# Inclusive social prescribing.

## Learning from engagement with grassroots VCFSE organisations

Faith Action

VCSE health & wellbeing alliance

## FaithAction

FaithAction is a national network of faith and community-based organisations (FBOs) involved in social action. We empower these organisations by offering support, advice and training—we help the 'doers' do. We also have a key role in facilitating partnerships, sharing good practice between organisations and between sectors, and acting as a connector between government and grassroots organisations. We work to highlight the contribution that faith-based organisations are making to communities up and down the country. We know that the extent and impact of this work, and the reach of faith-based organisations into communities experiencing inequalities, mean that faith is too significant to ignore. Find out more at:

- www.faithaction.net

## VCSE Health and Wellbeing Alliance

FaithAction has been a member of the VCSE Health and Wellbeing Alliance every year since its inception in 2009, working with the Department of Health and Social Care, NHS England and Improvement, Public Health England and the UK Health Security Agency (UKHSA). As the faith 'voice' within the Alliance, we ensure that faith is taken into account in the development of new health policies and initiatives. We believe that faith-based organisations have a role to play in improving health outcomes, particularly among communities that typically suffer from health inequalities.

For definitions of underlined terms, see page 6.

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# More about this project

## Background

### What is social prescribing?

Whilst social prescribing holds the potential to offer a more joined-up, holistic approach to preventative healthcare and tackling loneliness, evidence suggests that as an approach it will not reduce health inequalities without strategic investment and inclusion of at-risk communities[1].

Through our own work we are aware of many innovative community-based approaches involving faith and community settings to reduce inequalities in access to loneliness and wellbeing-related initiatives. However, we are also aware that, whilst many faith groups are committed to tackling loneliness, their involvement in social prescribing schemes to date has been inconsistent[2].

In 2022, we set out to uncover best practice in the inclusion of faith- and community-based centres in the roll out of social prescribing and tackling loneliness. This project forms part of FaithAction's work within the VCSE Health and Wellbeing Alliance, in partnership with the Department of Health and Social Care, NHS England and the UK Health Security Agency (UKHSA).

- www.faithaction.net/hwa/

1. See National Voices (2020) *Rolling Out Social Prescribing*. London: National Voices.
2. See FaithAction (2019) *Right Up Your Street: How faith-based organisations are tackling loneliness.* London: FaithAction. This was also confirmed through polls in our 2022 roundtables.

# What did we do?

We held two roundtables in the summer of 2022, gathering twenty-five voluntary, community, faith and social enterprise (VCFSE) colleagues, as well as representatives of social prescribing schemes and structures.

The roundtables were framed around three discussion themes:

1. What does “inclusive social prescribing” mean to you?
2. What challenges do we face in making this a reality?
3. What actions are needed:
    a. From voluntary, community, faith and social enterprise organisations?
    b. From statutory partners?

We followed up the roundtables with seven one-to-one conversations with VCFSE organisations, which further enriched our findings and provided us with deeper insight on some of the barriers and enablers to achieving an inclusive roll-out of social prescribing.

This document summarises the findings from the roundtables and interviews, presenting best practice and recommendations for both commissioners and faith groups to support the reduction of inequalities in access to social prescribing.

# Key terms

## Faith-based organisations (FBOs)

In our work, we refer to different types of faith-based organisation (FBO). These include:

- Worshipping communities that provide support to their own congregations and/or the local community.
- Faith-based and faith-inspired charities, which may or may not be linked to a particular worshipping community. These may provide services to people who share their faith and/or to the wider community.
- Faith-based or faith-inspired providers of specific services.
- Inter-faith groups and networks.

In this document we prefer the term 'faith-based organisations (FBOs)' to cover all of these, although for the sake of variation we also use 'faith groups' and 'faith communities' and refer to the 'faith sector'. In specific instances we refer to 'places of worship' as community-based settings for communal worship practices.

## Social prescribing

Social prescribing is a way for people to be referred to non-medical forms of support. Sometimes referrals come from the GP, but they can be from other professionals, too, and you can even self-refer. Often social prescribing will involve a conversation with a link worker, who is able to listen to the concerns of patients and connect them with forms of support best suited to them.

## VCFSE

We use the term 'VCFSE' to refer to the Voluntary, Community, Faith and Social Enterprise sector throughout this document. This expanded acronym, including Faith, is used less widely than 'VCSE', but has been used by some ICSs, local authorities, and government departments.

## Integrated care systems (ICSs)

Integrated Care Systems (ICSs) are a new way of organising health and care across England. The King's Fund describes ICSs as "partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of their population". The NHS Long Term Plan (2019) sets out an ambition that every part of England is covered by an ICS by 2021.

ICSs, sometimes referred to simply as "systems", aim to make health and care more joined up and efficient. They comprise 3 different levels where decisions are made: the system level, covering the entire ICS footprint (around 1-3 million people); the place level, often the same as a council or borough footprint (250,000-500,000 people); and the neighbourhood level, made up of groups of GP practices organised into Primary Care Networks or PCNs (30,000-50,000 people).

## Place-based partnerships

Place-based partnerships are collaborative agreements between organisations involved in delivering health and care in a 'place' or locality. They cover much smaller footprints than ICSs, and often operate across the same geography as local authorities. Different kinds of organisations will make up a place-based partnership, including the NHS, local government, the VCFSE and health and social care providers.

## VCFSE Alliances

Increasingly, ICSs are choosing to work with the VCFSE sector through local VCFSE Alliances. These are leadership groups made up of representatives of the VCFSE sector. They are intended to be a means of communication between ICSs and the sector and facilitate stronger partnership working.

## Core20PLUS5

Core20PLUS5 is an approach to tackling health inequalities developed by NHS England and implemented by local ICSs. "Core20" identifies the target population as the 20% most deprived according to the national index of multiple deprivation (IMD); "PLUS" references specific communities in need of targeted action, such as ethnic minorities and people experiencing homelessness; "5" identifies the clinical areas of focus, including asthma, diabetes, epilepsy, oral health and mental health. NHS England have now developed an accompanying Core20PLUS5 approach for children and young people.

# Summary of recommendations

Throughout our engagement, we asked participants about their suggestions for how to better embed partnership working between local social prescribing schemes and grassroots VCFSE organisations. The following thirteen recommendations, for social prescribing host organisations/commissioners, wider health systems, and the faith and community sector, summarise the key themes of their responses.

For the full recommendations and action points, see page 32.

## Social prescribing commissioners and host organisations should...

### Ensure local social prescribing schemes are relatable and approachable for communities experiencing inequalities

The face of any service needs to be recognisable to communities. Recruitment campaigns for link workers, as well as other roles supporting social prescribing, should seek to proactively include people from seldom-heard communities.

### Reframe language surrounding social prescribing so that it is accessible for communities

Local social prescribing schemes should work closely with faith/community groups to co-design, test and rollout a vocabulary surrounding their social prescribing offer that is clear and accessible.

### Create visible communication pathways for VCFSE organisations

Clarify where grassroots VCFSE organisations should go if they have questions about social prescribing or want to get involved. National and regional mapping should be combined with proactive local marketing and outreach.

Make sure any local mapping of services goes beyond the 'usual suspects'

Be aware that, whilst helpful, mapping exercises will not always capture the full diversity of the VCFSE sector. Make every effort to fill blind spots or gaps, and involve grassroots VCFSE organisations in mapping exercises, with appropriate renumeration.

# Wider health systems should...

## Encourage representation of the faith and community sector in place-based forums

Chairs and members of place-based VCFSE Alliances should proactively include faith representation. Consider what funding or non-financial support may empower a range of communities to participate.

