

Social prescribing at a glance

North West England

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A scoping report of activity for the North West

March 2016

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Acknowledgements

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Readers note

Navigating this report

This report is intended as an introductory online resource to encourage wider understanding and exploration of the benefits of social prescribing to promote wellbeing. It is the result of a regional scoping exercise supported by Health Education England (HEE) working across the north west during 2015. The document has been designed to promote consideration of the necessary issues to better understand and harness social prescribing assets. HEE hope it will help increase awareness of the type of social prescribing activity being delivered across a range of sectors, and will help encourage more collaborative action in order to promote individual and community wellbeing.

As a dynamic PDF this paper is designed to enhance both the way you search the document and the relevance and richness of the content your search will return. By utilising the internal section links your journey through the content will be more direct and individualised. By using the external web links you will be able to reach further multimedia content and resources. So by taking advantage of the dynamic properties of this PDF you will be able to assemble the “chunks” of information you need most.

To enable ease of navigation the paper uses multiple bookmarks and hyperlinks both within the table of contents itself and also within each section. These bookmarks take you to what is described as the Further Information section (links in the blue boxes will return you to the main body document) and more specifically to the actual social prescribing case studies that have been included here. Although the report can be read with or without reference to the Further Information section, it is strongly suggested that you take advantage of this resource as it provides access to a range of illustrative examples and references which provide insights into the diversity of social prescribing activity and simultaneously supports awareness of the issues for further consideration.

Wherever possible the report uses the words of the respondents that engaged with the information gathering process, or it paraphrases feedback from interviews when necessary to ensure it captures and reflects the nuances of practice and breadth of debate surrounding social prescribing; and most importantly to underline different organisational approaches, commitments and values.

Some of the featured case studies are well established and others are in early development or potentially at risk due to funding changes. All contributors have indicated a strong wish to share their learning, to build new partnerships and to increase cross sector understanding. So there is an open invitation to explore social prescribing networks and make connections. This paper is a companion document to the North West directory of social prescribing in museums Heritage Matters which can be accessed from: <https://www.hee.nhs.uk/sites/default/files/documents/Partner%20museum%20directory.pdf>

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Social prescribing scoping exercise North West England

1.0 Background and context to the regional social prescribing scoping exercise

1.1 Adult learners' week

This scoping exercise was a direct response to emerging intelligence generated through the Health Education England (HEE) led Adult Learners' Week North West Awards in Health and Care and the linked annual learning campaign which continues in 2016.

www.hee.nhs.uk/nw/alw2016

This campaign is delivered in partnership with North West Employers and Voluntary Sector North West. This partnership is supported by the Innovation Agency and the Greater Manchester Strategic Clinical Network as award sponsors.

Through this campaign's commitment to generating examples of innovative and transformative practice at an individual and organisational level a number of important case studies have emerged.

They have highlighted the importance of recognising and responding to:

- the value and significance of a number of non-clinical interventions in a patient journey and the benefits of a 'more than medicine' agenda
- the continued need for different sectors to do more together in relation to addressing the wider determinants of health
- the huge opportunity afforded from harnessing patient and carers' voices and knowledge
- new but simple solutions to seemingly intractable problems generated through cross sector and cross boundary partnership working and collaboration.

These case studies have included:

Dancing Recall – an innovative collaboration between community dance practitioners and physiotherapists, which set out to help people living with dementia to lead more fulfilling and active lives whilst seeking to reduce trips and falls; which is demonstrating how dance can help improve concentration and responsiveness as well as overall mobility, enabling people to express themselves more fully in a safe and fun atmosphere.

House of Memories – a ground-breaking museum reminiscence project which supports people to live well with dementia by focusing on what people have got, not what they have lost; which is increasing understanding and empathy for those living with and caring for people with dementia whilst helping to promote care and compassion in the healthcare workforce.

Chorlton Good Neighbours – a community based and community led charity – working in direct partnership with local health colleagues; to promote living well agendas by providing social, practical and emotional support to older people in the community facilitated through highly effective integrated working practice.

1.2 Joining up healthcare priorities

The adult learners' campaign provided a platform to generate a number of interrelated and extended cross sector conversations about how the actual awards activity itself could also feed into and support a number of cross cutting themes and priorities which in themselves would directly foster a climate for collaboration.

These included:

- military veterans' transition to civilian life
- dementia awareness and treatment responses
- widening participation in healthcare education
- mental health and co-production agendas
- volunteering
- international collaboration
- personalised care and patient and carer engagement agendas.

1.3 Voluntary Sector North West (VSNW) and the *if: Volunteering for wellbeing* programme

Throughout the development of the adult learners' awards partnership HEE encouraged partner reflection and this triggered key regional conversations about the very nature of partnership working. From an early stage Voluntary Sector North West (VSNW) was keen to foster an understanding and raise awareness about social prescribing activity. VSNW's interest lay in developing the role of the third sector in an emerging social prescribing landscape through reference to the benefits of projects such as the Rotherham social prescribing pilot.

<http://www.shu.ac.uk/research/cresr/ourexpertise/evaluation-rotherham-social-prescribing-pilot>

This VSNW dialogue triggered a series of wider HEE conversations with a range of organisations delivering a 'social prescribing offer' in the community and particularly some key national museum players operating in the region. In this way the adult learners' campaign helped forge a kind of deliberative inquiry which cut across traditional organisational boundaries drawing in a diverse range of interested parties such as the Strategic Clinical Networks (SCNs), the Veterans Council and Clinical Commissioning Groups (CCGs).

These conversations with the museum sector dually reflected a common interest in widening participation and engagement agendas across health and culture and the opportunity for scaling up activity. They touched upon the importance of establishing support mechanisms for the most disadvantaged and vulnerable members of society, so that they could ultimately re-engage and play a part within the wider community. They also began to explore in detail the work of a unique, ten-partner museum project the *if: Volunteering for wellbeing* programme where early evidence confirmed a positive and transformative influence on wellbeing for participants benefiting from the programme.

1.4 Building a cross sector pipeline

What stood out about this museum volunteering for wellbeing programme and other non-museum social prescribing activity was the need for a better strategic engagement with the wider healthcare economy, in order to create the opportunity to scale up successful localised activity.

This was underlined by:

- a lack of any formal links with other large neighbouring NHS volunteer schemes despite proximity and shared values
- a general lack of connectivity between the NHS own trust's volunteer activity and their own pre-employment provision
- evidence of successful transition from the *if: Volunteering for wellbeing* programme to local health-led widening participation initiatives (pre-employment programmes) despite a lack of formal 'pipework'
- an increasing number of ad hoc referrals from primary and secondary care clinicians into the *if: Volunteering for wellbeing* programme with successful outcomes but no formal recognition.

1.5 Opportunity awareness

This early engagement activity focused attention on 'how and why' might health and care players, museum partners and others work better together to increase awareness of museum wellbeing activity; and what was it specifically about this type of museum programme that meant the participants were able to make real progress when other medical or clinical type interventions had limited impact.

It seemed a logical next step to move these conversations on to a broader exploration of the role and value of museums in contributing to wellbeing or wellness agendas and to use this process to reflect on the fit with a wider healthcare landscape. What also became apparent very quickly was that there was no one place that anyone could go to explore these questions and more specifically, how this unfolding conversation could relate to both regional social prescribing agendas and other key health priorities.

1.6 A joint commitment to cross sector activity mapping and analysis

Both health and museum partners expressed a general lack of clarity about what was meant and understood by the terms 'wellbeing' and 'social prescribing', either in terms of actual concepts, or as a process or specific activity or intervention. It was therefore agreed that both health and museum partners would work together to bridge this gap and use the actual process of information gathering to build relationships and increase understanding across the sectors. With a subsequent joint funding commitment in place between HEE and the museum partners it was agreed to both map wellbeing provision in the museum sector through a case study approach and for HEE to support a broader scoping exercise and analysis of social prescribing in the region. This document is a key output from this process. It should be seen as a first iteration as well as a companion document to the regional directory of wellbeing and social prescribing in museums. Heritage Matters, which can be found at <https://www.hee.nhs.uk/sites/default/files/documents/Partner%20museum%20directory.pdf>

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2.0 Defining social prescribing

2.1 What is it we are talking about exactly?

2.0.1 At the start of this scoping exercise a significant number of individuals were interviewed and they were asked what they thought constituted social prescribing. An expert group was also convened through a national roundtable event and a desk based literature review was undertaken.

The words people used when discussing social prescribing were very different but they identified a number of common elements which highlighted:

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

2.1.1 Understanding value and language

Respondents said in effect that both health language and literacy; and the question of how to improve healthcare was a wicked problem. They believed health stakeholders couldn't agree on a solution because they couldn't agree on the problem. Respondents highlighted the role of a public and professional misunderstanding about the difference between health and illness because of convenient shorthand. They also said that social prescribing was as much about 'perspective and approach' as the tools used. There was some clear reflection on how the term social prescribing itself could be seen to simultaneously refer to: an actual programme of activity and where or how this fitted in a care pathway; what an actual activity hoped to achieve or how it contributed to local or national policy objectives and where the actual term social prescribing rested within the context of the prevailing medical model.

The terms social prescribing and health and illness were subject to much deliberation, given as most respondents pointed out, 'they read as one thing but are often taken to mean something quite different'; i.e. what was described as the social prescribing oxymoron, with the apparent contradiction between an approach which sees more patient engagement and control as central to success but which still uses language which implies patient subjugation. Furthermore in relation to the health and illness debate this highlighted an apparent and common confusion about each respective state, which then presented itself as an 'either or' in terms of a prevention or cure options; when in effect this promised something more in the way of telling us something about ourselves, our society and the way we live in it. Respondents agreed on an urgent need for more public awareness and health literacy and a reframing of the health paradigm away from a debate about illness treatment services.

How does social prescribing present as an opportunity for reframing health to embrace the design of our wellbeing?

2.1.2 Enriched personalised care pathways

Respondents were very clear that social prescribing wasn't about austerity. They said it was about doing things better because 'we know how to' and because 'it makes sense'. They said this required a commitment to re-thinking a patient journey; to see patients in the context in which they live their lives and to understand how this context impacts on both wellness and illness. This in turn requires the removal of what was described as 'the false divide between mental and physical health' and an acceptance of an approach which recognises the interplay between the two. Taken together this was seen to be about creating more patient choice and freedom.

2.1.3 More patient autonomy

The term social prescribing itself was identified as problematic because it doesn't imply 'working with' rather it still sounds like 'doing to' or 'for'. So this language does not easily support a rebalancing of the relationship between patients and practitioners, nor does it create any sense of increasing patient autonomy and power, which is deemed a necessary step for real success. Marmot puts this well in Fair Society, Healthy Lives (2010) where he in effect identified social prescribing as an:



approach [that] facilitates greater participation of patients and citizens and support in developing health literacy and improving health and wellbeing'.

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2.2 Theoretical perspectives

2.0.2 The second stage of this scoping exercise was to identify a set of theoretical perspectives to help shape an understanding of social prescribing and to provide a framework to underpin and support next steps. This process also helped identify a wider policy context.

2.2.1 The Ottawa WHO Charter (1986)

The Ottawa WHO Charter (1986) provided a key starting point. It states:



Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to wellbeing.'

This charter crucially recognised that health improvements would not occur just by developing more health services or by imposing public health solutions from the centre. It heralded a shift in power from the providers of health services to the consumers of those health services and the wider community. Importantly the Ottawa Charter identified a range of prerequisites for

health, including peace, a stable ecosystem, social justice and equity, and resources such as education, food and income (WHO, 1986b). It highlighted the role of organisations, systems and communities, as well as individual behaviours and capacities, in creating choices and opportunities for better health.

http://heapro.oxfordjournals.org/content/26/suppl_2/ii163.full%20-%20ref-15

2.2.2 Salutogenesis

Medical sociologist, Antonovsky's 'Health Stress and Coping', (1979) provides an underpinning theoretical perspective for social prescribing. Antonovsky's work is described as an asset based approach to health. This approach understands health as being a positive state of wellbeing (salutogenic) rather than seeing health as just about illness and disease (pathogenic). In this context the 'assets' are any factors that support the creation of health and wellbeing - the skills, strengths and resources of individuals, communities and organisations that contribute to health.

