Together Co

Social Prescribing

Impact report 2019–2020

Contents

Foreword

I am delighted to present this Social Prescribing impact report, which this year includes Together Co Social Prescribing, our Social Prescribing Plus project, and an outline of the important role social prescribing is playing in Brighton & Hove's city-wide covid response.

I am so proud of the way our service has developed in partnership with our colleagues in Primary Care and BH CCG, and our Voluntary Sector partners, especially our SP Plus partners, always holding the client experience at the heart of the way we deliver link work. We invest in our link workers, providing high quality ongoing training and support whilst contributing to the overall development of SP link work as an emerging professional discipline within the health, social and community sectors.

Alongside this, there is a huge added value in our service providing SP across the city for a range of community and individual referrers, and for Primary Care Networks — both in terms of economies of scale, and in shared knowledge. I am especially proud of the depth of expertise and sophisticated infrastructure we can offer through the service, through our SP Providers network, and through sharing our training and tools.

Social prescribing is evolving, with a demanding national policy agenda, and the challenges of emerging structures at all levels. In Brighton & Hove we have the opportunity to build a high-quality, coherent city-wide service that is focused on the needs of individuals, actively addressing health inequalities and inequality of access, and I look forward to embracing this with all partners in the coming months.

Jo Crease
CEO, Together Co

What is social prescribing?

Social prescribing is a way of supporting people to access a range of local activities, social groups and advice services to improve their health and wellbeing. A trained link worker assesses a person's needs and helps them find non-clinical services that enable them to feel more in control of their circumstances and health conditions.

We know people can find it difficult to navigate the range of services available in their local community. Social prescribing enables people to access the right resources for their individual needs and circumstances. Link workers liaise with external agencies and can assist with making appointments and travel plans, which removes barriers to accessing services and groups.

Our process

Stage 1	Stage 2	Stage 3	Stage 4
Initial telephone assessment with a Link Worker Face-to-face visit arranged if required Occasional direct onward referral (e.g. housing support, Wellbeing Service, Adult Social Care)	**Social Prescribing first session** Face-to-face visit with a Link Worker Person-centred assessment and action planning Advice on available services	**Social Prescribing follow-up sessions** Follow-up sessions via phone or face-to-face Action planning Facilitated onward referrals to services	**Additional support to engage** Accompanied visits to groups and services agreed as necessary

Key benefits

Social prescribing can:

- reduce isolation and loneliness
- improve feelings of wellbeing
- promote the appropriate use of health services
- increase resilience and independence
- prevent mental health decline
- help people find the right help at the right time.

96% of clients reported a positive change in their lives

> “It’s given me a bit of space for myself — makes me feel better in myself and less stressed. It’s given me a bit more self-confidence.”

About our team

We have a team of five citywide link workers (3.6 FTE) who accept referrals from a range of external agencies, as well as self-referrals via our Social Prescribing Hub. A link worker's role is to speak with clients who are referred to find out more about their individual circumstances and needs, before identifying groups and services that may be able to help. Where other services may offer simple signposting, Together Co's link workers facilitate referrals and offer a number of sessions to ensure clients feel supported whilst they explore the best ways to achieve their goals.

Since April 2020, Together Co has also been hosting a team of five link workers across three Primary Care Networks (PCNs) in the city. These PCN link workers accept referrals from surgery staff, as well as self-referrals prompted by GPs that go directly to the named link worker for each GP practice.

A team of fully-trained volunteers work alongside our paid staff. Under the supervision of a link worker, these volunteers help with tasks such as keeping our directory of resources up-to-date and telephone follow-ups, as well as undertaking social prescribing activities with less complex clients. They are all highly skilled and many have backgrounds in health and social care or other one-to-one support roles.

19 volunteers gave 2,736 hours of their time in 2019-20. Without volunteers, the number of people supported would have been 13% lower.

About our team continued

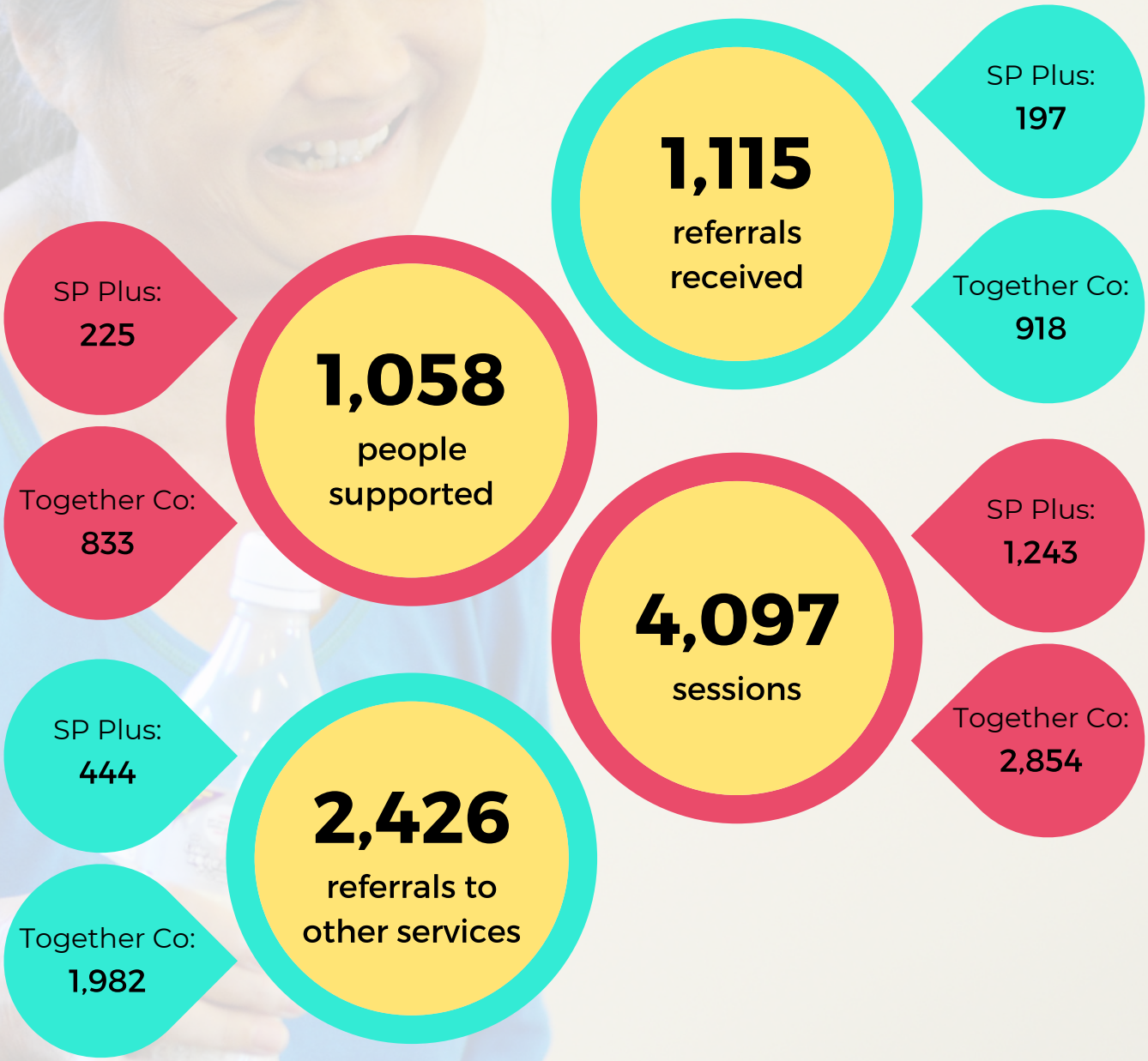
In addition to our core team, we have partnerships with specialist social prescribing providers:

- **Friends, Families and Travellers** — for the Gypsy, Roma and Traveller communities.
- **LGBT Switchboard Trans Link** — for trans and non-binary individuals.
- **Trust for Developing Communities** — for people from Black, Asian, and minority ethnic backgrounds.
- **Sussex Interpreting Services** — for those with a language need.

These partnerships mean that people referred to us who would like more specialist help can easily access social prescribing in a way that fits with their particular requirements and circumstances. For more information, see page 21.

Citywide and SP Plus summary

Below are some key figures from Together Co's citywide team and our Social Prescribing Plus partners combined.



Citywide SP team summary

918 referrals received

40% aged over 65

833 people supported*

2,854 sessions

8 hours of support per person on average

3.4 sessions per person on average

10 weeks average case length

1,982 referrals to other services

2,736 volunteer hours given

6,116 staff link worker hours

*We supported fewer people than were referred because some did not access the service, for example because we were unable to make contact with them or the referral was beyond the scope of social prescribing. For more information, see Appendix A.

