Social Prescribing and Community Navigation Strategy

For the people of Kent and Medway

Produced by Kent and Medway Social Prescribing and Community Navigation Strategy Steering Group

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Working together

Kent and Medway Integrated Care System (ICS) is a partnership of organisations working together at different levels of the system to:

- **improve** outcomes in population health and healthcare
- **tackle** inequalities in outcomes, experience and access
- **enhance** productivity and value for money
- **support** broader social and economic development.

Strategic importance

Social prescribing and community navigation **support** the long-term shifts and **core purposes** of an ICS, as listed above.
Our ICS Strategy recognises how beneficial it can be for residents wellbeing when they **connect** with community groups and services to support **mental** and **physical** health. Social prescribing and community navigation help people to make these **connections**.

This strategy sets out the **ambition** of partners across the Kent and Medway ICS to work in increasingly **collaborative** and **joined up** ways**.** To **build on** and **strengthen** the **community navigation** and **social prescribing services** and drive forward the **agreed goals, ambitions** and **priorities** set out in this strategy.

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1. Leadership and governance

1.1 National context

In 2019 the NHS Long Term Plan (LTP) set the ambition for all parts of the country to become integrated care systems (ICS). Following several years of development - The Health and Care Act (2022) established 42 ICSs across England, in law, on 1 July 2022. ICSs help to bring the **NHS**, **local government** and voluntary, community and social enterprise partners (**VCSE**) together to plan and deliver services, to **improve** the lives of people in their area. The LTP highlights the need for **closer** working across these sectors to both **improve** care and **support** and **address** the wider **determinants** of **health** and **wellbeing**. It is through the **support** of the VCSE sector that ICSs have been able to make considerable progress towards addressing health **inequalities** and supporting people with **complex multiple needs** and **reducing** loneliness and social isolation. [1]

"Loneliness has been identified as one of the **greatest public health challenges** of our time."

Government loneliness strategy launch, Oct 2018. [2]

Impacts of loneliness and social isolation

- Harmful to health
- Increased pressure on health and social care services
- People who are socially isolated are:
  - 1.8 x more likely to visit GP
  - 1.6 x more likely to visit A&E
  - 1.3 x more likely to have emergency admissions
  - 3.5 x more likely to enter local authority funded residential care. [3]

	**Loneliness** is linked to a **greater risk** of inactivity, smoking and risk-taking behavior, increased risk of coronary heart disease and stroke, an increased risk of depression, low self-esteem, reported sleep problems, stress response, risk of Alzheimer's and cognitive decline. [4]
	It is estimated that approximately **20%** of patients consult their general practitioner (GP) for what is primarily a **social problem**. [5]
	Up to a **fifth** of all UK adults feel lonely most or all of the time, with evidence showing **loneliness** can be as bad for health as **obesity** or **smoking**. [2]
	Around 200,000 older people have not had a conversation with a friend or relative in more than **a month**. [2]

Jo Cox MP

> "Loneliness is a serious problem with long-lasting consequences [6] and only by **working together can we make a real difference** to the lives of those affected by it.[7]"

Loneliness and Social Isolation Select Committee Report, Kent County Council, March 2019. Page 38. Sharing the view of the late Jo Cox MP.

Everybody has a role to play in tackling **loneliness,** the **wider determinants of health** and **wellbeing,** and providing **personalised care**. A "**whole system**" approach is needed, with local authorities, health services, central government and the voluntary and private sectors all helping to create a more **connected society**.[6]

The Government loneliness strategy (October 2018) [4] recognises the importance of allowing people to **build** and **form relationships** and by doing so; **improve** the social relationships of people across the country, helping them to lead **healthier** and **happier** lives. Chapter two of the strategy is described as marking a turning point in the way public services and organisations promote social connections as a core part of their everyday role, **connecting** people to the **support** they need. It commits to improve how organisations and services connect people by ensuring all GP practices can offer **social prescribing services** and exploring how other frontline staff can also direct people to support.

What is social prescribing?

Social prescribing is an approach that **connects** people to activities, groups, and services in their community to **meet** the **practical**, **social**, and **emotional** needs that affect their **health** and **wellbeing**.
Local agencies such as local charities, social care, and health services refer people to a social prescribing link worker (SPLW). SPLWs give people time to focus on '**what matters to me**' to coproduce a simple personalised care plan, and support people to take control of their health and wellbeing, the wider determinants of health.

SPLWs also support existing community groups to be accessible and sustainable, and help people to start new groups, working collaboratively with all local partners. Social prescribing is an **all age**, **whole population** approach that works particularly well for people who:

- have one or more **long term conditions**
- who need support with low level **mental health** issues
- who are **lonely** or **isolated**
- who have complex **social needs** which affect their wellbeing.

NHS England [8]

1.1.2 The NHS Long Term Plan

NHS **England's Long Term Plan** [9] (published in January 2019) set out a vision to give people more **personalised care** [10] when they need it. This includes a wider, more diversified and accessible range of support across the country through **social prescribing. Link workers** within **P**rimary **C**are **N**etworks (PCNs) work with people to develop tailored plans and connect them to local groups and support services. NHS England committed to increase the number of **link workers** by funding over **1,000 additional** trained **social prescribing link workers** across the country by 2020/21 rising further by 2023, with the aim that over **900,000** people would be able to be referred to a **social prescribing scheme** by then. This means that more people will be **connected** with the care and support they need when they are experiencing loneliness, no matter where they live.

- Give people **more** personalised care
- **1,000** additional link workers by 20/21
- Over **900k** people referred by 2023/24
- **100%** reimbursement for link worker salary
- Funding from **1 July 2019** when reformed GP contract (5yr) began
- **Biggest** investment in social prescribing by **any** national health system.

1.1.3 Care Act

Social prescribing and community navigation **supports** a number of strategic aims and responsibilities for Local Authorities outlined within the Care Act 2014. Section 1 (promoting wellbeing) and Section 2 (prevention). The statutory requirements of the Care Act 2014 and amendments is to ensure that people have **access** to information and advice regarding their care and support. This information and advice requirements is for those who are eligible for care services and the whole population. It aims to facilitate a vibrant, diverse, and sustainable market for **high quality care** and **support** that **prevents** and **reduces** or **delays** the needs at key points. It also supports Health and Social Care Act 2012 and amendments (Feb 2022) by joining up of care for people, places, and populations, focusing on wellbeing, to **strengthen** how care and support is delivered and the tools to deliver on both.

Care Act aims:

- **Promote** individual well-being
- **Prevent**, reduce or delay need for care and support
- Ensure people have **access** to information and advice for their care and support
- **Join up** care
- **Strengthen** how care and support is delivered.

What is community navigation?

Community navigation is a **coordination process** and a key mechanism to help achieve **integrated** care provision and **improve** health and well-being. A person providing navigation is usually based in a multidisciplinary team, to help to identify and **signpost** people to available services, acting as link workers. They offer a service that is based on an equal relationship between the person receiving support and the link worker.

