Social prescribing and community-based support
Summary guide

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document we have:

o given due regard to the need to eliminate discrimination, harassment and victimisation; to advance equality of opportunity; and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it

o given regard to the need to reduce inequalities between patients in access to and outcomes from healthcare services, and to ensure services are provided in an integrated way where this might reduce health inequalities.

Other formats of this document are available on request. If required please contact england.personalisedcare@nhs.net

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Introduction

Social prescribing and community-based support is part of the NHS Long-Term Plan's commitment to make personalised care business as usual across the health and care system.

Personalised Care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths and needs. This happens within a system that makes the most of the expertise, capacity and potential of people, families and communities in delivering better outcomes and experiences. Personalised care takes a whole-system approach, integrating services around the person. It is an all-age model, from maternity and childhood through to end of life, encompassing both mental and physical health support.

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

Personalised care is implemented through the Comprehensive Model for Personalised Care (see Figure 1). The Model has been co-produced with a wide range of stakeholders and brings together six evidence-based and inter-linked components, each defined by a standard, replicable delivery model. These components are:
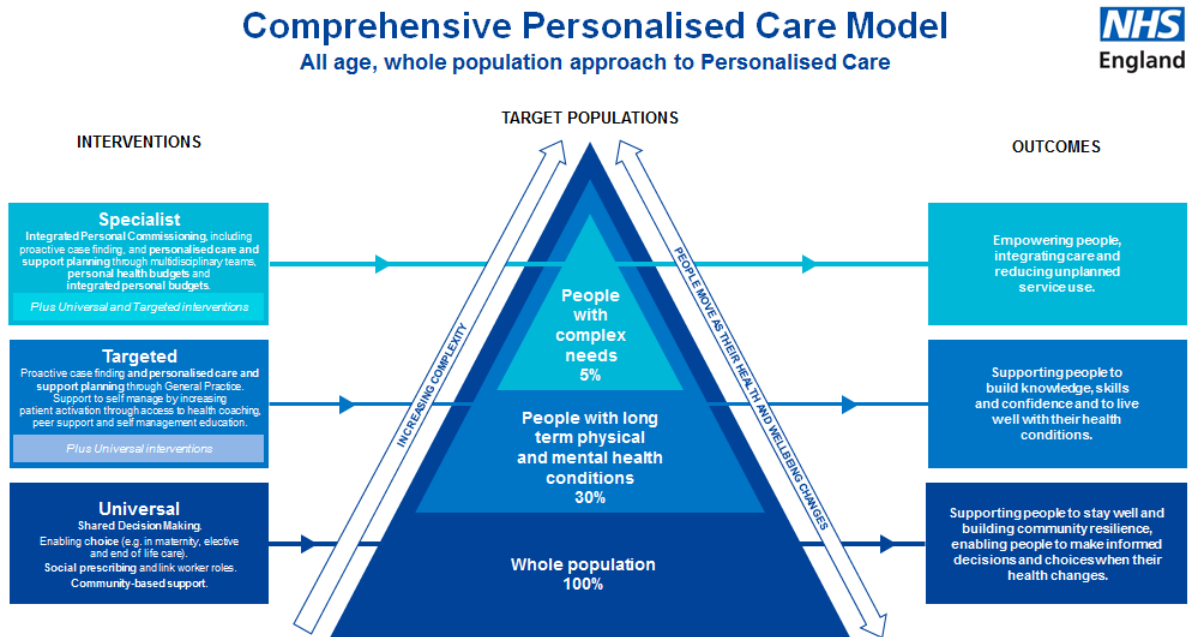
1. Shared decision making

2. Personalised care and support planning

3. Enabling choice, including legal rights to choice

4. Social prescribing and community-based support

5. Supported self-management

6. Personal health budgets and integrated personal budgets.

The deployment of these six components will deliver:

- whole-population approaches, supporting people of all ages and their carers to manage their physical and mental health and wellbeing, build community resilience, and make informed decisions and choices when their health changes

- a proactive and universal offer of support to people with long-term physical and mental health conditions to build knowledge, skills and confidence to live well with their health condition

- intensive and integrated approaches to empower people with more complex needs, including those living with multi-morbidity, to experience co-ordinated care and support that supports them to live well, helps reduce the risk of becoming frail, and minimises the burden of treatment.

Figure 1: Comprehensive Model for Personalised Care

Comprehensive Personalised Care Model
All age, whole population approach to Personalised Care

NHS England

TARGET POPULATIONS

INTERVENTIONS

OUTCOMES

Specialist
Integrated Personal Commissioning, including proactive case finding, and personalised care and support planning through multidisciplinary teams, personal health budgets and integrated personal budgets.
Plus Universal and Targeted interventions

Targeted
Proactive case finding and personalised care and support planning through General Practice. Support to self manage by increasing patient activation through access to health coaching, peer support and self management education.
Plus Universal interventions

Universal
Shared Decision Making.
Enabling choice (e.g. in maternity, elective and end of life care).
Social prescribing and link worker roles.
Community-based support.

People with complex needs
5%

People with long term physical and mental health conditions
30%

Whole population
100%

INCREASING COMPLEXITY

PEOPLE MOVE AS THEIR HEALTH AND WELLBEING CHANGES

Empowering people, integrating care and reducing unplanned service use.

Supporting people to build knowledge, skills and confidence and to live well with their health conditions.

Supporting people to stay well and building community resilience, enabling people to make informed decisions and choices when their health changes.