## Ensure that sustainable resource flows to the neighbourhoods that need it most

Integrated Care Systems (ICSs) should invest strategically in social prescribing schemes proportionate to the need in communities. Decision making around fund allocation should be driven by local data, as well as priorities set by the Core20PLUS5 approach for reducing inequalities.

## Ensure all primary care professionals are supported to make appropriate use of social prescribing

Social prescribing schemes should be supported to engage with local monthly GP teaching provision to ensure ongoing awareness raising among professionals about the function of social prescribing.

## Adopt 'community champions' models to raise awareness of social prescribing within communities

The power of 'trusted voices' among communities, including influencers, community coordinators and faith leaders, will be key to ensuring everybody knows about social prescribing and has opportunity to take part. Learn from existing social prescribing 'champions' pilots, such as those happening in Brighton and Hove, and roll these out more widely across the country.

# For leaders of grassroots faith and community organisations...

## Familiarise yourself with the local health and wellbeing landscape

There are Thriving Communities leads in each region of the UK who will be happy to help identify the best way for you to link in, locally, or put you in touch with a link worker. Local Councils for Voluntary Services (CVSs) or Healthwatch can offer information about how to get involved in VCFSE Alliances or other strategic forums.

## Identify what you have and what you need

Periodically assess the assets of your faith community: things like available spaces, personnel, time and resource. Be as specific as possible when describing what you may need to statutory partners like local authorities, public health teams or commissioners.

## Seek to work collaboratively with other faith and community groups

Seek to find out which other organisations are doing things that might complement your own offer. Work in partnership and dialogue with other organisations; be willing to form networks and consortia to attract new funding and facilitate effective social prescribing.

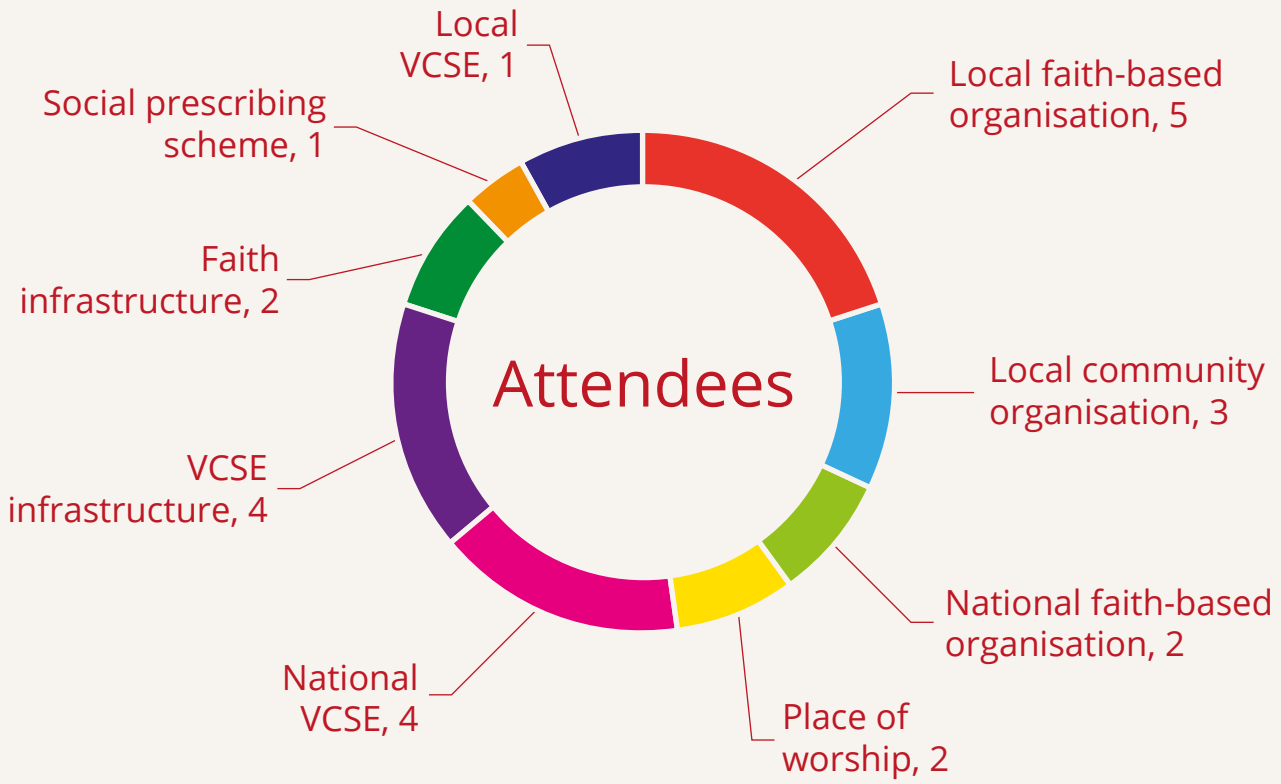
## Seek to better understand the people you work with and the health challenges they face

Understanding the kinds of people who use your services will help you tailor activities to the specific challenges and inequalities they may face. Knowing where to find data about your area and the kinds of inequalities residents experience can also allow you to think more strategically about what you offer.

## Evaluate the impact of what you do

Data can be captured through simple feedback surveys, as well as things like case studies and stories or testimonials. Remember, you will have insight and expertise on the people you support, as well as your faith or community context, that will be extremely helpful to those within your local health system.

# Our roundtables at a glance




We held two roundtables in June and July of 2022, bringing together twenty-five organisations across different sectors.

Most attendees came from VCFSE organisations, with one attendee representing a local social prescribing scheme. Two attendees, although situated in the VCFSE sector, were regional leads for the National Academy for Social Prescribing (NASP) Thriving Communities programme.

We had representation from five regions of the UK—London, South East, East of England, West Midlands, and East Midlands—with six attendees representing national organisations.

Faith-based organisations (FBOs) in attendance included four Muslim-led charities, two churches, one mosque and one synagogue. One Buddhist chaplain attended, as well as three leaders of interfaith groups with memberships comprising multiple faith communities.

Eleven attendees represented VCFSE organisations without any faith affiliation.

## "People in my community are **aware** of social prescribing"


We conducted two polls to gather a snapshot of the opinions of the group. The first asked about the degree to which those attending agreed with the statement *"People within my community are aware of social prescribing"*.

Half of those who answered the question disagreed with the statement (twelve) with nine people saying they agreed. Three answered "neither agree nor disagree".

## "People in my community know how to **access** social prescribing"


The second poll sought to understand access to social prescribing, asking how far participants agreed with the statement, *"People within my community know how to access social prescribing"*.

Overwhelmingly, participants answered negatively, with sixten saying they disagreed with the statement (two strongly) and only three agreeing. Five answered "neither agree nor disagree".

Whilst clearly not a significant sample, and acknowledging challenges in interpreting understandings of a term such as "my community" across such a broad range of organisations, these responses suggested to us that there is work to do in raising awareness of social prescribing among the VCFSE sector, and improving access among underrepresented groups.

*Key themes from our engagement*

# What does inclusive social prescribing look like?

Throughout our roundtables, and interview, participants identified the following five themes as hallmarks of inclusive social prescribing.

## Inclusive social prescribing is...

### 1. ...something everyone is aware of and can fully understand

- ☑ Marketing and promotion is co-produced with the communities that will benefit from the offer, especially those who experience health inequalities.
- ☑ Patients are able to recognise that social prescribing compliments clinical care, rather than replaces it.
- ☑ GPs and other clinicians are also aware of the purpose and remit of social prescribing, and are able to utilise the pathway for those patients that will most benefit.