HEE Care Navigation Competency Framework 11 p6 (2.3)

1.2 Local Context - Kent and Medway

Our communities can provide us with **support**, **resilience**, and a feeling of **belonging** that **help** us to lead **healthy** and **fulfilled** lives and **reduce** the need for health and care services.

Alongside the role of public sector partners, it is often the informal support from the thousands of local organisations, community networks and local volunteers that help to make a community and create a sense of identity. As a system we recognise, value and support the **vital** role that these groups and individuals play, and will engage in a way that utilizes these community assets for our population's health and wellbeing.

Social prescribing and **community navigation** is helping to **connect** people to community-based support, services, resources, and groups in the local area. This is helping to **improve outcomes** for people, **supporting** people to **stay well**, **independent** and **resilient**, **reducing** social isolation and helping to **support physical** and **mental health**.

> **"Social Prescribing** is one of the **most radical changes** in primary care in the 30 years I have been practicing as a GP."
>
> **Primary Care GP (West Kent)**

£17.6m invested
> 63,000* SP referrals delivered.
Ambition to deliver over 31,000 referrals per year at ICS level by 23/24.

Across Kent and Medway just over **£17.6m** has been invested into social prescribing and community navigation services (see section 2.1, figure 1), with an additional **£5.8m** invested in Universal Wellbeing Support in the Community. As of March 2023, over **63,000** people have been referred to a social prescribing service (*cumulative number of individuals who have been referred to a social prescribing service since April 2019). The ambition is to deliver **over 31,000** social prescribing referrals per year by 2023/24. Organisations are working in partnership to lead local implementation of social prescribing and community navigation. An important role for all partners across the ICS is to ensure there is a **consistent offer** for the whole population, **ease of access** and a way of understanding the uptake and impact of social prescribing and community navigation on **population health** outcomes.

1.2.1 Kent and Medway Integrated Care System (ICS)

System | **1.9m people**

At a **system level** Kent and Medway was placed on a statutory footing on 1 July 2022, bringing together the different partner organisations within the Integrated Care System (ICS). **All** partners constitute the system. System-wide partners include **NHS Kent and Medway Integrated Care Board (ICB)**, **Kent County Council** and **Medway Council**, working with the **NHS Providers**, the **Voluntary, Community and Social Enterprise** (VCSE) sector and other partners to better **integrate** services and take a more **collaborative** approach. The ICB and Integrated Care Partnership (ICP) will set overall system strategy in collaboration with partners. Together they will manage resources and performance, share research and good practice, plan specialist services and drive strategic improvements.

Kent and Medway Integrated Care Partnership
Members include: Kent and Medway ICB, Kent County Council, Medway Council Health and Care Partnerships, District Councils, VCSE representative

NHS Kent and Medway Integrated Care Board
Responsible for the Joint Forward Plan

Kent County Council and Medway Council

NHS England

At a system level we must focus on the complex issues that can only be dealt with by acting together. We are facing a period of significant financial challenge and recognise the tangible benefits that can come from **closer working** with partners in **commissioning and delivery** of services. Effective and sustained achievement can only be realised through genuine **integrated collaboration** and **partnership** arrangements across all key stakeholders, including the substantial number of Voluntary Community Social Enterprise organisations. Therefore, we will position **VCSEs** as our **strategic partners** in various workstreams through the ICS by having an established **VCSE alliance** with formal agreements on how we will work together. Such as, a Memorandum of Understanding (MOU) outlining the working relationship and arrangements that we wish to achieve between the VCSE sector, the NHS and other partners, serving as a framework for collaboration and supporting delivery of the Kent and Medway Integrated Care Strategy and other related strategies and delivery plans across agreed partnerships.

Memorandum of Understanding
The MOU confirms that VCSE representatives will be involved in the development, governance, and delivery of the Kent and Medway Integrated Care Strategy and other related strategies and delivery plans, including the co-design of relevant activities, and thus play a key role in efforts to build a resilient local economy, address inequalities and inequity, and improve the health and wellbeing of people who live, work and study in Kent and Medway. The VCSE partnerships covered under this agreement include the Kent and Medway VCSE Steering Group and each Place Based Health & Care Partnership VCSE Alliance.

Social prescribing and community navigation
Work has begun to co-ordinate the approach to social prescribing and community navigation at a system level. A workshop was held in February 2022 and the highest priority identified was the need for a social prescribing strategy. A strategy board was set up in June 2022 to set the strategic direction and a steering group began in July 2022 to take the work forward and develop this social

prescribing and community navigation strategy to provide a framework for social prescribing and community navigation across the Kent and Medway system.

1.2.2 Health Care Partnership (HCP)

Places | **260,000 – 720,000 people**

There are 4 Place Based Health and Care Partnerships in Kent and Medway. These are alliances of health and care partners working together to design and deliver integrated services to improve outcomes for their populations within delegated responsibilities and budgets. The four Place Based Health and Care Partnerships include: **Dartford Gravesham and Swanley**; **East Kent**; **Medway and Swale**; and **West Kent**.

4 Place-based Health and Care Partnerships

12 District Borough Councils

Provider Collaboratives

HCPs are designing, commissioning, and delivering social prescribing and community navigation services. This is discussed further in the commissioning section of this strategy.

1.2.3 Primary Care Networks (PCNs) and Integrated Neighborhood Teams

Neighbourhoods | **Typically, 30,000 – 50,000 people**

These are local decision making and integrated teams, developed to meet the unique needs of their populations including: local health and care organisations, the VCSE, community groups, community assets and primary care networks. PCNs are collaborations of GP practices working together to meet the needs of their registered patients.

41 Primary Care Networks

Individual Providers
including voluntary and community services, independent sector, NHS Trusts and NHS Foundation Trusts

There are 41 PCNs across Kent and Medway. Following a national review by Claire Fuller PCNs have started to work with the full range of local partners in a local area to establish Integrated Neighborhood Teams to jointly address the needs of the local population together using their shared resources.

To support PCNs, the Government Additional Roles Reimbursement Scheme (ARRS) provides additional roles to help create bespoke multidisciplinary teams in practices. One of these ARRS roles is a social prescribing link worker (SPLW), funded since July 2019. In some areas PCNs have chosen to sub-contract to VCSE organisations to provide a social prescribing service, while in other areas the PCNs have chosen to employ Link Workers directly. **ACTION 1:** As a system we will continue to support PCNs to maximise their use of ARRS social prescribing staff to effectively address patient demand, notably for those with complex health and care needs.