More information about the Comprehensive Model for Personalised Care and supporting summary guides for its successful implementation are available on the personalised care pages of the NHS England website.[1]

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[1] https://www.england.nhs.uk/personalised-health-and-care/

Who is this document for?

This summary guide is aimed at people and organisations leading local implementation of social prescribing. It enables:

- increased understanding of what good social prescribing looks like and why social prescribing improves outcomes and experiences for people, their families and carers, as well as achieving more value from the system

- commissioning of local social prescribing connector schemes, enabling all general practices, local authorities and other agencies to refer people with wider social needs to community-based support

- collaborative working amongst all local partners at a 'place-based' local level, to recognise the value of community groups and assets and to enable people to build or rebuild friendships, community connections and a sense of belonging, as well as accessing existing services.

The guide provides best practice advice, not statutory guidance.

What is social prescribing?

Social prescribing enables all local agencies to refer people to a link worker.

Link workers give people time and focus on what matters to the person as identified through shared decision making or personalised care and support planning. They connect people to community groups and agencies for practical and emotional support.

Link workers collaborate with local partners to support community groups to be accessible and sustainable and help people to start new groups.

The core elements of the link worker role and a generic link worker job description are described in Annex A.

Social prescribing particularly works for a wide range of people, including people:

- with one or more long-term conditions
- who need support with their mental health
- who are lonely or isolated
- who have complex social needs which affect their wellbeing.

When social prescribing works well, people can be easily referred to local social prescribing link workers from a wide range of local agencies, including general practice, local authorities, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise (VCSE) organisations. Self-referral is also encouraged.

Social prescribing complements other approaches in a local area, such as 'active signposting' For more information about how social prescribing complements other approaches, see Annex B.

There is emerging evidence that social prescribing can lead to a range of positive health and wellbeing outcomes for people, such as improved quality of life and emotional wellbeing.[2] Though there is a need for more robust and systematic evidence on the effectiveness of social prescribing,[3] social prescribing schemes may lead to a reduction in the use of NHS services,[4] including GP attendance. 59% of GPs think social prescribing can help reduce their workload.[5]

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[2] Dayson, C. and Bashir, N. (2014), The social and economic impact of the Rotherham Social Prescribing Pilot. Sheffield: Sheffield Hallam University: https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham.pdf

[3] Bickerdike, L., Booth, A., Wilson, P.M., et. Al. (2017), Social prescribing: less rhetoric and more reality. A systematic review of the evidence, BMJ Open 2017;7:e013384. doi: 10.1136/bmjopen-2016-013384

[4] Polley, M. et al. (2017), A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications. London: University of Westminster

[5] RCGP (2018). Spotlight on the 10 high impact actions. Available online http://www.rcgp.org.uk/about-us/news/2018/may/rcgp-calls-on-government-to-facilitate-social-prescribing-for-all-practices.aspx (accessed 2 June 2018)

What good social prescribing looks like – for people

- People, their families and carers know about social prescribing and can easily be referred to social prescribing link workers from a wide range of local agencies.

- People, their families and carers can refer themselves to social prescribing link workers.

- Building on 'what matters to me', people can work with a link worker to co-produce a simple plan or a summary personalised care and support plan, based on the person's assets, needs and preferences, as well as making the most of community and informal support.

- People, their families and carers may be physically introduced to community groups, so that they don't have to make that first step to join a group and to meet new people on their own.

- People, their families and carers are encouraged to develop their knowledge, skills and confidence by being involved in local community groups and giving their time back to others. For some people, this may provide volunteering and work opportunities to help find paid employment.

- People, their families and carers may be supported to work with others to set up new community groups, particularly where gaps exist in local community support.

- The sense of belonging that comes from being part of a community group and having peer support can reduce loneliness and anxiety. It helps people to find a new sense of purpose, enjoying activities they might not otherwise have tried before, such as arts, cultural activities, walking, running, gardening, singing and making connections to the outdoors.

- Being connected to community groups through social prescribing enables people to be more physically active and improves mental health, helping them to stay well for longer and lessen the impact of long-term conditions.

What good social prescribing looks like – for people

What good social prescribing looks like – for communities

- Communities are stronger and more tolerant, because people from all backgrounds are supported through social prescribing to be involved in community groups. There are more people who volunteer and give their time back to others.

- Communities understand the power of social prescribing in reducing health inequalities, by supporting a power shift, enabling people to take more control of their lives, be less isolated and make connections.

- Communities are aware of how social prescribing encourages community development and increases local community assets. Resources and support are available locally to spot gaps in community provision, help people to create new groups and provide informal support in their neighbourhoods.

- Communities work with social prescribing to ensure that services are fully accessible to all communities, including those in greatest need, who may be hardest for agencies to reach.

- Communities recognise that the NHS, local authorities and statutory services alone cannot meet all people's support needs. This understanding releases energy across all stakeholders in addressing the wider determinants of health.

- Communities are actively involved in developing and delivering social prescribing. VCSE organisations such as advice agencies are commissioned to receive referrals and deliver services. Local community groups are able to take referrals from link workers because they have sustainable grant funding.

- Communities support the improvement of health literacy of professionals and local residents through social prescribing service development and referrals.

- Communities are able to support people who participate in social prescribing, improving their confidence and ability to manage their own wellbeing.

What good social prescribing looks like – for the system

- Social prescribing connector schemes are locally and collaboratively commissioned by partnerships of primary care networks, CCG and local authority commissioners, working with the (VCSE) sector and people, their families and carers.

