# Social Prescribing in NCL General Practice

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# Foreword

Social prescribing services in North Central London are part of a broader effort to enhance personalised care and improve the well-being of our communities. The Review of Social Prescribing by NCL Training Hub over 12 months, is an ambitious project designed to assess current social prescribing provision in each of the five London Boroughs, assess the strengths and areas for development, and produce a plan for each of the boroughs. This is reviewed against the social prescribing maturity matrix, a framework designed by NHSE to evaluate, measure and improve social prescribing.

The project, commissioned by the NCL Integrated Care Board, has involved patients and local stakeholders from the Voluntary and Community Sector, Adult Social Care, Public Health, General Practice, Children's Social Care, Mental Health, health and social care commissioners in each of the five boroughs. Stakeholders have attended workshops, contributed their knowledge skills and time to produce a document that will help us improve our services and serve as a resource document for Social Prescribing.

The review has produced a clear set of recommendations for the ICB, Boroughs and neighbourhoods. Going forward we will review these recommendations within the relevant organisational structures, (i.e.at scale, borough or neighbourhood) and within available resources.

I am grateful for the time and energy our partners across the ICP have committed to this project and for the diligence and dedication shown by colleagues in the NCL training hub, without whom we would not have been able to arrive at this point. Neighbourhood Health will be a key deliverable of the NHS 10-year plan, and I believe social prescribing will be a key enabler. This review puts us in a strong position to strengthen our social prescribing offer across NCL so enhancing personalised care for all our residents. I thank everyone for the contributions you have made this far. I look forward to working with you all to continue the work of maximising the potential for social prescribing.

Dr Katie Coleman
GP and NCL Clinical Director for Primary Care

# Introduction

This report is a stocktake of Social Prescribing (SP) in General Practice across the five boroughs of North Central London (NCL): Barnet, Camden, Enfield, Haringey and Islington. It has been led by NCL Training Hub and was commissioned by North Central London Integrated Care Board. The stocktake ran between January and July 2024.

The report considers the national and regional strategic direction of SP and, within this wider context, reviews NCL's activities, provision and progress. Working collaboratively with each borough, the report highlights trends, opportunities, impact measurement approaches and resource implications of current and future provision at both place and system level.

The timing of the report is important as neighbourhood integration, prevention, health promotion and personalisation are all set to develop further against the backdrop of a one-year contract for GP practices and Primary Care Networks (PCNs) whilst longer term arrangements are agreed. SP is a key system activity that impacts on all these strategic developments.

# Executive Summary

## Background

Social prescribing (SP) is a constituent part of the personalised care agenda, which is at the heart of recent NHS reforms. It has evolved over decades from an ambition to tackle both the social and the medical causes of complex health problems to become what it is today: a key part of the NHS strategy and service.

SP services have been introduced as part of a broader effort to enhance personalised care and improve the well-being of the community. However, despite progress, significant challenges remain in the effective delivery and integration of these services. This review aims to evaluate the current provision of SP services in the five boroughs Barnet, Camden, Enfield, Haringey and Islington in the North Central London (NCL) Integrated Care System (ICS), identify key successes and challenges and co-create a strategic plan to advance SP within NCL.

## Objectives

The primary objectives of this strategic review are:

1) **Co-production of a Borough-Wide Strategic Plan:** Develop a comprehensive plan that outlines the ambitions and goals for personalised care roles, ensuring these services align with community needs.
2) **Assessment of Current SP Provision:** Review the existing SP services to identify areas of strength and those requiring improvement.

3) **Analysis of Successes and Challenges:** Use the SP Maturity Framework to evaluate the integration of SP services, focusing on leadership, workforce development, digital systems and community engagement.

## Methods

The strategic review was conducted through stocktake of SP activity, interviews with SP leads and a series of workshops that engaged key stakeholders, including healthcare providers, social prescribing link workers, local authorities, voluntary sector representatives and patients. These workshops facilitated a co-creative process to evaluate existing services, share experiences and identify areas for improvement. Data was collected on referral rates, patient outcomes and feedback from service users and providers. The Social Prescribing Maturity Framework provided a structured approach to assess the maturity of SP services across various dimensions.

## Key Findings

### Strengths:

- **Positive Reception:** SP services in NCL have generally been well-received, with patients reporting improved wellbeing and a stronger sense of community connection.
- **Community Engagement:** Effective collaboration with community organizations has enhanced the reach and impact of SP services, particularly in addressing social determinants of health.

### Challenges:

- **Service Inconsistency:** There are significant variations in the delivery of SP services, leading to uneven patient experiences and outcomes.
- **Staff Burnout:** High levels of stress and burnout among SP link workers have been identified as major issues, affecting service continuity and quality.
- **Insufficient Resources:** The lack of adequate community resources for referrals has hindered the effectiveness of SP services in some boroughs.
- **Digital Infrastructure:** The absence of a unified digital system for managing SP data has created inefficiencies in tracking patient progress and service outcomes.

### Opportunities:

- **Enhanced Collaboration:** There is potential to strengthen collaboration between SP services and other local agencies, including public health and social services, to create a more integrated approach to personalised care.
- **Leadership Development:** Re-establishing strong leadership at the borough level can provide better strategic oversight and improve the coordination of SP services across NCL
- **Workforce Support:** Addressing workforce challenges through improved training, supervision and improved career development opportunities can enhance staff retention and service quality.

Recommendations

1) Strengthen leadership and governance: Establish a borough-wide lead for personalised care roles to ensure consistent oversight and strategic direction for SP services across NCL. This role should focus on fostering collaboration among stakeholders and driving the implementation of the strategic plan.
2) Enhance workforce development: Implement measures to support SP link workers, including regular professional development opportunities, enhanced supervision and the creation of clear career progression pathways. Addressing staff burnout and improving job satisfaction are critical to maintaining service quality.
3) Upgrade digital infrastructure: Develop a unified digital system for SP services to streamline data collection, sharing and reporting. This system should facilitate more effective monitoring and evaluation of service outcomes, enabling continuous improvement.
4) Promote greater collaboration: Strengthen partnerships between SP services and other local agencies, such as public health and social services, to create a more integrated and comprehensive approach to personalised care. This should include efforts to engage underserved populations and ensure that SP services are accessible to all residents.
5) Ensure sustainable funding: Secure long-term funding for SP services to ensure their sustainability and ability to meet the evolving needs of the local population. Explore innovative funding models, such as Community Chests, to support the scaling of successful SP initiatives.

Conclusion

This strategic review provides a comprehensive assessment of SP services in NCL, highlighting both strengths and areas for improvement. By implementing the recommendations outlined in this report, NCL ICS can enhance its SP services to better meet the needs of its residents, creating a more robust, sustainable and impactful framework for personalised care.

# Aims and objectives

There is broad recognition that SP activities in NCL are delivered in a range of settings, by a number of different professionals and with varying approaches to measuring impact.

Referrals to SP can come from a wide range of local agencies. This review focuses on SP delivered within the general practice setting. It considers:

- Learning identified through NCL's delivery and measurement of SP in general practice.
- The progress and impact made through SP roles in general practice, as well as the interplay of these roles with Health and Wellbeing Coaches and Care Coordinators, and including current SP activities, provision and impact.

- Recommendations for future delivery and impact measurement of SP in general practice.
- Identifies networks and functions that are supporting SP and community navigation within the broader system (e.g. local authorities) to inform a potential Phase Two.

Objectives of the review include:

- Outline the strategic context for SP at National, Regional, System and Place levels, drawing on Transformation Partners in Health and Care's (TPHC) Regional SP work to date. The emphasis will be on the delivery of SP activities, within the strategic context.
- Review known best practice and apply in the local context, in discussion with stakeholders and to identify system enablers.
- Complete a stocktake/mapping exercise of SP activities in NCL, including identification of successful activities within each borough partnership and resource capacity (including funding models) in each borough.
- Assess each borough and the ICS against the SP system maturity framework, which may be synthesised for the purposes of the review. In doing so, identify areas of improvements in collaboration with each borough partnership.
- Collaboratively develop plans for each borough with ownership from local stakeholders based on maximising opportunities (at both NCL and borough level) and a consistent approach to measuring and reporting impact. This will include service sustainability, optimisation, workforce retention, and the role of SP in building integrated neighbourhood teams (including how personalised care roles can act as enablers in integrated neighbourhood teams).
- Identify resource implications to progress against the borough development plans.

# Context and best practice

## National policy context

SP is a key part of the NHS commitment to personalised care, as set out in the NHS Long Term Plan, the Fuller Stocktake Report, and the Health and Care Act. Personalised care means that people have choice and control over the way their care is planned and delivered. Read together, the Long Term Plan, Fuller Stocktake Report and Health and Care Act, bring personalised care into the NHS service specification and set out a path to deliver joined up health and care, with prevention at its heart.

SP is one of the six components of personalised care set out in NHS England (NHSE)'s Universal Personalised Care Comprehensive Model, which sets out how the Long Term Plan commitments to personalised care will be met. The guidance for implementing the Comprehensive Care Model explains that:

> *"...social prescribing enables all local agencies to refer people to a 'link worker', to connect them into community-based support, building on what matters to the person as identified through shared decision making / personalised care and support planning, and making the most of community and informal support."*

SP is intrinsically linked to primary care and focuses on the socioeconomic and psychosocial issues, referred to as the social determinants of health. It is both a response to the increasing health and social complexities of the population and the increased demands on general practice. The SP approach aims to reduce the health inequities people experience and support the clinical workforce. It does this by:

- enabling local agencies to refer people to non-clinical, community-based services and support;
- building on what matters to the person;
- empowering residents to self-refer;
- and making the most of community and informal support.

If SP and community-based support is delivered according to the Universal Comprehensive Model of Care standard, the indicative expectation is:

- 100 per cent of GPs and GP practices are able to involve link workers in practice meetings and make referrals to them.
- 90 per cent of link workers have received accredited training and feel confident in carrying out their role.
- 80 per cent of people take up their social prescription after referral.
- There is a positive impact on GP consultations and A&E attendances and wellbeing for those referred, achieving:
  - 14 per cent fewer GP appointments
  - 12 per cent fewer A&E attendances.

To embed SP and broader personalised care practices, the NHS has published a range of information and guidance, including the Additional Roles Reimbursement Scheme (ARRS) and the Network Contract Directed Enhanced Service 2024/25.

ARRS enables PCNs to be reimbursed for a number of roles that support personalised care delivery, including care coordinators, health and wellbeing coaches and social prescribing link workers (SPLWs). The NHS Long Term Plan set out targets for SPLWs by the end of 23/24, with the Universal Comprehensive Care Model aiming for around one full-time equivalent link worker per 10,000 local population. Transformation Partners in Health and Care (TPHC) calculated that London should be working towards circa 800 SPLWs, approximately four per PCN (average population of 50,000).

There is emerging evidence that SP leads to a range of positive health outcomes, including improved quality of life and emotional wellbeing. The King's Fund highlight that evidence across a variety of social prescribing studies shows the approach leads to reductions in a range of factors – from hospital admissions to a reliance

on prescriptions and GP consultations. Studies also show improvements across factors including self-reported measures of health and wellbeing, long term condition self-management and physical activity levels. Evidence includes Public Health England's Effectiveness of social prescribing: an evidence synthesis and a growing body of research from the National Social Prescribing Academy (NASP), which was established to build the evidence base and share best practice.

NASP has found:

- For every £1 of the £180,000 funding spent supporting vulnerable people, the SP service produced more than £10 of benefits in terms of better health.
- A significant (40%) reduction was seen in visits to the GP… It is therefore highly likely that the SP service is having a significant reduction on the number of GP consultations.
- SP, including community-based arts on prescription, can impact wellbeing and self-efficacy, and alleviate pressure on community nursing and community mental health services.

In a recent evaluation of the impact of social prescribing on health service usage and costs substantially reduced pressure on the NHS was noted across the nine local health systems examined across England with marked reduction in GP appointments, hospital admissions, A&E attendance and healthcare costs, particularly for high intensity users.

Whilst the evidence base for SP is expanding and much of it positive, further work is needed to strengthen it. Many available studies are small scale, without a control group or are at risk of bias. The localised and heterogeneous nature of SP complicates evaluation, as multiple components vary by context making generalisability difficult. Practical difficulties also exist include maintaining researcher independence and tracking health and social care impacts effectively via a myriad of different community activities referred to. A report examining the evidence gap in SP highlighted that over half the outcomes SP activity could deliver are not routinely being measured, including those that impact on the social determinants of health such as housing, crime and work. Those outcomes that are measured are often over a short period, when benefits in some cohorts may take years to demonstrate impact.

The prevalence of community resources is important to the success of SP in an area. The Health Foundation has highlighted that, "…ultimately, the impact of SP is linked to the resources available in the community to address social needs… there is also a risk of exacerbating inequities, if more disadvantaged patients face greater barriers to accessing support."

As SP matures, more consideration is being given to how systems, places and neighbourhoods measure the impact of activities. In the Institute of Health Equity's Health Inequalities in London report, it called for "…a more systematic and consistent collection, recording and coding of data relating to geography, across all protected characteristics, and of key inclusion health groups should remain a priority". To support a consistent national approach to measuring impact, the NHS is rolling out of a new Social Prescribing Information Standard. With a

minimum data set and shared IT codes at the core, the Information Standard is designed to aid the consistent recording and sharing of information for the whole SP patient journey. In doing so, it aims to provide a better understanding of the needs and support required of a locality and evidence of how that need is being met.

# London

## Social prescribing and the ICS model

The recent NHS reforms which introduced Integrated Care Systems (ICS) are a central component of SP because they bring together NHS, local government and other organisations including the Voluntary, Community and Social Enterprise (VCSE) sectors. These organisations all have a role to play in improving people's health as they support people with the wider conditions of their lives that impact health (e.g. housing, money, employment and environment).

Within each ICS, borough partnerships coordinate and oversee the delivery of care and act as an interface between sectors. Within each borough, Primary Care Networks (PCNs) are seen as anchor institutions with an important role in promoting joined-up care in the community and optimising individual and population health. PCNs are integral to personalised care, formed with the vision of:

- greater provision of proactive, personalised, coordinated and integrated services;
- improved access for patients with increasingly complex socio-medical problems;
- and proactively caring for people and communities.

## London

In the Institute of Health Equity's Marmot Review 10 Years On (published in 2020), the research found marked regional differences in life expectancy, particularly among people living in more deprived areas. It found the largest 'health gap' increases in the least deprived 10 per cent of neighbourhoods in London. Its recent (December 2022) snapshot of health inequalities in London showed "…variations exist across London boroughs in healthy life expectancy. This ranges from:

- 58.1 years in Barking and Dagenham to 70.2 years, in Richmond upon Thames for males; and 57.8 years in Tower Hamlets to 70.1 years in Wandsworth for females;
- Ethnic inequalities in life expectancy and disease are evident for instance with South Asian and Black people 2-4 times more likely to develop type 2 diabetes mellitus;
- High numbers of individuals belonging to inclusion health groups such as rough sleepers, asylum seekers and Gypsy, Roma and Traveller communities live in London. There is limited timely data available on the health of some of these populations, though data available consistently shows high

health needs and higher prevalence of communicable and non-communicable diseases compared to the general population."

The report snapshot further explores the social determinants specifically impacting the London population – from smoking to obesity and housing.

There is a lot of activity in London to tackle health inequalities and to use SP as a lever to reduce the impacts – from a broad regional view to pockets of innovation in neighbourhoods. One of the Mayor of London's key ambitions is "…to help more Londoners in vulnerable or deprived communities to improve their health and wellbeing through social prescribing". The Mayor of London and the GLA's health inequalities strategy outlines commitments to addressing London's health inequities. This includes making the case for SP offers, such as active travel and connecting professionals supporting creative activities, as well as supporting new initiatives and trialling innovative approaches, such as:

- Funding Bromley By Bow Centre to provide generalist and specialist Social, Welfare and Legal Advice training to SPLWs, to enable them to support patients regarding benefits and finances. This has included exploring different models of collaboration and funding between services across London – including North Islington and Enfield.
- Funding London Plus to grow its SP network
- Working with Transformation Partners in Health and Care to support commissioning of VCSE services through a community chest model -- the model is designed, developed, and owned by local partners and joins up funding from the NHS and Local Authorities to commission VCSE activities in response to unmet local needs.
- The Social Prescribing London website which provides information and resources to support the voluntary, community and social enterprise (VCSE) sector's involvement with supporting the SP agenda.

The NHS Regional team in London works with TPHC on the spread, scale-up and sustainability of SP across London. Through a combination of SP programmes and activities, TPHC's role is to:

- Support the workforce through recruitment and retention initiatives
- Supporting ICSs and PCNs to develop SP strategies
- Driving innovation in SP
- Communicating the benefits and the impact of SP

TPHC has a number of current and historic programmes and initiatives that encourage collaboration, co-production and the spread of best practice, ideas and ways of working across the region. The work spans: funding models, ways of working, and mapping and connecting provision. These are summarised in Appendix A highlighting key outputs and outcomes, and NCL participation to date.

## North Central London

NCL is the second most deprived ICS in London with areas of deprivation present in each of the five boroughs, often in direct proximity to areas of affluence. The population of just under 1.8 million is ethnically diverse with around 40% of the population being from Black, Asian and Ethnic Minority (BAME) communities. There are significant healthcare inequalities both across the ICS and within each borough. The life expectancy for men living in Upper Edmonton West in Enfield is around 15 years lower than for men and women living in Frognal and Hampstead Town in Camden. There is also a nearly 20 years variation in healthy life expectancy between the most and the least affluent areas of the ICS. An overview of the NCL demographic can be found in Appendix B.

The NCL ICS Population Health Strategy outlines its shared vision for a more proactive, holistic and person-centred approach to care with a focus on prevention and early intervention, delivered in partnership across a joined-up system. The strategy aims to reduce health inequalities across the ICS by working together to identify unmet needs across NCL's different communities and to address these with support and services which are inclusive and accessible.

It describes the ICS as:

> *"…a complex health and care economy with 12 major healthcare providers (many of whom provide specialist services to the rest of London and across England), five local authorities, 33 primary care networks (PCNs), more than 280 domiciliary care providers and around 220 care homes and hundreds of voluntary, community and social enterprise (VCSE) organisations. The system is also supported by UCL Partners and a flourishing world-class wider academic community."* NCL ICS Population Health Strategy

Specifically in relation to SP, the strategy outlines the ambition to:

- embed a focus on tackling the wider determinants of health across all of its work streams;
- ensure SP is visible, accessible and available across all life courses, and is valued by all partners equally.

SP has been implemented in a variety of ways across the ICS, with a total of 72 SPLWs, 18 health and well-being coaches and 243 care coordinators being employed across its five boroughs. A mixture of arrangements is in place with some PCNs employing link workers directly whilst others are subcontracting the service to voluntary organisations. Each borough is at a different stage of maturity in embedding these roles and has different systems and infrastructure in place for supporting, training, supervising and measuring their impact. This report seeks to deepen understanding of the current landscape of NCL SP provision to support the implementation of the Population Health Strategy.

# Developing a social prescribing offer

This section looks at information available to help develop a SP offer within the context of PCN funded social prescribing through the PCN DES (Primary Care Network Directed Enhanced Service). The sections draw heavily on TPHC's PCN Toolkit: Using Social Prescribing, Health Coaching and Care Co-ordination to Tackle Health Inequalities. The toolkit was co-produced with partners and stakeholders and includes practical tools, tips, resources and examples of good practice. TPHC notes that it encountered several challenges when supporting and advising PCNs and workforce leads on SP. This section therefore includes information aimed at helping people address the challenges others in London have experienced. The key challenges summarised by TPHC are:

- Recruitment, retention and support: where to recruit, who to recruit, competencies, minimum standards and regulation, retention and career progression.
- Working in systems at multiple levels across practice, PCN, ICS, neighbourhood level, community organisation- ways of working, partnership and leadership, co-production, referral pathways, community development.
- Workload and wellbeing: supporting PCN CDs/managers with queries on contract, funding and targets, and supporting the personalised care workforce on queries around supervision, caseload, risk escalation/safety, wellbeing initiatives and support networks.
- Identifying unmet need: identifying underserved and at-risk cohorts, methods of engagement, accessing data and intelligence.
- Measuring impact and evaluation comes.

## Social prescribing design principles

The Universal Comprehensive Care Model is at the centre of designing a SP strategy. It sets out six design principles for local SP schemes and a standard model.

The six design principles:

1. Be appropriately funded and supported by local partnerships of commissioners and primary care networks.
2. Receive referrals from all local agencies, including General Practice.
3. Involve a one-stop SP connector service, typically located in primary care, which employs link workers to give people time and personalised support, connecting them to community support, based on what matters to the person.
4. Connect people to community groups and voluntary organisations that are supported to receive referrals.

5. Put in place operational protocols about expected priority groups, expected numbers of referrals, workforce, costs, and effectiveness.
6. Have access to a range of community-based approaches providing peer support, advice, increased activity and access to community-based support.

Within the above framework, places and neighbourhoods have agency to create a SP offer that reflects local health needs and priorities. There are different offers, types and levels of provision across England, as previously identified by the University of Westminster. More recently, the National Academy of Social Prescribing has summarised the types of SP as:

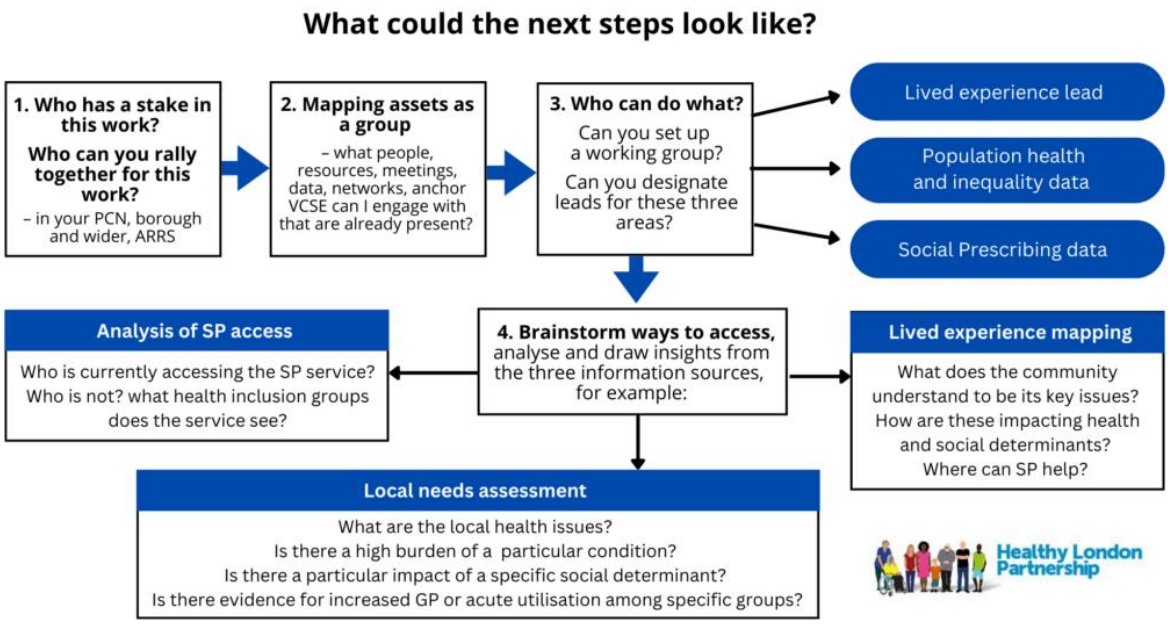
- Advice and Information
- Arts and Culture
- Heritage
- Natural Environment
- Physical Activity

The incoming Information Standard for Social Prescribing further breakdowns the 'types' of SP offers within its minimum dataset.