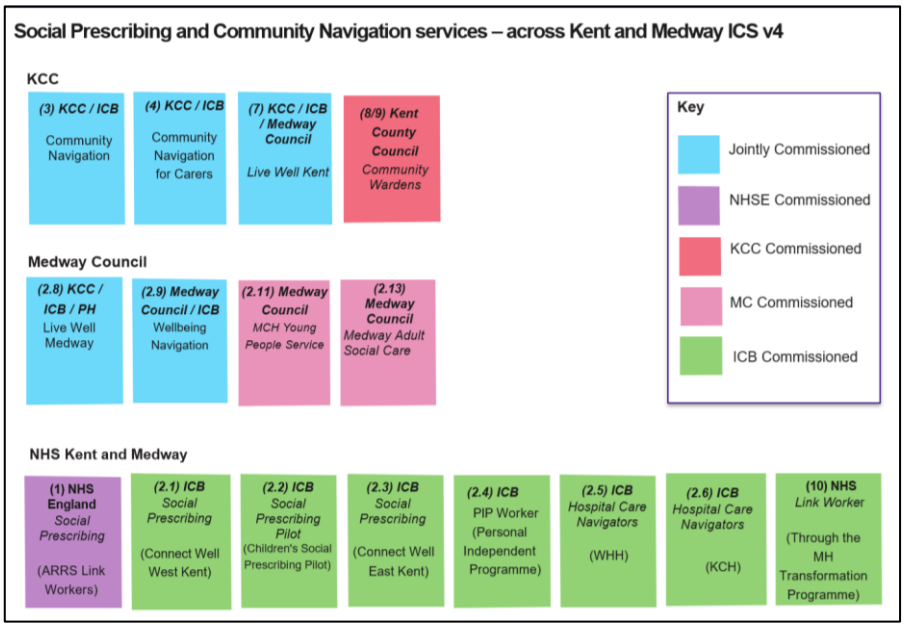
There are **92** SPLW funded through ARRS (as of March 2023), **73** community navigators and **64** Community Wardens.

2. Planning and commissioning

2.1 Planning and commissioning social prescribing and community navigation

As a system work has started to co-ordinate the approach to planning and commissioning social prescribing and community navigation across the ICS. Historically, due to the number of Kent and Medway commissioners, different approaches were taken to commissioning in different areas. Therefore, as part of producing this strategy, some mapping work was undertaken to look at what is commissioned, contract value, provider of the service and length of the contract. This identified a total annual investment of just over **£17.6m** in social prescribing and community navigation services (shown in figure 1, below). These are commissioned by Kent County Council, Medway Council, NHS Kent and Medway and NHS England. Community Navigation Services jointly commissioned by KCC, Medway Council and NHS Kent and Medway include the functions of both care navigation and social prescribing [12]. In addition to the £17.6m mentioned, a further **£5.8m** is invested in the Community based Wellbeing Services to support people in the community, promote independence and keep people connected to where they live.

Figure 1: Commissioned services



The mapping work demonstrated variation in funding and services commissioned across Kent and Medway. The ICS provides a unique opportunity to work together in different ways, coproduce plans, work in increasingly joined up ways, align commissioning and tackle inequalities. **ACTION 2:** Kent and Medway will continue to coproduce plans and will undertake gap analysis to systematically identify inequalities in access to social prescribing and community navigation services, undertake needs assessment, and align commissioning to tackle inequalities in access to services. This will include looking at support, investment, and capacity building models, including VCSE. There are several funding models and pilots in our system, such as Medway's Community Navigation service, ensuring 5% of the contract value is ringfenced to support the VCSE to ensure sustainability and support activities to refer to. Medway and Swale's social prescribing pilot supports the sector with money following the referral to the activity provider. Involve Kent VCSE Grants. Deal and Sandwich PCN pilot to set up activities and Kent's VCSE Wellbeing contract.

2.1.1 Population health management

Population health is one of the core strategic aims for an ICS [13]; to improve physical and mental health outcomes, promote wellbeing and reduce health **inequalities**, with a specific focus on the wider determinants of health. The **wider determinants of health** have a significant impact as only 20% of a person's health outcomes are attributed to the ability to access good quality healthcare, as shown in figure 2 below. Population health is a partnership approach to tackling the interdependent issues that affect people's health and wellbeing to address our populations most pressing needs.

Our vision is to ensure that Kent and Medway's population has the best health possible. Population Health Management uses historical and current data to understand what factors are driving poor health outcomes in different population groups, taking a broad view across the wider determinants. Local services can then design new **proactive** models of care, such as bespoke social prescribing and community navigation, which will improve health and wellbeing today as well as in future years.

Figure 2: Wider determinants of health

Examples:

- Housing
- Employment
- Education
- Living Environment
- Income
- Lifestyle factors and behaviors
- Access to health care.

The overwhelming evidence is that the wider determinants of health such as **socioeconomic** factors, our **physical environment** and our **health behaviors** have the **most** impact on our health. Variation in peoples experience of wider determinants such as, **housing**, **education** or how safe they feel in their **community**, has a fundamental effect on health, creating health inequalities. These are the preventable, unfair and unjust differences in health status between groups, populations or individuals.

Housing

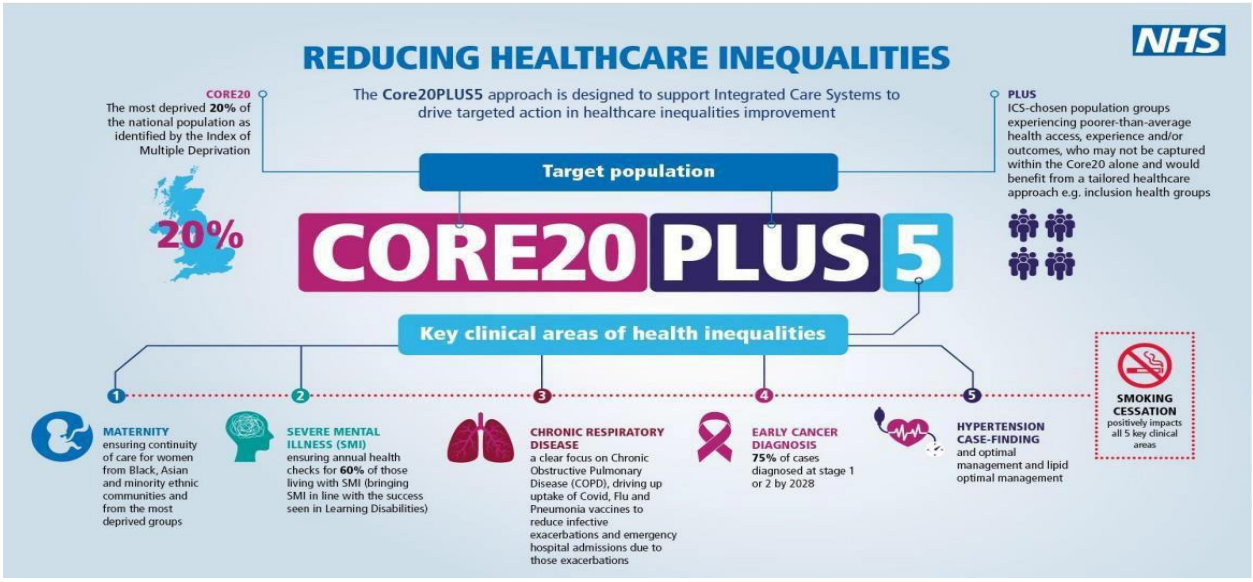
Adults and children who live in cold, damp housing may be more likely to develop **respiratory problems** over future years because their lungs are affected by the mould spores in their home. If we **improved** their housing now by working with partners such as local councils and housing associations, they may not end up with various health conditions in the future which can result in poor quality of life (conditions like asthma, chest infections, and other respiratory problems) and could avoid the need for multiple health and care services, helping to **reduce** health inequalities.