- Whilst social prescribing link workers are attached to general practices and primary care networks, they may be employed by local social prescribing connector schemes, typically hosted within the VCSE sector. Connector schemes may also be hosted by other agencies, depending on local partnerships.

- There is a clear and easy referral process for all local agencies involved. Referrals are received from general practice, local authorities, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and VCSE organisations. Self-referral is encouraged.

- Social prescribing connector schemes provide local agencies with a single point of contact for appropriate referrals of people who need link worker support in a local area. This reduces pressure on statutory services and facilitates a more integrated approach, particularly where people have complex lives and may come into contact with a number of local agencies and services. This requires a strategic approach to integration at local level with all partners recognising the value of link worker roles.

- Connector schemes have an important role in supporting the development of local community groups, working in close partnership with local infrastructure agencies, where they exist. Link workers have strong knowledge of local community groups, map community assets, recognise gaps in community provision and find creative ways of encouraging asset-based community development approaches, alongside local commissioners and partners.

- Typically, social prescribing link workers support people on average over 6-12 contacts, which can be done in a variety of ways, depending on people's preferences. Link workers typically have a caseload of up to 250 people per year. Where people are isolated or lonely, it may be helpful for link workers to carry out home visits.

- Link workers complement, and connect to, other relevant approaches in an area where they exist, such as active signposting or local area coordinators. Annex B sets out how social prescribing fits in with these other approaches.

Implementing social prescribing: what needs to be in place locally

NHS England has engaged a wide range of stakeholders – including people with lived experience, GPs, social prescribing link workers, local authority commissioners, CCGs and the VCSE sector – to set out the key elements of what makes a good social prescribing scheme and what needs to be in place locally. Figure 2 below captures these key elements.

Figure 2: Model for social prescribing

For an implementation checklist for local partners and commissioners for these key elements, see Annex C. The rest of this section sets out more detail of what each of these features requires in practice.

1. Collaborative commissioning and partnership working

Social prescribing works best when all local partners work together to build on existing assets and services. Successful schemes generally have collaborative commissioning and creative partnership working, with the following common characteristics:

- **All partners build it together.** VCSE partners, primary care networks, local authority and CCG commissioners, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services and housing associations are working together in local areas to build on existing community assets, co-producing and co-commissioning local social prescribing connector schemes.

- **Local relationships matter.** Strong community networks are built on trust and take time to develop. Local organisations with deep-rooted community networks need to be commissioned to provide social prescribing services.

- **The VCSE sector is involved from the start**, including local infrastructure agencies where they exist. Social prescribing relies on the capacity of small community groups to receive referrals and provide support. Community groups themselves typically rely on grants for survival. For social prescribing to work locally, ongoing support is needed for community groups and organisations. Local infrastructure agencies, link workers and others need to work closely together to nurture community groups, helping them be sustainable and safely manage referrals. In areas where there is less community capacity or little infrastructure support, more capacity building support may be needed.

2. Easy referral from all local agencies

It is important that a wide range of agencies, including all general practices, are able to refer people to social prescribing and that this process should be as easy as possible. To be effective, the following is needed:

- **A wide range of local agencies are able to refer to social prescribing** in order to coordinate support around the person and encourage partnership working. General practices are important referrers, together with other agencies, such as pharmacies, local authorities, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and VCSE organisations. Self-referral is also encouraged.

- **Informed decision-making** happens before referral to social prescribing to ensure people can exercise choice, they know what to expect from social prescribing, and that it is right for them.

- **National social prescribing codes in GP IT systems to capture social prescribing referrals**: NHS England has worked with NHS Digital to establish national SNOMED CT[6] codes for social prescribing:

    871691000000100 | Social prescribing offered (finding)

    871711000000103 | Social prescribing declined (situation)

    871731000000106 | Referral to social prescribing service (procedure).

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[6] SNOMED CT is a structured vocabulary to classify activity and ensure that all GP IT systems share the same language.

All general practices should use these codes to record the number of social prescribing referrals. SNOMED CT is currently being deployed across all GP IT systems and will replace Read coding.

- **Easy referral within general practice.** Typically, link workers are attached to general practices and primary care networks as an important part of the practice team. This makes it easy for general practices and all referral agencies to refer people to them. There also needs to be a clear process for self-referral, with awareness and understanding of this process in all agencies.

3. Workforce development

For social prescribing to work successfully, link workers need suitable support and training. It is also vital that the wider workforce have an understanding of social prescribing to enable appropriate referrals.

- **All referrers need support to understand link worker roles** and how local systems can make the best of them. Commissioners, primary care networks, and link workers may wish to organise training sessions for local referral agencies. An important element of this learning will be about what makes an appropriate social prescribing referral.

- **Social prescribing link workers need regular access to 'clinical supervision'** to support them in their connecting roles. Link workers often see people in crisis and vulnerable situations. To be effective, the issues people present, including domestic violence, sexual abuse, family dynamics, self-harm and suicidal thoughts, need to be heard in a safe supervision space. Link workers need dedicated time to offload and to have clear safeguarding procedures to deal with situations appropriately.

- **Accredited learning and link worker qualifications.** Social prescribing commissioners and practitioners emphasise personal qualities and life experience of link workers, such as empathy and listening skills, above qualifications. However, link workers should receive accredited training and ongoing development to support their role.

