Social Prescribing in Liverpool

Position statement
May 2015

LCVS

LCVS IS THE United Way IN LIVERPOOL

Social Prescribing in Liverpool
Position Report May 2015

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1. Introduction

Liverpool Charity and Voluntary Services (LCVS) has been commissioned by the Families Strategic Group at Liverpool City Council to gather information about current social prescribing (SP) activity in Liverpool; namely, the shape and reach, who is doing it, and what development opportunities might exist.

Specific requirements of the brief were to look at:

- Scope and range of current practice
- Measuring the impact
- Funding
- Links to local strategies
- Voluntary sector understanding of health determinants/mental health issues

A recent report commissioned by LCVS into the size and shape of the voluntary sector has revealed that there are currently around 1,300 registered voluntary sector organisations in the city, with an estimated 1,700 more operating 'below the radar'. Across the city region, the voluntary sector has proportionally more organisations involved in the delivery of public services, emotional support and befriending, advice and support and advocacy and representation than is the case nationally, which gives a clear indication of the level of experience and expertise the sector can offer, and the potential for partnership with the statutory sector to improve health and well-being *(Measuring the Size and Scope of the Voluntary and Community Sector in the Liverpool City Region; Jones, G and Meegan, R, European Institute for Urban Affairs; Liverpool John Moores University; March 2015).*

2. Methodology

A combination of desk-based research, telephone and face to face unstructured interviews and focus groups, along with attendance at various network events was used to inform this document.

Whilst the primary focus is on Liverpool, social prescribing projects elsewhere in the country are included to provide a wider context for the report.

3. What is 'Social Prescribing'?

It has been evident throughout the research for this report that there are variations in understanding of what social prescribing is. For example, the definition below,

proffered by the Centre for Regional Economic and Social Research defines SP as follows:

'*Social prescribing commissions services that will prevent worsening health for people with existing long-term conditions and reduce costly interventions in specialist care. It links patients in primary care, and their carers, with non-medical sources of support within the community'*. (*The Social and Economic Impact of the Rotherham Social Prescribing Project, September 2014).*

Within the context of the report from which it comes, this definition makes sense, as the Rotherham SP project relates specifically to patients with long-term conditions, pre-identified by their GPs as meeting the criteria for a commissioned service. However, literature searches and conversations held as part of this research would suggest that the definition extends more widely than this, to encompass programmes that exist within secondary care to address step-down and recovery, as well as those that attempt to meet the needs of people for whom adverse social factors play a significant part in their health and/or well-being.

Perhaps a more appropriate definition is the broader: 'A mechanism for linking people to non-medical sources of support within the community'. These services may or may not be commissioned directly by statutory services, and referrals to them may come from a wide range of professionals across health and social care services. It could even be argued that the only role a professional might play is that of signposting a patient to an appropriate activity.

Broadly speaking, SP divides into two categories, although some studies have sub-divided these further. For example, Dr Richard Kimberlee from the University of the West of England (*Developing a Social Prescribing Approach for Bristol, 2013)* identifies four different models of SP that give an idea of the ways in which it can be implemented. In the interests of simplicity, this report will confine its focus to:

Information and signposting – where a practitioner, who may be a GP, but is more likely to be either a health trainer or a community link worker of some kind, provides information and encourages the individual to access appropriate support, based on the outcome of discussions with the patient about their needs and interests. This might be another health-linked service, such as exercise or advice on prescription, or a community-based activity such as a men's social group or 'Knit and Natter' sessions.

Supported referral – where an intermediary, such as a community link worker or adviser works with the individual to ascertain the most appropriate activity, according to their needs and personal preferences, and then pro-actively assists that individual to engage. This pathway is most often seen where there is a clearly defined, funded

SP project, or within a wraparound wellness service, (see examples of these models later in this report).

Why social prescribing?

Proponents of SP cite a number of benefits, or potential benefits for both patients and the health service. Most social prescribing initiatives focus on activities such as arts and creative pursuits, access to the green environment, sports and other physical activity, learning and volunteering. Addressing the wider determinants of health in more creative, non-medical ways can produce benefits such as:

- Increased self- esteem and raised mood
- Reduction of social isolation and/or loneliness
- Sense of purpose and independence (e.g. through volunteering)
- Improved transferable skills (e.g. for employment)
- Better engagement with self- care and behaviour change in relation to health.

