



An exploration of co-commissioning approaches to social prescribing services

A Bromley by Bow Centre study commissioned by the Greater London Authority with the intention of supporting the development, growth, and commissioning, of social prescribing in London

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Introduction

This short study was undertaken in late 2018 and early 2019 by Jo Goodman of Bromley by Bow Insights at the Bromley by Bow Centre and commissioned by the Greater London Authority with the intention of supporting the development, growth, and commissioning, of social prescribing in London. Social prescribing has developed across London and the rest of the UK over the past 20 years and a wide range of models have occurred. Most commonly this has involved local authorities (particularly public health) and Clinical Commissioning Groups (CCGs) being commissioners of services and other local parties including the voluntary sector, other statutory services and local residents and communities themselves being involved in shaping and delivering services.

This report comes at a time when the NHS and local government representatives are thinking increasingly about how they can best work together to meet the increasingly complex needs of their populations. The NHS Long Term Plan and the increasing emphasis on population health encourages greater collaboration and integration between local authorities and CCGs including pooling of budgets and sharing of responsibilities through Integrated Care Systems (2019, 1.5). The Local Government Association (LGA) has also advocated for a more collaborative, place-based approach to population health (2018). Social prescribing now finds itself as a central pillar of these new approaches, as well as more recently being brought into wider initiatives around personalised care.

This report aims to look at how co-commissioning approaches can contribute to the development and growth of social prescribing:

- What can co-commissioning and collaborative approaches look like?
- What are the benefits of local authorities and CCGs co-commissioning social prescribing services?
- What are the conditions and enablers for collaboration and co-commissioning?
- What are the common challenges for collaboration and co-commissioning?

It is hoped that this study will help to inform and encourage increased collaborative working around social prescribing and its connected agendas both in London and beyond.

Methodology

During the course of this research, the Bromley by Bow Centre team have conducted 8 semi-structured telephone interviews with a range of participants from CCGs, local authorities as well as the voluntary and community sector (VCS) who are involved in the design and delivery of the schemes. All participants were involved in either co-commissioned social prescribing schemes or schemes where there is some element of collaboration between the local authority and CCG, often along with other key local partners. Participants were identified through existing networks as well as recommendations of other participants and involved parties i.e. snowball sampling. In total five schemes were based in London and three were based outside London.

In addition to these interviews, the team also met with sector representatives from the GLA and NHS England to identify potential participants and sense check the approach.

We also scoped relevant policy documents and journal articles that we will refer to throughout.

The schemes included in the report, with thanks for their involvement are:

- City and Hackney
- Greater Manchester
- Merton
- Redbridge
- Rotherham
- Shropshire
- Tower Hamlets
- Waltham Forest

Please note that quotes have not been attributed to maintain anonymity of respondents.

A note on language

Differing terminologies and languages used by local authorities and CCGs, emerged as a theme early on in the study. e.g. social prescribers vs. link workers, patients vs. clients/service users/residents. This demonstrates the different perspectives that local authorities and clinical providers operate in. For the purposes of this report, we will be using the terms link worker and client to represent the reality that, particularly in co-commissioned contexts link worker roles can extend beyond clinical settings, and that 'patients' become clients of a range of different services through their engagement with social prescribing services.

What can co-commissioning and collaborative approaches look like?

Through the interviews undertaken, it quickly became clear that while some interviewees saw co-commissioning of social prescribing as the natural end point of collaboration, this is not the case for all, with many seeing and valuing the practical benefits of a more broadly collaborative approach over the potential benefits of a more formal exercise of co-commissioning a service. What works depends largely on the local context, those involved and the starting point.

Through this research, three different models of collaboration emerged:

1) Single commissioner with collaborative working

In these models, either the CCG or local authority provide the sole funding for the social prescribing scheme, however it is set up in such a way that there is input and formal or informal oversight from both parties. Often there is also input from other local organisations which have an interest in the scheme's effective design and delivery. This is largely through the form of a steering or working group or forum, though can also operate through reporting mechanisms and connections linked to existing forums such as Health and Wellbeing Boards where a range of stakeholders already come together. In some cases, social prescribing schemes are overseen within forums focused on broader health and wellbeing agendas that the scheme fits within e.g. prevention, long term conditions, and health promotion.

"I think there's a lot of appetite for Public Health to be working on developing the scheme together [with the GP care group]. In particular in relation to training, joint management, shared systems, shared approach and I guess it remains to be seen whether or not that actually will result in shared funding."

2) Collaborative commissioning of complementary services

In other areas, social prescribing sits within a wider connected agenda and collaborative approach to commissioning whereby local authorities and CCGs have worked together to commission different parts of connected schemes. This can entail one party commissioning the social prescribing scheme, while another commissions a hospital discharge scheme with similar referral pathways and the two working closely together. In other cases, it has involved collaborative locality-based teams whereby local authority and NHS staff work closely together and share data on clients to ensure more cohesive and coordinated support is available.

"We don't always have to have a pot of money to facilitate joint working as we have local priorities where it is beneficial for us to work together so where we can contribute to each other we can feel part of one team working towards the same goals anyway"

There is also an argument that as local authorities are already a significant commissioner of local VCS services referred into by social prescribing schemes they are effectively already commissioning the greatest enabler of social prescribing services. In some areas there has been collaboration between social prescribing services and local authority commissioners whereby intelligence on the demand for and quality of local services gained through link workers' real world engagement has informed commissioning decisions and approaches thereby creating interconnected commissioning approaches. However, this necessitates some understanding of the complementary functions of the commissioning of social prescribing and the commissioning of voluntary sector services to ensure that the benefits of shared data, such as a shared understanding of demand, and the informing of VCSE service commissioning can be realised.

“I think over time we'd be able to build up a better picture because we've got to understand a cohort of patients coming through, what their social prescription needs are. And I think you have to I guess in terms of where patients are concerned, there's a risk, I don't know what the right terminology is but if you're a plumber the only solution you're offering the patient then is plumbing related but the demand is an electrician.”