Comparison with previous years

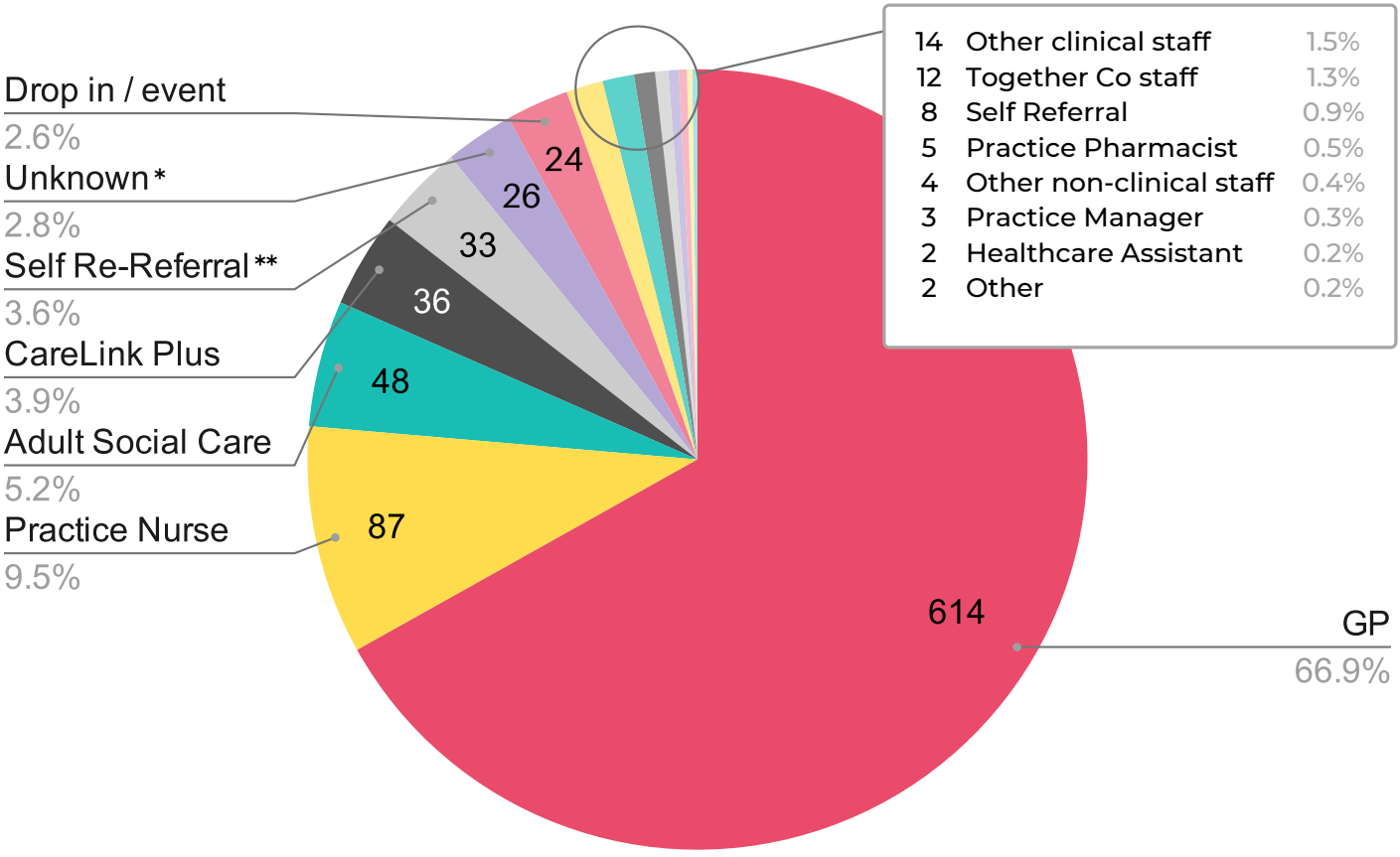
	2017-18	2018-19	2019-20
Referrals to Together Co SP	516	599 (+16%)	918 (+53%)
% of referrals for over 65s	44%	41%	40%
People supported	549	533 (-3%)	833 (+56%)
Number of sessions	1825	2,023 (+11%)	2,854 (+41%)
Average hours of support per person	7.5	10 (+33%)	8 (-21%)
Average sessions per person	3.3	3.8 (+14%)	3.4 (-10%)
Average case length in weeks	12	14 (+15%)	10 (-30%)
Referrals to other services	1922	1,520 (-21%)	1,982 (+30%)
Volunteer hours	2644	2,645 (+0.04%)	2,736 (+3%)
Staff hours	2927	5,834 (+99%)	6,116 (+5%)

Referrals we receive

81%
of referrals were from GP surgeries

The remaining 19% were primarily from Adult Social Care, the Carelink Plus Living Well project, and people who had previously accessed the service re-referring themselves.

The chart below provides a breakdown of referral sources, including individual roles within GP surgeries.

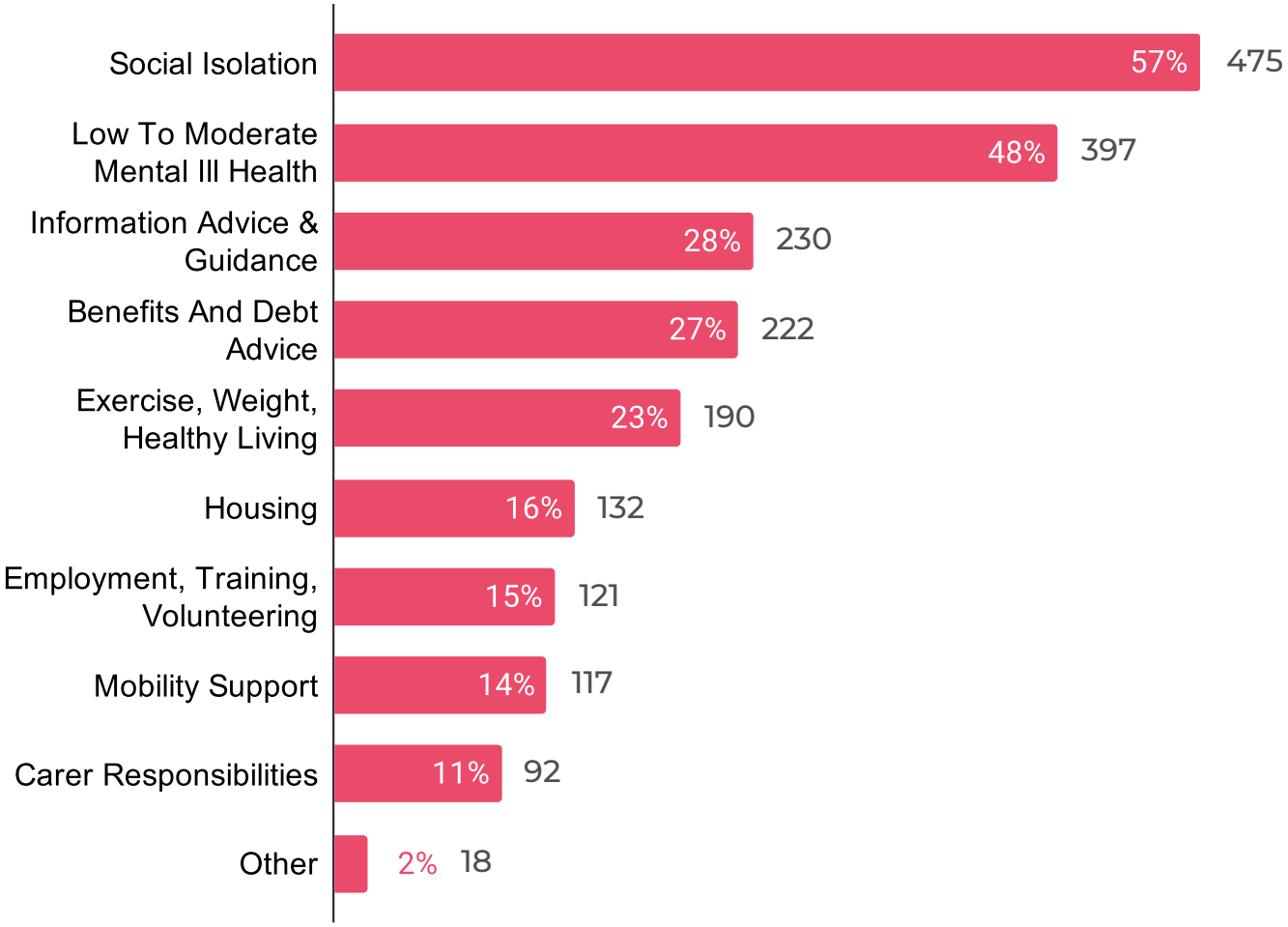


*The 26 'Unknown' are due to incomplete referral forms missing the referrer's name and role.
**Self re-referrals represent people who had previously accessed the service who then contacted us for further support after their original case was closed.

Our clients' needs

Social Prescribing can help people in a wide range of situations with a variety of non-medical issues that are worrying them.

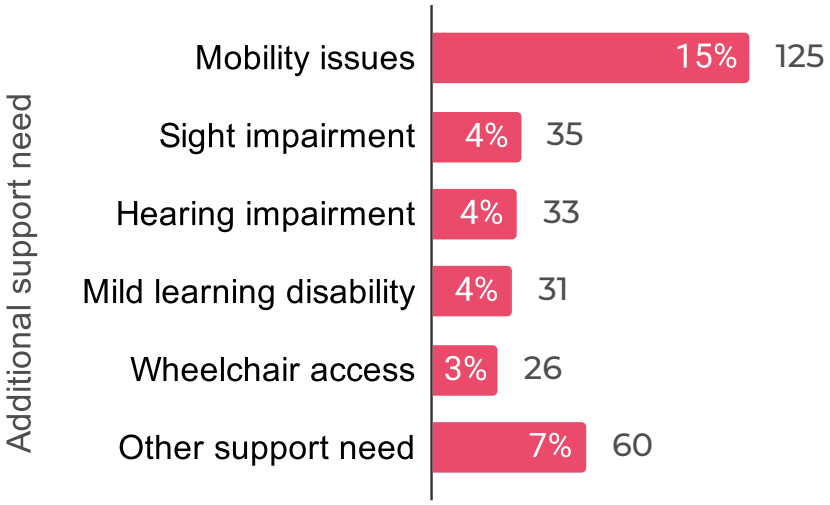
People who accessed the service required support with the following needs. The total is more than 100% because most people access the service for more than one reason.



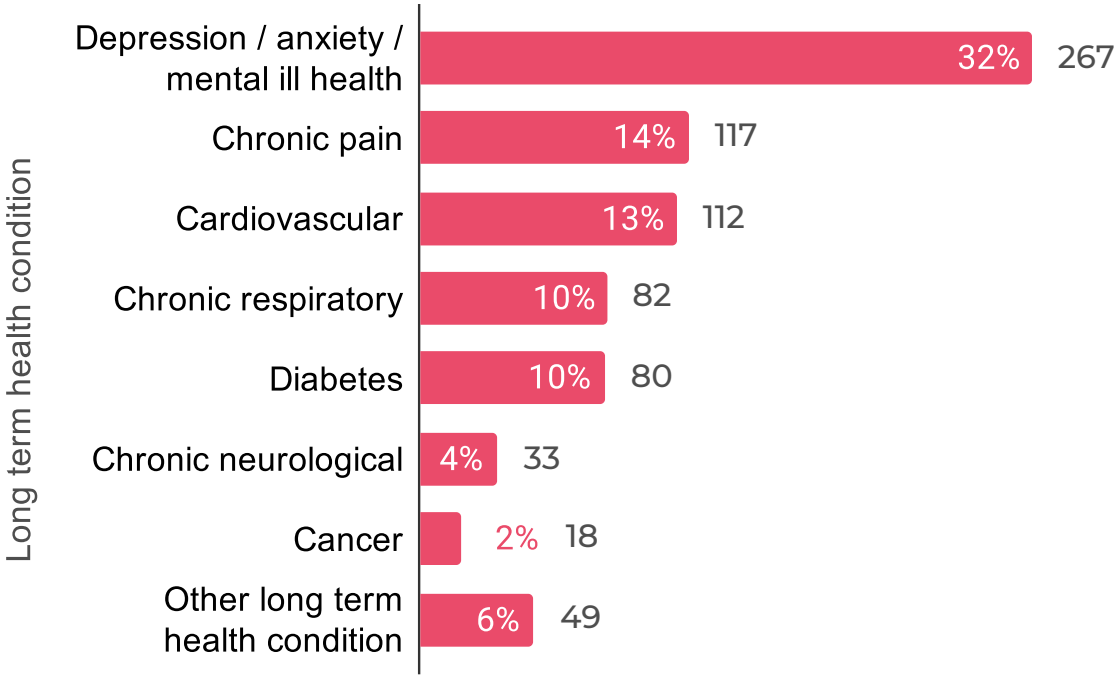
Other consists of: *Adult learning, bereavement, cancer, confidence, form filling, home care.*

Information about additional support needs and long-term health conditions is provided by the referrer or identified by conversation with a link worker.