## Identifying needs

The following diagram from TPHC (formally Healthy London Partnership) illustrates steps that can be taken to work collaboratively with partners and utilise data to understand local needs:

*Figure 1* *TPHC Proactive Social Prescribing Strategy*



The TPHC PCN toolkit further sets out guidance for using Social Prescribing, Health Coaching and Care Co-ordination to tackle health inequalities.

## Working in partnership

TPHC's toolkit sets out:

> "Personalised care takes a whole-system approach, integrating care services around the person, across the life course, encompassing physical and mental health and wellbeing, and makes most of the expertise, capacity and potential of people families and communities in delivering better outcomes and experiences. It creates a positive shift in power and decision making that enables people to have more choice, a voice, and improve connection to each other and their communities, representing a new relationship between people, professionals and the health and care system.
>
> "A key part of personalisation is using asset-based approaches which highlight the strengths, capacity, knowledge of all those involved."

The types of place-based partnerships and the ways of working are summarised as:

- Neighbourhood / borough based;
- Local authorities;
- Training Hubs and workforce;
- Secondary care services and community organisations / VCSE sector.

The Social Prescribing, Assets and Relationships in Communities (SPARC) Network is currently (April 2023-April 2024) co-producing a community-driven research project focusing on enabling community groups and partner organisations to develop their asset-based approaches to SP in a disadvantaged neighbourhood in Birmingham. This is an approach which Dr Koen Bartels, associate professor in the Department of Public Administration and Policy at the University of Birmingham, outlines in The MJ, as "...an opportunity to transform relationships towards genuine co-production of community wellbeing."

## Personalised care roles

Roles that support the personalised care agenda, including social prescribing roles, ".... can help form an effective bridge into local communities, building trust, connecting services and galvanising the wealth of expertise in the VCSE sector," according to the Fuller Stocktake Report.

In 2019, the GLA published a systemic map of the literature on navigation roles in primary care: social prescribing link workers in context. It found "11 types of navigators which respond to the basic definition of 'people who provide support to patients and help them to access further services where necessary'". It went on

to conclude that there is 'boundary spanning' in these roles and that "…social prescribing link workers appear to share similarities with other roles particularly health coaches and health trainers. However, SPLWs are clearly different in their orientation toward the positive involvement of the VCSE sector and their recognition of health but also tackling health inequalities". It is useful to consider this in the context of SPLW roles in relation to their clinical and non-clinical colleagues.

The following is edited and adapted from the TPHC toolkit:

Funding for new personalised Care roles, SPLWs, Health and Wellbeing Coaches (HWBCs) and Care Coordinators (CCs), has been made available to Primary Care Networks through the ARRS. These roles best work together as part of a "One Team Personalised Care Approach" due to the complementary nature and synergy between their practice.

The three personalised care roles form an important part of a PCN's strategy to address health inequalities, but they must be effectively embedded – as set out in the Five Key Principles for Using Three Personalised Care Roles to Reduce Health Inequalities [see Appendix C].

Ethnic minority communities experience some of the worse health inequalities and they are also under-reached in SP. There are multiple ways the three roles can be used to reduce ethnic health inequalities:

- Care coordinators proactively calling and recalling patients for health checks, annual reviews and screening to reduce inequalities in outcomes from cardiovascular disease, diabetes, cancer and other long-term conditions.
- Specialist social prescribing link workers to support ethnic minority women during pregnancy and in the postnatal period to reduce maternal health inequalities.
- Mental health specialist social prescribing link workers to increase trust, engagement, compliance and reduce inequalities in access, outcomes and experience of mental health services patients.
- Health and wellbeing coaching using culturally and linguistically relevant resources and tools.
- Recruitment of the 3 roles from ethnic minority communities as part of building trust, engagement, and a responsive personalised care workforce.
- NHSE has produced an e-learning module to support culturally responsive social prescribing which can be accessed here.

In March 2022, NASP commissioned a review into accessibility of social prescribing schemes in England to people from Black, Asian and ethnically diverse population groups. It found, "…it is clear that people from Black, Asian and ethnically diverse population groups are under-represented in social prescribing", and that there is need for "…a far more complete picture of both awareness and use of social prescribing services by people from ethnically diverse population groups." Although there was limited evidence available to review, NASP points to common indicators of good practice when working to support social prescribing with people from Black, Asian, and ethnically diverse population groups. These are:

1. Investing in awareness-raising about SP within communities (often through networks that certain communities access already).
2. Having staff and volunteers from a range of backgrounds that are representative of local communities.
3. Identifying or developing community offers that reflect the needs and expectations of local communities.
4. Ensuring people feel welcome in SP services.
5. Considering alternative venues for delivering SP, that are easy for people to access.

The Welsh Government published its National Framework for Social Prescribing in January 2024, and includes addressing inequality and inequity as one of its crosscutting themes, …"the Competence Framework for Social Prescribing Practitioners in Wales includes the impact of social inequalities on health; working in a culturally competent way that values diversity; equality and inclusion; respecting the beliefs, practices and lifestyles of people who use SP services; and how these may affect their experience of the service; the planned national specification will also include the requirement to target currently underserved groups and the national standards will consider barriers to access."

Christiana Melam, chief executive of the National Association of Link Workers has advocated for link workers sharing their lived experience of supporting people experiencing health inequalities back into ICS, because they "…employ an inclusive approach that advocates patient empowerment and enablement. Their experiences will be vital to inform integrated care systems. Black Country and West Birmingham ICS Training Hub, for example, has created a SPLW ambassador role to ensure SPLWs' voices feed into the system."

One of the main functions of SP is to connect people to resources to support them with their non-medical needs. While SPLWs link and refer people to services, research by Westlake et al has identified an overlooked component which they term "Holding". This is often invisible and is crucial for people with complex needs or those who lack social or familial systems of support. The research identified four elements to holding; supporting patients waiting for services, sustaining patients as they prepare for change reducing the emotional burden of primary health care professionals and bearing witness to patients' distress. In NCL, this appears to be an increasing part of an SPLWs role as services become more stretched, yet this emotional labour is often not recognised or acknowledged except by patients.

There are several forums, networks and groups available to support SPWLs, as well as share ideas and best practice for SPLWs. These are summarised by Social Prescribing London. In addition, other networks and forums include Health Equity Network, a platform set up to enable people who are doing great work on health equity in regions, towns, cities and organisations across the UK to share what they are doing with others, be inspired by what others are doing and collaborate in joint working.

## PCN Health Inequalities Lead

The Health Inequalities DES supplement outlines the role of PCNs in reducing health inequalities and the responsibility of a Health Inequalities Lead to lead the work. In a TPHC Population Health webinar, it was noted that the Health Inequalities Lead is:

- to work on priority areas including:
  – Learning Disabilities (LD) register health checks
  – Serious Mental Illness (SMI) physical check
  – Ethnicity recording
  – Identification of populations experiencing HI by PCNs.
- A named HI lead in each PCN can work with the personalised care roles to map and address local unmet needs and coordinate HI activities
- The HI lead does not have to be the PCN CD, it can be any suitable clinical or non-clinical person
- ICSs are expected to create a peer network of HI leads, provide analytics for PHM, support co-production.

The webinar also noted some challenges that have been experienced with embedding a PCN Health Inequalities Lead:

- Many PCNs in London have not yet appointed an HI lead with a formal role and/or strategy
- We have heard PCN leaders and current HI leads reporting challenges with:
  – Understanding the nature and purpose of the roles- creating job descriptions and job plans have helped with this.
  – Adequately funding and resourcing these roles- a checklist and case study below may be used for ideas.
  – HI leads not feeling supported- some HI leads are exploring ways of setting up a support network.

TPHC has produced a Checklist for Embedding and Working with a PCN Health Inequalities Lead – see Appendix D.

## Workforce development

SPLWs must complete the NHS England e-Learning for Healthcare modules (e-LFH). The e-learning resource include the core elements and skills required to deliver SP as part of a PCN multi-disciplinary team. The e-learning sections to be completed are:

1. Introduction to the social prescribing link worker role
2. Developing personalised care and support plans with people

3. Developing partnerships
4. Introducing people to community groups and VCSE organisations
5. Safeguarding vulnerable people
6. Keeping records and measuring impact
7. Supporting people with their mental health through social prescribing
8. Social welfare, legal support and money guidance
9. Social prescribing for children and young people
10. Supervision
11. Social prescribing and the Armed Forces Community
12. Culturally responsive practice

The training standards, as outlined by the Personal Care Institute, are met in the e-LFH modules.

SP is currently an unregulated profession and there is no current requirement or funding for link workers to have completed an accredited qualification. There are now accredited courses available from a range of providers including **Bromley by Bow Level 3 qualification** and the **National Association of Link Workers Level 5 qualification**.

## Impact, measurement and evaluation

It is widely accepted that measurement and evaluation will further make the case for and build the evidence of SP. As SP approaches have evolved, so to have different approaches to measurement and evaluation.

In late 2023, a NASP review of supporting the voluntary community, faith and social enterprise sector to evaluate social prescribing found over 60 resources (toolkits, guidance and deep focus on elements of the evaluation cycle) - the materials found are available in the full report here, which were developed into an online toolkit published in November 2024. The TPHC Social Prescribing Evaluation Toolkit provides suggestions on how to gather data and measure the impact of local social prescribing services. It also gives practical ideas and guidance to meet the challenges with demonstrating the impact of social prescribing services.

With the incoming Social Prescribing Information Standard, there is now a concerted national push for a consistent approach to measure impact, allowing evaluation and insights at all levels of the system: from neighbourhoods to places, regions and national level. According to the Professional Records Standards Body:

> "The Social Prescribing Information Standard will enable the sharing and recording of information for the whole patient journey, from initial referral, throughout the period of social prescribing and the message back to the referrer and GP at its conclusion.
>
> "The standard supports the recording and sharing of information including:
> - The information required to support the conversations between the link worker and the person

- Information to support people, show their healthcare is joined up and avoid them having to retell their story multiple times
- Information that can be shared with the person themselves, their family or carer
- Summary information back to the referrer and GP for the person's overall record
- Information for secondary uses, e.g. for understanding the scale and effectiveness of social prescribing services, planning, population health etc.

"The standard is UK wide with involvement from all four nations. It was commissioned by NHS England and NHS Improvement and has an important role to play in the English national drive to widen the use of social prescribing to support citizen empowerment and personalised care, as stated in the NHS Long Term Plan."

Early adopters of the Information Standard include the North East London (NEL) ICS, which is trialling an ICS-wide dashboard to evaluate impact across the system. It uses the codes identified in the Information Standard's Minimum Data Set and additional codes identified by NEL's SP evaluation working group. The dashboard, in PowerBI, provides an overview of the SP activity across the seven boroughs in North East London, including visualisations on the demographics of the patients by:

- Wellbeing score
- Patients refereed to / attending / not eligible for the service/s
- Reasons for referrals
- Type of consultation
- Support offered

The dashboard collates data daily from clinical systems including EMIS and SystemOne, with plans to integrate JOY case management too, and uses data suppression for patient anonymity. The vision is that the dashboard will allow different stakeholders across the ICS to:

- Integrate disparate data collection systems
- Identify patterns and trends across the ICS
- Improve data quality
- Review supply and demand: support offered v provision of services
- Evidence the improvement in wellbeing outcomes because of SP interventions
- In time, map unmet need.

*Figure 2* NEL Dashboard – SP Referral Reason

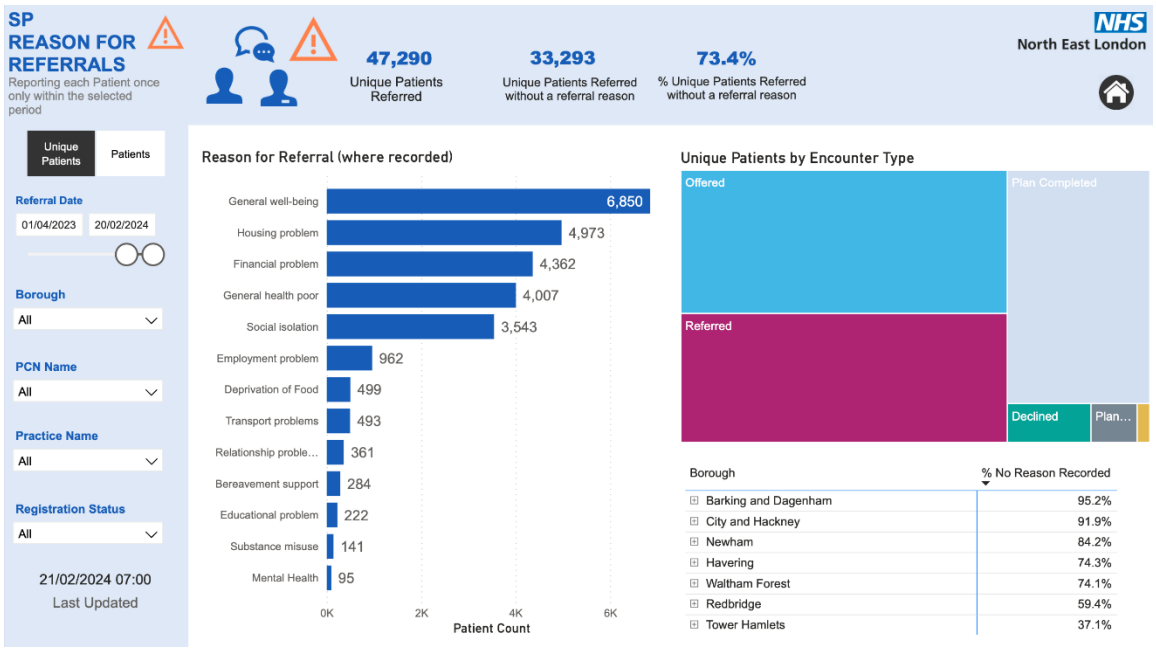
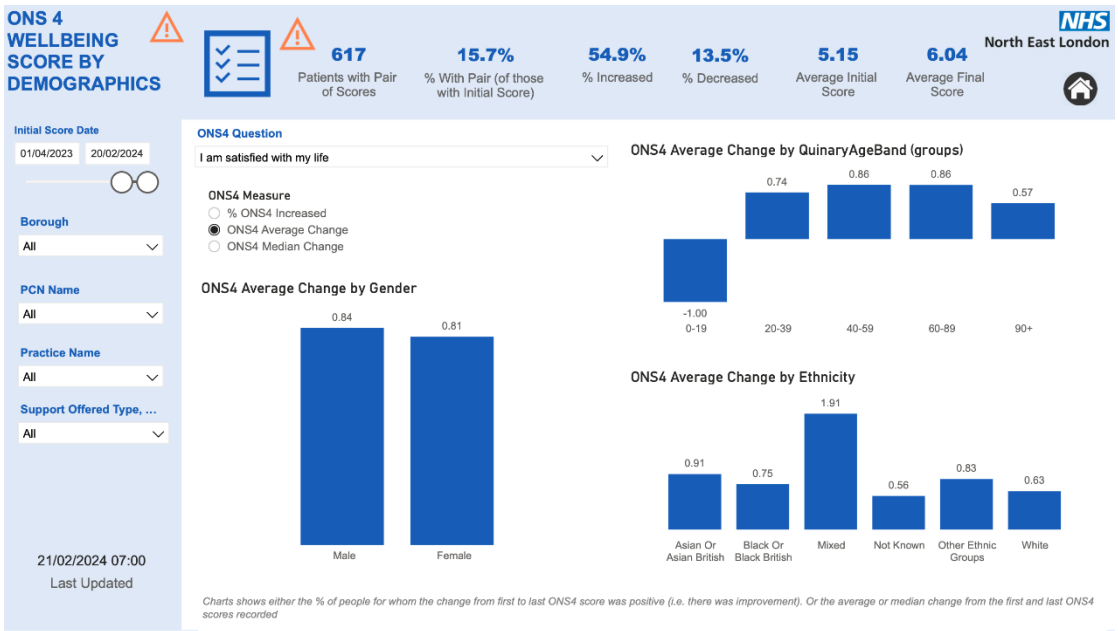



*Figure 3* NEL Dashboard – ONS4 Impact Data




This dashboard will improve consistency of data collection across the system in NEL and is a huge step in the right direction towards evidencing the impact of social prescribing. There remains further work to be done to determining the most meaningful measure for social prescribing outcomes as ONS4 is a broad wellbeing measure which may not fully capture the diverse potential impacts of social prescribing such as social connection, access to community services, or addressing the broader determinants of health like housing or employment issues.

# Case studies

SP case studies, across a variety of sources, provide inspiration, increased granularity, insight and learning. The collated case studies in this section span innovative models, funding and partnerships to first-hand accounts of the impact of interventions on lives. The breadth of approaches and the impacts shows the importance of building offers that:

- Reflect the priorities of the area;
- Identify current gaps in service provision;
- Think creatively about partnerships and funding models;
- Experiment with new approaches and funding streams;
- Use data to plan, deliver and evaluate provision – to both show the value of social prescribing and to review and manage services.

## Models and approaches

TPHC has produced a collection of case studies from across London, in addition to those collected through its Innovators Programme. The case studies give examples of social prescribing interventions – such as guided meditation in Ealing – through to inspiring examples of funding models and approaches. For example, social prescribing pioneers, Bromley by Bow, on funding and delivering creative and low-impact activities for people living with cancer.

Bromley by Bow also piloted a micro-commissioning model, which is explored in its report on social prescribing commissioning, commissioned by GLA.

TPHC's collection of case studies also include examples of leadership across PCNs, showcasing a joined-up delivery approach spanning nine PCNs in Stockwell.

The Health Foundation published a framework for NHS action on the social determinants of health. In it, it found, "…many areas report using budgets pooled via the Better Care Fund to support social prescribing. In Greater Manchester, public sector agencies have pooled spending and decision making to improve health and reduce inequalities in the region, including by prioritising interventions related to employment, school readiness and housing."

In the London Borough of Redbridge, GPs can refer patients to a 12-week intensive SP intervention, and an exit package of support which includes a follow-up after six months. The multi-stakeholder SP board meets quarterly. Meanwhile, the Havering Volunteer Service has tapped into the power of volunteers: a team of 27 volunteers supporting just 1.5 FTEs. Including some additional 600 volunteers recruited to support services during the COVID-19 pandemic, the volunteers have delivered over 9,700 hours, equivalent to £126,000 of services.

A Green Social Prescribing directory has been set up by Voluntary Action Camden to help residents and social prescribers find healthy activities and social opportunities in Camden's green spaces and parks. Similarly, in its Fairer and Healthier Waltham Forest report, the Institute if Health Equity includes a case study of Waltham Forest Adult Learning Service's partnership with Waltham Forest Social Prescribing to deliver art and horticulture courses in green spaces across the borough, enabling local residents to enjoy and connect with nature.

Volunteer Centre Hackney has set up Together Better where volunteers and patients run activities within surgeries, resembling hybrid community centres. The Health Foundation cites a similar approach in Derbyshire where Citizens Advice Bureau advisors are placed in most GP Surgeries to help patients with social and financial issues. Similarly the Institute of Health Equity cites an example in Blackpool where Citizens Advice Blackpool works closely with GPs and has delivered advice in surgeries since 1997. It now works in partnership with five PCNs to deliver a social prescribing model across the Flyde Coast.

A City Hall blog explored the links between health and arts by speaking to Free Space Project in Camden and Entelechy Arts in Lewisham. They found:

- When people have access to digital technologies, it can simplify processes and expand access.
- Meaningful relationships are key.
- Contact is crucial however it is made – one to one contact is essential but unsustainable.

City Hall further explores the opportunities and challenges of social prescribing of arts and culture, setting out a number of recommendations including training for volunteers, developing social prescribing champions and a flagship culture programme in conjunction with London Borough of Culture. Prescribe Arts, together with NASP, share a number of lived experience and programmatic case studies.

## Supporting places

The Institute of Health Equity's Marmot Places initiative works with places to reduce inequalities in health. Over 40 local authorities in England and Wales have committed to improve health equity over the short, medium and long term by:

1. Developing and delivering approaches, interventions and policies to improve health equity.
2. Strengthening their health equity systems.
3. Involving communities in the identification of the drivers of poor health and in the design and implementation of actions to reduce them.
4. Broadening advocacy on health equity and engaging with other Marmot Places to share knowledge, roll out best practice alongside partners in local regions and nationally.

To strengthen ICS and voluntary sector partnerships, the South East London ICP has produced a draft charter outlining commitments to working together. It acknowledges the importance of grass roots organisations that help to tackle health inequalities. It will:

1. Treat the VCSE sector as a full strategic partner in setting strategic direction and in system planning, in addition to its role in delivery services;
2. Increase funding provided for the VCSE sector and secure services in ways that deliver greater social value;
3. Ensure proportionate procurement and contract monitoring processes. This will reduce the transactional burden for commissioners and providers and ensure a level playing field for VCSE organisations;
4. Invest in strengthening the VCSE sector's infrastructure so that it can play an effective role in the strategic leadership of our system and service delivery.

## Lived experience

The National Social Prescribing Academy has published a collection of its case studies which captures perspectives from people with lived experience of services through to how social prescribing is being used to address specific conditions, such as Diabetes.

NHS England's case studies give the view from the SPLWs' perspective as well as the GP's perspective. The case studies highlight the importance and power of time and connections, as well as the impact of art on a person's life and wellbeing.

The NCL Borough workshops included people with lived experience. Hearing the voices of people who use the service and incorporating this evidence along with activity and outcome supports the development of the borough plans.

## Children and young people

In October 2023, Barnardo's called on the Government to provide the 'missing link -social prescribing' in youth mental health support.

There are a number of insights from Youth Social Prescribing in Practice, a 3 year programme across four locations (Luton, Sheffield, Brighton & Hove, Southampton), run by Street Games and funded by partners including the Department of Health and Social Care. The evaluation report found that, "Social prescribing appears to be particularly effective in supporting the most disadvantaged groups of young people, and those who experienced the lowest levels of personal wellbeing". For every pound invested, there was a £5.04 return.