3) Fully integrated co-commissioning

Some areas are working towards fully integrated co-commissioning of social prescribing whereby funding is pooled and schemes effectively apply and report to a single funder. In some cases this funding may incorporate a wider basket of services connected to social prescribing e.g. VCS services, complementary schemes around health promotion. This presents some practical challenges to fully integrate commissioning and reporting cycles and requirements, however can help to maximise collaborative working and joined up thinking and avoid duplication and disjuncture.

“So what we have decided I think is what we don't want to do is say, this pot of money is for this bit and this pot of money is for this bit because we want the providers to be flexible in how they use the money to the best effect for what we're trying to do.”

What are the benefits of local authorities and CCGs co-commissioning social prescribing services?

On discussion with the interviewees, all felt that having both parties involved had been beneficial for both the delivery of their social prescribing scheme, and for the organisations themselves. There were a number of reasons why this was valued:

Bringing a complementary perspective – Many interviewees reported that having the involvement of both the local authority and CCG brought a diversity of perspectives to the table and helped to make their schemes more effective in a range of areas.

Local authority focus on prevention – Although the targeting of social prescribing varies from scheme to scheme, it is often primarily an intervention focused on prevention, or prevention of deterioration. This focus aligns closely with the priorities of public health teams within local authorities who hold statutory duties to improve the health and wellbeing of the local population. This means local authorities have a vested interest in getting involved in the scheme, especially if it aligns with their local health and wellbeing strategy. It also means they have experience in proactively addressing the health and wellbeing of their community, often through a focus on the social determinants of health which is valued by the CCG.

Local authority experience of working in the community space - The community space was felt to be more traditionally local authority terrain, and so an understanding of how to operate in this space has been hugely beneficial in the set up and ongoing operation of schemes.

“We make a non clinical or non medical offer to the population and of course Local Authorities really get that and always want to find solutions which are community based and are often very comfortable working on the prevention agenda. So for us it was easy”

Expertise on effective ways of working – Local authorities and NHS partners were reported to bring specific skills and expertise, from other services where they have utilised similar approaches e.g.

motivational interviewing, Making Every Contact Count. Where VCS partners were involved with delivery they were also able to bring significant experience of working within community settings.

Generating real time local knowledge and data and utilising it for effective service design and investment Local authorities have long taken a key role as one of the largest funders of the VCS operating at a local level, with social prescribing emerging as one of the primary referral routes into these services. This presents a number of opportunities both for local authorities to feed in their knowledge and expertise around commissioning of and collaboration with these services, but also to utilise the experience of social prescribing schemes to learn more about the demand for and effectiveness of services. The kinds of data and case studies that can be gathered through social prescribing can usefully supplement population level data to enable local authorities to gain a deeper and more nuanced understanding of local needs.

Examples from practice: In Shropshire, the local authority's commissioning lead sits on the Healthy Lives steering group which includes the social prescribing scheme as well as other population health programmes around diabetes and physical activity. This enables them to use live data from both social prescribing and these other schemes to influence commissioning decisions.

City and Hackney also have a feedback loop whereby the social prescribing lead communicates with the local authority regarding demand for services to help with planning and recommissioning decisions.

In Rotherham, a wide range of services are commissioned directly from the VCS as part of the scheme itself utilising intelligence gained on demand from service users, as well as making use of feedback on their experiences of onward referrals.

A number of schemes in Greater Manchester (currently Tameside & Glossop, Salford, Wigan, Bolton and soon to be Bury) have a pot of funding which sits alongside the social prescribing scheme with the aim of this being used to micro commission voluntary sector services, intelligently informed through the insights on need generated through the social prescribing service.

In Waltham Forest, the social prescribing scheme which sits within adult social care acts in part as the 'eyes and ears' for the local authority as it gathers valuable 'real life' insight into what is happening on the ground. In addition to this, the social prescribing scheme has established a networking space for local VCS services and acts as a lynchpin for these services to build connections with the scheme and each other.

Tower Hamlets schemes have also established regular locality based 'networking breakfasts' which bring together VCS services to build more cohesive referral networks.

The Redbridge scheme works closely with commissioners to identify gaps in services and ways for services to become more effective and innovative. Redbridge CVS has worked with local organisations to develop offers specifically for social prescribing clients, for example the local Institute of Adult Education who have set up bespoke short courses specifically for Social Prescribing clients including Basic Digital Skills, Mindfulness and Meditation.

“What it did do was it made a case for us to continue investing in something. So I can't say that we decided to commission something new or change what we were doing but it did form part of the case to continue with stuff that might have got deprioritised I think.”

Reducing silo working and enabling discussion on overlap, duplication and cooperation between services

In some areas, social prescribing has facilitated a wider discussion between local authorities and CCGs around the range of services on offer and how they work together, particularly in terms of enabling service users' journeys between them to flow as smoothly as possible.

By identifying areas of overlap, duplication and opportunities for cooperation, this has opened up new ways of working including integrating systems between services working with similar client groups, data sharing and shared referral systems, and more locality, primary care network based approaches as encouraged by the King's Fund (Ham and Alderwick, 2015) and now the NHS Long Term Plan (2019). Other areas are looking at co-location of services to increase integration with social prescribing sitting within this.

Some interviewees reported this integration taking place through conversations at a senior level, particularly where more place-based approaches were high on local agendas, while others reported this happening through closer working relationships amongst different teams on the ground.

“Social prescribing... can be a potential answer to so many challenges but it can also be a way of encouraging partnership working, working with the voluntary sector, supporting community development and supporting overstretched services really.”

