the most reported weaknesses by most respondents was that the **quality of support delivery could not be met** at the current level of provision. PCN link workers felt that caseload targets were very challenging.

> *"I mean this, it's just humongous, the increase has been so so high that I'm not really sure how we're gonna get there" (RSP03; PCN link worker).*

> *"I think they're really looking at a quantity over quality erm, they're really looking at numbers which is so disheartening [..] I probably follow up two patients a month. The rest are just new, you do what they got and they're off and it's the next lot. [..] "That's when we gave our patients time we don't have time to give these patients anymore, all that you know, it's a, 'What matters to me approach, giving patients time.' That doesn't happen anymore" (RSP02; PCN link worker)*

These views were echoed by one PCN manager who summarised the challenge with social prescribing very succinctly and is worth quoting its entirety:

> *"I [PCN link worker] can't do my job the way I've been trained to do it.' 'Why's that?' Well if you expect me to deal with a person in 20 minutes my experience is you can talk with a person up to an hour, hour and a half and still not know what the issue is. Why? First of all you are dealing with people and their own personal information, right so that's number one. People hold their personal information dear. So as far as I can see, they do not let go of their personal information willy nilly unless they feel they're in a safe space. You cannot safe space an individual and form a relationship in X amount of minutes. Doesn't happen. What you do is, you will get something which maybe, a small piece of information that then you can link in to and send them off on that piece of information. And then what you do, you'll get what I call the revolving door. You've not actually heard the story to understand what the issues, and the real problems are in order to get them sign posted to the right places" (RSP21; PCN manager)*

The lack of capacity in PCN link workers had various implications: First, one of the implications of the current level of service was that, according to Redbridge CVS staff, this leads to a **high turnover** of staff within the PCNs.

> *"Turnover of LWs is huge. PCN link workers are moving to another job very frequently. It is matter of caseload and the fact that they cannot look after the patients. It is too driven by numbers" (RSP05; Redbridge CVS)*

Second, **lack of time available to support clients** translated into lack of follow up contacts which led to the 'revolving door' issue mentioned a PCN manager above.

> *"And how do you know that the patient has engaged with the service that you've referred them to? You don't because we're not following up. What if that service wasn't suitable and didn't meet their needs? Then we would find an alternative service if we was doing social prescribing" (RP02; PCN link worker)*

In at least one PCN, the problem was not just lack of PCN link worker capacity but also the **demand to deliver on other GP practices priorities** which may be partly related to the lack of knowledge of SP and PCN link worker roles. One PCN link worker highlighted that their time was taken up by completing cancer care reviews which resulted in QOF for the GP practice concerned.

> *"We're just, it's like the cancer care reviews, I've got to phone the patients even if they don't want social prescribing. I do the QOF for the cancer care review and the provision of information given and, that doesn't go towards my numbers because they don't want any support services. However, we're just doing their QOF. Surely that's not for us to do" (RP02; PCN link worker)*

The lack of knowledge of SP was emphasised by two PCN managers who suggested that some clinical staff were **not clear about the role of link workers** and did not value them.

> *"you know somebody will go, 'Well what does she [i.e. link worker] do again?' And its that that I think if you don't value those roles then they're gonna disappear" (RSP25; PCN manager)*

Most respondents agreed that the current service is disjointed and lacks clarity. Some respondents talked about lack of leadership and others talked about the lack of recognition of current leadership (i.e. Redbridge CVS coordinator).

There is also an issue of **data collection and analysis across PCNs and CVS**. Whilst social prescribing data from Redbridge CVS is available and analysed regularly, social prescribing data from other PCNs is not available for discussion at the wider social prescribing board level.

Commenting on the challenges, one respondents pointed out the **social determinants of health and associated health inequalities** which affect the development of social prescribing in the borough.

> *"I've never seen as many that I've seen in the last two years where you know, you're having family breakdown, you're having loss of income, either through loss of benefits or loss of jobs and now with inflation kicking off you've got all of that. So there's a real risk that this, you know is that you know, 'the social prescribers they can deal with it all.' And unfortunately they can't and that's what needs to be fed back to the politicians and the ICS's and the teaching systems" (RSP16; clinical director)*

4.1.4 The future of social prescribing in Redbridge

Following challenges to the existing model of social prescribing, this section examines respondents' suggestions for the future of social prescribing in the borough. This theme refers to proposed actions, processes, or concepts – intended predominantly for the NHS and/or council – to increase the quality of existing social prescribing, care, and support.

Respondents identified the need for recognised **leadership across the PCN and Redbridge CVS social prescribing teams** as one of the key areas for improvement. The present model of social prescribing in Redbridge was seen as lacking direction and cohesiveness due to the absence of a 'recognised' leader. This is aptly described below:

> *"I think a manager, yeah I think it's not erm, I don't think it has to be a clinical person, in fact one of the link workers is quite vocal in, one of the PCN link workers, always says it's not what, clinical isn't what we need, what we need is somebody who is endorsed by the PCNs to be our, you know be that conduit that says, 'Okay is everyone getting supervision, I meet with you once a month as your kind of like you know CPD objective setting but I also advocate for you in your PCNs that,….are you getting your supervision regularly? Are you talking about case management?' I am also, that person then is also the link to us, because I'm always looking at pan North East London representation and the biggest gap sits in Redbridge." (RSP04; CCG)*

> *"So there's some really great relationships that have been developed. I did say all along I think we need like a social prescribing lead because I don't think we're led by anyone or supported." (RSP02; PCN link worker)*

> *"I think that's what I was looking forward to happening, erm, and I think, but then I feel like it's going away from that now it's kind of like becoming more and more separate and the part of the social prescribing board and the social prescribing board will obviously see everyone together, Redbridge, Redbridge. But it's not like that in our own real life we don't like have that connection with them, like they know what's going on and you know we're getting advice from them anymore, it's kind of like, become a bit separate so yeah I wish for us to become like just like together and benefit from like, [Shahida] does and lead, something like that would be nice." (RSP08; PCN link worker)*

However, as explained by a respondent from Redbridge council, a lead exists but with low level of awareness borough wide. The role of a lead is also currently limited to being the point of contact, whereas the need for leadership transcends this. Requests for accountability, supervision, and clear direction of the service were amongst the main expectations of a leader.

"I mean the model that we have at the moment is [Shahida] who is actually the lead. If the lead for anyone, some single point of contact for health, for anyone else, because I think people, and local authority because she is the one we have delegated to be the link point of contact as a social prescribing link whether it's for north east London, London wide, Borough, or the PCN link workers. I think it took a bit of time for people to realise that." (RSP28; Redbridge council)

The importance of leadership was closely followed by respondents' suggestion for a **standard operating procedure and accountability guide**. Respondents stressed the need to have a coherent and systematic referral pathway and access to lists and contacts for activities and services delivered by the VCSE and/or statutory sector across the borough. These two aspects are extremely important to ensure the service provided meets the needs of the population as well as giving quality experience to the service providers.

"You know, and that's what I'm saying for new people that join now when I look back now, and I see everything I've done it's like, I wish if I leave and somebody comes in everything I've done was somewhere, so that that person knew I need to do this training, these are the services, these are the contacts, you know there is not such a thing for anyone. You know so I think we need to avoid, I think the resources need to be utilised to the fullest. Same goes with funding you know, if we all utilise the resources to the fullest then there won't be that, everybody that comes onboard needs to re-invent the bloomin' wheel again and create something new, it's just such a waste of time and resources, money everything." (RSP03; PCN link worker)

"So, for me I would want a consistency of protocol and process and how, what the expectations are. And because it saves a hell of a lot of misunderstanding space and then you can work in a much more structured framework." (RSP21; PCN manager)

"We can go and link in together and having more knowledge and more depth to a service, rather than just being something that is the, very standard, a bit more bespoke to what we need it to be to meet the demands of the patient and to meet the demands of also the network as well" (RSP23; PCN manager)

"Yes, I suppose I'd like to see, we've talked a lot about a pathway, but a clear and consistent pathway so all residents in Redbridge get the same sort of service. I'd like to be able to see residents and patients are clear of how they access the service." (RSP27; CCG)

Respondents also raised important points about **mapping the gaps across PCNs and identifying Redbridge CVS's role in addressing them**. This is complementary to the desires for leadership and coherency between the social prescribing service providers.

"I think the other aspect would be, what is available that we do not have, as, that we cannot provide, just generally provide, and Redbridge CVS might have that in their services. That's the other element about, it's that amalgamation of service, I guess." (RSP23; PCN manager)

One PCN manager went further by suggesting that the experience of Redbridge CVS staff should be utilised to supervise PCN link workers on a consultancy basis rather than building a referral pathway to Redbridge CVS for more complex cases:

"As far as I'm concerned what we should have been doing is looking at the CVS model and saying, 'Right you've got some key experienced people, er, can we buy some of that key experiences person time to actually supervise all of our people? And can we get them to come in and help them with setting up their processes and their maps?' Yeah. So for me it's like a consultancy basis to try and get these things off the ground and consistent yeah?" (RSP21; PCN manager)

Ultimately, these suggestions of joint efforts and coherency between the PCNs and Redbridge CVS supported an underlying aspiration for expanded service of social prescribing in the borough.