For the NHS, the benefits would potentially be reduced number of attendances at primary care appointments, fewer unplanned hospital admissions, and consequently, a financial saving. Some SP programmes, e.g. Rotherham's, have generated some positive evidence to support this, and to suggest that communities can benefit from the mobilisation of the voluntary sector that is enabled by access to NHS funding, but to date this is small-scale.

With the current impetus towards more integrated service provision, and an increasing emphasis on empowering people to take more control of their self-care and well-being, it would seem that an SP-friendly climate already exists in Liverpool. However, the translation of simple ideas into actual delivery is often far from straightforward, and finding an appropriate delivery model can be a challenge.

4. Liverpool and Social Prescribing – the current picture

At time of writing, Liverpool has two commissioned programmes operating on a social prescribing basis, i.e. referrals from a primary care practitioner into a non-medical intervention. These are:

Advice on Prescription, a service commissioned by Liverpool Clinical Commissioning Group and now available in all GP practices in Liverpool. Provided by the CAB, it allows GPs and other practice staff to refer patients for practical advice and support, around issues such as redundancy, domestic abuse and benefit suspensions. Clients most likely to be referred are those presenting with anxiety and stress-related symptoms caused or exacerbated by their life situations. The service, which began its phased roll-out in January 2014, is now operating city-wide.

Between April and October 2014, the service had received 2000 enquiries, leading to an estimated household income increase across the city of £2.2m. This has been achieved in various ways, including enabling access to unclaimed benefits to the value of £250,000 and a debt reduction of £100,000 for patients signed up to the scheme. The CCG is planning to evaluate the service in 2015/16, and has identified an investment requirement of £500,000 for delivery in 2016/17 as part of the Healthy Liverpool programme.

Exercise for Health is a programme supported by the City Council, through which GPs can prescribe 12 weeks of exercise sessions at council-run Lifestyle Gyms at a reduced cost to the patient. This service in its current form is potentially under threat from cuts to City Council budgets, which are leading to the closure of some Lifestyle Centres.

In addition to these commissioned services, there are numerous examples of informal referral into non-medical, community- based providers by GPs and other primary care practitioners, as well as social care staff. This kind of referral happens on an ad hoc basis, and is largely dependent on the knowledge of primary and social care practitioners about what is available in their area.

5. 'Community Referral' initiatives

Health Trainers, employed by social care charity PSS, and based in a number of GP practices in the city, have a remit to work on a one-to-one basis with patients deemed by the GP to be in need of a focused intervention around behaviour change, for example, smoking cessation, increasing physical activity and reducing alcohol intake. Under current arrangements, 80% of referrals to health trainers have to come directly from GPs.

Although it is not yet a formal part of their role, some health trainers will refer patients on to another service or community activity at the end of their 12 week behaviour change programme. After a discussion with the patient, health trainers will either use their own knowledge of the locality, or a directory of services to find an appropriate activity to which they can signpost the individual. It does not appear that any formal follow-up of these patients is carried out once they have been signposted into the community.

Age Concern runs a service called **Community Health Ambassador Teams**, or CHATS. Funded by Public Health, they run health information events in the community for people aged 16 and over and make referrals, where appropriate, to the Health Trainer Service or to other organisations, e.g. the smoking cessation service Fag Ends.

At time of writing, Liverpool City Council has just commenced a re-tendering process for Health Trainer and Community Health Ambassador services, with the publication of a ‘soft market testing’ questionnaire on The Chest North West Portal.

Healthwatch Liverpool occupies a central position in terms of signposting for both members of the public and practitioners. Healthwatch hosts the Livewell Liverpool service directory, which is constantly updated, and which can be accessed by anyone looking for a service or community activity. Anecdotal evidence suggests that the directory is used to some extent by health trainers, but that usage by GPs is sporadic at best, despite a GP-friendly version (RALFY) having been produced.