*"I think any approach which is exclusive is not true social prescribing ..."*

— Regional Lead for the National Academy for Social Prescribing (NASP) Thriving Communities programme

*"'Social Prescribing' ... My community will not recognise that. We have so much faith in the medical field, that they know best ... So it's about actually re-educating ... That you can look after your wellbeing as well."*

— Leader of Muslim-led VCFSE organisation

*"...sometimes I think we need to be ever so slightly cautious that healthcare professionals don't see social prescribing as the answer to every patient that ... comes through the door."*

— Service manager at a carers centre in Essex

## 2. ...accessible to all, especially for those who struggle to access primary care

- ☑ Language and terminology do not present a barrier for anybody. Communications are available in community languages, and easy read, as standard.
- ☑ Any stigma attached to medicalised terminology, or associations with "social services", is addressed by the co-production of vocabulary with seldom-heard communities.
- ☑ Social prescribing pathways are just as available, and resourced, in deprived areas as in affluent areas.
- ☑ Nobody is seen as "hard-to-reach". Link workers receive appropriate resource to proactively include seldom-heard communities. Commissioners know what matters to local people, designing pathways that best meet the needs of a population.

*"I don't think the general public are familiar with the term 'social prescribing'. I have had to describe it to everyone in my personal life when describing my job."*

— Regional Lead for the NASP Thriving Communities programme

*"...to get to the doctor in the first place is very difficult ... but even to be able to speak to the doctor and say, 'I've been having quite a few low days recently', to say that to a GP from our perspective ... it's like, 'if I say that to the GP they are going to take my children away'...*

— Leader of Muslim-led VCFSE organisation

## 3. ...focussed on the whole-person, and what and who matters to them

- ☑ Faith and culture are part of holistic assessments of what matters to people and what might be included in their care, but this is not assumed.
- ☑ Social prescribing schemes are informed by an intersectional approach to referral pathways, recognising the richness and complexity of people's beliefs, identities, and interests.
- ☑ Specific and culturally-tailored referrals are also available to those patients who would benefit from them.
- ☑ Link workers have resource and capacity to accompany people to referrals where needed, supporting patients on longer-term pathways to improved wellbeing.
- ☑ Schemes are built around not just what matters to people, but also who matters. This may involve taking a 'whole-family' approach[3], since many people seek social prescribing services not just for themselves but on behalf of their family members and other loved ones.

### What is intersectionality?

Intersectionality is a term referring to the ways in which multiple forms of identity, disadvantage and discrimination can interact, particularly in the experiences of marginalised individuals or groups.

*"The reverse is also true ... assuming that because somebody doesn't belong to a particular faith community that they don't belong there and that there's nothing there for them."*

— Regional Lead for the NASP Thriving Communities programme

*"... it's not making the assumption that just because somebody is Jewish, that they would want to come to our synagogue ... I think that collaborative approach of being open and being able to access and give agency to the individual so they can make their individual choice rather than make it all up for them"*

— Rabbi at a North London synagogue

3. See the framework for whole-family approaches to social prescribing developed by Barnardo's, here:

## 4. ...involves communities from the start, and throughout

- ☑ Social prescribing schemes are co-designed with the people and communities who most need to benefit from them.
- ☑ Citizens are empowered to play an active part throughout the social prescribing journey, recognising that everyone can be both referred and a referrer.
- ☑ Health ambassadors, or social prescribing "champions", are recruited from seldom-heard communities to help promote the offer among networks, friends and families.

*"We need to make sure activities on offer are wide-ranging and diverse so that the person can be part of the decision making"*

— Leader of an inter-faith social action charity in the West Midlands

*"a lot of [our] service is social prescribing. But we're not included in the design at the moment ... and we're not engaged in the process locally or regionally."*

— Leader of an inter-faith social action charity in the West Midlands

*Deeper insight...*

## Canal & River Trust: Widening participation through targeted outreach

**Canal & River Trust** in the East Midlands (the Trust) piloted a project in 2021 which sought to improve wellbeing by encouraging participation in activities around waterways, in partnership with local social prescribing services. Recognising that some local communities, including black and ethnic minority communities, were not accessing the offer as regularly as others, the Trust engaged in proactive outreach to overcome barriers to participation.

This typically involved going to where people were, including featuring on community radio stations and Facebook advertising, as well as partnering with local places of worship, such as Sunday church services. Hosting events directly aimed at engaging these groups was also key. A series of Black History Month events, for example, celebrated and raised awareness of the voices of everyone who participates in their activities and the diversity of ideas.

### Advice for inclusive social prescribing

One of the main challenges some organisations providing social prescribing services have faced is finding ways to engage with the people who would most benefit from their services in the local community. This is especially an issue for trying to reach those often termed "hard to reach" groups, such as minority ethnic groups, people with disabilities or longstanding physical or mental health difficulties, young people, and those with limited literacy.

The Trust do not view any group as hard to reach, and actively strive to listen to the voice of those who are seldom heard to find out what they want to see from their services.

Proactive, targeted work will be key for engaging communities who may not otherwise think to get involved in particular activities. The Trust have actively worked to challenge perceptions that activities around waterways are primarily for older, white men, and broadened engagement in their offer in the process. Alternative forms of outreach are therefore vital in overthrowing misconceptions and engaging as many people as possible in social prescribing activities without discrimination to improve their wellbeing.

> *"Going on community radio stations is a must. Because that is what communities listen to ... But also a lot of walking out on the beat, I've done a lot of that ... knocking on doors, talking to people, going to where people are..."*
>
> — Wellbeing co-ordinator, Canal and River Trust, East of England

*Deeper insight...*

## Brighton and Hove Faith in Action: faith-based 'social prescribing champions' pilot

**Brighton and Hove Faith in Action (BHFA)** were established to improve communication between local faith groups and the city council. With a focus on facilitating faith-based social action, BHFA have strong links with the city council through the local Faith Covenant, as well as with the NHS and other partners.

The COVID-19 pandemic saw BHFA become well established within the wider VCFSE sector, and the prominence of faith-based responses saw local churches and mosques recognised as landmarks and 'safe spaces' in neighbourhoods. In 2021, BHFA joined with two other VCFSE charities and local link workers to initiate a pilot, funded by the council, whereby volunteer social prescribing 'champions' from two local churches and one mosque would be trained to map local provision, and help signpost residents who may otherwise not access primary care.

### How it works

Each faith venue has a volunteer contact for social prescribing. Two or three other volunteers assist in connecting with social prescribers and mapping referral destinations. Faith venues then advertise themselves locally to signpost these activities.

### Challenges

BHFA say that the issue of language has emerged as a barrier time and time again in network meetings, noting that whilst from a medical perspective social prescribing has a clear and obvious meaning, patients do not always share this understanding.

> *"[social prescribing is] a buzz term, it's talked about a lot. But I do wonder how many people understand exactly what it is and what is meant by it..."*
>
> — The Titular Archbishop of Selsey, Dr Jerome Lloyd, Chair of Brighton and Hove Faith in Action

### Advice for inclusive social prescribing

BHFA recommend that link workers find out which faith groups are working with vulnerable groups in the community, such as older people or people experiencing homelessness. This, they suggest, is the fastest way to become linked into social action networks among faith groups that are already active. BHFA are also pushing for a better way to host referral destinations online, recommending a single platform for use by VCFSE and statutory partners.

