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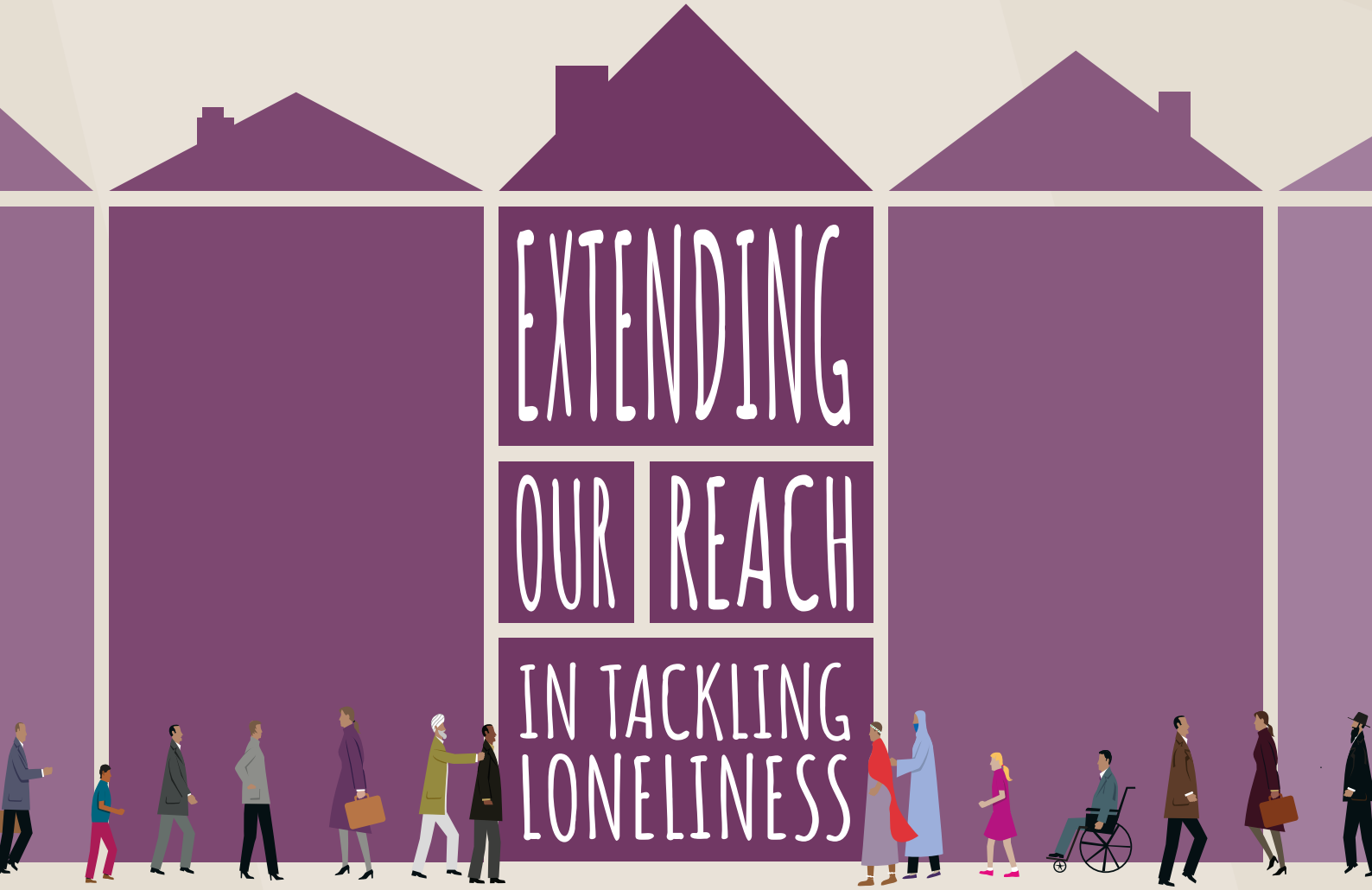

EXTENDING OUR REACH IN TACKLING LONELINESS

HOW SOCIAL PRESCRIBING CAN ACHIEVE ITS AIM BY INVOLVING FAITH-BASED PROVISION

Jeremy Simmons, Jenny Hadgraft, Rodie Garland

Building on *Right Up Your Street: How Faith-Based Organisations are Tackling Loneliness*

About FaithAction

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

» Find out more at www.faithaction.net.

