Social Prescribing in Brent

An Overview and Scrutiny Task Group Report

Chair, Councillor Ketan Sheth

Community and Wellbeing Scrutiny Committee

Members of the Task Group

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Dr MC Patel*

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*Denotes co-opted member

The task group was set up by members of Brent Council's Community and Wellbeing Scrutiny Committee on 22 September 2022.

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Chairs Foreword

Social prescribing is a non-traditional form of healthcare that uses a holistic approach that deals with residents as a whole person and supports patients to address non-medical factors such as poor-quality housing that may cause medical issues, such as mental ill health through non-medical support in the community. Social prescribing is still in its early stages of its development in England, and it was not until 2014 that the NHS recognised the range of benefits that social prescribing could have on its population's health at a national level. As social prescribing has developed in Brent its focus has had to adapt, with factors such as the 12 years of austerity and the cost-of-living crisis changing the support residents need in the community. It was imagined that residents would be prescribed gym memberships and swimming classes through social prescribing, however, many residents who receive support from social prescribing in Brent are referred to welfare services, food banks and social care support. It is important to note that social prescribing operates within this context in Brent.

Social prescribing has been identified as being potentially key to addressing health inequalities across Brent, as residents who live in areas of high deprivation are more likely to have worse health outcomes due to socio-economic factors. To enable social prescribing to effectively tackle Brent's deeply entrenched health inequalities, its resources and funding must be distributed fairly, so that residents who are more likely to be impacted by health inequalities have sufficient opportunities to access the support they need.

"The key drivers of health inequalities are inequities in the conditions of daily life: the conditions in which people are born, grow, live, work and age. Action at the community level to address these is both necessary and feasible." – Sir Michael Marmot

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The Task Group were encouraged by how social prescribing has developed in Brent so far. The Task Group hopes its findings and recommendations will assist in the development of social prescribing model for Brent that all residents can access fairly and makes a significant contribution to reducing health inequalities in Brent.

I would like to thank all the partners who participated in this process and gave up their time to come together for the benefit of our residents, your knowledge and contributions have been invaluable to the Task Group. I would finally like to thank my fellow Task Group members – Councillor Tazi Smith, Councillor Rajan-Seelan, Dr MC Patel and Anita Thakkar.

Councillor Ketan Sheth,
Chair, Social Prescribing Scrutiny Task Group

Recommendations

The Social Prescribing Task Group makes the following recommendations to the Brent Integrated Care Partnership (ICP). It is imagined that Brent Council's Cabinet will endorse any possible response to these recommendations as part of the executive response.

Recommendation 1: It is recommended that Brent's social prescribing model is widened from NHS primary care settings, to enable ICP partners, front line social care and selected front-line council staff to use social prescribing approaches. The Brent Integrated Care Partnership should lead in developing a social prescribing approach for Brent, where partners work together to ensure that all of Brent's residents have the opportunity to benefit from the holistic approach of social prescribing, as a way of further tackling health inequalities in the borough.

The Task Group recognises the good work in developing social prescribing in primary care and sees the benefits that using a holistic approach can have in improving health outcomes for Brent residents. However, it is known that there are Brent residents who are not registered with a GP and therefore cannot currently access social prescribing services. These residents may not be registered with a GP due to historical barriers to access for residents impacted by health inequalities, or because some Brent residents may be mistrustful of traditional health services.

The Task Group believes that the Brent Integrated Care Partnership should drive the development of a Brent social prescribing approach that is available to all Brent's residents. This would ensure every resident can benefit from the holistic approach used in social prescribing and would help to address the unmet health needs of resident's who are currently excluded from accessing social prescribing. Existing health and social care staff within the Brent Integrated Care Partnership and staff in selected local authority 'access points' should be enabled to use social prescribing approaches in their work as part of the Brent social prescribing approach.

Recommendation 2: It is recommended that there is an equitable social prescribing offer across the borough that explicitly addresses deeply entrenched and intersectional health inequalities, listens to, and responds to communities, and ensures funding is allocated by areas of Brent with higher levels of deprivation.

The Task Group believes that social prescribing resources and funding should be weighted towards areas of Brent with higher levels of deprivation. Throughout the Task Group's work, partners have outlined that social prescribing is particularly important for residents living in areas with high levels of deprivation. The Task Group also recognises that residents living in areas of high deprivation are more likely to be impacted by health inequalities. It is therefore vital that these residents are supported

with sufficient resources, especially in the context of a cost-of-living crisis which is continuing to have a detrimental impact on the health of our deprived residents.