"So actually, you want more capacity, you want to see more growth, more expansion, if people are hiding in plain sight, if there is like needs that you hadn't realised were coming up, they're not, I mean in my heart they're not competition, because you know, together the whole is greater than some of the parts." (RSP04; CCG)

"So, I would still invest in because it adds value to a person's health and wellbeing, it integrates into a, social policies that we spoke about earlier that are being neglected in one form or another, I would invest in it. I would invest and I'm keen to get more social prescribers because our team that we've got is amazing." (RSP16; clinical director)

4.1.5 The wider policy context of social prescribing in East London (MB)

This section focuses on how social prescribing in Redbridge fits into the wider policy context of East London including the introduction and development of Integrated Care Systems (ICS), and within this the Integrated Care Board (ICBs) and Integrated Care Partnerships (ICPs) which will substitute the CCGs once they are legally established from July 2022. North East London Health & Care Partnership (ICS) covers a population of about 2 million residents across eight local authorities (Redbridge, Barking and Dagenham, Havering, Waltham Forest, Newham, Tower Hamlets, and City and Hackney).

When asked about how social prescribing will fit into the new ICS structures, most respondents felt that it would be difficult to predict. One respondent alluded to the fact that social prescribing may become more centralised but stressed the need to maintain a service that is delivered by people who live in the borough and are geographically and emotionally close to the final user, reflecting the socio-demographic and ethnic profile of each location.

As ICS will be more integrated, social prescribing may receive referrals from different parts of healthcare system (e.g. physios). A respondent from Redbridge CVS thought that this would be a positive development for social prescribing

One respondent highlighted that there will be work at ICS level in relation to workforce to determine workforce needs and training for that, including for instance, leadership training. This will also include social prescribing training. In addition, a dashboard is being created which will provide information about prevalence in relation to social prescribing at the GP practice level.

Another respondent felt that the lack of capacity to deliver high quality social prescribing within the PCNs should be highlighted at the higher ICS level where synergies may be found to tackle the lack of capacity.

One respondent felt worried about the development of the ICS as this would effectively include strategic health authorities with the delivery of social policies from the council. The respondent felt that this would lead to chaos as there are too many agendas to take into account.

"I call the ICS the strategic health authority but it's not just a strategic health authority it's also social policies and so you know you've got a whole load of other people. Counsellors and so many other people sitting around the tables and their agenda's and their knowledge base is completely different." (RSP16; Clinical director)

"So ICS structures well I can guarantee to you that will change again within five years because that's

how health works. Now, that timeframe doesn't work in patients' health or children health you know." (RSP16; Clinical director)

Another respondent underlined that the ICS level would be a good place to share learning from each locality and perhaps tackle barriers for people accessing services and activities across boroughs.

4.2 Results from the investigation of Social prescribing for Young People and families

For this report we reviewed case studies of social prescribing for young people and interviewed one scheme providing social prescribing support centred upon the family.

Redbridge CVS and Young Advisors have already carried out co-design work with young people (aged between 15-24) to define the details of how a social prescribing for young people would look like in the borough. This is an important piece work which recognised the input of young people in co-designing where the services should take place, who should help YP and what form the support should take.

Through our contact in the Social Prescribing Youth Network (Bertotti is one of the founders of the network), we sought similar schemes across the UK but could not find schemes that offered the same variety of roles for young people. Thus, we set out to review the co-design document and compare that with current evidence on social prescribing for young people so to be able to make some recommendations about the ideas put forward by Redbridge CVS and Young Advisors.

4.2.1 Review of the Youth Mental health social prescribing model

We followed the structure of the Youth Mental health social prescribing model (YMHSP) to provide an assessment based on previous limited evidence of social prescribing and young people models we have evaluated in the past.

4.2.1.1 Target group and eligibility criteria

YMHSP targets all 14 to 24 year-olds with no eligibility criteria. It is not a crisis service so those with higher needs will be referred to NHS mental health services if they haven't already accessed them. Other social prescribing schemes for YP evaluated are consistent with this view. In relation to level of mental health need, other schemes (e.g. Sheffield) supported young people who had been referred to CAMHS and waiting to be seen.

4.2.1.2 Referral pathways

As part of the YMHSP, young people can self-refer, and referrals can also come from their friends and family. Referral pathways should also be set up with a range of entities and local professionals (e.g. schools, community groups) not just GPs. The referral process is designed to be as easy as possible and will enable professionals to refer by email.

This is consistent with other evidence about social prescribing young people. Evidence has shown that many young people do not go to their GPs if they experience any issues but they may alert the schools, siblings, parent or friends. As a result, the choice of using different referral routes is backed up by other evidence.

4.2.1.3 Outreach

Various channels have been suggested to promote the service. It may be useful to create a group of young people meeting regularly who could advice on the design of promotional material, promotional channels etc. A consultation with 647 people involved in social prescribing suggested that the following organisations could be approached to promote SP for YOUNG PEOPLE: 'parents and carers', 'Youth Justice', 'Further and Higher Education'.

4.2.1.4 Venues

Community venues such as libraries, community hubs, cafes and parks will be specifically targeted. These are preferred to schools. However, it is important to consider that the office for national statistics published data claiming that the first port of call for a lot of young people is the school and teachers are not adequately trained to support children. As a result, SP for young people should consider involving schools but perhaps offer young people in school sessions outside the school in a neutral space so to prevent potential issues of stigma on school premises.

4.2.1.5 Social prescribing staff and volunteer roles

The YMHSP included a variety of roles in the model including community networkers, peer linkers and peer champions. We searched across the social prescribing youth network which counts over 500 members but could not find a similar model which involved the collaboration between expert link workers (community networkers) and peer linkers/peer champions. As one of the key issues in supporting young people is to identify them in the first place, the involvement of peer linkers and peer champions who can be involved in outreach activities and word of mouth recruitment appears to be a good idea as community networkers provide training and regular supervision.

4.2.2 Social prescribing for families

We also conducted an interview with one family and young people social prescribing in Hackney and presented the results below in a case study form.

The local PCN in Hackney identified a gap in families with young people in primary school, but because of the background of the link worker in social work and young people, the service became tailored to both young people and their families. This is a small service delivered by one PCN link worker who advertises the service in primary schools and VCSE sector organisations in the knowledge that not all parents go to visit their GP so the service needs to be more flexible. Yet because of the link with the PCN, most referrals still came through the GP practice.

What were the main reasons for referral?
Families had various reasons for seeking support including depression, anxiety with some children self-harming. Housing was also particularly important reason particularly the former as many families experienced problems with overcrowding. Financial difficulties were another important reason as all families were on low income. Some reasons for referral included children weight management issues.

How many sessions and how were these delivered?
Parents would receive on average 12 sessions. We felt from the beginning that the work with families should be longer than the adult ones, because the parents come, they talk through their issues and by the time the relationship is built with them and support is offered to the parents, it is time to start thinking about the specific needs their children may present with.

What kind of services were families and young people referred to?
One of the important aspects of supporting families is to gain their trust first of all as parents are worried that they may be referred to social services if they reveal too many details about their circumstances. So it is key to build trust with the parents as a starting point. One way of building that trust is to provide financial support whenever possible as a first step. Once the trust had been established, link workers were sometimes able to persuade families that approaching social services would be the right course of action.

We would be able to refer to family support telephone line or the link worker knew of good family support organisations inside or even outside the borough. There are also counselling and psychotherapy services for children between 13 and 25 years old, but waiting lists are long, between three to eight months in some cases. However, if the case is really urgent young people can access a drop-in centre but then they may have to wait a long time for further treatment.

What did you learn from delivering the service in Hackney?
The service needs to be delivered outside GP practices, in community spaces and home visits should be considered but that requires more capacity for link workers. Many families and young people do not like to meet in a clinical environment.

Some families requested further support beyond what we normally provide (6 or 12 sessions), so we organised a parent's support group that runs once a week. We are currently testing that.

4.3 Results from Redbridge CVS data analysis

We analysed baseline and six months follow up data from 182 social prescribing clients (Nov 2019-May 2022) but for 96 clients we only had either baseline or follow up data but not both. Where possible, we analysed the entire clients' sample on their socio-demographic profile, general health, personal wellbeing (ONS4), mental wellbeing (SWEMWBS), social capital (social capital harmonized questionnaire set) and health service use (GP visits, A&E attendance and in-patient stays).

4.3.1 Descriptive analyses of participant characteristics

There are no major differences between the age profile of baseline and follow-up samples used for data collection (Table 1). However, there are some differences between the sample of respondents and the population of Redbridge. The proportion of those over 65 is considerably higher in both baseline and follow up sample databases than it is on the overall population of Redbridge (27% versus 12%). This is to be expected as, over the period of data collection, Redbridge CVS targeted socially isolated and lonely groups which are more likely to be older.

As it is for the vast majority of social prescribing schemes, the proportion of participants is predominantly female (58% versus 50%) and is higher than Redbridge as a whole indicating and over-representation of women in social prescribing. On the other hand, the proportion of male participants is substantially lower than that of the population of Redbridge (28% over 49.2%), indicating and under-representation.

White and Asian representation is lower than that of the Redbridge population for both the baseline and follow-up samples, whereas black representation is slightly higher.

Around 30% of the service users live alone, while around the same percentage live with spouses or partners. Interestingly, the proportion in the sample is similar to Redbridge (29.7%), although last available data is from Census 2011. In line with the slightly older age group, a large number of participants had retired from paid

work (around 29% versus 9.5% for Redbridge). Interestingly, the proportion of people 'unable to work due to long term sickness' is not too different from Redbridge as a whole (20% versus 24.2%).