Antonovsky raised the key question, 'why do some people stay well despite highly stressful situations and significant hardship whilst others succumb to ill health'. He underlined the symbiotic relationship between both the human mind and body and between an individual and a given context or environment. Through his later work, 'Unravelling the Mysteries of Health' (1987), working with female holocaust survivors he rejected the traditional medical-model and dichotomy separating health and illness. He described this relationship as a continuous variable, what he called the '*health-ease versus dis-ease continuum*'. As a scientific response he introduced the salutogenic concept of 'sense of coherence' as a specific way to view life as comprehensible, meaningful and manageable.

He underlined the value of a person being able to develop and exercise a **Sense of Control** to stay well. Most importantly, he argued if a person believes there is no reason to persist and survive and confront challenges, if they have no sense of meaning, then they will have no motivation to comprehend and manage events and this will impact on health. He also identified what he termed 'Generalised Resistance Resources', a set of genetic, constitutional and psychosocial resources available to people which can be used and reused to promote wellbeing.

Craig M Becker's short video on salutogenesis provides a useful commentary on this approach:

<https://www.youtube.com/watch?v=RWkTdqmULVo>

Antonovsky's work was later developed and presented in the UK by Antony Morgan and Erio Ziglio.



Many of the key assets required for creating the conditions for health lie within the social context of people's lives and therefore [the asset model] has the potential to contribute to reducing health inequities.'

(Morgan & Ziglio, 2007, IUHPE briefing)

2.2.3 Exploring the longitudinal relationship between arts engagement and health

Threads of Antonovsky's work resonate in the research of Dr. Rebecca Gordon Nesbitt (Manchester Metropolitan University 2015) in the report [Exploring the Longitudinal Relationship between Arts Engagement and Health](#) she demonstrates a positive impact from arts engagement on a range of chronic diseases by reference to fifteen studies.

2.2.4 Likewise in the USA the [University of California](#) presented evidence on the impact of the feeling of awe people experience during encounters with art, nature and spirituality which has an anti-inflammatory effect, protecting the body from chronic disease.

2.2.5 Asset based community development

Building on the work of Antonovsky et al, Jane Foot and Trevor Hopkins (2010) suggest that the traditional medical model, based on exploring pathogenesis inadvertently increases the demand for services because it engenders a kind of learned helplessness. Hopkins et al (2010) advocate an Asset Based Community Development (ABCD) approach based on the principle of mobilising individual and community 'assets', rather than focusing on problems and needs i.e. deficits.

In the publication 'A Glass Half Full', Jane Foot and Trevor Hopkins make the case that:



As well as having needs and problems, our most marginalised communities also have social, cultural and material assets. Identifying and mobilising these can help them overcome the health challenges they face...The more familiar 'deficit' approach focuses on the problems, needs and deficiencies in a community such as deprivation, illness and health-damaging behaviours. It designs services to fill the gaps and fix the problems. As a result, a community can feel disempowered and dependent; people can become passive recipients of services rather than active agents in their own and their families' lives.' (Foot and Hopkins, 2010, p7)

The Community Development and Health Network produce a short fact sheet on Models of Health.

<http://www.cdhn.org/fact-sheets>

2.3 Summary

We might tentatively begin to describe, social prescribing as both an activity and a process which may be experienced in a range of settings or contexts. Ultimately, it involves access to a range of non-clinical interventions and activities which can impact positively on individual wellbeing and resilience. It therefore provides a mechanism for people to stay well and to get well. Most importantly, it puts the individual or service user in the driving seat so it creates the opportunity for real and lasting behaviour change because it involves learning and making choices. Effective social prescribing is about providing the building blocks for personal learning and knowledge application in a wellbeing context.

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3.0 Key activities and approaches in social prescribing

3.1 Health warning

Given the sensitivity around the language and the terminology of social prescribing itself it seemed sensible to start to collate information on the specific kinds of activities which are commonly associated with social prescribing and to use the approach and perspectives highlighted earlier to indicate their fit with wellness not illness agendas.

It is important to note that key commentators flagged a deep concern that some organisations are simply preparing to rebrand existing services as 'wellness' activity without any movement away from a commitment to a deficit based model of health and they are therefore both doomed to fail and skew any evaluation of impact. Others like Trevor Hopkins have expressed a concern that as social prescribing gains political parlance without real cultural change it simply risks becoming a 'buzz word' lacking any real substance.

This paper has therefore sought to both start to define and examine the range of activities typically found under a social prescribing banner through the identification of key characteristics and the grouping of a number of specific regional case studies with a view to engendering a wider debate and analysis. These case studies are drawn from a range of sectors and serve as a point of comparison and commentary for the work illustrated in the companion document and regional directory of social prescribing in museums Heritage Matters. <https://www.hee.nhs.uk/sites/default/files/documents/Partner%20museum%20directory.pdf>

The case studies that are presented reflect a range of activity models which adhere to some key principles and not others, reflecting a more blended approach between wellness and illness perspectives or the traditional medical model. From an early discussion with the CEO of Wellbeing Enterprises, the first CIC in the UK dedicated to wellbeing (Halton), it seems fair to say a good social prescribing model can accommodate the best aspects of any medical model, it isn't either or – it is 'as well as' but the trick is achieving the right balance.

The case studies featured reflect a common set of aspirations in relation to desired outcomes. These can be summarised as:

- improved (and recognised) levels of confidence and self-esteem as a personal resource and asset (Generalised Resistance Resources)
- increased levels of psychological wellbeing and positive mood states
- a reduction in anxiety and or depression
- improved physical health, levels of activity and intellectual inquiry
- increased levels of motivation, meaning, hope and optimism to support a sense of control
- improved sociability and communication skills and feelings of belonging
- embedded life-long learning as a resource for living
- a commitment to foster new interests and skills.

And as a result of all or some of the above a subsequent reduction in:

- visits to GPs and use of other specialist services
- levels of prescribed drugs and alcohol use
- weight levels and periods of inactivity
- feelings of social isolation, loneliness and hopelessness.

3.2 Five ways to wellbeing

All the social prescribing commentators we spoke to were clear that any social prescribing activities should also mirror a commitment to embedding the New Economics Foundation (NEF) [Five Ways to Wellbeing](#) (2008) a set of evidenced based actions to promote wellbeing. The Five Ways to Wellbeing were developed by the New Economics Foundation as part of the government's Foresight project on mental capital and wellbeing.

3.3 An emerging social prescribing typology

The case studies that were identified have been grouped under eight headings:

3.3.1 Information support or advice on prescription

This approach reflects an understanding of the impact of what Antonovsky describes as Generalised Resource Deficits (GRDs) for example: the negative impact of debt, poor housing or low self-esteem on wellbeing. There are numerous regional examples of Clinical Commissioning Groups (CCGs) and NHS foundation trusts working in conjunction with local authorities supporting the development of information and signposting services in partnership with other agencies, like Healthwatch or Citizens Advice, which acknowledge the need to address health in a broader social context. There is also evidence of thematically focused project activity which is responding to regional demographics, particularly around veterans' agendas.

There are two case studies to illustrate this work. [Advice on Prescription Liverpool](#) and related developments with a city wide [on-line database](#) and linked directories are featured; along with the development of a [health trainer service](#) across all GP practices.

A corresponding focus on an armed forces directory highlights the early work of the Veterans Council in Merseyside in relation to the development of the [AFCOM directory](#) which reflects a wider commitment to addressing what they describe as the five pillars of health and wellbeing:

- education
- employment
- housing
- legal
- welfare.

3.3.2 Bibliotherapy

Bibliotherapy is an *'umbrella term related to ideas for using books to help people with physical or mental health problems'* (Brewster 2008). Brewster and Turner (2008) make a clear distinction between [self-help reading](#) and creative bibliotherapy. The now well established self-help programmes focus heavily on a non-fiction book prescription prepared by a health professional for a specific condition. The self-help reading programme is based on the principles of cognitive behavioural therapy (CBT) and has been NHS driven. In terms of self-help reading programmes you can access a full case study produced by the national Cultural Commissioning programme here: [Reading Well Books on Prescription](#)

Creative bibliotherapy has been much less widespread but has its roots in the region. It uses fiction and poetry and has not necessarily set out to influence wellbeing but appears to be highly effective in doing so. The case study that is referenced from The Reader Organisation demonstrates the positive impact of such activity on wellbeing and the importance of participants developing what Antonovsky describes as a Sense of Coherence. Through shared reading participants are able to develop understanding and meaning together.

3.3.3 Eco-therapy or green prescriptions

There is plenty of evidence to show that regular contact with the natural environment enhances both physical health and mental wellbeing. Whether it's a gardening project, an environmental programme or simple walk in the park, being outdoors and being active is proven to benefit mental health. The consistent message from all the research is that contact with green space improves psychological health and mental wellbeing. It reduces stress and improves mood. It provides a restorative environment for people to relax, unwind and recharge their batteries. It facilitates social contact and brings people together. However, despite the evidence base Mind argue few GPs consider referral to a local conservation project or a local walking group for the treatment of depression, often because of a lack of awareness of such schemes or because they don't exist locally.

<http://www.mind.org.uk/media/273470/ecotherapy.pdf>

[Green Dreams](#) provides a case in point, a GP led eco-therapy activity developed to meet a pressing patient need.

3.3.4 Arts on prescription

The current levels of psychosocial distress in society are significant, as evidenced by the number of prescribed anti-depressants and the numbers of working days lost as a result of stress and anxiety. There is a growing body of evidence that active involvement in creative activities provides a wide range of benefits, including the promotion of wellbeing, quality of life, health and social capital. In this region there are currently a number of projects operating the offer arts on prescription for people experiencing mental health problems, low level stress/ anxiety and social isolation. The purpose of such schemes is to help people to deal with anxiety and so offset any deterioration whilst providing an opportunity to aid recovery through creativity and increasing social engagement. Although the schemes vary in both approaches (multi-genre) and settings, the common theme is that there is a referral process and creative activities take place in the community facilitated by artists (creative practitioners) rather than therapists.

This paper references two well established service models, one delivered by Sefton Council, which supports a broad based arts and health programme and the other led by a leisure trust. Both services support self-referral. See: [Creative Alternatives](#) in Southport; and the [Pendle Trust Arts on Prescription](#) programme in Lancashire.

3.3.5 Exercise on prescription or exercise on referral

Exercise on prescription and exercise referral schemes have been well established since the early part of this decade. They have traditionally operated as partnerships between primary health care and local authority leisure services. A general practitioner (or another member of the primary care team) generally identifies and refers a sedentary individual with evidence of at least one cardiovascular risk factor to a third party service, often a sports centre or leisure facility. This service then prescribes and monitors an exercise programme tailored to the individual needs of the patient. Schemes generally allow GPs to prescribe a course of exercise to people with certain conditions, including musculo-skeletal problems, such as chronic low-back pain, problems caused by falls, coronary heart disease and hypertension.

In many instances a two-tier funding and delivery system has emerged in localities:

- level one for more general exercise, frequently picked up through Public Health funding
- level two for more specific conditions, requiring more extensive input to support for example: stroke rehabilitation; which is funded by Clinical Commissioning Groups.

Recent changes in NICE guidance has (2014) meant that a number of more specialist exercise programmes have also developed in response to specific conditions which take a more asset based approach. [Active Cumbria](#) provides a good example of both general and specific activity streams for exercise and they have also developed a highly effective, collaborative dance programme [Dancing Recall](#) that responds to the needs of those living with dementia. This takes as its starting point, the need to build on what people have not what they have lost. Dance research has shown over and over again, that dance, 'the lyrical, non-didactic flow of movement', can still engage the latent muscle memory that survives the onset of the disorder and as Daphne Cushnie, the Dancing Recall founder argues, 'there has been a balanced approach to the blending of clinical and dance know how in a community context.'

See Moving Magic:

<http://www.activecumbria.org/sports-and-fitness/dance/dancing-recall/>

3.3.6 Volunteering and community groups

Volunteering is an important part of the UK's social fabric. It is estimated that around fifteen million people volunteer through formal groups or organisations in the UK, equivalent to around 1.25m full-time employees. The International Labour Organisation (ILO) defines volunteering as: 'Unpaid, non-compulsory work; that is, time individuals give without pay to activities performed either through an organisation or directly for others outside their own household.' Within this, there is formal and informal volunteering. The former is done through groups, clubs or organisations and is typically easier to measure; the latter can be through any arrangement and so is often much harder to capture. Whilst the economic metrics may come easy to hand it has far less easy to find any evaluation that focuses on the impact of individual and community wellbeing. However, the *if: Volunteering for wellbeing* museum consortium programme has uniquely tried to do just that. It provides a good example of the positive effect of a structured volunteering programme on wellbeing. The Imperial War Museum North work is of particular interest because of its focus on veterans. The value of volunteering is highlighted in recent commentary by the [Bank of England](#) and in a specific health context by the [Kings Fund](#).