These are not necessarily areas people want social prescribing support with, but they provide insight into the wider needs of those accessing the service and are useful for link workers to consider.



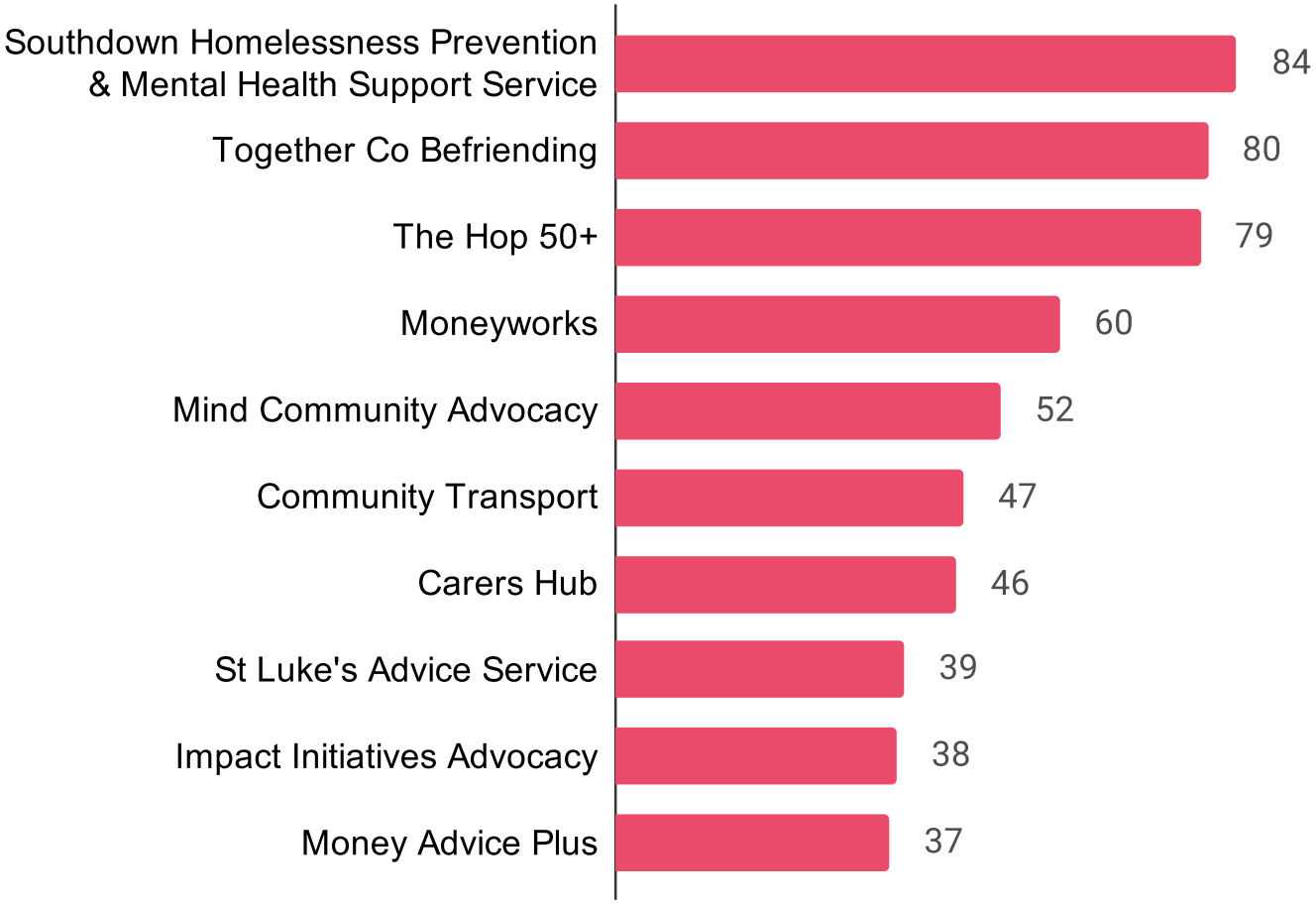
Other support needs include: *ADHD, agoraphobia, ataxic gait, autism, cannot read or write, dysgraphia, dyslexia, frail, homeless, housebound, incontinence, speech impairment.*



Other long-term health conditions include many different specific conditions, such as: *Arthritis, Asperger's syndrome, cerebral palsy, chronic fatigue syndrome, chronic liver disease, COPD, Crohn's disease, epilepsy, fibromyalgia, HIV, irritable bowel syndrome, multiple sclerosis, obesity, osteoperosis, polymyalgia rheumatica.*

Onward referrals

We made 1,982 referrals to 444 unique services, groups or activities. Here are the top ten and how many referrals were made to each:



A category is assigned to each service we refer on to. Of the total referrals made, 12% (n=236) were to social groups; 11% (n=212) mental health services; 10% (n=190) exercise, weight, healthy living; 8% (n=161) benefits and debt advice; 6% (n=124) befriending.

Other categories of service referred to included:

Carer responsibilities, older people's services, volunteering, disability, general information, advocacy, transport, counselling, employment and training, arts, adult learning, care services, buddying, Adult Social Care, peer support, housing, social prescribing, food bank, autism, LGBT services, mobility support, home food delivery, drug and alcohol recovery, GP surgery, learning disability, personal funding/grants, BME services, home from hospital services.

About complex cases

Some people seen by Social Prescribing have higher needs or more complex situations than others. These cases tend to require more in-depth support from link workers, which often means more sessions are provided and the case remains open for longer.

Because it is difficult to define what makes a case more complex, we estimate the number of complex cases by counting how many last for longer than three months and have more than six sessions.

In 2019-20, **9% (n=76) cases were complex**, compared to 19% (n=100) the previous year.

The slight decrease in complex cases reflects service changes rather than indicating any reduction in need. During this period there was an enhancement of phone support, where needed, as well as triage processes for people that did not meet social prescribing criteria. These improvements helped ensure that clients were supported within the short-term timescale of SP support. After case closure, people are able to re-refer at a future date if required.

Client-reported outcomes

We ask clients the same six open questions in their first and last sessions. Using our bespoke distance travelled monitoring tool, we can track changes.

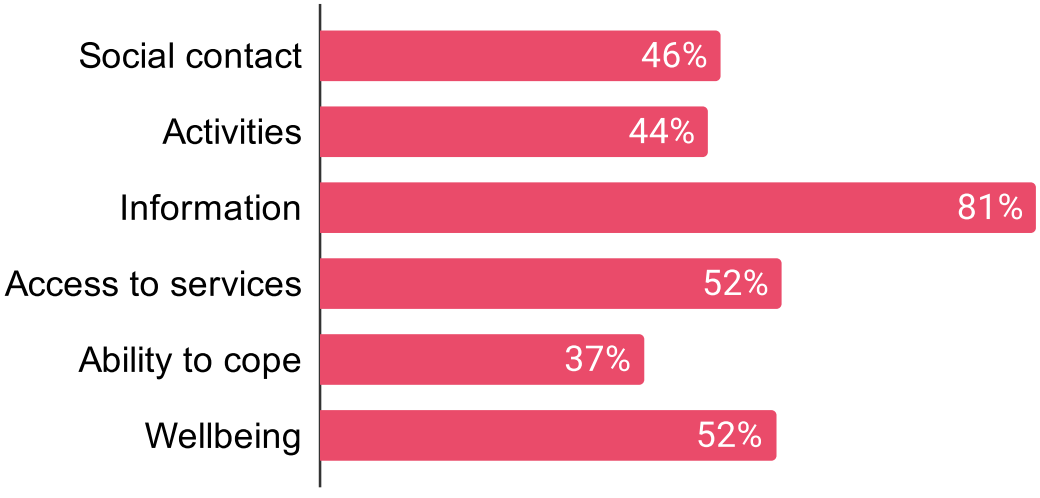
81%
felt better informed after meeting with a link worker

This allows us to provide person-centred support by tailoring our recommendations to the person's situation. It also enables the person to recognise and celebrate their achievements.

We ask about:

- how satisfied clients are with how much they socialise
- whether they use local services and facilities
- how well informed they feel about services available
- whether they get the support they need from formal services such as counselling, care or social work
- how able they feel to cope with their situation
- how they would describe their wellbeing.

The chart below shows the percentages of people surveyed who reported a positive change in each area by the end of our work.



Client satisfaction

After the first session and when the case is closed, we ask how useful people found the service:

88%

said they found the service useful or very useful

We offer to follow up with people a few months after closing their case. This is a good way to reassure people that the service is still there should they need support, but also gives us the opportunity to ask additional questions about their experience of the service:

88%

said they felt understood by their link worker

94%

said they would recommend the service to family or friends

“It’s made me feel a lot happier, I don’t feel so depressed as I was. They encouraged me to be more independent.”

Ray's story

Evicted from his home, Ray began to feel suicidal. As part of his support package, Ray's GP referred him to Together Co Social Prescribing. Here he was supported by staff to find the people and places that could help him get back on his feet.

When I was in temporary accommodation, I was in a very bad way. My doctor referred me to counselling because I was suicidal... I didn't know which way to turn.

Having no furniture and very little money was just terrible, I was sleeping on the floor until I eventually got myself an inflatable bed. But really that's not very suitable.

Together Co stepped in and were amazing. They put me in touch with the right people so I was able to get a furniture voucher from the council. I also gained attendance allowance and help with managing my finances.

I would never, ever have been able to do this on my own. Together Co know exactly the right people to approach. There must be hundreds of people like me who just don't learn how to deal with the system.

I'm so grateful that I found Together Co. I've been in permanent housing for almost 18 months, and have even joined some exercise classes.

I can't say I want for anything at the moment. My life has completely turned around.

Linda's story

Linda was struggling with feelings of isolation during lockdown, so her GP referred her to Together Co. She was matched with a befriender who called each week, and with a link worker from the Social Prescribing team who facilitated contact from services which were crucial in this difficult time.

Together Co were an absolute godsend for me. I was really struggling – particularly right at the start of lockdown when you couldn't really go outside or see anyone. But I was put in touch with a lovely gentleman and my link worker Jenny who were just wonderful to have around in such a challenging time – and with no judgement.