4. Link workers employed to give time

Paid link workers are a fundamental feature of good social prescribing. They play a pivotal role by developing trusting relationships and providing personalised support. As a result, their work:

- strengthens community resilience
- reduces health inequalities by addressing the wider determinants of health, such as debt, poor housing and physical inactivity
- increases people's active involvement with their local communities.

Key features include:

- **Personalised coaching approach.** Link workers develop trusting relationships and give people time to tell their stories. It is crucial for link workers to start with 'what matters to me' and to value what motivates the person. Link workers have a mix of skills and personal qualities which they bring to the role. In addition, they have excellent listening and communication skills, empathy, emotional resilience and are able to work in a person-centred, non-judgemental way across whole, diverse communities. For a sample link worker job description, see Annex A.

- **Workload.** Link workers typically work with people over 6-12 contacts (including phone calls and meetings) over a three-month period (depending on what the person needs) with a typical annual caseload of up to 250 people, depending on the complexity of people's needs and the maturity of the social prescribing scheme.

- **Salary**. The average salary of a social prescribing link worker is around £25,000 per annum, which is equivalent to NHS pay grade 5, mid-scale.

- **Home visits and introducing people to community groups.** Link workers organise home visits to make initial assessments and build rapport, especially to engage with hard to reach ethnic groups or where people are isolated from their community. It may be necessary for link workers to accompany people to community groups to facilitate and support that first step, where people don't have the confidence to do this on their own.

5. What matters to you? Co-produced simple plans or summary personalised care and support plans

An important element of social prescribing support is for the person and their link worker to co-produce a simple plan or a summary personalised care and support plan, which outlines:

- what matters to the person – their priorities, interests, values and motivations

- community groups and services the person will be connected to

- what the person can expect of community support and services

- what the person can do for themselves, in order to keep well and active

- what assets people already have that they can draw on – family, friends, hobbies, skills and passions.

Examples of such plans are available on the NHS England website.[7]

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[7] https://www.england.nhs.uk/personalised-health-and-care/

6. Support for community groups

It is essential to ensure that local voluntary organisations, community groups and social enterprises are locally sustainable and can plan ahead, if social prescribing is to be embedded across all local areas. Support should include:

Funding. There are different ways that local commissioners can provide funding:

- develop a 'shared investment fund', bringing together all local partners who can provide funding to charities and community groups, including the private sector.

- commission existing, staffed VCSE organisations, which provide services such as welfare benefits advice and befriending, to deliver social prescribing

- provide small grants for volunteer-led community groups providing peer support and activities, such as walking groups, choirs and art classes

- micro-commission new groups where there are gaps in community provision - which may be in the form of a start-up grant and development support

- enable people to use their Personal Health Budget (PHB) to pay for support in the VCSE sector

- explore social investment opportunities, as well as outcome-based commissioning. This is particularly suited to co-commissioning with health and social care, where a set of outcomes are agreed, money is loaned and paid back when outcomes are achieved.

Safe referrals. It is necessary to ensure that community groups have support with all relevant aspects to ensure both people and link workers are safe. This includes, but isn't limited to, appropriate insurance, safeguarding, lone working, first aid (including mental health first aid), data protection, DBS checks, food safety and working with vulnerable citizens. All referral agencies and statutory bodies need to have an honest and transparent relationship with VCSE organisations to support and reduce risk to people, link workers and organisations in the VCSE sector.

The culture of risk aversion in statutory agencies can prevent innovative community initiatives from getting off the ground. For example, people who need support with their mental health may be prevented from joining gardening groups because sharp tools are involved. Statutory bodies should work with partners to create reasonable and safe referrals, based on what matters to people, whilst minimising bureaucratic controls and working to overcome an overly risk-averse approach to local community development.

7. Common Outcomes Framework

As social prescribing is locally driven, different approaches to evaluation and the measurement of outcomes have emerged across England.

To encourage consistent data gathering and reporting of outcomes, NHS England has worked with a wide range of stakeholders to develop a Common Outcomes Framework for measuring the impact of social prescribing. Working with a wide range

of stakeholders, a consensus has been built for all social prescribing connector schemes to measure the following outcomes:

- **Impact on the person.** How a person's wellbeing has improved, whether they are less lonely, whether they feel more in control and have a better quality of life.

- **Impact on the health and care system.** An evidence summary published by the University of Westminster[8] suggests that where a person has support through social prescribing, their GP consultations reduce by an average of 28% and A&E attendances by 24%. NHS England and partners want to test this, by supporting local social prescribing schemes and CCGs to develop data sharing agreements around impact on the health and care system. We are learning from local areas where this works, to share with everyone across the country.

- **Impact on community groups:** NHS England and partners will support local areas to introduce a regular 'confidence' survey of local community groups, to identify development needs, test whether groups are fully involved and supported to receive appropriate social prescribing referrals.

The full Social Prescribing Common Outcomes Framework is in Annex D.

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[8] Polley, M. *et al.* (2017) op. cit

What guidance and resources are available?

There are many good case studies and resources on social prescribing across the country, which demonstrate where effective social prescribing is in place.