3.3.7 Learning prescriptions

There is a strong, well evidenced link between education and health but historically any exploration or articulation of the benefits of these links tends to be siloed or adhoc at best; and it does not appear to be easy to translate the theory or practice into sustainable action. In 1999 the NHS White Paper, 'Saving Lives' indicated:



Education is vital for health. People with low levels of educational achievement are more likely to have poor health as adults. By improving education for all we will tackle one of the main causes of inequality in health'.

Hence in February 2003, the Department for Education and Skills (DfES) funded the National Institute for Adult Continuing Education (NIACE) to facilitate a consortium of 'Prescriptions for Learning' projects with sixty members from different organisations across the UK.

http://www.centreforliteracy.qc.ca/sites/default/files/prescribing_learning.pdf

In 2013, NIACE undertook further research in to the value of learning and health. Using Community Innovation Funding (CLIF) and Skills Funding Agency (SFA) resource they produced six thematic papers which looked at the contribution of community learning to key policy areas. Through their [Community Learning in Health report](#) they generated evidence which showed even a modest investment in community learning can have significant health outcomes for individual learners, families and communities, ‘including supporting people to feel more positive about life, increasing understanding of a health condition, through to improving diet.’

In parallel to this work the [Workers’ Education Association \(WEA\)](#), a national designated college, continues to develop a unique model of adult learning that they describe as ‘social purpose learning’ which is strongly aligned to their mission to harness the transformational power of learning for both personal and social development.

Most recently a key health publication reflecting the value placed on learning to reduce health inequality through increased social mobility can be seen by referencing the HEE directory of best practice in widening participation in health education: [here](#)

There is also much to be learnt from the approach in secondary care around the experience of a [Recovery College](#) model in health. This might be defined as social prescribing in action.

3.3.8 Museums in health or museums on prescription

Museums are particularly well placed to contribute to people’s stock of Generalised Resistance Resources (GRRs) and what Antonovsky describes as a person’s need for a Sense of Coherence but they are in an early stage of development in terms of a sector wide response to social prescribing agendas. The University College London (UCL) is part way through a three year Museum on Prescription research project (2014-2017) which is exploring the value and role of museums in social prescribing.

<https://www.ucl.ac.uk/museums/research/museumsonprescription>

That being said wellbeing agendas have long been part of a museum DNA. Individual museums have been delivering wellbeing or social prescribing focused projects in all but name since their inception but many museum activities around wellbeing have simply been going under the radar. A good example of this is the Art Museum in Ancoats led by Thomas Coglean Horsfall which was inextricably linked to Manchester University Settlement. This art museum was a direct response to the work of Ruskin and an articulation of Horsfall’s commitment to a belief in the personal and wider social benefits of appreciating beauty through art.

http://www.infed.org/settlements/manchester_art_museum_and_university_settlement.htm

Much of the established museum work has been tightly defined in a museum not health context and the links to wellbeing impacts have not been made explicitly. This work has frequently developed organically out of a concern to grow and respond to new audiences and to use the assets that museums possess, their collections and buildings.

The regional museum directory of social prescribing and wellbeing-Heritage Matters makes this point well. It underlines the importance of recognising the intrinsic value of an activity and the need to allow an activity to play to its strengths; and not to be skewed by a focus on making activity fit a funding model because providers and commissioners may then not see that which is making the difference.

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4.0 Delivery models and social prescribing pathways

4.0.1 The case studies referenced in this paper are striking from the perspective of the diversity of form and function. There is no 'one size fits all' even where activity is located in one specific geographical area. It appears activity often emerges organically in response to local circumstance and conditions or because of what is frequently termed, 'place based leadership'. From the wider case study review of regional museums delivering wellbeing in the companion document Heritage Matters it seems that standalone activity can thrive as well as provision embedded in an overarching referral structure.

Historically, much analysis of social prescribing has tried to simply locate activity purely in a primary care context ignoring the wealth of work which occurs in secondary or acute care arenas, or which straddles the two. Commentators argued this often reflects a concern to replicate or reinforce many of the organisational silos people may operate in. More crucially this perspective ignores a key feature of social prescribing activity, in that social prescribing frequently emerges in order to fill the gaps people experience on any healthcare journey. Whatever the context social prescribing provides a framework for responding to the wider social, cultural, environmental factors that impact on health and wellbeing so it invites people to respond in a more holistic way to causes of the causes of poor health.

It is clear from the case studies reviewed that social prescribing pathways are generally not linear nor hierarchical and delivery models can be very simple or complex reflecting problem solving behaviours in a locality. Clearly there are strengths and weaknesses in any system which grows organically but there are some common elements or features which support the emergence of a particular range of models.

There appear to be three delivery models or approaches emerging but with a multitude of other types of activity occurring in between:

- a structured programme of courses and opportunities collected centrally which may or may not include signposting support
- a more iterative semi structured programme of courses and activity
- a fully integrated social prescribing service with signposting embedded

There seems to be an opportunity here to learn from the experience of the adult community learning sector and established Information Advice and Guidance (IAG) principles. However, the short term nature of funding may well not support this type of investment.

4.1 Signposting

Social prescribing provides an infrastructure for connecting patients and the public to other community services to address a range of health and social issues. Sign posting roles provide an important bridge between busy health professionals who don't have time to stay up to date on all the opportunity reflected in community based activity. Signposting is a key element of 'community navigation' and helps connect people to traditional services and informal support in the community ensuring that patients can navigate their way through the various sources of help that exist. It helps ensure joined up and holistic care. This can help prevent people from moving through the health and social care system being referred from one provider to the next and never really getting their needs met. It also creates a valuable opportunity to establish a feedback loop to support understanding and service improvement.

It would seem fair to suggest that the current social prescribing infrastructure reflects a fairly laissez-faire attitude as to the role and value of non-clinical interventions. This is mirrored by

the short term and ad hoc nature of much of the funding. There appears to be an absence of any clear guidance on frameworks for service design and improvement and a lack of recommendations regarding expectations of service providers. When 'stuff happens' it is because of local champions with a clear vision as to 'fit in a locality'. There is clearly an opportunity to be had from opening up these kinds of communications and raising these questions.

Community signposting is a common feature cutting across all delivery models. What seems to be significant is the value of word of mouth and personal recommendations to support referral and actual engagement. Self referral is frequently encouraged and this is an important dimension of most activity. Potential clients are often able to identify literature in a range of community venues such as libraries. Or people may act upon advice from volunteers, carers and friends. This self referral component helps to underpin service development and buy in by reinforcing engagement opportunity and choice. Likewise some activity may also typically involve a practitioner (e.g. a health trainer or community navigator) providing self-help information and advice to an individual or signposting them to an appropriate source of support, advice or further information.

Signposting may (or may not) include referral to a range of community groups and services via a referral directory or electronic database of services. In this instance ideally the referrer needs a trusted directory/ database of services and source of information that is up to date, clear and easy to use. This may be provided through a website for the public and/or professionals. This kind of activity requires a range of partners to come together collaboratively and can be illustrated by the [Liverpool Information on Prescription and Healthwatch](#) scheme in the case study section. This referral process may also happen in a secondary care context and Pennine's [My Health My Community](#) approach is an example of recent activity.

4.2 Supported community referral and socially prescribed activity programmes

This includes referral to a more structured intervention, sometimes co-ordinated via a local social prescribing programme or a single point of access such as an integrated wellness service. This type of service is deemed appropriate for people who may need more support to access services and who are vulnerable, often lacking motivation and confidence to find and navigate opportunities. Support may be practical or emotional and could include provision of individual support to access mainstream services or provision of discrete group programmes providing psychosocial interventions. [Wellbeing Enterprises](#) in Halton provide a clear example of this level and type of work. They also operate across a primary and secondary care continuum using a team of community navigators.

In this context, a secondary care provider may also invest in developing a range of approaches designed to support and maintain wellbeing or an existing provider operating in the community may establish a two way pathway. The most well developed provision can be seen through the work of mental health trusts and the establishment of a [Recovery College](#) model as evidence through the work of Mersey Care and their [Creative and Wellbeing Programme](#); and in a cancer care context the development of the Maggie's Centre at the Christie in Manchester.

<https://www.maggiescentres.org/our-centres/greater-manchester-campaign/maggies-at-the-christie/>

What makes this activity stand out is the reaching out to the patients, their carers and family members. There is clear recognition of the role of carers in developing and maintaining wellbeing. Pennine Care NHS Foundation Trust has also developed a series of tools focused around a website [My Health My Community](#) which connects up with resources available from the local authorities it works with. The focus of this activity is to remove any barriers between primary and secondary care transitions at any juncture.

5.0 Policy context

5.0.1 In any consideration of social prescribing it is essential to understand the key health policy influences whilst simultaneously locating this work in a broader public policy context. Herein lies a clear strength as well as a weakness of social prescribing in its ability to foster and support behaviours and attitudes (both public and professional) which are essential in driving forward integration and transformation activity but which simultaneously create a lack of clear funding parameters. It is helpful to reference any emerging definition of social prescribing in the light of [established adult learning theory](#) which also resonates well with Antonovsky's concept of the Sense of Coherence; both emphasise the importance of meaningful activity and personal engagement. In this context it is important to explore how knowledge is acquired, understood and brings about change. Similarly, we can learn much from the experience of [Information Advice and Guidance \(IAG\)](#) processes and delivery models in relation to emerging social prescribing process activity.

5.1 Adult and community learning

It has been well argued by [Dr Leon Feinstein](#) et al that education is not only about developing economic productivity and economic growth, jobs and employment, but it also has wider implications for the lives of individuals, families and society. In this setting participation in adult learning has positive effects on changes in smoking, exercise taken, and life satisfaction (Feinstein and Hammond, 2004).

The National Institute for Adult Continuing Education (NIACE) produced a series of six thematic reports in 2013 demonstrating the contribution of community learning to a number of key policy areas. These included: health, employability, families, socially vulnerable groups and volunteering. Their report on community learning and health, see: <http://shop.niace.org.uk/clif-impact-health.html> demonstrated how modest amounts of investment can produce significant health outcomes for learners, families and communities.

During their 2013/14 national Adult Learners' Week campaign the National Institute for Adult Continuing Education (NIACE) demonstrated five key benefits from participating in adult learning: wage gains, health benefits, civic participation, social value and improving family life chances. They demonstrated how learning can reduce someone's chances of entering into the most costly of UK public services, including the adult social care system, acute NHS services and mental health provision. Issues like these are at the core of the national debate on the future shape, purpose and funding of public services and education across the UK.

Building on this research the Scottish Government has taken a strong policy lead to advance what it refers to as '[Community Learning and Development](#)' (CLD). One of the key features of the Scottish approach is its attempt to link community-based learning opportunities with the idea that local people can and should have more influence over local services and decision making. Exercising such influence requires skills and confidence, and it is in this combination of developing skills for individuals whilst helping to benefit communities that CLD has great potential. This equally applies to health.

5.2 Widening participation

Widening participation remains a continuing priority in higher education and stands as a workforce priority for Health Education England (HEE) to ensure that the healthcare workforce represents the communities it seeks to serve. HEE's commitment to promote social mobility is articulated in its mandate. The value of establishing clear links from social prescribing activity in either a primary or secondary care context have not been explored but the establishment of

any pipeline into NHS activity designed to increase social mobility can only add value for those delivering or exploring provision.

5.3 Health and social care integration

It is commonly accepted there are better ways of organising care and there is a need to break out of the artificial boundaries between hospitals and primary care, between health and social care, between generalists and specialists – all of which get in the way of care that is genuinely coordinated around what people need and want.

For health, care and support to be integrated it must be person-centred, coordinated, and tailored to the needs and preferences of the individual, their carer and family. This means moving away from episodic care to a more holistic approach to health, care and support needs, that puts the needs and experience of people at the centre of how services are organised and delivered. Social prescribing provides both a platform and a vehicle to drive forward integration agendas and as previously illustrated it blurs the traditional boundaries between primary and secondary care, between health and other sectors, creating a platform for joint working.