The Stort Valley and Villages PCN's Young People's Social Prescribing Service is highlighted in the Fuller Stocktake. It supports young people aged 11 to 25 with their physical and mental health and was developed in recognition that services for young people can be confusing and difficult to navigate.

NCL ICB funded Haringey, Camden and Barnet to deliver CYP social prescribing pilots. The funding was targeted to the three boroughs because Enfield and Islington already had CYP social prescribing provision in place. Below is a summary of the pilots:

Barnet:

- Phase 1 of the pilot aimed to work towards a sustainable CYP Social Prescribing model using the Early Help/ Universal Plus referral process by supporting families and young people who need additional support and who have complex and/or long-term health conditions
- Phase 2 aimed to pilot a specialist SPWL role using the developed referral pathway and CYP social prescribing model

Camden:

- Commissioned a Social Prescribing Service for CYP across three VCS providers following a pilot
- Funded two link workers who work with CYP to enable access to individual and group activities to improve wellbeing, mental health, life skills and self-confidence, and to reduce isolation
- Over 100 young people supported to develop a range of activities to meet the needs and interests of CYP
- Referral pathways established with schools, integrated youth support service, early help and GPs

Haringey:

- Intervention officers within the Youth Justice Service are offering SP to CYP based on need
- Pilot funding was used to fund SP activities identified through engagement with CYP

Within Islington, a service for referred 11–23-year-olds who feeling stressed, overwhelmed or low, to help them improve how they feel. The team focuses on the benefits that social, creative and sporting activities can make to a young person and the next steps in their lives. There are several activities from archery and bakery to robotics, woodwork, and yoga.

## Social prescribing provision in NCL's places and neighbourhoods

A detailed mapping exercise was conducted to assess SP activities across NCL's boroughs. The stocktake highlighted significant variation in funding models, evaluation approaches and service provision across the

region. While this diversity reflects local needs and priorities, it also presents challenges in achieving consistency and comparability of outcomes. The report suggests opportunities for standardising certain elements of SP, such as impact measurement, while allowing for local flexibility.

The report also assessed each borough and the ICS against the SP system maturity framework, which measures the development and integration of SP within local health systems. This analysis highlights areas of strength, such as the widespread adoption of SPLWs, but also identifies gaps in training, funding and evaluation. The Universal Comprehensive Care Model's expectations—such as 100% GP practice involvement in SP and a reduction in GP consultations—are used as benchmarks to evaluate the progress and identify areas for improvement.

## Barnet

The Social Prescribing service in Barnet began in November 2019 with link workers initially being employed directly by PCNs. In June 2020, Age UK Barnet was commissioned to manage and deliver the Social Prescribing service for 6 out of 7 of Barnet's Primary Care Networks, with PCN5 continuing to recruit and manage three social prescribing link workers directly. The population of 432,182 is served by 25 Social Prescribing Link Workers (SPLWs), 5 Health and Wellbeing Coaches (H&WBCs) and 35 full time Care Coordinators (CCs) and 37 part time Care Coordinators with all practices having access to social prescribing.

The service is funded via the ARRS budget and uniquely in Barnet additional funding is provided by the PCNs and Public Health to fund Age UK's Social Prescribing Manager and Deputy Manager. Barnet is also the only borough in NCL to utilise a digital case management system (Elemental) which was joint funded for a 3-year contract by the former Barnet CCG and Public Health between June 2021 and 2024. Social prescribing is high on Barnet's health agenda, being integral to the Barnet Joint Health and Wellbeing Strategy and the Barnet Corporate Plan.

There is a wider community navigation offer which includes the Barnet Wellbeing Hub which is ICB funded mental health community navigation and social prescribing offer provided by Meridian Wellbeing. Self-referrals and agency referrals are accepted to a community navigator who will "ascertain your goals and needs, and employ a person-centred and tailored, social prescribing to inform and encourage you to access the appropriate services" to support mental wellbeing.

### Leadership and Governance

A key enabler of the success of the Barnet Social Prescribing service has been the cohesive working between Age UK Barnet, PCN Leadership, Public Health and the Local Authority in regular steering group meetings. The Age UK SPLW managers, Caitlin Bays and Bianca Illi, have provided excellent leadership for the service, implementing standardised governance processes across the borough, developing a robust supervision system

and working across place collaboratively. The SP managers have also developed strong community networks throughout Barnet with presence on multiple steering groups and on specialist MDTs supporting patients with housing problems and complex mental health patients.

Strong buy-in from the local training hub has also contributed to the maturity of the Barnet offer, with two training hub funded clinical lead roles being employed when the service began: a clinical lead for the personalised care roles and a GP fellowship project supporting the CCs. These roles were both instrumental at engaging with primary care teams to increase awareness of the service, ensure appropriate referrals and in promoting strong connections between the PCNs and Age UK Barnet. They also provided regular clinical supervision and attended peer support. One of these positions is no longer funded but their support in setting up the service at the outset positively contributed to how well the offer has embedded in Barnet. The GP Fellow has recently taken up a position with the training hub as Clinical Lead for the Personalised Care roles aiming to offer supervision and support to these roles. PCN2 have also separately funded a clinical lead position for the personalised care roles. This extra investment has resulted in a well-supported, cohesive SP team with 100% retention over the last 5 years. Enhanced training and regular weekly clinical supervision calls have created a psychologically safe working environment for the team. Staff have also been given the creativity to develop their own interests which has supported retention. She has also acted as a champion for the service, promoting the successes of the team by regularly sharing positive outcome data and publicising the proactive projects taking place with PCN leadership and partners groups to ensure continued support and investment in the service.

The H&WBCs support patients with lifestyle utilising coaching techniques. They are proactively targeting patients with prediabetes or newly diagnosed diabetes and are also providing support with patients in creating universal care plans. They receive referrals from SPLWs but are not otherwise collaborating closely. The CCs at PCN2 are well supported by their GP clinical lead who has a robust system in place for ensuring the projects they take on are well managed and coordinated. All projects must have a process map and a short training video explaining the project requirements to the workforce. Extra virtual supervision is offered with the launch of any project for troubleshooting and regular reporting is completed to ensure the targets are met. Across the rest of Barnet there is another clinical lead, Dr Rafif Mansour who is the Care Coordinator Network manager who has recently re-started running peer support events in September 2024.

## Social Prescribing Workforce

At Age UK Barnet all SPLWs complete a 3-week induction process working with both Age UK Barnet and the PCN to complete baseline training and the e-LFH modules. SPLWs are then buddied up with a more experienced SPLW for one session per week for a further 2 months to support progression to independent working.

There is a robust supervision system in place for the SPLWs as Age UK Barnet provide bi-weekly mandated supervision with optional additional drop-in sessions to discuss challenging cases. There is monthly one to one

professional supervision with a deputy manager and the SPLWs are all connected on a WhatsApp group for peer support. Peer supervision is monthly with all SPLWs invited, including those from PCN 5 who are not managed by Age UK Barnet. Once a quarter, peer supervision is opened to all the personalised care roles, but current attendance and engagement by the CCs and H&WBCs could be improved. Practice meetings are attended on a 6 monthly basis.

Clinical supervision is provided monthly by a training hub funded GP clinical lead, Dr Rafif Mansour with any urgent cases being discussed via the duty doctor system. In PCN2, SPLWs are offered weekly 1:1 clinical supervision with Dr Gadelrab when needed.

PCN2 have employed a team lead social prescriber who helps to manage the team. They have specifically recruited social prescribers with a variety of special interests and each SPLW is affiliated to one practice to support integration into the practice team. SPLWs are given the flexibility to develop proactive projects according to their own interests. These have included a face-to-face offer of SP for patients with learning disabilities with an SPLW with prior experience working with this cohort; a proactive project supporting patients with dementia along with community engagement events. Most recently they ran a winter wellness event with free soup, a range of community organisations attended along with the SPLWs to promote the service and bring the community together.

Recruitment and retention to SP roles has been successful with factors such as high-quality clinical and professional supervision, flexible working and involvement in proactive social prescribing projects which diversify the working week all supporting this. Short-term fixed contracts have previously had a negative impact on retention.

Ongoing training opportunities for the workforce are delivered through peer support where regular service updates are given. There are other ad hoc training opportunities with the voluntary sector and local authority, The London Social Prescribing Network and NHSE but there is not a local NCL Training Hub - Barnet programme offer for personalised care roles and no extra protected time for training outside of peer support. The SPLWs in PCN2 have completed extra training on dementia, workforce wellbeing and compassionate teamworking delivered by their clinical lead.

Current challenges for the workforce include the limited opportunity for career progression for SPLWs risking highly skilled staff leaving the service. The link workers are also mainly working and meeting remotely which could cause isolation. There is also currently no SP service for children and young people in the borough as they have been unable to recruit to this role.

## Planning and Commissioning

Regular Social Prescribing Steering Group meetings encourage cross system involvement in the planning and design of local Social Prescribing services. Unmet community needs and gaps in services are routinely

identified, and this intelligence is fed to commissioners and providers through regular reporting which is conducted by Age UK Barnet.

Funding is available via the Community Grants Programme of up to £10,000 to support the development of local community activities. Age UK Barnet SPLWs have utilised intelligence on unmet need gathered via social prescribing to support small voluntary organisations to successfully apply for these grants thus directly enhancing the offer for support for Barnet residents. A gardening project was initiated by Age UK Barnet in an area with a high number of referrals for social isolation and low mood to bridge the gap

A digital case management system "Access Elemental" was commissioned by the former Barnet CCG and Barnet Public Health. This example of integrated commissioning and collaborative working across place has resulted in strong partnership working and efficient use of limited resource.

Social prescribers are given time to build trusting relationships with local community groups although less than the recommended one day per week is spent on community development. Community wellbeing hubs are available throughout Barnet in local community centres, Barnet Wellbeing Hub and Meridian Wellbeing. However, these do not provide equitable access across the borough with some residents finding it difficult to access these services.

## Digital Systems and Enablers

The digital case management system "Access Elemental" is used across the borough and ensures standardised data collection and consistent impact data is recorded. Age UK barnet recognise how critical this system has been to develop their mature Social Prescribing service and are keen to ensure that this system is sustainably procured and implemented long-term. It allows simple referral and self-referral, efficient tracking of casework and reduces the need for patients to repeat their history allowing more time for supporting patients with what is important to them. It encourages the collation of impact data such as wellbeing scores and anxiety scores and can also be used to capture change in GP appointments or hospital attendance. Data collected is compliant with the Minimum Data Set for the Social Prescribing Information Standard. Generating reports is simple and time efficient utilising this system facilitating regular reporting.

Digital exclusion is a major concern amongst Barnet's elderly population and Age UK Barnet have conducted Proactive SP work to try to improve digital inclusion amongst residents. There are multiple digital inclusion offers available through Digital Barnet activities including Digital Skills Support; Digital Champions, Barnet's get online network and Age UK's own Get Active and Connected programme.

## Evidence and Impact

Monthly, quarterly and annual reports are generated for both the PCNs, Barnet Federated GPs, Public Health, ICB and Health and Wellbeing board. An annual evaluation is conducted for Public Health reviewing patient outcomes as measured using ONS4 data and feedback survey results as well as an analysis of EMIS data to determine the impact of social prescribing on GP and A+E attendance.

A total of 8029 referrals were received between April 23 and 24 which was a 13% increase in referrals from the previous year. Wellbeing scores are recorded before and after the social prescribing intervention to demonstrate impact, with 79% of patients reporting an improvement in their wellbeing. Elemental also allows EMIS data on GP attendance rates to be analysed, with reports of a 70% reduction in GP attendance for patients seen by the social prescribing service. Feedback is requested from every service user but the return rate for the feedback is disappointingly low at around 5%. 97% of patients providing feedback advise that they would recommend the service, and the commonest concern voiced by patients was waiting times for destination services rather than any complaint about the SP service.

The most common reasons for referral to social prescribing were for support with mental health, emotional wellbeing, housing, financial support and support for carers. The most common referrals made by the SP team were to Barnet Adult Social Care and to the IAPT service. The most common signposting by the social prescribers were to Age UK Barnet or Mind in Barnet. Data currently demonstrates a 29% DNA rate for appointments with a social prescriber demonstrating a need to fully educate patients on what the social prescribing offer is before arranging referral and to ensure that practice staff are referring appropriately. Self-referral DNA rates are much lower. Patients with more complex mental health needs have historically been referred inappropriately to the service but this has already improved with targeted training for referrers.

Data from Elemental has demonstrated that demand for the service has increased each year, and they have also been able to document trends in referral needs. Intelligence is gathered routinely on any unmet needs of service users, and this has been utilised to inform strategic work in the borough including the creation of a Housing MDT between social prescribers and the local authority to support patients with complex housing needs. A gardening group was also set up in one of the Barnet PCNs due to documented high referral rates for emotional wellbeing, anxiety and depression and long waits for counselling services to try to meet this demand. The SPLW managers have also worked closely with the Barnet Local Authority Prevention and Wellbeing Officer to support providers to access the prevention and wellbeing fund and community innovation funds to create services where there is documented unmet need.

Elemental has also been utilised to assess team productivity, to set targets for the team and to provide positive feedback to the workforce during one-to-one supervision. It has also allowed a new public facing Directory of Services to be hosted on the platform, which was commissioned by the Barnet Together Team, which can be updated directly by Providers.

Barnet's key priority for the service is to secure ongoing funding for the digital case management system which has been instrumental in the success of the local offer. It was acknowledged that the current data set may not fully capture the social return on the social prescribing investment and that urgent work must be conducted to

determine the most useful measure of the impact of SP. Whilst uniform data is collected in Barnet, they recognise that a London wide or national methodology for data collection is needed to further increase the credibility of the profession and service.

### Tackling Health Inequalities

Age UK Barnet are currently conducting a pilot on self-referral in 12 out of 48 practices to determine if this referral route is sustainable and whether it increases access to groups impacted by health inequalities. Proactive social prescribing projects have been conducted with housebound patients, to improve digital inclusion, with frequent attenders and proactive support for patients over 80 to access support for paying bills and staying warm in winter. They have ambitions to utilise lived experience volunteers, but none are currently in use. They are also looking at ways to encourage more meaningful co-production and co-design of the service with residents via increased community engagement events.

One particularly successful project in Barnet to tackle healthcare inequalities was run by Lamarra Alo, the Deputy Social Prescribing Marager for Age UK Barnet, who created a training programme for Culturally Appropriate Social Prescribing (CASP) in response to conversations with Barnet Social prescribers indicating that more than half (53%) were not confident at suggesting culturally relevant services. A two-hour training programme was developed and delivered to all SPLWs in the borough. Training included cultural literacy & understanding bias; a workshop on having culturally sensitive conversations; an exploration of what culturally relevant and appropriate services are and the importance of the existence of these services and finally training on how to suggest these services in an appropriate manner. This work also involved the creation of a CASP directory to support SPLWs in providing personalised care for clients requiring culturally appropriate services.

## Camden

Camden has 16 SPLWs, the majority of which are employed through the PCNs and practices. Age UK Camden employs four of SPLWs funded through the ARRS budget and an additional five Care Navigators that are not ARRS funded but are funded by the ICB as part of the Camden Care Navigation and Social Prescribing Service. The Camden GP practice population of 299,852 is further supported by 26.5 CCs and one H&WBC. All practices have access to SP.

The wider system offer is through the following organisations, The Camden Care Navigation and Social Prescribing Service delivered by Age UK Camden (Care navigation and Four SPLWs) Voluntary Action Camden which hosts Community Links, the first point of access for triage and for connecting residents to Care Navigators, Wish Plus+, SPLWs and community-based activities. Wish Plus+ hosted by the London Borough of Camden provides access to a range of warmth, income safety and health and well-being services. This includes things like home energy efficiency checks and is a major referral route for the Handyperson Service. In addition, Mind in Camden offers a mental health SP service to its clients.

As part of the wider system offer, Camden has commissioned social prescribing services for CYP across three local VCS organisations supporting a minimum of 100 CYP per year on a 1:1 basis and allowing a minimum of 100 CYP to access group activities. Fitzrovia Youth in Action provides social prescribing services including a link worker for young people 12-18 years of age. The Brandon Centre employs a link worker for young adults 16-24 years of age. Link workers develop trusting relationships with young people to identify and co-produce a plan of personalised activities based on the young person's needs, preferences, and motivation. They work in a flexible, person centred, non-judgemental way with young people with mild to moderate mental health needs from diverse communities, and those with long term medical conditions. The Hive runs a social prescribing project developing youth-led activities to improve health and well-being for young people aged 16-24 with young people supported to plan activities responding to the needs and interests of their peers. The service aims to support CYP to access activities to improve their well-being, mental health, skills, and self-confidence. A small budget is available to enable CYP using the service to access community-based activities and opportunities (including music, arts and sports) which may not otherwise be financially of logistically available to them. Alongside reduced social isolation and opportunities for improved community connectedness, the service is part of Camden's focus on early intervention to avoid pressure on clinical services.

## Leadership and Governance

Although there is no clear borough plan for SP in Camden there is a shared leadership group called the Social Prescribing Borough Partnership that meets six-weekly to discuss and progress SP matters. Age UK Camden, (Katalin Swann), London Borough of Camden Adult Social Care (Jessica Lawson), and Voluntary Action Camden (Donna Turnbull) and Holborn Community Association (Paul Crozier) share the leadership. It is co-chaired by Donna Turnbull and Paul Crozier and membership includes, several voluntary sector organisations, CYP SP services, Children's commissioning, Adults' Commissioning, mental health social prescribing and NCL Training Hub – Camden as well as Public Health and other Council Services such as Libraries, Community Partners, Leisure including Green Spaces.

Voluntary Action Camden and Age UK Camden have been developing and delivering SP services for many years prior to the introduction through the Primary Care Networks as part of the NHS Five Year Plan in 2019. Voluntary Action Camden leadership is well conversed in the benefits of SP and the need for systems leadership and stakeholder management to ensure its development.

Several PCNs who employ their own SPLWs have identified GP leads to support the work. There is no regular collaboration with the PCN leadership and the wider social prescribing group. Dr Sarah Morgan was the Personalised Care Lead for the borough though this post is no longer funded and there is no clinical leadership in the wider multi sector social prescribing group.

## Social Prescribing Workforce

SPLWs in Camden all complete the required e-LFH training before seeing patients. Host practices provide a practice induction for those SPLWs employed through the PCNs. Age UK Camden provides their own induction programme and includes a shadowing programme with more experienced SPLWs for the new starters which supports the transition to working independently. Coaching for Health courses are available for all through NCL TH and all SPLWs are actively encouraged to attend. In addition, other programmes such as Managing Patients with Challenging Behaviour (provided by LBC Adult Social Care), Dementia Care (NCL Training Hub) are available. There is no regular offer of training from NCL TH - Camden though this has been provided in the past.

Supervision practices vary across the borough. For SPLWs employed through Age UK Camden, there is regular one to one supervision every 6-8 weeks with their line manager and additional case sessions are offered if needed. It was not clear how this need was determined and by who. SPLWs employed through Age UK also had an annual appraisal which was an opportunity to identify training and support needs. Clinical supervision was offered monthly to staff in Camden North PCN, alternatively ad hoc supervision was often dependent on the SPLW requesting it.

Jo Lynch, SPLW from Caversham Practice, offers monthly sessions for all SPLWs to come together. These function like a peer support session for SPLWs in the borough. Another excellent initiative in Camden is the Camden Big Team meeting which is held bi-monthly. Staff from all sectors are encouraged to attend this forum and regular attendance from SPLWs, Care Navigators, voluntary sector organisations, local authority representatives and clinical staff from NHS organisations produces a regular opportunity for networking and the exchange of information and ideas.

Recruitment and retention of SPLWs across the borough is, in some instances, impacted by the higher rates of pay offered to Care Navigators. This is reflected by the quality and calibre of applications received through Age UK Camden. The PCNs employing their own SPLWs did not cite this as an issue. However, coupled with the lack of career progression for the role, retention remains a cause for concern. Professional development opportunities are limited and highlighted as an issue by both voluntary sector and LBC Social Care. Annual contracts provided to the voluntary sector is also a concern as there is no certainty of employment for staff. For some SPLWs that are based in GP practices, their work location meant their roles were not fully integrated into practice. Although this experience varied from practice to practice, where there was limited integration, examples included; lack of a private room for in-person appointments, back-to-back appointments resulting in n time to speak with a GP to gain a clearer picture of a referral, SPLWs working from home and arranging meetings with patients in public places such as cafes due to limited or no private rooms in practice.

A typical week for a SPLW is taken up with case work, leaving little time for community collaboration. This was reflected across the borough and a recognition that more time should be allocated for community networking. Camden has expressed an ambition to be involved in more proactive SP projects despite the limited capacity

due to case work. For some SPLWs, work and time pressures has meant there is limited opportunity to network and exchange information about services that are available in the community. The impact on delivery has also resulted in patients missing opportunities to access specific services that are available for their support needs While some SPLWs based in GP practices experienced isolation in their work, this was nor replicated for those SPLWs based in the voluntary sector who were generally able to connect with other services e.g. housing.

Two projects were funded through the TPHC (Transformation Partners in Health and Care) Innovators Project. The first project was through the Camden Care Navigation and Social Prescribing Service which aimed to tackle recruitment and retention through the development of voluntary roles to support SPLWs with the administration around referral. The second project was initiated by the West and Central Camden PCN which aimed to increase the number of people from an Asian, Black Somali or Arab ethnicity receiving SP and ensure high satisfaction rates with the service.

Camden also has a green SP directory. Caversham Practice has a SP garden project, a community collaborative crowd funded project called The Listening Space which holds a variety of activities and is hosted by a volunteer with lived experience of mental health issues.

In 2024, a multi-sector collaborative project with MIND, Voluntary Action Camden, City University and CNWL Physiotherapy provided peer support for 12 Long Covid Patients. Two peer facilitators have been identified from this group to be trained up by MIND to continue facilitating the group. SPLWs encounter additional challenges that can be prevented or reduced through support and buy in from the Council in their work. SPLWs require a stronger partnership with LBC so referrals go directly to the relevant departments instead of having to go through Contact Camden and the automated phone system. While some relationship building is happening, this is still a challenge for many individual SPLWS.

## Planning and Commissioning

SP in Camden is funded mostly through the ARRS budget. The current contract does not allow for a full cost recovery or the staff hours that are needed. This is being subsidised by the VCSE. There is also wider provision of similar services with community navigation roles funded through the London Borough of Camden and other grant bodies. It is worth noting that most of the voluntary sector services in Camden are funded through LBC and grant giving charities. Camden's Integrated Care Plan highlights SP as a top priority within the community connectedness workstream. This encourages all sectors to work together to improve access to SP in the borough and develop it from case work into more proactive offers. The current model operating through the Voluntary Sector Care Navigation and Social Prescribing Service is efficient, open access and can handle high numbers of referrals. This model attracts self-referrals from residents who may not be accessing help from other sources and is particularly effective amongst black and other ethnic minority communities. With additional funding this could be expanded. There is some disconnect with this offer and the services provided through the PCNs and GPs are often unsure whether to refer to SPLWs or Care Navigators.