6. Social Prescribing/Community Referral in the Wider Sector

It would not be feasible for this document to try and list every incidence of primary care referral into third sector provision, since any attempt to do so would inevitably be inaccurate. However, it is fair to say that there is currently no city wide system or framework in place for social prescribing, a statement borne out by the conversations with commissioners and providers that have informed this report.

Informal interviews with representatives from ten third sector organisations of different sizes and areas of benefit revealed a variety of experiences of interacting with health and social care services. The unifying factor was a belief that statutory services were ‘missing a trick’ by not utilising the knowledge and expertise of the sector more widely. All the organisations consulted had a good understanding of the concept of social prescribing, and of its potential benefits both for patients, in terms of increasing their options for managing their health and well-being, and for the organisations in terms of sustainability, assuming that the service was commissioned.

Of the 11 organisations who participated, only 2 had any kind of regular flow of referrals from GP practices, and this was because of their own pro-active engagement with practices in their locality. This would appear to align with the perception that, on the whole, GPs tend to be more likely to ‘prescribe’ a social intervention if there is either a pre-existing relationship of trust between the GP and the provider organisation, or the provider organisation has a track record, or an existing arrangement for provision of health-focused activity (*An Investigation into GPs and Social Prescribing, Glasgow Centre for Population Health and Glasgow South East Community Health and Care Partnership, 2007).* To give a local example of this: one organisation, an education-focused provider in the north of the city offers person-centred counselling, delivered in-house by qualified volunteers. The management team has actively promoted their service, which is solely grant funded, to local GP practices, and received 80 referrals from GPs in 2014. The counsellors

refer a significant number of their clients into the education services provided by the organisation, and monitor their progress, although no formal evaluation of the individual outcomes is ever asked for by GPs. However, it does illustrate GPs' willingness to refer into a service they recognise as having direct links with health, and also provides an example of a delivery model in which the 'link' role between primary care and the wider community (in this case the counsellor) bridges the gap into more socially focused activity.

The three PSS-run Well-Being Centres in the City Centre, Belle Vale and Speke provide another, more 'managed' option for referral into non-medical provision. These Centres are accessed by appointment only, following a referral from a GP, psychiatrist, CPN, or other related professional. Services are focused around mental health issues such as depression, anxiety and emotional distress, and are delivered in partnership with other voluntary and community organisations.

The issue of demand versus capacity, identified as a widespread concern for potential SP service providers, is illustrated by the case of a small-scale project in the south-centre of the city that provides social activities for older people. Having contacted a number of GP practices by email, letter and personal visits to raise awareness of their services, the project found itself having to turn away referrals from health and social care professionals because of a shortfall in resources.

During conversations with third sector organisations of all sizes, it was made clear that any significant increase in demand for a service needs to be resourced; the will to work more closely with statutory services was there in abundance, but 'voluntary doesn't mean free' was an oft-heard refrain. There is a clear impression coming across from the third sector of frustration that the CCG and the City Council, whilst regularly voicing their appreciation of the value of the sector, and initiating frequent 'engagement' activity, seem to be reluctant to take the extra step towards commissioning more of their services.

7. Liverpool Policy Context

'**Healthy Liverpool'**, the CCG's prospectus for change to the way in which health and social care services are provided, commits to a transformation of the system to embrace person-centred care. Whilst not explicitly referencing social prescribing, it acknowledges that the voluntary sector has a high degree of understanding of the needs of local communities, coupled with an ability to engage with them. It then goes on to stress the need for more preventive health services to support sustainability, and to state that:

'*Health, Social Care and Voluntary Care services will be provided in a variety of settings'*, including '*at the GP practice – this may mean pro-active prevention and partnering with Voluntary Care Services throughout pathways'*.

Following the recommendation by the Mayor's Health Commission that a neighbourhood model should be followed in order to implement the integration of health and social care, the CCG is undertaking a mapping exercise to identify voluntary sector care provision in each of the GP neighbourhoods.