NHS England has set up an online learning platform to share the latest resources. To join the platform, please contact england.socialprescribing@nhs.net

Below is a summary:

What is social prescribing - The Kings Fund (02 February 2017)
https://www.kingsfund.org.uk/publications/social-prescribing

Social prescribing animation - Healthy London Partnership:
https://www.healthylondon.org/our-work/proactive-care/social-prescribing/

Making Sense of Social Prescribing – University of Westminster:
https://westminsterresearch.westminster.ac.uk/item/q1v77/making-sense-of-social-prescribing

Social prescribing: a pathway to work? – The Work Foundation, Lancaster University (February 2017)
http://www.theworkfoundation.com/wp-content/uploads/2017/02/412_Social_prescribing.pdf

Spotlight on the Ten High Impact Actions - Royal College of GPs
http://www.rcgp.org.uk/policy/general-practice-forward-view/spotlight-on-the-10-high-impact-actions.aspx

A guide to implementing social prescribing in London – Healthy London Partnership
https://www.healthylondon.org/resource/social-prescribing-steps-towards-implementing-self-care/

Social prescribing – a guide for local authorities
https://www.local.gov.uk/sites/default/files/documents/just-what-doctor-ordered--6c2.pdf

A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications – University of Westminster
https://docs.wixstatic.com/ugd/14f499_75b884ef9b644956b897fcec824bf92e.pdf

Creative Health – All Party Parliamentary Group report
http://www.artshealthandwellbeing.org.uk/

Information:

This guide has been produced by the Social Prescribing team within the Personalised Care Group at NHS England. You can contact us at england.socialprescribing@nhs.net

Annex A: Link worker job description

There are many different names used to describe the link worker role. These include wellbeing advisor, community connector, community navigator, community health worker, community health agent, health advisor, depending on local preference. Whilst the names may be different, the core elements of the role remain the same, hence the generic 'link worker' term.

It is vital that link workers have a strong awareness and understanding of their role and responsibilities. This includes awareness of when it is appropriate or necessary to refer people to other professionals or qualified practitioners.

There are also other aspects to be typically expected of link workers. They:

- are attached to general practices and primary care networks, where they take referrals from a range of local agencies. Although they are part of the primary care network team, they may be employed by local social prescribing connectors typically hosted within the VCSE sector
- receive accredited training and ongoing development to support their role.
- work with people on average over 6-12 contacts and hold a caseload of up to 250 people per year.

The average salary of a social prescribing link worker is around £25,000 per annum, which is equivalent to NHS pay grade 5 mid-point.

The next page shows a sample link worker job description and person specification.

Social prescribing link worker. Draft job description and person specification
Created by NHS England and partners, Personalised Care, October 2018

Note: This generic link worker job description is for general guidance based on existing good practice. It is particularly suitable for new social prescribing schemes starting up, and those where individual link workers deliver all the functions. In areas where there are existing schemes, we recognise that some elements of the job description may apply to other roles in a scheme – such as a service manager or community development worker. Depending on the size and maturity of your social prescribing programme, it may be helpful to separate roles providing support for community groups out from those giving personalised support direct to individuals.

Purpose of the role
Social prescribing empowers people to take control of their health and wellbeing through referral to non-medical 'link workers' who give time, focus on 'what matters to me' and take a holistic approach, connecting people to community groups and statutory services for practical and emotional support. Link workers support existing groups to be accessible and sustainable and help people to start new community groups, working collaboratively with all local partners.

Social prescribing can help to strengthen community resilience and personal resilience, and reduces health inequalities by addressing the wider determinants of health, such as debt, poor housing and physical inactivity, by increasing people's active involvement with their local communities. It particularly works for people with long-term conditions (including support for mental health), for people who are lonely or isolated, or have complex social needs which affect their wellbeing.

Proposed salary: Equivalent to NHS Band 5 (if employed in the not-for-profit sector) £24,214 - £30,112 (2019/20 salary scale)

We recognise that existing social prescribing schemes may employ link workers on a different salary scale, however this proposed salary reflects the complexity of the situations that people present with, and the need for a significant level of multi-agency working, including supporting community groups to receive referrals.

Key responsibilities
1. Take referrals from a wide range of agencies, working with GP practices within primary care networks, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations, and voluntary, community and social enterprise (VCSE) organisations (list not exhaustive).

2. Provide personalised support to individuals, their families and carers to take control of their wellbeing, live independently and improve their health outcomes. Develop trusting relationships by giving people time and focus on 'what matters to me'. Take a holistic approach, based on the person's priorities and the wider determinants of health. Co-produce a personalised support plan to improve health and wellbeing, introducing or reconnecting people to community groups and statutory services. The role will require managing and prioritising your own caseload, in accordance with the needs, priorities and any urgent support required by individuals

on the caseload. It is vital that you have a strong awareness and understanding of when it is appropriate or necessary to refer people back to other health professionals/agencies, when what the person needs is beyond the scope of the link worker role – e.g. when there is a mental health need requiring a qualified practitioner.

3. Draw on and increase the strengths and capacities of local communities, enabling local VCSE organisations and community groups to receive social prescribing referrals. Ensure they are supported, have basic safeguarding processes for vulnerable individuals and can provide opportunities for the person to develop friendships, a sense of belonging, and build knowledge, skills and confidence.

4. Work together with all local partners to collectively ensure that local VCSE organisations and community groups are sustainable and that community assets are nurtured, by making them aware of small grants or micro-commissioning if available, including providing support to set up new community groups and services, where gaps are identified in local provision.