5.4 Personalisation of care

When Simon Stevens (Chief Executive, NHS) announced the NHS is serious about personalisation he underlined a growing understanding of the need for health services to provide a service focused on the individual, their aspirations, needs and assets, and their context within a community. In the 'Five Year Forward View' Simon Stevens identifies this as one of the key ways in which the NHS needs to change, moving from a 'factory model of care and repair' to one that focuses on much wider individual and community engagement.

<http://www.england.nhs.uk/ourwork/futurenhs/>

Getting serious about personalisation, in the NHS, complements the NHS England prospectus for the Integrated Personal Commissioning (IPC) Programme being taken forward with support from local government and voluntary sectors as well as people who need care and support, their families and carers. The IPC Programme confirms the next stage of personalisation will be its most ambitious – a person-centred, coordinated approach to combining resources around people with some of the most complex health and care needs, strengthening communities, transforming commissioning and supporting self-management. It also extends the idea of integration into areas involving early intervention, prevention, self-care and promoting and supporting independent living. It also highlights the value of exploring both the individual and community 'assets' not 'deficits' in any given context. Put simply, social prescribing adds to patient choice but only if the appropriate investment is made to create the infrastructure to make this happen.

5.5 Patient and carer engagement and volunteering

The NHS has expended considerable energy in developing patient carer engagement agendas in order to transform the quality of services, to support commissioning and drive forward personalisation agendas. Patients, carers and the public who are already engaged with the NHS (for a whole range of reasons) present as a valuable bank of 'engaged others' for improving care and widening participation in health education. They can also benefit from and contribute to any emerging social prescribing activity.

5.6 Digital inclusion

Since 2013, the Tinder Foundation has been working with NHS England and over 130,000 people to drive up digital health inclusion. The goal of the NHS in this context is to make digital access and approaches a key part of health and care services. The opportunity for the public to benefit from digital access to health services and information must be inclusive. The insight developed in to barriers to digital inclusion resonates across widening participation agendas more generally.

<http://www.tinderfoundation.org/our-thinking/blog/innovation-digital-health-inclusion-and-barriers-overcome>

The opportunity to link digital inclusion agendas to both social prescribing activity and widening participation work is significant. The common thread is digital literacy and discovery. A digitally empowered patient or member of the public can do more to manage self-health.

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6.0 What the experts said

6.1 Emerging priorities and issues

HEE working across the North West supported a national social prescribing roundtable event on 26 May 2015 in partnership with Professor Tom Jefferies at Manchester School of Architecture. Participants from a range of sectors shared their knowledge and experiences and this also presented as an opportunity to 'sense check' and identify other relevant research. The following represents a summary of the findings from this discussion and draws together what the social prescribing experts who came together in Manchester said.

6.2 Key areas for development

6.2.1 Information management and control

Social prescribing information management and infrastructure development provides a real opportunity to 'join things up' but this isn't currently happening in any systematic way nor are developments being shared. Likewise, there was a common view that there is huge opportunity to make links and contribute to other priority works streams within the NHS and care sector; and to build on or work with what we already have, for example: existing systems to support digital inclusion, patient/ carer engagement and health widening participation agendas (Tinder Foundation and HEE). However, most frequently information systems are often generally fragmented and not linked up even in a single locality.

There is often:

- variable development of online resources/ directories to support signposting and referral and/ or duplication across any given patch
- little evidence of sharing and building on best practice within, or across, any geographical areas
- no links being made to the experience of community adult education and information advice and guidance (IAG)
- little effective data sharing
- information governance and patient tracking is still problematic as process issues are getting in the way.

6.2.2 Evaluation

Evaluation of social prescribing interventions can be problematic for example, [Perry and Mather 2012](#) warn where evaluation is politicised there is a 'need to show value for money in narrowly conceptualised commissioning frameworks and understandings of legitimate evidence of effectiveness', so there is still:

- the need to be clear about what we want to measure and why; and a need to agree what actually constitutes success
- an obsessive fixation and energy being expended on evaluation but this isn't always focused on the right things
- an unwavering view that clinical evaluation methods are best in all circumstances and that more heuristic (qualitative) approaches are almost 'less-than' despite their proven value elsewhere
- a research hierarchy which isn't helpful
- no level playing field because social prescribing is treated differently than other areas of clinical work and there is a different ask.

Many commentators referenced the fact that most social science and arts based research is generally focused on areas which cannot be easily monetised or more significantly in relation to what is evaluated, i.e.: things which cannot be seen, in terms of a prevention and/or intervention focus; or researchers are overly honest about the messiness of research methodologies unlike their science counterparts who are equally quick to talk in terms of immutable laws.

6.2.3 Funding

Respondents said:

- current stop and start funding streams and the actual size of funding levels are jeopardising long standing infrastructure and inhibiting growth
- providers are frequently under valuing their services and this means activity is not sustainable in the long-term.

More worryingly, RSPH (2015) research indicates because of funding cuts, 'that in some local authorities these pressures are resulting in a greater focus on commissioning for outputs rather than outcomes ' (page 12).

http://www.rsph.org.uk/filemanager/root/site_assets/our_work/position_statements/r1485.dcrs.report_hires_.pdf

6.2.4 Leadership development and alignment

There is a clear pattern emerging in a locality of the role and value of specific individuals operating at different levels, driving social prescribing agendas, champions who appreciate and value asset based approaches and then make things happen. This is what the Kings Fund describe as a 'post-heroic, shared or distributed leadership model' i.e.: 'a world involves multiple actors who take up leadership roles both formally and informally, and, importantly, share leadership by working collaboratively, often across organisational or professional boundaries – thus shared and collaborative leadership is more than numerically having 'more leaders'.

It is therefore important:

- to both identify and understand the role of key individuals, at all levels, who work in and across organisations driving activity; who also act as 'bridge spanners'
- to explore specific patterns of relationships in a locality that make things happen - both key alignments and motivations
- to understand the role of values in any organisation and how this drives social prescribing work and creates momentum
- to acknowledge the incredible power generated from a focus on what is working, what people have; not what they have lost in any context
- to recognise the huge opportunity this presents to share ideas about co-production and link with expert patient models.

There was acknowledgement that despite the evidence of the impact of asset based approaches the work is still often undervalued and not fully appreciated in many areas. There was consensus that more open perspectives and appreciation of the value of different methodologies will be required by some stakeholders if the evaluation impact of social prescribing is to be recognised.

6.2.5 Training and development

It is widely accepted that there is a need for a new kind of health and social care workforce to support seamless care pathways but what is not clear is what this workforce will look like. From a social prescribing perspective it needs to be one that values both medical and social models alongside each other, one which can work flexibly within a biopsychosocial framework.

Respondents therefore said:

- medical models are increasingly problematic but still dominate thinking, training and funding
- the focus is still on illness not wellness – so social prescribing developments tend to get siloed, not mainstreamed or are deemed a last recourse not first choice
- services are still separating out mental health from physical health and there is a need for 'parity of esteem'
- there are untapped resources to support the development of a social prescribing workforce but key professionals and others are currently not accessing this resource for ongoing development
- when training is available, for example the Dementia Friends initiatives, there is a tremendous impact on practice and understanding
- the role of volunteers is crucial in many cultural or arts based interventions as well as within the NHS but progression into health careers is not being exploited. The concentration on elderly people with long term conditions in demonstrator projects is laudable but reflects the current status of the social prescribing approach. It isn't always about driving forward an asset based approach and wellness.

6.2.6 Promoting integrated care developments

Respondents said it isn't helpful to pigeonhole social prescribing in any given context because it will limit opportunity. There are good examples of longstanding work which bridge the primary and secondary care context and interesting examples of social prescribing activity to promote workplace wellbeing in an NHS context at for example: the Central Manchester Foundation Trust and the Christie NHS Foundation Trust. It is crucially important to recognise this agenda is not just about older people, it is equally about children and teenagers and all adults.

For further detail on this roundtable event see [next steps](#) in the Further Information section.

Conclusions:

This feedback underpins the findings from the broader HEE led scoping activity with a focus on providing some insights into and an understanding of key principles, issues and potential benefits of social prescribing. From the research undertaken thus far it appears that whilst there is significant work to do to ensure that the contribution and value of social prescribing interventions are fully understood and appreciated there is enormous potential for development. This opportunity is however dependent on developments in co leadership, more integrated working across sectors, focused training and development, shared and novel commissioning approaches and further research and evaluation.

The imperative of achieving this change is echoed by Professor Ged Byrne, Director for Quality and Education – Health Education England who asserts:



It is therefore both timely and proper that we should push forward with an investigation of the opportunity afforded from adopting a much broader approach to health, one that places equal value on fighting disease as preventing illness by promoting wellbeing; an approach which acknowledges that to achieve health and wellbeing we all require 'more than medicine' and we cannot do this alone.'

Director of Education and Quality, Health Education England

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Further information

A1.0 Defining social prescribing

A1.1 Common elements

A1.1.1 Asset based approaches; what the roundtable respondents said:

- it's about 'wellness' not 'illness': getting to people before they become ill or develop illness
- it is about causes not symptoms: why stuff happens in the first place
- it is based on a clear set of values which are about harnessing personal and community assets
- it focuses on helping people and communities developing their own strengths and abilities to live independent and fulfilling lives
- it is about 'additionality': it makes more and different resources available to do the job
- it promotes different perspectives, new ways of thinking and in turn new ways of doing: driving innovation.

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A1.1.2 Personal choice and control

- social prescribing links people up through a signposting or a referral process with non-clinical interventions and services in the wider community that can address psychosocial or economic factors that impact positively on wellbeing
- it is tailored and person-centred because it starts with the person not the condition or illness
- it changes the relationship between the health practitioner and the patient as it requires a collaborative exploration of any given opportunity to improve and maintain wellbeing
- it changes the role of the professionals because it requires power sharing with the patient and ideally it does 'with' not 'to' or 'for' a person
- it has the power to change attitudes and behaviours that traditional health promotion activity struggles with because it is about patient self-learning and reflection.

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A1.1.3 Transformation

- social prescribing spans primary and secondary care as well as acute settings: it joins stuff up
- it highlights the social context in which people live their lives and the importance of any given policy context
- it isn't just about individual behaviours it is about systems too
- it brings new ways of developing and articulating prevention agendas by empowering people to look after themselves and others better
- it is about a physical and mental health continuum: a world where things are linked not separate
- it creates a focus and energy for partnership working because silos and agency boundaries get in the way of people-centred outcomes
- it highlights the fact that health inequalities, that could be avoided by reasonable means, are unfair
- it has huge implications for workforce development and training.

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A1.2 A theoretical perspective

A1.2.1 Sense of control

According to Antonovsky's 'Health Stress and Coping' (1979), control is made up of three key elements:

- *comprehensibility*: a belief that things happen in an orderly and predictable fashion and a sense that you can understand events in your life and reasonably predict what will happen in the future
- *manageability*: a belief that you have the skills or ability, the support, the help, or the resources necessary to take care of things, and that things are manageable and within your control
- *meaningfulness*: a belief that things in life are interesting and a source of satisfaction, that things are really worthwhile and that there is good reason or purpose to care about what happens.

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A1.2.2 Exploring the longitudinal relationship between arts engagement and health

In 2015 Dr Rebecca Gordon Nesbitt compiled an evidence base comprised of fifteen longitudinal studies which documented the benefits of arts engagement on health and wellbeing. These international studies collectively suggest that attending high-quality cultural events has a beneficial impact upon a range of chronic diseases over time. This includes cancer, heart disease, dementia and obesity, with an inevitable knock-on effect upon life expectancy. Many possible reasons for this positive association are speculated upon by the researchers brought together in this report – from increased social capital to psycho-neuroimmunological responses – all of which are interrogated in detail. One of the most compelling potential explanations for any positive association observed between arts engagement and health comes from the field of epigenetics. This work posits that specifically the idea that environmental enrichment (in this case, cultural activity) can cause certain harmful genes to be switched off, enabling health-protective effects to be communicated from one generation to the next.