Social prescribing in primary care currently allocates resources based on GP practice need at a Primary Care Network (PCN) level. There is an opportunity for Brent's social prescribing approach to be developed so that it is guided by residents' needs and focuses its resources and funding in areas of the borough with higher levels of deprivation, where residents are more likely to be affected by health inequalities. Ensuring that the approach listens and responds to Brent residents is essential in developing an equitable social prescribing offer that tackles Brent's deeply entrenched health inequalities.

Recommendation 3: It is recommended that the Brent Integrated Care Partnership sponsors a social prescribing working group that brings partners involved in social prescribing together quarterly to develop a Brent approach to sharing knowledge, best practice and working together on social prescribing. This will ensure there is greater shared understanding of all social prescribing opportunities in Brent to increase partners' ability to effectively meet residents' needs.

The Task Group found that there is currently not a comprehensive, real-time picture of all the social prescribing opportunities in Brent. This issue is currently hindering the effectiveness of social prescribing in Brent as not all services are connected into NHS frameworks and social prescribing link workers do not have the time to proactively research opportunities in the community and voluntary sector, which means that suitable opportunities for residents could be missed.

The Task Group believes that in order to develop more joined up working and information sharing on social prescribing between partners, the Brent Integrated Care Partnership should take ownership of bringing partners involved in social prescribing together to share information on social prescribing opportunities, best practice and adopt a shared understanding of how partners will work together on social prescribing. This will foster better information sharing and develop a Brent approach to working together on social prescribing. This will improve residents' experience of social prescribing, giving partners more knowledge on support in the community to refer residents into, therefore enhancing Brent's social prescribing offer by making it more diverse, targeted and community specific.

Recommendation 4: It is recommended that the Brent Integrated Care Partnership develops a Brent approach to capture further activity data and develop an understanding of how resources are distributed. In order monitor behaviour change and the effectiveness of social prescribing in Brent. This approach should complement partners' respective reporting mechanisms and be used by all partners involved in social prescribing. This will further support

the Brent Integrated Care Partnership to develop a joined-up approach to data collection amongst partners in the borough.

The Task Group believe that issues around data collection and evaluation are the key challenge for social prescribing's development locally and nationally. To improve data evaluation there must be sufficient data collected on social prescribing activities in the borough, which would show how social prescribing is developing and allow partners to monitor how social prescribing is contributing to behaviour change in the borough.

The Task Group believe that the Brent Integrated Care Partnership should develop its own approach to collecting further data from all partners on social prescribing activities in Brent. Any further data collected by the Brent Integrated Care Partnership would be separate and additional to the reporting measures that already exist for separate partners. The ICP's additional data collection should complement partners' existing reporting measures and be a standalone measure that develops a shared view amongst partners. This further collection of data, driven by the ICP will develop a joined-up approach to data collection and give the ICP strategic oversight of how social prescribing is evolving and changing resident's behaviour.

Recommendation 5: It is recommended that social prescribing activities are reported quarterly to the Brent Integrated Care Partnership's Health Inequalities and Vaccinations Executive Group, to evaluate social prescribing activities for the borough. This will create greater consistency and alignment for social prescribing across the borough.

The Task Group consider a mechanism must be put in place which ensures social prescribing activities are reported across Brent. Currently there is no overall picture of how social prescribing is developing across the borough, which elevates risks of inconsistency in the social prescribing offer across the borough which could negatively impact residents. Reporting social prescribing activities into the Brent Borough Based Partnership (ICP) will allow the ICP to have strategic oversight of social prescribing's development in Brent, which will promote greater uniformity and alignment across the borough.

The Task Group believe that social prescribing activities should be reported into the ICP's Health Inequalities and Vaccinations Executive Group. The Task Group recognises that social prescribing is vital in areas with higher levels of deprivation, as it can play a significant role in improving health outcomes for Brent residents who are impacted by intersectional health inequalities. It is therefore logical that social prescribing activities should be reported into this executive group, so it can review the impact of social prescribing in reducing the deeply entrenched health inequalities that exist in Brent and the rest of the United Kingdom.