I was amazed at how quickly everything happened. Within only a few days of being referred I had a phone call, and Jenny put me in touch with several services that really helped me solve a lot of my problems in how I was feeling. I was so impressed by how resourceful and well-connected the team are.

I'm extremely grateful for the service, and the kindness and the support I received from Together Co.

Volunteer survey

We always welcome feedback from volunteers, whether at one-on-ones, team meetings or otherwise. However, it is also important to provide an anonymous platform for volunteers to share their thoughts about their role.

A recent survey shows that the majority of volunteers feel very positively about their role and the support provided by Together Co staff, as well as the quality of wider Together Co services and values.

When asked “What are the best things about volunteering at Together Co”, volunteers said:

> The best thing about Together Co are the link workers and other staff who support the volunteers. They make me feel like a valued part of a team.”

> Being able to have a positive impact on people's lives.”

> Excellent supervision and support from staff and coleagues. Feeling I have done the best I can for each client.”

> The sense of fulfillment. The welcoming and supportive team.”

> Feeling valued, working alongside lovely people and being able to learn from them. Knowing that I am working for a good cause and giving time to something that is important to me.”

Social Prescribing Plus

A three-year grant from the Department of Health and Social Care and Brighton and Hove CCG facilitated an expansion of the Social Prescribing service to offer specialist SP that aims to further tackle health inequalities in Brighton and Hove.

A partnership of five organisations is now offering social prescribing to people from harder to reach communities experiencing some of the worst predicted health outcomes locally and nationally.

Funding began in July 2018 and after a period of planning, recruitment and training, the first clients were supported in November 2018. The data on the next page represents the first fully operational year and the following review discusses the learning so far.

The five partners are all deploying dedicated social prescribers who utilise the SP infrastructure, model and tools and a variety of engagement approaches, before linking people with appropriate support services. The social prescribers include:

- a complex cases link worker at Together Co
- a transgender and non-binary link worker employed by LGBT Switchboard
- a BAME link worker at Trust for Developing Communities (TDC)
- language needs Bilingual Community Navigators (BCNs) — trained sessional workers via Sussex Interpreting Services (SIS)
- a specialist Gypsies, Roma and Travellers link worker employed by Friends, Families and Travellers (FFT).

Social Prescribing Plus continued

Headline figures from the Social Prescribing Plus partnership, in total and separated by partner:

Totals	Together Co	Trans Link	TDC	SIS	FFT
Referrals received: **431**	234	25	58	58	56
People supported: **389**	164	24	68	63	70
Sessions: **1,771**	528	56	265	498	424
Sessions per person: **4.6**	3.2	2.3	3.9	7.9	6.1
Average case length: **16 weeks**	10	36	20	26	16
Onward referrals: **925**	481	33	47	142	222
Aged over 65: **17%**	54	0	2	8	1

SP Plus review – the learning so far

Social prescribers across all the organisations received bespoke SP training from Together Co and use the same model and process, adapted to suit the needs of each client group.

SP Plus is a national trailblazer. We are not aware of any other scheme that has the infrastructure to reach out to such a broad range of equalities communities to provide a social prescribing service. Nationally, social prescribing is predominantly promoted via primary care referral, which relies on individuals having trust in and an ability to access primary care services with ease.

The cost savings for preventing crisis are well documented. The awareness that specialist social prescribing is an investment that will pay dividends not only for individuals, but within the whole health and social care system is less well researched and warrants further study at a regional and national level.

Making a lasting change for an individual within a marginalised community has a significantly expansive and long term impact not only for that person, but also for their family and wider community. It is not easy to quantify this 'ripple effect'. The growth of learning, awareness and trust fostered as a result of dedicated support and removal of obstacles in the way of access to services, at a local level, is demonstrated less in the data and more in the stories of SP Plus service users and the feedback and comments they share.

Key findings

- Overall and perhaps unsurprisingly, the SP Plus work has seen more complex needs and issues arising and it has been necessary to work with people more intensively and for longer.

- The success of specialist SP relies heavily on an existing infrastructure of services within the delivery organisations, e.g. the three tiers of support with SIS and the SP specialism and training available within Together Co. Providing a successful specialist SP service also relies on relationships between the organisations and the wider networks they are part of locally and nationally. Social value is the main key to SP Plus delivery.

- A shared identity between client and staff member is key to the success of most SP Plus roles.

- There is a need with these client groups in particular to work more flexibly to remove barriers to access and this sometimes means blurring the boundary between link work and advocacy.

- There is a lack of suitable referral pathways for these client groups due to their particular needs, e.g. lack of appropriate interpreting services is a barrier to accessing statutory and clinical services and poor demonstration of trans awareness within wider groups and services is a barrier to appropriate referral.

- Referrals for SP Plus rarely come from primary care. Most come from outreach and targeted promotion.

SP Plus review continued

- It is rarely possible to move onto activities that support quality of life if basic needs are not met first. Supporting clients to access healthcare and statutory services like housing, welfare benefits and healthcare are the key priorities, and these fundamental needs often had to be met before any conversation about social activity was possible.

- Although most SP Plus partners met their annual KPIs (100 people supported by Together Co and 50 per year for each of the other organisations), quantitative targets are less meaningful for these client groups and do not reflect the complexity or outcomes of the work. This is especially true for Trans Link where the higher level of complexity meant it was not possible to meet the annual target originally set.

- Distance travelled monitoring is not well received by SP Plus client groups and not helpful to them.

Appendix C provides a more detailed review under each of the specialist areas within SP Plus.

Learning from Covid

Evidence is now emerging about the increased pressure brought about by coronavirus. The UK is now officially in recession for the first time in 11 years and the furlough scheme is coming to an end in October. These factors look set to become the perfect storm for mental health deterioration, inequalities, unhealthy lifestyle choices and life struggles in general. A direct consequence is likely to be increased pressure on GPs and NHS services.

Locally, SP work has uncovered a significant gap in service provision related to food. The Covid lockdown has revealed that obtaining and/or preparing food was not only an issue related to the pandemic, but was a consistent significant problem for people with mobility problems and/or who are housebound. Adult Social Care thresholds mean that most of this group are not eligible for support and there was not a service available to meet their need. This was resulting in this group being unable to access fresh and healthy foods. Together Co and other local VCSE organisations are now working in partnership to continue providing shopping and food delivery services beyond lockdown.

Together Co Social Prescribing during the Covid lockdown

Overall, Together Co Social Prescribing supported 647 people during April-June 2020 which was a 280% increase on the same time the previous year.

Together Co Social Prescribing moved from a face to face service based within our offices to an entirely telephone based service working remotely within one week in late March 2020.

Working closely with the BHCC Community Hub Manager, we co-designed an assessment process and appropriate operational systems for referring and safeguarding. Daily meetings took place to establish safe and effective working practices.

Learning from Covid continued

Together Co redesigned their Guided Conversation assessment tool to include Covid specific questions and trained redeployed council staff working within ASC on how to use it effectively.

This enabled otherwise inexperienced staff to efficiently triage and pass on information when referring to other services, including SP.

In addition to this training session, Together Co developed and published online training that was made freely available to any organisation. This involved producing a range of written and recorded materials, and our operational leads running Q&A sessions.

PCN and Citywide SP link workers stepped up to take a huge number of referrals for people that were identified as vulnerable, either via the Community Hub or from the CEV (clinically extremely vulnerable) lists.

Clients' needs were assessed via telephone before helping them to access a range of services, both to reduce isolation and to support access to food/shopping. Providing this support prevented some clients from entering crisis, and strengthened relationships with ASC to promptly raise safeguarding concerns.

Additionally, with consent from clients, their GPs were contacted if there were health matters that needed to be addressed, further preventing decline in health and wellbeing.

Creative workarounds were found to offer appropriate and timely support, especially for people who: live in poverty; do not have bank accounts; use key cards for their utilities; have no internet access; and those who had recently been evicted from their homes with no access to alternative accommodation.

Learning from Covid continued

In addition to the Community Hub referrals, the SP team kept in regular contact with all existing clients that wished to have a phone call.

There was a significant increase in anxiety and mental ill health amongst SP clients during the Covid lockdown and working with people more regularly and for longer gave reassurance and prevented further escalation. Without this support, these clients would likely have shown up elsewhere in the health and social care system, possibly in crisis.

Together Co are continuing to work with GP surgeries and PCNs to ensure the right support is offered to patients on the CEV lists.

Although the crisis phase of Covid was at times overwhelming for Together Co, it showed us that the skills, experience and dedication of our front line staff, along with the usual systems we use, are well aligned to being part of a citywide crisis response team.

SP Plus during Covid

The available SP infrastructure that was developed as part of SP Plus lent itself well for repurposing support during Covid, not only to ensure access to appropriate services but also to outreach into communities where Covid support and messaging could not effectively reach through statutory channels.

All services were able to quickly adapt to working remotely and still provide an effective SP service to their current cohort of clients, alongside additional Covid-related support.

- **Together Co** worked with an additional 473 Covid-related clients via community hub referrals for a range of access needs and providing food-related support via other referral routes.
- **Switchboard** worked with an additional 24 people managing complex cases, providing peer support sessions over Zoom, increasing support via their helpline and providing health promotion information.
- **TDC** supported an additional 96 clients via regular check in calls, removing blocks to accessing statutory services, supporting via online community groups and sharing health information.
- **SIS** supported an additional 77 clients and trained seven new BCNs to conduct regular wellbeing telephone calls and to remove blocks to accessing services. They also conducted research to source Covid information for the full range of languages and published this via the SIS website and Facebook pages, and worked extensively with CCG commissioners to help GPs become more accessible by using SIS rather than a national provider for telephone interpreting.
- **FFT** supported 15 new clients to access support and for their vulnerable community members to be registered on the government website. They actively supported GRT roadsiders in Brighton to access basic facilities such as water, sanitation and refuse collections. FFT also linked with hot food deliveries in East Sussex to ensure that GRT were included in grocery supply chains and delivery of hot food parcels as appropriate.

Current work and developments

PCN link workers

Together Co have been hosting five link workers across three of the six PCNs in the City since April 2020.

Despite the Covid lockdown preventing link workers from working face to face within surgeries, the team have still been able to support patients remotely during the pandemic, especially those on the clinically extremely vulnerable list.

Together Co adapted their bespoke face to face training into online Zoom sessions and matched new link workers with experienced members of the team to train and induct them remotely and they were all ready and able to work with patients within the target of a month from joining the team.

Together Co's senior team are immensely proud of the commitment and tenacity shown by all the new staff that began their roles remotely. For roles that rely on connections and relationship building, this was not an easy task and they all rose to the challenge positively.