About the APPG on Faith and Society

The All-Party Parliamentary Group (APPG) on Faith and Society is a cross-party group of MPs and peers, chaired by the Rt Hon Stephen Timms MP, who work together to highlight the contribution to society by faith-based organisations, to identify best practice, and to promote understanding of the groups providing innovative solutions around the country. FaithAction acts as the secretariat for the group.

With the support of FaithAction, the APPG on Faith and Society has drafted the Faith Covenant, a joint commitment between faith groups and local authorities to a set of principles that guide engagement, aim to remove the mistrust faith groups can face, and promote open and practical working on all levels.

» You can learn more about the APPG on Faith and Society at www.faithandsociety.org.

Key Terms

Social prescribing is a way for people to receive referrals to local, non-clinical services that can help with a range of needs. These referrals, or 'introductions', often come from a healthcare setting, but a wide range of organisations can make them, and self-referrals are also possible.

We use the term "connector schemes" to refer to local social prescribing initiatives. These schemes are diverse in structure, including local councils, health and care systems, and the voluntary sector.

Primary care networks (PCNs) are a new way of organising care in England, bringing together existing local health and care services to offer more joined up care for patients. PCNs cover areas between 40,000–50,000 people.

Faith-based organisations (FBOs) include worshipping communities that provide support to their own congregations and/or the local community and faith-based or faith-inspired charities, which may or may not be linked to a worshipping community. We prefer the term "faith-based organisation" to cover all of these, but for the sake of variation we also use "faith groups" and "faith communities", and refer to the "faith sector".

Thank you

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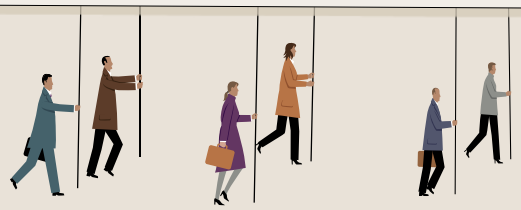


ABOUT EXTENDING OUR REACH

In July last year, FaithAction published *Right Up Your Street*,[1] a report demonstrating the wide-ranging activities of faith-based organisations (FBOs) in responding to loneliness.

This work followed the launch of the government's loneliness strategy, *A Connected Society*[2] (October 2018), as well as the *NHS Long Term Plan*[3] (January 2019), which made a commitment to personalised care and prevention dovetailing with many of the government's ambitions around loneliness.

Right Up Your Street highlighted the government's pledge to instigate "a turning point in the way public services and organisations will promote social connections as a core part of their everyday role. They will develop the expertise necessary to confront loneliness and put in place mechanisms to connect people to the support they need."[4] Social prescribing—which features in both the strategy and the *Long Term Plan*—will play a key role in this, and the NHS have pledged funding to ensure that by the end of this year over 1,000 social prescribing link workers will be in place, with the figure rising by 2023/24.

Extending Our Reach follows on from *Right Up Your Street*, and has been shaped through a series of interviews with individuals involved in the implementation of social prescribing connector schemes, as well as with our members.

At its core are a series of recommendations for national policy makers, the health and care system, and FBOs. We believe the implementation of these will help ensure social prescribing reaches right to the heart of communities through embracing the full diversity of faith-based provision.

Our Recommendations

The government promises in its loneliness strategy to strengthen social prescribing nationally, with NHS England and NHS Improvement responsible for implementing much of this. According to the NHS, good social prescribing will ensure that "services are fully accessible to all communities, including those in greatest need, who may be hardest for agencies to reach."[5]

Achieving this will mean taking stock of the full range of local faith-based service provision, since we know that many communities are beyond the "reach" of services, and facing the starkest health inequalities, will remain an active part of a local faith group – whether a church, temple, mosque, synagogue or gurudwara.[6]

The NHS has committed to building a more personalised health service, with preventative measures tailored to the individuals' needs.[7] You might argue that few things are more "personal" than where we place our faith. Any truly personalised efforts to tackle loneliness, and its attendant health risks, **must take faith into account**.

We believe that adoption of the following recommendations will strengthen the national roll-out of social prescribing and personalised care to ensure that efforts to tackle loneliness, prevent illness and reduce inequalities are as inclusive as possible, and do not miss out on vital faith-based assets.