Table 1: Participant characteristics at baseline and follow-up

Profile	Baseline		Follow up		Redbridge
	n	%	n	%	%
Age groups (years)					
18-24	4	1%	1	1%	
25-34	20	7%	5	6%	65[1]
35-44	28	10%	8	9%	
45-54	30	11%	14	16%	
55-64	36	13%	12	14%	
65-74	21	8%	6	7%	12[1]
75-84	29	11%	11	13%	
>=85	19	7%	8	9%	
Missing Data	80	30%	21	24%	
Gender					
Male	75	28%	29	34%	49.2[2]
Female	156	58%	51	59%	50.8[2]
Other	1	0%	1	1%	#
Missing Data	35	13%	5	6%	
Ethnicity					
White British	72	27%	24	28%	42.5%[1]
White other	9	3%	7	8%	
Mixed	7	3%	1	1%	4.1%[1]
Black or Black British	29	11%	9	10%	8.90%[1]
Asian or Asian British	102	38%	36	42%	41.8%[1]
Other	12	4%	4	5%	1.5%[1]
Missing Data	36	13%	5	6%	
Employment		0%			
Full Time	20	7%	8	9%	64.9[4]
Part Time	14	5%	5	6%	33,8[4]
Self-employed	6	2%	3	3%	9.4[3]
Unemployed and Looking for job	22	8%	12	14%	7.5[3]

At school or Full-time education	3	1%	1	1%	32.2[3]
Unable to work due to illness	53	20%	18	21%	24.2[3]
Looking after house/family	22	8%	7	8%	24.8[3]
Retired from paid work	77	29%	23	27%	9.5[3]
Other	21	8%	8	9%	#
Missing Data	29	11%	1	1%	
Living Arrangements					
Alone	80	30%	30	35%	29.7[1]
With spouse, partner	71	27%	29	34%	54.3[1]
With housemate	8	3%	5	6%	22.8[1] (*)
Secure housing	16	6%	4	5%	11.1[1] (**)
Temporary accommodation	6	2%	1	1%	
Rough sleeping	0	0%	0	0%	1.2[1] (***)
Other	53	20%	15	17%	#
Missing Data	33	12%	2	2%	

[1]2011 Census [2] ONS Population Estimates [3] ONS Annual Population Survey [4] ONS Business Register and Employment Survey (*) Represents residents that are under private tenancy (**) Represents residents that are under social tenancy (***) Represents residents who live rent-free, with or without a home (#) Represents cases in which there wasn't enough data or the sample was not representative enough.

4.3.2 Statistical analysis of changes in health outcomes over time

This section provides a summary of statistical tests on health outcomes regarding personal well-being. The following sections will analyse each of these outcomes in more detail. Table 2 examines whether there is a statistically significant difference of a range of health outcomes between baseline and follow-up. Unless otherwise stated, tests performed here are paired sample t-tests which compare the means at baseline and follow-up and statistical significance is indicated as a p-value in bold.

The first three measures of the ONS4 life satisfaction, worthwhile and happiness are scored from negative (0=not at all) to positive (10=completely). However, anxiety is reverse scored from positive (0=not at all anxious) to negative (10=completely anxious). The reverse code may have been mis-interpreted by most respondents and led to the negative response below (Table 2).

The rest of the ONS4 results are statistically significant. Whilst satisfaction with life, worthwhile and happiness have improved over the 6 months period, anxiety has deteriorated albeit the result is not statistically significant.

Table 2: Statistical analysis of health outcomes between baseline and follow-up

Effect of SP						
Measure	N	Mean Diff	CI (95%)		P-Value (*)	
			Lower	Upper	One-sided	Two-sided
Satisfied with life	207	0.805	0.47	1.14	**0.001**	**0.001**
Things in life worthwhile	206	0.774	0.42	1.13	**0.001**	**0.001**
Happiness	204	0.687	0.34	1.03	**0.001**	**0.001**
Anxiety	201	-0.087 (**)	0.67	-0.09	0.334	0.669

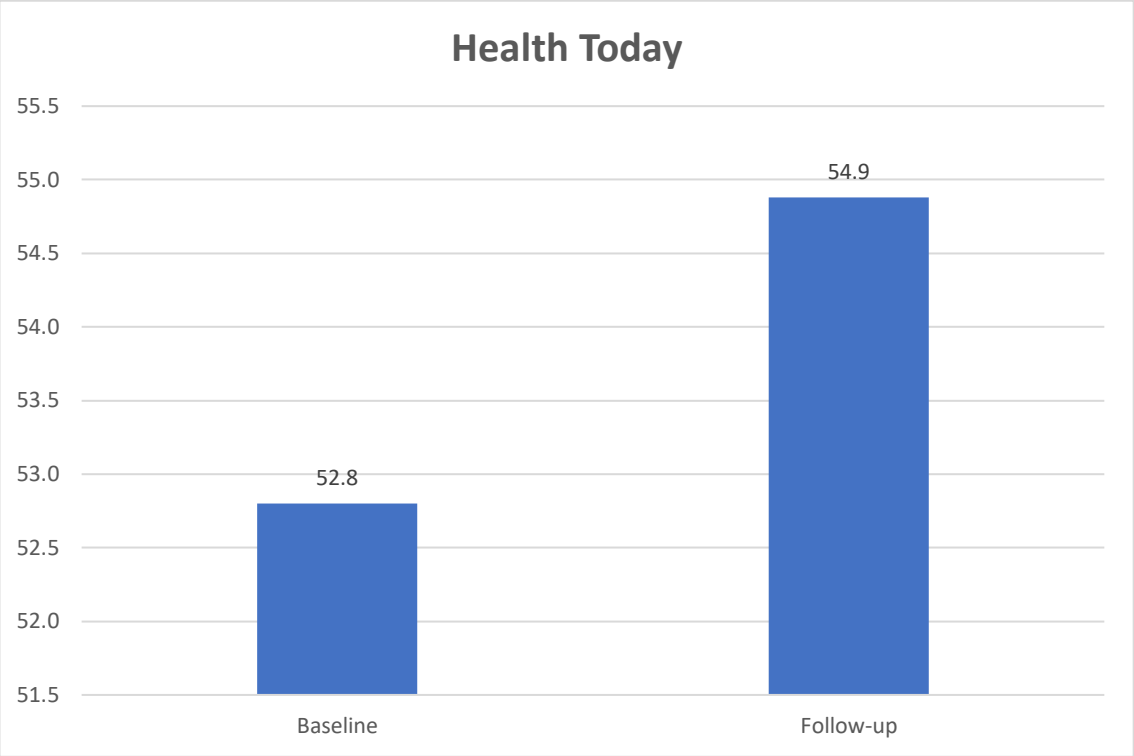
(*) Significant p values in **bold**, p <= 0.05; (**) this is to be interpreted as a negative change in anxiety (but see sec.4.3.4, for more details)

4.3.3 General Health

Respondents were also asked to rate their own health on the day they completed the questionnaire, using a tool called EQ VAS (Visual Analog Scale) which rates health between 0 (worst possible) and 100 (best possible). EQ VAS shows respondent's own assessment of their health rather than responses to a set of questions.

As shown in Table 3, analysis showed positive change in respondent's own rate of health between baseline and follow up. This change is corroborated by the mean change from 52.8 to 54.9. in

Figure 1: changes in health from respondents' own views



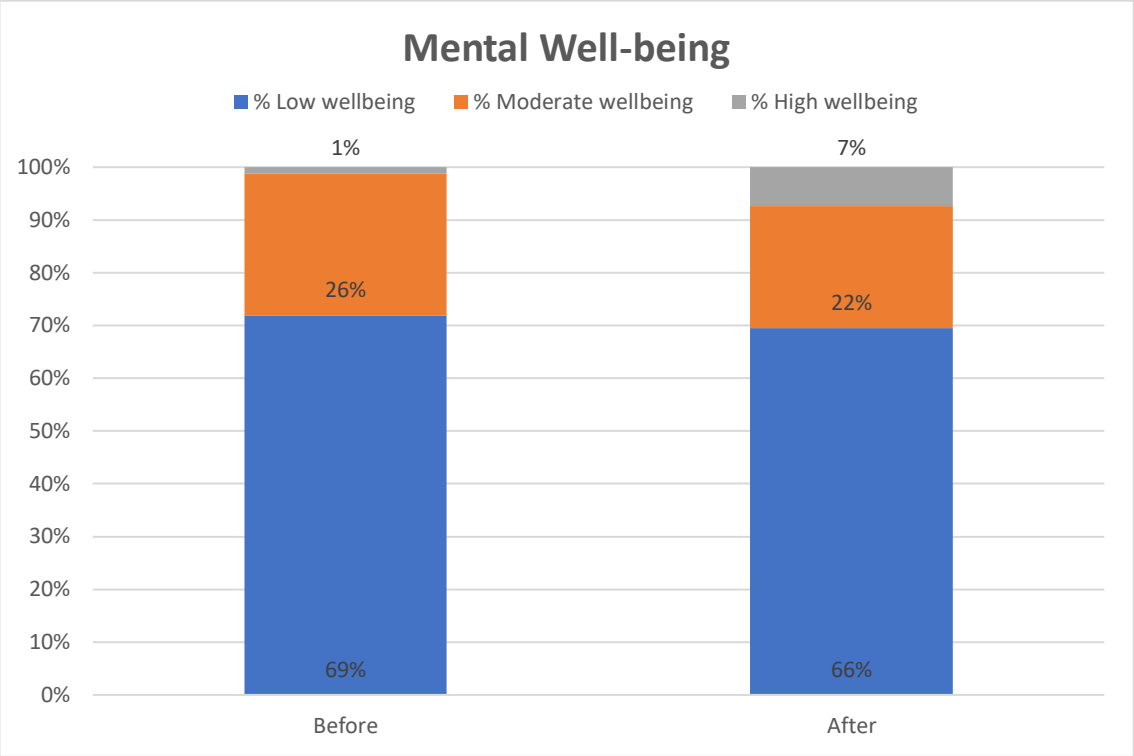
4.3.4 Mental wellbeing

Mental well-being was measured using the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) which is a validated scale of 7 items used for the measurement of mental wellbeing of any population aged 13 to 74. It comprises seven positively worded statements and participants are asked to rank on a Likert Scale (from 'None of the time' to 'All of the time') each mental wellbeing statement in the previous two weeks. Mental wellbeing refers here to positive states of being, thinking, behaving and feeling and is a good indicator of how people and populations are able to function and thrive (Putz et al 2012).