<http://www.artsforhealth.org/research/artsengagementandhealth/ArtsEngagementandHealth.pdf>

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A1.2.3 University of California Berkeley study (2015)

The University of California, Berkeley, study [published in the Journal Emotion](#) in January 2015, suggests that the feeling of awe we may experience during encounters with art, nature and spirituality has an anti-inflammatory effect, protecting the body from chronic disease. The researchers found a correlation between feelings of awe and lower levels of cytokines; the markers that put the immune system on high alert by triggering a defensive reaction known as inflammation. While inflammation is essential to fighting infection and disease when the body is presented with a specific threat, chronically high levels of cytokines have been linked to a number of health problems, including heart disease, Alzheimer's, depression and autoimmune conditions.

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A2.0 Key activities

A2.1 Five ways to wellbeing (NEF)

A2.0.1 NEF argue there are five simple and practical steps that we can all take to improve our wellbeing, the Five Ways to Wellbeing are:

- connect – connect with the people around you
- be active – physical activity is good for the mind and the body
- take notice – become aware of the world around you
- keep learning – learn new skills and set yourself challenges
- give – be a good citizen and help others (NEF 2008)

<http://www.neweconomics.org/projects/entry/five-ways-to-well-being>

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A2.1.1 Information support or advice on prescription

A2.1.1.1 Advice on prescription Liverpool

Advice on prescription was a direct response to the Liverpool Clinical Commissioning Group's (CCG) duty to reduce health inequalities. Advice on prescription partners in Liverpool are committed to sustained action on the social determinants of health. This service aims to increase community resilience by supporting those individuals vulnerable to mental ill-health to develop practical strategies in the face of hardship and deprivation. Early consultation on the Liverpool strategy for mental health indicated strong approval for the inclusion of anti-poverty measures as a preventative element of an integrated primary mental health care system. The Liverpool Clinical Commissioning Group (CCG) therefore included a 'practical offer' of advice and advocacy in its primary mental health care strategy. This approach also has a strong strategic fit with national policy emphasising the need for prevention and integration with social care and reduced dependence on specialist services.

Liverpool CCG is developing a primary care mental health system to support people who are vulnerable to common mental health disorders such as anxiety and depression. As part of this commitment a pilot project providing welfare advice in primary healthcare settings was developed in Liverpool from July 2012 to July 2013 using an investment of £65k. This model offered welfare advice on an outreach basis into five primary health care centres. The practices were located in a range of areas including deprived inner city communities as well as more prosperous suburbs. Referrals were gate kept by staff in primary mental health care teams and these referrals were found to have a complexity of health and social issues. 30% of referrals made during the evaluation period were surviving on a household income of less than £400 a month.

This service also kept activity data during the pilot period which indicated that the model was targeting the most vulnerable in society and that, after a 'bedding in' period it was found that appointments offered were taken up without waiting lists beginning to accumulate.

This pilot project was overseen by a steering group which included representatives from the participating practices and the CCG. An independent evaluation of the pilot focussed on the service model and outcomes, but also incorporated a literature review of evidence pertaining to advice in health settings. Findings and conclusions were drawn from activity and outcomes data, and analysis of group and one to one discussions with GPs and other practitioners in the participating practices as well as colleagues from South Liverpool CAB providing the service.

Liverpool CCG have consistently highlighted the fact that insufficient income is bad for health and poor mental health is the biggest contributor to Disability Adjusted Life Years in Liverpool (1 DALY = 1 year of healthy life lost due to disability, illness or premature mortality). Based upon 2010 data, the estimated overall number of DALYs lost in Liverpool was 57,323, of which the largest proportion of DALYs lost (13,138 years - 23%) were due to mental and behavioural disorders. Evidence indicates unmanageable debt increases the risk of developing depression/ anxiety disorders by 33% in the general population.

Household income in Liverpool during 2012 was the second lowest of the eight core cities in England. Furthermore, household income in Liverpool fell by over £700 between 2011 and 2012, whereas many of the other core cities saw an increase. Data from CACI suggests that almost 40% of Liverpool households can be considered to be living at or close to the poverty line, with an income of less than £17,279.

A report by Sheffield Hallam University (2013) looked into the impact of the changes to welfare in England. They found that as a general rule the more deprived the local authority, the greater the financial impact of the reforms, a consequence of which will be to widen the inequality gap between the best and worst local economies. Their analysis showed that Liverpool is ranked fourth worst hit among Local Authorities, with an absolute financial loss due to welfare reforms of £227million. This equates to an average loss per working age adult of around £700 per year.

After an evaluation of pilot activity Liverpool CCG launched their Advice on Prescription programme (APP) in April 2014 in partnership with Citizens Advice across Liverpool. There are 23 hubs in place across the city, reaching into every GP practice. This scheme has also enjoyed the full support of many partner agencies including the Mayor's office, Public Health Liverpool and a number of patient and service user groups. In the first six months of going live, this service worked with health professional and vulnerable patients across Liverpool via 93 GP practices. The APP team dealt with: 3057 enquiries, helped patients manage £1.8 million of debt (£1,815,118) and maximised patient income to the value of nearly £3.5 million (£3,473,226).

<http://www.southliverpoolcab.org.uk/index.php/en/about-us/2012-04-22-07-19-05/advice-on-prescription-project>

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A2.1.1.2 On-line database and directories in Liverpool

In parallel to the advice on prescription development, Liverpool City Council and partners also launched a series of online directories designed to support the public and professionals to identify opportunity to promote wellbeing. Healthwatch Liverpool has developed and is maintaining the Liverpool City Council database to support these directories and any linked social prescribing activity.

There are three online directories working together from one database supported by a telephone helpline:

- LiveWell Liverpool - a wide ranging directory (for any member of the public) of the city's resources that can be used to search for information and explore options for care and support, as well as social activities and clubs
- Wellbeing Liverpool - a new directory of services to help adults or young people with their mental wellbeing
- RALFY - (a web application of LiveWell that GPs can use to find help for their patients). It contains details of services provided by community trusts, charities and local authorities. The purpose of RALFY is to help GPs quickly find a service during a consultation.

A steering group made up of key partners drawn from Healthwatch, the Liverpool Council, PSS and Liverpool CCG oversees this online activity.

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A2.1.1.3 Health trainer service Liverpool

Person Shaped Support (PSS), a national charity, deliver a health trainer service across the majority of GP practices in Liverpool to support, motivate and encourage individuals to make healthier lifestyle choices. Health trainers are drawn from their local communities. They can work with clients for up to twelve weeks on a one-to-one basis and by working with a client they can create a personal health plan to assist individuals in achieving their goals.

They help people who are looking to:

- eat more healthily
- become more active or mobile
- reduce stress and or anxiety
- reduce the amount they smoke
- keep their drinking in check.

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A2.1.1.4 Armed forces community directory (AFCOM)

In July 2013, the LIBOR Fund awarded the Veterans Council resource to develop the means to provide a 'one stop shop' and directory of services for the armed forces community. This was designed so that services including support pathways into mental health, NHS priority treatment and other tailored methods of transition are more accessible to the armed forces community through one initial point of contact and on-line directory.

In May 2014, Veterans Council launched the AFCOM Directory (then known as the Armed Forces Community Directory, or AFComD). The AFCOM Directory is designed to ensure those who need help, find the right help in the right place, at the right time. Veterans and family members can access the directory directly or through a GP referral.

Organisations registering their services must complete an approval process and commit to Accreditation Criteria and a Code of Conduct to uphold the Armed Forces Covenant and NHS constitution before they meet the eligibility criteria. In the case of healthcare all registered organisations should comply with the relevant NHS, NICE or CQC guidelines.

Phase 2 of the directory development went live in November 2014, incorporating a new look and feel and many improvements as a result of user feedback. User feedback was central to the directory development. The directory incorporates what are described as six key pillars of support:

- education
- housing
- health and wellbeing
- welfare
- employment
- legal.

There is a specific facility to encourage GP registration and referral. At the time of writing the Veterans Council was about to undertake a review of veteran need in the region facilitated through a 'Veterans Voice' activity. This work will again influence and inform the directory development. The Veterans Council is also able to offer support to veterans through the provision of a pathway management service and dedicated staff to support veteran transition who are called pathway managers.

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A2.1.2 Bibliotherapy

A2.1.2.1 Self-help reading

The national Reading Well Books on Prescription scheme is based on a book selection protocol for non-fiction text. Reading Well Books on Prescription is designed to help readers understand and manage their health and wellbeing using self-help reading. It is endorsed by health professionals and supported by public libraries. The scheme was developed in partnership with the Society of Chief Librarians, with funding from Arts Council England. It builds on local best practice to create a quality-assured national scheme for England, based on the model developed in Wales by Professor Neil Frude.

The Reading Well approach presents a particular view of the value of non-fiction literature to promote wellbeing more generally, and doesn't yet fully capitalise on an emerging evidence base which demonstrates the direct importance of engaging with fiction and poetry for wellbeing. In this context the encouragement of active reading to connect a particular reader with a diverse range of fiction can have enormous benefits.

<http://readingagency.org.uk/adults/quick-guides/reading-well/>

In January 2015, the Reading Agency also launched [Reading Well Books on Prescription for dementia](#), which provides help and support for people with dementia, carers of people with dementia and anyone who would like to find out more about the condition, or is worried about symptoms. The [booklist](#) is divided into four categories: information and advice; living well with dementia; support for relatives and carers; and personal stories. Reading Well Books on Prescription also helps people discover other library wellbeing services including [Reading Well Mood-boosting Books](#) and [reading groups](#).

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A2.1.2.2 The Reader Organisation Liverpool

The Reader Organisation has through their pioneering Reading for Health scheme developed an innovative intervention, 'Shared Reading', in order to promote wellbeing in a range of contexts, which include community, hospital and acute settings. The shared reading model brings people together in weekly groups to listen to poems and stories read aloud. Thoughts and experiences are shared; personal and social connections are made.

This approach focuses on the person rather than any health issue. By focusing on people not problems it identifies resource. The underlying tenet or central power of the shared reading model means that through works of fiction or poetry reading can help individuals to make changes to how they feel about themselves and how they relate to other people. In this way, literature has a powerful potential to contribute to both general wellbeing as well as healing processes.

Storytelling seems to be able to strike a deeply human chord which can in result in the development of constructive solutions to problems and the transformation of unhelpful and destructive feelings. The interaction between the book and the reader with its underlying process of meaning creation and imaginative ventures is of central interest to understand these effects.

More significantly this approach firmly identifies bibliotherapy as a resource to promote wellbeing for everybody through the use of fiction and does not restrict it to a treatment for mental ill health. Wellbeing is associated with the cultivation of positive emotions such as joy, interest and contentment (Frederickson 2000). Frederickson argues positive emotions lead to novel, expansive, or exploratory behaviour, and that, over time, these actions lead to meaningful, long-term resources such as knowledge and social relationships. These emotions can also thwart the development of negative thinking which can be by its nature disabling; and by encouraging a broader way of thinking things through provide new solutions. As a result a person can build better resources for looking after themselves and be better equipped when facing life's challenges. In this way 'positive emotions' become more than the absence of negative emotions in the same way wellbeing is more than the absence of illness.

The Reader Organisation is currently reading with 2,000 people per week(2015) across a variety of settings; in the workplace, in prisons, on mental health wards, in care homes, in schools and in local communities. They are working with: 5 Boroughs Partnership Trust, Cheshire East Council, Cheshire West and Chester Council, Knowsley CCG, Knowsley Council, Greater Manchester West Mental Health Trust, Mersey Care NHS Trust and Royal Liverpool and Broadgreen University Hospitals NHS Trust.

A report conducted by the Centre for Public Health at Liverpool John Moores University (May 2013) examined the social impact of 'Get Into Reading' groups in Wirral, showing how the lives of the group members are being improving in real, measurable terms. The report found that for every £1 spent on the delivery of shared reading groups in Wirral, an average of £6.47 is brought back in social return – meaning that members get the equivalent of this amount as an improvement to their overall health and wellbeing. To find out more about the shared reading SROI report on the [Centre for Public Health blog](#) and [read the full report here](#).

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A2.1.3 Eco-therapy or green prescriptions

A2.1.3.1 Green Dreams East Lancashire

Green Dreams is a good example of a GP led activity and the role of social enterprises in a social prescribing landscape. Dr James Fleming set up Green Dreams initially to provide support for any of his patients who were struggling with employment, debt, low self-esteem, unacceptable rental housing and reduced opportunities. Dr Fleming said, "I found I was being asked to give anti-depressants in situations where it was obvious that they weren't going to make anything any better. For some groups of patients, the problem was that they were long term unemployed, or couldn't read – or that their housing was making them sick, or they were in debt or dealing with some other crushing social situation which they were unable to escape from."

