# Bristol Ageing Better Learning: Social Prescribing

**Collective learning from seven social prescribing services in Bristol: March 2020**

Within Bristol there are multiple models of social prescribing, each with a different remit and delivered by different providers. In order to help inform future commissioning and service delivery within the city, Bristol Ageing Better (BAB) has captured the collective learning and recommendations from these existing providers.

This document presents the collective learning from the following seven social prescribing services in Bristol: Community Navigators, SPEAR, Neighbours Connect Southmead, Community Webs, First Call Support at Home, RSVP Surgery Volunteers and Positive Minds.

## 1. Open to referrals from any source

Current services have found that it works well to allow open referrals from any source, not just health professionals. While health professionals may have a good understanding of who needs support, an open referral system **enables a wider range of clients to access the service** who may not otherwise seek support through a GP practice.

Current services with open referral options have received many referrals from social services, housing workers, third sector organisations, self and family members. **Self-referrals can be particularly empowering for clients** and lead to higher engagement with the service as it is a decision they have made for themselves.

By being open to referrals from any source, it enables some individuals to be supported by social prescribing without having to first make a GP appointment. This has the **potential to reduce pressures on primary care** by avoiding duplication and allowing these GP appointments to be used by others.

However, being open to referrals from any source can result in a long **waiting list if the service does not have enough capacity** to manage this. It can also result in clients being referred who have complex support needs and who require higher levels of tailored support (see point 2). When self-referrals need to be declined (for example due to complexity), it is important for the service to provide adequate signposting to avoid feelings of personal rejection and further decline.

## 2. A flexible model with support tailored to the individual

While straightforward signposting may be suitable for some clients, the **majority will require in-depth support that is tailored towards them as an individual.** For many clients with complex lives it is not sufficient to simply provide information about services and activities. In the wider shift towards patient-centred care and helping people to manage their own health in a way that works for them, current service providers have found it valuable when a service model can offer the following options:

- **To see an individual within their own home:** This enables the social prescriber to gain a better understanding of the individual's day-to-day life. It can reveal additional practical or physical issues for the service to help the client overcome (e.g. hoarding, damp, ability to cope with domestic tasks), which may not otherwise be identified. Some individuals are also more willing to reveal sensitive matters, such as debt or benefit problems, when they are in their own home. Furthermore, it ensures the service is accessible to those who have difficulty leaving the home (e.g. due to physical or psychological difficulties).

- **The ability to accompany clients to activities**: For some clients, particularly those who are anxious or under-confident (for example due to bereavement), being accompanied to an activity can make a significant difference in whether they carry through and keep to their social prescribing plan. This could possibly be undertaken by volunteers (see point 4).
- **The option of extending support beyond 6 sessions:** To genuinely tailor support to an individual, service models need to have the option of being flexible and extending support beyond 6 sessions when needed. There are often multiple practical issues to resolve (for example involving debt, housing management or transport difficulties), possibly alongside complex mental health needs. In practice, this requires more than a referral to the appropriate agency; it requires advocating on behalf of the individual, for example about the urgency of their situation.

## 3. Client feedback and co-design

Client feedback is vital and a **robust system** needs to be implemented in order to capture this feedback properly. Current service providers have trialled many different methods of gathering client feedback, including feedback questionnaires and follow-up phone calls. These follow-up phone calls have the potential to work well, however it is likely that there will have been significant **changes in a client's life since the case was closed** and therefore any follow-up phone calls should be undertaken by someone with the skills and knowledge to provide appropriate support for the client. This may involve signposting/referrals to other services or even re-referring back into the social prescribing service.

Co-design goes beyond client feedback and is a way for clients to shape the service. Current service providers have learnt that **co-design within a social prescribing service can be challenging** due to complexities in clients' lives as well as a number of other barriers. However when it is achieved, for example through a steering group or clients becoming volunteers, it is **highly valuable** for both the client themselves and the social prescribing service as a whole.

Preventative services need to be an affordable part of the overall offer from the NHS, but in order to actively involve clients in decisions made within the service there **needs to be an adequate budget to support this and a culture which avoids this being tokenistic.**

## 4. Staff and volunteer structure

Social prescribing requires skill and nuance; a **high-quality training programme** is important to ensure skills are developed and maintained. Existing service providers particularly recommend training in motivational interviewing, mental health awareness and dementia awareness. Social prescribers also need to be **knowledgeable about the local area**, including the social and cultural dynamics of the community they are working within.