At baseline, the mean from the Redbridge sample was 17.7. This is considerably lower than the Health Survey for England (2016) which produced a mean of 23.6 from a nationally representative sample of 7,196 people. However, it is slightly higher than the last evaluation of social prescribing in Redbridge (Bertotti et al., 2020) which showed a mean value of 16.8.

Mental well-being was not statistically significant. However, there was an overall improvement in mental wellbeing across different groups (low, moderate, and high) as shown in Figure 2.

Figure 2: changes in mental well-being

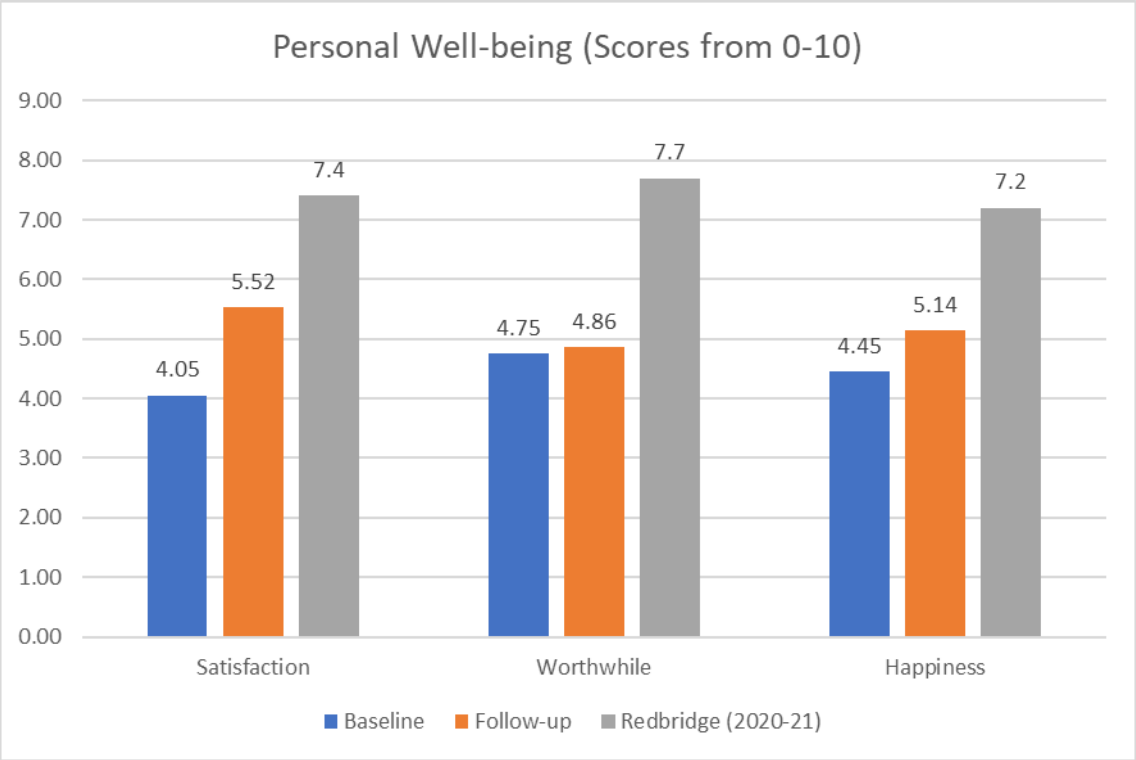


4.3.5 Personal well-being

Personal well-being is a validated and widely use of personal well-being used routinely by the Office for National Statistics (ONS). It is made up of four components including life satisfaction, a worthwhile life, happiness and anxiety. Respondents are asked to rate these four components from '0' (not at all satisfied) to '10' (completely satisfied). We found that the values for the wellbeing component 'anxiety' was confusing and contradictory with the results from other outcomes so we have not included that in this report. We explained the reasons for this further in sec. 4.3.2.

As shown in Table 2 p.27, statistical test shows that although life satisfaction, worthwhile and happiness registered a statistically positive mean change between baseline and follow up. This result is reinforced in Figure 3 which shows that all aspects of personal well-being improved over the period, although the improvement is still substantially below Redbridge averages.

Figure 3: personal well-being means scores at baseline, follow up and for Redbridge