*"So what we're trying to do is to encourage the faith groups, who … so far have … delivered [services] very much within the interior of their own community … what if these could be shared with people who are of non-faith, and likewise by setting up these champions to make contacts within the local community, with GP surgeries and other VCSE groups working in their local area…"*

— The Titular Archbishop of Selsey, Dr Jerome Lloyd, Chair of Brighton and Hove Faith in Action

The Faith Covenant was developed by the All-Party Parliamentary Group for Faith and Society to enable effective partnership working between local authorities (and other commissioners) and faith groups. It entails a joint set of principles agreed to by the local authority and faith groups across a region. It has been signed by 24 local authorities to date, with strategic projects undertaken on issues such as homelessness, loneliness and isolation and public health messaging. The county-wide Essex Faith Covenant, for example, is currently delivering a project with a range of statutory and VCFSE partners looking at how FBOs can be better integrated into social prescribing.

- www.faithandsociety.org/covenant/

## 5. …is sustainable

- A proper triage of patients means schemes are not overwhelmed with people for whom social prescribing is not the most appropriate solution.
- The link worker role is properly supported and funded, ensuring job satisfaction and the time to focus on what matters most.
- Funding for schemes is sustainable and committed to the long term. Funding follows referrals to strengthen grassroots providers; schemes are not be propped up by "implicit" volunteer power within VCFSE organisations.
- Local networks of providers are engaged in collaboration and pooling of resources.

*"The reality is there is not enough funding within the system at large to make this work … so there needs to be collaboration to make this work"*

— Regional Lead for the NASP Thriving Communities programme

*"… the other side of funding pots is the people we're supporting in my … community, they are tired of being what they call a 'project', they are tired of being part of a pilot, they are tired of 'this will run for a year and then we're gone'."*

— Leader of church-led social enterprise

# What challenges do we face in making this a reality?

Our engagement highlighted six challenges for implementing inclusive social prescribing. These challenges are felt both within the VCFSE, or 'provider', sector, as well as within the health system, and are addressed within our recommended actions below. They are summarised as follows:

| Challenge | Faith/community groups | Health system |
|---|---|---|
| **— 1 — Language** | VCFSE organisations may use terminology at odds with the health sector<br>Practical language barriers; need for translation | "Social prescribing" may sound clinical/or be associated negatively with social services |
| **— 2 — Gaps in awareness** | Communities are unaware of social prescribing<br>Communities are unaware of the value of non-clinical interventions, and would rather see a doctor | Clinicians or social prescribers lacking awareness of health assets within the faith/ community sector<br>GPs unaware of when/ how best to use the social prescribing offer |
| **— 3 — Capacity** | Busy, underfunded VCFSE organisations may feel stretched or unable to receive more referrals | There is a high turnover of staff within social prescribing<br>Some link workers feel overburdened, which limits capacity for proactive outreach |
| **— 4 — Geographical inequality** | There is poorer social infrastructure and investment in deprived areas than in affluent areas | There are fewer GPs per head in deprived areas than in affluent areas<br>There is less GP funding per head in deprived areas than in affluent areas |
| **— 5 — Access** | Digital, language and structural barriers to accessing primary care limits access to social prescribing | Faith sector can seem complex or hard to navigate for statutory partners<br>Some faith groups can be perceived as "hard to reach" |
| **— 6 — Negative perceptions** | Some communities lack trust and confidence in healthcare<br>Communities face stigma surrounding seeking help for social or mental health needs | There are some fears within the public sector about a lack of professionalism among smaller faith and community groups |

# 1. Language

Both VCFSE organisations and the health system face challenges in communicating the meaning behind social prescribing.

## Faith/community groups

Some language used by the VCFSE can seem at odds with that used by the health system. Faith and community organisations might refer to "friends" rather than "clients", or "introductions" rather than "referrals". Pressure to adapt language and "translate" terminology may mean that community-based supports lose their distinctiveness. This is also beyond the capacity of smaller organisations.

Some people also need terms translated into a language that they can fully understand, as first impressions of the phrase can be very ambiguous and unrelatable.

> *"We use volunteers, and often I get inundated with emails from NHS, CCGs, etc., but we translate them into simple forms, or to be talked to our volunteers, so we say, 'this is what this is about' ... We bring in the other stakeholders, the NHS organisations, but we also make sure we simplify everything and bridge that gap."*
>
> — CEO of a Muslim-led VCFSE organisation in Birmingham

## Health system

Some health terminology can be alienating for patients. For example, the 'social' element of "social prescribing" has sometimes created an association with "social services", whilst "prescribing" has clinical connotations.

Clinicians therefore need to work alongside faith and community organisations to hear from the people they are serving to arrive at an inclusive term that conveys the true meaning of the phrase social prescribing.

> *"The word social prescribing ... I can imagine it might come off as a very medical term ... I think it needs to be something that is recognisable so ... even if someone is presenting something or talking about something ... that needs to be done by someone from that community so people can relate to them ... and giving examples of people having gone through social prescribing ... we've certainly found that referrals increase when we use that approach."*
>
> — GP and community lead in a mosque in North London

# 2. Gaps in awareness

There is some lack of understanding on both sides about the existence and usefulness of social prescribing services in providing non-clinical interventions.

## Faith/community groups

Some communities are unaware of social prescribing. Others are unsure about non-clinical interventions, preferring to visit a GP. A better integration of VCFSE provision into social prescribing can reduce the burden on primary care[4], so these gaps in awareness among faith leaders ought to be addressed.

Where community leaders are aware of social prescribing as a concept, they sometimes struggle to know how to get in touch with their local link workers.

*"...it took me reams of phone calls and lots and lots of emails, I had to be really proactive, and eventually ... by coincidence, I came across someone who said, 'Oh, I know your link worker'."*

— CEO of a Muslim-led charity in the West Midlands

*"I think it is really important to help faith leaders, who are often brought the problems of their communities, to understand that social prescribers exist in their community to help with those non-medical needs. Even if it is advice on what is available."*

— Regional Lead for the NASP Thriving Communities programme

*"We haven't actually got, as far as I'm aware, social prescribing running in our area..."*

— Founder of a faith-inspired domestic abuse charity in the West Midlands

## Health system

Clinicians can be unaware of the reach and the potential of faith and community groups, despite their being an asset in delivering non-clinical health interventions. GPs are also unaware of the array of social prescribing services they can refer into, be it counselling or debt support, to gardening and arts activities.

4. For example, research from the NHS shows that a large amount of GP appointments are made for issues that are non-medical in nature. www.england.nhs.uk/gp/case-studies/social-prescribing-reducing-non-medical-gp-appointments-and-delivering-a-better-service-for-patients-brownlow-health-princes-park-health-centre-north-west/

*Deeper insight...*

## Food for Purpose CIC

**Food for Purpose CIC (FFP)** are a not-for-profit nutritional wellness platform, born out of CEO Shola Oladipo's work as a dietitian within the NHS, as well as her experience as a church leader. FFP exist to support black and ethnic minority communities through adopting a two-fold approach:

- A prevention agenda with a focus on avoidable chronic illnesses
- Helping people live with illnesses such as type-two diabetes and obesity through culturally-relevant tools and resources

### Who do they partner with?

FFP operates in the south-London boroughs of Greenwich, Lambeth, Lewisham and Southwark, an area which has the highest number of black-majority churches in Western Europe. They have primarily worked at place level, delivering funded contracts NHS Clinical Commissioning Groups and public health teams through relationship with local councils.

### Barriers to communities accessing social prescribing

A major issue Food for Purpose have noticed is *perception of illness causation* in minoritised communities. Illness may be viewed as having a spiritual or supernatural origin, or be the result of factors such as racism and poor socioeconomic opportunities. Because of this, many seek to manage illness in spiritual ways, such as prayer, instead of taking advice from health professionals.

There is also an issue of *trust and misinformation*—after the COVID-19 pandemic, there are many pervading myths around accessing healthcare that are preventing people from coming forward.