“And then there's the opportunity that if you combine that you could actually do the admin once, because they're finding, both services are seeing increasing complexities of patients or clients or service users. But actually the admin is also really time intensive and both of them have been saying the same thing and I think if you could integrate that somehow, we're not trying to take money out of it, we're just trying to make better use of the money that's available.”

“All these people operating out of the same office space even though they're out and about with patients or clients all day that's starting, obviously, that old adage about if you share the milk in the fridge, you know, and you make tea and coffee together you start to work as a single team”

Examples from practice: City and Hackney recognised that there was some duplication and overlap between the social prescribing scheme and the local authority commissioned Health Coach scheme, whereby both were providing a similar service but in different settings, a number of clients were being referred between the two services and training/supervision needs of staff delivering the services were shared. They are now exploring joining the two services together to reduce the administrative burden, increase capacity and maximise the impact of the services, particularly for those with more complex needs.

In Redbridge, there has been a move to a more locality based model with interdisciplinary teams which include link workers working alongside other roles including community nurses and social workers. This enables those with more complex needs to access more cohesive and better integrated support. Additionally Redbridge has recently endorsed the Three Conversations model across frontline health and social care teams. This model steps away from the traditional care management process towards a person centered approach. This enables the individual to ascertain what is important, what they would like to achieve and how they can help themselves. By focusing on what is important to people and their families this enables people to remain in control of their lives by utilising support in their own network and connecting them to community assets. After a pilot in two localities, this will be rolled out on a borough wide basis later this year.

In Greater Manchester, each of the 10 local authority areas is developing a 'local care organisation' bringing together different healthcare providers within a locally based partnership arrangement. Although the agreements vary from area to area, these generally include community health services, community mental health trusts, primary care federations and adult social care departments alongside voluntary sector and social prescribing services, with acute hospital trusts sometimes directly involved and in other places more at arm's length. This is derived from the Greater Manchester devolution deal for health and social care which had a strong focus on place-based approaches to health (NHS in Greater Manchester and Greater Manchester Combined Authority, 2015). Some areas are also looking at 'community hub' models whereby GPs and other statutory and voluntary sector services are co-located within one venue.

In Waltham Forest, there has been a segmentation of service user need whereby the 10% with the most acute needs are supported through a Managed Network of Care and Support, while link workers focus on supporting those with long term conditions or shorter term needs.

In Shropshire, link workers who are local authority funded work closely with 'Community and Care Coordinators' who support effective hospital discharge, ensuring holistic support to those they work with, which seeks to prevent readmission. As part of the social prescribing initiative, a 'Healthy Lives' steering group has been established including representatives from the local authority, CCG, VCS, fire and rescue and social care services (amongst others) which has enabled broader collaborative working alongside the joint working around the social prescribing scheme itself.

Promotes use of diverse outcomes and measurement tools to create a more rounded understanding of the schemes

– A number of interviewees reported that the CCG and local authority were interested in different ways of measuring the outcomes and impact of social prescribing interventions. Often CCGs were considered to be more concerned with measuring social return on investment (SROI) and reduced GP and A&E attendance and hospital admissions, whereas local authorities were interested in gathering insight on self-reported wellbeing measures e.g. Warwick Edinburgh, outcome stars, as well as onward journeys into services and progression routes. Although this may lead to an increased workload in terms of data collection, this was largely not viewed to be an operational problem for schemes, particularly as most were able to use NHS numbers to track patients rather than needing all outcomes to be captured by delivery staff.

“They [local authority] have a different type of population level evidence and a very different kind of population level thinking. In the present climate, the NHS can be quite fixated on how to reduce our activity in a very concrete way, around activity and cost.”

Broadening scope for social prescribing approaches – Although social prescribing has developed primarily through the health sector to date and therefore much of the measurement and focus has been on savings for the NHS and improvements in health and wellbeing, there is certainly scope for the very understanding of what social prescribing is to be challenged and expanded upon through local authority involvement. For example, rather than looking at reduced hospital admissions and GP attendance, local authorities may wish to focus equally on reduced incidence of homelessness or reliance on benefits which are areas which affect their costs in relation to an individual and their household.

Furthermore, there can be greater exploration of moving link workers or link worker functions (for example community navigators) beyond health spaces and into other community settings such as schools, children’s centres, housing options teams and community centres.

Examples from practice: Across the local authority areas of Greater Manchester, a number of social prescribing schemes have a broad focus with referrals coming from a wide range of services beyond GPs as well as self-referrals. In some areas, GP referrals are as low as 30% of the total number of clients. In addition, a number of schemes operate in a range of settings with many more often meeting clients in their own home or a neutral community setting than a health setting. In areas where a range of options have been offered, some schemes have found that less than 10 per cent of appointments take place in GP surgeries, although the trusted referral source remained key whether this was a GP, social worker, occupational therapist or other. The schemes aim to be as holistic as possible in terms of the areas of focus and outcomes measured.

Similarly, in Redbridge through the transformation programme, the scheme is led by both local authority and CCG jointly and this has led to an interest in a more holistic range of outcomes and a broader view of the kinds of savings to statutory services that can be made through these kinds of upstream interventions. Redbridge Council is also moving to a new hub based model that will provide services and space aligned with localities to make services more community based and accessible. Alongside this, the Social Prescribing Board is developing a Social Prescribing offer which includes advice across a broad range of topics for those who can confidently use the internet and need less intensive support to those who may need more one to one support.

The Waltham Forest scheme is based within the local authority adult social care team and this has led to much more integrated working, with clients being able to access support through both statutory and voluntary sector services as needed.

The Shropshire scheme is funded by the local authority and operates across both primary care and community spaces, as well as taking referrals from a range of teams including GPs, adult social care, JobCentre workers and the voluntary sector. They are currently exploring the possibility of having link workers based in different ‘parts of the system’ e.g. hospital discharge.

“It’s relevant to everyone because we have got the transformation programme [jointly led by local authority and CCG]. So what we’ve said is any intervention that we jointly do, the savings should be to the local authority and to the CCG.”