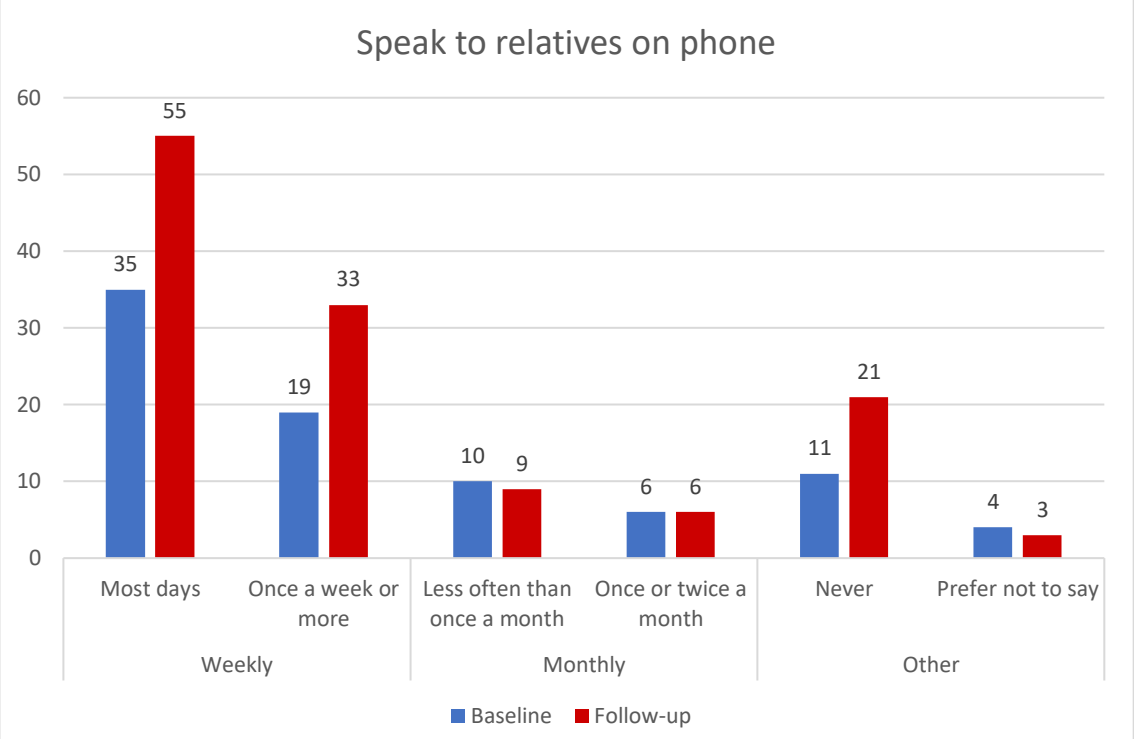
4.3.6 Social capital

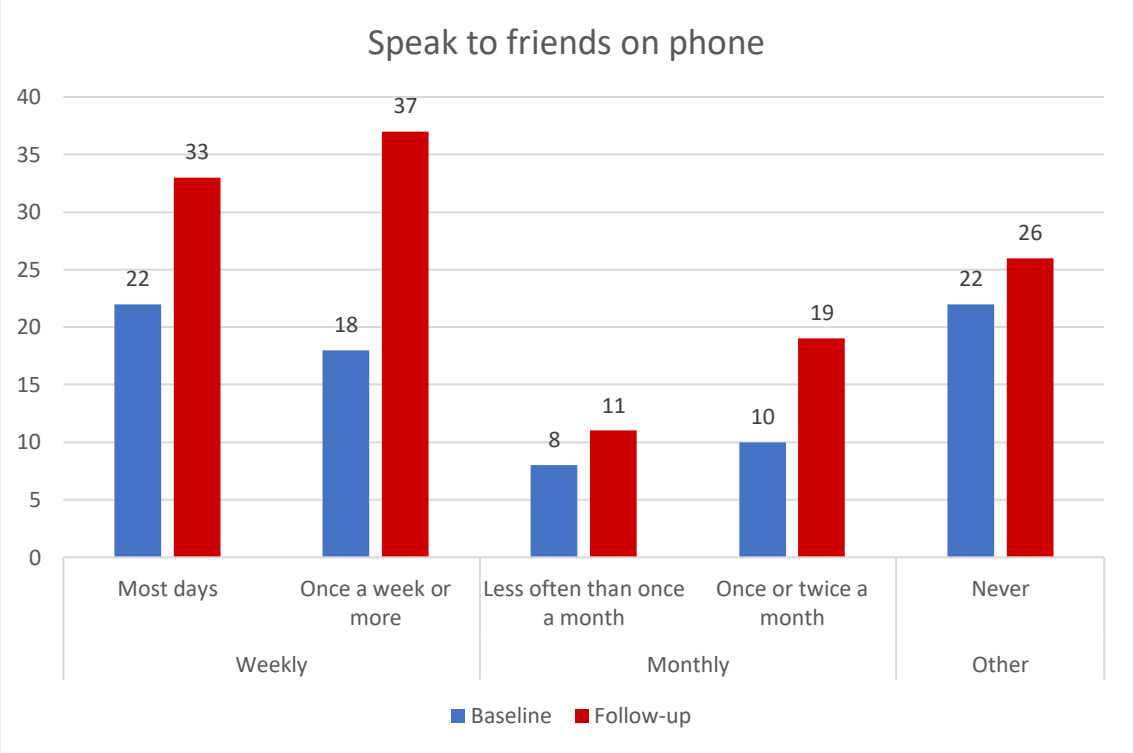
In the questionnaire, we asked social prescribing service users questions about social capital by using questions from the social capital harmonised questionnaire set. These include two dimensions of social capital: social networks and social support. Social networks could be likened to the 'quantity' of social capital whilst social support could be likened to the 'quality' of social capital. 'Social networks' was measured by asking people questions about their interaction with relative, friends and neighbours through different means of communication including phone, letter, email, chatroom and text. 'Social support' was measured by asking respondents three questions whether they would be comfortable with asking others help with their shopping if they were unwell, asking others to lend them money or asking others for advice and support in a crisis.

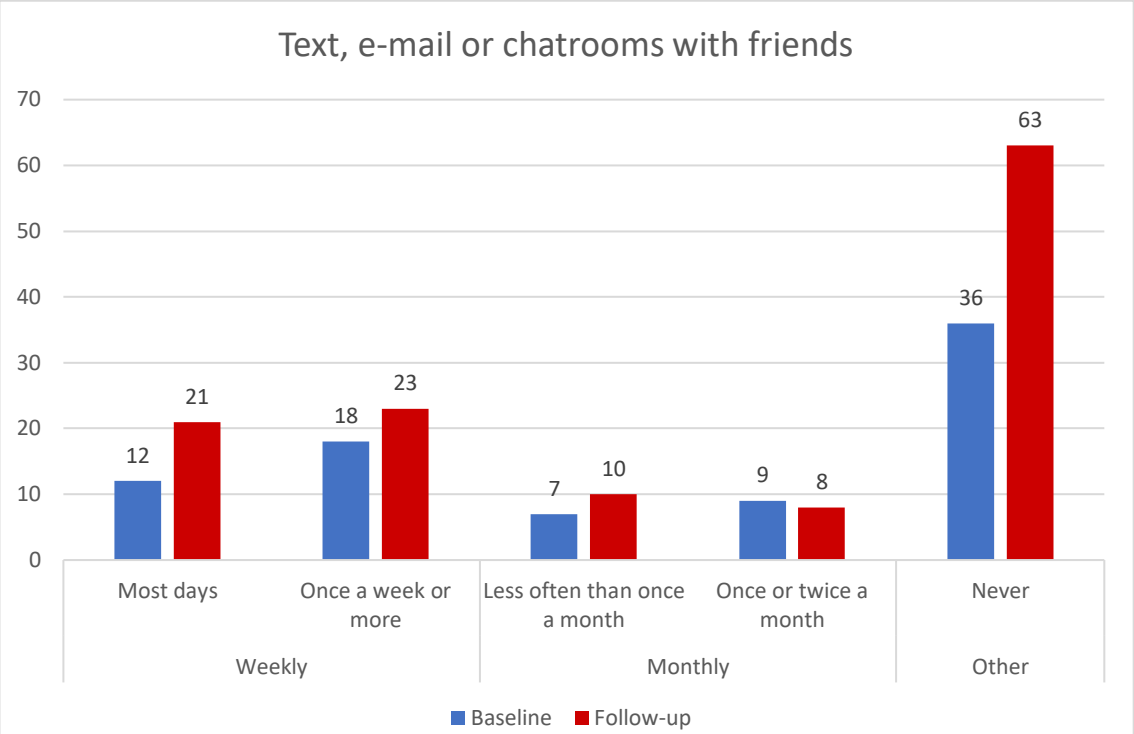
Social networks: Figure 4 shows that contact between service users and friends, relatives and neighbours increased over the period. It is also clear that the most used means of communication was spoken rather than via text, email or chatrooms. However, it is particularly noticeable that the proportion of people who 'never' spoke with friends, relative or neighbours also increased in all means of communication with all types of networks (relatives, friends, neighbours).

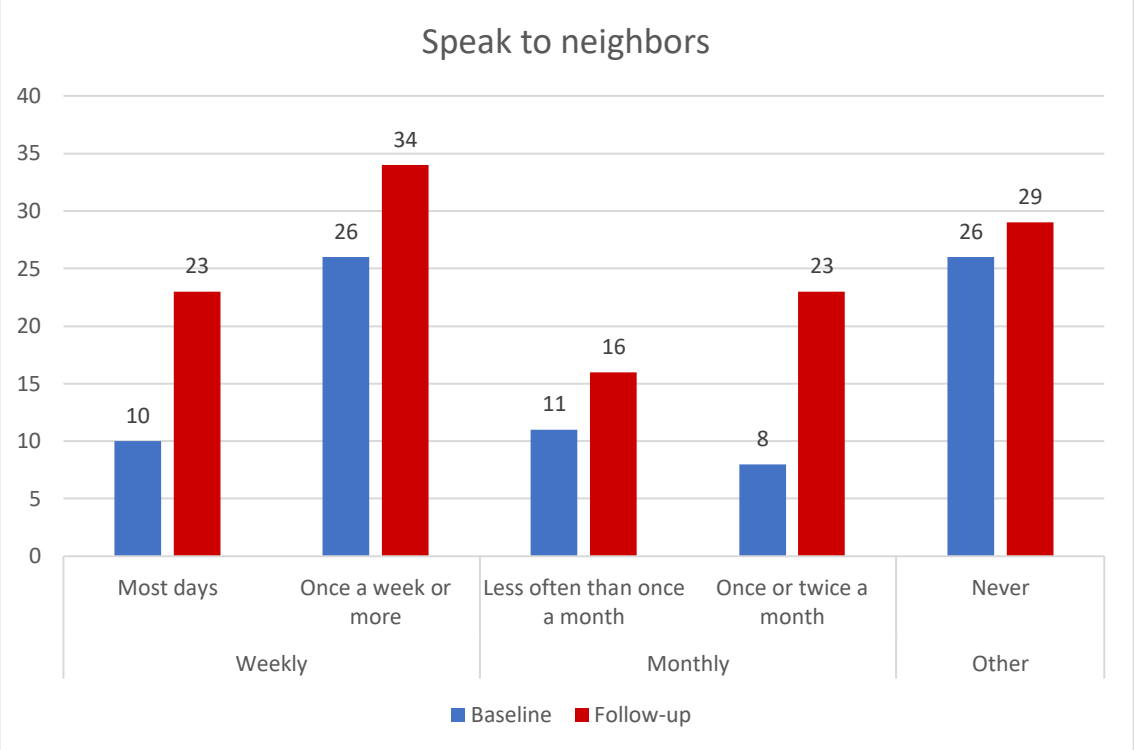
It is difficult to make sense of this data as the pandemic may have had a substantial impact on how people communicate with each other, and we do not have a control group to draw upon for comparison. The high number of people who 'never' communicate is in part expected as 30% of respondents live alone and they are older on average therefore being more likely to be socially isolated and/or lonely. Despite this, the overall 'quantity' of social capital seems to have improved particularly for those participants who have a steady, more frequent contact with family or friends than those participants who have a less frequent interaction with them.