Introduction:

Social prescribing is an intervention in healthcare that allows healthcare professionals to refer patients onto a range of local, non-medical services in the community. It seeks to improve health outcomes by addressing a patient's wider issues that may contribute to their overall health. The organisations and activities residents are referred into through social prescribing are varied, some examples of referrals in Brent include to Brent Citizens Advice, dementia support groups, and food banks. Social prescribing uses a person-centred, holistic approach to treating patients, that looks at the whole person to understand possible non-medical issues that contribute to an individual's medical condition. For example, a patient may go to their GP with symptoms of depression; instead of prescribing anti-depressants, the social prescribing approach will look at the non-medical issues that could be contributing to their symptoms such as welfare issues or poor-quality housing. Whilst there are different social prescribing models, a typical social prescribing scheme has three key components: (i) a referral from a healthcare professional, (ii) a social prescriber (link worker), and (iii) a range of local opportunities in the community and voluntary sector that a patient can be referred into.[1]

Social prescribing approaches are not new, since the 1990s schemes have been practiced in the NHS, and the pioneering Bromley by Bow Centre was established in 1984.[2] However, until 2014 social prescribing largely went unnoticed by the NHS at a national level. It was research that was influential in putting social prescribing on the national agenda. The Foresight Capital and Wellbeing Project found that positive mental health and wellbeing was associated with social and economic factors, such as education and social connectivity[3]. The Marmot review of 2010 highlighted the social determinants of health inequality, which meant that wealth, geography and race have an impact on a person's physical health[4]. Furthermore, The World Health Organisation found that stress, unemployment, debt, loneliness, lack of education and support in early childhood, insecure housing and discrimination can impact 30-55% of the health outcomes people experience.[5] Research on the impact of social determinants of health have highlighted the positive impact that social prescribing approaches could have on a population's overall health.

Since 2014 national NHS bodies have committed resources to its national development, multiple NHS forward views have placed an emphasis on the role the community and voluntary sector could play alongside GP services in offering patients community-based support. The NHS long-term plan (2019) incorporated social

[1] University of Westminster (2017), Making Sense of Social Prescribing
[2] The Kings Fund (2020), What is Social Prescribing?
[3] Foresight Mental Capital and Wellbeing Project. (2008). Mental capital and wellbeing: Making the most of ourselves in the 21st century
[4] Michael Marmot (2010) Fair society, healthy lives: Strategic review of health inequalities in England post-2010.
[5] NHS England (2022), Social prescribing as a way of tackling health inequalities in all health settings

prescribing into its comprehensive model of personalised care, as part of this Primary Care Networks with a population of over 30,000 people were reimbursed for the costs of employing a social prescribing link worker.[6] This was instrumental in advancing social prescribing, and it is estimated that there were 2,264 link workers in post nationally in March 2022.[7]

The Social Prescribing Task Group was established in September 2022 to conduct an in-depth review of how social prescribing has been implemented in Brent so far and to evaluate the options for its future development. This was relevant and timely given the move towards further integration of health and social care as a result of the Health and Care Act of 2022[8], which led to Integrated Care Systems (ICS) being formalised as legal entities with statutory powers and responsibilities. These ICS' focus on places and local populations as the driving forces for improvement in health services.[9] A review of social prescribing was therefore considered as it would give the Task Group an opportunity to positively influence the development of social prescribing in the borough in a period of further integration of health and social care.

Task Group Membership

The Task Group was comprised of the following members:

- Councillor Ketan Sheth (Chair)
- Dr MC Patel*
- Councillor Rajan-Seelan
- Councillor Tazi Smith
- Anita Thakkar*

*Co-opted member

Task Group Terms of Reference

The following Terms of Reference for the Task Group were agreed at the 22 September 2022 meeting of the Community and Wellbeing Scrutiny Committee:

i) To review Brent's current social prescribing offer, including both the infrastructure and attitude to social prescribing and evaluate whether Brent is fully realising the potential benefits of social prescribing.

ii) To understand the opportunities for social prescribing in Brent and what can be achieved through social prescribing locally for all residents.

iii) To consider the most effective ways of further developing social prescribing in Brent in collaboration with the NHS and other partners.

[6] The Kings Fund (2020), What is Social Prescribing?
[7] The Nuffield Trust (2022), How many social prescribing link workers are there in England?
[8] Department of Health and Social Care, Health and Care Act 2022
[9] The Kings Fund (2022), Integrated care systems explained

Methodology

As part of its work the Task Group has collected both quantitative and qualitative evidence which has contributed to the Task Group's report and its recommendations. Between October and December 2022, the Task Group carried out a number of evidence sessions with partners involved in social prescribing. The Task Group thanks all those who contributed to the sessions, a full list of those who participated is included in Appendix A.

The Task Group Members carried out four evidence sessions, during these sessions the task group questioned expert witnesses on issues related to social prescribing in Brent. More detail on the content of these sessions is included in Appendix B. In addition to the information gathered at evidence sessions, the Task Group also requested both qualitative and quantitative data from a number of partners.