National policymakers should ensure that...

Ongoing funding and support is made available to the voluntary sector, including faith-based organisations.

We found Even the smallest community group can make a big difference. Social prescribing will depend upon a diverse and dynamic VCSE sector to succeed, yet many smaller organisations, including FaithAction members, express concern that they lack capacity to meet increased demand.

We recommend The government should listen to feedback regarding the impact of social prescribing on voluntary, community and social enterprise (VCSE) organisations taking referrals, gathered through NHS England's Common Outcomes Framework.[8] Appropriate funding should be allocated to nurturing the VCSE sector, as well as to local infrastructure organisations for capacity building.

FBOs should be actively considered as mapping of local assets is developed.

We found There are a number of successful connector schemes already in place, with excellent mapping of a range of services. FBOs are often present in databases, but faith has not been included intentionally as a "sector", and many key FBOs are still "under the radar".

We recommend Best practice in mapping and evaluating the impact of the VCSE sector should be examined, made widely available, and implemented nationally. FBOs should be deliberately incorporated into any pilot initiatives to improve mapping of local assets.

The link worker role is continually reviewed, adapted and resourced as it seeks to relieve pressure on GPs.

We found Primary care networks (PCNs) serve populations between 30,000 to 50,000, with only one funded link worker promised for each. The role is broad, involving consultations, home visits, networking and mapping, and requires a high degree of flexibility and creativity in pairing patients with the right interventions.

We recommend NHS England and NHS Improvement should measure and report on the impact of social prescribing on the link worker role, as part of the Common Outcomes Framework, with additional funding and training allocated if necessary.

PEOPLE LEADING LOCAL IMPLEMENTATION OF SOCIAL PRESCRIBING SHOULD...

IDENTIFY A CLEAR POINT OF CONTACT FOR THE VOLUNTARY SECTOR.

WE FOUND Some connector schemes are drawing upon council directories and databases, but these can lack functionality, not capturing the full breadth and diversity of the voluntary sector. Smaller organisations are not included, and do not always know who to contact in order to be integrated into social prescribing.

WE RECOMMEND PCN clinical directors and link workers should make themselves as contactable as possible for voluntary groups. Link workers should strive to actively outreach to engage smaller voluntary organisations and faith groups in their area.

REFRAME LANGUAGE USED AROUND THE IMPLEMENTATION OF SOCIAL PRESCRIBING.

WE FOUND Our members think more in terms of "introductions", "friends" and "activities" than "referrals", "clients" and "services". Some connector schemes have started reframing language to better embed social prescribing within the local voluntary sector.

WE RECOMMEND To better embed the voluntary sector into social prescribing, key local partners, including PCNs, local authorities and existing schemes, should consult with faith and VCSE organisations to agree a common, non-clinical vocabulary that is accessible to local communities.

ENSURE FBOS ARE EMBEDDED WITHIN SOCIAL PRESCRIBING NOT JUST AS PROVIDERS BUT ALSO AS REFERRERS.

WE FOUND For social prescribing to be as effective and inclusive as possible, referrals should come from a range of agencies, including voluntary-sector organisations and self-referrals, yet some connector schemes are struggling to achieve this breadth, maintaining a largely "top-down" model.

WE RECOMMEND FBOs, and other voluntary-sector groups, should be included in the co-production of connector schemes and equipped to support self-referral into social prescribing. This could improve access to social prescribing for communities that are much less likely to access primary care.

FAITH-BASED ORGANISATIONS OUGHT TO...

CLARIFY THEIR "OFFER" TO SOCIAL PRESCRIBING.

WE FOUND Link workers and connectors are keen to make introductions to FBOs but exactly what each organisation can offer, and for whom, is not always clear.

WE RECOMMEND Social prescribing schemes need to know what FBOs can provide: their assets, remit and limits. For example, is the offer for individuals of one faith, or for all, and what is the capacity of each activity? We will provide guidance for FBOs to this effect, as outlined in "Next Steps".

CONTACT THEIR LOCAL LINK WORKER AND PCN CLINICAL DIRECTOR.

WE FOUND Link workers are being trained and equipped to map local VCSE organisations, as well as draw upon existing databases, but the quality of these databases is patchy, and sometimes FBOs are "hard to find". Clinical directors have a broader overview of the relevant PCN patch.