What are the conditions and enablers for collaboration and co-commissioning?

Although the interviewees we spoke to represented different types of schemes and the nature of the localities they work in varied significantly, there were a number of common enablers for collaboration which featured in our conversations. While some of these cannot be manufactured, they provide a strong basis to understand if an area is ‘co-commissioning ready’ and how to create the conditions for effective joint working. Our findings chime strongly with a recent meta-analysis conducted by Pescheny, Pappas & Randhawa (2018) on facilitators and barriers for delivery of social prescribing schemes which is summarised in the table below.

Figure 1: Summary of identified facilitators and barriers to the implementation and delivery of social prescribing services

Facilitators	Barriers
<ul style="list-style-type: none"> • A phased roll out implementation approach • Realistic planning of ‘lead in’ time to set up a SP service • Workshops to design and discuss SP services prior to implementation • Standardised trainings, briefings, and networking events for involved partners • Flexibility during the development, implementation, and delivery of a SP service • Shared understanding, attitudes, and perspectives of stakeholders • Good relationships and effective communication between stakeholders within and across sectors • SP champions in CCGs and general practices • Navigator ready general practices • A general practice culture that supports the biopsychosocial model of health • General practice staff engagement • A wide range of good quality third sector based service providers 	<ul style="list-style-type: none"> • A ‘go live dates’ approach to implementation • Lack of partnership and service level agreements • A collaborative approach to project management, which results in the lack of a targeted approach to strategic and robust project management • Absence of a robust risk management systems • Volunteers as navigators • Staff turnover • Limited financial resources to fund service providers or secure a high salary for employed staff • Lack of shared understanding among stakeholders and partners • General practice staff disengagement • Patient disengagement • A reduction in available and suitable service providers in the third sector

Pescheny, Pappas & Randhawa, 2018, p.10

Building on what’s already there

Although social prescribing is still relatively new in most areas, a number of interviewees spoke of how much similar activity was in existence prior to the advent of their scheme in its current form. In some cases this was a link worker role which had been introduced by a forward thinking GP practice or within social cares services, while in others roles with similar kinds of functions had been introduced for particular demographics or conditions e.g. frail patients or to support at critical moments e.g. hospital discharge. Many spoke of the importance of recognising that they were not working with a blank canvas, and of building on pre-existing good practice and learning through existing initiatives.

“We didn't suddenly just decide one day, right we're going to go set up social prescribing. We very much didn't do that because my philosophy and the philosophy of others is that there's always good practice in place. Let's build on what we've got, we are aware of pockets of good practice and let's build on that rather than trying to start something fresh and just cut across everything.”

Examples from practice: Redbridge already had a highly successful TB buddy scheme which resulted in much lower incidence of TB and gradually evolved into a social prescribing model due to similar skillsets being required and staff already being in post. The Buddies' role expanded to raising awareness on other health conditions and topics such as Latent TB, HIV, Cancer, Diabetes and domestic abuse. The Health Buddy scheme gradually evolved into a social prescribing model due to similar skillsets and experience being required and staff already being in post.

Laying the groundwork

As a new intervention and one which refocuses approaches in a potentially significant way, social prescribing can generate a huge amount of excitement. However, a number of interviewees felt that taking proper time to lay the groundwork was key to their ongoing success. In particular it was felt that it was important that all stakeholders took appropriate ownership of the scheme so that it does not become the sole responsibility of one partner (often the one who is providing funding and/or delivering the scheme). Pescheny, Pappas & Randhawa (2018) also identified a phased roll out approach as being preferable to artificial fixed 'go live' dates in order to ensure sustainability.

Alongside this, communication with different stakeholders at all levels in the area was seen as key – both decision-makers and other local services, to ensure that the scheme has as much buy in as possible and that it is able to embed itself in the broader service ecosystem in a way which maximises opportunities for sustainability.

“I would say that the stuff in the literature about these sorts of things taking about three years really to get embedded and really accepted... but I think now it's quite hard to find a GP (in Hackney) who doesn't think this is a good idea, and it's actually quite hard to get referrals in the first 18 months.”

Willingness to test and learn

Almost all schemes had begun with a small scale pilot of some form e.g. with a small number of GP practices, often through some one-off funding whether that was external or from the CCG or local authority. This had enabled schemes to test out the approach and see how it fitted into the local patchwork of services without having the pressure of a significant financial outlay for any party or needing to set it up across a whole geography with the additional complications that can bring. This has been particularly helpful in the early days of social prescribing as the evidence base was still being established.

“So that's the other bit for us is we're constantly testing what we're doing. If it doesn't work we stop it and if it does we build on it and keep it going.”

Example from practice: Social Prescribing in Redbridge began life as an initiative from the Redbridge Fairness Commission in 2015, to be jointly owned by the NHS and Local authority - as a result the Social Prescribing Board was established to set the initiative into motion and provide joint oversight. The scheme was initially joint-funded by the Local authority and the CCG to implement in one locality covering 9 Practices in the borough in 2017.

External funding

With funding envelopes for both CCGs and local authorities experiencing significant pressures, external funds were critical for many either in being able to start their scheme, or in being able to move to scale. The Better Care Fund and transformation funds linked to devolution have been instrumental in a number of cases, and the necessity for both CCGs and local authorities to be involved has helped to ensure that everyone was actively engaged from the outset.

Examples from practice: In Greater Manchester, a number of local authority areas have, supported by the Greater Manchester Health and Care Partnership, utilised devolution transformation funds which have enabled social prescribing schemes to roll out almost all areas which make up Greater Manchester.

Redbridge have established an Accountable Care System alongside the London Boroughs of Barking and Dagenham and Havering as part of a devolution deal and through this they have been able to work collaboratively across organisational and borough boundaries. Redbridge CVS (the organisation delivering the Social Prescribing Service in Redbridge) made a successful funding bid to the Department of Health and Social Care and secured funding for 4 years for expansion of the Social Prescribing Service to all 42 General Practices in the borough from December 2018. The funding is for 4 years, with match funding from the Local authority and CCG.