Work to embed PCN link workers more fully into surgery teams is still understandably challenging at the time of writing (August 2020) and the team are developing creative and diverse ways to communicate with GPs and surgeries to ensure referrals to their link workers are made.

Social Prescribing referral hub

Since April 2020, Together Co opened its services to receive referrals from any individual or agency through the Social Prescribing Hub. This means that people needing an SP service can refer themselves, and agencies working with individuals that need support can refer to Together Co.

We continue to publicise this expansion via outreach to groups and presentations to agencies as well as via established community networks in Brighton and Hove.

Brighton and Hove SP Providers network

Together Co convenes this local network that meets quarterly, bringing together all organisations providing specialist, medium, and holistic link work in the city to share updates, good practice and learning.

There are currently 19 member organisations, including BHCC Healthy Lifestyles team; B&H Libraries; Brighton Housing Trust; Carers Hub; Southdown Community Roots; Community Works; East Sussex Fire & Rescue Service; Elder Abuse Recovery Service; Friends, Families and Travellers; Robin Hood Health; Impact Initiatives; LGBT Switchboard; Possability People; Sussex Interpreting Services; Trust for Developing Communities; Voices in Exile; Wellsbourne Healthcare CIC; and YMCA.

The network is currently collaborating on a position statement on gaps in services with the aim of informing commissioning and service development going forward.

Local partnerships

The Together Co SP team continue to attend a steering group for SP in Brighton and Hove, hosted by B&H CCG in partnership.

Link workers attend Multi Disciplinary Teams (MDTs) within PCNs and the Head of Social Prescribing represents SP work on the citywide MDT Development Group.

SP staff also attend a range of other networks in the city to participate in citywide service development and ensure SP clients' needs are represented, including Community Works networks, the Single Point of Contact network, Digital Brighton and Hove, Advice Matters, Mental Health Sector connector forum, Green Wellbeing Alliance and various neighbourhood networks.

As well as Brighton and Hove networks, Together Co SP staff also attend meetings and conferences held by the South East SP Network and the more informal Sussex SP network that brings together SP providers from East and West Sussex.

National networks

Together Co are an active member of the National SP Network, attending conferences and taking part in discussions and consultations.

Alongside this, the NHS Collaborative Forum and Social Prescribing Hour forums provide an opportunity to share news and updates.

Together Co are also members of the National Association of Link Workers, who created a link workers day to bring together providers across the UK.

Additionally, the Head of Social Prescribing convenes an informal network of the 23 Health and Wellbeing Fund VCSE providers nationally, to share good practice and information pertaining to the fund.

Monitoring and reporting

The SP Team is currently in the process of investigating options for a more suitable data collection and reporting system going forward. The intention is to provide even more robust evidence as well as decrease data burden on the team by reducing the amount of staff and volunteer time spent inputting and retrieving client and service data.

National debate on suitable validated tools for SP continues. Although national guidance promotes the use of the four ONS Wellbeing questions and the Patient Activation Measure, evidence from providers suggests these tools are either unpopular with clients or ineffective at measuring progress of SP, which is also reflected in the recent National Voices report commissioned by NHSE. To date, there is yet to be a suitable distance travelled monitoring tool that meets the specific needs and appropriately captures the unique work of social prescribing.

For now, Together Co continues to use our bespoke SP monitoring tool that is person centred and embedded into the assessment and review conversations link workers have with patients, until an appropriate and validated tool that is agreed upon nationally is made available.

Local context

Social prescribing in Brighton and Hove continues to see people who are experiencing difficult and complex lives; and social isolation and poor mental health present as significant problems in the city.

There is increasing job insecurity, growing financial hardship and housing issues, which are on the rise following Covid. Claimants are facing difficulties being accepted for and receiving benefits and there are many uncertainties and insecurities created by the economic outlook and political landscape.

Many people are living with multiple long-term health conditions. This can drastically affect their ability to lead connected and fulfilling lives without support to access the right services.

Person-centred sessions with link workers are uncovering more substantial underlying mental health issues than ever, including some people who are unable to engage with social prescribing or with ongoing community services.

The availability and level of statutory mental health support in the city affects a significant number of social prescribing clients with many falling through the gaps between primary and secondary mental health care. Link workers across the city are in a unique position to see the impact of issues in mental health support, and the SP Network and Community Works are bringing together our experience and evidence on this issue to feed into city-wide strategic planning.

National context

Social prescribing (SP) continues to grow nationally and internationally, both in numbers of schemes and in awareness of its potential to help address the social determinants of ill health. The Secretary of State for Health and Social Care has stated that social prescribing forms a core part of the thinking around prevention and personalisation, and has pledged to support expansion of SP nationally.

In January 2019, NHS England announced in its Five Year Forward View that Primary Care Networks (PCNs) would be formally developed, with each having at least one link worker by April 2020. This work commenced in July 2019, with the formation of the first PCNs.

In September 2020, a report by National Voices, commissioned by NHSE, outlined a number of issues and recommendations for social prescribing going forward. The report authors interviewed Together Co CEO and Head of Social Prescribing as part of their research and profiles the work as an example of good practice in citywide collaboration.[1]

The report details some concerns relating directly to the NHS rollout and recruitment of link workers:

- The funding and management arrangements, role descriptions and performance expectations that are being put in place for new link workers.
- The measures being used to assess the outcomes of social prescribing.

[1] https://www.nationalvoices.org.uk/sites/default/files/public/publications/rolling_out_social_prescribing_-_september_2020_final.pdf

National context continued

Other concerns include structural issues underpinning successful social prescribing:

- The need for funding to help the VCSE sector meet increased demand.
- The need to ensure that social prescribing actively tackles inequality.
- The need to invest in relationships and support ongoing collaboration and partnership.

The main recommendations include the following:

- Revise the guidance on social prescribing roles in relation to caseloads, and the need to create capacity for community building.
- Make it explicit that the default is to recruit link workers via the VCSE sector.
- Revise funding arrangements to enable responsiveness to both individual and population health needs.
- Clarify guidance on social prescribing measurement.
- Develop solutions to ensure appropriate funding flows to the VCSE sector to support social prescribing activity.
- Provide additional funding and guidance to support social prescribing in addressing health inequalities.
- Put the right infrastructure and resources in place to enable collaboration.

National context continued

The National Voices report states in its conclusion:

“Social prescribing has its roots in the VCSE sector, and in the insight that most of what matters for our health and wellbeing happens in our daily lives, not in clinical settings. As such, it is a vital element of personalised care, enabling people to take an active role in their own care and helping them to do the things they want and need.”

Together Co fully supports these recommendations and conclusions and is committed to further developing the relationships and good practice established over the past 6 years of delivering social prescribing in Brighton and Hove.

Appendix A

Referrals declined

918 referrals were received and 833 people were supported. 130 of those supported were referred in the previous year.

23% (n=215) referrals did not access support from Together Co in 2019-20:

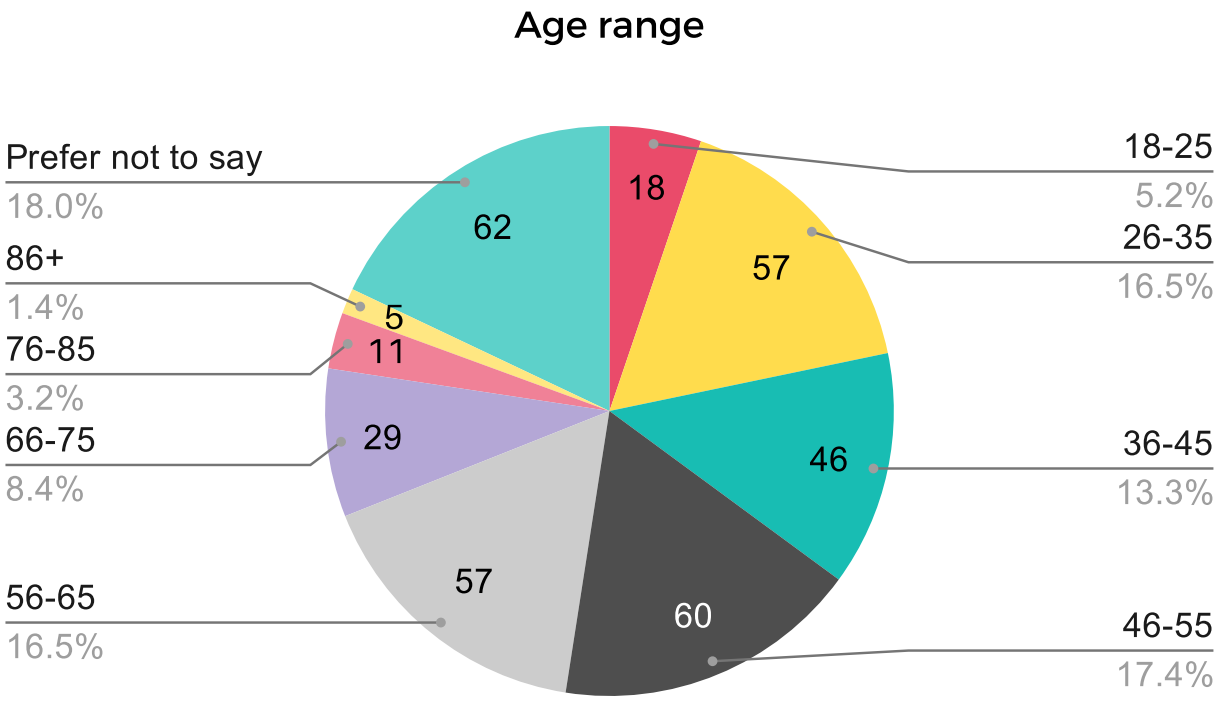
- **11% (n=102)** referrals were declined by the client (uncontactable, unable to engage for health reasons, or told us they didn't need the service).
- **7.6% (n=70)** were inappropriate referrals. These were sometimes sent onto Adult Social Care or recommended for secondary mental health support.
- **2% (n=17)** were referred in March 2020 and contacted in April, so will be represented in 2020-21 figures.
- **1.6% (n=15)** were referred for specialist support from one of our Social Prescribing Plus partners instead of Together Co.
- **1% (11)** were existing clients.

Appendix B

Demographics

The following information was gathered by Together Co and our SP Plus partners using an optional equalities monitoring form.