The Task Group has developed its recommendations in line with existing local authority scrutiny legislation. Whilst the Task Group recognises that a local authority executive or external body is not compelled to act on a recommendation, a local authority executive must respond within two months and NHS organisations are expected to give a meaningful response within 28 days of recommendations being agreed by a scrutiny committee.[10]

Background:

Social Prescribing in Brent

Much like the rest of England, Brent developed social prescribing arrangements following the commitment of resource to its national roll out by the NHS nationally. Currently social prescribing is delivered as an intervention in primary care, where social prescribing link workers work as part of a multi-disciplinary team within a GP practice. Social prescribing has been located in primary care for multiple reasons, and because one in five GP appointments relate to issues wider than health,[11] social prescribing link workers are well placed in primary care to support patients who have issues that are broader than healthcare alone. Link workers use a person-centred, holistic approach, which involves supporting a patient over an extended period of time to build rapport and trust. This allows a patient to develop confidence and openness with their link worker, which in turn enables the link worker to refer the patient onto the most appropriate support in the community. Using this holistic approach over an extended period of time is the key asset of social prescribing, which can effectively address non-medical issues that contribute to a person's overall health.

Social prescribing has also been used as a way of managing demands on GP practices, given the significant demands and pressures on the health service in 2022,

[10] Department of Health (2014), Local Authority Health Scrutiny
[11] NHS England (2022), Social prescribing as a way of tackling health inequalities in all health settings

social prescribing link workers taking on some patients who have non-medical issues that are contributing to their ill-health reduces pressure on clinicians. This in turn allows clinicians to see more patients who require traditional medical interventions.

Social prescribing link workers have a significant impact within primary care, an example of their role and impact is outlined by a Brent GP Partner below:

> *The Social Prescribing Link Workers offer a monumental holistic support service for our patients. We have a very high prevalence of patients facing major health inequalities, severe deprivation with underlying major social and welfare challenges, including benefits, housing, relationship, cultural and social problems. Many patients are facing extreme cost of living problems and cannot afford to "heat and eat" or make basic healthy food and medical choices. As a result, this leads to major medical/health problems including poor nutrition with health and wellbeing lifestyle challenges, weight problems with earlier onset and prevalence of chronic disease conditions e.g., Type II Diabetes Mellitus, Hypertension, Serious Mental Health problems and worsening complications. The Social Prescribing Link Workers offer an incredible practical support towards tackling some of the mountain of problems faced. As a result, patients report huge benefit in having a service that can help signpost and direct them towards improving their health, wellbeing, financial, social and lifestyle situation.*

In Brent social prescribing is currently delivered differently to residents depending on which Primary Care Network (PCN) their GP practice is part of. A Primary Care Network is a group of GP practices that work together to enable residents to receive more proactive health and social care close to their homes.[12] Brent has 7 Primary Care Networks; the practices within each PCN are reflected in Table 1. Harness North and South and K&W PCN areas commission Brent Mencap to deliver social prescribing in their GP practices, whereas the Kilburn Partnership PCN has its own arrangements for social prescribing.

Table 1: Brent Primary Care Networks and Practices[13]

PCN Area	GP Practice
Harness South	Forty Willows Surgery
	Church End Medical Centre
	The Stonebridge Practice
	Brentfield Medical Centre
	Freuchen Medical Centre
	Oxgate Gardens Surgery

[12] NHS England, Primary Care Networks
[13] NHS Digital (2023), Patients Registered at a GP Practice – January 2023: Mapping (Commissioning Regions – ICBs-SICBLs-PCNs-GP Practice)

	Walm Lane Surgery
	Hilltop Medical Practice
	Park Royal Medical Practice
	Roundwood Park Medical Centre
Harness North	Willow Tree Family Doctors
	Preston Hill Surgery
	Church Lane Surgery
	Lanfranc Medical Centre
	The Sunflower Medical Centre
	The Surgery
	Preston Medical Centre
	Pearl Medical Practice
	Wembley Park Drive Medical Centre
	Sms Medical Practice
Kilburn Partnership	Mapesbury Medical Group
	Kilburn Park Medical Centre
	Staverton Surgery
	Chichele Road Surgery
K&W North	Uxendon Crescent Surgery
	Jai Medical Centre (Brent)
	The Fryent Way Surgery
	Brampton Health Centre
	Kingsbury Health And Wellbeing
	Neasden Medical Centre
	Kings Edge Medical Centre
K&W South	St Andrews Medical Centre
	The Willesden Medical Centre
	The Lonsdale Medical Centre
	Gladstone Medical Centre
	Willesden Green Surgery
	St. Georges Medical Centre
	Burnley Practice
K&W Central	Ellis Practice
	Chalkhill Family Practice
	Preston Road Surgery
	The Tudor House Medical Centre
	Sudbury Surgery
K&W West	Premier Medical Centre
	The Law Medical Group Practice
	Sudbury & Alperton Medical Centre
	Stanley Corner Medical Centre
	Lancelot Medical Centre
	Hazeldene Medical Centre
	Alperton Medical Centre
	The Wembley Practice