Key Tasks

Referrals
- Promoting social prescribing, its role in self-management, and the wider determinants of health.
- Build relationships with key staff in GP practices within the local Primary Care Network (PCN), attending relevant meetings, becoming part of the wider network team, giving information and feedback on social prescribing.
- Be proactive in developing strong links with all local agencies to encourage referrals, recognising what they need to be confident in the service to make appropriate referrals.
- Work in partnership with all local agencies to raise awareness of social prescribing and how partnership working can reduce pressure on statutory services, improve health outcomes and enable a holistic approach to care.
- Provide referral agencies with regular updates about social prescribing, including training for their staff and how to access information to encourage appropriate referrals.
- Seek regular feedback about the quality of service and impact of social prescribing on referral agencies.
- Be proactive in encouraging self-referrals and connecting with all local communities, particularly those communities that statutory agencies may find hard to reach.

Provide personalised support
- Meet people on a one-to-one basis, making home visits where appropriate within organisations' policies and procedures. Give people time to tell their stories and focus on 'what matters to me'. Build trust with the person, providing non-judgemental support, respecting diversity and lifestyle choices. Work from a strength-based approach focusing on a person's assets.
- Be a friendly source of information about wellbeing and prevention approaches.

- Help people identify the wider issues that impact on their health and wellbeing, such as debt, poor housing, being unemployed, loneliness and caring responsibilities.

- Work with the person, their families and carers and consider how they can all be supported through social prescribing.

- Help people maintain or regain independence through living skills, adaptations, enablement approaches and simple safeguards.

- Work with individuals to co-produce a simple personalised support plan – based on the person's priorities, interests, values and motivations – including what they can expect from the groups, activities and services they are being connected to and what the person can do for themselves to improve their health and wellbeing.

- Where appropriate, physically introduce people to community groups, activities and statutory services, ensuring they are comfortable. Follow up to ensure they are happy, able to engage, included and receiving good support.

- Where people may be eligible for a personal health budget, help them to explore this option as a way of providing funded, personalised support to be independent, including helping people to gain skills for meaningful employment, where appropriate.

Support community groups and VCSE organisations to receive referrals

- Forge strong links with local VCSE organisations, community and neighbourhood level groups, utilising their networks and building on what's already available to create a map or menu of community groups and assets. Use these opportunities to promote micro-commissioning or small grants if available.

- Develop supportive relationships with local VCSE organisations, community groups and statutory services, to make timely, appropriate and supported referrals for the person being introduced.

- Ensure that local community groups and VCSE organisations being referred to have basic procedures in place for ensuring that vulnerable individuals are safe and, where there are safeguarding concerns, work with all partners to deal appropriately with issues. Where such policies and procedures are not in place, support groups to work towards this standard before referrals are made to them.

- Check that community groups and VCSE organisations meet in insured premises and that health and safety requirements are in place. Where such policies and procedures are not in place, support groups to work towards this standard before referrals are made to them.

- Support local groups to act in accordance with information governance policies and procedures, ensuring compliance with the Data Protection Act.

Work collectively with all local partners to ensure community groups are strong and sustainable

- Work with commissioners and local partners to identify unmet needs within the community and gaps in community provision.

- Support local partners and commissioners to develop new groups and services where needed, through small grants for community groups, micro-commissioning and development support.

- Encourage people who have been connected to community support through social prescribing to volunteer and give their time freely to others, in order to build their skills and confidence, and strengthen community resilience.

- Develop a team of volunteers within your service to provide 'buddying support' for people, starting new groups and finding creative community solutions to local issues.

- Encourage people, their families and carers to provide peer support and to do things together, such as setting up new community groups or volunteering.

- Provide a regular 'confidence survey' to community groups receiving referrals, to ensure that they are strong, sustained and have the support they need to be part of social prescribing.

General tasks

Data capture
- Work sensitively with people, their families and carers to capture key information, enabling tracking of the impact of social prescribing on their health and wellbeing.

- Encourage people, their families and carers to provide feedback and to share their stories about the impact of social prescribing on their lives.

- Support referral agencies to provide appropriate information about the person they are referring. Use the case management system to track the person's progress. Provide appropriate feedback to referral agencies about the people they referred.

- Work closely with GP practices within the PCN to ensure that social prescribing referral codes are inputted to EMIS/SystmOne/Vision and that the person's use of the NHS can be tracked, adhering to data protection legislation and data sharing agreements with the clinical commissioning group (CCG).

Professional development
- Work with your line manager to undertake continual personal and professional development, taking an active part in reviewing and developing the roles and responsibilities.

- Adhere to organisational policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety.

- Work with your line manager to access regular 'clinical supervision', to enable you to deal effectively with the difficult issues that people present.

Miscellaneous
- Work as part of the team to seek feedback, continually improve the service and contribute to business planning.

- Undertake any tasks consistent with the level of the post and the scope of the role, ensuring that work is delivered in a timely and effective manner.

- Duties may vary from time to time, without changing the general character of the post or the level of responsibility.