Figure 4: Social Networks as a measure of social capital


Speak to relatives on phone
60
50
40
30
20
10
0
55
35
33
19
10
9
6
6
21
11
4
3
Most days
Once a week or more
Less often than once a month
Once or twice a month
Never
Prefer not to say
Weekly
Monthly
Other
Baseline
Follow-up


Speak to friends on phone
40
35
30
25
20
15
10
5
0
33
22
37
18
11
8
19
10
26
22
Most days
Once a week or more
Less often than once a month
Once or twice a month
Never
Weekly
Monthly
Other
Baseline
Follow-up

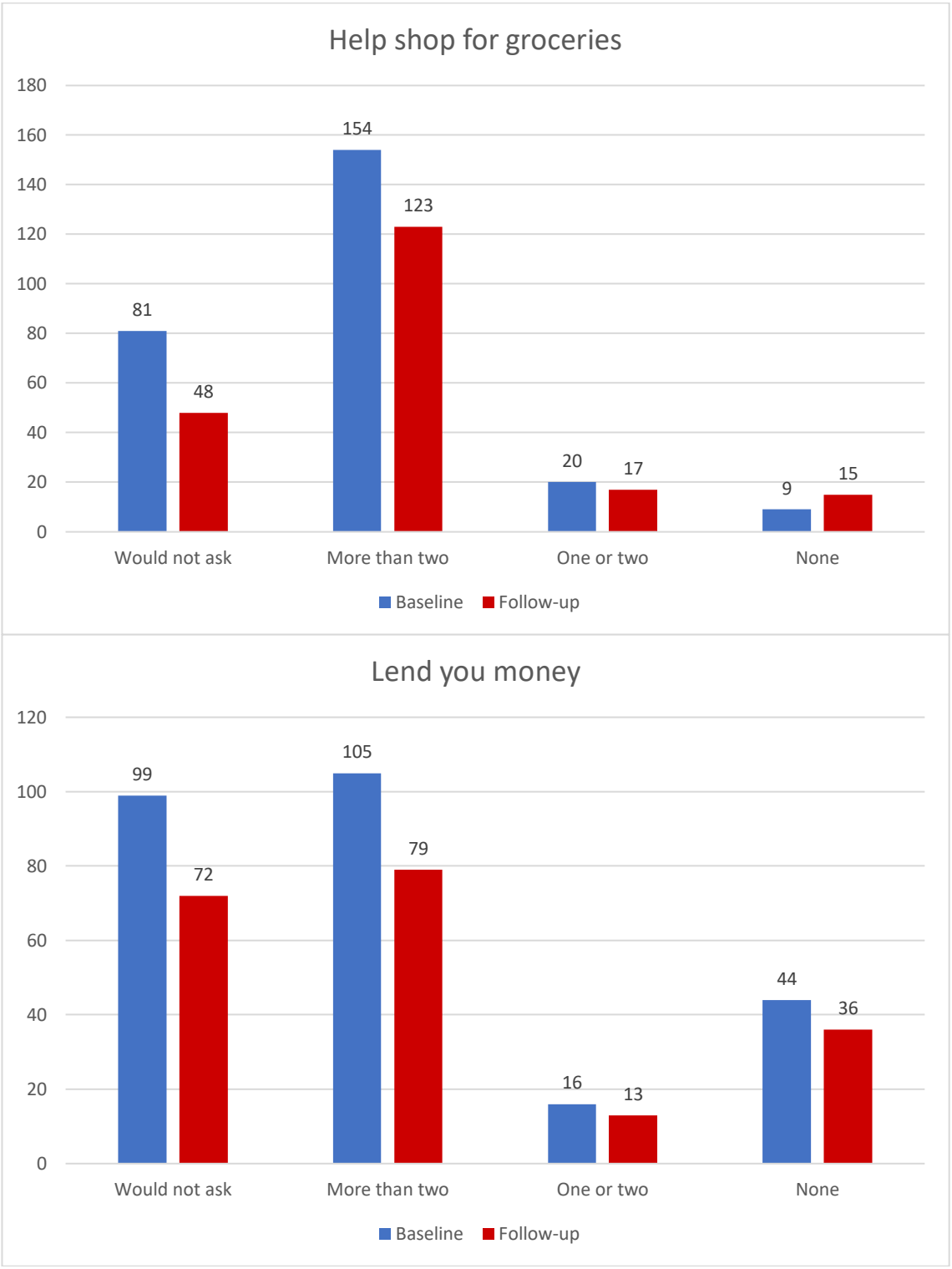


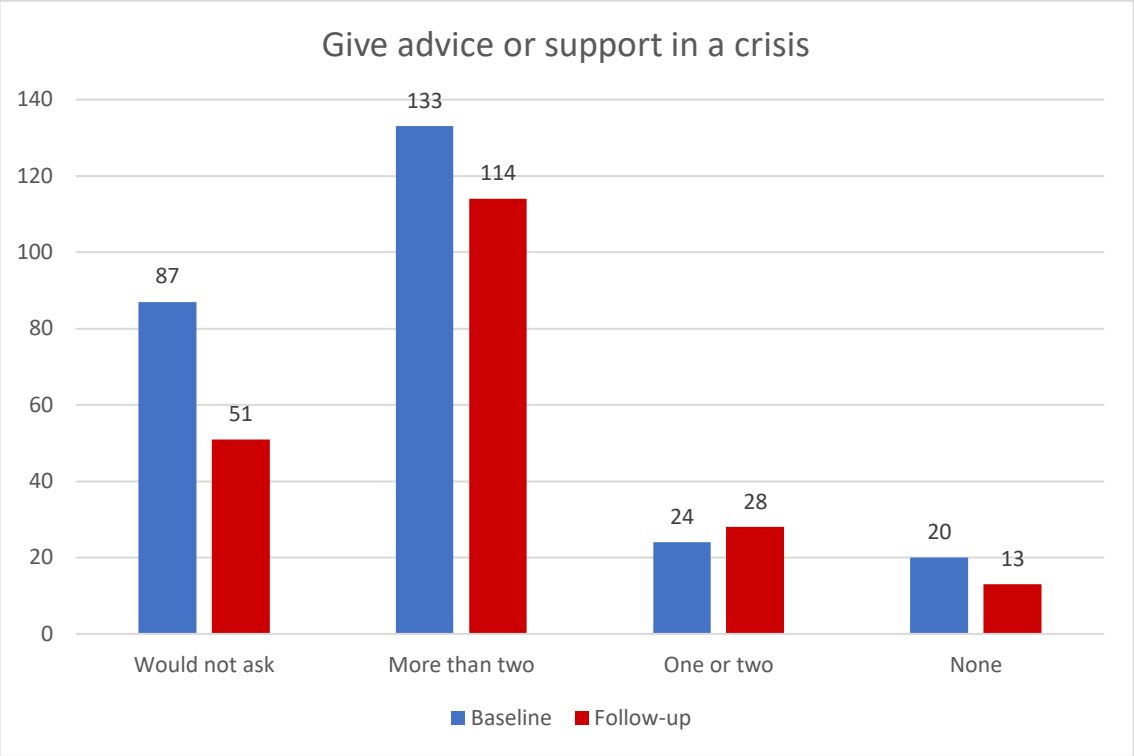


Social support:

Figure 5 shows a negative change in the number of individuals (relatives, friends or neighbours outside their home) service users would be willing to ask for help with groceries, finance and advice. The vast majority of respondents (between 30-50%) rely on 'more than two' individuals in all categories of support, and relatively fewer (under 30%) rely on less than two individuals. Overall, this shows a negative change in the 'quality' of social capital.

Figure 5: Social support as a measure of social capital





4.3.7 Health service use changes

Redbridge CVS also collected GP consultations, A&E attendance and in-patient stays from clients between baseline and six months follow up. Baseline and follow up data about health service use was collected by asking respondents to remember their attendance in the previous six months. This is not the best possible way to collect this data as it is open to recall bias, respondents may not accurately remember how many times they have used health services in the previous six months. However, it does at least provide an indication of the potential contribution of social prescribing to the use of health services.

At baseline, just over one out of four respondents (25.7%) had attended A&E in the last six months. The most widely used definition of 'frequent attendance' to A&E is five times or over per year (Hayhurst, Smith and Chambers, 2017). According to this definition, 9.4% of respondents were frequent attenders to A&E. The average mean GP consultation at baseline was eight visits (6.41; n=266), once per month. More than half of respondents (53.2%) could be classified as frequent attenders to GP practices (Bellon, 2008)[1].

We tested whether there is a statistically significant difference between health service use at baseline and follow up (
Table 3). We used a paired sample t-test which looks at whether there is a significant change in means between baseline and follow up. The test revealed a statistically significant decline In GP consultations between baseline and follow up in GP consultations (md=-1.826; p<0.001), and a statistically significant decline in A&E attendance (Md=-0.118; p=0.024). In-patient stays recorded an increase, but this was not statistically significant.

[1] People attending at least six GP consultations

Table 3: Health service use statistical test

Effect of SP						
Measure	N	Mean Diff	CI (95%)		P-Value (*)	
			Lower	Upper	One-sided	Two-sided
A&E last six months	187	-.118	-.23	.00	**.024**	.048
Inpatient stays last 6 months	185	.043	-.05	.13	.171	.342
GP visits last six months	197	-1.826	-2.37	-1.28	**<.001**	**<.001**

5 Discussion

This evaluation has three main aims:

Aim 1: to examine the experience of the integrated social prescribing in Redbridge in order for inform the future development of the intervention. This section summarises the results of sec. 4.1.1, 4.1.2, and 4.1.3, describes the strengths and weaknesses of PCNs and Redbridge CVS and recommends ways forward in the recommendation section 6.

Aim 2: to assess the feasibility of social prescribing for young people and families as proposed by Redbridge CVS documents.

Aim 3: to assess health outcomes and economic impact of Redbridge CVS data delivered service.

We consider these in order below.

5.1 The current integrated service in Redbridge

All respondents agreed that there is a considerable number of complex cases requiring a multiple and coordinated response. This shared response appears a good starting point to consider the future of the social prescribing service in Redbridge. Complexity is caused by several factors as follows:

- An ageing population with increased co-morbidities
- The increased level of long-term conditions which require 'management' of disease rather than just 'cure'. The management of disease require support that is not found in traditional primary and secondary care offer as this is set up to 'cure' people. Management of disease requires a different approach which bio-psycho-social rather than biomedical. It requires coordinated action and more long-term support.
- Growing health inequalities and the associated social determinants of health require coordination between healthcare professionals in primary and secondary care and social services (e.g. housing, employment, debt and financial advice).
- Increased complexity due to the impact of the pandemic. Evidence shows that this is the case particularly for mental health problems.