### Advice for inclusive social prescribing

FFP have learned that the means of communicating important health messages to minoritised communities, including around social prescribing, should be carefully considered.

> *"...there are groups they are not reaching ... groups who do not have Instagram or read the newspaper... so ways of reaching the community probably need a bit of a rethink as well."*
>
> — Shola Oladipo, Food for Purpose CIC

Language is also important and needs to be relevant and accessible.

*"...if there was a different way of wording [social prescribing] it may help some people ... it's like a prescription paper that came from the doctor... it makes sense to the public sector but not ordinary people."*

— Shola

FFP recommend a holistic approach, delivering church-based health interventions to try and bridge the gap between faith and health spaces. Shola notes the absence of targeted, culturally-specific health interventions in the NHS, and suggests we should not be "squeamish" about bringing faith and culture into interventions, including social prescribing.

# 3. Capacity

Both the VCFSE sector and the health system are facing capacity challenges in their bid to deliver social prescribing, which can lead to restrictions in provision.

## Faith/community groups

VCFSE organisations are already very busy, and running on very tight budgets, meaning they are often limited in the numbers of referrals they can receive. This is frustrating for both those who are looking to deliver social prescribing and those who are waiting to be referred for social prescribing services.

*"... we've had to say to our local CCG, unfortunately we don't have capacity because ... it's a voluntary organisation run by volunteers who are putting in their own time ... they can see it's actually helping the clients they are sending, but I don't think they've thought through how we can sustain this with a funding model that works for the third sector."*

— CEO of a Muslim-led charity in south-west London

## Health system

A high turnover of staff within social prescribing services and the wider health system mean that link workers can be overburdened and overstretched, limiting the number of patients that they can realistically reach out to. It also creates difficulties in allowing GPs to connect consistently to social prescribing services provided by VCFSE organisations in their communities, limiting provision further.

*"And the other thing is just the turnover of staff, so we might invest that time in getting a social prescribing link worker connected to places but then they might move on, so we've had at least one change in our area, and that does lead to a loss of those connections, a loss of the capital that's been built up ... and that's an increasing challenge, the more demand and pressures on social prescribing there are the more you are likely to get a turnover of staff and people moving on from those roles quite quickly."*

— CEO of a church-based charity in the West Midlands

*Deeper insight...*

## Karis Neighbour Scheme

**Karis Neighbour Scheme (KNS)** grew from an awareness among GPs in Birmingham that the lack of wellbeing for which people seek help from their doctor often has multiple causes. Some of these are not clinical, but can be related to other issues such as isolation and inadequate housing. One local practice had pioneered a solution to this by appointing a GP Chaplain to help connect patients with capacity within the community to meet social need. Inspired by this model, KNS was set up in 1999 as an independent charity to help join up church-based supports with the social and emotional need identified in primary care.

The remit of KNS is to utilise people's time and skills to address the needs of the local community. Operating in the areas of Ladywood, Harborne and Edgbaston in Birmingham, their work ranges from English courses for newly arrived refugees, to befriending projects for older people experiencing social isolation. They host a variety of drop-in sessions, offering practical guidance for things such as chasing up housing repairs and filling out benefits forms.

Some of the barriers Karis Neighbour Scheme said that people in their community face in accessing social prescribing include:

- *Seeing a GP*—whilst Karis Medical Centre has a strong record on patients accessing appointments, capacity issues within the NHS mean that, more broadly, access to appointments, and therefore social prescribing opportunities, can be tricky.
- *Digital access and exclusion*—some people in the community have no internet at home, meaning they struggle to access information about health services. KNS also note a huge risk here that those living in temporary accommodation are not registering for a GP, but they are currently working with Birmingham City Council on ways to solve this.
- *Gaps in the workforce*—there is a high labour turnover for link workers, and gaps in recruitment mean that support is often unavailable when needed.

### The approach

KNS work within a 'wellbeing team' in the medical practice with which they are connected. This team supports with 'triaging' of patients referred by the GP, taking pressure off busy link workers and ensuring that link workers only see patients for whom social prescribing is the right solution.

*"...that's helping our social prescribing link worker ... it's filtering out some of the things that might have been just pointed their way [so that] there is a triage function which will look at things ... is that social prescribing? What's the need here? Could it go to someone else?"*

— Harry Naylor, CEO, Karis Neighbour Scheme

KNS are unique in that they act as a visible hub for social prescribing in their community – local people know where they can find support when they most need it, without having to navigate complex online systems or try to access the GP.

### Advice for inclusive social prescribing

KNS emphasise the need to think about the remit and capacity of link workers:

- Resource should be allocated to enable link workers to get to know the groups to which they refer, since referrals based on knowledge and relationship are more effective;
- High turnover of link workers affects continuity and local knowledge; systems should ensure that the link worker role is sustainable, with sufficient support.

Finally, KNS stress the need to ensure social prescribing is easier to access, with multiple routes in including community hubs themselves, not just GP surgeries.

# 4. Geographical Inequality

Deprived areas have much worse outcomes in terms of both community and health system provision of social prescribing.

## Faith/community groups

Poorer social infrastructure in deprived areas compared to affluent areas[5] means there is a discrepancy in the quality of social prescribing services available. Furthermore, those living in deprived areas are more likely to be unaware of what social prescribing is due to poorer levels of literacy and education.

## Health system

Some areas have better resourced health systems than others. For example, in 2020 the Health Foundation found that there are fewer GPs per head in deprived areas, than in affluent areas[6]. GP practices in the most deprived areas also have worse Care Quality Commission (CQC) ratings and lower patient satisfaction scores than practices serving more affluent populations.

5. See the report for the APPG for Left Behind Neighbourhoods, "Communities of Trust" (2020): www.appg-leftbehindneighbourhoods.org.uk/wp-content/uploads/2021/03/8118-APPG-Communities-Report-NEW.pdf
6. The Health Foundation, "Level or Not?" (2020): www.health.org.uk/publications/reports/level-or-not#:~:text=There%20are%20fewer%20GPs%20per,for%20doctors%20in%20these%20areas

# 5. Access

There is a disconnect that still exists between communities, faith groups and the health system, ultimately hindering both delivery and referrals to social prescribing services.

## Faith/community groups

For many people, the health system feels alien, exclusive, or closed-off. This can be due to difficulties in getting timely appointments, but it can also be due to external social or economic barriers, such as literacy and digital exclusion, as well as cultural barriers like lack of trust in the health system and professionals.

> *"I work for the NHS as admin for maternity, and I've found that a lot of the time patients … who share the same culture or the same faith come to me first rather than go to the midwives, and that is because … we share a common interest … the same faith or the same culture … and they come to me first because they think that they can say something more openly before going to the midwife and speaking about it, whereas they will reserve a few things when they are speaking to the midwives and the doctors …"*
>
> — Leader of a community-based charity in Tower Hamlets

## Health system

Some people working in the statutory sector see the faith and community sector as complex and difficult to navigate, viewing some faith communities as "hard to reach". The diversity of types of community and faith-based organisation, from places of worship, to faith-based social enterprises, to larger, multi-faith infrastructure bodies, can make it tricky to know where to start when engaging with the sector. In some places, there can be a hesitancy to engage with faith organisations for fear of exclusivity, or inappropriate use of public funds.

This means there can be a gap in knowledge within the statutory sector of the breadth and depth of support offered by community and faith organisations.

When it comes to social prescribing, link workers "don't know what they don't know" when it comes to community and faith organisations. Often proactive research and outreach is needed before referrals can be made.