Person Specification

	Criteria	Essential	Desirable
Personal Qualities & Attributes	Ability to listen, empathise with people and provide person-centred support in a non-judgemental way	✓	
	Able to get along with people from all backgrounds and communities, respecting lifestyles and diversity	✓	
	Commitment to reducing health inequalities and proactively working to reach people from all communities	✓	
	Able to support people in a way that inspires trust and confidence, motivating others to reach their potential	✓	
	Ability to communicate effectively, both verbally and in writing, with people, their families, carers, community groups, partner agencies and stakeholders	✓	
	Ability to identify risk and assess/manage risk when working with individuals	✓	
	Have a strong awareness and understanding of when it is appropriate or necessary to refer people back to other health professionals/agencies, when what the person needs is beyond the scope of the link worker role – e.g. when there is a mental health need requiring a qualified practitioner	✓	
	Able to work from an asset based approach, building on existing community and personal assets	✓	
	Able to provide leadership and to finish work tasks	✓	
	Ability to maintain effective working relationships and to promote collaborative practice with all colleagues	✓	
	Commitment to collaborative working with all local agencies (including VCSE organisations and community groups). Able to work with others to reduce hierarchies and find creative solutions to community issues	✓	
	Demonstrates personal accountability, emotional resilience and works well under pressure	✓	
	Ability to organise, plan and prioritise on own initiative, including when under pressure and meeting deadlines	✓	
	High level of written and oral communication skills	✓	
	Ability to work flexibly and enthusiastically within a team or on own initiative	✓	
	Understanding of the needs of small volunteer-led community groups and ability to support their development	✓	
	Knowledge of and ability to work to policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety	✓	
Qualifications & Training	NVQ Level 3, Advanced level or equivalent qualifications or working towards	✓	
	Demonstrable commitment to professional and personal development	✓	
	Training in motivational coaching and interviewing or equivalent experience		✓
Experience	Experience of working directly in a community development context, adult health and social care, learning support or public health/health improvement (including unpaid work)	✓	

	Experience of supporting people, their families and carers in a related role (including unpaid work)	✓	
	Experience of supporting people with their mental health, either in a paid, unpaid or informal capacity		✓
	Experience of working with the VCSE sector (in a paid or unpaid capacity), including with volunteers and small community groups	✓	
	Experience of data collection and providing monitoring information to assess the impact of services		✓
	Experience of partnership/collaborative working and of building relationships across a variety of organisations	✓	
Skills and knowledge	Knowledge of the personalised care approach		✓
	Understanding of the wider determinants of health, including social, economic and environmental factors and their impact on communities	✓	
	Knowledge of community development approaches	✓	
	Knowledge of IT systems, including ability to use word processing skills, emails and the internet to create simple plans and reports	✓	
	Knowledge of motivational coaching and interview skills	✓	
	Knowledge of VCSE and community services in the locality		✓
Other	Meets DBS reference standards and has a clear criminal record, in line with the law on spent convictions	✓	
	Willingness to work flexible hours when required to meet work demands	✓	
	Access to own transport and ability to travel across the locality on a regular basis, including to visit people in their own homes	✓	

Annex B: How does social prescribing fit with other approaches?

a. **Active signposting**

Active signposting is a light-touch approach where existing staff in local agencies give 'light touch' information to people. They provide information and choice to signpost people to services, using local resource directories and local knowledge. Active signposting works best for people who are confident and skilled enough to find their own way to services after a brief intervention. It complements social prescribing when viewed in terms of 'as well as social prescribing' not 'instead of social prescribing'.

b. **Local area coordination**

Local Area Coordination is a long term, integrated, evidence based programme centred around supporting people with disabilities, mental health needs, older people and their families/carers, by working together with people to help them:

- build and pursue their personal vision for a good life,
- stay strong, safe and connected as contributing citizens,
- find practical, non-service solutions to problems wherever possible,
- build more welcoming, inclusive and supportive communities.

Where local area coordination already exists in an area, it can complement social prescribing by supporting particular cohorts of people for the longer term and building community capacity and connections.

c. **Health coaching**

Health coaching is a personalised approach that is based upon behaviour change theory and is delivered by health professionals with diverse backgrounds.

Within the NHS there are 'health coaching' roles, both within primary care and acute settings. NHS health coaching differs from social prescribing in that emphasis tends to be placed on the behaviour change, rather than connecting people with community groups and services. However, there are many similarities, as a motivational coaching approach is an integral part of a social prescribing link worker role.

Annex C: Implementation checklist for local partners and commissioners

Key features	Notes
1. Collaborative Commissioning and Partnership Working a. Are you working with all partners, including VCSE sector leaders, local infrastructure organisations, CCG, local authority commissioners, primary care networks, referral agencies and local Health & Wellbeing Board to create a clear local plan for social prescribing? b. Are you building strong local relationships with VCSE sector organisations and community groups? Are VCSE sector leaders and local infrastructure organisations involved as trusted partners? c. Are local Primary Care Networks using their social prescribing link worker funding to commission link worker support from existing social prescribing schemes?	
2. Easy referral from all local agencies a. Do you have a wide range of local agencies confident to make referrals to the social prescribing link workers? b. Before being referred to social prescribing, is the service fully explained and are people given choice about whether to be referred? c. Are all GP practices using the new national social prescribing SNOMED CT codes? d. Are link workers valued as part of the general practice and primary care network team?	
3. Workforce development a. Is there training and support for local agencies to understand link worker roles? b. Do link workers have access to regular 'clinical' supervision? c. Do link workers have access to accredited learning and qualifications?	
4. Link workers employed to give time a. Do link workers have empathy, listening and coaching skills to motivate people, based on the 'what matters to me'? b. Are link workers given time and flexibility to undertake home visits and build trust with people? Is this reflected in their caseloads? c. Do link workers take people to groups and introduce them, ensuring they are comfortable and included?	