The Social Prescribing Borough Partnership group aims to share population health data between social prescribers and organisation providing support to Camden's five health and care neighbourhoods. To ensure there are no postcode exclusions, all PCNS will need to be involved in this activity.

Funding for small community groups is currently available through We Make Camden Kit a partnership which includes LBC is a small grants and wider support offer that enables citizen led social action in response to Camden's "We make Camden" missions and challenges. Grants of up to £2,000 are available and there is a rolling deadline of every two weeks. Projects must align with the goal to achieve Camden's Core Missions by 2030 – everyone eats well every day, young people have great opportunities, there is diversity amongst people in power and people are living in sustainable neighbourhoods. Grants of up to £20,000 are available through the We Make Camden Project Fund to support projects that are shaped by people and communities with firsthand knowledge of problems and solutions. The find aims to increase equity and tackle inequalities making a difference to Camden's communities.

The stocktake review identified service gaps which included befriender type services especially for those who are housebound or isolated in other ways. Housing and the many issues associated with inadequate housing, damp, mould, repairs were also highlighted as a gap.

## Digital Systems and Enablers

The systems currently in use in Camden are EMIS used by the PCNs, Charitylog used by Age UK Camden and Salesforce used by Voluntary Action Camden. For both voluntary organisations, this means double data entry to satisfy both systems and difficulty in tracking casework. The EMIS system records basic data such as reason for referral, who they are referred to, GP practice, employment status, disability status, language, accommodation type, homeless status, anxiety and depression score.

Age UK Camden and VAC write regular reports on patients referred to the service and the Social Prescribing Borough Partnership looks at these. There is no overall requirement for reports that identify gaps or reasons for referral to be collected on a borough basis. Some PCNs thought that report writing was an unnecessary function of social prescribing.

There are several Directory of Services in the borough, with Voluntary Action Camden holding a directory of voluntary services and a directory of Green Social Prescribing. Age UK Camden has an internal list. There are also specific directories held by LBC e.g. Camden Care Choices the website for adult care and support, and the new "Camden Together" campaign launched in partnership with London Borough of Camden and Voluntary Action Camden which aims to reduce loneliness by providing ways for residents to meet new people and try new things through social groups and befriending. The range of activity is available on the LBC website.

The subject of a universal case management system for SP was met with a mixed response. As many of the PCNs do not collect data, some did not see the need for such a system. Charitylog is used by Age UK Camden and there was a reluctance to jettison that for another system. Data collection systems across the borough are not uniform. There was a lack of knowledge in the PCNs about the information standards for the social prescribing minimum data set and how this could support the development of SP. Feedback from patients is not routinely collected across the PCNs and the lack of uniform systems make it difficult to track casework and assess impact across the borough. The Social Prescribing Borough Partnership is exploring data development with Public Health.

## Evidence and Impact

Age UK Camden provides monthly quarterly and annual reports to the ICB that commissions the Care Navigation and Social Prescribing Service SP. From January 2023 to December 2023 a total of 1876 referrals were received. This was a combination of 1216 for the Care Navigation service and 660 for the SP service. Onward referrals totalled 2918 with SPLWs making 1625 referrals for 660 patients which means an average of 2.5 referrals for each patient. Care Navigators made a total of 1293 referrals. There is no time limit on how long a case stays open for a SPLW and they can support with frequent attenders to general practice. In addition, the Community Links part of the service supported approximately 800 residents who were triaged directly into community-based support. The most common reasons for referral were housing, benefits, social activity, financial support and mental health.

Once a patient is discharged from the Age UK Care Navigation and Social Prescribing Service, a patient satisfaction survey is carried out. An example is as follows. Using a Lickert scale from 0-10 to self-report patient well-being (with 10 being the highest level), patients report that the service increased their health and well-being by an average of 200%. Reporting at the start of the intervention health and well-being is an average of 2 and after the intervention an average of 6. The same scale was used to report on anxiety levels. On average clients reported their anxiety levels before the intervention as 9 (10 being highest level) and after the intervention as 4. The service reduced on average anxiety levels by 56%.

There is no systematic reporting across the other PCNs and no borough wide agreement to what could be collected. While some individual case studies are collected again, Age UK Camden aim to do one per month, but this is not uniform or systematic. While SPLWs may collect data from patients and share it with their PCN or individual practices, this is not collected at a borough level which makes it difficult to assess impact across the borough. Intelligence on unmet need is not routinely gathered or shared with the ICB to inform commissioning choices or strategy.

## Tackling Health Inequalities

The successful projects with TPHC were designed with to improve health inequalities. The Camden Care Navigation and Social Prescribing service trained volunteers most of whom were economically inactive to support SPLWs with their workload. After training, volunteers supported patients with regular welfare calls, regular social activities, accompanying patients to a medical or other appointment, supporting gentle exercise or walking activities. This programme provided volunteers with valuable experience to support them on their employment journey which is further supported by the Camden Links team at Voluntary Action Camden. In the six months of the project the service retained a 90% retention rate compared to 53% experienced in the previous year.

The project at Brondesbury Medical Centre targeting ethnic minorities in Camden saw 176 patients over a four-month period. The presenting problems were benefits, housing, depression, homelessness, forms/applications, debt/foodbanks. The benefits led to an increased usage of the service by ethnic minority patients, with exceptionally high satisfaction rates, 100% of respondents indicated that they would recommend the service to others. There have been numerous success stories related to housing, benefits, and grant applications. As a result of this project, demand for social prescribing has grown.

Vulnerable groups are supported by multi sector projects when opportunities arise which currently aids patients with Long Covid, and the three young peoples' social prescribing services initiatives targets vulnerable young people in the borough. The Social Prescribing Borough Partnership is keen to develop this work across the borough.

Support for people with autism and support for housing needs across all populations are two of the themes increasingly encountered. This is coupled with challenges accessing the services that support these needs. In Kentish Town there is a pilot to address support for complex housing issues, including repairs. The reach out Wellbeing Alliance was launched by Voluntary Action Camden in July 2024 to address the challenges people with Mental Health Needs experienced when accessing services. In addition to enabling easier access to Mental Health support in the borough, The Alliance aims to support residents who may not be eligible through the Healthy Minds programme provided by Camden Mind and funded through LBC and the Mental Health Partnership

## Enfield

Enfield employs the lowest number of SPLWs (7) of any NCL borough, with one PCN having no SP provision at all. SP does not feature as a strategic aim in Enfield's Draft Joint Local Health and Wellbeing Strategy 2024-2030.

Prior to 2022, Enfield Voluntary Action was recruited to run the SP service for Enfield Care Network and Enfield Unity PCN. Following 2022, the PCNs elected to directly employ SPLWs themselves within their own PCNs so there is no longer any cross-borough collaboration for the link workers. The largest PCN in the borough, Enfield Unity, employs four SPLWs who work as a team with a SP manager, Jacqueline Williams. Three PCNs;

West Enfield Collaborative, Edmonton and Enfield Southwest all employ one SPLW directly and Enfield Care Network, has no social prescribing provision.

Enfield Care Network formerly employed a SPLW for around one year but were unable to retain this staff member due to the reported high emotional toll of the role and the frustration of working in a deprived area with insufficient community activities to connect patients into. This PCN has instead chosen to employ five H&WBCs, who provide support with lifestyle changes including smoking cessation and tier 1 weight management. Additional funding from the health inequalities fund supports this project. The team has weekly hour-long supervision and training with a lead GP, Dr Ross Cunningham, and they are encouraged to attend community engagement and networking events during their half day per week for professional development. They have employed staff from within the communities they are trying to reach, three of whom are Turkish speaking. Whilst this PCN does not have any SPLW provision, the H&WBCs do offer limited community linking to services which can support with weight management. There is no SP offer for any issue other than lifestyle change and the staff are providing lifestyle advice rather than utilising health coaching techniques. The service has received positive feedback from participants, and for those that engage with the smoking cessation offer they have a 60% quit rate.

## Leadership and Governance

At its inception, in 2019, the SPLW workforce received borough wide peer support with leadership from NCL Training Hub – Enfield manager Kerree Ahern. Regular SP steering group meetings were held which were attended by the training hub, EVA, the council and the voluntary sector. Following EVA losing the social prescribing contract and SPLWs being employed directly by PCNs there is now no overarching leadership for the borough on SP. Enfield Unity employ a link worker manager, Jacqueline Williams, who provides supervision and leadership for their team. There is no shared SP plan in the borough and no SP lead in the locality integrated care partnership. The voluntary sector leaders and local authority are no longer well connected with the PCN SPLWs and there are no regular strategy meetings with LA, Public Health, SPLW managers or PCN leaders in attendance.

## Social Prescribing Workforce

A monthly peer supervision group is held by Unity PCN, with link worker staff from all other PCNs being welcome to attend. Unfortunately, not all staff were aware of this opportunity, so weren't regularly attending. The team at Unity meet twice weekly to discuss difficult cases and connect with their peers. They also have access to regular clinical supervision with Dr Anita Shah, lead GP for SP at Unity. Professional supervision occurs monthly at Enfield SW with clinical supervision via the duty Dr as required. At West Enfield Collaborative the SPLW attends practice meetings and has weekly clinical or professional supervision as needed. At Edmonton PCN the SPLW is a former social worker who is working completely autonomously and does not have access to regular supervision.

The majority of SPLWs are providing telephone support only due to insufficient estates for face-to-face working. Where a face-to-face working is available at Carlton House GP surgery, this SPLW is particularly well integrated into the practice team, is well supported and can identify cases she may be able to provide support for during practice meetings.

The majority of SPLWs in the borough had completed the e-learning modules for SPLWs but one at Edmonton PCN was yet to fully complete them. There is no local training hub offer for the personalised care roles but SPLWs attend training opportunities as they arise from EVA, TPHC and NASP. During monthly peer support meetings at Unity there is the opportunity to discuss cases, and local voluntary organisations are invited to provide updates.

There are no career progression opportunities for the workforce other than the link worker manager position at Unity and there have been some challenges with workforce retention with staff burning out due to high emotional toll of the work. The greatest challenge reported by all the SPLW workforce in all PCNs in Enfield is the perception of insufficient community activities to refer into and the slow responsiveness or long wait times for activities which are available. This concern was also voiced by PCN clinical directors as the reason for social prescribing being less mature in the borough and has led to reduced NHS investment in SP. Services felt to be lacking in borough include activities for younger people, for those wanting to lose weight and those with mental health problems. The SPLW workforce also reported challenges accessing support via the local authority and citizens advice to support patients with housing or financial concerns. Finally, support via the community hubs was felt to be inadequate, with clients reporting being turned away from the hubs if they did not speak English. Lived experience volunteers are not being utilised to support SPLWs across the borough.

## Planning and Commissioning

Across Enfield all PCN CDs and most of the SPLW workforce cited a lack of community activities related to legacy underfunding of the voluntary sector and lower spend on community services per head of the population compared to other NCL boroughs, as being the greatest risk to SP success in the borough. Enfield is the only borough to report this as a major concern. Increased waiting lists seen at Enfield Unity PCN were felt to be related in part to increasing demand but also due to difficulty handing over cases to destination services in the community due to either long waiting lists to be seen or insufficient community activities. The SPLW working in Edmonton is a former social worker and has lived in the borough all her life. Her perception was that there were sufficient activities for most cases she was seeing, though felt activities for adults between 25 and 50 years were lacking and support for refugees and non-English speakers could also be improved.

An integrated community chest commissioning approach is utilised in the borough with the Enfield Local Fund which is managed by EVA and funded by the ICB, the local authority, City Bridge Foundation the National Lottery and others. It provides grants of up to £5000 to local voluntary and community groups to fund projects that benefit residents in Lower Edmonton and Edmonton Green council wards. EVA reported that they have

delivered grants to over 130 small grassroots organisations to date. Projects must meet the key themes of supporting children and young people; improving community wellbeing or cohesion; developing opportunities for local people or improving the local environment.

The majority of the SPLW workforce time is spent on casework. There is some flexibility and autonomy for staff across the borough to spend time building up their community networks, but this is limited and less than the recommended one day per week. Both the local authority and voluntary sector organisations in Enfield reported a lack of regular connection or integration with the SPLW workforce, suggesting that another barrier for the Enfield SPLW workforce is keeping updated with what is available locally.

As there are no regular reporting requirements for SPLWs and no digital case management system there is no infrastructure for identifying unmet community needs and gaps in services or for sharing this intelligence with place-based commissioners.

Community hubs at Edmonton Green Library and Enfield Town Library are part of the Council's Early Help for All Strategy providing help with money; jobs and skills; health and wellbeing and housing stability. There are several leisure centres in borough but none that provide free access to activities.

### Digital Systems and Enablers

All SPLWs in Enfield are utilising an EMIS template for data collection to encourage appropriate recording and coding of referrals. There is no borough wide agreement on which data to capture but all include demographic data, reason for referral and onward signposting. There is no digital case management system and SPLWs at Enfield Unity expressed frustration at having incomplete access to EMIS records, needing to enter data twice and difficulty tracking casework. In Edmonton the SPLW utilises EMIS for documentation but there is no EMIS template used.

There is no single commissioned directory of services. Three are currently in use in Enfield; MyLife, Love on your Doorstep and a new directory called Enfield Activities is being launched by EVA. The workforce also holds lists of organisations they commonly refer to but have found that some of the activities are no longer available and it is difficult to keep these personal directories up to date. A single, regularly updated list of community activities utilised by all SPLWs would simplify the process of identifying active appropriate activities. The workforce is not well connected across the borough and is not utilising a WhatsApp group or Teams Channel to facilitate easy access to advice from each other.

Digital exclusion is a major issue in the borough as noted in Health Watch Enfield's recent Report on Digital Exclusion in September 2023. The SPLWs have not been linked to projects to improve digital inclusion as yet, but these are occurring elsewhere with Edmonton PCN launching their digital inclusion service in October 2024.

## Evidence and Impact

There is no borough wide agreement or uniform collection of data to demonstrate impact. At Unity, goals are set with clients, and they record whether SMART goals have been achieved at the end of the intervention along with satisfaction with the service. Between April 2023 and 2024 Enfield Unity social prescribers saw 834 patients with the commonest referral reasons being low mood; weight management; benefits advice; housing and social isolation. Demand increased by 41% between the last quarter of 23/24 and the previous three-quarter average, with waiting times increasing from 1 to 3 weeks. The most common referrals made were to Age UK; Mind in Enfield; Enfield Carers Centre; Citizens Advice, Enfield Community Hub; Solace; local leisure centres or the foodbank. A sample of 91 patients were examined to compare GP attendance in the 6 months before referral to a SPLW and the 6 months after the SPLW case was closed. 47% of patients in the sample had reduced GP appointments after SPLW intervention, which they estimated to be 61 hours of GP appointments being saved. They also conducted a social prescribing feedback questionnaire with patients reporting an average 4/5 score for satisfaction with the service and respondents stating they felt more connected to their community and had an improvement in their wellbeing.

Enfield SW employs one link worker who received 328 clients in 23/24 with the commonest referral reasons being housing, finance and loneliness. Edmonton PCN SPLW is not collecting data on referrals so was unable to provide any reports. She verbally reported that the most common cases seen were patients with housing, mental health and financial problems.

SPLWs across Enfield have conducted case studies, which they share with their own PCNs but there is no systematic way that this is happening. Feedback is not routinely sought from all service users though periodic feedback surveys have been collated at Unity which have been positive. There are currently no reporting requirements; therefore, intelligence on unmet need is not being captured or presented to commissioners.

## Tackling Health Inequalities

Proactive SP projects have taken place at Enfield Unity with patients with pre-diabetes, frequent attenders and outreach to Foodbanks to advertise the SPLW offer. In Enfield Southwest PCN they have focussed on proactive work with housebound pts and in West Enfield Collaborative with isolated elderly patients. The SPLW at Edmonton PCN has arranged some community engagement events including a wellbeing day where patients were invited to attend an event with clinical staff and voluntary organisations such as Age UK, North Side Youth, Solace, Enfield Food Banks and ABC Parenting to educate the community about the local health service and community offer. They had fantastic engagement and are planning future events over Christmas to distribute toys and appliances to families in need whilst promoting the SP offer.

There is currently no coordinated collaborative work between the SPLW service, Public Health, the local authority or Enfield Voluntary action to identify cohorts which might benefit from proactive SP and the above initiatives are driven by committed SPLWs trying to make a difference in their communities.

### Children and Young People

There were historically some social prescribing projects for children and young people in Enfield including the Youth Alive pilot project managed by Enfield Voluntary Action and delivered by Oasis Community Hub, Chicken Shed and Focus CIC. Children and young people aged 10 to 19 who live or study anywhere in Enfield were offered SPLW support to look after their wellbeing and build their confidence and learn new skills such as basketball, football, cooking, acting and drama lessons. This project reportedly received a low volume of referrals from primary care and is no longer funded. The delivery partners continue to offer similar projects. Chicken shed a local theatre company offer a variety of free projects for young people aimed at community empowerment. Oasis Community Hub offers open access youth clubs, 1:1 and group mentoring and their youth workers have extensive knowledge on local services within the community that they link young people in with.

Project Dove, funded through the NCL Health Inequalities Fund, aims to identify young people at risk of becoming involved in serious youth violence and provide targeted SP support to reduce this risk. The SPLW is part of the Early Help Team at the London Borough of Enfield, and it forms part of the Enfield Community Safety Plan. They have received 30 referrals for children between 12 and 17 years of age for problems such as substance misuse, negative peer influences, school non-attendance and theft. Individuals have been linked with organisations including Sort–IT a substance misuse agency, North Middlesex mentoring scheme and youth centres in ponder end providing boxing and music production sessions. They have reported outcomes of improved educational attendance, reduced offending and improved physical and mental wellbeing.

## Haringey

Public Voice London is commissioned to deliver the SP service in six out of the seven PCNs in Haringey, employing 11 SPLWs and one health and wellbeing coach. Northwest PCN employs one SPLW directly and another is employed via Bridge Renewal. 59 CCs are employed across the borough. The East and West of Haringey have different population challenges with a much older, frailer population in the West and higher deprivation in the East and as such different services have been commissioned to best meet the needs of the local population. There is a much wider community navigation offer available in Haringey including but not limited to the frailty care navigators with the Multi-Agency Care and Coordination team, diabetes care navigators, the homeless health inclusion team, heart failure care navigators and the reach and connect team who offer a similar community connecting service to the SPLWs.

The SP offer at Public Voice provides up to 12 weeks of support with a SPLW with initial contacts lasting one hour and subsequent interactions are half an hour. Waiting times to assessment are short at around one to two weeks. The H&WBC offers up to 8 weeks of sessions focusing on lifestyle changes.

## Leadership and Governance

Leadership responsibility is pooled between Public Voice, Bridge Renewal, the local authority, PCN Clinical Directors and the ICB. There is great enthusiasm and support for progressing personalised and preventative care in the borough, but currently no oversight group in place for the personalised care roles. Leadership support for the workforce via Public Voice and via Northwest PCN leadership team is strong but system wide leadership for social prescribing could be strengthened for improved efficiency. The Haringey workshops had the highest attendance and the largest representation from PCN Clinical Leadership, suggesting strong buy in and support for SP. There are, however, no GP clinical leads for the personalised care roles in Haringey and no regular collaboration between the PCN leadership and the SPLWs which could impact progress.

## Social Prescribing Workforce

The workforce is offered a good support system with Public Voice providing weekly peer support huddles with individual professional supervision in person every 6 weeks with a senior link worker. Every three-months there are whole team sessions on reflective practice. In Northwest PCN, the SPLWs attend monthly supervision sessions with Bridge Renewal and are well embedded into the practice team via attendance at weekly practice meetings.

Currently SPLWs complete an induction process including completion of the e-learning modules for SP. There is currently no accredited training programme offered at induction and ongoing opportunities for training are ad hoc with some sessions being available through the council or voluntary organisations but no regular offer from NCL Training Hub - Haringey. There is no regular protected time for professional development or community collaboration with most of the SPLW time being spent on clinical casework. Recruitment and retention are reasonable at Public Voice but staff who have left reported frustration with workload and limited career progression opportunities as contributing factors to them leaving. In Northwest PCN it was felt that unattractive staff paygrades and lack of access to the NHS pension scheme are both risks to staff retention. An innovative SP project has been conducted in Haringey in collaboration with NCL Cancer Alliance, where SPLWs have been upskilled to provide bespoke support for patients living with cancer in Haringey's deprived communities. By developing a special interest these link workers have diversified their working week which may be a novel way of promoting retention within the workforce and is something Haringey are hoping to expand on in the future. Lived experience volunteers are not currently being utilised to support the SP team directly, but coproduction is a major theme in Haringey's Health and Wellbeing Strategy 2024-2029.

Several notable proactive social prescribing projects are being conducted across the borough including work with frequent attenders, a gardening group in Queenswood Practice, Haringey walks walking groups and dementia teas in Northwest PCN. Staff at workshops and interviews with leads felt that the current contracts do not encourage proactive work as there is an expectation to manage waiting lists and appointments rather than investing time in community collaboration and proactive work. SPLWs are not given the recommended 1 day per week to build their networks with community groups.

## Planning and Commissioning

The SP service is funded through the ARRS budget, but the wider community navigation offer is supported through a combination of ARSS funding, Better Care Fund (BCF) Plan, Council funding and VCSE externally funded projects. Resource is pooled to optimise the funding of these projects.

Haringey's Early Help and Prevention model is a partnership between the NHS, Council and VCSE, with three distinct workstreams 1) Improving Information & Communication, 2) Community Navigation and 3) Improving Community Assets.

One of Haringey's unique successes is the commissioning of their innovative Community Navigation Network 'NavNet'. This is a group of over 275 community navigators (including SPLWs and care coordinators) connected by 'WhatsApp' which acts as a dynamic resource directory and practical network of mutual support allowing ease of communication and sharing of ideas and opportunities. The BCF funds a dedicated post to coordinate the development and infrastructure to support NavNet, with ongoing investment planned to further expand membership.

Haringey is co-designing a community chest approach to grant funding VCE organisations to promote community asset building, with Haringey being the first borough to pilot this approach. The borough is well served with a wide array of diverse community activities with the main gap in provision felt to be around housing responsiveness and activities to reduce social isolation for the frail population. The Haringey Multi-Agency Care and Coordination (MACC) team provide support to those with extreme frailty but there are plans for PCNs to work with community partners and residents to codesign early help to support people with mild frailty to manage their condition/risks and age well.