ACTION 3a: Kent and Medway ICS are committed to tackling health inequalities to improve the health of our population and we will continue to adopt the **Core20Plus5 model** to support our targeting of those most in need.

2.1.2 Reducing health inequalities in Kent and Medway

The NHS Long Term Plan emphasises the need to strengthen the NHS contribution to reduce health inequalities. Core20PLUS5 is a national approach to support this priority at both national and ICS level for adults, children, and young people. The **Core 20** is the most deprived 20% of the population identified by the national Index of Multiple Deprivation (IMD). The IMD has 7 domains with indicators accounting for a wide range of social determinants of health: income, employment, education, health, crime, barriers to housing and services and living environment. The **PLUS** population groups are locally identified population groups experiencing poorer-than-average health access, experience and/or outcomes, who could benefit from a tailored healthcare approach. The **5** sets out **five** clinical areas of focus which require accelerated improvement.

Figure 3: Core20PLUS5 model



Core20PLUS5 will support us to drive targeted action in improving healthcare inequalities. This aligns with our approach to population health management where we are identifying specific local population groups. **ACTION 3b: "**Using population health management to target health inequalities in patient cohorts (including those identified through Core20Plus5) and then offering social prescribing to support them is extremely valuable. **Proactive** social prescribing is part of the 2023/24 GP contract**"** (K&M Link Worker).

Social Prescribing support for those facing Health Inequalities

Working across West Kent, Involve Link workers supported 976 people facing **health inequalities through building links** and collaborating with networks, faith groups, communities, and voluntary organisations to **engage** people including BAME, unemployed, care experienced, gypsies and travellers, people living in deprived areas, people with housing issues and on low income. A **proactive** engagement approach was deployed including attending **foodbanks**, **soup kitchens** and **homeless support services** to meet with and talk to people accessing these services. (Programme report March 2023).

The service engaged people with **long term conditions** (such as diabetes, cancer, serious mental illness) alongside social issues such as **debt**, **poverty**, **social isolation** and **poor housing**.

Many had lost trust in services or felt ashamed and rejected support on multiple occasions before engaging.

3. Workforce development

3.1 Kent and Medway Integrated Care System

3.1.1 Whole system context

There are over 80,000 health and care colleagues across a range of services based in Kent and Medway. While good examples of collaboration and innovation exist and should be adapted and scaled up where we can, there are differing experiences across our teams which should be tackled. The demand for staff is outstripping supply and along with an ageing workforce, this is putting increased pressure on our teams. There are many opportunities to **work together** as a system to grow and develop our workforce and make Kent and Medway a great place for our colleagues.

Our ICS **ambition** for workforce states:

> **"**We want our people to work together across organisations and **collaborate** with local residents to create **communities** that are amongst the **healthiest** in England.
>
> We want our workforce to **work together**, across **health**, **care** and **voluntary sector**, **enjoy** their **work**, **learn** and **develop** in their jobs, be **empowered**, **engaged** and **develop** to be **excellent** at what they do.**"**

To do this the interim Kent and Medway ICS strategy describes how organisations will work **together** to **attract** and **retain** professionals, work with education and training providers to develop exciting and diverse careers and training opportunities, provide talented and capable leadership and offer flexible and interesting careers.

3.1.2 Social prescribing and community navigation

As discussed in section **2.1** of this strategy, there are a variety of different social prescribing and community navigation services and models of care across Kent and Medway. The range of workforce colleagues includes: **92** Social Prescribing Link Workers (through Primary Care ARRS), **73** Community Navigators and **64** Community Wardens. To support both employers and employees to effectively deliver these services, system partners have identified some priority areas for workforce development and planning. The frameworks discussed below, helps to inform and support these such as, recruitment and retention, training and development, competency framework, career pathways, supervision and peer support.

3.2 Frameworks

Several frameworks have been developed which provide a rich source of materials, guidance, support and resources for workforce development. These include:

- Care navigation competency framework
- Social prescribing competency framework
- Health and wellbeing coaches competency framework

- Social prescribing maturity framework
- Social prescribing workforce development framework

3.2.1 Care Navigation competency framework

The purpose of Health Education England's Care Navigation Competency Framework is to describe a core, common set of competencies for care navigation. These core competencies are brought together in a tiered competency framework, recognising three successive levels; essential, enhanced and expert. This will help provide a coherent benchmark or set of standards for care navigation, to help ensure relevant staff receive the necessary education, training and support to work effectively.

3.2.2 Social Prescribing Link Worker competency framework

NHS England's Competency Framework sets out the core competencies that all SPLWs need in order to deliver their role, and is designed to assist those who employ or direct the activities of SPLWs to understand the competencies for practicing safely and effectively in their role, and how these competencies can be achieved.
It should be used to ensure that people with the right skills and abilities are being recruited to the role, and as a tool to support CPD. These competencies are aligned to the sample job description discussed above.

Table 1: SPLW competency framework areas

The competency framework is divided into four areas:			
1	Competencies to **engage** and **connect** with **people**	3	Competencies to **enable community development**
2	Competencies to **enable** and **support people**	4	Competencies for **safe** and **effective practice**

Recruitment, induction, and supervision of SPLWs should include consideration of the competencies and plan how SPLWs will be supported to demonstrate and develop their skills.

The new NHS competency framework is the gold standard. It is recognised this may not be achievable for some providers across Kent and Medway. **ACTION 4:** Therefore, a working group will be set up to decide on a common minimum set of competencies a link worker will be expected to meet. This group should consist of representatives from the NHS, Primary Care, VCSE, Local Authorities, commissioned providers, and community services. Once agreed, the minimum set of competencies should be used to inform training requirements for SPLWs and CNs.

3.2.3 Health and wellbeing coaches workforce development framework

The health and wellbeing coaches workforce development framework, developed by NHS England, supports health and wellbeing coaches, and their employers, to understand the role and to deliver a safe and effective service. The framework includes competencies for the role and links to resources to support employers to recruit and embed health and wellbeing coaches in services.

3.2.4 Social prescribing maturity framework

The Social Prescribing Maturity Framework is a draft quality improvement tool developed by NHS England for Integrated Care Systems to strategically embed plan, and delivery social prescribing at neighborhood (PCN), place (HCP)and system level (ICS).

3.2.5 Social Prescribing Workforce Development Framework

The workforce development framework has been developed by NHS England to support Social Prescribing Link Workers and their employers to maximise impact of the role. It is intended as a useful resource for organisations across the health and care sector including the **NHS**, voluntary, community and social enterprise (**VCSE**) partners, and **local authorities**.

The framework focuses on the core **functions**, **skills** and **competencies** of the role alongside the professional **support** and **development** needed to enable **safe** and **effective** practice and support **improved outcomes** for people and communities.