5. What matters to you? Personalised support plans a. Do link workers create a simple, personalised support plan with people about what support they can expect from services and what they can do to improve their own wellbeing?		27
6. Support to Community Groups a. Funding – is funding available locally to commission VCSE organisations receiving referrals? Are community groups supported through grants? Is development support/funding available to fill gaps in local provision? b. Safe referrals – are community groups and VCSE organisations supported to receive referrals safely, checking that they are insured, have first aid training (including mental health), basic health and safety, lone working, data protection, food handling certificates and DBS checks when working with vulnerable citizens? c. Is support available locally to nurture and develop new community groups, including at local neighbourhood levels, building on the skills and interests of citizens?		
7. Common Outcomes Framework a. Is the Common Outcomes Framework used to assess the impact of social prescribing on the person, the NHS and community groups receiving referrals? b. Are CCG analysts able to work with local partners through data sharing agreements to track the person's use of the NHS, using their NHS number (with appropriate consent)?		

Annex D: Common Outcomes Framework

Background

There is a clear need for a common approach to documenting the impact of social prescribing schemes. NHS England has therefore worked with commissioners, practitioners, providers, evaluators and other stakeholder groups to create a consensus on what outcomes and outputs should be measured to show the impacts of social prescribing.

To develop the common outcomes framework, an action research approach has been used. This approach provides a method that allows data gathering, analysis, reflection and action.

To date, three cycles of data gathering, analysis and reflection have been carried out between October 2017 and May 2018. We have heard feedback from a wide range of stakeholders, including social prescribing connector schemes, primary care staff, local authorities, CCGs, VCSE organisations, academics, researchers, public health leaders and other government agencies.

In June 2017 a steering committee representing key stakeholders for social prescribing was formed to guide the production of the framework. All feedback from the steering group and the wider consultation has been analysed and incorporated into the framework.

This framework will enable social prescribing connector schemes across the country to capture core impact data, in order to create a consistent evidence base, support the business case and build a national picture on the impact of social prescribing.

Measuring the impact of social prescribing

NHS England has heard that there are different aims, target groups and funding sources for social prescribing schemes, which means that flexibility is essential in measuring the impacts of social prescribing.

We believe that the existing evidence, both academic and anecdotal, suggests that the outcomes of social prescribing cover the following three key areas:
1. impact on the person
2. impact on community groups
3. impact on the health and care system.

We will continue to work with stakeholders in a phased approach over the next two years to embed these impacts and the following outcomes in the evaluation of social prescribing schemes:

Impact on the person

Social prescribing schemes are already collecting data on the impact on the person using a variety of tools. In 2019/20, schemes should continue to use their existing wellbeing tools in order to show impact on the person.

Depending on the needs identified by the person, we anticipate one or more of the following aspects of wellbeing to be improved. The person:

- feels more in control and able to manage their own health and wellbeing
- is more physically active
- is better able to manage practical issues, such as debt, housing and mobility
- is more connected to others and less isolated or less lonely.

We will seek feedback on the use of existing wellbeing outcome measurement tools, such as the patient activation measure (PAM), the ONS wellbeing scale and the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS). During 2019/20, this feedback will be used to explore whether it is possible to co-produce a new free wellbeing measure for the system that everyone can use to inform social prescribing, including small community groups.

NHS England will also work with partners to look at good practice on reporting on employability outcomes.

Impact on community groups

We will co-produce and test a freely available short 'confidence' survey for local community groups and the VCSE sector about the impact of taking social prescribing referrals. This will be available from April 2019.

This survey will test whether community groups and VCSE organisations are more resilient as a result of their involvement in social prescribing at a local level. This will include changes in the number of volunteers, capacity of the voluntary sector to manage referrals and what support is needed to make social prescribing sustainable.

Impact on the health and care system

We advise that all social prescribing connector schemes (and their commissioners) collect data on the following outcomes:

- Is there a change in the number of GP consultations as a result of referral to social prescribing?
- Is there a change in A&E attendance as a result of referral to social prescribing?
- Is there a change in the number of hospital bed days as a result of referral to social prescribing?
- Is there a change in the volume of medication prescribed as a result of referral to social prescribing?
- Is there a change in the morale of staff in general practice and other referral agencies? We will provide a mixed methods survey to help with this task.

In order to systematically collect the above data and track patients through the system robust data-sharing agreements and local partnership working is essential. We will provide development support, case studies and examples to promote robust data-sharing.

Consistent national SNOMED CT coding for social prescribing has been established in GP IT systems to support a national data collection on social prescribing referrals from primary care. The codes to be used to record this activity are as follows:

871691000000100 | Social prescribing offered (finding)
871711000000103 | Social prescribing declined (situation)
871731000000106 | Referral to social prescribing service (procedure)

In 2019/20, we will find good practice and explore whether it is possible to show the impact on social care packages for people receiving social prescribing support. We are aware that some local areas are already working on this and we welcome their involvement to co-produce a measure which we will aim to introduce from 2020 onwards.

Output measures

To complement the outcomes outlined in the framework and encourage a consistent approach, we suggest all social prescribing connector schemes need to measure the following outputs:

- number of people referred into social prescribing connector schemes, number of people taking up referrals and number of people rejecting a referral
- characteristics of people referred: age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation
- referral criteria such as Long Term Conditions or in receipt of social care packages.
- referral process and pathway – who refers into the scheme
- number of community groups referred to
- nature of community groups referred to – what kind of support they provide
- number of personalised support plans co-produced with people receiving support
- number of link workers
- number of volunteers
- average amount of time spent with each person
- total investment in the social prescribing connector scheme (input measure).

This information will help to build a national picture about the size and nature of social prescribing.

Continuing development of the framework

To complement and utilise the gathering of information and data against the outcomes defined in this framework, we will look to develop and test the framework as part of the work towards an overall Personalised Care Dashboard.