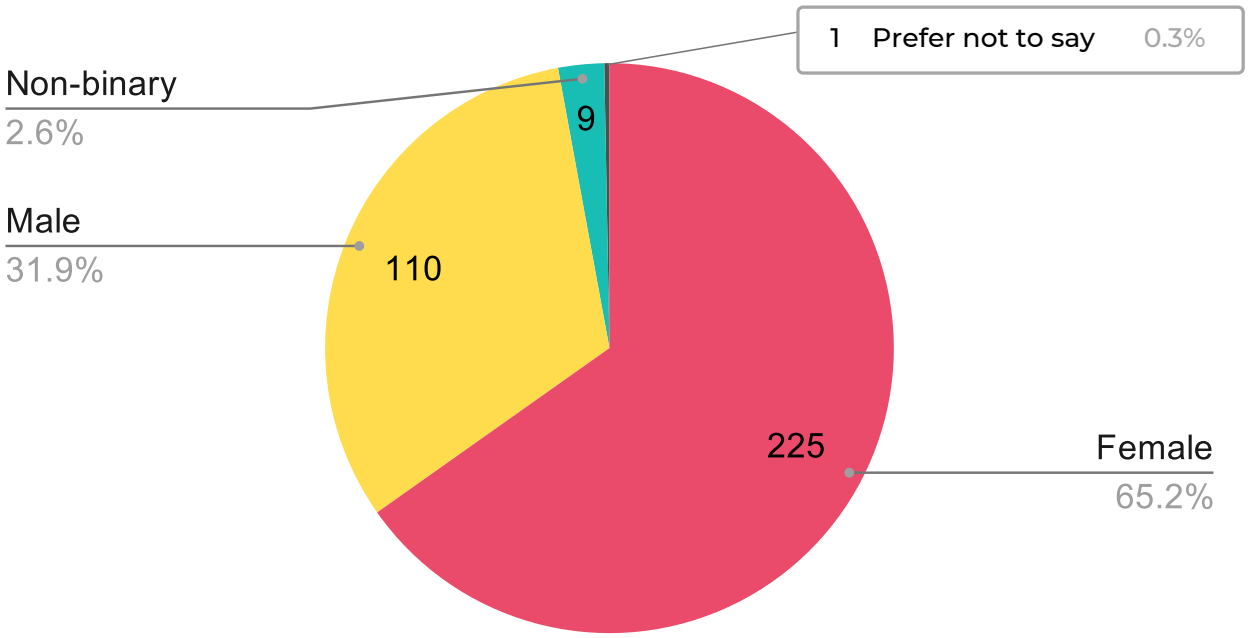
The form was completed by 345 (33%) people in 2019-20. Clients are able to skip questions as they wish.



The % aged over 65 earlier in this report is based on client dates of birth, so it is different to the figures presented here as not all clients complete this form.

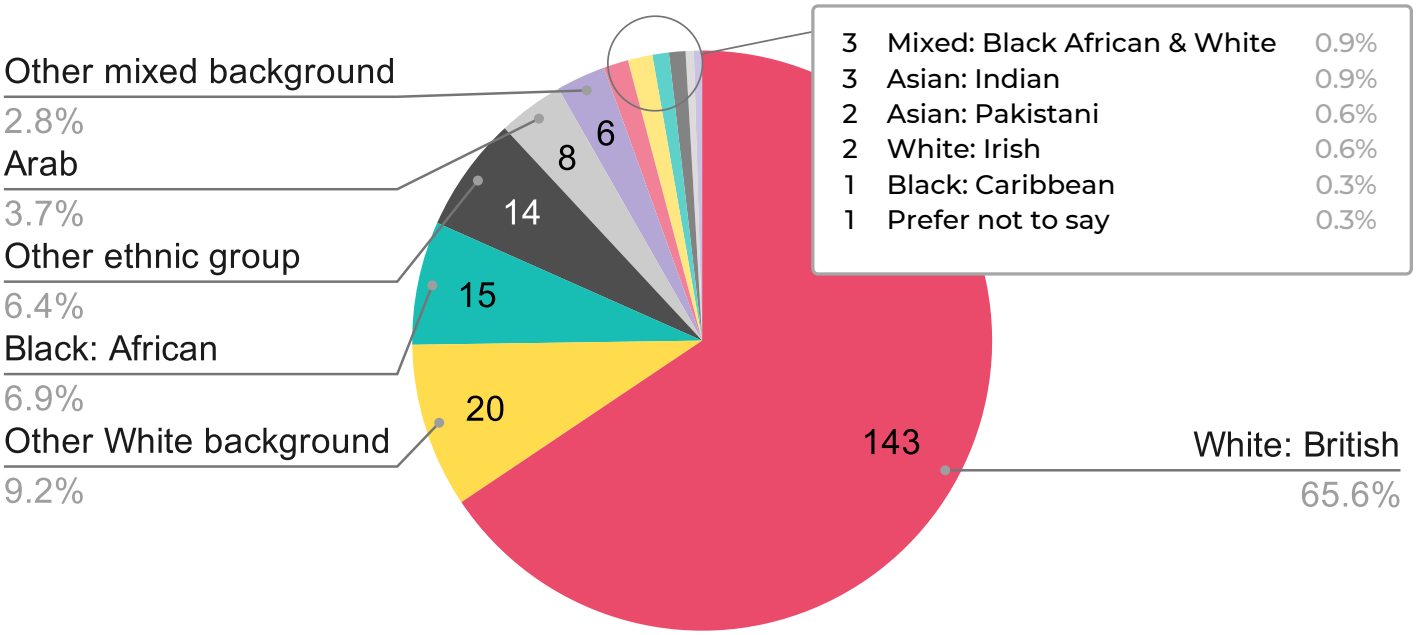
Appendix B – Demographics

Gender



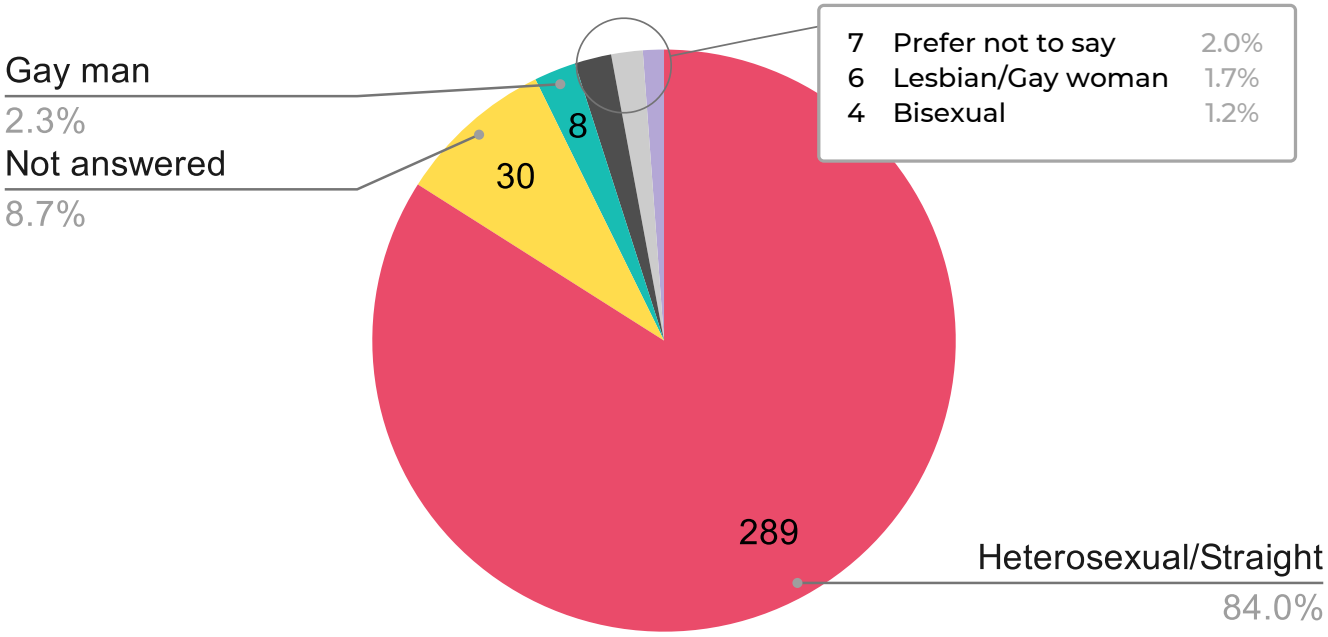
Clients were also asked whether they identify with the gender they were assigned at birth. 87% (n=301) said yes, 7% (n=25) said no, and 5% (n=19) preferred not to answer the question.

Ethnicity

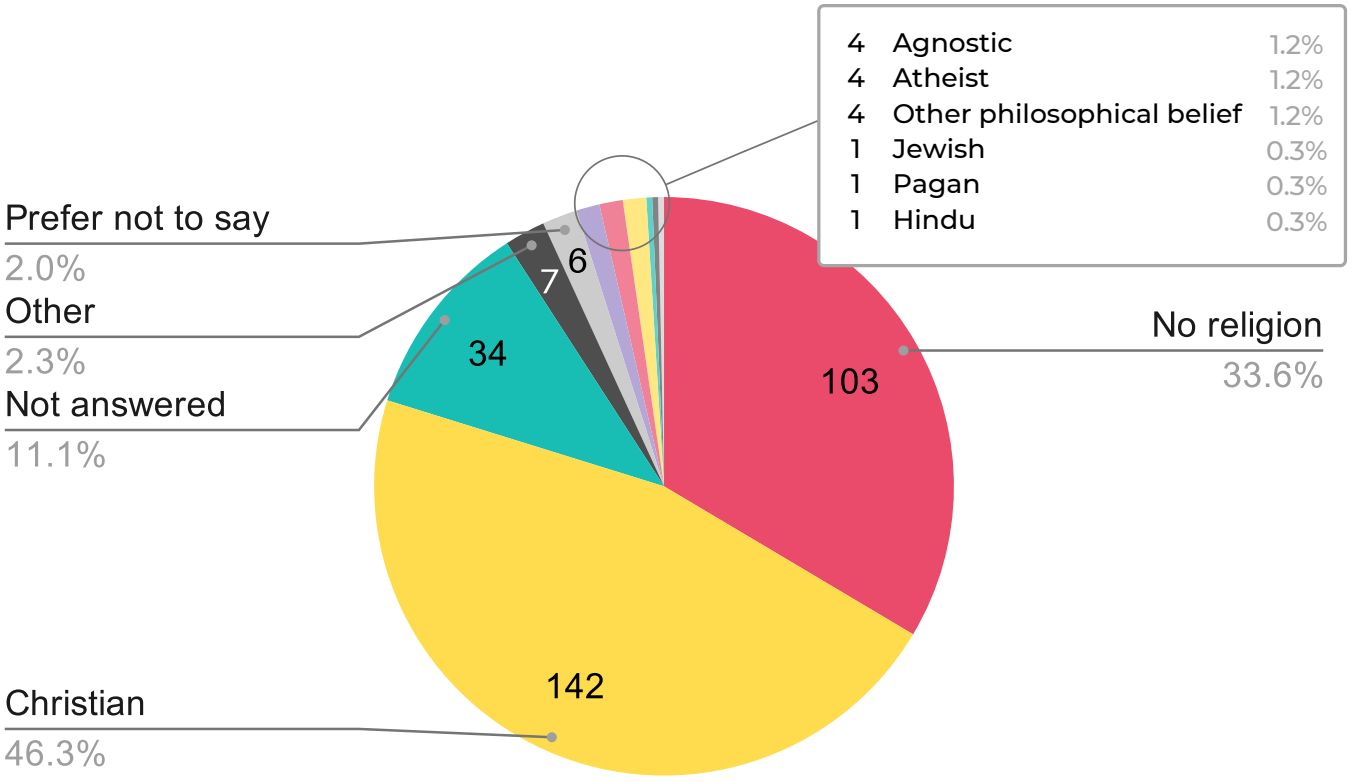


Other backgrounds written in were: *Iranian, Egyptian, Bulgarian, Hungarian, Italian, Portuguese, Black Caribbean/Mixed/White English, White Middle Eastern, Arab/White, English/French/German, Japanese/European, Algerian, Afghani, Mediterranean, Egyptian/Spanish/German/Turkish, Sri Lankan, Kurdish from Iraq, Kurdish from Iran, Guinean, Brazilian, Latin American, Brazilian/Spanish, Moroccan, Egyptian, Sudanese, Polish, Spanish.*