Relationships

As Pescheny, Pappas & Randhawa (2018) identified, relationships based on reciprocity and trust are key to the successful establishment and delivery of social prescribing, and amongst interviewees pre-existing or developing relationships between CCG and local authority representatives were considered critical to the development of collaborative working in most cases. This was particularly at a senior level where connections were largely forged either through participation in Health and Wellbeing Boards or joint working on other related initiatives in the locality. However, often good working relationships at an operational level were also key to success – for example in terms of the connections between social prescribing and related services which may be provided by either CCG or local authority, this was often forged through frontline workers or operational managers.

“I would say [aligning systems and priorities is going] quite well really because I think partly it's to do with I've actually got quite a good relationship with a person on the CCG who commissions social prescribing. Also for the last year Public Health has sat on the social prescribing steering group as well as a commissioner of the community services that people are referred onto. So we've got quite a good relationship so I think it does align and that's why we're doing it I suppose.”

Buy in at senior levels and amongst elected officials

A number of schemes were instigated by senior staff within CCGs and/or local authorities or by elected representatives such as council leaders or cabinet members while others took more of a bottom up approach. Regardless of who the key instigators were, all interviewees appear to have found that senior level buy in was absolutely crucial to either securing local funding or being able to apply for external funding.

“It's one of the essential ingredients, working closely with our local elected member, he has been working with us since the start of this and is vitally important as he is also the Cabinet Lead for Health and Care. Not only does he play an influential role, he also challenges us and champions the model”

“It’s an agenda that he [Andy Burnham, Greater Manchester Mayor] is passionate about and knowledgeable on and social prescribing has been highlighted as a key priority focus for health and wellbeing in the Greater Manchester strategy. Andy has regularly spoken publicly about his strong support for social prescribing including giving a keynote address to an audience of 300 at an event last year. I think to be honest that vision and commitment is driving a lot of the closer working and that’s sort of how it’s manifesting itself on the commissioner side and then on the provider side in health and care”

Buy in amongst frontline staff

A number of interviewees said that it was equally important that frontline staff were invested in social prescribing and could see the impact it was having on their day-to-day work. This often resulted in this positive feedback being filtered upwards to decision-makers and commissioners. GPs were considered particularly influential within the CCG, as well as local authority teams such as adult social care who could see the benefits first hand.

Examples from practice: In Waltham Forest, GPs have been hugely positive about social prescribing as it is protecting them as the frontline who would otherwise have to deal with whatever issues patients presented with. There has also been huge positivity within adult social care where the service is based due to the way the services are able to work together. In Merton, the positivity of GPs who can see the direct benefits to their patients has also been critical.

Motivated individuals and organisations

Almost all interviewees felt that the energy and enthusiasm of a small number of highly motivated and passionate individuals had been a huge catalyst to the progress of their scheme. In some cases they can pinpoint one particular individual who was instrumental to getting others on board and building consensus and a will for programmes to succeed. However, there are also instances of key people moving on and challenges due to momentum being lost so it is critical that the entire success of the scheme does not rest on one individual or relationships between a small number of individuals, but that responsibility is shared more widely and agreed institutionally.

“The natural allies and champions you have in the system could be anywhere, they might be in public health teams, they might be in adult social care teams they might be in the CCG, they might be in local care organisations on the provider side, you know your VCSE colleagues are always supportive and wanting to do it but... you don’t have a natural network of structure like you’ve got networks and things like directors of public health or directors of adult care, so we’ve had to try and create a very fluid network and just whoever happens to be an advocate and champion for this... and try and build up to a critical number of people... so you often get people, that’s sort of in middle ranking type positions who are real champions and want to try and do this and the top of the office are going, yeah, yeah, great, great, they’re not really practically supporting it or giving them any capacity or resource.”

Backgrounds of key individuals

In a small number of cases, key individuals had experience of working in both healthcare and local authority settings and this helped ensure a strong understanding of the connections between agendas of both types of organisations and an ability to negotiate different working cultures and practices. Although this mixed skillset and knowledge is not currently common, it does raise questions about the possibilities for secondments and joint roles between CCG and local authority teams and the potential this could have to increase capacity for collaboration.

Example from practice: Greater Manchester has gone one step further and in four local authority areas out of ten there is a single Chief Officer for both the local authority and CCG and there is some merging of senior leadership teams. Although this is still in its very early days, it is hoped that this will help to ensure that programmes of work are integrated and connected from the outset from the top down. It may also help to break down some of the cultural barriers between the two organisations e.g. languages and vocabulary used, historic ways of working, drivers and primary areas of focus. These kinds of models and similar are encouraged within the NHS Long Term Plan (2019, section 1.58).

Creating shared vision and spaces for connection

Almost all respondents reported that there was a steering group or oversight committee of some form for their social prescribing scheme. In some cases this was specific to the scheme, whereas in others it covered a range of initiatives within a connected agenda. A number of schemes also reported into Health and Wellbeing Boards where developments and emerging outcomes were fed back to representatives across a range of organisations. Regardless of the way reporting and oversight was configured, having representation from different services was felt to be highly useful in getting shared buy in, vision, understanding and ownership from all parties, as well as helping to cement connections and relationships. This is consistent with the findings of the recent study by Pescheny, Pappas & Randhawa (2018).

Examples from practice: In Tower Hamlets there is a social prescribing partnership group which has representation from the CCG and main providers, local authority public health team, the VCS as well as local housing associations. This has created a space where the scheme can continue to develop, as well as promoting joined up thinking on training, systems and approach across agencies.