> *"The diversity of the sector means it can be daunting for ICSs to engage with it systematically…"*
>
> — Statutory sector representative working at a national level

# 6. Negative perceptions

Similarly, the disconnect and lack of trust between faith groups and the health system also means there are negative perceptions from both sides that need healing.

## Faith/community groups

Some communities lack trust in the health and care system. There can also be stigma surrounding receiving professional help for mental health and social care needs amongst some faith communities, which can further hinder people from accessing social prescribing services.

Trust therefore needs to be rebuilt and faith organisations can play a role in facilitating better channels of communication between faith congregations, local communities and the healthcare system.

*"[The community] are still reluctant to actually get a referral from GPs, because of adverse effects and things that have happened in the past, and what's been said in the community, so building back the faith again and trust in people ..."*

— Leader of a community-based charity in Tower Hamlets

## Health system

We have heard that some health professionals lack knowledge about the type of work that faith and community groups are carrying out around social prescribing, especially when it comes to smaller faith organisations. There can also be fears within the statutory sector around a lack of professionalism in grassroots faith and community groups, as well as fears around faith groups trying to evangelise or convert people through their work.

*"Social prescribing needs to include the faith organisations ... so mosques, churches, synagogues, they need a hub or something there so that people go directly to them ... we did a workshop in the community and people did bring that up ... that they prefer going [to] social prescribers in those settings than to go into the GP and talk to the GP or the receptionist."*

— Leader of a community-based charity in Tower Hamlets

*"...there's a distaste for working with faith communities that still exists in some bits of the public sector ... because they think about proselytism ... that is still there and it is still real."*

— Director of public health in the East of England

*Deeper insight...*

## Approachable Parenting: responsive, flexible support for Birmingham Muslim communities

Birmingham-based charity **Approachable Parenting (AP)** was established over a decade ago to meet the needs of black and ethnic minority families, particularly within the local Muslim community, who struggled to engage effectively with parenting support schemes and other services. The organisation has since offered a wide variety of programmes. Drawing from psychology and the Muslim faith, AP offers support from pre-marriage, through to parenting teens, offering peer support and counselling where needed to help beneficiaries navigate through their life journey. AP supported 4,000 individuals during the COVID-19 pandemic alone.

### How it works

AP adopts a flexible, relational approach when it comes to referrals to and from healthcare, maintaining long-standing links with local healthcare professionals, including midwives, counsellors and representatives from NHS trusts.

AP receive referrals directly from primary care, as well as other services, like local perinatal services. They also receive referrals from schools and children's centres and are included on a number of local asset registers, including Green Square Accord housing association, the Flourish register and the Faith Alliance Connect directory. AP prioritise prevention and pre-emptive intervention, looking for ways to help families as early as possible, and preventing problems from becoming deep-rooted.

### Challenges

Seeing a GP in the first place can be difficult for communities that AP engage with. Some parents assume there will be repercussions, for example, if they describe mental health difficulties or vulnerability to a health professional.

> *"To even be able to say to the doctor, 'look, I've been having quite a few low days, recently...', to say that to a GP ... from the parents' perspective is like, 'if I say that to a GP they are going to take my children away, automatically."*
>
> — Manager, Approachable Parenting

Part of the solution, AP recognise, is breaking cultural stigma around mental health and wellbeing, in part through encouraging strong peer-mentoring networks. These support networks allow parents to share their problems with likeminded people in a stigma-free environment, whilst encouraging engagement with healthcare services. Reframing

language and translation into community languages is at the heart AP's inclusive approach, recognising that overly-clinical language automatically creates a barrier.

> *"Everything is around language. When it's branded in a certain way there's a barrier automatically there. 'Why are they targeting me?' It has to be simple."*
>
> — Pakistani mum

### Advice for inclusive social prescribing

For AP, social prescribing should be built upon accessible, relatable language, cutting through any stigma associated with referral for social or emotional needs. It should also place an emphasis on working from trusted, long-term relationships – both across sectors, and with beneficiaries. Support offered should be personalised and tailored to beneficiaries' needs, be that accompaniment to the GP, or speaking with teachers at school. Social prescribers should also seek to link with places of worship, as faith leaders will be trusted messengers for their communities. AP are currently working with a local imam, who is an experienced counsellor and supervisor with extensive experience working in NHS contexts; they hope more partnerships like this will enable other faith congregations to support their members holistically.

# How can we apply this learning?

Throughout our engagement we asked participants about their suggestions for how to better embed partnership working between local social prescribing schemes and grassroots VCFSE organisations. The following thirteen recommendations, for social prescribing host organisations/commissioners, wider health systems, and the faith and community sector, summarise the key themes of their responses.

## Social prescribing commissioners and host organisations should...

### Ensure local social prescribing schemes are relatable and approachable for communities experiencing inequalities

We heard that communities experiencing inequalities will feel more welcome within social prescribing pathways if link workers and other practitioners come from similar backgrounds, and are able to empathise with their own situation. In some cases, patients have expressed that being referred to non-clinical supports felt like being passed around a system, rather than an opportunity to receive more personalised care.

- ☑ The face of any service needs to be recognisable to communities. Recruitment campaigns for link workers, as well as other roles supporting social prescribing, should seek to proactively include people from seldom-heard communities.
- ☑ Funded or volunteer-led "community champions" schemes could be an effective way of bridging the gap between community-led organisations and social prescribing schemes.
- ☑ Local schemes could develop multimedia 'stories' illustrating how different community members have accessed and benefited from social prescribing. These assets could be shared widely via channels such as Facebook or community radio.

> *"The face of any service ... I think it needs to be [someone] that is recognisable ... even if someone is presenting something or talking about something ... that needs to be done by someone from that community ... we've certainly found that referrals increase when we use that approach..."*
>
> — GP and community coordinator in a mosque in North London

**Brighton and Hove Faith in Action** have developed a social prescribing 'champions' pilot, in partnership with Brighton and Hove City Council, two local churches and one mosque. Local VCFSE providers have teamed up to provide training for several volunteer champions within local faith communities, who are able to signpost their local community members to social prescribing schemes. The programme has been made possible by a small amount of funding from the city council.

*"I work for the NHS as admin for maternity, and I've found that a lot of the time patients … who share the same culture or the same faith come to me first rather than go to the midwives, and that is because … we share a common interest … the same faith or the same culture …"*

— Leader of a Muslim-led community organisation in East London

## Reframe language surrounding social prescribing so that it is accessible for communities

We heard that many communities experiencing inequalities find that the term "social prescribing" can be alienating when used out of context, and without proper explanation. In some cases, it has been viewed as overly clinical, in others, it has been associated negatively with referrals to social services. Local schemes should consider marketing and language around their offer and ensure that it is presented in a way that makes sense to communities.

- ☑ Local social prescribing schemes should work closely with grassroots faith/community groups to co-design, test and roll-out a vocabulary surrounding their social prescribing offer that is clear and accessible.
- ☑ In some cases, translation into community languages may be necessary, as well as adoption of formats such as easy read.
- ☑ For consistency, 'social prescribing' should be retained as an umbrella term but de-emphasised within local marketing. Co-designed names and vocabulary for schemes could be adopted at a hyper-local level.

*"Language is so important. We're really used to categorising everything in organisations, and that's not how people listen, or hear, is it?"*

— Regional Lead for the NASP Thriving Communities programme

*"The term 'social prescribing' throws people off, as people associate it with social services or with health…"*

— Community co-ordinator at an East Midlands-based social prescribing provider

The **Social Prescribing Plus Partnership** in Brighton and Hove, led by Together Co. and developed in partnership with Trust for Developing Communities, Sussex Interpreting Service, LGBT Switchboard and Friends, Families and Travellers, is an excellent example of a social prescribing service tailored for specific communities. These partnerships work with people facing the greatest inequalities, and recruit link workers with lived experience who can understand and empathise with patients facing multiple barriers to accessing traditional schemes. Approaches have included translation of messaging, as well as reframing language around services to make them more culturally appropriate.