Community wellbeing hubs are available including Hornsey Health Centre, the Selby Centre, Northumberland Community Space and Living Under One Sun.

Regular collaboration between the SP service and Public Health to analyse population health data to inform commissioning is not currently happening and unmet need in the community is not currently being documented by SPLWs in a systematic way or monitored to inform commissioning. The team at Public Voice have noted a specific challenge in the borough around long waits to access housing support, long waits for

housing repairs and a lack of community groups appealing to young men and have presented these concerns in their annual report.

## Digital Systems and Enablers

An EMIS template is used to record data including basic demographics, reason for referral, goal setting, referrals made and whether the goal has been achieved. There is no routine reporting to the PCNs and no budget provided for doing this. It is difficult to track cases and generate reports from the current system and PVL feels a digital case management system would more effectively follow and manage the patient journey, freeing up staff to focus on the patients. The current system is also not facilitating the identification of patients who may need preventative care. There is a need for a uniform system across Haringey to ensure alignment and connectivity.

## Evidence and Impact

Public Voice received 7690 referrals between April and December 2023. Up to 12 weeks of social prescribing support is offered either face to face or on the telephone. Initial assessments are one hour with follow-ups of half an hour. The H&WBC offers up to 8 weeks of coaching on behaviour change. The commonest referral reasons were housing, finance and social isolation. Data is collected on whether a patient achieves their goal, with 88% of patients reporting they had achieved their goals and 97% feeling they had partially achieved their goal. An EMIS template is utilised for data collection which includes basic demographics, referral reason, goal setting, whether the goal was received and referral made. Tracking casework and creating reports is time consuming without a specific digital case management system. Feedback is not consistently sought from service users. Desire to do more preventative outreach work and for link workers to be given time to network more closely with their communities. build the case for SP with digital case management system.

NW PCN service supports a different population, with the commonest referral reasons including supporting carers, signposting for those at increased risk of falls and financial support. There is 6 monthly reporting to the PCN regarding referrals received and workload but there is no consistent collection of impact data and feedback from patients is collected in an ad hoc manner. There is a perception of insufficient services available for the elderly population in NW PCN.

Public Voice London collates data on goal achievement as a methodology for determining impact. For cases between April and December 2023, 88% of clients had achieved their goal and 97% had at least partially achieved their goal. There is no regular reporting of this data to the PCNs or ICB and data is sometimes missing or blank as goals are not always documented. It was felt that a system wide agreement of the most useful data and intelligence to be collating is essential. Longer term follows up at 6 months after intervention to assess outcomes and offer ongoing support.

### Tackling Health Inequalities

Haringey is the 4th most deprived London borough with a 15-year gap for men in health life expectancy between the most and least affluent areas and a 17-year gap for women. Haringey Health Inequalities Fund supports the Healthy Neighbourhoods programme which aims to improve inequalities in health, well-being, and life chances those living in deprived and diverse communities in the east of Haringey. Co-ordinating and expanding SP, health coaching and peer support is one of the five main themes of the programme along with hearing and empowering residents. This fund has supported the expansion of Navnet and the production of a toolkit on how to empower local people and support co-production.

Haringey was also involved in a pilot study with High Intensity Users where social prescribers from Public Voice contacted individuals with frequent attendance to North Middlesex hospital A+E department to proactively offer support. The pilot was successful, though impacted by the Covid 19 pandemic. The new High Intensity User service for individuals with complex needs is now delivered by CCs with Mind in Haringey and Mind in Enfield. The top 120 high intensity users attending A+E are triaged to identify who may benefit most from support. They are then linked with a CC who uses a personalised approach is used to understand the individuals' issues and identify any unmet needs. A bespoke Urgent Care Plan is created in partnership with the patient that can be shared with all NHS professionals to support continuity of care. Twelve weeks of support is offered at which point users are connected to community or VCSE support services. Outcome measures from the pilot have shown that wellbeing increased by nearly 25% (using the Warwick Mental Well-being Scale) with a 30% reduction rate in A+E attendances.

Proactive work has also been conducted with the frail population in the SW and dementia teas have been set up in NW PCN to support those caring for patients with dementia.

### Children and Young People

The Haringey Youth Justice strategic plan outlines ambitions to work in a systemic way to reduce youth offending and repeat offending by providing children with supportive interventions, including SP, which address the root causes of offending behaviour. A strength-based model is used to create intervention programmes that build on the interests of the child to improve health and wellbeing and reduce offending. Several activities were offered including drama and graffiti sessions, football training, Caribbean food groups and practical support sessions to get into retail and hospitality work. They have plans for 24/25 to run pottery projects, girls' groups and an arts identity project.

## Islington

Islington has benefited from a SP service for some GP practices before the provision of ARRS funded social prescribers in Primary Care Networks. The current service commenced in 2019 and was available to all practices in Islington. Initially there were three voluntary sector organisations providing SP services Manor Gardens, Age

UK Islington, and Help on Your Doorstep (HOYD) for all the five PCNs. In 2023 PCN N2 began to deliver their own SP Services when the contract with Manor Gardens finished. Age UK Islington and HOYD continue to provide these services and are contracted through the Islington Federation. The Islington population of 263251 is served by 15.5 SPLWs, 31.45 (whole time equivalent) Care Coordinators and 3 H&WBCs. All PCNS and their practice populations have access to SP services. Age UK provides services to Central 1 Network and North Network, HOYD provides services to Islington North 1 and Central 2 Network.

Funding for SP is through the ARRS budget. HOYD provides a Care Navigation Service funded through the lottery grants and the London Borough of Islington. Age UK also provides a Care Navigation service (6 FT equivalents) which supports local people. Care Navigators work with people with multiple issues that require coordinating and longer-term case management and support. There is very little self-referral for either the SP or the Care Navigation services. PCN N2 social prescribing accepts referrals from clinical and non-clinical staff in the PCN.

A unique feature of Islington is the well-established Children and Young People's Social Prescribing Project for young people. Isledon Arts are commissioned to provide this service and employ two SPLWs. The project helps young people (11-25 years) access creative, social and sporting activities in the local community.

## Leadership and Governance

Delivery of the SP Service in Islington is overseen by senior personnel in both Age UK (Michael O'Dwyer Head of Services for Personalised Care and Support) and HOYD (Ken Kanu Chief Executive). Commissioning through the Islington Federation for these services provides additional governance. While there is no overarching borough plan or a central group where the remit is to consider the strategic development of SP in the borough, support for SP as an important part of a wider health and social care system is strong with all the PCN CDs supporting the development though there are no identified leads in the PCNs though the PCN Manger in PCN N2 oversees the service. Multi sectorial collaboration with Public Health, London Borough of Islington and other voluntary sector organisations to develop social prescribing is ad hoc. There is strong support from both voluntary sector providers for systems leadership and development to aid the maturity of social prescribing in the borough.

## Social Prescribing Workforce

There is a high demand for SP services in Islington. SPLWs are fully embedded within practices and are part of the team. The referral pathway is clear, and practices are keen to refer, resulting in a high number of referrals. Access to assessment is quick which also increases referrals as patients are seen in a timely manner. The service is able to manage complex cases and is keen to be involved in more preventative and early intervention work. This may be easier in PCN N2 which employs its own SPLW.

SPLWs in both Age UK and HOYD are required to complete the e-LFH modules. Age UK provides an intensive programme for its social prescribers which occurs over a six-month period and includes a detailed understanding of the additional services offered by Age UK and an overview of what services and facilities are available in Islington. SPLWs are also required to complete the care navigation competencies from NHSE WTE and Age UK competencies. HOYD staff have access to part of the induction provided by the GP Federation and there is an internal HOYD induction they must complete. This includes information about other HOYD services as well as information about the voluntary sector in Islington. PCN N2 ensures all staff complete the e-LFH modules and provides a practice and PCN induction.

Supervision varies slightly. At Age UK, all SPLWs receive six weekly supervisions from the management team and additional support from care navigators for complex case. While the PCN provides clinical supervision in theory, this does not occur in practice. At HOYD supervision is offered in three tiers, two of which are in their control. The SPLWs' line manager provides regular supervision which is in house. The organisation also pays for monthly external clinical supervision with a clinical psychologist. This covers casework and includes well-being. Supervision is also offered at the practices, but this is very patchy even though there are named people. PCN N2 provides supervision to the SPLW and there is ad hoc clinical supervision if required. Peer support is provided monthly through the Islington Federation and the core mental health team. This provides an opportunity for ongoing training and updates about local services. It is accessible to all the personalised care roles and care navigator in Islington and is well attended. Additional internal training is provided through both organisations for all staff irrespective of occupation.

Recruitment and retention have historically been an issue in Islington and there are many reasons for this. The main issue is the lack of job security. Voluntary organisations cannot guarantee that a PCN will issue an SLA for Social Prescribing Services and individual staff were leaving for other roles. Voluntary sector organisations can't compete with the salaries offered by the NHS. HOYD lost three people in 12 months to the NHS. Age UK report similar issues and add that the nature of the job increases burnout in people. Staff were losing empathy with patients and the organisation offered well-being support, a platform for SPLWs to talk about the issues and they looked at different ways of delivering the service. There are more proactive social prescribing projects that enable social prescribers to vary their working day and not just be involved in case work. There is limited opportunity for career progression though the variety of proactive projects does aid skill development. Projects include work with asylum seekers, nutrition workshops, cardiac rehab and MSK.

## Planning and Commissioning

Islington benefits from a strong and well-funded voluntary sector with good access to benefits and legal advice. The main gap is in mental health and counselling services. An overarching strategic group to align both social prescribing and care navigation is absent in Islington, and this is frustrating for the lead providers as there is nowhere to feed into to support the development and design of local SP services, document unmet community needs or to identify gaps.

Funding is available through the local community chest funded by the council and run by Cripplegate Foundation. There is the Make it Happen scheme where groups can apply for funds to deliver projects. HOYD holds funding for this. Cloudesley Trust specifically supports people and organisations in Islington has grants available up to £20k. Previous recipients have been ADHD parents and other access groups. These community grants are available however there is a lack of awareness about them or limited skills to apply for these in smaller organisations.

At the start of PCN SP, there was initial support for the Bromley by Bow model when the service was commissioned in 2019. Voluntary sector organisations felt that co production was possible, ARRS funding was powerful, and the service would be co designed that would be built for patients in the best possible way using leverage and knowledge from local communities. There is still a strong desire for this to happen from the Voluntary sector and for an overarching group to explore these issues but there are inhibitions. The annual SLA means that organisations are unable to plan beyond a year which makes it difficult to build for infrastructure and not the most positive way to build relationships in the community. The voluntary sector is subsidising social prescribing as management, recruitment and many other costs are absorbed by the voluntary sector provider. In many instances organisations are viewed as a commissioned service and not a partner. This does not support community cohesion.

Social prescribers are given limited time to build trusting relationships with community groups and services. While both HOYD and Age UK can engage with this on an organisational level, individual social prescribers do not have time to do this affectively. The model job description includes capacity building but for the average SPLW, their time is taken up seeing patients. Pressure to keep waiting times low is a factor here.

## Digital Systems and Enablers

The two main providers in Islington use their own digital system. Age UK uses Dynamics and HOYD uses another data base system. PCN N2 uses an EMIS template to record and code referrals. For both Age UK and HOYD data must be uploaded onto EMIS manually, a double data entry which is time consuming. Tracking case work and generating reports is also difficult. There is no digital case management system and while there are concerns about who would fund this, if central funding was available, CDs and the voluntary sector providers would strongly support this development.

Information on the outcome of the social prescribing intervention is fed back and individually recorded on EMIS system and liaison with GPs through emailing them or to the practice. Monthly referral data is also fed back. Miniature case studies are produced including demographics, key outcome areas and what people have achieved.

There is no single Directory of Services. LBI, Age UK and HOYD all have their own. It is difficult to maintain these directories, and not all are current. Age UK did a recent review of green social prescribing projects mostly provided by small voluntary sector groups. There were 30 different providers and on review over half of them

were no longer running. Islington has many local services which increase the problem as there are more to review.

## Evidence and Impact

Social prescriber caseload is between 200-250 per year depending upon the complexity of the case. Common reasons for referral are benefits, housing and mental health issues. Some patients do want connectivity with community activities and Islington is well provided for.

Regular reports are generated by both providers for the PCNs. Age UK reports monthly and annually to its PCNs, and HOYD provides monthly and quarterly reports for its PCNs. The monthly reports give an overview of the patient and what is planned, the quarterly report gives an idea of changes that have taken place based on what the Social Prescriber has done, and the interventions suggested. After patients have been supported and the interventions have been accessed, a review is initiated after three months. Questions asked include do you feel more connected to your community, have your issues been resolved). This is more useful than the ONS4 measure which is unwieldy and not that helpful.

The data collected for the reports is similar and includes patient demographics, (the referral form does not record ethnicity data) reason for referral, referral source, services signposted to, outcome areas (these are identified as connectedness, housing and home, money, positivity, safety, wellness, work and meaningful activity), throughput and cases closed, time to assessment.

The referral data is analysed to identify any differential referral rates and understand the reason for these. This is then fed back to the PCNs. Patient feedback is sought after the end of every case for Age UK and patients are asked how they would rate the service and areas for improvement. HOYD follows up after three months asks what has changed for the patient. They report that ONS4 is cumbersome and prefer their own three-month follow up which includes questions about community connection and if their issue has been resolved. Islington Federation is asking for information on patients to be documented after every encounter and for this information to be included in reports. The present system is unwieldy as the report writers must trawl through multiple systems. There is no formal way of capturing the patient experience, the reporting requirements are about what has changed for them.

There is inconsistent data collected, and different systems used for collection. Collecting the information from each system is labour intensive and it is difficult to make comparisons or demonstrate impact across the borough. Different outcome data is used, and the providers do not receive the information about changes to GPs appointments or hospital admissions. There is no requirement for any data to be collected on a borough basis which means there is no routine capture of information on unmet need. There is no information shared with the ICB from the borough.

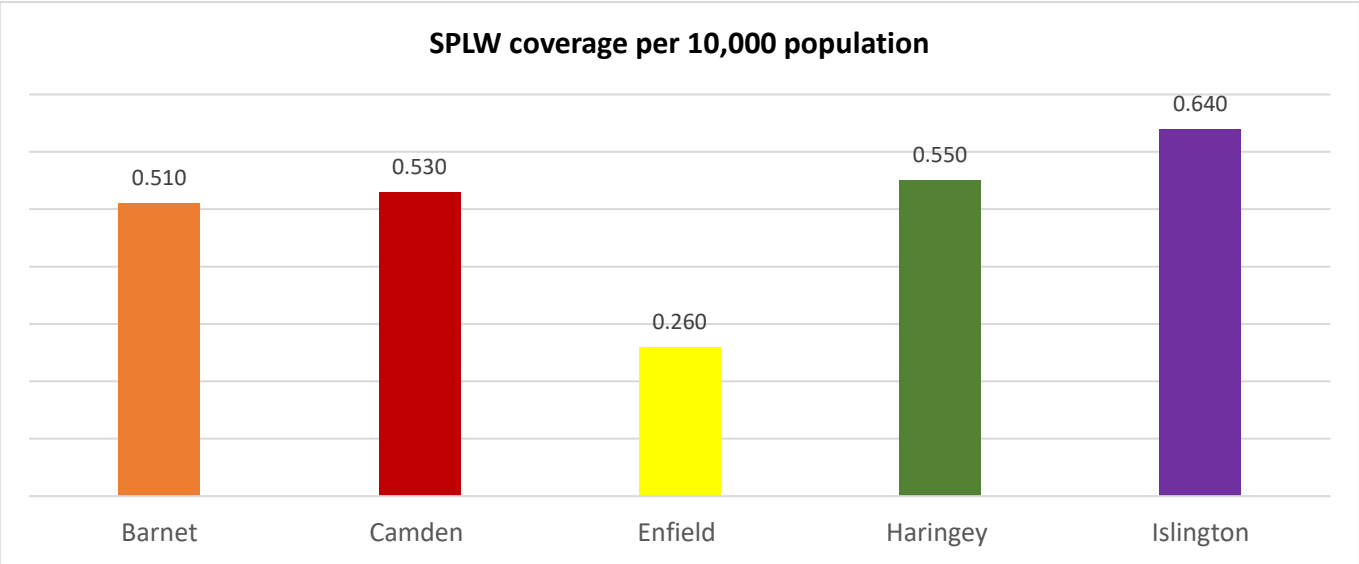
## Tackling Health Inequalities

Several projects support health equity across the borough and have the added value of developing social prescribers' skill set and aiding retention. The projects are delivered by Age UK and are broad in their scope. A nutrition project run in partnership with Metropolitan University supports people with diabetes with nutrition and food concerns. The cardiac rehabilitation pilot project aims to evaluate if Social Prescribing can enable people to engage and maintain engage with CR, sustain and continue activity after CR (this project will complete in June 2025). A project with asylum seekers based in hotels delivered sessions on the NHS and its services, ran exercise classes, ran motivation sessions. Translators in Arabic, Sylheti, and Farsi supported the monthly sessions. Other projects supplying services to housebound people and those with COPD or MSK issues. This approach diversifies the way SP is delivered and supports population groups that may not present at General Practice.

# Analysis of NCL's social prescribing provision across places and neighbourhoods

SP has been widely embraced across much of NCL, with four out of five boroughs offering extensive coverage and most GPs across NCL having access to a social prescriber. The Universal Comprehensive Care Model aims for one full-time equivalent link worker per 10,000 people, and good progress is being made toward this goal. Islington is leading with 0.64 link workers per 10,000, followed closely by Camden, Barnet, and Haringey, each with around 0.5 per 10,000. Enfield lags significantly behind, with only 0.026 link workers per 10,000 of the population.

*Figure 4 SPLW Coverage per 10,000 Population in NCL Boroughs*



Transformation Partners in Health and Care (TPHC) calculated that London should be working towards circa 800 SPLWs, approximately four per PCN (average population of 50,000). More recently (June 2023), the NHS Long Term Workforce Plan sets out the potential expansion of personalised care roles, from circa 3000 posts (as of September 2022) to 9000 by 2026/27, equivalent to circa 1450 roles in London. More investment is needed to meet these targets.

SP maturity varies across NCL boroughs, with each facing unique challenges and serving different populations. Following the restructuring of the ICB, the boroughs are yet to have a named social prescribing lead in the locality Integrated Care Partnership and there are no co-produced PCN-level social prescribing plans in any borough mapping out strategy.

## Leadership and Governance

Individual boroughs have utilised different approaches when implementing their social prescribing services with varying degrees of success and maturity. Barnet stands out for its well-organised leadership, regular steering group meetings and strong collaboration among stakeholders across the system, crucially including clinical leads and PCN Clinical Directors. It benefits from collaborative leadership and extra funding from public health which fully covers the cost of the social prescribing managers. It is also the only borough using a digital case management system, improving efficiency, demonstrating impact and tracking unmet needs.

Camden benefits from a strong borough partnership involving public health, the voluntary sector, and the local authority. However, limited collaboration with clinical leadership and the absence of representation for PCN-employed prescribers in the steering group have led to a more fragmented service.

Haringey has strong voluntary sector leadership and PCN-level support and but lacks a system-wide oversight group, impacting efficiency and cohesion. Islington are also relying on voluntary sector leadership without a borough-wide plan or dedicated clinical leads, leading to disjointed collaboration. For those voluntary sector organisations providing SP services in Camden, Haringey and Islington there is not full cost recovery to cover management and training which understandably is frustrating and not sustainable. Enfield has no cross-borough leadership for social prescribing and limited stakeholder integration, resulting in the least developed SP structure.

## Social Prescribing Workforce

The SP workforce across all NCL boroughs face common challenges with no requirement for link workers to complete a Level 3 Qualification in Social Prescribing and no structured ongoing training offer via the training hubs. All link workers across NCL have completed the e-learning modules for SP except for one SPLW in Edmonton PCN who was yet to complete them. Barnet, Camden, Haringey and Islington voluntary sector providers are offering a structured induction and shadowing with ad hoc training opportunities through their

organisations. Protected time for professional development and community collaboration is challenging in all areas with very few receiving the recommended one day per week for community development due to the challenge of meeting the demand of casework.

Supervision structures are particularly strong in Barnet where the workforce has access to mandated biweekly supervision, a monthly well attended peer support and access to clinical supervision via the Clinical Lead for personalised care. Supervision with a senior manager within the voluntary care organisations in Haringey, Camden and Islington is also robust but less frequent than in Barnet and access to clinical supervision is more challenging. Supervision within the Enfield Unity PCN is robust with regular weekly huddles and access to a Clinical Lead for social prescribing. Where social prescribers are employed directly by practices or PCNs, the supervision offer varies widely with some link workers being very well integrated into the clinical team and attending all practice meetings and others being more isolated.

Peer support is available across all boroughs with wide membership and good attendance across Barnet, Camden, Islington and Haringey. Enfield Unity have a peer support offer and do welcome link workers from neighbouring PCNs but there was limited awareness and uptake of this offer. Haringey particularly excels in community connectivity, with its innovative initiative "NavNet," connecting over 275 community navigators via WhatsApp.

All boroughs sited concerns that the lack of career progression opportunities, job security and the high emotional toll of the roll could impact on recruitment and retention. One PCN in Barnet has had phenomenal success with retention through excellent management and support, flexibility for staff to pursue individual interests and through creating dual experience roles. Haringey also has ambitions to create similar roles with extra expertise in managing housing or provision of benefits advice.

## Planning and Commissioning

Community grants funds are available in all boroughs through the Community Chest Programme which was developed by TPHC as a mechanism for partners working collaboratively across place to reduce health inequalities. Shared investment funds between the NHS and local authority and other voluntary sector organisations are created to support local needs led commissioning to increase VCSE capacity and capability. Haringey was the first NCL borough for this to be piloted but it has now been adopted throughout NCL.

Barnet is utilising its digital case management system to good effect to document unmet need within the community. This data has been utilised to collaboratively find solutions to gaps in provision through supporting voluntary organisations to apply for community grants to meet the unmet need. This collaborative work is supported by the close working between the social prescribing service and the public health department. The other boroughs are not currently utilising data from social prescribing to inform local commissioning which presents a key opportunity for progressing the service in these areas.

Most boroughs felt that there are sufficient community activities available for social prescribers to connect patients with. However, in Enfield, this was cited as the major reason for the lack of maturity of social prescribing in the borough suggesting either further investment is required in voluntary sector or that there is insufficient collaboration and connection between the social prescribing workforce and the community. Housing support responsiveness and access to mental health support services were consistently raised as concerns across NCL causing frustrations to link workers and patients and delays in closing cases.