WE RECOMMEND While schemes are in their infancy FBOs interested in social prescribing should not wait to be contacted. They should become acquainted with surrounding GP surgeries and ask to be put in touch with the clinical director of the relevant PCN to be linked into social prescribing.

CONSIDER INDIVIDUALS FOR WHAT THEY CAN CONTRIBUTE, RATHER THAN WHAT THEY NEED.

WE FOUND Organisations see the most positive outcomes for people introduced through social prescribing when they begin to volunteer, give back and "take ownership" over activities. That is, when they become part of the solution, not the problem.

WE RECOMMEND FBOs should continue to embed this culture of ownership into the activities they offer, considering individuals not as recipients of 'prescriptions' but as assets in themselves.

Key Themes

In the course of our interviews we have learned the following regarding the current picture of social prescribing throughout the UK, its connection to efforts to tackle loneliness and the involvement of FBOs within these initiatives. These themes have informed the above recommendations, as well as our commitments to work going forward.

Social prescribing and loneliness

Loneliness remains an issue front-and-centre for connector schemes...

"[Loneliness] is one of the primary concerns people come with – either from living alone or having caring responsibilities that cut them off."

—Hampshire

"Loneliness is the most prevailing thing in my workload..."

—Durham

"Often loneliness is a key referring issue, lack of social connections."

—Yorkshire

However, there were questions around language, with individuals not identifying as lonely, and schemes also considering the reframing of 'clinical' terminology.

"The top issue is befriending, also depression and anxiety. People will not say they are lonely as such, but it often turns out that they are."

—Essex

"We're trying to talk about 'introductions' to the service rather than 'referrals' ... so we're using different language with the new contract."

—Yorkshire

Whilst interviewees talked primarily about loneliness among older people, they agreed that it affected a much broader sweep of the population.

"It's not always older people, many new young mums are lonely due to social media, non-working parents whose children start school, often eased by volunteering, etc. Divorces, uni students, etc."

—Essex

"There is a whole breed of lonely person, like young people, gamers, who sit up all night..."

—Durham

"A lot of people in the area are talking about a neglected group – young mothers and fathers who are socially isolated."

—Devon

Structure of connector schemes

Mapping of activities is patchy, and some databases lack functionality...

We heard about some excellent, proactive mapping, however a number of interviewees acknowledged that, on the whole, the picture was inconsistent. This was particularly true of localities that had more than one database to draw from, or multiple schemes and structures within a single county.

"At the moment everyone is doing their own mapping, which doesn't make sense."

—Yorkshire

Where schemes drew upon council-based databases it was acknowledged that these were limited in their awareness of the voluntary sector, and sometimes lacked functionality. A further challenge was keeping records of services up to date.

"We had to start from scratch ... now we have a network of contacts ... The council does have a directory ... however a lot of things were out of date."

—Durham

"At the council we have a directory, which is excellent but lacks some functionality ... It's a question of how you keep that information live. For example, if a lunch club changes the day it operates, how do you update the mapping? The information is only as good as how live it can be."

—Yorkshire.

"Council directories lack functionality and are too public-sector based. They don't include the smaller groups. They are not kept up to date and are not searchable."

—Cornwall

"The council has a database but ... there isn't anyone that is employed full time to work on it, to ensure that it is up to date. You have to check what is on there as no one is adding to it. So it's useful but limited."

—Devon

"Most schemes are only as good as the database and links that they have with the voluntary sector. In terms of databases, people are doing different things. Some councils have a database, there is lots of variety."

—Greater Manchester

Social prescribers are largely unclear about how the new funding for link workers will integrate with current schemes...

"The high-level strategy is that they will continue to support [Council for Voluntary Services (CVS)] services and will then signpost the PCNs to commission the existing link workers ... but the guidance states that [the link workers] have to be new to the system so I'm unsure as to how it is going to work out."

—Essex

"We've already perfected the system. We've got it to a place we're happy with."

—Greater London

"I hope the experience, training and passion that the [connector scheme] volunteers have already will be able to be used in some way to support link workers when they're in post."

—Hampshire

"There is not one delivery model ... There are different models even within each locality. The PCNs are now coming on the scene and some will merge with existing models and some will set up new schemes."

—Greater Manchester

Yet there has been some positive movement to think strategically about how the new funding can learn from existing schemes.

"One of the first things we're doing with the new PCN contract is around social prescribing ... How do we align our existing social prescribing work with the new funding...?"