## Create visible communication pathways for VCFSE organisations

Awareness of social prescribing, generally, was low among VCFSE participants we engaged with. Where some people had heard of the concept, they often did not know how to get involved. The diversity of models, across primary care, local authority and VCFSE host organisations, means there can be no universal 'route in' to social prescribing, but greater clarity on where link workers are situated in localities will help VCFSE organisations engage.

- ☑ Clarify where grassroots VCFSE organisations should go if they have questions about social prescribing or want to get involved. This may be a named individual, an email inbox or a phone number.
- ☑ National and regional mapping of social prescribing host organisations should be completed for all regions of the UK. This should be combined with proactive local marketing and outreach, since online directories, whilst helpful for those who know where to look, will not be accessed equally by all communities.
- ☑ Consider commissioning multiple physical locations to act as local social prescribing advice "hubs". These might be approachable, locally-known venues, such as a shopping centres, or libraries, or could be co-located within the VCFSE sector.

*"I was running a programme telling voluntary sector organisations, 'get in touch with your link worker', and then I realised how impossible it was!"*

— Regional Lead for the NASP Thriving Communities programme

The **Barking and Dagenham place-based partnership** have established six VCFSE 'locality leads' across the borough, with a view to better networking local non-clinical support and building connection between sectors. The six 'localities' map directly onto PCN footprints, allowing for the VCFSE leads to build relationships with local clinical directors and social prescribers. VCFSE leads are using WhatsApp groups to draw together local community partners, including many smaller, grassroots groups that may not be captured within larger mapping exercises. The goal is to join up local provision across primary care, wider social prescribing services and the VCFSE.

*"I haven't really seen much advertising of social prescribers, what they do, on TV or radio … I regularly get patients saying, 'Oh, I just heard I need a prostate examination because of the risk of prostate cancer' … but I personally haven't come across much in the way of social prescribing"*

— GP and community co-ordinator at a mosque in North London

## Make sure any local mapping of services goes beyond the 'usual suspects'

A greater diversity of social prescribing providers and destinations will allow for a more personalised social prescribing offer. Our roundtables revealed both the advantages and challenges of attempting to map local services. Good service directories can raise awareness of the breadth of services available, however, they must be regularly tested and updated to have lasting effectiveness.

☑ Be aware that, whilst helpful, mapping exercises will not always capture the full diversity of the VCFSE sector and will be very quickly out of date. Make every effort to fill blind spots or gaps, and be willing to persistently ask, "who are we missing?" both internally, and as you speak with VCFSE organisations.

*"The services out there that social prescribers would like to put people in touch with are subject to such constant change … you know they do things they weren't doing, they don't do things they were doing, they are doing them in different areas, they've got different criteria, it's incredibly difficult for anybody, whether a member of staff or a volunteer, to keep up to date even in quite a small geographical locality or a particular community."*

— Service manager of Carers support organisation in the East of England

- Involve grassroots VCFSE organisations in mapping exercises, with appropriate renumeration; they may have a richer knowledge of local provision and be able to help point out where existing directories are lacking.

*"[we were] recognising some of the referrals we were getting weren't appropriate for us so we were able to ... connect [the link workers] to other local groups, just go down and make introductions, so there's sometimes a kind of network effect of being able to support each other in that respect which can work well, but obviously we're not really paid to do that..."*

— Director of faith-based social prescribing provider in the West Midlands

*"...a real difficulty in this sector is that ... there is a huge amount out there but when you work with citizens from any communities, what people always say is, "I never knew that was happening .... how long have you been doing that, 10 years? I've never heard of you!" ... If there was a better way of ... collating and disseminating that information more effectively that would be a huge time saver and lead to much more effective interventions for people."*

— Service manager of Carers support organisation in the East of England

## Wider health systems should...

### Encourage representation of the faith and community sector in place-based forums

The formation of VCFSE Alliances across the country presents an opportunity for greater alignment across the charitable sector around programmes such as social prescribing. Yet we know that many grassroots groups do not know about these Alliances, much less how to have their voice heard. Place-based leaders should proactively ensure the voice of the faith and community sector is represented in strategic local forums such as these.

- ☑ Chairs and members of place-based VCFSE Alliances and partnerships should proactively include faith representation in these groups. They might consider approaching the sector through local inter-faith fora, Faith Covenant chairs, or other faith-based infrastructure organisations.
- ☑ Be continually asking, "whose voice are we missing?" Don't assume that because one kind of organisation is represented, the whole sector is spoken for.
- ☑ Consider what funding or non-financial support may be needed to empower a range of communities to participate in place-based forums.
- ☑ Build upon existing engagement work and networks, particularly those forged during the COVID-19 pandemic. Many strategic local partnerships were formed around public health messaging, vaccination uptake and surge testing; there is great opportunity to build upon these partnerships through strategic work around social prescribing.

**Brighton and Hove Faith in Action's (BHFA)** social prescribing 'champions' pilot was a direct result of joint work between BHFA and the City Council around COVID-19 priorities. New networks and partnerships were formed, and local groups seized the opportunity to apply this learning to widening access to social prescribing.

*"I think we've got a real opportunity at the moment with the formation of these Integrated Care Systems in the NHS, a real opportunity to make sure that people who are out there working in the community are heard ..."*

— Regional Lead for the NASP Thriving Communities programme

*"...so this is where that ... point about making sure you're represented on those patient participation groups and ... Voluntary Sector Alliances [is important] ... because if you're not represented ... that's where funding and thought on funding is going to filter down ... that's going to be a forum to discuss this subject ... so I think it's really important that we get people from different faiths and communities represented there..."*

— Regional Lead for the NASP Thriving Communities programme

## Ensure that sustainable resource flows to the neighbourhoods that need it most

We heard that VCFSE organisations, link workers and social prescribing network leads alike are experiencing capacity challenges limiting their effectiveness. To achieve truly inclusive social prescribing there must be strategic, long-term investment in connector schemes, so that link workers are able to build diverse networks of grassroots providers, and that these providers are equipped to receive new referrals.

- ☑ Integrated Care Systems should invest strategically in social prescribing schemes proportionate to the need in communities. Decision making around fund allocation should be driven by local data, as well as priorities set by the Core20PLUS5 approach for reducing inequalities.
- ☑ Sustainable funding should be made available specifically for VCFSE organisations within communities who face barriers to accessing healthcare.
- ☑ Approaches to grant funding should be flexible, and commissioners should move away from 'competitive' tendering models which may exclude smaller, less experienced organisations. Monitoring and accountability should also be simple and proportionate.
- ☑ Any funding should be equitable and not exclude organisations with a faith basis.

☑ Where appropriate, non-financial forms of support and resourcing should be offered to the VCFSE sector, including training opportunities, capacity building and involvement in wider workstreams.