Healthy Liverpool states: '*We will ensure we know which voluntary care services are in our communities to enable us to signpost people appropriately to get the support they need, when they need it.'* It is worth noting two issues at this point:

- According to Healthwatch Liverpool, service provision across the city is 'patchy' and the concept of preventative activity to address physical health and well-being is not as well-developed as it is in mental health services. For instance, there is a lack of peer support groups for physical conditions such as heart disease and COPD, so the options for signposting are somewhat limited.
- The proposed neighbourhood model is problematic for organisations that support communities of interest, most of which are not large enough to operate in all neighbourhoods where their services may be needed. This issue was highlighted by a number of organisations; among them, Irish Community Care Merseyside, Chinese Well-Being, and MENCAP Liverpool.

According to the CCG, the mapping is being done by Locality Managers working closely with GPs to identify the most prevalent health conditions in the neighbourhood, and determine which services are available to address the associated needs. Part of this process will involve the 'bringing together' of organisations that have been delivering work funded by CCG grants – a report on this activity was to be produced and used as a means to facilitate discussions with clinicians. To date, this report has not been made available, but a conversation with a local GP produced some interesting perspectives on the way forward for the neighbourhood model, including the implementation of social prescribing:

- *Social prescribing should form part of GPs' and other neighbourhood practitioners' armoury, and needs to happen to fulfil the Healthy Liverpool ambitions.*
- *The CCG should have a 'longlist', and each neighbourhood a shortlist of organisations that provide health and well-being services.*
- *These services should be commissioned and paid for – the commissioning process buys quality assurance.*
- *There is a need to have the freedom and the money to be able to prescribe appropriately for neighbourhoods.*

- *Health trainers will be key to the success of the neighbourhoods model and the success of social prescribing. Case management within practices needs health trainers to carry out more outreach work, and to formally deliver behaviour change programmes for individuals.*
- *The directory of services (RALFY) needs to be directly integrated with the EMIS GP software system if it is going to be used to its full potential.*
- *There is a need for neighbourhood-based family health trainers, who should be given data-sharing privileges to enable access to non-clinical information stored on the GP system.*

Liverpool Primary Mental Health Care Strategy for Adults sets out four core offers that can be accessed via self- referral or through an 'integrated gateway'; one of which is a 'social' offer to include social prescribing, alongside community learning, time banking, peer support and volunteering.

Non-clinical mental health support is currently provided by a combination of third sector and local authority services. The strategy states that for people presenting in primary care settings with common mental health conditions: '*There is currently no mechanism in place to support the safe and easy navigation of third sector services for people experiencing mental distress.'*

Social prescribing might potentially provide that mechanism for people at the lower end of the stepped care model, as it can empower people to take more control over their own well-being through activities such as peer support and volunteering. Merseycare has for some time commissioned The Reader Organisation to deliver shared reading activities in care settings and in the community. A recent innovation has been the development of an 'app' for young people with mental health issues. Funded by Innovation Labs, and in partnership with FACT and Merseycare, creative technology company Red Ninja designed the app as a means by which young people could track their own mental health, and take action when prompted to do so. The app is currently being prescribed by staff at Alder Hey Children's Hospital, and there is anecdotal evidence to suggest that some GPs are also doing so.

With the stated intent to equip GPs and other primary care practitioners with information about services available; the documented support from service users for making use of individual advocacy to enable them to access that service provision *(BME Communities & Mental Health Stakeholder Engagement Report, LCCG, September 2014),* and the overarching aim of integrating services across the sectors, it seems a relatively small step, in theory at least, to create a commissionable model for primary mental health care.

Ongoing research by the Arts & Humanities Research Council (AHRC) and Liverpool John Moores University is looking into the future development of the commissioning of arts and culture interventions for mental health. This project is currently grappling

with the issue of how best to evidence the impact of 'arts on prescription' in order to support its strategic development in the city. A 2014 paper by Anna Goulding of Newcastle University for the Journal of Applied Arts and Health identified a number of problems with evidencing impact, which could apply to any social prescribing programme.

Issues include:

- Tension between (arts) activity and health requirements
- Commissioners unclear on desired outcomes
- Overstating impacts
- Measuring long-term impact
- Burden of evaluation

(JAAH 5 (1) pp. 83-107 Intellect Limited 2014)

The findings from the AHRC will look at these in more detail in due course, but it seems clear that making a case for a social prescribing model will involve finding ways to address the collection and presentation of evidence to support the claim of positive outcomes.