Shropshire have established a Healthy Lives steering group which involves the local authority public health and social care teams as well as an elected member, the CCG, VCS representatives as well as fire and rescue services. This has connected social prescribing into wider working around shared local priorities and has been a space for the facilitation of increased joint working in a number of areas.

In Merton it was considered to be key that Better Care funding had ensured that all key stakeholders were round the table from the outset and were able to take on key learning and ownership of the scheme.

Redbridge Social Prescribing service reports to a Social Prescribing Board which meets quarterly and has representation from senior officials from the Local authority, CCG, Redbridge CVS and other partner organisations that provide sign posting or other bespoke services to local residents. The Cabinet Member for Health, Social Care, Mental Health & Ageing is also in attendance. The Board is chaired by the Director of Public Health and periodic reports of the progress on the Social Prescribing service are presented at the Health and Wellbeing Board.

“I think one of the key ingredients has been all of us actually working together and sitting around a table and actually taking decisions... about it rather than it being enforced upon us so that's really helped and I think it could be a lot more challenging but I don't think it's been as tough as I envisioned it to be.”

“We don't just talk about things we have made them happen collectively, we see ourselves as a Team of Teams even though we are from different organisations and departments”

Interest in shared agendas

Social prescribing can form a part of a number of different strategies and agendas, for example integrated care, prevention, long term condition management, patient activation and combatting health inequalities. Collaboration often appears to have come about due to a shared interest in these agendas, whether that be through a jointly created strategy or compatible strategies within the respective organisations. In some cases there was a sense that both local authority and CCG were working on similar agendas, but using different language and following separate internal strategies, whereas in others there was very much a sense of a common approach.

Examples from practice: In City and Hackney, the local authority and CCG are working closely together on the integrated care agenda, coordinating service provision around resident need with a strong focus on self-management and peer support. This has brought services such as social prescribing to the forefront. In Shropshire, the scheme sits within the Health and Wellbeing Strategy agreed by the Health and Wellbeing Board. There is also a lot of connectivity between the scheme and the local reimagining of social care. At both the CCG and local authority in Rotherham there is a strong interest in long term condition management, and this has aided collaboration around social prescribing. In Merton, prevention and reducing health inequalities are key areas of interest while in Waltham Forest there was clear crossover between the local authority public health team's focus on prevention and the CCG's priority of preventing deterioration of conditions.

"It came up through the integrated commissioning and integrated care agenda - the idea that the NHS and social care need to work in a more kind of holistic patient centred and coordinated way to improve care and reduce fragmentation and waste across the system."

Building an evidence base

As previously mentioned, local authorities and CCGs can have different requirements when it comes to evidencing impact and it is important that opportunities to do this are built in at an early stage. For example, early investment in analytics, careful consideration of appropriate metrics and collaborations with research partners established early in the life of the scheme can help to build a clear picture of impact and influence scheme development. Many also felt that sharing more qualitative data e.g. case studies, stories was also hugely valuable, particularly in terms of getting buy in from referral partners.

Examples from practice: In Tower Hamlets, analytics were a key focus in the early stages of the development of social prescribing. The system that was created brings together primary and secondary care data using anonymised patient IDs, and link workers are able to access patient records and code directly onto EMIS enabling effective analysis of cost and activity among the patient cohort who receive a social prescribing intervention.

In Shropshire, there is regular reporting on referrals, which although sometimes onerous for the operational team has helped to ensure that everyone has a strong shared understanding of the scheme and its impacts on GP practices and clients.

The Merton scheme has made a lot of use of stories and case studies including creating videos to engage local partners in a more engaging, person-centred way.

Redbridge Social Prescribing service will be externally evaluated by the University of East London and a research organisation called Ecorys. The University of East London as an external evaluator was involved from a very early stage of development of the service while Ecorys have been commissioned by the Department of Health and Social Care to evaluate all of the Social Prescribing schemes that have been funded by them to gain a broad perspective.

“And everyone’s seeing that and they’re like ‘Right we want it’ because they can relate to those people and they say they’re my patients I really struggle with medically and now I see that’s because I’ve been barking up the wrong tree.”

What are the common challenges for collaboration and co-commissioning?

Challenging funding environment

Most interviewees expressed the view that the current funding environment presented significant challenges in securing long term sustainable funding commitments. As social prescribing approaches are still fairly new, some are still working on building a sufficient evidence base to secure recurrent funding, and with local authorities and CCGs having to make difficult funding decisions, more exploratory spending, and that which is focused on prevention can be deprioritised. In some cases schemes have to spend a significant amount of time justifying funding through evidencing the financial savings to other services, particularly in the NHS to be able to get approval or re-approval for funding through decision makers.

“If your house is burning down you’re more interested in trying to deal with that acute side of it rather than thinking about building a new one.”

“So this kind of perception emerges that, ‘oh well surely if we co-commission if we just make people work together there will be some way in which we can just fudge this and make it work.’ But the reality is that Public Health and CCGs are both on their knees at the moment in a really fundamental way and it might be just that actually the reason that we haven’t co-commissioned anything is because there’s just no money.”

“CCG is committed to prevention it’s not that at all and they do want to work with us but it is actually the pounds, shillings and pence in terms of identifying it.”

Since undertaking these interviews, the NHS Long Term Plan (2019) has committed to funding 1,000 link workers. This may alleviate some of the challenges around securing funding for schemes, though there is still uncertainty as to whether this funding would also support the infrastructure required for make these roles effective e.g. training, management and supervision, database and evaluation systems.

Sustaining momentum and building security after external funding

As mentioned in earlier sections, external funding can be critical in getting social prescribing schemes off the ground and enabling them to position themselves amongst the patchwork of services in their locality. However, despite buy in and no small amount of enthusiasm from local stakeholders, it can still be challenging to convert this into financial support and identify suitable funds to enable

sustainable delivery, and particularly to ensure long term security to enable schemes to progress and plan for the future.