An important response to this complexity appears to be offered by the deployment of different skills from healthcare professionals (including Redbridge CVS) interacting with each other and other parts of the system (e.g. housing, welfare and debt advice, employment) in a network or ecosystem. It is important to consider the assets that each part of the system brings to the care and support of people in the borough. Social prescribing can offer this networked response bringing together different parts of the health and social economy via the work of PCN link workers and Redbridge CVS staff.

It is therefore important to consider the main features of the social prescribing pathway and the experiences of stakeholders involved.

Referrals into the service: Many different healthcare professionals, primarily the GP, referred clients to PCN link workers. In most cases, PCN link workers spent significant time building relationships with GP practices and recognised that this process takes time and needs to be continuously repeated on a regular basis to ensure that social prescribing is kept high in the priorities of GP practice staff. Despite this investment of PCN link workers' time, a wide variation in referral numbers from GP practices was apparent. Evidence from other social prescribing services show that this is common, and 'buy-in' from GP practices varies widely and takes time and continuous investment.

The experience of PCN link workers: The interviews with PCN link workers were guided by the NHS Social Prescribing Link Worker Competency Framework (NHS, 2022). Overall, PCN link workers demonstrated a good knowledge of the key principles of social prescribing, particularly in relation to empathetic and active listening, co-production of the solution with the client, providing support with health and social issues as well as safe and effective practice achieved through multidisciplinary work and the involvement of the different range of expertise to support client's health and wellbeing.

The level of support PCN link workers were able to provide clients varied widely across the PCNs from extremely light touch (15 minutes) to in-depth support involving six sessions over a 3-month period and, in some circumstances, accompaniment of clients to VCSE sector activities

Most PCN link workers were unhappy about their current working conditions. The most important issues include:

- Most PCN link workers and some PCN managers were unhappy with their caseload. They found it difficult to deliver a quality service in such a short space of time. In some PCNs, it was clear that there was a growing disparity between roles expectations. PCN link worker wanted to deliver a more flexible service but were not able because of targets imposed by their PCN managers. Some PCN link workers defined this situation as 'overwhelming' with very high workload targets up to 840 clients per year. This exceeds the threshold set up NHS England which requires supporting 250 clients per years and was found too high by a review of link workers workforce needs (NALW, 2019).

- One PCN link workers reported having to cover a very wide geography including 86,000 patients

- Lack of clarity about the boundaries between their roles and other roles particularly within primary care. One PCN link worker was engaged in completing cancer care reviews for the QOF which appear to have little to do with their role as social prescribers.

- Poor working environment with some PCN link workers having to provide confidential sessions to clients on the phone from GP practice corridors or being given inadequate space and furniture to work from.

- PCN link workers reported receiving none to limited clinical supervision. Given the level of vulnerability of some clients, regular clinical supervision is an important aspect of PCN link workers' mental wellbeing.

This issue was highlighted in different reports on social prescribing (NALW, 2019; Frostick and Bertotti, 2019).

Alongside the experience of PCN link workers, we identified and summarised the most important strengths and weaknesses of PCNs and Redbridge CVS as this would provide evidence for considering the way forward for the service.

PCNs have important **strengths** primarily:

- Funding to employ PCN link workers. This is an extremely important aspect of delivery as funding enables to employ at least one link worker per PCN. The service overall depends on this funding for its continuation, although funding from CCG and council have also been invested in supporting the work of Redbridge CVS since 2017 .

- Access to other primary care staff with their expertise, including Multi-disciplinary Teams (MDTs). Respondents emphasised this positive aspect as it enables to provide a higher quality support to clients

- Access to GP practice patients' databases (eg. EMIS) with its data about their health and wellbeing profile. This has enabled PCN link workers to build a profile about clients before each session. It is also likely to be an important factor in considering 'pro-active' social prescribing as GP practice databases enable the identification of target groups that could be contacted and recruited into social prescribing without the intervention of GPs or other healthcare professionals in the practice.

PCNs have also some **weaknesses**:

- PCN link workers lack time as their caseload is extremely high. Pressure to deliver a 'light touch' rather than an 'in-depth' and flexible service is very high and is not likely to change. This is a problem across other social prescribing schemes in other parts of the country.

- Respondents reported that high caseload have the following Implications:
    - High turnover of staff as PCN link workers may find it difficult to deliver. Some PCN link workers reported that they are thinking of changing job.
    - Lack of time available to support clients which leads to a 'revolving' door as clients keep on coming back to primary care and use healthcare services.

- PCN link workers have improved their ability to deal with complex cases but have not time to deal with the most complex cases, particularly those cases which require time and a more social response

- The network of PCNs is limited to healthcare and primary care in particular rather than extend to other parts of the system which require a more coordinated approach aimed at addressing the social determinants of health

- Inconsistent data collection across PCNs. Without a coordinated data collection system, it is difficult to assess the effectiveness of PCN delivered social prescribing on health outcomes of its clients. This may be addressed by work taking place at East London level but requires consideration in the short and medium term.

PCN link workers: The level of support PCN link workers were able to provide clients varied widely across the PCNs from extremely light touch (15 minutes) to in-depth support involving six sessions over a 3 months period and, in some circumstances, accompaniment of clients to VCSE sector activities

Most PCN link workers were unhappy about their current working conditions. The most important issues include:

- Most PCN link workers and some PCN managers were unhappy with their caseload. They found it difficult to deliver a quality service in such a short space of time. In some PCNs, it was clear that there was a growing disparity between roles expectations. PCN link worker wanted to deliver a more flexible service but were not able because of targets imposed by their PCN managers. Some PCN link workers defined this situation as 'overwhelming' with very high workload targets up to 840 clients per year. This exceeds the threshold set up NHS England which requires supporting 250 clients per years and was in itself found too high by a review of link workers workforce needs (NALW, 2019).

- One PCN link workers reported having to cover a very wide geography including 86,000 patients

- Lack of clarity about the boundaries between their roles and other roles particularly within primary care. One PCN link worker was engaged in completing cancer care reviews for the QOF which appear to have little to do with their role as social prescribers.

- Poor working environment with some PCN link workers having to provide confidential sessions to clients on the phone from GP practice corridors or being given inadequate space and furniture to work from.

- PCN link workers reported receiving none to limited clinical supervision. Given the level of vulnerability of some clients, regular clinical supervision is an important aspect of PCN link workers' mental wellbeing. This issue was highlighted in different reports on social prescribing (NALW, 2019; Frostick and Bertotti, 2010).

5.2 Strengths and weaknesses of Redbridge CVS

Redbridge CVS have **important strengths** recognised by most PCN link workers and other respondents:

- They accumulated experience and expertise since they started delivering social prescribing in 2017 so they could advice on what works and does not work in relation to the pathway and the relationship between link workers and clients.

- Their expertise was recognised as useful particularly in addressing complex cases such as refugees and homeless people or clients who experienced issues with housing and they are generally close to the council so can access some specific services.

- They also have access to a wide range of activities offer by the VCSE sector

- It is interesting to note that PCN link workers would refer clients to Redbridge CVS for a variety of reasons including number of sessions needed, type of activity needed or geography of the client or workload at any given point in time. Respondents felt that it would be useful to create a standardised set of referral criteria. This does not seem available at the moment

- PCN link workers felt that Redbridge CVS has more capacity and time to deal with complex cases.

Redbridge CVS have also some **weaknesses:**

- Redbridge CVS do not have access to GP data (e.g. EMIS) and cannot take advantage of the same level of healthcare support PCN link workers have access to (e.g. MDTs).

- Redbridge CVS was not recognised by some PCNs as an equal partner. The role of Shahida Begum as employee of Redbridge CVS but also as coordinator for social prescribing was recognised by some as positive but not (yet) sufficient in providing direction for social prescribing across the borough. This was compounded by the lack of clarity on the role of Redbridge CVS

- Some PCN link workers reported that referral to Redbridge CVS would take too long. Once Redbridge CVS was used once, PCN link workers would then refer directly to activity or service (e.g. bereavement service) the following time in order to provide a quicker service

- Redbridge CVS was seen by some as protecting their links with local community organisations.

- Redbridge CVS data collection system has been affected by the pandemic and by the current CRM management system.

The involvement of a wide array of expertise both health and social in addressing complex needs leads to conclude that the role of PCN and Redbridge CVS is both needed, and integration needs to maximise the strengths and minimise the weaknesses of both PCNs and Redbridge CVS. In the next section, the key recommendations for PCN, Redbridge CVS and all stakeholders are considered.

5.3 Analysis of Redbridge CVS data: key points

The demographic profile is broadly in line with the target group for social prescribing. Large number of participants had retired from paid work (29.5% versus 9.5% for Redbridge) and the proportion of over 65 was higher than Redbridge (27% versus 12%). In line with other social prescribing evaluations and data from the social prescribing observatory (Anant et al., 2020), men are considerably underrepresented. On the other hand, 'Black or Black British' are slightly overrepresented in relation to the overall population of Redbridge. This appears to be an exception, as an evidence summary from Tierney et al., (2022) showed that Black, Asian and ethnically diverse population groups are under-represented in social prescribing.

Positive statistically significant differences were recorded for personal wellbeing (ONS4) as measured through life satisfaction, things that are worthwhile in life, and happiness (see Table 2 for more details). However, these values are still considerably lower than personal wellbeing for Redbridge as a whole Figure 3 (p.29).