*"Because of the economic climate … not everybody can afford to give their time for … well it's never for nothing … but without renumeration."*

— Leader of faith-based health promotion charity

*"We've had to say to our local CCG, 'unfortunately we don't have capacity because … it's a voluntary organisation run by volunteers who are putting in their own time' … They can see it's actually helping the clients they are sending, but I don't think they've thought through how we can sustain this with a funding model that works for the third sector."*

— Leader of faith-based community organisation in South West London

*"Within the Indian subcontinent area you have the notion of 'sewa', service to others selflessly, and this is where … you know you just naturally provide, in your mosque … in your temple, in your gurudwara … and a lot of that service is social prescribing. But we're not included in the design at the moment … in terms of allocating funding for the provision of the service. And then it falls down to volunteering and 'sewa' … where does a person's notion of 'sewa' begin and end …?"*

— Leader of multi-faith community organisation in the West Midlands

## Ensure all primary care professionals are supported to make appropriate use of the social prescribing offer

We heard from participants that, whilst awareness of the social prescribing offer seems to be increasing among GPs and other professionals within primary care, there is a lack of clarity about the proper function of the service. Inappropriate triaging of patients led to link workers receiving referrals which they were ill-equipped to deal with, as well as being overburdened with the sheer volume of patients being referred.

☑ Social prescribing schemes should be supported to engage regularly with local monthly GP teaching provision to ensure ongoing awareness raising among professionals about the function of social prescribing.

☑ Link worker host organisations should ensure link workers are adequately resourced to do the work of engagement and training of other health professionals. Link workers should also have access to ongoing supervision, peer support, and wider training and support networks.

### Adopt 'community champions' models to raise awareness of social prescribing within communities

Funded and volunteer-based community champions schemes were effective during the COVID-19 pandemic at ensuring key public health messaging was being heard at community level. Recognising the power of 'trusted voices' among communities, including influencers, community coordinators and faith leaders, will be key to ensuring everybody knows about social prescribing and has opportunity to take part.

- ☑ Learn from existing social prescribing 'champions' pilots, such as those happening in Brighton and Hove, and roll these out more widely across the country. Partnership with a range of community groups, including those representing faith, LGBT+, carers, and people with learning disabilities, will ensure a wider reach.
- ☑ Ensure that any such schemes allocate proper funding and renumeration for champions themselves.

> *"One of the brilliant things that Trust for Developing Communities did is that they actually … paid community connectors from communities … so it was £10 an hour for [10 hours a week] … because people cannot afford to do all this volunteering, to keep doing everything for nothing …"*
>
> — Regional Lead for the NASP Thriving Communities programme

## Grassroots faith and community groups should...

### Familiarise yourself with the local health and wellbeing landscape

It is not always easy to know where to go to get connected with your local social prescribing scheme, but there are a few good places to start:

- ☑ The National Academy of Social Prescribing (NASP) Thriving Communities programme is all about helping grassroots VCFSE organisations get more involved with social prescribing. There are Thriving Communities leads in each region of the UK who will be happy to help identify the best way for you to link in, locally, or put you in touch with a link worker. You can find these contacts for your region, and get in touch, here:
  - socialprescribingacademy.org.uk/our-work/thriving-communities/regions-contacts/

☑ Speak to other VCFSE organisations near you who seem active and well connected with health and care services. Explore how you can work together to better serve the needs of residents, and link into existing social prescribing schemes.

*"From the social prescribers I know, if you can get hold of one of them … they are usually quite good at sharing information across their locality as well … so if you can get hold of one in your area you can usually get hold of all of them."*

— Health Inequalities Officer at a local authority in the South East

Across the UK, groups of charitable organisations called VCFSE 'Alliances' are forming to help connect communities with decisions being made about health and care.

☑ Contact your local Council for Voluntary Services (CVS), or local Healthwatch, to find out more about what this Alliance looks like where you are, and how you might get involved. Even if you are not eligible to join the Alliance, there may be ways to have your voice heard at this strategic level.

*"I think it's incumbent on statutory organisations who are forming those Alliances to make sure there is a place at those tables where conversations are happening for local faith and community organisations to have their say, and to make sure the needs of the communities they represent are heard."*

— Regional Lead for the NASP Thriving Communities programme

## Identify what you have and what you need

VCFSE organisations have a wealth of 'assets' that are of value to the health and care system. These could include physical buildings, vehicles, the time and capacity of staff or volunteers, as well as specialised knowledge. Some faith communities have an ethos of care or compassion, or a commitment to giving of their time in service or 'sewa'.

☑ Periodically assess the assets of your faith community; note that assets at your disposal (spaces, personnel, time and resource) may change over time.

☑ Clarify your offer to health and care services, as well as your remit and your limits. For example, do you work with individuals of one faith, or all? What kind of work is possible within your current capacity, and what would you need extra funding for?

☑ Try to be as specific as possible when describing what you may need to statutory partners like local authorities, public health teams or commissioners. Funders will be more likely to provide resource when your proposal is clear and specific.

☑ Consider whether you can pool resources/assets with other like-minded VCFSE organisations. Can you achieve more by better joining up local provision?

## Seek to work collaboratively with other faith and community groups

Building strong local partnerships is great for three reasons:

1. It improves efficiency and cost effectiveness as organisations pool resources, work in complementary ways and avoid duplication.
2. It's better for beneficiaries, as greater networks of connected faith and community groups mean larger pools of activities and referral destinations to suit people's needs.
3. It can attract more financial resource to the sector, as networks and consortia can often more effectively apply for statutory funding than lone organisations.

☑ Seek to find out which other organisations are doing things that might complement your own offer. For example, are there community or support groups that are open when you are closed? Could you help refer your own beneficiaries to them?

☑ Local Inter Faith fora, as well as VCFSE infrastructure organisations like CVSs, are good ways to find out about other faith/community groups locally.

☑ Work in partnership and dialogue with other organisations; be willing to form networks and consortia to attract new funding and facilitate effective social prescribing.

*"We've got to try and avoid becoming 'pillared' in our thinking, at a local level, at a regional level, at a national level. If we keep on thinking of the provision of a service down a Christian [route], a Jewish [route], a Hindu [route] ... things are not sustainable ... we are bringing people and communities together from different faiths ... so that the back end of the service is interreligious and co-operative, but the front end is about the individual need..."*

— Leader of West-Midlands-based multi-faith charity

*"No one person or organisation knows everything ... we need collaboration to get perspective and allow projects to thrive."*

— Community co-ordinator in an East Midlands social prescribing provider

## Seek to better understand the people you work with and the health challenges they face

Understanding the kinds of people who use your services will help you tailor activities to the specific challenges and inequalities they may face. Knowing where to find data about your area and the kinds of inequalities residents experience can also allow you to think more strategically about what you offer. It will also help you articulate your strengths when applying for funding.

- ☑ Build a picture of the people that make up your locality, and those who use your services. Ask them about any challenges they may face in accessing healthcare. Can changes be made to your programme of activities considering this?
- ☑ Public health data on different local authorities throughout England has been captured by OHID, and can be found here:
  - fingertips.phe.org.uk/profile/health-profiles/data#page/1/ati/101/are/E09000033

## Evaluate the impact of what you do

Your activities may seem simple, but there are lots of ways to begin to capture different kinds of data, and prove its effectiveness at making people feel more connected, pointing them to the right kinds of support, and improving wellbeing. Showing that your activities are good value and make a difference will help with accessing funding. It will also help you determine what is working well, and what can be improved.

- ☑ Consider how to evaluate your work and demonstrate your impact. Data can be captured through simple feedback surveys, as well as things like case studies and stories or testimonials. Sometimes a simple quote about the difference your organisation has made to someone's life can be incredibly powerful.
- ☑ Remember, what might seem simple or "everyday" to you might be entirely new to someone working in the NHS. You will have insight and expertise on the people you support, as well as your faith or community context, that will be extremely helpful to those within your local health system.
- ☑ FaithAction have produced further guidance and training on evaluation for VCFSE organisations, which can be accessed here:
  - www.faithaction.net/working-with-you/health-and-care/evidence/how-to-evaluate-your-work/

Faith Action

VCSE health & wellbeing alliance