Sexual orientation



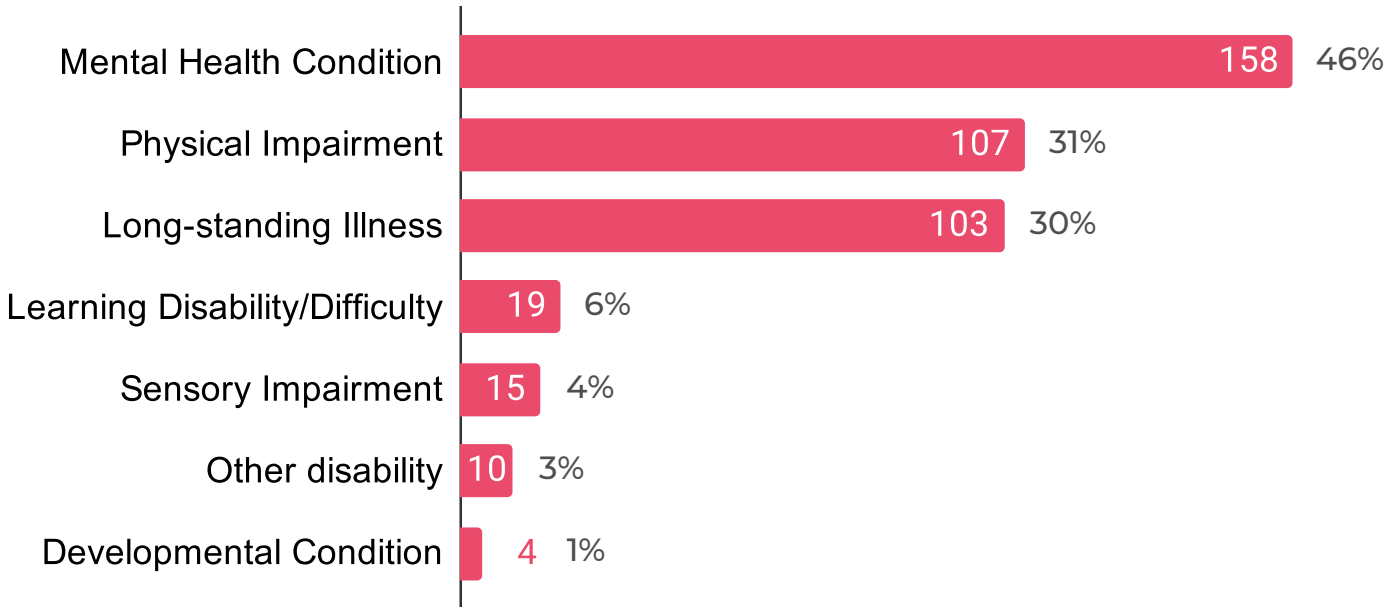
Religion or belief



Other religions or beliefs written in were: *Spiritualist, Jedi, Christian spiritualist, Moderate Muslim, Circle of life/re-incarnation, Catholic, Pantheist, Bit of everything.*

Disabilities and impairments

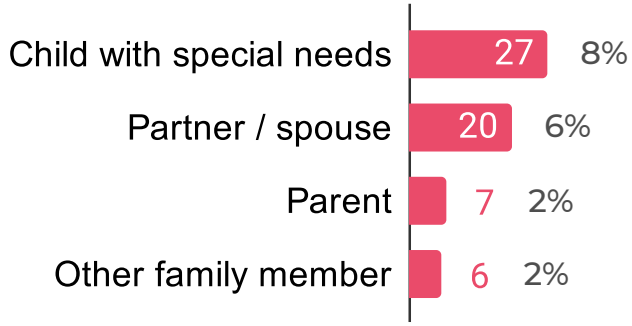
67% (n=232) clients said their day-to-day activities are limited by a disability or impairment. They were given the option to specify the type of impairment.



Other disabilities or impairments written in were: *Age related, Agoraphobia, Anxiety, Autistic, Back pain, Dyslexia, Fahr's Disease, Neurological condition, Other, Prefer not to say.*

Carer responsibilities

17% (n=60) identified themselves as a carer. They were given the option to specify who they care for.



Appendix C

SP Plus specialist link work review

Together Co – Complex social prescribing

Together Co's SP Plus work focuses on complex cases, taking referrals from a range of agencies including Adult Social Care (ASC) and CareLink Plus.

An existing Together Co link worker with a social work qualification was seconded to the SP Plus project to work with this client group. An adapted referral system was established. To avoid social workers having to duplicate information, an ASC initial assessment was sent to Together Co, with client's consent, by way of referral.

The quality and appropriateness of referrals relies mainly on the relationships and communication channels between services. ASC and Together Co operational managers established clear channels from the outset, which ensured a steady stream of referrals, and it has been essential to invest energy into maintaining and growing these relationships.

The high turnover of Access Point staff was at times a barrier as new staff coming in tended to send referrals beyond the scope of SP. This is not uncommon when there is a change of personnel and happens also in primary care. In this case, the link worker responded by upskilling social workers on appropriate use of the service.

Some systems were established to mitigate this, e.g. attendance at ASC staff team meetings to present on who and how to refer to SP Plus. In busy times and with changing staff in ASC, it has at times been difficult to sustain these systems of direct communications.

The majority of cases referred from Adult Social Care and CareLink Plus were for crisis prevention. This group does not meet the threshold of support for social care but are nonetheless vulnerable and unable to access services or navigate the healthcare system by themselves. Mental ill health is prevalent in this group.

The link worker had to take extra care with this group during assessment. Due to the complexity of issues it was not always possible to assess a client's needs in one appointment and more time was needed for a full picture of need to arise.

Access to services, e.g. housing, benefits and mental health required more facilitation than is usual across the rest of the SP service because a more thorough explanation of client needs was required and more reassurance was needed by clients to encourage them to take up the services they needed.

A cross referral route was also established so that safeguarding concerns could be more quickly escalated. This enabled the link worker to avoid back and forth referral and time delays, which are a frequent occurrence when clients fall in the gap between thresholds of support.

The project benefits from being part of a larger infrastructure at Together Co. The link worker is part of a wider team of citywide link workers in an organisation that has been delivering a social prescribing service for several years and also delivers a large befriending service. The SP Plus project also benefits from the expertise Together Co has in terms of developing services, including Social Prescribing, at a strategic level. In particular, ensuring links are made between services across a range of public sector agencies, with the emerging PCN and ICS structures, and linking in to national policy conversations about tackling health inequalities, loneliness and social isolation.

"I feel very comfortable talking to you. I think it is very helpful for me to be able to articulate what is going on for me. I think if someone did not understand you they would not understand anyone."
— Together Co SP Plus client

LGBT Switchboard – Trans Link

Cases have been more complex than expected, veering close to advocacy or needing more mental health support. There has been close working and cross referral with the trans advocacy worker in MindOut, but they do not have the capacity to meet demand, so the Trans Link worker needed to oversee some of the more complex issues.

It has been difficult to find suitable places to refer people onto, particularly for the softer wellbeing referrals like gardening groups, choirs and social activity. If people are struggling with their trans identity or experiencing transphobia, it is not always possible to know that those groups or services are going to be accepting and welcoming, which presents a barrier. When good relationships are being established between the link worker and client and progress is being made, making a potentially poor referral is not worth the risk of complete disengagement with the service. E.g. it is not always possible to know which women's spaces are genuinely inclusive.

Provision of training for all kinds of organisations across the city on trans awareness is needed. Although LGBT Switchboard can provide this, it is difficult to identify a need and encourage organisations to adopt training when there is an associated cost.

Sometimes the link worker is not able to refer onto activities due to the client having complex mental and emotional health-related concerns that need addressing first. Some clients need an ally and feel they want an ongoing relationship with the link worker. When this happens, Switchboard refer onto other trans and non-binary services, and activities with social activities provided so that clients can establish a support network. Referrals are also made via services with one to one workers that can engage directly, e.g. smoking cessation, weight management, healthy eating.

Appendix C — SP Plus specialist link work review

Outreach and sending out communications via social media elicits more referrals in the immediate term but this activity has to be regular and ongoing. Referring from other groups within the organisation and between other LGBTQ+ organisations also works well, e.g. via the disability project, MindOut, Clare Project.

For this client group, the distance travelled monitoring questions are difficult to ask sometimes, especially at the first appointment. This needs further exploration and possible flexing of monitoring tools.

Feedback from clients suggests that accessing the SP Plus service has been of huge benefit and that they needed that person there to help them feel safe and grounded. A key aspect of the project's success is having a worker with lived experience which matches the client group. People come because they know it's a safe space and they are understood.

At the same time, this is a difficult job for someone from the trans community to do. It can be upsetting to support people that may have had similar stories, or coming with difficult situations related to their identities that the worker found traumatic when transitioning themselves. This increases staff turnover and management support needed. Trans clients often have quite complex MH needs and where there is a long waiting list or the service is not adequate for a trans person, that can be difficult for both clients and staff. Clinical supervision is essential.