General health and mental wellbeing improved but the result was not statistically significant and not meaningful in relation to mental wellbeing. This is against the trend of the previous evaluation which showed a statistically significant a meaningful positive change in mental wellbeing (Bertotti et al., 2020a). A recent evidence summary from NASP (2022) showed that social prescribing can address mental health difficulties, in particular mild to moderate depression and stress, although they concluded that stronger evidence is needed.

We tested whether there was a statistically significant difference between health service use at baseline and follow up (

Table 3; p.35). The test revealed a statistically significant decline in GP consultations between baseline and follow up in GP consultations (mean diff=-1.826; p<0.001), and a statistically significant decline in A&E attendance (mean diff =-0.118; p=0.024). In-patient stays recorded an increase, but this was not statistically significant.

In relation to social capital, it can be concluded that over the period of the delivery of social prescribing, there has been a negative change in social capital across both 'quantity' and 'quality' dimensions. However, it is important to note that the pandemic is likely to have had an effect, particularly on patterns of socialisation and reciprocal support given severe restrictions to mobility. It would be necessary to have a comparison group in order to draw firm conclusions.

It is important to recognise some of the limitations to this analysis. This analysis suffers from the following limitations: first, as there is no control group, changes in health and social outcomes cannot be attributed solely to social prescribing. Previous data analysis show that changes measured should be discounted by between 20-25% to achieve a more realistic value. Second, this analysis is only partial as over the same period (Nov 2019-May 2022), Redbridge CVS received a total of 789 referrals thus the data analysed may be affected by validity bias. The reasons for the discrepancy between data collected and client supported are multiple:

- Some 210 users did not go on to use the service as they were inappropriate referrals or refused the service or did not want to complete the questionnaire.
- The pandemic had an impact on data collection too as SP advisors reported difficulties in collecting data during phone rather than conventional face to face sessions. This was particularly the case with vulnerable and elderly clients.
- Finally, a rise in complex and urgent cases made data collection unfeasible for a proportion of clients.

5.4 Review of social prescribing for young people and families: key points

The WHO estimates 70%–90% of healthcare takes place in the home (Sacks et al., 2018). Thus, some social prescribing interventions have focused on the household production of health—the role of broader family or household members in shaping an individual's health behaviours and disease management (Morse et al., 2022).

One potential strategy to start addressing these issues is social prescribing for families and young people. The Long Term Plan (NHS, 2019) introduced social prescribing as an all-age intervention. Despite this, a review of the evidence on social prescribing for children and young people (Hayes et al., 2020) highlights the paucity of rigorous research and the urgent need to investigate the intended place of social prescribing for children and young people within existing care pathways for youth mental health and how this compares with an adult setting.

The review of Redbridge CVS proposal to set up a Youth Mental health social prescribing model targeting 14-24 years is novel particularly in terms of recruiting young peer linker and peer champions who can be involved in outreach and be more accessible to younger people.

Much of what is proposed in this model is confirmed by evidence. For instance, the plan to recruit young people from many different sources alongside GP practices, or the plan to run sessions in different places depending on the requirement of each young client.

The only potential issue could be the management of the relationship between young peer linkers and young clients. Training is provided on safeguarding and other aspects of this role, but it appears to be relatively new, so it is likely to need some careful planning and piloting at small scale.

6 Key recommendations

Given the reported increased in the number of complex cases in Redbridge and the long term trend of healthcare (sec 5.1 p.35), it would appear to be sensible to make use of all expertise and experience available to build an effective integrated service that can deal with different levels of vulnerability. PCN link workers have very high targets which push them to reduce the amount of support they provide to each client. Whilst not all clients have the same level of need, the pandemic, the rising cost of energy and the long-term trajectory of our healthcare system (e.g. an ageing population, increased long-term conditions) lead to expect more rather than less vulnerable cases. In this context, the role and expertise of Redbridge CVS appear important in order to provide additional capacity, add a social dimension (e.g. housing) and tap into the strengths of the VCSE sector. These three aspects cannot be easily substituted by the work of PCN link workers as they are fruit of long-term networks and experience working multiple partners. Furthermore, more complex and vulnerable cases require a more structured and networked response bringing together all available asset across primary care, the council and the VCSE sector. Social prescribing should not just be seen as an intervention, but an approach aimed at changing relations between different parts of the health ecosystem.

to achieve this, we make the following recommendations:

6.1 Recommendations for PCNs

It is important to note that the level of investment and approaches to social prescribing varied widely across PCNs. Whilst some PCNs had only one link worker and very limited commitment and were asking link workers to cover different roles (e.g. cancer care review), others had multiple link workers and a mental health practitioner. Thus, the recommendations below are primarily for PCNs which have a limited engagement in social prescribing.

Recommendation 1: PCNs to agree on a coherent approach towards PCN link workers across the borough: "*link workers give people time and focus on what matters to the person as identified through shared decision making or personalised care and support planning*" (p.7; NHS England, 2020). Some PCNs need to find greater balance between quantity of clients supported and quality of support provided. Some of the cited targets of over 800 clients per year are not achievable.

Recommendation 2: To agree on a standard job description for PCN link workers across the borough to clarify the expectations of their role.

Recommendation 3: Some GP practices need to recognise the importance of PCN link workers and provide them with at least some basic space to operate from (sec.4.1.2 p. 11).

6.2 Recommendations for Redbridge CVS

Recommendation 1: Continue to provide training and support to PCN link workers as well as additional capacity particularly for more complex cases, and those requiring support with housing, employment, debt advice as well as specific services delivered by VCSE sector.

Recommendation 2: Some PCN link workers felt that referrals to Redbridge CVS took too long and impinged on their caseloads. Redbridge CVS should review their practices with PCN link workers and find ways to improve their support system, where possible.

Recommendation 3: Redbridge CVS to continue investing in data collection and monitoring.

6.3 Recommendation for the overall delivery system

Recommendation 1: The joint creation of a standard operating procedure which all stakeholders would commit to. One of the key stages of this would be to clarify criteria for assessing 'complexity'. Once the level of complexity is identified, PCNs need to commit to referring clients to Redbridge CVS when complexity is high and requiring individuals to be supported for a long period of time. It is important to recognise that if this does not happen many clients will go back to primary care and contribute to the 'revolving door' mentioned by one clinical director.

Recommendation 2: In order to maximise delivery effectiveness, all stakeholders (PCNs, Redbridge CVS, CCG, Healthbridge, Redbridge council) need to share details of support available ranging from details of VCSE sector available support services to council services. In the long-term, Redbridge CVS should be given access to EMIS databases to facilitate the referral process and the background information available to each advisor. There are other social prescribing case study sites where this has happened for clients' benefits.

Recommendation 3: The Network Contract Directed Enhanced Service (NHS 2022) discusses the introduction of 'proactive social prescribing' which encourages PCN, commissioners, local authorities, VCSE and local clinical leaders to proactively offer social prescribing to an identified cohort with unmet needs. One of potential ideas proposed by some respondents was to involve suitably trained receptionists in GP practice to refer directly clients to PCN link workers. The benefit of this proposal would be to make less use of GPs and other healthcare professionals time as referrals would be made by receptionists instead. The other proposal involved to use EMIS databases across GP practices to identify a cohort with unmet needs and engage PCN link workers to contact clients. This potential scheme could also be run with the help of Redbridge CVS.

Recommendation 4: Shahida Begum from Redbridge CVS was identified as a leader to guide social prescribing within the borough. However, she is not recognised by all PCNs equally and some respondents felt that a clinical representative may be needed whom would be more likely to be recognised by the PCNs. Other respondents stressed Shahida's experience and expertise in social prescribing over several years is an important asset and she need to be given more time to cover this new role. It is important here that primary care and VCSE sector find a common ground.

Recommendation 5: PCNs and Redbridge CVS to review their data collection systems in order to facilitate assessment of their impact on health and social outcomes. The North East Evaluation Group led by Barts Health is working on a uniform data collection system across East London which may facilitate data analysis for both Redbridge PCNs and CVS. The availability of a unified system may provide very important information about the effectiveness of social prescribing and a rationale for further investment. As this may be a long-term plan, in the short term the data from some selected PCNs could be analysed to understand their effectiveness in terms of clients' health and social outcomes.

Recommendation 6: PCNs, HealthBridge and CCG to consider pulling resources to employ a clinical supervisor who could provide regular psychological support and advice to PCN link workers. It should be noted here that Redbridge CVS coordinator and advisors already receive monthly clinical supervisions sourced externally. This support service is also important in order to maintain service quality and safeguarding measures to the best standard possible and would find wide support amongst PCN link workers.

6.4 Recommendations for the social prescribing for young people approach

Recommendation 1: After a pilot stage, the intervention should create criteria to identify YP who may be too high threshold for social prescribing.

Recommendation 2: The other practical issue is about consent. YP under 16 cannot – in most cases - consent independently and need their parent/guardian assent. This could have considerable implications for the way the link worker operates as the involvement of parent/guardian can be part of the solution but also part of the problem.

Recommendation 3: Include the 'voices' of young people (14-24 years old) throughout the design, implementation, and evaluation of a potential new SP for young people scheme. A youth voice advisory group could be set up to regularly provide advice from a young person's perspective. This could be made up of peer champions who can provide an independent voice on the development of social prescribing.

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8 APPENDICES

8.1 Flowchart of social prescribing in Redbridge