—Yorkshire

"We are offering to work with PCNs and have a steering group to look at how to bring the two together so that they systems are aligned."

—Yorkshire

"We are having conversations with a number of PCNs across our patch. It's still to early to know."

—Hampshire

Referrals into social prescribing are largely through the healthcare system, as well as self referrals...

Our interviews suggested that connector schemes still see the healthcare system as the primary point of entry for social prescribing, although the possibility of self-referrals were acknowledged throughout.

"We are the single point of access for social prescribing ... people are referred into our service by a health professional or self-referral."

—Essex

"People can self-refer as long as they are a patient registered with this surgery, other sources can refer them, such as midwives, community nurses, etc."

—Devon

"[Social prescribing] is located in once surgery per district, although anyone in the district can be referred in or refer themselves into the service."

—Hampshire

"In the future, we realise [social prescribing] needs to be more in the community. Social prescribing is very 'top-down'."

—Cornwall

Three interviewees mentioned the voluntary sector, and other services, as possible referral routes, with the suggestion that a link worker model may encourage a wider range of referral pathways.

> *"You've always been able to self-refer/introduce, and that's carrying on ... voluntary-sector organisations can introduce people to the service. [NHS England and NHS Improvement] have brought the link worker model in so that any organisation can refer."*
>
> —Yorkshire

Faith groups and social prescribing

Faith groups are a part of connector schemes, but inclusion of the sector could be more intentional...

FBOs were a part of all the connector schemes we examined.

> *"Churches make up a considerable amount of our membership. So local voluntary-sector organisations are invited to be members of the CVS, and that doesn't exclude faith-based organisations in any way."*
>
> —Hampshire

> *"Yes, there are faith-based organisations on [the council database]. I always look at churches and what's going on in the religious community as there is usually lots going on."*
>
> —Devon

> *"Most of the social prescribers are Bangladeshi Muslims ... I've not encountered any stigma."*
>
> —Greater London

There was acknowledgement, however, that this inclusion was not always the result of efforts from community connectors or link workers to actively seek out faith groups, or to consider faith as a 'sector'. Rather, FBOs themselves were expected to contact schemes, or were linked in through their provision of other services, like foodbanks.

> *(When asked if faith groups were intentionally included) "I don't think so, in the main, places like foodbanks are housed under the umbrella of a church, so faith groups support the social prescribing agenda but the door in is through the food bank."*
>
> —Durham

> *"I don't think all [faith-based provision] is on [the council database] because it's actually up to the faith group to contact the council to be added to the database – that doesn't always happen."*
>
> —Devon

We encountered no reluctance among interviewees to work with faith themselves, but some expressed concern that misunderstandings around the role and remit of FBOs could limit involvement in schemes.

> *"These [FBOs] are real assets and if we're not making good use of resources because of misunderstandings, that's not getting the best"*
>
> —Yorkshire

> *"I think sometimes people are a bit worried about mentioning a faith-based organisation. I'm not personally, but it's difficult for some people."*
>
> —Devon

Those implementing connector schemes desire a clearer offer from faith groups...

Interviewees suggested that greater clarity from faith groups in articulating their offer would aid their inclusion in schemes. For example, was their offer open to everyone, or directed more at those of a particular faith? And would the activity involve faith-based content, or simply a space to make friends?

> *"I think if the churches are making themselves available, they need to be particular about what service they can offer ... they'll know what their capacity is, how many volunteers they have got, what funding or donations, etc. You can't put yourself out there and say 'we're here' and then get an influx that you cannot handle."*
>
> —Durham

> *"If someone has a very strong faith, and there are faith-based services in their area, that could be something that feels quite comfortable for them. But equally, that service offered by a church/synagogue/mosque/Gurdwara is open to all. Perhaps that's something we need to be clear about..."*
>
> —Yorkshire

Geographical details and transport links were also listed as helpful indicators, especially for groups with limited capacity.

"Some services referred to are local, but transport is an issue, so they need to be location specific."

—Cornwall

"It needs to be very localised – i.e. surrounding streets, not the whole town having access. People that could walk there."

—Durham

Smaller-capacity initiatives may be missing out...