“There was a bit of a deep dive in our programme and [everyone was] saying all the right things about good intentions to carry on with the funding but obviously it’s too early yet, there’s no clear plan from any of [them as to] how they are going to fund these schemes beyond the end of [the current] funding”

Sustainable funding is also critical to preventing high staff turnover as discussed by Pescheny, Pappas & Randhawa (2018) and low morale. Thought should be given as to sustainability from the outset even where funding starts out fairly short term in nature.

“I think [the external funding] created an illusion of co-commissioning when in fact what wasn't happening was the embedding of ownership and knowledge about social prescribing within the... major commissioning bodies, the CCG or the council. So when that funding came to an end the expertise also left. The Public Health Consultants were absolutely fantastic and really brought the scheme to life and brought some capacity with them which we would have never had access to otherwise. But it almost seemed like it got forgotten that only the CCG was commissioning social prescribing to a very minimal degree.”

Gathering right evidence

Linked to the previous challenges, with multiple funders or partners with a diverse range of interests, it can be challenging to gather the right kind of evidence and in some cases funders can be less interested in some elements of the impact of social prescribing. Some specifically expressed the challenges with accurately identifying cost savings to other statutory services (both within and outside the health sector) through social prescribing, though many are progressing evaluations in these areas. This was a specific area of interest for a number of CCGs who were keen to demonstrate direct savings to other parts of the NHS and SROI prior to investment. Some also note the challenges in following up with patients following on from a referral or intervention to get robust evaluation data:

“If you give a prescription to a patient you don't know whether they then go to the chemist and cashed in the prescription”

“The CCG is essentially run by medical scientists who have a very particular view of what the NHS is trying to do. Particularly at a time when the chips are down and there's no money. So it becomes very difficult to talk about the social determinants and talk about broader motivational interviewing and coaching type conversations which are the core parts of social prescribing. When you've got less and less money to perform really vital biomedical interventions and operations and procedures.”

Joining up commissioning processes can be highly complex

Commissioning processes within statutory services clearly come with many layers of complexity and therefore actually joining up or effectively ‘pooling’ funding pots comes with significant challenges, particularly as there is little precedent for this kind of practice. However, in areas where this is happening, the benefits are clearly viewed as being worth the additional outlay of work to set this up and it seems that this clarity of purpose is meaning that challenges are met with increased efforts to ensure it works.

Examples from practice: In Greater Manchester, there has been a strong focus on developing a single commissioning framework shared across local authorities and CCGs. In some areas where both local authority and CCG share the same Chief Officer and are starting to effectively work within a single budget. This can bring increased flexibility to jointly commission and share ownership of funding decisions and processes. For example in Tameside, the local authority and CCG now share the same Chief Officer, Finance Director and Director of Commissioning and now describe themselves as a single commissioner as they are able to manoeuvre around the financial constraints placed on both organisations.

In City and Hackney, work is currently ongoing to create a single commissioning process across both CCG and local authority. The desire is to ensure that for those applying for funding it feels like a unified and harmonious process with one application, one stream of funding, one contract and one body to report to, even if things are more complex behind the scenes.

“Because on the flipside in terms of what's difficult I think having this as a priority and having a relationship has meant that some of the things that would get in the way people are going “oh we’ll just sort that out” so it's just the practicalities of how you jointly commission something, like who is going to do it? Where does the money fit? Given that each statutory organisation has its own responsibilities about how its money is spent, its own accountabilities and they're very different in the local authority and the CCG. And so we're just working through our finance and contract schemes to just work out how we're going to do that but actually the conversation isn't, oh no you can't do that, it's like that's a bit tricky but let's see how we can do it but let's think about how we can resolve it”

“It doesn't magic money out of thin air, it just means you've got more flexibility in how you move things around and the strategic decisions you take”

Addressing under-resourcing in VCS

A number of interviewees noted the challenges of working with a VCS who are also struggling to sustain themselves due to funding shortages, as was the case in literature reviewed by Pescheny, Pappas & Randhawa (2018). In some areas such as Merton, some services have reported a 20-40% uplift in demand. A number of schemes are either already addressing this or looking to do so through collaboration and co-commissioning utilising information on demand for services coming through from social prescribing. In some cases this has also involved working closely with or being led by the local CVS in order to identify what is already running, what's working well and what is needed.

Examples from practice: Rotherham undertake commissioning and spot purchasing of VCS services directly through their social prescribing scheme, identifying gaps and needs amongst clients and ensuring that the most needed services are available to them for onward referrals. Similarly, in Greater Manchester, some areas have an additional pot of funding which sits alongside the social prescribing scheme to award grant funding for services where there is a demonstrable need as well as smaller scale spot purchasing of local services for clients.

“We're asking them [the voluntary sector] to do more and more and more and we do need to reimburse them and to reward them proportionately really.”

Lack of space to have open and honest conversations

The need to justify funding, particularly for new and emerging services amid a time of restricted budgets, can create difficulty in having entirely open conversations about challenges for schemes and what can be done to address them together. There can be pressure to paint a more positive picture for fear of disrupting momentum and damaging levels of buy in when this is likely to be needed to allow for more long term funding. This can be a significant obstacle to honest and open dialogue.

Negotiating differing priorities, cultures and languages

It is clear that true collaboration initially requires some translation between differing spheres of interest and operation, and approaches and languages as, even where there are similar agendas within the NHS and local authorities these can be under different guises and fall under different strategies e.g. patient activation vs. asset based community development. However, working together around initiatives such as social prescribing can help to bridge these gaps and establish a shared narrative and approach.