Alongside training and knowledge there should be time for **reflective practice, debriefing and peer-support** (both formal and informal) in order to continuously improve the service quality and reduce staff burnout in what is an intensive role.

Furthermore, the **service coordinator or triager needs to be highly skilled** in assessing a client's appropriateness for the service, the level of support needed and whether a referral to another agency is required first in order to resolve a particular barrier.

Current service providers have found that it can be **valuable to involve volunteers** in the service model, particularly if their involvement brings an element of peer support for the client or they bring the capacity to accompany clients to activities (see point 2).

However, it is **important for the volunteer role to be suitable**, particularly in terms of how complex the case is, the time commitment and the emotional intensity. This will vary depending on the individual volunteer and their existing skills or knowledge. In some cases this may involve allocating the more complex clients to staff and the less complex ones to volunteers, unless a volunteer is explicitly happy to take on a complex case and utilise their skills.

When volunteers are involved in the service model they need to receive adequate support and debriefing, and for this to be factored into the service budget. Similarly, **managers need to be skilled in volunteer coordination** and have adequate capacity to undertake this alongside the social prescribing work.

## 5. Collaboration with mental health services

Cuts to mental health services are likely to have increased the extent to which social prescribing services work with clients with complex mental health needs. Existing services have particularly observed a **high prevalence of complex anxiety and depression**.

Sometimes a referral to a specialist mental health service is needed first, before progress can be made on other issues. Similarly, mental health services value the ability of social prescribing to identify individuals who may not otherwise seek mental health support or who need help negotiating the system.

As such, a **joined-up approach is needed between social prescribing and mental health** services, including:

- Ease of referrals between the two services.
- Open communication when working with the same individual at the same time to avoid duplication and to work according to service strengths.
- Processes to ensure a client returns to the social prescribing service in a timely manner after receiving mental health support.

## 6. Factors that help or hinder the effectiveness of social prescribing

In addition to the service model, the effectiveness of a social prescribing service will be affected by the infrastructure of local services and community groups. Existing services have found they are **only as good as the 'end organisations' to which they can make referrals to.**

There are an impressive range of opportunities available in Bristol but they are **not evenly distributed across all areas, leading to a postcode lottery**. Many areas of the city have gaps in the opportunities available, particularly for certain communities for example activity groups that are appropriate for ethnic minority communities or accessible for people living with physical disabilities. This variance can act to reinforce existing health inequalities.

In addition to this postcode lottery, current services providers have identified three significant barriers presented by the availability of:

- **Transport:** In some cases, bus routes can be unsuitable, community transport can be unreliable and taxis or individual specialist transport for those with mobility problems can be prohibitively expensive. Even those who would like to use local buses find themselves unable to do so if there is no bus shelter where they can sit while waiting.

- **Mental health services:** As discussed in point 5, some clients require a referral to mental health services and for this support to be given first, before the social prescribing service can have an impact. Funding cuts for mental health services, and associated long waiting lists, can leave social prescribing services 'holding' complex clients with no other support.

- **Befriending services:** Not everyone wants or is able to go to activities, perhaps because of mobility, frailty or other conditions, and prefer to have someone to visit them regularly. There are a number of well-established befriending organisations in the city however demand for volunteer befrienders exceeds supply, particularly for face-to-face befrienders or those who can also accompany the individual outside of the home.

Funding cuts have seen a reduction in some of the key services in Bristol, for example social work involvement, advice & information, mental health, home adaptations and community development. While social prescribers can support with some of these circumstances, **they are not specialists in all of these fields and cannot fill these gaps in service provision.** Moreover, an increase in social prescribing services may result in 'end organisations' being stretched beyond capacity without additional funding to respond to this higher demand.

The above factors can all limit the effectiveness of a social prescribing service. However, in order to *increase* effectiveness, it is important for social prescribing services to have **highly local in-depth knowledge about even the smallest community groups available**. This is key in being able to offer a high standard of support to a diverse range of clients with a wide variety of needs, interests and personal circumstances. One way to achieve this level of knowledge is for social prescribing to **work closely with local third sector organisations and community groups**. By doing so, it also helps the social prescribing service to identify gaps in what is available, which can then be addressed through community development.

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