There was an awareness that for social prescribing to be successful the full breadth of voluntary-sector provision must be included, from tiny, pop-up lunch clubs to much larger organisations. Yet interviewees acknowledged that these smaller initiatives may lack resources to promote their services, or may simply be unaware of connector schemes, resulting in them being "under the radar" of local mapping.

"It can tend to happen that the organisations that are the most well promoted are the ones that are the most referred to. Certainly some might be getting on very effectively but quietly, not promoting what they do as well as others, and be overlooked."

—Hampshire

"[Link workers] have to actually ... go out and find out. A lot of these smaller organisations are very stretched ... maybe they don't want the world to know about them ... because then they would be overloaded ... there's a limit to what they can do."

—Durham

"Sometimes you have your list of statutory services, and you have organisations that are really good at self-promotion and getting their message out, but the smaller or more limited services – they are not so known. The smaller-scale things are getting missed and those are so important to people living in local areas."

—Yorkshire

"Council directories ... don't include the smaller groups."

—Cornwall

"Some churches seem to be quite isolated and don't tend to advertise what they do, it might be down to time and finances but you have to really dig around to find out what's happening."

—Devon

Next Steps

In response to these findings, FaithAction will...

1 Equip FBOs to measure the impact of their interventions.

We will draw on the NHS Common Outcomes Framework, as well as the Office of National Statistics' recommended loneliness measures, to produce training for faith groups taking referrals.

2 Help FBOs articulate their offer.

We will create a multi-faith framework to help organisations review their health assets and better articulate exactly how they can support the health and care system.

3 Pilot a local project to strengthen faith/statutory sector partnerships.

We will work with those implementing social prescribing in one locality to explore new ways to partner with the faith sector with a view to sharing learnings that are scalable.

More About Our Research

Our research involved interviews with 9 individuals implementing social prescribing across 8 county regions of the UK.[9] This included people in clinical commissioning groups (CCGs), local CVSs and other organisations involved in connector schemes. Three themes directed our questions:

» How does your scheme work?

» What difference do you see the new national funding/structure making?

» What has been the role of FBOs in your scheme thus far?

» What are the most common reasons for referral?

In addition, we held multiple conversations with our members around social prescribing, as well as desk-based research on the implementation of the national strategy. This document represents the synthesis of our findings and our recommendations to national policy makers, local connector schemes, and the faith-based organisations themselves.

References

1 FaithAction (2019). *Right Up Your Street: How Faith-Based Organisations Are Tackling Loneliness.* London: FaithAction.

2 Department for Digital, Culture, Media and Sport (2018). *A connected society: A strategy for tackling loneliness – laying the foundations for change.* London: HM Government.

3 NHS England (2019). *The NHS Long Term Plan.* Available at: https://www.longtermplan.nhs.uk/

4 Department for Digital, Culture, Media and Sport (2018), p. 24, emphasis added.

5 NHS England (2019). *Social prescribing and community-based support: Summary guide.* Online: available at: https://www.england.nhs.uk/wp-content/uploads/2019/01/social-prescribing-community-based-support-summary-guide.pdf, p. 9.

6 FaithAction and November, L. (2014) *The Impact of Faith-Based Organisations on Public Health and Social Capital.* London: FaithAction.

7 NHS England (2019). *The NHS Long Term Plan*, p. 12.

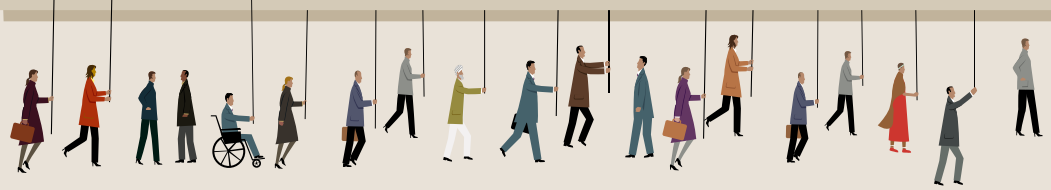
8 NHS England (2019). *Social prescribing and community-based support.*

9 These counties were Essex, Greater London, County Durham, Yorkshire, Devon, Greater Manchester, Cornwall and Hampshire.

WHO WE ARE

FaithAction—because faith is too significant to ignore.

We fund, train, advise, campaign, research, and innovate. We do this as a national network supporting faith-based organisation at work in their local communities.



FaithAction

Supporting people to put their faith into action;
bringing faith into policy making; building stronger communities.

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