Table 2: Workforce development framework

The aim of the framework is to:	
1.	Provide clear and consistent standards for SPLW practice, including their knowledge, skills and behaviours
2.	Provide information about the **training**, **support**, **supervision** and **continuous professional development** (CPD) needed to enable them to succeed. Provide guidance on the support, supervision, and learning and development offer required from employers to support SPLWs
3.	Promote the development of a strong and capable workforce of SPLWs and their future development
4.	Support improved quality and consistency of social prescribing and **reduced variation** in **outcome** and **access** standards
5.	Demonstrate the benefits of SPLWs working as part of a multidisciplinary team (MDT).

3.3 Employing Link Workers

3.3.1 Employment

As with any role in a health, care or community setting, colleagues need to be supported and enabled to succeed in their role. Before employing a member of staff, employers should be clear on the **purpose** of the role and how it can contribute to meeting people's needs and neighbourhood/place/system priorities, and that they have the **resources** and **capacity** to **manage** and **support** the roles. This includes having appropriate supervision arrangements in place, which is essential, and provision for training and ongoing CPD.

Considerations for setting up a service, such as social prescribing, are set out in the Reference guide for primary care networks for social prescribing and include a checklist, social prescribing planning template and recruitment support including a sample job description and an induction checklist.

3.3.3 Caseload

Colleagues tend to support people for an average of **6-12 contacts** over a three-month period, but this will be flexible, depending on the support the person needs. A full time member of staff can have a typical annual caseload of up to a maximum of **200-250**. This may be lower depending on the complexity of peoples' needs, the maturity of the service and wider work they may be undertaking, such as community development activities or outreach.

Colleagues should manage their own caseload to work with people in a format that works for them, including face to face appointments, home visits and community-based activity.

3.4 Training

The World Health Organisation's (WHO) Social Prescribing Toolkit makes several recommendations in relation to training. They describe the overall training objectives to be for colleagues to be able to: **identify** and analyse patient and client **needs** in the context of **social determinants of health**; **locate and match community resources**; and perform tasks to **improve the overall well-being** of patients and clients.

3.4.1 Induction

Local induction is necessary for onboarding of new colleagues, and this should promote good working relationships within the workplace and with other areas of the health and social care system, to help colleagues feel supported and valued at work. Local induction should also include information for the wider workforce about the role and appropriate referrals and allow colleagues to work effectively as part of a team.

Employers may wish to include shadowing colleagues, being observed and receiving feedback, and establishing peer support relationships with other colleagues as part of the onboarding process. It may also be helpful to establish reflective practice at the outset, and employers should think about the learning environment for colleagues, as with all staff.

Sole working colleagues may need additional support during induction to establish peer support relationships across organisational boundaries. Employers are encouraged to support colleagues to connect with networks and to provide protected time to attend peer support sessions. Colleagues may find the social prescribing link worker welcome pack and induction check list useful resources.

3.4.2 Training

Colleagues should receive training and on-going development to support their role. It is the responsibility of the employer to ensure that staff have the appropriate level of training, and/or to support their training needs by funding and allowing time to attend training. The National Association of Link Workers offer training through e-learning courses.

a) Social Prescribing Link Workers

In line with the Network Contract DES SPLW employed by a PCN must:

- Complete the mandatory HEE e-learning for healthcare
- Enrol in or qualify from appropriate training as defined by the Personalised Care Institute (PCI)
- Attend the peer support networks delivered at place or system by the integrated care system (ICS)

b) Community Wardens training includes:

- Esther Improvement Coach training,
- Regard of the NHS Care Navigation Competency Framework, and its bronze, silver, gold levels/expectations aligned to the service structure.
- National Association of Link Worker (NALW) membership and associated training and CPD requirements (4 x e-learning modules plus ongoing CPD to evidence)

c) Community Navigation

- Mental Health Awareness and the Mental Capacity Act (MCA), Safeguarding, Sensory Awareness, Equality and Diversity, Managing Violence and Aggression, Drug and Alcohol Awareness, Lone Working
- Esther Improvement Coach training
- Motivational interviewing
- Dementia Friends Information session

ACTION 5: Medway are in the process of producing a referrer training module to help ensure appropriateness of referrals. The learning and benefits will be shared with system colleagues.

3.4.3 Supervision

Supervision is a process by which individual colleagues work with another person to meet their professional, organisational and personal objectives, which together promote best outcomes for the patient/client. The workforce development framework sets out how different types of supervision are delivered, by whom and what the supervisor training needs maybe. This includes workplace supervision, clinical supervision, group supervision and training and support for supervisors.

3.4.4 Continuing Professional Development

Employers should support continuing professional development, giving dedicated time, and where necessary funding, for training and CPD. Regular supervision sessions, appraisals and personal development planning should all be used as opportunities to focus on specific needs to progress and/or meet the competencies for the role, as well as future career aspirations. Colleagues themselves, their supervisors and employers have collective responsibility for CPD. The workforce development framework recommends using the Competency Framework and Portfolio of Evidence to provide structure for conversations about CPD during supervision sessions.

3.4.5 Kent and Medway Social Prescribing Link Worker support programme

The Kent and Medway – Social Prescribing Link Worker support programme started in November 2022. The aim is to develop a sustainable programme of training and development support for social prescribers. The programme includes the development of peer support, induction and CPD, training and development, managerial supervision, access to information and resources and creates a progressive learning culture within the community of social prescribers across the Kent and Medway area. The network meets monthly and is supported by the Primary Care Training Hub. **ACTION 6:** To ensure longevity of the programme, sustainability will be explored, and a sustainable plan will be put in place. For further information, please contact **kmpcth@nhs.net**

3.4.6 Local peer support networks

There are several locally set up networks across Kent and Medway such as East Kent, DGS and Medway. The networks provide an opportunity to share practice and information. In DGS the network meets quarterly to promote communication, and collaboration among local services with a social prescribing or care navigation function. The group have produced a 'directory at a glance' to help providers understand the different types of support on offer. **ACTION 7:** To better understand what exists, identify gaps, raise awareness of what is available and reduce duplication a scoping and mapping exercise will be undertaken to map all the networks across Kent and Medway.

In **Medway**, there are several providers from different organisations delivering social prescribing, both within health care setting as well as in the community. The roles of the link workers vary depending on how they are commissioned, with many working in specific roles such as children and young people or supporting those with mental health needs, meaning the scope of social prescribing is vast across the area.

Medway Link Worker Forum

The Medway Link Worker Forum was set up in **November 2019**. The aim is to provide a space to share information and knowledge, access peer-to-peer support, training, and enable collaborative working to advance skills and knowledge in delivering social prescribing interventions. The forum also provides the platform to raise concerns, challenges, opportunities and ideas. Utilising the whole system approach in Medway these are then collated and escalated to the relevant groups such as the Medway Leader's Consortium, the Medway and Swale Social Prescribing Steering Group or the Health and Care Partnership.