*__Please see Appendix 1 of this report for an update on 'The Art of Social Prescribing: Informing Policy on Creative Interventions in Mental Health Care'.__

8. Examples of Social Prescribing in England

Social prescribing is not a new idea; there are numerous examples of pilot projects that have run their course and then disappeared when their funding has ended. Most would claim to have had a degree of success, and can cite case studies and anecdotal evidence of improvements in health and well-being, and even reductions in attendance at GP appointments.

Voluntary Action Rotherham (VAR) has been running a social prescribing project since 2012, which began as a two year pilot and is now being funded for a further three years from the Better Care Fund, on an annual renewal basis. The initial investment by the NHS into the pilot was around £1 million.

The initial idea came out of discussions between Voluntary Action Rotherham and the local CCG about ways to reduce the number of emergency hospital admissions of (mostly older) patients with long term conditions. These patients were being case-managed by GPs as part of another pilot, Integrated Case Management, so there was a favourable climate for social prescribing in place, and, crucially, a champion of social prescribing in the form of the CCG Chair.

After consultation sessions with the local voluntary sector, the project was commissioned with VAR as the lead organisation with responsibility for managing the contracts of the selected provider organisations. VAR also employed 5 link workers to connect patients referred by GPs into the 26 organisations, who had been selected via a procurement process (for larger organisations), and a simplified process for smaller ones, providing 33 services. Work was undertaken with GPs to establish the 'menu' of services required, based on the issues with which patients presented most frequently. Money was ring-fenced to enable 'spot purchasing' of additional services to meet unforeseen demand.

The cohort of patients selected for the project at the start consisted of the top 5% most at risk of unscheduled hospital admission, identified by a risk stratification tool used by the GPs. These individuals would then be referred into the SP programme, and be assessed by a link worker, using an 'outcomes star' method to measure current levels of well-being, who would help them identify an appropriate pathway. This part of the process constitutes the 'social prescription'; it is the link worker rather than a clinician who does the 'prescribing'. Patients would initially be guided into a funded service for a defined number of weeks, after which time a follow up meeting with the link worker would take place to assess progress against the outcomes measure. This information would be fed back to the GP practice. Thereafter, subject to the continued availability of funding, the individual could either continue to attend the activity, or be referred on into the wider sector. The expectation was that patients might also be empowered to set up peer support groups to continue their journey towards independence. An important point to note is that patients could only access the funded service once, so once an individual had completed the 'journey', they could not be re-referred.

Evaluation data for the pilot phase of the project shows that within its fairly narrow confines, it has achieved some success. A full evaluation report carried out by Sheffield Hallam University shows the following outcomes in usage of hospital services by patients who had accessed the programme; 1,607 in total by the end of the pilot phase:

- Inpatient admissions reduced by as much as 21 per cent
- Accident and Emergency attendances reduced by as much as 20 per cent
- Outpatient appointments reduced by as much as 21 per cent
- Greater reductions in inpatient admissions and Accident and Emergency attendances were identified for patients who were referred on to funded VCS services.

In terms of social impact, after 3-4 months' involvement, 83% of patients had experienced an improvement in at least one of the outcome areas, with an estimated saving to the NHS of £552,000, equating to 50 pence for each £1 invested.

Detailed analysis of the impact of the pilot can be found in the aforementioned evaluation report *(The Social and Economic Impact of the Rotherham Social Prescribing Project, Dayson and Bashir, September 2014)* available from Sheffield Hallam University website.

In addition to the benefits for patients and savings for health services, the project has increased the resilience of the local voluntary sector, through additional funding, capacity building input from VAR, and the opportunity to raise the profile of its services.

In **Newcastle**, the CCG was awarded £100,000 from NESTA innovation charity to implement a social prescribing pilot. *(Networks that work: partnerships for integrated care and services, 2013)*

The model adopted was that of a new consortium, with five organisations signed up to provide services in the areas identified by the GP practices; namely, older people, carers, lifestyle change and mental health. These organisations were described as Linkwork Organisations, and each appointed a link worker, whose role it was to support patients who were to be referred via GP practices, through direct input from the link workers and through signposting, to achieve their individual health and well-being goals.