Regarding appropriateness of KPIs, some are longer, more complex cases and, similar to TDC, push the boundaries of social prescribing into advocacy, especially concerning mental health, housing and employment needs. Switchboard is well placed to provide this as a service as clients want to access a trusted organisation that actively outreaches into the community. Due to the complexity of cases and staff turnover, Switchboard supported half their target number of cases.

Appendix C — SP Plus specialist link work review

Switchboard was beginning to take referrals through the Mill View inclusion award. This has been delayed due to Covid but there are hopes this will continue again.

One of the things that has fostered growth in success is the community infrastructure. Other partner organisations and in-house projects have grown alongside the dedicated trans link work, e.g. Switchboard hosted a Clare Project worker while that organisation grew and there is a trans advocacy worker now in place in MindOut. Having more specialist roles in the city means support is more visible and connected.

“The Link Worker is kind and friendly. They have given me invaluable help and support around my mental health during these difficult times.” — Trans Link client

Trust for Developing Communities – BAME link work

There are very few referrals from GPs and other providers, so outreach is a much larger part of the project than expected. This could potentially be improved through developing the likelihood of referrals from the current Locally Commissioned Service offering Holistic Checks to people from BAME communities.

Link workers have needed to do more advocacy than social prescribing work due to the complexity of cases and barriers to accessing services, especially regarding language issues. There have been numerous cases where a client was referred onto a support service and then referred back to TDC to access interpreting services, rather than linking with SIS directly.

Language support is often needed and TDC is very clear that link workers don't provide interpreting during appointments and use trained interpreters instead, but this has meant support for clients takes much longer, especially where they are referred back from services that should have accessed the interpreting service directly.

That said, it has been helpful to have specialist SP link workers that speak specific languages as the shared identity helps build trust, e.g. where a school were not able to support regarding attendance at an early help safeguarding meeting, the link worker was able to get the client to attend because they had established trust.

Often, BAME clients have poor previous experiences of local authority and social housing services which leads to low expectations, anger and frustration. Expressing this can create an ongoing loop of lacking support and adds a further barrier to access. Some of the work TDC has been doing involves smoothing out frustrations and advocating where needed, in order to break the loop of unequal access.

It has been particularly challenging to access support with housing,

money and debt advice through the usual channels. This provides a further barrier to accessing groups and activities. It is rarely possible to move onto activities that support quality of life if basic needs are not met first. Emergency housing can often take clients out of Brighton and Hove, which then makes it more difficult for a link worker to provide effective support.

TDC have sometimes needed to provide support with access to clinical care, e.g. a client who needs hospital operation but was too scared to go, receiving support to access the hospital. The link worker phoned the client just before arriving at hospital to provide reassurance and ensure she got to her appointment.

More management time is needed to oversee each case. Complex cases are discussed in staff supervision and during catch up meetings but this does not give a clear overview of every case, considering the complexity involved. Support is offered via peer meetings between workers and via clinical supervision at which managers are not present.

The diversity of contact time means that KPI targets may be less meaningful for BAME link work as clients tend to need either signposting or, in most cases, longer term support that edges on advocacy/case work. Often the whole family becomes involved as it becomes clear the issue is not only with the person being referred.

The project has benefited from TDC infrastructure, with cross-referrals within TDC being particularly useful, especially via their ESOL, Community Roots and MESH work. The project has been enormously successful, growing by word of mouth rather than from referrals. Clients are telling people they know that SP Plus provides genuine support.

“I was pleased to talk to the link worker and discuss my issues. This is a new country and culture and I did not know about the help I could get. I now have someone to ask if I am lost.”
— TDC SP Plus client

Sussex Interpreting Services – Bilingual Community Navigation

Bilingual Community Navigators (BCNs) are sessional interpreters at Sussex Interpreting Services who also work as social prescribers.

Cultural understanding can represent as much of a barrier to access as language. Even clients who have good English don't necessarily understand the systems in place or the subtleties of power dynamics, non-verbal communication and cultural differences. Belonging to the communities they are supporting, BCNs are ideally placed to support migrants. Shared lived experience facilitates building rapport and engenders trust between clients and the services they go on to access.

SIS receive mostly self-referrals resulting from internal advertising (mailings, social media, website) and word of mouth. Referrals from SIS linguists and staff are also helpful. There is a small but steady stream of referrals from GP practices (via Together Co) and other service providers that are made aware of BCN by interpreters.

Liaison work to support onward referral is intensive and time consuming because the language barrier usually precludes direct contact between the client and service.Additional support to foster learning is often needed. There is a lack of understanding of what, why and how a particular service can help and information has to be reiterated frequently.

BCNs attempting to support their clients are often passed around departments, particularly within the NHS and BHCC, to try and find the right person to help with a particular issue. It is necessary to introduce the BCN role to individual workers in these agencies to promote the service within a range of departments.

SIS photography by Howard Davies

Appendix C — SP Plus specialist link work review

BCNs observe that charity-based services are usually helpful and accommodating and the CCG discretionary grant for VCS interpreting bookings is essential for ensuring language support is available. However, this is not available to statutory services. Frequently, having requested an interpreter and double checked that one is being booked, a client would attend an appointment with no interpreter. This is most common in NHS and BHCC and it is often difficult to find out why. Some BHCC staff openly admit they are trying to save money. Developing relationships between Bilingual Community Navigators and key individuals in statutory agencies has helped smooth referral processes and facilitate easier access to support in some cases.

Clients vary enormously in the amount they will engage with the suggested 'quality of life' activities and services despite the use of motivational interviewing techniques. Basic life needs (e.g. housing, immigration, financial security, food) have to be resolved first. Physical and mental health concerns are often a barrier to engaging with activities.

Closing a case for people with language needs can be very difficult. Language barriers often mean there is an ongoing flow of issues that the individual needs help with regarding understanding correspondence, understanding public information and accessing services, even when the big issues have been resolved.

SIS discourages BCNs from attending appointments with their client in favour of encouraging the client to self-advocate with the use of a different interpreter. The driving factors for this are:

- avoiding BCN being drawn too far into advocacy
- empowering clients to take control where they can
- cost saving for SP Plus to enable more clients to be supported.

Although this approach can occasionally cause frustrations, with information having to be relayed, it also fosters client learning and improves resilience. Where advocacy is assessed as a need, SIS can provide this as an additional service.

The SP Plus project benefits from SIS infrastructure. SIS also has a volunteer drop in and an advocacy project. Together, these three projects function as tiered support. A volunteer can resolve simple enquiries and provide signposting via a drop in and refer to a BCN for issues that need more support. A BCN can then see the person up to the point they need advocacy, then the advocate takes over. Most of the trained BCNs are also advocates, so there is an ability to refer to a different part of SIS, whilst keeping a consistency of service.

The SP Plus project relies on volunteer linguists at the fortnightly drop in service for triage and signposting support. Clients that need a BCN will be less likely to be identified if this does not continue. The funding for volunteer linguists ended in March 2020. A Covid grant enabled this to continue short term but there are concerns about longer term effectiveness of bilingual community navigation. If volunteer linguists are not funded, BCN and advocacy delivery is less effective.

SIS have consistently met or exceeded KPI targets and their ability to support clients via other projects within the organisation offers additional value.

"I felt so proud when I heard community members talking about the SP Plus service amongst themselves and saying how amazing it was."
— SIS Bilingual Community Navigator

Friends, Families and Travellers – Gypsy, Roma and Traveller link work

Friends, Families and Travellers (FFT) have few referrals from outside the organisation, so a majority of the work has come from assertive outreach and self-referral through the dedicated national support helpline, then fed into their outreach meetings for allocation of a link worker.

There is some crossover between FFT specialist link work and advocacy. In response, they designed a system to refer into their other projects, to ensure clear boundaries between each of their other roles and responsibilities. This means the client only has to tell their story once and will always have the SP Plus link worker as their key contact to ensure continuity.

The specialist link worker role works especially well for GRT as many people have historical and current difficulties accessing statutory and third sector services. Having a trusted individual present at initial meetings, providing phone support and organising appointments gives an air of authority and permission, which has reduced stigma and fear of exclusion.

FFT finds that most cases are complex cases and very few are short. This is due to literacy, health literacy, discrimination (historic and present), lack of confidence and understanding, low expectations and stoicism.

FFT needed to adapt the wellbeing web (the client outcomes scoring) by explaining it in a culturally meaningful way, often referring to scenarios as a prompt. Clients continue to be reluctant to give indications and scores at the end of the engagement. At the end of the process, reminding the person of their original scores helps the process, otherwise they would invariably say ‘put me down for what you think’. Client outcomes scoring requires pressing people via telephone, often calling multiple times.

This task is usually left to volunteers who have become adept in supporting this part of the process. It is useful to FFT as an organisation as an indicator of distance travelled, but is not useful to clients.

GRT community members who have used the SP Plus service have all expressed that they find the shared identity and culture of the FFT staff a key reason for the programme's success. The experience of the staff and their ability to navigate a complicated system of support has resulted in GRT getting the services which had been previously unreachable to them.

There are huge gaps in appropriate onward referral pathways for this client group, particularly regarding mental health support. Long waiting lists and a significant proportion of this client group being digitally excluded are key factors in preventing access to support. Referring into their own frontline services, particularly around health improvement and specific housing and benefits casework is often more effective.

FFT consistently meet and exceed their KPIs and do not operate a waiting list but rather soak up the additional work by employing a whole team approach, which offers additional value.

"Thank you very much you have been the constant in my life and I felt very supported." — FFT SP Plus client

Solutions/recommendations

- Together Co and our B&H SP Providers network have identified a lack of suitable referral pathways and are **developing a position statement to inform commissioning and service provision.**

- To increase access and support reduction in health inequality, there needs to be a more systematic approach to providing **equalities training for all service providers** (especially statutory but also VCS) on issues faced by SP Plus communities and their barriers/solutions to access. This needs to be additionally funded and should be provided by those with expertise in working with these specific communities.

- SP Plus work is made possible by the existing infrastructure within and between the delivery organisations. Where reductions in other funding streams threaten the effectiveness of the work, there needs to be a **commitment to systematically funding with a broader lens** e.g. volunteer linguists, GRT health promotion work, trans advocacy and citywide link work are all essential components of the system that makes SP Plus a success.

- **Specialist SP work is more complex**, working with people more intensively and for longer. **This needs to be reflected in the funding and in the KPIs.**

- The use of **distance travelled monitoring tools** is not necessarily helpful for vulnerable groups and can be a barrier to participation. This points to a question around “how much evidence is enough?”; is there enough evidence nationally that we do not need to measure the success of every client? What does an appropriate, proportionate, person-centred client outcome measure look like? **This needs addressing when commissioning SP Plus services, and indeed SP services in general.** National guidance is the subject of much debate and there is not yet an appropriate and effective SP outcomes tool available.

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