Fleming says he instinctively knew what kinds of intervention would help, but didn't know the words or the framework for what he was trying to do, until he completed an MSc in Primary Care, where he learned about salutogenesis: the idea of focusing on the factors which support human health rather than factors which cause disease.

Green Dreams now offers patients in its Padiham practice access to a range of support services including individualised plans to help people improve their quality of life; access to an outdoor garden and theatre, where volunteers are able to get a reference when they need to find paid employment but have no other means of getting one; and advocacy support, where it's possible to offer a strong, impartial voice on behalf of clients who might be vulnerable at that time. At the heart of the project is one to one counselling, so the practice can see what is going wrong for people and what help they need. Then comes very practical assistance; handholding while they go to court for debt, or confront their landlord about an uninhabitable flat. Often problems need multi-agency help, and the practice is able to get this working in a co-ordinated way.

Second tier activity is groups and voluntary work, which reintegrate people with their communities. The Jubilee Garden in Padiham is one centre for this work. Donated by the Unitarian Church, it used to be a wasteland but has been reclaimed as a working garden where 'peace and hard graft' are both available. For those who have been out of work for a long time, a reference offered at the end of a stint in the Jubilee Gardens can be invaluable for getting back into paid employment. For those not looking for work, the friendship and therapeutic aspects of gardening can help people rebuild their lives.

Green Dreams started with one project worker. They are now in seven surgeries, with around forty GPs referring into the programme with five full-time project workers. They prioritise those who other agencies have been unable to help, those who are furthest from the labour market, and those who are elderly and isolated.

The project had no capital investment and found its first three years funding for staff with help from the NHS in East Lancashire. It has been essential to prove that the money spent on working in this way saves the NHS money. Evaluation from the University of Lancashire has helped track its impact, right down to the most practical outcomes like the reduced need for prescriptions.

Around 27% of patients who have engaged with Green Dreams had some benefit to their mental or physical health directly attributable to the project. There has been a 20% reduction in appointments with the GPs. Many patients have also returned to work, become work ready, become less depressed and anxious, reduced medication or become more medically compliant.

Support from the Prince's Charities, Pennine Community Farms and many others helps sustain the project. After this funding ends, Green Dreams intends to continue work through a payment by results social investment fund. "We know this work is replicable" says Dr Fleming "because we have since created similar projects on seven other sites, spanning a fifteen mile radius and connected to other surgeries in our group."

<http://www.greendreamsproject.co.uk/>

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A2.1.4 Arts on prescription

A2.1.4.1 Creative Alternatives Sefton

The Atkinson in Southport hosts Creative Alternatives, Sefton's Arts on Prescription programme which was established in 2006. The Atkinson is a local authority (Sefton) funded art centre housing a theatre, art gallery and museum. Sefton seeks to maximise the impact of its museums and galleries on those experiencing depression, social isolation or the ill health associated with ageing. Sefton has a higher than average population of people over sixty-five and The Atkinson seeks to use its collections of decorative and fine art and its museum holdings of local and social history to encourage active and positive ageing. The arts on prescription programme, Creative Alternatives, integrates arts activity with mindfulness principles and workshops based on the Five Ways to Wellbeing. The programme is funded by the Sefton Public Health team.

Creative Alternatives has collected evaluation data for the past eight years which it shares with Sefton Public Health. This data is used as an advocacy tool to demonstrate the impact of creativity on health to policy makers from within the health and social care sectors. Creative Alternatives reports are freely available:

www.creativealternatives.org.uk

Participants are able to access the core programme for four blocks of five weeks, with breaks in between. Depending on when their start date is, this may span a period of six-eight months. Once the participant has completed the core programme, they are welcome to join optional extras which can be anything between one day events to five week workshops. They are also welcome to attend special outings and trips indefinitely.

The Creative Alternatives team believes all people are innately creative. 'Creativity lies at the root of personal health and growth, as well as contributing significantly to the development of our communities and our society. We are dedicated to creating activities and projects which nurture wellbeing, confidence and self-esteem, by providing opportunities for relaxation, rejuvenation and creative expression. We strive to enable our participants to develop new skills through the creation of art works across all media. We believe that creativity brings us into a deeper relationship with ourselves and the world around us, and we are committed to creating pathways for personal and community development, to empower our participants and to reinvigorate their sense of self and community.'

Creative Alternatives aims include:

- clear and demonstrable improvements to mental wellbeing among participants
- increased acknowledgement of the therapeutic benefits of creative activity by healthcare professionals
- increased arts and cultural engagement among current and former participants
- improvement in such lifestyle factors as diet, smoking and alcohol reduction and increased physical activity
- improved participant confidence, resilience and independence
- strong evaluation data for influencing public health policies and strategies
- establishing the relationship between arts and complimentary healthcare services
- fewer demands on traditional and more expensive, specialist health and care services.

Creative Alternatives is process driven, it uses creativity within its core workshops as a tool that alleviates the impact of mental ill health and fosters greater independence, coping and functioning among those who have become marginalised from mainstream life. Creative Alternatives is based at The Atkinson and benefits from privileged access to the buildings resources including museums, galleries and theatre spaces. The impact on participants is captured through the Warwick and Edinburgh wellbeing (WEMWBS) evaluation scale and a lifestyle questionnaire. The programme's funding from the Sefton Public Health Team is contingent on the quality of the resulting evaluation data against Service Level Agreement targets.

A Social Return on Investment (SROI) analysis commissioned by Sefton Public Health team demonstrated that every £1 of Creative Alternatives expenditure resulted in £6.95 worth of benefits to clients or savings to other services.

Creative Alternatives believes changing the hearts and minds of healthcare professionals is a long process requiring tenacity and the secure funding required to take risks and to develop evidence. Creative Alternatives has earned the respect of the medical profession only by being hard-headed with its evidence and has worked consistently to dispel the common misconception among policy makers and scientists that the arts are an indulgent luxury with no serious role to play within healthcare.

Creative Alternatives has now incorporated a series of mindfulness sessions as part of its core offer to all clients and has integrated a programme called 'Think Differently Cope Differently' (TDCD). TDCD offers resilience training based on each of the Five Ways to Wellbeing. In spite of the economic hardships within local government, Creative Alternatives has maintained its funding although each pound needs to work harder to meet increased targets. The principles that underpin Creative Alternatives will now be developed for the benefit of other service users at The Atkinson including those with memory loss and their carers and an increasingly older local population. The Atkinson has a duty to ensure that its cultural resources are used to affect the greatest impact on the greatest numbers.

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A2.1.4.2 Pendle Arts on Prescription

The Pendle Leisure Trust (PLT) was set up in 2000 when the local authority handed over all responsibility for managing leisure services. The council provides an annual subsidy which has been subject to cut backs. The Pendle Arts on Prescription programme was established in 2007. This programme is funded through a number of funding streams but their core budget still comes from the local authority through an adult learning budget and Target Wellbeing resource (via Big Lottery). The programme provides twelve week arts and crafts courses, three times a year, in a number of community locations across Burnley, Pendle and Ribblesdale.

Pendle Arts on Prescription has three very simple aims: 'Make Stuff. Make Friends. Make Life Better.'

This arts on prescription programme provides art courses free of charge to adults suffering from depression, anxiety, isolation and low self-esteem. Courses include: mixed media and crafts, drawing, painting, glass, creative writing, journaling, cookery, cake baking and textiles. All of the courses are run by professional artists, who are experts in their own field but who also have a passion for helping others and understand how people who are feeling a bit fragile need to work at their own pace in a friendly and relaxed environment.

Donations are accepted and anyone over nineteen years old who has not been on a course is welcome to attend. People are not asked their reasons for coming but are encouraged to set goals to achieve during the course - these can be as simple as attending each week or talking to one other person in the group. Courses are described as informal and welcoming and 'people only need to bring themselves.'

Running across Burnley, Pendle and Ribble Valley the project has worked with over twelve hundred people since 2007 and has developed effective course names, descriptions, referral partners and ways of marketing the courses that work. There is a steady stream of interest – a mix of individuals calling for themselves and health agencies wanting to refer people – from a referral database of over two-hundred and fifty health and support workers.

The programme monitors participants' mental health using the Warwick-Edinburgh scale of wellbeing. This is a series of questions people answer as they start the course and then again as they finish. Across Lancashire the average score amongst general residents is fifty-five, across East Lancashire it is fifty-four. The average score for participant starting the course is forty-three, which is significantly below average and when people finish the programme this averages at fifty-one.

The programme is extensively evaluated and they have recently carried out a full social return on investment analysis which indicates a value to society of £17.02 for every £1 invested in the Pendle Arts on Prescription programme.

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A2.1.5 Exercise on prescription or exercise on referral

A2.1.5.1 Active Cumbria

Exercise on prescription aims to prevent deterioration of conditions, and views exercise as a preventative health measure. The benefits of regular physical activity have been clearly articulated: for adults, achieving one-hundred and fifty minutes of moderate intensity physical activity a week helps prevent and manage over twenty chronic conditions including coronary heart disease, stroke, type-2 diabetes, cancer, obesity, mental health problems and musculoskeletal conditions.

Active Cumbria is focused on helping people and communities across Cumbria create a sporting habit for life. They are one of forty-five county sports partnerships (CSPs) covering England. They present as a network of local agencies committed to working together to increase the number of people taking part in sport and physical activity. CSPs develop sports programmes and policy at a community level on behalf of various stakeholders including Sport England, Youth Sport Trust, DCMS and local authorities.

Exercise on Referral, was first established in Carlisle and Allerdale and is also offered to patients in Eden and Copeland. North Country Leisure, who run Penrith and Appleby Leisure Centres are working with local family doctors and rehabilitation teams, and Specialist Nursing teams to provide a twelve week exercise programme for patients with conditions such as diabetes, respiratory diseases, arthritis, osteoporosis, neurological conditions, obesity, muscular skeletal conditions, stress, anxiety and depression.

<http://www.cumbriaccg.nhs.uk/news/2014/april/Exercise-on-Referral.aspx>

This scheme has been funded by the leading commissioner of health services in Cumbria, NHS Cumbria Clinical Commissioning Group (CCG) in Carlisle and Allerdale. The CSP is working with Greenwich Leisure Ltd formerly Carlisle Leisure Ltd to provide exercise support and tips aimed at helping patients to carry on being more active after the twelve week course is completed. For £2 per visit, patients can use the facilities at the leisure centres in Keswick, Cockermouth and Workington, the Wave in Maryport and G&S Fitness Gym in Wigton with support from Carlisle Leisure's clinical exercise instructors.

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A2.1.5.2 Dancing Recall

Dancing Recall is an innovative county wide, community dance and movement programme developed in conjunction with Active Cumbria, specifically developed for those living with dementia and their carers. It was developed by Daphne Cushnie, a neurological physiotherapist and community dance artist. It is founded on community dance principles where community building and relationships are key but seamlessly weaves in a logical structure based on clinical knowledge and understanding. It simultaneously addresses physical, cognitive, emotional and social effects associated with dementia in a creative and highly enjoyable way.

The project benefited from seed funding from the transitional resource to support the movement of public health teams into the local authority. The project was devised as part of the Cumbria Dementia Strategy Action Plan and reflects the convergence of the arts and medicine. It has trained a team of specialist community dance practitioners whose team teach eight weekly music and dance sessions taking place in six different locations throughout Cumbria. They also visit eight care homes for in-house sessions. Dancing Recall has recently become a social enterprise and is now seeking to secure ongoing funding.

Founder, Daphne Cushnie argues Dancing Recall demonstrates how dance can support health and care to deliver a "more compassionate and person-centred approach to care" and directly help people living with dementia lead more active, independent and fulfilled lives. She states, "The response has been overwhelmingly positive with participants clamouring for more."

Growing evidence from worldwide research shows that dance really can help people with dementia to improve concentration and responsiveness as well as overall mobility, enabling people to express themselves more fully in a safe and fun atmosphere. Rhythm, music, touch and movement enables dancers with dementia to connect with and relate to others, and the release of feelings can help communication. This is underpinned by a widely accepted understanding that regular exercise reduces the risk of dementia in older people.