### Digital Systems and Enablers

EMIS templates are used across the majority of NCL to capture data on SP, but the data collected varies within and across boroughs. The systems used are frequently inefficient with many social prescribers having to double enter the data into different systems which do not communicate seamlessly with each other. Barnet is utilising access elemental as a digital case management system which simplifies data collection and case tracking, allows unmet need to be documented and supports regular reporting of social prescribing data to Public Health and the PCNs to inform planning and improvements to the service. It is the only borough to be fully compliant with the Minimum Data set for the Social Prescribing Information Standard. There is mixed support for an NCL wide digital case management system with the principal concerns coming from Voluntary sector organisations who require reassurance that it would interact well with their own systems.

All boroughs have access to a directory of community services, but most are utilising several different directories hosted by various organisations which could cause confusion. A single digital directory of services in each borough which is regularly maintained and updated could support SPLWs to have improved awareness of available community activities.

*Table 1 Digital Systems and Directories of Services for Social Prescribing in North Central London*

| Borough | Digital Systems | Directory of Services |
|---|---|---|
| Barnet | Access Elemental | Public facing community directory of services and CASP directory hosted by Elemental. |
| Camden | EMIS (PCNs)<br>Charitylog (Age UK)<br>Salesforce (Voluntary Action Camden)<br>All data manually uploaded onto EMIS. | Green Social Prescribing directory and directory of voluntary services set up by VAC.<br>Internal directory of services held by Age UK. |
| Enfield | EMIS | MyLife directory of services.<br>Love on your Doorstep directory of services.<br>Enfield Activities launched by Enfield Voluntary Action. |
| Haringey | EMIS | Public Voice London and local council have internal directory of services.<br>Community Navigation Network 'Navnet' connected by WhatsApp used as a resource directory. |

| | | |
|---|---|---|
| Islington | Dynamics (Age UK)<br>Internal database (Help on Your Doorstep)<br>All data manually uploaded onto EMIS. | Age UK, HOYD and local council have internal directory of services. |

## Evidence and Impact

All boroughs are utilising different methodologies and outcome measures to capture the impact of SP (see Table 3) making it difficult to compare and analyse data across the boroughs. There is a need for a consistent approach across NCL to standardise the data collection methodology to validate the value of social prescribing, elevate the profession and promote ongoing investment.

All boroughs have documented a demand for the service, positive feedback from service users and evidence of either improved wellbeing scores, reduction in anxiety scores or evidence of goals being achieved. Barnet is the only borough to consistently and regularly capture data on impact on GP attendance which is facilitated by the digital case management system which readily captures this data.

*Table 2 Outcome Measures and Data Collection Methodologies for Social Prescribing in NCL*

| Borough | Outcome Measure | Quantitative Data | Qualitative Data |
|---|---|---|---|
| Barnet | ONS4 Wellbeing Score, Impact on GP appointments and A+E attendance. | 79% reported improvement in wellbeing score. 70% reduction in GP attendance following intervention. | Feedback requested for all patients but poor response rate (5%). 97% of those who responded to feedback reported they would recommend the service. SPLWs aim to do one Case study/ month. |
| Camden | Patient satisfaction survey using Likert scale out of 10 to self-report wellbeing and anxiety. | Increased health and wellbeing scores by 200% and reduction in anxiety scores by 56% | Ad hoc case studies and feedback. |
| Enfield | Varies across borough, some not using any outcome measures. At Unity they review whether SMART goals have been achieved. | In a sample of 91 patients at Unity a 47% reduction in GP attendance was documented in 6 months following social prescribing compared to 6 months before. | Feedback questionnaires requested at Unity- 4/5 satisfaction scores and reports of feeling more connected with the community. |

| | | | |
|---|---|---|---|
| Haringey | Public Voice measure whether goals are achieved. | 88% goal achieved following intervention; 97% goal achieved or partially achieved. | Ad hoc case studies and feedback. |
| Islington | Age UK - connections; housing; money; positivity; safety; wellness; work and meaningful activity<br>HOYD - assess if presenting issue has improved or resolved. | Age UK - gain across all areas assessed before and after intervention (2-3 x increase).<br>HOYD- 70% of those linked into services felt that their presenting issue has either improved or resolved within 3-month time scale. | Ad hoc case studies and feedback. |

Across all boroughs there is a need for enhanced feedback mechanisms to better capture patient experience to inform areas for service improvement. Even in areas where feedback is requested consistently, response rate is poor and may be missing cohorts impacted by health inequalities. There is no uniform agreement across NCL on the frequency of conducting case studies.

More consistent strategies are needed to capture unmet needs in all boroughs other than Barnet to inform future commissioning. It was acknowledged that much of the impact of SP may take time to be fully realised, so longer term follow-up assessments may be of benefit in all boroughs to try to capture these outcomes.

### Tackling Health Inequalities

Several proactive projects have been conducted across all boroughs to try to tackle healthcare inequalities with notable work in Enfield performing outreach in foodbanks; work with asylum seekers in Islington and with high intensity A&E users in Haringey. Camden has done impressive work to increase the uptake of referrals amongst Black and Asian Minority Ethnic groups by proactively employing a SPLW from within the BAME community and introducing self-referral, both of which have resulted in a higher proportion of BAME patients accessing the service than before the interventions.

## Borough Plans

The following plans have been developed with local stakeholders from each borough based on identified areas of improvement at both NCL and borough level. Each borough has identified the need for a consistent approach to measuring and reporting impact and alignment with the NCL Population Health Strategy. The borough plans reflect the different levels of maturity with social prescribing across NCL.

# Barnet Borough Plan

## Leadership and Governance

1) Widen Participation of SP Steering Group

Whilst Barnet is already holding regular steering group meetings with key stakeholders, their links with the ICB have been impacted by the ICB restructure, which risks stalling progress. They have ambitions to widen participation of their steering group meeting to improve the speed with which key decisions can be made to include ICB and PCN leadership. They also plan to connect with borough wide partnerships and place-based initiatives.

2) NCL Community of Practice

The Barnet SP team are regularly networking with other teams across London via the London SP Managers meeting and the London SP Data and Evaluation network and nationally via the National Social Prescribing Network. They would like to see an NCL-wide Community of Practice for SP to share learning and best practice.

3) Lead Social Prescribers in Each PCN

To strengthen career progression opportunities within the service each PCN would like to employ a lead SPLW. This would require extra funding but would promote retention and local innovation.

4) Strengthen Leadership for Other Personalised Care Roles

There is a highly successful leadership system in place via Age UK for the social prescribers which has driven progress in the borough. A desire for the care coordinators and health and wellbeing coaches to emulate this success within their own teams is planned. A GP SPIN Fellow was previously appointed by NCL Training Hub - Barnet to support the CCs, and the end of their fellowship left a gap in leadership and support. They were recently reappointed by the Training Hub with plans to restart peer support. The personalised care roles are coming together quarterly but it was felt more frequent collaboration and joined up working to best support patients would be helpful.

5) Reduce DNA Rate Through Education Campaign for Patients and Referrers and Self-Referral

The DNA rate for SP remains high, particularly for cases who have been referred by their GP. An education campaign amongst primary care staff around the support available via social prescribing and to understand

where the responsibilities lie for each personalised care role may ensure that referrals are appropriate. It was also felt that residents still have a low awareness of the term social prescribing and lack of understanding of how social prescribers can support them. Primary care staff could provide an explainer leaflet at the point of referral or a link so they could self-refer to reduce DNA rates.

## Social Prescribing Workforce

1) Special Interest Social Prescribers

To support retention and the professional development of the SP workforce there is an ambition to create special interest SP roles, with link workers with additional training and expertise for example in benefits or housing problems. This may improve access to advice services for residents and reduce waiting times for accessing support. Importantly, it may also support with retention and career progression opportunities for staff.

2) Strengthen Supervision and Support for Other Personalised Care Roles

A robust supervision system is already in place for the SPLWs in Barnet but to improve the offer they wish to expand the support system to the care navigators and health and wellbeing coaches.

3) Retain the Workforce

A risk to retention and workforce wellbeing highlighted at the workshops were remote working and staff feeling isolated. To address these increasing opportunities for the workforce to collaborate face to face are planned to boost morale and peer networking. Integration into the GP practice teams could also be improved with more frequent attendance at practice meetings. Staff should, as a minimum, have access to bypass numbers for ease of access to clinical advice when needed. Clinical supervision in PCN 3 via a GP clinical lead provides a weekly huddle has been particularly successful and other PCNs could seek to recreate this model. Providing opportunities for the workforce to be creative through proactive SP projects and community engagement events requires flexibility and protected time but may support retention by diversifying the working week.

4) Improved Training

The regular peer support sessions provide an opportunity for shared learning and keeping abreast of local services. However, there is no protected time for ongoing training and no specific training programme for the personalised care roles.

5) Lived Experience Volunteers

Barnet has supported a lived experience volunteer to share his story via TPHC. It was recognised that those with lived experience of SP can provide powerful examples of the impact of SP, but also could be given the opportunity to volunteer either to support the social prescribing workforce or to engage with their own communities or to set up local support groups. This could benefit the local community but also positively impact the volunteer's wellbeing.

6) Expand the Workforce to Include CYP Provision

They have so far been unable to recruit a social prescriber into a CYP role so are hoping to recruit one as soon as possible.

7) Expansion to Secondary Care

The Age UK service currently only provides social prescribing to primary care, but they have ambitions to expand the offer to secondary care.

## Planning and Commissioning

1) Funding

A key challenge mentioned across all the boroughs was the current funding model with short contracts making long term planning more challenging. A call for longer-term contracts and borough specific funding recognising the variability of need across the ICS was suggested. Increased funding will be needed to realise the ambitions to provide PCN leadership roles and dual experience roles within the workforce. In addition, protected time for learning and community collaboration would also require increased funding streams.

2) Commission an NCL Wide Digital Case Management System

Elemental, the digital case management system, has been instrumental in the success of Barnet's social prescribing offer and the continued funding of this system is key to their ongoing success. There are significant resource implications for using a case management system but procuring an NCL-wide longer-term contract would bring economies of scale. NCL-wide SP data demonstrating the impact of SP will also support greater investment in SP and prevention activity in the VCSE. Robust data enables improved understanding of local populations and can inform strategy for local neighbourhood teams, such that resources can be targeted appropriately to tackle health inequality.

3) Align Borough Commissioning Opportunities

There was acknowledgement of the importance of ensuring intelligent place-based integrated commissioning opportunities to ensure the best use of limited resource.

4) Regular protected time for community collaboration

Connecting with community ambassadors, community groups and grassroots micro-organisations can promote visibility of the SPLWs to communities impacted by health inequalities and promote co-production to better tailor and personalise the support for patients. The workforce needs protected time to achieve this.

5) Expanding Estates

Barnet is the largest borough in NCL, and the workshops identified that provision of community hubs in the borough is not accessible to all. Some residents cannot engage with recommended activities as they are too far for them to travel so further investment is required to ensure adequate coverage across the borough.

## Digital Systems and Enablers

1) Develop a Business Case to Secure Funding for Digital Case Management System Elemental

2) Expand the Offer for Digital Inclusion

## Evidence and Impact

1) Regular Improved Data Reporting

Acknowledgment was made that despite use of a digital case management system that there can still be gaps in data, particularly where information is missing from EMIS. The importance of recording language and ethnicity for all patients was noted and the workforce will be reminded of this. The Age UK SPLW managers currently complete the reporting, but time and funding is required for analysis of the data and to implement any resulting strategic improvements.

2) Improved Protocols for Patient Feedback

Feedback is requested from all patients, but the response rate is poor. Plans were therefore made to offer clients different methods for providing feedback to determine which had the higher response rate. An NCL-wide methodology should be agreed for feedback, including agreeing intervals for feedback. An example of a follow up call 6 months after the intervention to provide extra support and gather feedback may be beneficial.

3) Regular Case Studies

Case studies provide rich insights into the support that SPLWs are offering our residents. An NCL-wide agreement on the frequency that these should be conducted, where this portfolio of cases should be stored and how they can be utilised to promote future social prescribing investment and share learning and the ICS.

### Tackling Health Inequalities

1) Identifying Unmet Need Using Elemental Gap Analysis

The digital case management system can perform a gap analysis on specified cohorts to identify unmet needs. This intelligence has already been used to support the application of community grants for local activities but could also be used to create bespoke proactive preventative social prescribing projects. Ensuring robust population data collection including protected characteristics, language and ethnicity will support this.

2) Advertising Campaign to Patients / Staff

Barnet social prescribing team have already collaborated with TPHC to produce a video with one of their clients on their experience of social prescribing. They plan to utilise this video in an education campaign to increase awareness of SP services to target those harder to reach populations. Plans were also made to test educational material to ensure it is readily understandable by those with reduced literacy and to ensure materials are available in different languages. Inviting lived experience volunteers to community engagement events could also support uptake in these communities. Finally, NHS App could also be harnessed to send updates and promote the SP offer.

## Camden Borough Plan

### Leadership and Governance

1) Clinical Leadership for Personalised Care for the Borough

Camden stakeholders identified the lack of clinical leadership as a significant factor for the maturation of Social Prescribing in the borough. This role would oversee SP across the VCSE, and those SPLWs employed in both practices and PCNs.

2) Widen Membership of the Social Prescribing Steering Group

The current steering group has limited input from the ICB and Camden PCNs most of whom employ their own social prescribers. Strengthening connections with primary care and decision makers in the ICB can reduce the isolation of the PCNs from the wider system, provide a stronger foundation for the borough partnership work and identify an agreed lead for social prescribing to join up the different parts of the system.

3) NCL Community of Practice

Some SPLWs in Camden network across London via the London SP Managers meeting, the London SP Data and Evaluation network and nationally via the National Social Prescribing Network. This is not the network of most social prescribers. They would like to see an NCL- wide Community of Practice for SP to share learning and best practice and to reduce isolation for those employed through PCNs and practices.

4) Stakeholder Communication

Ensure that the SP offer is communicated on all staff inductions that covers the breadth of the SP offer in integrated neighbourhood teams. Development of a diagram that illustrates how the SP service and system works across the different providers and includes the patient's journey will support understanding of the provision available for all stakeholders. Including the names of individual social prescribers and an explanation of the social prescribing offer on practice websites will also enhance communication and understanding. The Social Prescribing Borough Partnership group to support with communicating to stakeholders including general practice and medical centres the various services that are available to refer or signpost to and to support with an approach to making connections to those services.

Social Prescribing Borough Partnership to agree on a set of actions to take forward following the NCL strategic review of social prescribing in general practice report. To take the agreed actions to the Camden Integrated Care Partnership and seek their buy-in and commitment of support to developing social prescribing in Camden.

## Social Prescribing Workforce

1) More Secure Contracts

The annual cycle of contracting for SP with VCSE organisations impacts on retention and the ability for longer term planning. Securing longer term contracts will support both individual SPLWs and voluntary sector organisations that employ them.

2) Career Progression

The lack of career progression for SPLWs impacts on retention which then impacts on service delivery. The creation of a clear career pathway that included senior roles with some leadership responsibility for service development and line management could make the roles more attractive. Coupled with an accredited training pathway and qualification, the kudos for the profession would increase.

3) Supervision and Support

There are inconsistencies across the borough for both administrative and psychological support. SPLWs need support to manage distressing and complex cases, deal with challenging behaviour and safeguarding issues. While there is some provision and workshops for those employed through Age UK Camden, extending this offer to all SPLWs through NCL Training Hub - Camden was recommended. Induction for new staff on self-care and psychological safety could be added to the induction programme delivered by NCL Training Hub - Camden. A Clinical SP lead in Camden could support this development.

4) Uniform Job Descriptions for SPLWs and Other Personalised Care Roles

A variety of job descriptions and pay scales exist across the borough. Obtaining agreement from stakeholders for standardised job descriptions will reduce confusion about roles and increase the professional cohesion of these roles.

5) WhatsApp Group

A WhatsApp group for all the personalised care roles and wider systems stakeholders will connect people immediately and provide quick information exchange. Haringey have group with over 200 members which enables a quick exchange of information and improves connectivity.

## Planning and Commissioning

1) Commissioning of a Robust Needs Assessment in Camden

Camden is a borough of diverse health need. Some data is collected by VCSEs and SPLWs that can be viewed simultaneously with neighbourhood data sets from Public Health. Pooled data can provide both qualitative and quantitative information about the needs of residents for SP services and can help ensure that these plans align with capacity. Currently demand for SP services is higher than capacity. Conducting a needs assessment will help commissioners plan service provision which can include numbers of SPLWs, inclusion criteria across the borough and specialist provision.

2) Clarity of Funding Streams

There are several funding streams available for both the VCSE and PCNs to develop social prescribing. However, accessing these can be difficult and time consuming. Details of funding opportunities and their time frame would benefit the system and enable individuals and organisations the chance to obtain additional funds.

3) Equitable Provision of Service Across the Borough

Access to the SP service across Camden varies. Ensuring all residents have access to SP services and there is the availability of social prescribers to deliver this service is needed.

4) Protected Time for Community Collaboration and Connectivity

There was strong support from social prescribers employed through PCNs, practices and the VCSE for improved community collaboration. A suggested schedule was for all Camden SPLWs to join the two monthly Caversham Practice meeting, and to attend an NCL CoP should one be established. It was recognised that social prescribers employed through practices and PCNs were not plugged in to wider community activities. Protected time for NHS employed social prescribers to attend events and key themes delivered by LBC and VCSE organisations will increase knowledge of local community assets and enhance partnership working. The personalised care roles currently work in isolation including the CCs and H&WBCs at the Caversham Practice meeting is a step towards these roles working together for patients.

5) Community Based Needs Assessment

A collaborative exercise with other stakeholders will identify population cohorts that are not using social prescribing services. Analysis of self-referral data may provide additional information about use of the services and will support a more equitable approach.

## Digital Systems and Enablers

1) Consistency and Compatibility of Data Collection

There are different systems operating for collecting and collating SP activity and outcome data. The systems are not compatible and require dual entry. Some of the current systems work well though data sharing and accumulation is not currently possible. A unified system for data collection and evaluation would enable consistency of reporting across the borough and avoid duplication. (Sport England have developed a system to enable multiple data systems to communicate with each other.)

2) Digital Inclusion

Within the Camden VCSE, some offers exist to improve digital inclusion. A digital inclusion network is established in Camden. Social prescribing leads could work with this group to improve access for patients.

3) Self-Referral

Some self-referral exists in Camden and evaluation has shown positive uptake and zero DNA. Expanding this across the borough with a targeted information programme to include groups who are underrepresented will increase access.

## Evidence and Impact

1) Development of an NCL-wide Evaluation Tool

The creation of an agreed NCL tool would benefit social prescribers, their managers and commissioners and allow the measurement of activity and the impact of social prescribing at a neighbourhood, place and ICS level footprint. This would support the collation of evidence to analyse data and demonstrate impact while balancing the need of individual patients. A systematic evaluation tool would also encourage the use and development of efficient databases for good data collection.

2) Using Compatible and Agreed Terminology for Commissioners and Community Providers

3) Shared Reporting System and Outcome Framework

A shared system and agreed outcomes framework monitored by the borough partnership could include case studies, surveys, residents feedback alongside population health data.

## Tackling Health Inequalities

1) Proactive Social Prescribing Projects

Camden has a large homeless population, and this is one of several underserved population groups in the borough that could benefit from an outreach and proactive approach to SP.

2) Data Collection

Routine collection of data on ethnicity and language is not happening across Camden. Encouraging all SP service providers to complete the Social Prescribing Minimum Data set will produce a detailed picture of those accessing SP services. This is turn can be reported to the ICB for monitoring of the Population Health Strategy.

## Enfield Borough Plan

### Leadership and Governance

1) Establish a Social Prescribing Steering Group

The lack of leadership for SP across the borough has contributed to the lower maturity of the service in Enfield. A key priority for the Enfield borough plan is therefore to establish a regular social prescribing steering group, attended by key stakeholders and system partners to provide leadership and strategic direction to develop a more integrated, cohesive service. This would require leadership from a social prescribing lead and administrative support to take minutes and ensure actions are taken forward.

2) NCL-wide Community of Practice for Social Prescribing

It was also noted that an NCL-wide Community of Practice for SPLWs would further enhance peer networking and provide an opportunity to share good practice across the boroughs.

3) Equitable Provision of Social Prescribing Across the Borough

The ARRS SP workforce in Enfield is currently limited to 7 individuals, with one PCN having no SPLW provision. Ensuring equitable access for all Enfield residents to social prescribing is therefore urgently needed for progress to be made.

4) Education Campaign for Patients and Primary Care Staff

The workshops also felt that an education campaign is needed in borough to raise awareness amongst GP surgeries and residents about the SP offer, to increase referrals to social prescribing for patients who most need the service.

### Social Prescribing Workforce

1) Enhance Training Offer for the Workforce

Strategies to improve the support for the current workforce included improving the training offer, enhancing supervision and streamlining communication. A review of the current induction core training offer, suggested

to identify areas for improvement to improve staff preparedness for the role. It was felt that SPLWs should complete a Level 5 qualification or equivalent at induction and that the ongoing training offer should be enhanced. Specific training areas which should be included were felt to be mental health training, managing risk, training on health coaching and motivation of clients and on managing more complex cases. A consistent, well attended training offer which is regularly reviewed to ensure it is meeting the needs of the workforce could enhance their skills and support retention.

2) Enhanced Career Progression

A career progression pathway is needed locally to enhance workforce retention but no specific recommendations on how this could be achieved were made at the workshops. Hybrid roles with dual experience and leadership positions have been suggested as viable options in other boroughs.

3) Strengthen Supervision

The supervision offer across the borough is inconsistent and each PCN should identify a plan to ensure regular access to workplace supervision is available each week with monthly professional development supervision as recommended in the maturity framework.

4) WhatsApp and Teams Channel for Social Prescribers and Personalised Care Roles

To improve connectivity of SPLWs across the borough, suggestion was made to set up a Teams channel and WhatsApp group for streamlined communication across the entire workforce and other relevant stakeholders. Membership of the Enfield Unity hosted peer support group could also be expanded to reduce the isolation of the single SPLWs employed in each PCN.

5) Co-production with the Community

Workshop participants also highlighted the importance of co-creation with the community, empowering patients with lived experience to codesign the service. This could take the form of a regular participation group of community champions who would be empowered to share their experiences and desires for a local social prescribing offer and invited to steering group meetings. The borough already has significant experience of community collaboration through the ICB funded Community Powered Edmonton project (2022) where workshops, creative activity and focus groups were held to understand the needs and concerns of the local population. An NCL ICB funded Community Collaboration fund of £150,000 was made available following the project to implement the recommendations. The borough aims to expand on the experience gained from this project to collaborate with residents to ensure that the local offer is bespoke to local needs and responsive to what matters most to people.