This model of delivery was seen to be advantageous to the Linkwork organisations for the following reasons:

- The project fitted within an existing service for which there was capacity
- The project would increase the number of referrals for an existing service both during and after the project
- The project provided an opportunity to demonstrate the ability of the organisation to deliver to potential future commissioners, such as the CCG
- The project supported the moral and social obligation to support vulnerable people in line with their organisation's vision.

The success of this project was somewhat qualified *(see Newcastle Social Prescribing Project Final Report, August 2013, ERS and Beacon North Limited*), as the GP practices differed significantly in terms of the numbers of referrals they made to the project. It could be argued that the approach was flawed, in the sense that it

failed to secure a critical level of engagement from GPs in the very earliest stages, without which it was an uphill struggle to get the project off the ground. The governance structure, which as a newly-constructed consortium did not have parity of staff experience and skills across the five organisations, was such that, when a key staff member left, the ability to drive the project forward was significantly impaired. Moreover, consistency of practice across the organisations was difficult to monitor. There were also problems with the referral process, in terms of patients with complex needs finding their way into the project, which left the link workers feeling that their skill set did not adequately equip them to deal effectively with these individuals and referring them back to the GP.

Also, with only £100,000 of funding it was only possible for voluntary sector organisations to manage a very small number of referrals, and the evaluation report makes the point that for any future implementation of an SP scheme, the statutory services would need to ascertain the actual cost of the services provided in order for sustainability to be achieved.

In **Halton & St Helens,** a different approach to social prescribing has been taken, with the commissioning of a single organisation, Well-Being Enterprises, to deliver a 'wrap- around' service for GPs, to connect them with local sources of support for patients presenting with psychosocial issues.

As well as delivering well-being courses for individuals and businesses, the organisation has established the Well-Being Review Service in 17 GP practices in Halton. Patients who present with psychosocial problems at their GP surgery can be offered a referral to a community well-being officer, who will discuss the issues with the patient, help them to set personal goals and refer them either to one of the Well-Being Enterprises programmes, or to another organisation in the wider community. Patients can also self-refer via their GP practice.

Evaluation of patient progress is carried out using a fully automated data management system that profiles patients and uses health metrics to calculate impact. Qualitative evidence is gathered via participant interviews and 'story-telling'. According to WBE's website,' *60% of participants in our programmes have shown an improvement in their SWEMWBS score (a validated measure of a person's subjective wellbeing).'*

Links with the wider voluntary sector are created using community asset approaches, encouraging voluntary sector organisations to collaborate and share expertise and best practice. Details of the actual methods employed were not shared, as Well-Being Enterprises offers a consultancy service, but the underpinning ethos is that a willingness to work in partnership strengthens the sector's position in

relation to commissioning. WBE also gives out a limited number of small grants to organisations to promote sustainability.

9. Conclusions…

The direction of travel for social prescribing in Liverpool remains uncertain. Models such as the Rotherham project, with its somewhat narrow confines and highly structured approach, do not appear attractive to commissioners, and are expensive to implement. The Newcastle model provides a number of lessons for any aspiring consortia, and probably represents a step too far in terms of risk for the CCG and other commissioners.

Measuring impact is a significant difficulty intrinsic to social prescribing, not least because well-being is a subjective state, and therefore almost impossible to quantify. Most projects use a combination of quantitative measures, such as number of repeat visits to GP, with qualitative evidence such as case studies. The problem no-one has yet solved is how to present credible evidence in sufficient quantity to prove that improvements in health and well-being are directly attributable to social prescribing. Without this, it is perhaps understandable, in the current climate, that commissioners are reluctant to implement a city-wide initiative.

There is certainly an understanding and an appreciation by the CCG and the City Council of the benefits to the city of a broader and more innovative approach to health and well-being, in terms of better quality of life for individuals and families, reduction of health inequalities and financial savings. However, there is, to paraphrase comments made by representatives from both these organisations, a lack of ‘buy-in’ to social prescribing at a strategic level. With the focus on a neighbourhood model for primary care, it seems most likely that social prescribing activity will begin to happen within GP neighbourhoods, as workforce development and service integration progresses.