<http://www.activecumbria.org/sports-and-fitness/dance/dancing-recall/>

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A2.1.6 Volunteering and community groups

A2.1.6.1 *if: Volunteering for wellbeing* Imperial War Museum North, Manchester Museum and partners

if: Volunteering for wellbeing is the first major project to measure the impact of responsible volunteering in the heritage sector. It is a three year Heritage Lottery funded programme (2013–2016). The project uses a Social Return on Investment methodology to evidence improved wellbeing in participants. The on-going evaluation will explore how volunteering can combat social and economic isolation and articulate the benefits for individuals, organisations and society. The project evaluation is seeking to find out exactly how the *if: Volunteering for wellbeing* programme promotes individual wellbeing and how specifically volunteering in heritage venues contributes to this. The programme is in its second year and it is observing dramatic improvements in participants' states of mental and emotional wellbeing across a diverse range of abilities and challenging personal circumstances.

The first year evaluation report can be accessed at:

http://issuu.com/volunteeringmm/docs/if_annual_sroi_report_2014

The programme is designed to support two-hundred and twenty-five participants, seventy-five per year, to move away from social and economic isolation or exclusion through heritage volunteering and tailored accredited training. Volunteers attend a bespoke training course with an immersive volunteering experience in a historic and or cultural museum (or gallery) environment. Through this work the programme aims to be of deeper benefit to participants through significantly improving their social, mental and emotional wellbeing. Participants receive accredited qualifications and embark on a six to eight week placement at one of the partner venues. Volunteer roles range from object handling and or interpretation, through to administrative and marketing support; and all seek to improve a venue's face-to-face interaction with visitors.

The *if: Volunteering for wellbeing programme* is a volunteering and training project which targets five key, priority groups across Greater Manchester.

These groups include:

- people with mild to moderate mental ill health
- long term unemployed
- young people aged 16-25
- over 50s
- ex-military service personnel.

The project includes three *if: Volunteering for wellbeing* training partner venues:

- IWM North
- Manchester Museum and
- Museum of Science and Industry (MOSI).

Seven *if: Volunteering for wellbeing* placement venues including:

- Manchester City Galleries (Manchester Art Gallery and Gallery of Costume)
- Manchester Jewish Museum
- National Trust Dunham Massey
- Ordsall Hall
- Peoples History Museum (PHM) and
- the Whitworth.

For further information visit the programme website <http://volunteeringforwellbeing.org.uk/>

The *if: Volunteering for wellbeing partnership* are looking to identify follow on funding for the programme and to develop specific areas of expertise around key groups.

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A2.1.6.2 Volunteering more generally: Bank of England analysis

A recent speech by Andy Haldane, Chief Economist at the Bank of England, underlines the contribution volunteering makes to society. Ironically, Haldane argues although volunteering makes a huge contribution it frequently goes unappreciated. He states, “All in all, volunteers could be giving more than four billion hours per week – equivalent to almost 10% of the paid hours worked in the UK.”

He has sought to quantify the impact of volunteering through an analysis of impact on:

- economic value of goods and services created by volunteers if you like, the GDP equivalent value of volunteering services
- private value of volunteering activities, in particular the benefits felt by volunteers themselves
- social value of volunteering activities, as societal gains may be a multiple of economic and private benefits.

<http://www.bankofengland.co.uk/publications/Documents/speeches/2014/speech756.pdf>

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A2.1.6.3 The Kings Fund

The Kings Fund (2013) estimated that around three million people volunteer for health, disability and welfare organisations in England – the same number as the combined NHS and social care workforce. But very little is known about where these volunteers work or what they do. The Kings Fund therefore conducted independent research into activity in NHS acute trusts in England on behalf of the Department of Health.

They surveyed 99 acute trusts. Key finding included:

- acute trusts surveyed have on average 471 volunteers. Scaled up, this equates to more than 78,000 volunteers across all acute trusts in England, contributing more than 13 million hours per year
- a wide variation in the numbers of volunteers, with only a weak link between trust size and volunteer numbers. Some trusts report as few as 35 volunteers, while others have 1,300
- volunteer profiles have changed over the past five years, with new volunteers tending to be younger and more ethnically diverse (according to 66% and 56% of respondents respectively)
- all the respondents see volunteering as a growth area with 87% expecting the number of volunteers to increase over the next three years
- respondents felt that volunteers play a critical role in improving patient experience. But most trusts recognise that they were not doing enough to measure this impact more formally
- the survey data analysis suggests that for the average trust, every £1 invested in volunteering could yield around £11 in added value. But trusts need a more sophisticated approach for measuring the value of volunteering, to include patient experience and quality of care.

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/volunteering-in-acute-trusts-in-england-kingsfund-nov13.pdf

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A2.1.7 Learning prescriptions

A2.1.7.1 Community learning and health impact project

In 2013, the National Institute for Adult Continuing Adult Education's (NIACE) Community Learning and Health Impact (CLIF) project demonstrated tremendous benefits for participants, providing both learning and health benefits. However, in meeting these twin objectives, the work found itself falling into a funding gap: health funders suggested the work should be funded by education and education suggested the work should be funded by the health sector. This is a key issue for voluntary sector projects in particular. NIACE argue this funding gap needs to be addressed at a local level through joint working between health and wellbeing boards and community learning organisations.

<http://www.niace.org.uk/sites/default/files/resources/CLIF%20-%20Community%20learning%20and%20health.pdf>

Their research confirmed that community learning brings a wide range of benefits including:

- supporting people to feel more positive about life
- increasing their understanding of a health condition and
- improving diet.

Community learning:

- enables adults to take part in shared decision-making in their own healthcare
- helps adults to take part in shaping health policy, and
- is crucial to tackling the growing health inequalities gap.

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A2.1.7.2 The Workers' Educational Association (WEA) and social purpose learning

The Workers' Educational Association (WEA) is developing a social purpose learning approach in everything they do. This approach can be illustrated by reference to a partnership between the WEA, the Booth Centre for homeless people and the People's History Museum. The Workers' Educational Association (WEA) has had ongoing educational partnerships with the Booth Centre and the People's History Museum since 2009. In the past, many of the Booth Centre users have attended WEA courses that have incorporated inspirational visits to numerous museums and galleries in Greater Manchester.

In September 2014 the Booth Centre requested a WEA art class on Monday mornings. The course was set up for ten weeks for two hours per week. The tutor facilitated classes on drawing, painting and collage that were received very well by the course participants. Based on past experience, the WEA also wanted to ensure that the students had the opportunity to get out of the classroom and take part in cultural activities and the People's History Museum was a natural choice for the WEA. "Students find the exhibitions fascinating and it has its own dedicated art and printmaking room" (tutor). The then current exhibition, 'Election! Britain Votes', added an extra dimension to these visits in terms of 'social purpose' activity with a looming general election and a clear picture of disenfranchisement among the homeless due to a lack of fixed abode and a level of alienation.

The homeless students visited the People's History Museum twice. Their first visit was for familiarisation purposes (it can be quite daunting for some adults to visit museums, for various personal reasons) and to have a look at the temporary exhibition. The second visit took place in the art room, where a practicing artist gave the students expert tuition on screen-printing and poster making techniques. "The students produced some lovely, inspiring work, of which they were justifiably proud. They all left the museum clutching rolled up prints and posters to take back to the centre to show to their friends" (tutor).

Although this was an art course, it soon became apparent that for the vast majority of participants the main reason for attending the course was for the therapeutic benefits. The students were able to switch off from their everyday problems for a couple of hours and focus solely on producing art that was relevant to them and their lives. As the course progressed, the

tutor commented that the main outcome seemed to be improved health and wellbeing and, as such, the course learning outcomes were changed to reflect the emotional needs of the students.

The programme leader commented, "On a pop in visit to the Booth Centre I was struck by the way in which the students were able to block out the noisy, sometimes chaotic atmosphere in the room and in true zen-like fashion concentrate on their art, seemingly oblivious to all other distractions. I also popped into the poster making session at the People's History Museum and witnessed the sheer joy of the students trying something new in a cultural environment. The happiness in the room was palpable: lots of smiles and laughter and, again, total concentration as everyone worked together to screen-print their designs."

"For adult students who have chaotic, unstable lives, being 'given permission' to switch off and focus on something creative in a warm, welcoming and supportive atmosphere is invaluable to their emotional, and mental, health and wellbeing" (tutor).

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A2.1.7.3 Recovery College model

Mersey Care's Recovery College programme was officially launched in September 2013. The Recovery College isn't a school or a college in the traditional sense of the word but Mersey Care does deliver a comprehensive range of courses and learning programmes for people who use services, care for someone who does, or work in services as a route to recovery, not as a form of therapy.

This work has been co-developed based on the principles outlined at the ImROC conference in July 2015. The paper can be found at:

<http://www.imroc.org/imroc-conference-next-steps-for-recovery-focused-support/>

The Recovery College is designed to:

- promote an educational and coaching model that supports people to become experts in their own self-care on their recovery journey
- help students further identify and explore their talents and develop and make the most of their skills
- help students to set goals in terms of their recovery and wellbeing with the aim of achieving what they want in life and reaching their potential
- help students to further develop their confidence, skills and support to access opportunities.

At the heart of the Recovery College model is a commitment to co-production in all their work. The Recovery College model harnesses patient and carer expertise, tapping into the wealth of knowledge of both professionals and those other experts, with 'lived experience' to help both design and deliver courses. This approach appears to be a fundamental key ingredient in enabling the best session material and learning experience for students.

Recent Mersey Care reports highlight how this work has led to a transformation of the culture of service provision. Mersey Care believe, "Recovery is about having and building a meaningful, satisfying and contributing life." It is therefore about the development of new meaning and purpose in one's life.

The key components of this work were identified as:

- a move to person centred 'safety planning'
- streamlining the route to employment and meaningful occupation and
- empowering self-management and learning.

Mersey Care believe the key to the success of a Recovery College is peer support workers. Their job is to create hope, control and opportunity for students of the college, in order to allow them to develop their own expertise in their own recovery. It is about creating a route to recovery from mental illness, rather than a form of therapy.

The Recovery College obtained funding from the Department for Work and Pensions. The Recovery College philosophy is that public services are best delivered 'with' and not 'to' people. This requires a shift from the idea of 'fixers' to that of 'enablers'. So far, the Recovery College has run seventy courses, involving six hundred students. 84% of students attended after enrolment, and 82% of these attended the full course. This is an impressive achievement, and evidence that the Recovery College is providing what service users actually want and need.

Alongside this development there has been a clear commitment to developing an understanding of and using arts and cultural interventions. Dr Mandy Chivers argues:



Significant learning happens when different worlds come together, when you can tolerate that difference and create space for collaboration and when you can encourage flexibility in systems; then you can begin to innovate in ways that are truly transformational..."

(Shift Happens, Mersey Care NHS Trust, July 2011)

Mersey Care has commissioned extensive research into the value of creative approaches to mental health care within Mersey Care NHS Trust. 'No health without mental health' also reiterates the importance of high-quality services demonstrated by outcomes. Moreover, it emphasises the potential for greater personalisation and empowered communities to develop approaches to improving wellbeing (DoH 2011). No Health Without Mental Health defines key outcomes as enabling people to gain, 'a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.'

The idea behind the Recovery Model is to move towards a 'social model' of health and away from a 'medical model' which focuses on 'problems, deficits and dysfunction' to one that emphasises, 'building a new sense of self and purpose in life; discovering your own resourcefulness and possibilities, and using them'; whilst developing a sense of purpose, aspirations and goals.

For more information on Recovery Colleges see:

<http://www.mersecare.nhs.uk/media/1522/1recovery-colleges.pdf>

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A3.0 Key activities and approaches in social prescribing

A3.1 Supported community referral and socially prescribed programmes (community/primary care context)

A3.1.1 Wellbeing Enterprises Halton in Merseyside

Wellbeing Enterprises (WE) was established in 2005. It was the first health and wellbeing CIC in the UK. They currently operate across Halton, St Helens and Knowsley. They are funded by the local authority and the Halton Clinical Commissioning Group (CCG) and receive other grant funding. They work in both a primary care and secondary care context supporting discharge into the community.

Mark Swift the CEO and co-founder states Wellbeing Enterprises:

- are an award winning social enterprise and a leading light in community-led preventative healthcare
- empower people to take control of their health and live happier, longer lives
- work with, rather than for, people and communities to ensure the delivery of better health outcomes; saving lives and saving money
- believe working together they can unlock the true potential of people and communities.