3.4.7 Protected Learning Time (PLTs)

Integrated neighborhood teams have access to 9 PLT sessions a year to support workforce retention and resilience. These are divided across these 3 groups:

- 3 Kent and Medway wide
- 3 training hub locality wide
- 3 PCN wide

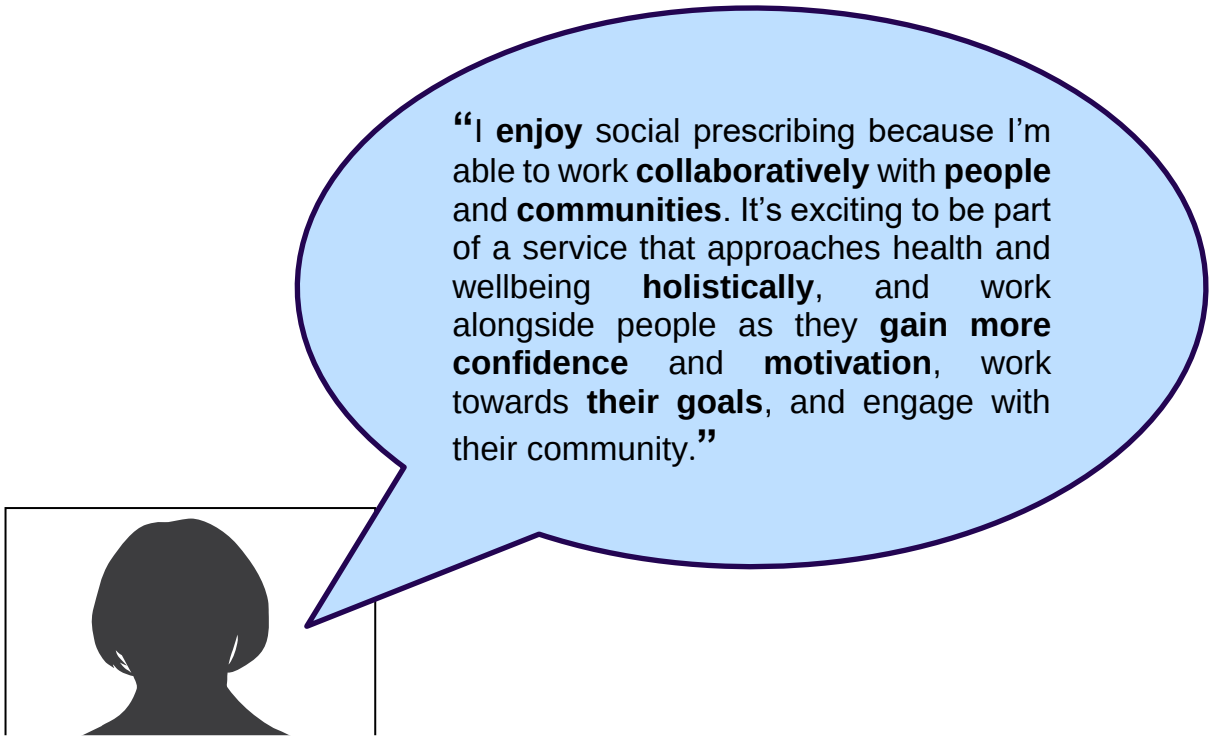
The PLT programme is advertised on the training hub website and disseminated by the Community Education Facilitator (CEF), through the training hub newsletter and general practice bulletin. The PLTs are supported by the four Primary Care Workforce Leads in each Health Care Partnership across the ICS. To register for the newsletter contact: kmpcth@nhs.net. If you have any suggestions for future PLT events, please do not hesitate to email the training hub on kmpcth@nhs.net.

3.4.8 Primary Care Network (PCN) booklet

The Kent and Medway Training Hubs have developed a booklet to support employers and employees to understand the benefits, skills, and support required for a number of roles including social prescribers. Social prescribing is currently on page 49 to 53 of the booklet. **ACTION 8:** The training hub is currently updating and amending the booklet and will announce when this is available through the Training Hub newsletter, via the PCN Community Education Facilitators and on the Kent and Medway training hub website. Information about the role is also available on the training hub website.

3.4.9 Peer Mentoring

The Training Hub offers one to one peer mentoring for multi-professional primary care workforce. Further information is available on the training hub website.



Senior Social Prescribing Link Worker, Weald PCN

4. Digital and technology

4.1 Whole system context

The data that our partners hold is a rich source of information that can provide valuable insights and, in turn, can drive improvement. Trusted frameworks and governance structures are needed to facilitate **combined datasets.** We must monitor progress of **activity** and our **impact** and hold each other to account for delivery on commitments.

For the first time, targets will encompass **combined metrics** for both health and social care. We will work to develop core outcomes that will enable us to show tangible improvement. Governance will enable coordinated prioritisation and planning of activities and sharing of best practice between partners. We will continue to develop relationships with our partners and get better at **using data** and evidence to inform commissioning decisions. **ACTION 9:** The ICS will develop a digital and data strategy and continue the work to increase digital maturity in Kent and Medway.

4.2 Digital enablers

4.2.1 Data architecture for population health management (PHM) [14]

Kent and Medway are deploying a population segmentation tool as a core component of a PHM solution. The tool will initially combine longitudinal primary care and acute data. This is a key infrastructure and intelligence building block to improve care and outcomes for our population through intelligence led insights and change.

The segmentation tool contributes to two of the four core purposes of ICS and is key to how system partners will work differently as set out in the Kent and Medway interim Integrated Care Strategy:

- ensure a whole system collaborative approach to adopting PHM, working across the NHS, council services including public health and social care, the voluntary and community sector and the communities and neighbourhoods of Kent and Medway
- directly supports the design of new models of proactive care and deliver improvements in health and wellbeing which make best use of our collective resources.

4.2.2 Community directories

There are a number of community directories available across Kent and Medway that are digitally accessible. Several of these enable people to self-refer to promote self-management.