## Planning and Commissioning

1) Improved Population Health Data and Documentation of Unmet Need

The planned SP steering group can feed into commissioning decisions, but it was felt that an assessment of the needs of communities most impacted by healthcare inequalities is also needed in Enfield to target commissioning activity effectively. Unmet need in the community must also be recorded by social prescribers and this intelligence utilised to direct funds via the Enfield Local Fund to grassroots organisations who can meet this demand.

2) Funding for a Single Directory of Service

A regularly updated single directory of service could facilitate the workforce providing up to date accurate information for residents and keeping abreast of local available activity. EVA are already developing such a resource which will be reviewed and updated weekly, but development is slow and increased funding is required ensure this resource is available in a timely manner and adequately maintained.

3) Increased Investment in Community Activities

The major risk to social prescribing progress in Enfield was felt to be the insufficient community activities for SPLWs to refer into. The most important commissioning activity for the borough is therefore to ensure that there is a robust and varied supply of community activities for residents to access and that the SP workforce is kept informed of the local offer.

4) Investment in Social Prescribing Leadership

To support the development of a local SP steering group, investment will be required to either upskill and support existing SP staff to take on this role or for voluntary sector organisations such as EVA to host them.

5) Protected Time for Community Collaboration

The importance of ensuring SPLWs have sufficient protected time to attend collaboration and community networking meetings so they can network with residents in the community and the VCSE organisations was also noted at the workshops along with plans to build time into the working week for two-way collaboration between SPLWs and primary care.

## Digital Systems and Enablers

1) Standardised Borough Wide EMIS Template

A key short-term priority in Enfield to improve digital maturity is to ensure that the same standardised EMIS data entry template is utilised across the borough to reduce inconsistency in data capture. The importance of capturing unmet need in the Enfield community is paramount to ensuring that the services most needed by residents can be developed, so must be included in the minimum data set agreed across the borough.

2) NCL Commissioned Digital Case Management System

Thinking long-term, the workshop participants were very supportive of a centrally commissioned digital case management system to avoid duplication of data entry, streamline reporting and document unmet need within the community.

3) Single Directory of Services

The multiple directories of services across the borough could cause confusion and delay in information finding for social prescribers so a single, regularly updated directory that integrates with the digital system would be helpful. MyLife and EVA's Enfield Activities directories could be jointly commissioned and brought together to a single directory utilised by all.

4) Self-Referral

Self-referral was identified as a strategy to increase access to specific communities who either may not have a GP or who find it more difficult accessing primary care. The borough also plans to review how care navigators can be utilised more effectively on the front line to triage patients to appropriate support.

## Evidence and Impact

1) NCL-Wide Social Prescribing Impact Evaluation

An agreed NCL-wide approach to evaluating SP data was felt to be essential with regular reporting of this intelligence to the local social prescribing steering group and ICB to inform ongoing strategy.

2) Standardised Feedback Form and Regular Case Studies

A standardised feedback form should be developed for use across the borough and an agreement reached on a protocol for seeking feedback from clients at agreed intervals following the SP intervention. Qualitative data such as case studies may provide a richer picture of how SP is impacting residents and should be collected systematically across the borough.

## Tackling Health Inequalities

1) Increase Proactive Social Prescribing Projects

The SPLWs are in a unique position to identify communities impacted by healthcare inequalities with unmet need. To tackle this, the workshop attendees felt outreach proactive SP projects targeting communities who may not be accessing social prescribing via their GP should be conducted. Collaborative outreach work across the PCNs was felt to be the most effective way to provide this offer and specific communities such as the Turkish community and attendees at local food bank should be targeted.

2) Education Campaign

Enfield also plans to conduct an education campaign to raise awareness amongst Enfield's diverse communities about the local social prescribing offer to ensure the most vulnerable residents are aware and able to access the service. Extra training for the workforce to better understand the communities they are serving, and their needs is also planned.

3) Expand the offer for CYP

Enfield does have several small social prescribing projects for children and young people, but these are not well connected to primary care as there is no ARRS provision.

4) Improved Data Collection

A robust data collection system is needed to ensure that language and ethnicity is always recorded so the borough can understand which groups are not accessing SP.

5) Increase Options for Accessing the Service

Home visits were suggested as an essential extra offer for vulnerable elderly patients who may find remote consultations more challenging or offering evening appointments for working individuals.

## Haringey Borough Plan

### Leadership and Governance

1) Create a Community Navigator Oversight Group

Attendees of the Haringey workshop were keen to create a Community Navigator Oversight Group for developing the Personalised Care roles with widespread membership of key stakeholders. There is already strong will in Haringey for SP to succeed but there is insufficient overarching leadership to drive forward change, provide support and accountability. This collaborative approach aims to maximise resource utilisation through efficient use of funding streams.

2) Define Personalised Care Roles and the Responsibilities of Each Role

Haringey has a broad community navigation offer, and it was felt there was some confusion amongst clinicians about the correct pathway for supporting patients using the personalised care roles. Developing a pathway which clearly defines the roles and responsibilities of each role was suggested as a helpful explainer for clinicians to understand the best place to refer patients.

3) NCL / Borough-wide SP Hub and Community of Practice

NavNet is a unique community asset in Haringey which has connected the borough workforce and acted as a live directory. It was recognised that sharing learning and best practice across NCL would be beneficial through an NCL-wide Community of Practice.

### Social Prescribing Workforce

1) Longer Term Contracts

Longer term contracts are required to improve planning and security for VCSE organisations such as Public Voice and for the workforce themselves.

2) Career Progression Opportunities

For the personalised care roles to be seen as attractive career options, there must be clear career and wage progression to reward expertise and experience. A major priority for Haringey was therefore to develop a hierarchy of team roles, including lead SPLWs and specialist dual trained roles with expertise in for example, providing legal or housing advice. The borough already has experience with SPLWs with dual experience through their collaboration with the cancer alliance and they are seeking to expand on this success to support retention of other link workers.

3) Enhance Workforce Wellbeing

The high emotional toll on the personalised care workforce was widely acknowledged at the workshops, so another priority in Haringey is to conduct wellbeing surveys amongst the staff and take appropriate action to improve staff wellbeing depending on the survey outcomes. Suggestions were made that standardised caseload numbers to ensure workload is manageable and flexible working opportunities may also support staff wellbeing.

4) Establish Peer Support Networks for All Personalisation Roles to Provide Mutual Assistance and Encouragement Among Staff

Whilst NavNet does provide connection for the ARRS roles and the wider Community Navigators, there are different offers available for peer support and it was suggested that the peer support offer for the non-social prescriber roles could be improved.

5) Robust Supervision for Managing More Complex Cases

Haringey does not have a GP clinical lead to provide clinical supervision, so support is accessed via the duty doctor or usual doctor. This can sometimes be challenging, and staff did not always have bypass numbers to access GPs. Ensuring that bypass numbers are available or that there is a named clinical lead to provide clinical supervision would improve this.

6) Professional Development Opportunities for Staff

Haringey also aim to introduce an SPLW Accreditation for new staff and offer an improved training pathway, with protected time for the workforce to attend. Mental health training was felt to be particularly needed. Protected time is also needed for the workforce to build their community networks and to complete proactive outreach work.

7) Train and Develop Volunteers with Lived Experience to Expand Workforce

Co-production with the community was felt to be essential in Haringey, to ensure the personalised care offer is relevant to communities and meeting their needs. One suggestion for meaningful coproduction would be training lived experience volunteers to expand and support the workforce and improve access to hard-to-reach communities.

## Planning and Commissioning

1) Align Longer Contracts for Personalised Care Roles with Long Term Workforce Plan to Support Retention and Aid with Planning in VCSE Organisations.

2) Commission work on accredited training for the workforce, ongoing standardise training pathways and on proposals of career progression

An NCL-wide accredited training programme for all the personalised care roles would promote standards and quality and ensure the workforce is able to meet the demands of the role. The innovative dual experience link worker roles would need to be commissioned

3) Continued VCSE Investment via the Community Chest to Ensure Sufficient Destination Services within the Community for SPLW to Refer

Services felt to be missing in Haringey include services for the frail population such as Age UK, services to reduce social isolation and services to support deprived communities with housing concerns due to long delays in support with housing via the council.

4) Continuously Assessing Service Delivery and Actively Engaging with the Community to Improve Service

Expanding on the borough's work and encouraging co-production with the community by involving the community in strategy meetings, evaluations and community engagement events. This ensures resident voices are included in service design and tangible co-designed outputs.

5) Commission a Robust Data Collection System

An NCL-wide, co-produced standardised data entry templated and evaluation templates for service delivery are urgently needed to ensure consistency; to document unmet need in the community and to demonstrate the impact of social prescribing to encourage ongoing investment.

## Digital Systems and Enablers

1) Capture SPLW Activity in a Consistent Framework Across the Borough

Haringey were supportive of utilising a digital case management system which communicates with EMIS and existing systems in the VCSE sector. A uniform system of data capture is urgently needed across Haringey to ensure alignment and connectivity and more efficient tracking of cases. In the short term, a standardised EMIS template which includes data on - source of referral, patient demographics, needs and concerns, onward referrals, both qualitative and quantitative outcome data, and patient feedback on services could be implemented.

2) Single Directory of Services

A regularly updated single directory of services utilised by the personalised care workforce, the VCSE and individuals themselves could build on the success of NavNet and provide a helpful resource for individuals and the workforce.

3) Digital Inclusion and Enablement Offers for Service Users

Expanding the digital inclusion and enablement offer and ensuring the personalised care workforce and aware of and linked into ongoing initiatives in the borough.

4) Creating Automated Responses from Statutory Services Re Response Times to Manage Expectations

5) Improve Access to Secondary Care Systems

The group also felt that improved access to secondary care systems for the workforce could aid staff trying to support residents navigating their secondary care appointments.

## Evidence and Impact

1) Digital Case Management System

A consistent way of capturing intelligence is needed urgently to demonstrate impact, document unmet need and track casework efficiently. Public Voice voiced concerns that the system must communicate seamlessly with existing VCSE tools.

2) Implement Systems to Monitor and Understand the Outcomes/Impact of Referrals Made by SPLWs

For the workforce to make informed choices regarding the referrals they make and organisations they link patients in with, it was acknowledged that destination services in the community must also produce outcome data to demonstrate impact. This will also improve patient care and service efficiency e.g. evaluating the impact of services such as Tottenham Talking.

3) Unified System for Collecting Feedback

An agreement should be reached on the most useful way of collecting feedback from service users from either surveys, interviews or regular case studies.

4) Develop a Single NCL-wide Evaluation Tool/Model to Assess the Impact of SP

To ensure consistent comparable data is collected across NCL so meaningful comparisons can be made there must be an urgent agreement on which outcome data is useful for assessing the impact of social prescribing. It was emphasised that there should be a focus on the "social return on investment" rather than a prescriptive fixation on KPIs.

5) Clarity on how Collected Intelligence will be Utilised

It was felt that those collating the data must have clarity on how the data is utilised. Regular reporting to the PCNs and the ICB can improve buy in, support and investment in social prescribing and can help inform strategy.

6) Longer Term Follow-Up with Service Users to Assess Long Term Impact

It can take time for the changes implemented through social prescribing interventions to demonstrate an impact; therefore, longer term follow-up at 6 to 12 months after intervention should be initiated.

7) Consistent Plan for Regular Case Studies on Patient Pathways

To build up evidence for the success of SP, regular case studies should be completed to capture qualitative evidence of impact.

## Tackling Health Inequalities

1) Ensuring Health Inequalities Data on Unmet Need is Collected and Analysed.

More robust data collection, particularly on language and ethnicity is needed to demonstrate which patients are accessing social prescribing, their outcomes also to understand which populations are not accessing social prescribing so they can be proactively targeted.

2) Outreach Proactive SP in Community for Specific Groups

An increased offer of proactive social prescribing projects aimed at tackling health inequalities with specific deprived cohorts in East Haringey and housebound patients throughout the borough are needed to improve access to these communities.

3) Education/ Awareness Campaign Within Deprived Communities

Community engagement events and advertising campaigns to alert individuals at risk of healthcare inequalities about the social prescribing offer and how to access support. Promotional materials and education campaigns must be available in relevant languages.

4) Self-referral - for Excluded Groups

It was felt that self-referral may increase access for deprived communities, but care would need to be taken not to overwhelm the system and increase referral times. This could be done by allowing self-referral for specific referral reasons such as housing or financial concerns or to specific ethnic groups or those living in certain postcodes.

5) Developing Strategies to Identify and Support Patients Who May Need Preventative Care

6) Working Collaboratively with Existing Teams

Learning lessons from existing multidisciplinary services in Haringey such as the Homeless Health inclusion team to expand the offer to other marginalised groups.

7) Developing and Expanding the Workforce to Address Health Inequalities

A proactive recruitment of personalised care workers from the East of Haringey or seeking to employ staff who speak appropriate languages may improve access for deprived communities accessing support. In addition, creating pathways for lived experience volunteers to support the personalised care roles could allow meaningful opportunities for coproduction. The existing workforce also needs regular training to ensure they are up to date with specialist services in their area for marginalised groups.

8) Strengthened Collaboration with Housing Team/ Local Authority

Housing problems were described as the "elephant in the room" at Haringey workshops and increased support is urgently needed to improve the responsiveness of the system to tackling housing concerns. Utilising social prescribers with dual expertise in managing low level housing concerns could improve access to quicker support and free up waiting lists for more complex cases to get support. An MDT could also be set up with social services, housing teams, mental health teams and social prescribers for managing more complex cases efficiently.

## Islington Borough Plan

### Leadership and Governance

1) Establish an Overarching Social Prescribing Steering Group

A wide range of stakeholders and members as part of a steering group with the shared values of co-production and a strong patient voice, would meet regularly to provide leadership and strategic direction for an improved and cohesive service. Improved collaboration with PCNs, VCSE, Local Authority, Public Health, patients and mental health services will strengthen service provision and improve relationships across the system.

2) Establish an NCL Community of Practice

Attendance at local social prescribing forums provided by NCL Training Hub - Islington is good. Stakeholders thought that the Islington system could benefit from a wider pool to share learning innovation and case studies.

3) Clinical Lead for Social Prescribing

The appointment of a clinical lead would support the maturity of social prescribing across the borough and provide oversight across the PCNs and the VCSE. Currently there is no dedicated leadership in Islington.

4) Review Current Funding Arrangements for Social Prescribing

There are two VCSE SP providers in Islington, one of the PCNs employ their own SPLW. Management costs for the service are borne by those organisations which means that VCSE is subsiding the services by 25-30% when they are the providers of the service. This is unsustainable for providers and a funding solution must be explored.

## Social Prescribing Workforce

1) Secure Long-Term Contracts for Social Prescribers

The bulk of SP in Islington is delivered by two Voluntary Sector organisations. The annual cycle of contracting means the organisations are not confident contracts will be awarded to them as PCNs may decide to bring the service in house and employ their own SPLWs. This means voluntary sector organisations and individual SPLWs are vulnerable. Organisations are unable to guarantee employment which can impact on retention and therefore ongoing service delivery. With increased caseloads, this impacts on waiting times and there are not sufficient staff to manage the increase. Longer contracts would help to alleviate this issue.

2) Career Progression

There are limited options for career progression within SP. The development of team leaders and specialist SPLWs would create a variety in the working work and strengthen the team. Creation of a career development pathway and increasing opportunities for innovative SP will enhance job satisfaction, improve retention and develop expertise and experience.

3) Improved Training Pathways

SPLWs employed through the voluntary sector have access to organisation training, however there is no specific training programme or agreed competencies for SPLWs beyond the NHSE mandatory e-LFH modules. Training is delivered in the regular peer support sessions which improves knowledge of local services. Recognition of SP as a profession is overdue. An accredited training programme and ongoing CPD will increase the reputation of SP.

4) Well-being Support

SPLWs can experience a high emotional toll managing busy and complex caseloads. There are several ways to provide well-being support to this workforce to prevent burnout and feeling overwhelmed. These include flexible working, standardised caseloads agreed across the system, local recruitment and managing expectation from clinical staff about workload.

5) Robust Clinical Supervision

Opportunities for SPLWs to access regular clinical supervision varies across the borough. Clear support structures for managing and dealing with complex cases is important for all SPLWs and set out in the Primary Care DES. Supervision was offered by a GP through the NCL Training Hub - Islington though this post no longer exists.

6) Lived Experience Volunteers

Those with lived experience of SP are powerful advocates for the service and can demonstrate the impact and benefits. Supporting patients with lived experience to tell their story, engage with their communities or set up support groups is an effective way of using the patient voice and experience to improve the service.

## Planning and Commissioning

1) Centralised Commissioning of Social Prescribing

Islington is keen to explore centralised commissioning for SP and remove the responsibility from the PCNs. Commissioning via the ICB or the federation would potentially resolve discrepancies in the service that occur. A unified triage system could also be set up which would also support this resolution.

2) Programme Funding

SP services are partially funded through the NHS DES Contracts as it is only individual SPLWs' salaries that are funded. Each organisation subsidises additional costs and provides a team leader to oversee the service and triage cases appropriately. There are multiple risks to this model and can impact on waiting lists and service quality.

3) VCSE Social Prescribing Contracts

The current annual contracting cycle impacts on service planning, retention and job security. Establishing a three-year social prescribing contract with the two main providers building in annual contract meetings will support organisational service planning, provide a degree of reassurance about job security for individual SPLWs and improve retention rates.

4) Vision Setting for the Borough

There is strong support in Islington to develop a clear vision for SP for the borough. A population needs assessment with support from Public Health and reviewing neighbourhood data will support the development of a vision. The establishment of a steering group will support this vision setting and create a consistent

approach across the borough for agreeing outcomes, demonstrating value for money and aligning the service with wider strategic goals.

5) VCSE Investment Strategy to Grassroots Organisations

An investment strategy will maintain and increase destination services within Islington for SPLWs to refer to. While provision in Islington is reasonable there are long waiting lists for some services e.g. counselling. Established green SP projects are now reduced by half due to short term funding. There is limited capacity and often a skills gap in smaller grassroots organisations to apply for grants and these groups often miss out on available funds as they are unable to complete applications. The investment strategy would need to address this inequity in knowledge and skills for some grassroots organisations.

6) Protected Time for Community Collaboration

NHSE recommends that 20% of a SPLW's time is spent building community connections. While this happens at a senior level in the voluntary sector, time for individual SPLWs to attend meetings or events collaborating and developing relationships with other SPLWs, voluntary sector workers and council employees is limited. Clear allocation during the week for a SPLW to build and strengthen these connections will support the maturity of the service across Islington.

## Digital Systems and Enablers

1) Digital Case Management System

The procurement of a borough wide case management system which captures SP activity in a consistent framework will reduce the admin burden across multiple platforms and capture all data in the one place without duplication of data entry. It will also enable incorrect data entries to be rectified easily. The system will need to be compatible with existing VCSE systems and EMIS. Tracking of casework will be streamlined and more straightforward. Generating of reports will be less time consuming.

2) Single Directory of Services

There is no central directory of services in Islington. A directory that integrates with the digital system will make updating easier, to include new services and remove those that no longer exist. This function can then be shared across the system. Multiple systems result in delays and frustration for individual social prescribers and others in the system who are signposting patients.

3) Digital Inclusion Offers

Identifying patients who are digitally excluded could be highlighted on the patient record through EMIS or other codes. SPLWs could then signpost patients to enablement and other digital support services to improve digital literacy.

## Evidence and Impact

1) Development of an NCL Evaluation Tool

The absence of a single accepted evaluation tool across the borough and NCL means there is no reliable way of assessing the impact of SP on a patient or a population basis. Such a tool that was respectful to individuals and mindful of confidentiality would support the development of social prescribing. It could be used at both a local and an NCL level, something which doesn't happen at the present time.

2) Collection of Data

Along with the development of an appropriate tool, collecting consistent data will enable comparisons among population groups and localities. Agreement with commissioners, SPLWs, Public Health, PCNs and others about the type of data to be collected is necessary. Such collection will enable outcomes to be measured both by patient and populations.

3) Establishment of a Data Sharing Hub

Islington currently has an evidence hub. Using a similar model establishing a hub for the sharing of data would support service development and identify gaps. Intelligence could be captured on unmet need and routinely feed into commissioners and others. Gaps in services would be easier to identify with such a system.

4) Shared Reporting Systems

Utilising a shared reporting system which works with existing VCSE tools and EMIS would lead to easier exporting and merging of data sets. A digital case management system may have the functionality for this to materialise. Shared reporting systems would mean that regular reports could be sent to PCNS and the ICB. There is currently no regular reporting to the ICB on SP that informs strategy.

5) Population Health Assessment

Creating a population health assessment would provide all stakeholders with a current baseline about health needs. New or changed populations would be identified through such an assessment. Identifying underserved groups who could benefit from proactive approaches to maintaining good health and connecting to others in the borough would be one of the many benefits of an assessment.

6) System for Collecting Patient Feedback

Some patient feedback is obtained though this is not uniform across the borough. Regular collection of case studies that can be shared across the system, as well as surveys and feedback from patients and service users will allow all within the system to have qualitative information about user experience. This will also be a driver for quality improvement.

### Tackling Health Inequalities

1) Community Based Needs Assessment

The population health assessment mentioned above will reveal intersectionality within the borough and identify excluded groups and cohorts for proactive SP. Although the evidence for proactive SP activated is limited, projects across Islington and other NCL boroughs show positive engagement from the targeted groups and there is some interest from commissioners to pursue more of these.

2) Data Collection

Collection of ethnicity and other demographic data is an important step in obtaining a comprehensive picture of the population. This data is not routinely collected in practices. Encouraging the use of the SP minimum data set across the borough will support a more detailed understanding of population needs. Analysing this information and reporting regularly to the ICB will provide a basis for discussing which groups to proactively target.

3) Proactive Social Prescribing

Islington has large numbers of refugee groups, homeless people, housebound residents and individuals with mental health problems. Building on the proactive work with refugees these additional groups may also benefit from a proactive approach.

## Recommendations and Resource Considerations

Social Prescribing has emerged as a vital component of Personalised Care within the NHS, aimed at addressing the social determinants of health by linking patients to community-based resources and ascertaining what is important to them. In NCL, SP services have been generally well received with some evidence indicating improved patient wellbeing and stronger community connections. However, the report identifies significant

disparities in the delivery and integration of SP across the different boroughs with varying levels of service maturity, workforce stability, community connection and digital infrastructure.

The Social Prescribing Maturity Framework used in the review highlights these disparities, offering a structured approach to assess and enhance SP services. The framework's application across the boroughs has highlighted both the strengths and the areas requiring attention. While patient feedback has been positive, issues such as staff burnout, inconsistent delivery and inadequate digital systems are recurrent challenges. These issues are particularly pronounced in Enfield, where workforce retention and service sustainability are critical concerns.

This discussion synthesises the findings and recommendations from the report, providing a critical analysis of the current state of Social Prescribing services, the challenges faced and the opportunities for improvement.