“Because where I think we're aligning a lot is from the patient activation end of things which is how they would describe it but for us it's very similar but we just wouldn't call it that and we might use a different tool but actually the social prescribing commissioned by the CCG that is their main focus... I think there is a growing common narrative about these things locally”

In some cases, genuine collaborative working will require some parties to relinquish control of certain aspects of their remit and think differently about their priorities. To give an example, in joint commissioning approaches such as those in place in parts of Greater Manchester, local authorities may share VCS service commissioning with CCGs or a commissioning board with broader representation. In other cases, commissioning of voluntary sector services which are connected to social prescribing may be passed over to other agencies, for example the local Council for Voluntary Services (CVS) as in Rotherham.

Where multiple agencies and parts of local authorities are involved, social prescribing may shift the emphasis away from a focus on traditional public health outcomes such as smoking cessation and physical activity to a broader conception of wellbeing based on social determinants of health, and this may initially feel uncomfortable for some.

“They historically come at it from what they've historically been trained to achieve in their different areas and that's a long slow process of collaboration, integration trying to design a shared understanding and vision and then wrap an operational model around that where everybody understands their role.”

However, it is clear from areas where more prolonged collaborative working has taken place this has helped to overcome these conceptual barriers and enabled all parties to build on, align and integrate their existing approaches.

Negotiating what's already there

Although many schemes reported that being able to build on what was already there and commissioned by local authority and CCG partners was hugely helpful to them in initiating or growing their social prescribing scheme, on some occasions it also brought challenges in terms of how to move from one model (or more often a range of different parallel models) to a new one.

“You’ve got historically local authorities, public health teams having sort of wellbeing advisor type roles and you’ve got more kind of social prescribing link worker type roles coming out now and you’ve got other people, you know doing different sort of work around broad prevention, so you’ve got all these different kind of roles that get called community navigators or wellbeing officers or link workers, you know, case workers, etc. and it’s like trying to work out how they all sit together so they don’t duplicate each other and where the different funding for them all comes from and, you know, so we’re into some of those quite complex operational design issues... just to try and make sense of all, because nobody’s starting with a blank sheet of paper.”

Creating clear lines of responsibility

With a wide range of partners involved, it can be challenging to identify who, if anyone, is leading on the scheme or what the different areas of responsibility are. This can lead to some issues in relation to decision-making and how this works.

“Having won hearts and minds and having got to the point where everybody’s agreed this is a good thing, nobody’s sure as to whether this is run by the public health team or the CCG, because it’s almost like everybody wants to be in charge of this and, so, even though they’re all agreed that they want to progress this agenda and it’s important, it’s almost like so many enthusiasts... everyone’s almost like vying for control... which is a bit bizarre and in a way it’s a good problem to have but it’s still, nevertheless, it’s meant it’s taken several months to try and agree some kind of governance framework for taking this work forward”

Allowing for local difference

London boroughs are not uniform in their population needs, local authority and CCG priorities, composition and strength of voluntary sector or locally developed approaches. It is therefore key that local leadership remains central to the ongoing rollout of social prescribing in Greater London. However, it is also clear that external support and learning from one another is critical to ensuring that best practice can grow and that schemes do not have to duplicate the same work.

Greater Manchester operates in a similar way and also has significant experience of supporting boroughs to implement social prescribing in the way that works for them. It is clear that there is much for the two areas to learn from each other in respect to how best to support locally led, high quality implementation of social prescribing.

“So, you know, it’s all about influence, sharing best practice, supporting them, acting as a bit of a critical friend, we can’t go into any of the ten and say right, no you’re doing that wrong we want you to do this, you know, not that that would be our style anyway but we don’t have the authority or the leverage even if we wanted to”

Conclusion

By virtue of their positioning, link workers and those involved with the development of social prescribing schemes can act as ‘boundary crossers’ as described by Kilpatrick et al., 2009 – straddling both community, local authority and health settings. As schemes evolve, and they become critical elements of broader emerging agendas emerging around asset-based community development, integrated care and patient activation, there is increasing scope for social prescribing schemes to become a bridge between community, local authority and health spaces. In understanding the experiences of schemes working in a diverse range of contexts, it has become clear that there is huge potential for co-commissioning and collaboration around social prescribing, but that this is actually about much more than where the money comes from and how it is allocated. Rather it is fundamentally about reimagining the central purpose of what we are seeking to achieve within our communities.

Many of the areas we have spoken to are leading the way in showing how local services and health and local authority commissioners can interact to ensure an integrated network of support for local residents with social prescribing as a critical part of this. Just as much of what we heard from interviewees was about how this collaboration works on the ground as it was about commissioning relationships.

The key now will be for those across London and in other parts of the UK with an interest in this area to come together to look at how to look at how commissioning and collaborative working at senior levels can act as an enabler for frontline teams to best meet the needs of their clients and communities in a holistic and empowering way.

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Appendix A – Interview Guide

How did the social prescribing scheme develop?

- Instigation, sponsorships, decision makers, connected agendas, business case, process, agreement, and ‘ownership’
- Enablers/challenges?

What is current situation with social prescribing in your borough/county etc?

- What model is it? Involvement of: NHS – local authority – CVS etc
- How /who operates it?
- Who funds it, and with what funds? What is the timescale of the funding?
- Who does it report to and how?
- What are the referral pathways (inward, and outward) – and are you happy with these? Any changes you’d like to see?

How does social prescribing meet local priorities (health and local authority and others): which policies/priorities/duties is it expected to meet?

- What are your target populations?
- What are the outcomes that you measure?
- Are you carrying out research and evaluation about the scheme, and if so, what are the themes you are researching?

How are you managing to embed social prescribing in local authority teams/priorities?

- Who needs to be mobilised to support social prescribing eg director of housing/families?
- How have you engaged elected representatives – and managed their expectations?
- Training and development needs? What are they and how are they being addressed etc
- Is social prescribing, and the data trends being identified informing commissioning decisions, for example about services commissioned of the third sector?

What have been the biggest challenges of developing the scheme and how have these been overcome?

What are the upcoming priorities for the scheme and how do you see it developing?

- Any info on business case/operating statistics/evaluations