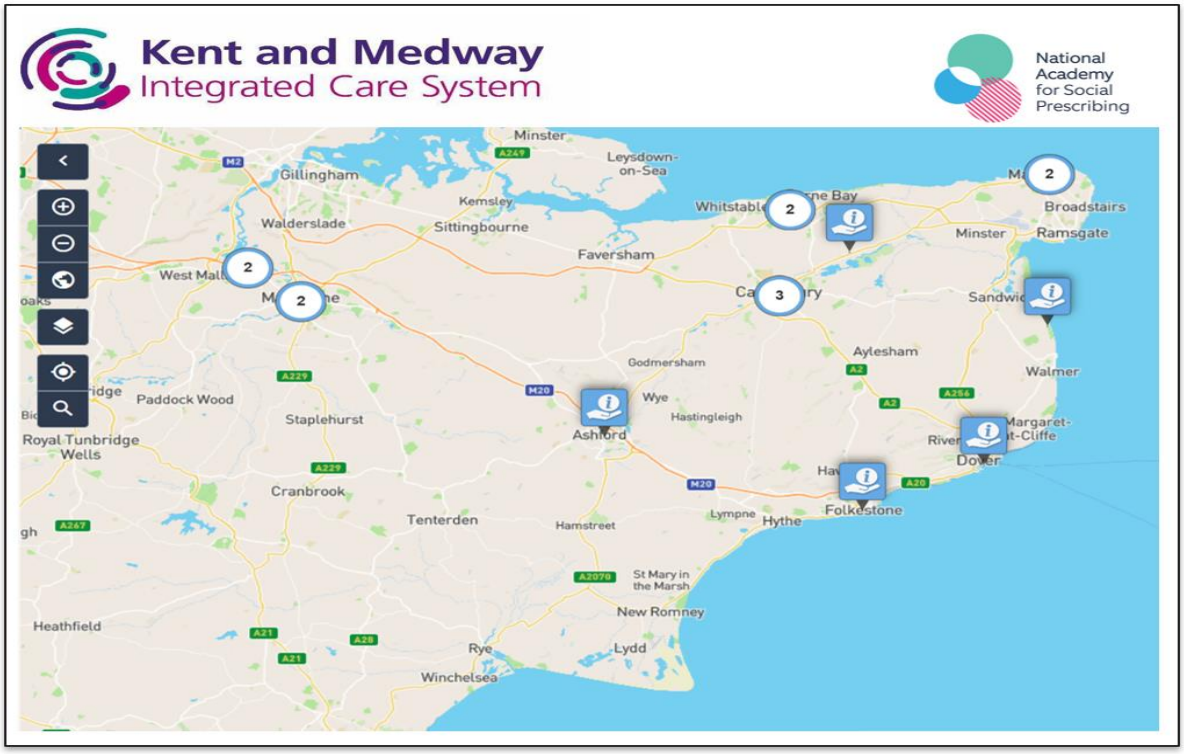
Table 3: Community directories

Ashford Volunteer Centre	Live well K&M Community Services	ReferKent - KCC
Involve Kent	Local Kent Directory – KCC	Small good stuff - KCC
Everyday Active	Medway Voluntary Action	Social Enterprise Kent
Explore Kent	Red Zebra	

4.2.3 Community map

The ICS is working in partnership with the National Academy for Social Prescribing (NASP) to populate a map of social prescribing and community navigation services across Kent and Medway. **ACTION 10:** The ICS will continue to support the population and moderation of the content for a Kent and Medway community map.

Figure 4: Kent and Medway social prescribing services map



4.3 Social prescribing data

The social prescribing reference guide and technical annex for primary care networks has been created to support PCN employers of social prescribing link workers. In the 'social prescribing data' section of the guide it says that all link workers embedded within PCN multi-disciplinary teams should have access to the **GP information system** used within the PCN.

4.3.1 SNOMED codes

ACTION 11: To successfully track the number of people benefiting from social prescribing, and in accordance with the Network Contract DES 22/23, the following SNOMED codes should be used to code activity:

Table 4: SNOMED Codes

SNOMED code	Description
• 871711000000103 • 871731000000106	-Social prescribing declined (situation) -Referral to social prescribing service (procedure)

4.3.2 Data fields

In addition to the above codes, national guidance suggests it would be helpful for social prescribing link workers within PCNs to collect the following information. Please note that introduction of a new minimum dataset for social prescribing is expected to be published in 22/23. This will be considered as part of the standard evaluation framework in **Action 12.**

Table 5: Data fields

Date referred to link worker	For indication of waiting times
Who made the referral	To capture which agencies or individuals are making referrals to social prescribing
Reasons for referral	Why the person was referred to the link worker
Equality monitoring	To ensure that social prescribing works inclusively to meet the needs of all communities
Contacts with link worker	Appointments and time spent
Where the person is being connected to	Statutory services e.g., housing, welfare rights, employment support Community activities e.g. arts, culture, physical activity, nature. Other (please state)
Outcomes for the person	How did their wellbeing and activation levels change after 6 months? (See 5.2.1 for examples) What changes took place? How satisfied were they with the service?

4.3.3 System Oversight Framework

We are nationally measured through the System Oversight Framework (SOF). The SOF Metric for social prescribing is part of the personalised care interventions metric (S031a), shown below.

Table 6: Social prescribing SOF metric

SOF Metric: SO31a	Description
• Number of personalised care interventions – Referrals to social prescribing	**-Referred to social prescribing:** Cumulative number of individuals who have been referred to a **social prescribing** service since April 2019

4.3.4 Personalised Care dashboard

We are also measured nationally and regionally through the Personalised Care dashboard.

Table 7: Personalised care dashboard metric

Personalised Care dashboard	Description
• Social Prescribing Link Workers • Social precribing declined	**- Link Workers:** Number of social prescribing **Link Workers** employed by a PCN or a GP practice (FTE) **- Declined:** Cumulative number of individuals who chose not to accept a **referral to a social prescribing** service since April 2019

5. Evidence and impact

There is a growing body of evidence which shows that **social prescribing improves wellbeing** for people, giving them more control over their lives.

The World Health Organisation (WHO) note in their Social Prescribing Toolkit that "several studies have evaluated the impact of social prescribing on health **outcomes** of patients, as well as its impact on **cost reduction** within the health sector."

Studies have shown that social prescribing may **improve psychological well-being**, **reduce anxiety** and **increase** the perceived **quality of life**".

NHS England report that "evaluations of local social prescribing schemes have shown **reduced** pressure on NHS services, with **reductions** in **GP consultations**, **A&E attendances** and **hospital bed stays** for people who have received social prescribing support."

Although hard to quantify, there is an expectation to see a reduction in the number of referrals to statutory services and that of social care.

The Royal College of General Practitioners (RCGP) reported that the practice of referring patients for social prescribing to be **one of the most effective** [of the NHS England 10 High impacted Actions] and **beneficial** for both **GP teams** and **patients**.[15]

The RCGP online survey found that:

"59% of GPs think that **social prescribing** can help **reduce their work load."**

According to a Royal College of General Practitioners survey [10]

Please see Appendix 1 (inserted below) for full details around the evidence and impact.

Appx 1 Evidence and Impact SP & CN

6. Engagement

6.1 Whole system context

We will not succeed unless we actively engage with and listen to the communities we serve and people working thought the system.

Our ICS ambition for engagement states that we want the approach to:

- **"**Raise awareness of the work to improve health and care in Kent and Medway and the wider determinants of health and wellbeing;
- give people the opportunity to influence decisions;
- ensure insights gathered are considered in future plans and strategies.**"**

Engagement activities will support us to identify **priorities** and **improve** the way we deliver services for local people. We will continue to develop and refine services as we engage with, and listen to, our communities. This strategy is underpinned by our Integrated Care Strategy.

6.2 Pre workshop

Prior to the strategy workshop, discussed in section 6.3, system partners were asked what they saw as the priorities for social prescribing.

The feedback from: Voluntary Community Social Enterprise organisations, Link Worker, Kent County Council, Medway Council and Integrated Care Partnership Social Prescribing Leads was categorised and prioritised, shown in table 18 opposite, based on the number of times the same category was mentioned. This was sent out in a pack prior to the workshop, along with a summary of the detail behind each heading.