## Challenges in Leadership and Governance

Leadership and governance emerge as pivotal factors in the effective delivery of Social Prescribing Services. The report highlights the absence of a centralised leadership structure within Enfield and other boroughs, which has led to fragmented service delivery and a lack of strategic oversight. The recommendation to establish a borough-wide SP lead and a steering group aims to address these issues by providing clear leadership and fostering better coordination among stakeholders.

The establishment of such leadership structures is crucial not only for ensuring consistent service delivery but also for integrating SP more effectively with other health and social care services. A dedicated SP lead can drive the strategic direction, ensuring that SP services align with broader health goals and respond to the specific needs of the community. Furthermore, the creation of a steering group, comprising representatives from healthcare providers, local authorities and community organizations, would facilitate better collaboration and integration, leading to more holistic care for patients.

A list of 20 actionable recommendations for the consideration of NCL ICB leadership are itemised overleaf in Table 3.

*Table 3 List of Actionable Recommendations*

| Category | Recommendation | Specific actions needed | Timeline | Cost implication | Priority |
|---|---|---|---|---|---|
| Strengthen Leadership & Governance | 1. Establish a SP Senior Officer in the ICB executive leadership team responsible for planning delivery and monitoring of SP within the ICS | Appoint a dedicated SP lead across the ICB who will develop the social prescribing system plan to dovetail with borough plans. | 3-6 months | Moderate | High |
| | 2. Create a SP Steering Group with a dedicated borough lead across each borough with representation from all sectors | Form a steering group with key stakeholders. Review membership where these exist. | 3 months | Low | High |
| | 3. Local borough social prescribing groups to report quarterly to Borough Integrated Care Board and Borough Partnership Board and six monthly to the ICB. | Integrated Care Boards and or Borough Partnership boards to agree reporting structures for both local and ICB governance, data requirements, and timetable schedule for all social prescribing providers. | 6 months | Low | High |
| Enhance Workforce Development | 4. Improve Training & Support for SPLWs including the establishment of an NCL Community of Practice for SPLWs | Implement ongoing accredited training programs<br>Establish an NCL wide regular SPLW Community of Practice | 6-12 months | Moderate | High |
| | 5. Provide clear career progression pathways | Develop structured career pathways for SPLWs | 6-12 months | Moderate | Medium |
| | 6. Address workforce wellbeing | Introduce wellbeing initiatives & flexible working arrangements | 3-6 months | Low | High |
| Upgrade Digital Infrastructure | 7. Implement a Unified Digital Case Management System | Secure funding & deploy a centralised digital system | 12-18 months | High | High |
| | 8. Standardise data collection | Develop & enforce standardised data collection protocols | 6 months | Low | High |
| | 9. Enhance digital inclusion | Launch digital access & training initiatives for service users | 6-12 months | Moderate | Medium |
| Strengthen Community Engagement | 10. Foster Stronger Collaborations with Community Orgs | Engage with local VCSE sectors to co-design SP services | 6 months | Low | High |
| | 11. Expand community outreach programs | Increase outreach to high-risk & underserved groups | 6-12 months | Moderate | Medium |
| | 12. Utilise lived experience volunteers | Integrate volunteers with lived experience into service delivery | 6-12 months | Low | Medium |
| Ensure Sustainable Funding | 13. Secure Long-Term Funding for SP Services | Advocate for stable & long-term funding models | 12 months | High | High |
| | 14. Invest in Workforce Stability | Allocate funds for extending contracts & providing career development | 6-12 months | Moderate | High |
| Improve Impact Measurement | 15. Develop a Borough-Wide Evaluation Framework | Create a consistent evaluation framework for all boroughs | 6-12 months | Moderate | High |
| | 16. Regular reporting & feedback loops | Implement routine reporting mechanisms for continuous improvement | 6 months | Low | Medium |
| | 17. Leverage Data for Service Improvement | Use data to identify trends & enhance services | Ongoing | Low | Medium |

| | | | | | |
|---|---|---|---|---|---|
| Expand Service Integration | 18. Integrate SP with Secondary Care | Expand SP services into secondary care settings | 12-18 months | High | Medium |
| | 19. Enhance Collaboration with Housing & Social Services | Strengthen ties with housing & social services for holistic support | 6-12 months | Moderate | High |
| Promote Health Equity | 20. Conduct comprehensive needs assessments | Perform regular assessments to identify health disparities | 6-12 months | Moderate | High |
| | 21. Facilitate self-referral pathways | Explore & implement self-referral options for vulnerable groups | 12 months | Moderate | Medium |

## Workforce development and retention

The workforce is the backbone of SP services, and the report highlights significant challenges in this area, particularly concerning training, support and retention of SPLWs. The findings indicate that SPLWs often face high levels of stress and burnout, exacerbated by a lack of professional development opportunities and unclear career progression pathways. To address these challenges, the report recommends enhancing workforce development through ongoing training programs, clear career progression pathways and wellbeing initiatives. These actions are essential for building a resilient and motivated workforce capable of delivering high-quality SP services. For instance, accredited training programs in mental health, community engagement and complex case management would equip SPLWs with the necessary skills to handle the diverse needs of patients. Additionally, providing clear career progression pathways would not only improve job satisfaction but also help retain skilled workers, thereby reducing turnover and ensuring continuity of care. The introduction of wellbeing initiatives, such as regular peer support groups and flexible working arrangements, can also help address the high levels of stress and burnout reported by SPLWs. These measures are not merely about improving job satisfaction; they are crucial for maintaining the quality of care provided to patients, as a well-supported workforce is better positioned to deliver compassionate and effective care.

## Digital Infrastructure and Data Management

The report identifies the lack of a unified digital case management system as a significant barrier to effective SP service delivery. Currently, the fragmentation of digital systems across different boroughs leads to inefficiencies, such as double data entry and inconsistent data collection, which in turn hampers the ability to evaluate the impact of SP services accurately.

The recommendation to implement a centralised digital case management system is a key step towards addressing these challenges. A unified system would streamline data collection, sharing and reporting, enabling more efficient service delivery and better tracking of patient outcomes. Standardising data collection protocols across all practices would further enhance the ability to measure the effectiveness of SP services, providing valuable insights that can inform continuous improvement.

In addition to improving operational efficiency, upgrading digital infrastructure would also facilitate greater digital inclusion among service users. The report highlights the need for initiatives that improve access to digital tools, particularly for those who are digitally excluded. By providing training and support in using health-related digital tools, SP services can ensure that all patients, regardless of their digital literacy, can benefit from the full range of services available to them.

### Community engagement and partnerships

Effective SP services rely heavily on strong community engagement and partnerships. The report emphasises the need for better collaboration with local voluntary, community and VCSE sectors to co-design SP services that are responsive to local needs. This is particularly important in addressing health inequalities and reaching underserved populations.

The recommendation to foster stronger collaborations with community organizations and expand outreach programs is vital for ensuring that SP services are inclusive and accessible to all segments of the population. Engaging with VCSE sectors in the co-design of SP services would not only enhance the relevance of these services but also build stronger community ties, which are essential for the long-term sustainability of SP initiatives.

The integration of volunteers with lived experience into SP service delivery is a promising approach to enhance relatability and trust between service providers and users. These volunteers can play a crucial role in bridging the gap between healthcare providers and the communities they serve, particularly in reaching individuals who may be hesitant to engage with formal healthcare services.

### Sustainable funding and resource allocation

The sustainability of SP services is a recurring theme throughout the report. The reliance on short-term funding models poses a significant risk to the long-term viability of these services. The report calls for securing long-term funding through sustained NHS investment and innovative models such as Community Chests, to provide stable financial support to the SPLW workforce and sufficient community capacity to meet local needs.

TPHC's Evaluation of Community Chests in London highlighted positive outcomes in addressing unmet needs, improving VCSE capacity, and in cross-sector collaboration. NASP has called for even longer-term investment in their report Envisaging a Social Prescribing Fund in England, which outlines a nationwide model for shared investment in social prescribing. This visionary fund would require £500 million over 10 years, matched by a national investment partner and could dramatically increase community capacity and improve efficiency.

Investing in workforce stability by extending contract durations and providing career development opportunities is also highlighted as a critical need. These actions would not only improve job security for SPLWs but also ensure the continuity and quality of care provided to patients.

Pertinently, this strategic review emphasises the importance of a consistent approach to impact measurement and evaluation. Developing a borough-wide evaluation framework would provide the necessary data to assess the effectiveness of SP services, justify continued investment and guide future improvements.

## Suggested model for NCL ICB Social Prescribing Strategy

The model outlined below in Table 4 for the NCL ICB Social Prescribing strategy provides a comprehensive framework for integrating SP services across the boroughs. By focusing on leadership, workforce development, digital infrastructure, community engagement & and sustainable funding, the model aims to create a cohesive and effective SP system that addresses the social determinants of health, improves patient outcomes and reduces health inequalities across NCL. This model not only aligns with the broader goals of the NCL ICB but also sets the stage for a more resilient and responsive healthcare system that is better equipped to meet the needs of its diverse population.

*Table 4 Suggested Operating Model*

### (i) 1. *Leadership and Governance*

A strong and centralised leadership structure is critical to the success of the SP strategy within NCL. The model proposes the establishment of a dedicated SP lead for each borough, responsible for overseeing the implementation of SP services, ensuring alignment with NCL ICB's strategic objectives and fostering collaboration across healthcare providers, local authorities and community organizations. This role is vital in driving the strategic direction, coordinating resources and ensuring that SP services are responsive to the needs of the local population. Furthermore, the creation of a borough-wide steering group, comprising key stakeholders, will facilitate the integration of SP services within the broader health and social care ecosystem. This group will serve as a platform for collaboration, enabling the sharing of best practices, addressing challenges collectively and ensuring that SP services are delivered consistently and effectively across the boroughs.

### (ii) 2. *Workforce Development*

The effectiveness of SP services is heavily reliant on a well-trained and supported workforce. The model emphasises the need for ongoing professional development for SPLWs and related roles. This includes accredited training programs in areas such as mental health, community engagement and complex case management. Additionally, the model advocates for clear career progression pathways, which are crucial for retaining skilled workers and maintaining high service standards. Wellbeing initiatives are also a key component of the workforce development strategy. By providing SPLWs with the necessary support, such as regular peer support groups and flexible working arrangements, the TOM seeks to reduce burnout and improve job satisfaction, which in turn will enhance the quality of care provided to patients.

### (iii) 3. *Digital Infrastructure and Data Management*

A unified digital case management system is at the core of the proposed model. This system will streamline data collection, sharing and reporting across all boroughs, eliminating inefficiencies such as double data entry and ensuring that accurate and consistent data is available to inform decision-making. The implementation of a standardised data collection protocol, aligned with the SP Information Standard, will further enhance the ability to monitor and evaluate the impact of SP services. The model also recognises the importance of digital inclusion. It proposes initiatives to improve access to digital tools for service users, particularly those who are digitally excluded. By ensuring that all patients can engage with digital health resources, the model supports the broader goal of equitable access to healthcare services.

### (iv) 4. *Community Engagement and Partnerships*

Effective community engagement is essential for the success of SP services. The advocates for stronger collaborations with VCSE sectors to co-design SP services that are tailored to the needs of local communities. This approach can enhance the relevance and impact of SP services and strengthen the ties between healthcare providers and the communities they serve. The model also includes proactive outreach efforts, particularly targeting high-risk and underserved populations. By

engaging these groups, Social Prescribing services can address health inequalities more effectively, ensuring that the benefits of personalised care are accessible to all.

*(v) 5. Sustainable Funding and Resource Allocation*

Sustainable funding is a cornerstone of the proposed model which calls for the adoption of long-term funding strategies, to support the scaling and sustainability of SP Services. This approach will provide the financial stability needed to maintain and expand SP services, ensuring that they continue to meet the evolving needs of the population. The model also emphasises the importance of investing in workforce stability. By extending contract durations and providing opportunities for career development, the model seeks to create a stable and motivated workforce that can deliver high-quality SP services over the long term.

# Conclusion

The strategic review of SP services in NCL, offers a comprehensive analysis of the current challenges and opportunities in delivering personalised care through SP. The recommendations provided in the report, if implemented, have the potential to significantly enhance the effectiveness, reach and sustainability of SP services across the region. By strengthening leadership, enhancing workforce development, upgrading digital infrastructure, fostering community engagement and securing sustainable funding, decision-makers can ensure that SP services continue to deliver meaningful outcomes for the residents of NCL. The success of these initiatives will ultimately depend on the commitment of all stakeholders to collaborate and invest in the long-term future of SP in the region.

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# Appendices

## List of Appendices

| *Appendix A TPHC Social Prescribing Initiatives, Impact and Learning Across London* | **Summary** | **Outcomes** | **NCL participation** |
|---|---|---|---|
| Patient Voices for Social Prescribing | The Patient Voices for Social Prescribing programme was an opportunity for people with lived experience of SP to share their experiences, build skills and confidence in telling their story and explore opportunities to help improve SP services in London. | Outcomes and themes from the final evaluation will be shared in 2024.<br>Cohort feedback showed participants:<br>- reported gaining confidence, inspiration, knowledge and skills;<br>- built a strong peer support network;<br>- feel motivated to explore opportunities to share their experiences and help shape services;<br>- wider impact on wellbeing and interests. | One patient participated from NCL (Barnet). |
| Social Prescribing Innovators Programme | The Social Prescribing Innovators Programme supported people on the frontline of SP in London to overcome challenges and improve services' ability to tackle health inequalities, through developing leadership skills, quality improvement and testing new ways of working. 12 projects from across London formed the first cohort of Social Prescribing Innovators (22/23). The participants received six months of Quality Improvement training, coaching and support, as well as a share of £120,000 in funding to find innovative solutions to local challenges to SP services. | Impacts included:<br>- patient and community: people accessing SP who hadn't before<br>- workforce: SPLWs better equipped to support people with mental health issues and have greater capacity to work with complex patients leading to better job satisfaction and retention<br>- system: GP appointments have been saved by using community hubs and process to evaluate the SP service with SPLWs at the core<br><br>The Innovators Toolkit provides a step-by-step guide to the approach including resources, time, tools and assets required to drive this work | - Camden Care Navigation and Social Prescribing Service<br><br>- West and Central Camden PCN |
| The London Social | The London Social Prescribing Map is a platform to share how SP is being approached in each of | This is a living map without an endpoint. It is reliant on the community inputting and updating the map. | There is basic information about each of the NCL boroughs within the map. It is |

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| Prescribing Map | the London boroughs, spotlighting examples of innovative, impactful and proactive SP service models or individual projects.<br>The purpose of the map is to help people understand how SP is being delivered across London, along with supporting collaboration and shared learning through connecting people working within SP services. The map was created to showcase SP service models and not to share local services that SP refers onto. | Expected impact/outcomes of adding a service onto the map include:<br>- Space to share and promote service models with a wide range of stakeholders involved or interested in SP, raising profile of services.<br>- Opportunity to connect & promote SP services in a local area, improving access for people in the local community<br>- Unique opportunity to support expansion of SP into new settings, such as secondary care, through providing open access to information about service models and pathways<br>- Opportunity to connect with other SPLWs, VCFSE & 3rd sector organisations. | unclear who the 'owner' is in each borough with a commitment to update the data. |
| Social Prescribing Managers Network | The SP managers meeting is a 6 weekly meeting facilitated by TPHC. The meeting aims to support managers of SPLWs through facilitating a space for managers to connect with others doing a similar role, share learning, receive updates/ information/ guidance on topics relevant to them. The meetings are attended by a mix of SP managers from VCSE organisations, GP Federations, Primary Care Networks and individual GP Practices. | Collaboration and shared learning between SP managers across London.<br>A safe space for SP managers to raise topics for discussion<br>Support for SP Managers & SPLW workforce through the advice/information/resources provided at the meetings. | There are currently five SP managers who attend the meeting across NCL. |
| Community Chests for Social Prescribing | Community chests are local shared investment funds where resources are pooled from the NHS, local authorities and other contributors such as, philanthropy and local businesses, to support the voluntary and community sector to | TPHC has produced:<br>- A selection of case studies showing Community Chests in action in Herts Valley, Ipswich and East Suffolk, and Wandsworth. | Haringey: co-designing a community chest approach to grant funding the VCFSE sector. Haringey will be taking a participatory budgeting approach which will be co-produced with representatives |

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| | deliver health and wellbeing activities for local populations. They're rooted in a collaborative, needs-led approach to funding that taps into the strengths and insights of a wide range of partners from across the local community.<br>TPHC has co-designed a community chest model which brings together key representatives from across the local community to work in partnership and use local intelligence to agree funding priorities. | - A how to guide for Creating Community Chests for Social Prescribing in London.<br>- A guide to Making the Case for Community Chests.<br>- An External Evaluation Report of Community Chests in London. | from across the local health and wellbeing sector.<br>Other boroughs have existing programmes which are similar to the TPHC community chest model:<br>Islington: community chest approaches have been harnessing local capacity to build local initiatives, such as youth football teams and community gardens<br>Barnet: Barnet Community Innovation Fund is for Barnet-based voluntary and community projects that aim to improve health and wellbeing in the borough.<br>Camden: Community Impact Project Fund is being developed as a part of a wider VCSE investment programme |
| Social Welfare Legal Advice and Social Prescribing: Training | With finite investment in social welfare legal advice provision, there is a huge disparity in numbers of people needing support and receiving it. Many PCNs operating in areas of particular deprivation, see the opportunity to upskill SPLWs in this arena of great value to the patients they are supporting.<br>As part of its Recovery Programme, the GLA funded TPHC and Bromley by Bow to deliver social welfare legal advice training for 100 SPLWs across London and also trained a cohort of hybrid advice link worker. | Awareness training on welfare benefits and other social welfare legal advice issues, financial inclusion and fuel poverty. The training was as delivered to a total of 96 SPLWs targeting areas of highest deprivation and demand, between March and July 2022.<br>The pilot training programme for hybrid advice-link worker role has taken the approach of upskilling existing SPLWs to deal with less complex social welfare advice matters, to help address the issues caused by the difficulties in signposting/ referring to advice agencies. | 16 SPLWs accessed social welfare legal advice awareness training.<br>One SPLW in Islington received training to become a hybrid advice link worker. |

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| London-wide evaluation showcase | The 2023 showcase explains the importance of evaluation to demonstrate SP impact, as it:<br>- Supports investment<br>- Influences decision making<br>- Enables better understanding of local populations and needs<br>- Evidencing value | Replay of the Social prescribing and evaluation London showcase is available, including:<br>- How TPHC is supporting evaluation and impact of SP across London<br>- Barnet SP service approach to reporting on impact<br>- The national SP information standard and minimum data set from NHSE<br>- NASP role in SP and evidence<br>North East London approach to SP impact and evaluation. | Barnet shared its approach to impact reporting. |
| PCN Toolkit | Collaboratively developed PCN Toolkit: Using Social Prescribing, Health Coaching and Care Co-ordination to tackle health inequalities. It includes practical tools, tips, resources and examples of good practice. | Available on the TPHC website. | |
| Secondary Care | TPHC are leading the Secondary Care workstream, working alongside stakeholders to support the achievement of the ambition that every Acute Hospital Trust in London has access to personalised care roles by March 2025. | TPHC has lead on:<br>- Mapping the landscape of SP & personalised care in secondary care across London<br>- Developing cases studies of innovative projects/pilots embedding personalised care roles in secondary care<br>- Providing direct support and resources to pilot projects in development<br>Bringing together a network as part of a Community of Practice to champion and support development of approaches & improve access to personalised care in secondary care across London.<br>- Hosted a webinar to showcase the impact and share a call to action that every Acute Hospital Trust in London has access to personalised care roles by March 2025. | NCL have shared six examples with TPHC that demonstrate the use of personalised care roles within Secondary Care. The examples showcase different themes including; Mental Health, Health Inequalities, Cancer, Discharge and Population Health.<br>There are currently 13 representatives from NCL that are on the distribution list for the Community of Practice meetings. |

NCL Population data.pptx

| Five Key Principles for Using the Three Personalised Care Roles to Reduce Health Inequalities | |
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| 1- Address the social determinants of health | 1 in 5 GP appointments focus on wider social needs with a higher proportion in more deprived practices that are also most likely to be under-doctored.<br><br>The personalised care roles link patients with these wider social determinants of health e.g.<br><br>• SPLWs have a vital role in community referral, development and linking with multi-sectoral agencies such as housing, employing, welfare support, education, and other social determinants of health<br>• CCs can identify cohorts of patients with unmet social needs and signpost to community resources or refer to SPLWs<br>• HWCBs can work on goal setting and behaviour activation with motivated patients to address social isolation, self-esteem and confidence building, among other areas to prevent ill health and maintain wellbeing |
| 2- Build community intelligence | Personalised care roles can take the time required to understand the local population, their needs and priorities in order to shape and provide care that is relevant, responsive, appropriate and acceptable. |
| 3- Work with specific groups who are experiencing inequality in access, experience or outcomes | Overcome barriers and close unacceptable gaps that exist in health and care through proactive outreach and trust and relationship building with under-served patient groups. |
| 4- Facilitate joined up working | Connect with community assets and resources, strengthen community development and facilitate joined-up working and whole system approaches to tackle health inequalities holistically, collaboratively and sustainably. |
| 5- Personalised care is an intrinsic tool for PCNs in community recovery | There is a significant ARRS underspend in London and funding and support is available to grow these teams. |

## TPHC Checklist for Embedding and Working with a PCN Health Inequalities Lead

- Support and commitment from PCN leadership- this is essential
- Ensure there is a named health inequalities lead who is a visible point of contact for health inequalities issues in the PCN
- Remember, an HI lead can be any suitable clinician and does not have to be a GP
- Ensure the role is funded with protected time and a clear job description and with opportunities and investment in training on health inequalities
- Use personalised care roles creatively to bridge the gap between primary care and the community and partner anchor systems to effectively address SDoH e.g. allocating time for community development and outreach work to build links and support referrals
- Adequate time to plan strategy, work with and supervise ARRS roles where needed
- Utilise asset-based approaches - with support from ARRS roles who have good local knowledge:
- Map local assets and resources
- Community engagement: join or form a stakeholder group or community forum with representation from local community groups, leaders and across agencies
- Co-produce solutions to address local health inequalities
- Outreach work: identify and reach out to underserved patient groups and communities.
- Data-driven approach; develop knowledge, data and dashboards to identify patient cohorts experiencing HI and progress national targets (e.g. ethnicity recording).
- Support funding for local community initiatives; without investment in community development the impact of the work of a HI lead is limited. Looking for co-commissioning models such as with local authority, community grants and PCN development fund
- Training opportunities and peer support for HI leads coordinated by ICSs
- Advocacy to raise awareness of health exclusion and inequalities and approaches for tackling them.