It should be noted that, as previously mentioned, structuring commissioning around neighbourhoods creates problems for voluntary organisations serving communities of interest. As these communities do not tend to sit neatly within a particular area, and the organisations that support them are rarely sufficiently large to provide services in enough locations, equality of access is clearly an issue.

The view expressed by the Healthwatch Liverpool representative interviewed as part of this research was that it becomes ever more important for the voluntary sector to align itself with the public health agenda, and to show clearly how their work aligns with the Healthy Liverpool priorities. It may well be the case that if this could be

made to happen, the prospects for more organisations to access NHS funding would improve, and sustainability would be easier to achieve.

Whether or not social prescribing proves to be the way forward remains to be seen, but few people could find an argument against the closer alignment of statutory and third sector services in the interests of resilient communities and a healthier, happier Liverpool.

10. About LCVS

LCVS (Liverpool Charity and Voluntary Services) was established in 1909 and we've been active in the city ever since. We work with diverse communities across the city to make a positive difference to people's lives.

We work to improve the wellbeing of individuals and communities in Liverpool. We do this through supporting, encouraging and developing voluntary action and charitable giving, and bringing people, organisations and resources **Together for Liverpool for Good**.

We are proud to be part of the global United Way network, and believe that a focus on health, education and income stability improves the wellbeing of individuals and creates strong communities.

Our Commitment

We want to see Liverpool being a city where all individuals achieve their potential through **education, income** and **healthy lives**. We believe these are the vital building blocks for achieving improved well-being of individuals and communities.

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Merseyside Polonia
Neuro-Support
Nugent Care
PSS
Red Ninja
Relate
Rotunda College
Sanctuary Family Support
Sefton CVS
Tomorrow's People
Voluntary Action Rotherham
Well-Being Enterprises
Wheel Meet Again.

Appendix 1

‘The Art of Social Prescribing’ was a project funded by the Arts and Humanities Research Council in 2014-15 to look at how social prescribing might work as an integrated commissioning model across arts and health in Liverpool.

The project looked to pinpoint the ‘key characteristics and lived experiences of ‘successful’ social prescribing and arts on prescription schemes’ and identified a number of issues; among them the following, all taken from the summary research paper **‘The Art of Social Prescribing – Informing Policy on Creative Interventions in Mental Health Care (Kerry Wilson, Institute of Cultural Capital, September 2015):**

‘As a commissioning policy, social prescribing is gaining traction within the NHS and is often discussed with reference to the Marmot Review. Despite widespread presentation and recognition of the social determinants of health in general practice – including economic disadvantage through unemployment and debt, isolation through carer responsibilities, social exclusion through lack of education and skills – clinicians are often powerless to address them appropriately. At the same time, it is recognised that local communities often offer a wide range of voluntary and statutory resources that could help, if the connection could be made. Social prescribing therefore potentially facilitates a primary care-led gateway to existing community assets, non-clinical community-based services and resources.’

The report goes on to say of successful social prescribing models:

‘Important conditions and mechanisms within effective programmes include extensive local knowledge and information, usually held within staff teams. It is essential to have a human resource infrastructure including Project Manager and co-ordinating roles, acting as liaison between health and social services making the referrals, service users and those providing the service or activity that has been ‘prescribed’. Meaningful leadership and advocacy are also key characteristics of existing schemes.’

Evidence bases for social prescribing have been criticised as unreliable and inadequate, but the report challenges this view, stating that although individual studies and methodologies have their limitations, there is consistency in terms of the application of quantitative measures of health and well-being, such as the Warwick-Edinburgh Mental Well-Being Scale (WEMWEBS) and the Global Quality of Life Scale (GQOL). The report identifies the need to combine research methods ‘to balance health and well-being outcomes with other social and economic impacts’,

but also to convey ‘a deeper understanding of the experiential value of the creative or cultural activity.’

The project will now go on to develop a policy framework for an asset-based model of cultural prescribing for Liverpool, which will involve asset-mapping of the inner-city region, accompanied by a research framework that provides guidelines on how to assess the holistic value of cultural prescribing.