This was used at the workshop, using Mentimeter, to prioritise the categories identified.

Table 18: Social Prescribing Priorities table

Priority	Category	No.
1	Strategy	10
2	Voluntary sector	8
3	Equitable and consistent	7
4	Evaluation	6
5	Access to a directory	5
	Link worker training	5
6	Networks	4
	Targeted co-horts	4
	Workforce development and progression	4
7	Funding	3
8	Comms and engagement	2
9	Digital systems	1
	Data sharing	1

6.3 Strategy workshop

A Kent and Medway strategy workshop was held in February 2022 bringing together 38 system partners shown in Table **19** to continue with the engagement and co-design of a Kent and Medway social prescribing strategy.

It was recognised that huge strides have been made and a great deal of **knowledge** and **experience** have been obtained, through a variety of projects, pilots, and initiatives. This has led to huge amounts of **learning**, **testing** and **development**, not only benefiting Kent and Medway, but also nationally, by feeding into and helping to shape and inform new models of care and national planning and policy. At the same time the national profile and level of investment in social prescribing has increased, leading to more social prescribers and providers in Kent and Medway. Therefore, it was recognised that Kent and Medway are in a good position and the aim of the workshop was to build on and strengthen what is in place by:

Workshop aims

- Bringing people together to look at what is **working well**,
- think about any **gaps**,
- establish some **priorities** and
- agree how we work together to **continue** to develop social prescribing for the people of Kent and Medway.

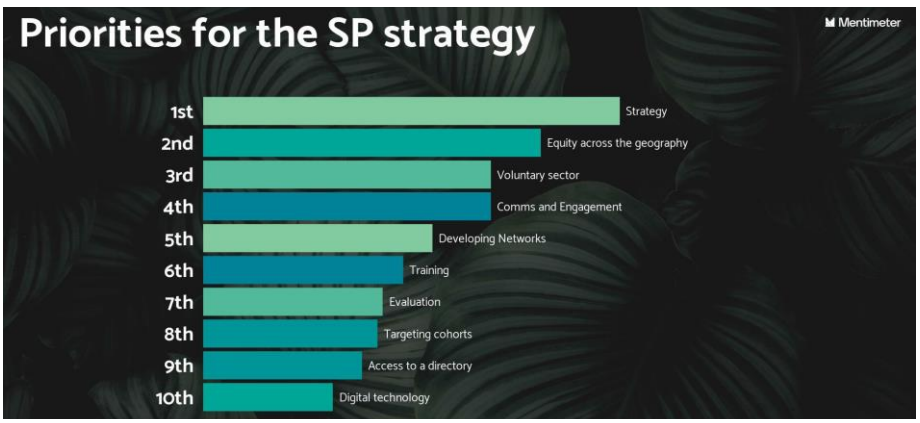
Table 19: Partners

• Voluntary Community Social Enterprise organisations	• NHS Kent and Medway Clinical Commissioning Group
• Kent County Council	• Medway Council
• Primary Care Networks	• NHS England
• Kent Association of Local Councils	• Age UK
• Primary Care Patient Participation Group	• Carers Support
• District Councils	

6.3.1. Priorities

The group used Mentimeter to prioritise the categories identified. It was suggested that **integration** and **funding** should be added to the list below:

Figure 5: Priorities for the strategy



These items have all been included in the strategy skeleton outline and mapped against the social prescribing maturity framework (discussed in section 3.2.4).

6.3.2 Steering Group

It was agreed that a system social prescribing steering group would be established to inform the development and delivery of the strategy, several partners from the system put themselves forward to be part of the group.

6.3.3 Communications and engagement plan

The engagement team at NHS Kent and Medway Clinical Commissioning Group offered to put together an engagement plan to ensure that lots of people have their say and that people are at the centre of the strategy.

6.4 Strategy Board

To ensure the strategy was collaboratively co-ordinated, developed, implemented, and embedded, with senior support within commissioning organisations, a strategy board was established. The first meeting was held in June 2022. The membership of the group included, NHS Kent and Medway, Medway Council, Kent County Council (Chair) and Health Care Partnerships.

6.5 Strategy Steering Group

One of the actions from the Kent and Medway workshop was to establish a steering group of system partners shown in table 20, to inform the development and delivery of the strategy. The first meeting was held in July 2022.

Table 20: Steering Group members

• Communications and Engagement	• District Councils
• Training Hub and Health Education England	• Kent County Council
• Patient Participation Group	• Medway Council
• NHS Kent and Medway	• NHS England & Improvement
• PCN Link Workers	• Voluntary Community Social Enterprise organisations

The group has:

- Agreed a work plan
- Advised on the scope of the strategy
- Advised on and produced definitions for social prescribing and community navigation
- Agreed a communication and engagement plan
- Provided case studies, existing user experience information, survey results, impact data and various reports on social prescribing and community navigation in Kent and Medway such as Healthwatch Medway and health inequalities west Kent programme report
- Advised on the structure and content of the strategy
- Provided Kent and Medway workforce and referral numbers
- Provided opportunities to socialise the development of the strategy and ensure engagement with design and development such as West Kent PPG chairs meeting, Kent Green Social Prescribing Group, Southeast Social Prescribing Strategic Group, East Kent Link Worker forum and completion of surveys across Kent and Medway.

6.6 Comms and Engagement plan

An action from the workshop was to produce a communication and engagement plan for the strategy. The plan aims to ensure that we hear from a diverse range of people who have used social prescribing and community navigation services and that we work with existing providers to reach people, including those who have not taken up the offer of social prescribing and community navigation. The three phases of engagement include:

- **Phase one** - review and summarise existing user experience information to establish what is working well and what could be better.
- **Phase two** - identify any knowledge gaps to help inform survey questions for two surveys:
    - one for users of the service (people with lived experience and
    - one for staff (health and care professionals) working within social prescribing and community navigation
- **Phase three** **ACTION 13** : Set up a reference group to help advise on improving social prescribing and community navigation services.

ACTION 14: To ensure ongoing engagement, the strategy board recommended creating a communication and engagement plan to implement the strategy.

Please see Appendix 2 (inserted below) for further details around our comms and engagement and our survey results.

Appx 2 Survey Results SP CN FINAL

7. Risks

Please see Appendix 3 (inserted below) for our full list of risks and mitigations

Appx 3 Risks SP & CN Stragegy.pdf

8. Operational action plan

Please see Appendix 4 (inserted below) for our Operational Action Plan referred to in this strategy.

Appx 4 ACTION Plan SP & CN Strage

9. Resources

Please see Appendix 5 (inserted below) for our full list of resources that have been utilised in the preparation of this document.

Appx 5 Resources SP & CN Stragegy.p

10. Glossary of terms

Please see Appendix 6 (inserted below) for a full glossary of terms used within this document.

Appx 6 Glossary SP & CN Stragegy.pdf

11. References

Please see Appendix 7 (inserted below) for a full list of references that have been quoted within this document.

Appx 7 References SP & CN Stragegy.p