They understand that unprecedented challenges lie ahead for our healthcare system and these include:

- developing social models of healthcare
- tackling the social determinants of health
- designing and delivering evidence based wellbeing interventions
- re-designing clinical pathways - putting wellbeing at the heart of these.

They deliver asset based social prescribing which includes non-medical sources of support and uses community assets. This includes:

Psych-education prescriptions:

- life skills training and CBT principles
- confidence classes
- stress management
- mindfulness.

Social inclusion prescriptions:

- tango dancing on prescription
- Nordic walking on prescription
- gardening on prescription.

For individuals:

WE work with individuals to design holistic interventions that help them to develop the skills and knowledge to improve their own wellbeing, and to become resilient in the face of difficulties. 97% of people who undertake interventions implement positive behaviour change to enhance their health and wellbeing.

For health and social care professionals:

WE work with partners in the NHS, local authorities and third sector to develop integrated services in which wellbeing stands at the core and co-design new ways of working to reduce the impact on services by approaching health and wellbeing in an asset based way. 60% of participants in the programmes have shown an improvement in their SWEMWBS score (a validated measure of a person's subjective wellbeing).

For communities:

WE work collaboratively with residents and local organisations to mobilise the skills and talents of people and to empower them to gain a greater sense of control over their health and wellbeing. We also help to connect people to assets in the wider community.

For businesses:

WE deliver training and consultancy services to businesses across the UK helping them embed wellbeing practices into their organisations. WE create programmes to ensure businesses maintain healthy, happy and resilient workplaces.

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A3.1.2 Supported referral and a structured learning activity in a secondary or acute care context

A3.1.2.1 Mersey Care NHS Trust Recovery College model

Mersey Care's Recovery College programme was officially launched in September 2013. The Recovery College isn't a school or a college in the traditional sense of the word but Mersey Care does deliver a comprehensive range of courses and learning programmes for people who use services, care for someone who does, or work in services as a route to recovery, not as a form of therapy.

This work has been co-developed based on the principles outlined by ImROC's top ten tips for recovery.

<http://www.imroc.org/what-is-recovery/recovery-top-tips/>

The Recovery College is designed to:

- promote an educational and coaching model that supports people to become experts in their own self-care on their recovery journey
- help students further identify and explore their talents and develop and make the most of their skills
- help students to set goals in terms of their recovery and wellbeing with the aim of achieving what they want in life and reaching their potential
- help students to further develop their confidence, skills and support to access opportunities.

At the heart of the Mersey Care Recovery College is a commitment co-production in all of the courses and learning programmes is, in a setting where the college is able to harness the expertise of professional experts and our 'experts with lived experience' to help to design and deliver courses. This approach appears to be a fundamental key ingredient in enabling the best session material and learning experience for students.

Recent Mersey Care reports highlight how this work has led to a transformation of the culture of service provision. Mersey Care believe, 'Recovery is about having and building a meaningful, satisfying and contributing life'. It is therefore about the development of new meaning and purpose in one's life.

The key components of this work were identified as:

- a move to person-centred 'safety planning'
- streamlining the route to employment and meaningful occupation and
- empowering self-management and learning.

Mersey Care believe the key to the success of a Recovery College is peer support workers. Their job is to create hope, control and opportunity for students of the college, in order to allow them to develop their own expertise in their own recovery. It is about creating a route to recovery from mental illness, rather than a form of therapy.

The Recovery College obtained funding from the Department for Work and Pensions. The Recovery College philosophy is that public services are best delivered 'with' and not 'to' people. This requires a shift from the idea of 'fixers' to that of 'enablers'. So far, the Recovery College has run seventy courses, involving six hundred students. 84% of students attended after enrolment, and 82% of these attended the full course. This is an impressive achievement, and evidence that the Recovery College is providing what service users actually want and need.

Alongside this development there has been a clear commitment to developing an understanding of and using arts and cultural interventions. Dr Mandy Chivers argues:



Significant learning happens when different worlds come together, when you can tolerate that difference and create space for collaboration and when you can encourage flexibility in systems; then you can begin to innovate in ways that are truly transformational..."

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Mersey Care has commissioned extensive research into the value of creative approaches to mental health care within Mersey Care NHS Trust. 'No Mental Health without Mental Health' also reiterates the importance of high-quality services demonstrated by outcomes. Moreover, it emphasises the potential for greater personalisation and empowered communities to develop approaches to improving wellbeing (DoH 2011). 'No Health Without Mental Health' defines key outcomes as enabling people to gain, 'a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.'

The idea behind the Recovery Model is to move towards a 'social model' of health and away from a 'medical model' which focuses on 'problems, deficits and dysfunction' to one that emphasises, 'building a new sense of self and purpose in life; discovering your own resourcefulness and possibilities, and using them'; whilst developing a sense of purpose, aspirations and goals.

For more information on Recovery Colleges see:

<http://www.merseycare.nhs.uk/media/1522/1recovery-colleges.pdf>

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A3.1.2.2 Mersey Care's creative and wellbeing programme

A good example of creative approaches to promote wellbeing in a secondary care context can be seen through Mersey Care NHS Trust's joint work with Liverpool Philharmonic. Liverpool Philharmonic has been commissioned to provide resident musicians across the trust since 2008. This activity includes a low and medium secure service for those with complex mental health issues, brain injury, learning disability, dementia, community mental health services, and the high security Ashworth Hospital. Berenice Gibson, Programme Support Manager for Creativity and Wellbeing at Mersey Care says, "Our aim was to give people who were inpatients the opportunity to enjoy cultural activities. We believe creativity supports wellbeing. Our service users and patients should have access to all the things that make us human beings. If you are in a mental health hospital and you can't go out to a concert, an art gallery, or a dance club, it could be a real struggle to get better." Read the case study in full [here](#).

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A3.1.2.3 My Health My Community (MHMC)

Pennine Care NHS Foundation Trust provides mental health and community services to people living in the boroughs of Bury, Oldham and Rochdale. They also provide mental health services in Stockport and Tameside and Glossop, as well as community services in Trafford. They are working in partnership with their seven feeder local authorities to develop a website which joins up preventative and community support activity at Pennine with each council.

My Health My Community was developed by Pennine Care NHS Foundation Trust as a portfolio of tools, information, guidance and education, which is both accessible online, face to face and through mobile apps. MHMC aims to support self-management across the community. All elements of MHMC are intended to educate and up-skill individuals about long term conditions and how they can be managed effectively at home while lowering the need for these individuals to attend A&E and reduce hospital admissions.

Pennine Care aims to grow a credible and trusted resource for communities. MHMC wants to support individuals and their families and carers to manage their long term conditions. It currently focuses on dementia; diabetes; stroke; COPD; cardiac disease; and end of life care. MHMC is also developing resources on practical skills to support individuals and carers.

This project supports social prescribing by linking people to activities, wider community support and reliable information and education. This enables people to grow their knowledge of both their condition and how they can access social resources to maintain and support health.

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A4.0 Policy context

A4.1 Adult learning theory

A4.1.1 Knowles' four principles of andragogy

The notion of andragogy has been around for nearly two centuries. It became particularly popular in North America and Britain as a way of describing adult learning through the work of Malcolm Knowles.

<http://infed.org/mobi/andragogy-what-is-it-and-does-it-help-thinking-about-adult-learning/>

In 1984, **Knowles** suggested **four principles** that are applied to adult learning:

- adults need to be involved in the planning and evaluation of their instruction
- experience (including mistakes) provides the basis for the learning activities
- adults are most interested in learning subjects that have immediate relevance and impact to their job or personal life
- adult learning is problem-centered rather than content-oriented.

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A4.1.2 Information, advice and guidance (IAG)

The following publications are useful for reference in terms of the historical development of the national system for IAG. There are many lessons to be learnt which resonate with social prescribing models. See:

Advice and Guidance for Adults – towards a national policy framework (2003).

Guidance for Adults: Harnessing Partnership. This includes a reference to the Challenge for Change (UDACE 1986) which identifies core guidance activities.

http://www.nicec.org/nicec_guidance_for_adults.pdf

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A4.1.3 Adult and community learning

A4.1.3.1 Dr Leon Feinstein

Feinstein's basic argument for the wider benefits of learning is that qualifications matter, basic skills matter, vocational skills matter and academic skills matter. However, there are also other wider skills that are often neglected and which are not only important in the labour market, but also in the formation of basic skills and for the achievement of qualifications. These wider skills may have essential implications for the wellbeing of individuals and society.

<http://www.niace.org.uk/lifelonglearninginquiry/docs/feinstein-sabates12.pdf> (page 3)

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A4.1.3.2 Community learning and development

CLD is defined as follows: "Community learning and development (CLD) is learning and social development work with individuals and groups in their communities using a range of formal and informal methods. A common defining feature is that programmes and activities are developed in dialogue with communities and participants. CLD's main aim is to help individuals and communities tackle real issues in their lives through community action and community-based learning."

For more information on adult learning in Scotland and more generally in a European context see:

<https://ec.europa.eu/epale/en/blog/what-can-scotland-teach-us-about-community-learning>

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A5.0 Key areas for development

A5.1 Perry and Mather 2012: A review of the implementation of the national health trainer service initiative

There are clear lessons to be learnt from the development of health trainers. The University of Birmingham (Perry and Mather 2012) national evaluation and research reflects some of the main concerns. This work highlights that there should always be a note of caution especially where evaluation is political and there is a, 'need to show value for money in narrowly conceptualised commissioning frameworks and understandings of legitimate evidence of effectiveness.'

<http://healthtrainersengland.com/wp-content/uploads/2014/05/Health-Trainers-National-Evaluation-Final-Report.pdf>

More recently, the adaption of the health trainer service in England (2015) report states that:



There is a growing polarisation of services, between on the one hand, services adopting more clinical work and on the other, services consciously resisting this move and instead, placing a far greater focus on the wider determinants of health and community development." (page 6).

http://www.rsph.org.uk/filemanager/root/site_assets/our_work/position_statements/r1485.dcrs.report_hires_.pdf

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A.5.2 Next steps

A.5.2.1 Social prescribing roundtable May 26 Manchester School of Art

Health Education England pulled together a national roundtable event in partnership with Professor Tom Jefferies at Manchester School of Architecture. Delegates came from across England representing CCGs, GPs, commissioners, provider agencies and arts and health networks.

The focus was on a deliberative discussion and fact finding. The roundtable included contributions from:

- HEE on the development of the social prescribing directory of museum wellbeing
- CHAMPS and Merseyside SCN social prescribing project
- the art of social prescribing - Institute of Cultural Capital (ICC)
- effects of shared group reading on wellbeing - the Reader Organisation

Key messages from delegates were:

- social prescribing isn't about austerity it is about a more holistic approach to health and wellbeing in the 21st century
- there is a need to develop and adapt our responses to current contexts and access, 'embedded assets' to promote wellbeing in communities.

Social prescribing is about:

- 'additionality' - enabling people to develop and maintain wellbeing through a re-focus on a social model of health and an asset based approach
- providing momentum for more and richer public engagement activity whilst deepening understanding about what we mean by living well
- delivering real person-centred care and support because social prescribing also provides invaluable intelligence about what matters to people and why
- extending the health and care resources we have by developing a more flexible toolkit for the future that reflects this new context
- demonstrating collaborative advantage and sum of the whole principles – doing things together better by working across traditional sectoral divides
- recognising that the social context in which people live their lives frequently determines their health and wellbeing
- appreciating the pivotal role that social networks and belonging play in health and wellbeing as well as understanding the broader spatial context and its impact
- empowering people to look after themselves
- changing entrenched behaviour by working with new allies and exploring ways to make this happen
- understanding how the 'intercultural dialogue' which social prescribing agendas promote drives adaptive capacity.

Delegates said:

- we need to be clear about the language we use to describe social prescribing and the difference it makes
- we need to influence commissioners by providing the opportunity to experience social prescribing first hand – so they can deeply connect to the experience and become champions
- we need to develop social prescribing infrastructure collaboratively in a locality – so databases are efficient and fit for purpose and avoid duplication
- we need to ensure we develop governance and information processes so we can measure impact together
- we need to connect social prescribing to a broader commitment to social justice and a reduction in avoidable health inequalities.

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OR

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