There are currently 32 social prescribing link workers who work across Brent's 51 GP practices.[14] Primary Care Networks are responsible for deciding which GP practices social prescribers are allocated to and the amount of time each practice is allocated with a social prescribing link worker. As social prescribing continues to develop in Brent there has been an increase in the number of referrals made by social prescribers across Brent. Harness North and South PCNs reported 2512 social prescribing referrals in 2021-22, which was a significant increase from the 1,575 referrals made in 2020-21. Kilburn partnership PCN collects data on social prescribing differently to other PCNs in Brent, however the PCNs four practices supported 524 patients through

[14] Evidence session 2

social prescribing from January to October 2022[15]. Whilst this increase may have been influenced by the Covid-19 pandemic in 2020-2021, or population growth in Brent, there is evidence that demand for social prescribing services across the borough is increasing. Due to the nature of social prescribing, for each referral a patient is typically contacted 5 times by their link worker, and if a referral is related to mental health support, social care, housing or welfare benefits link workers will often contact a patient between 8-10 times to ensure they receive appropriate support.

The other aspect of a social prescribing link worker's role is to connect patients with appropriate support in the community. These community led interventions are key in mobilising the power of communities to generate positive health outcomes for local people. Given Brent is one of London's most diverse boroughs it is important that there are culturally specific, diverse and targeted opportunities to refer residents into; otherwise, there is a risk that residents may not receive the most appropriate support in the community. A case study of a typical social prescribing referral in primary care is outlined below.

Case Study: Example of casework undertaken by a social prescribing link worker

Patient A, 57 was referred for social prescribing by his GP as they were struggling to get the right support. On the first initial assessment the social prescribing link worker listened to the patient talk about how they were feeling and why they were struggling. The patient stated that they were going through a difficult time for last few months and had been misusing drugs and alcohol and was gambling for some time. This resulted in that patient accumulating debts of £45,000. This debt issue was giving the patient severe anxiety and struggles with their mental health. The social prescribing link worker discussed different options with the patient to address their debt, alcohol and gambling issues. The patient initially declined the offer to be referred to a gambling clinic, however, on the third appointment the patient agreed, and the referral was made. The patient was also referred to other support services and was given medication by their GP to help with their anxiety. The patient agreed to be referred to Step Change - a debt advice service. Currently the patient is in work and is trying to pay off their debt. They were given advice on how to deal with debt and put in touch with the right services to help them re-pay their debt in instalments and create a budget plan. When the social prescribing link worker follows up with the patient, they check that they are coping well and feeds information back to the practice if required. If any further referrals are needed this will be done, with any clinical concerns being raised with their GP.

[15] Kilburn Partnership PCN (2022), Social prescriber feedback

Brent is fortunate to have a thriving community and voluntary sector that provides a range of support for residents across the borough. The diverse range of social prescribing opportunities allows for residents to be referred into community specific and diverse opportunities. An outline of the type of services social prescribing link workers refer into is provided in Figure 3:

Figure 3: Services/organisations referred to by Harness and K&W Social Prescribing Link Workers (April 2022-Nov 22

Service/organisation referred into:	Number of referrals
Social Services (Care needs assessment, Occupational Health etc)	471
Other Brent Council services (Housing, family wellbeing centre, SEND support, Benefits and Council tax department, Transport etc):	312
IAPT – Improving Access to Psychological Therapies	387
Citizens Advice Brent	325
Brent Hubs	194
Advice for Renters	132
Ashford Place	170
Brent Carers Centre	52
Brent Bereavement Services	47
Brent Mencap	43
Mental Health Services	94
Brent Single Point of Access (SPA)	58
Domestic abuse support services	49
Age UK Brent	86
Elders Voice	112
Cancer support services	54
Other support groups / societies (such as MS Society, Community Action on Dementia etc)	61
AJM Healthcare - Wheelchair services in Brent	45
Thames Reach (Brent Reach)	37
Shaw trust (Employment Services)	49
Twinnings (Employment Services)	52
Hestia (Employment Services)	23
Other employment supply services	17
Sufra NW London	131
Other food banks	61
Brent libraries	56
Community specific groups (Asian Women's resource, Brent Irish Advisory Services, Brent Somali Community Centre)	97

Brent's population & health profile

Brent is the 5th largest London borough by population, which was estimated to be 339,800 people in 2021,[16] its population is also growing more rapidly than the London and national average, increasing by 9.2% since 2011.[17] It is expected that Brent's

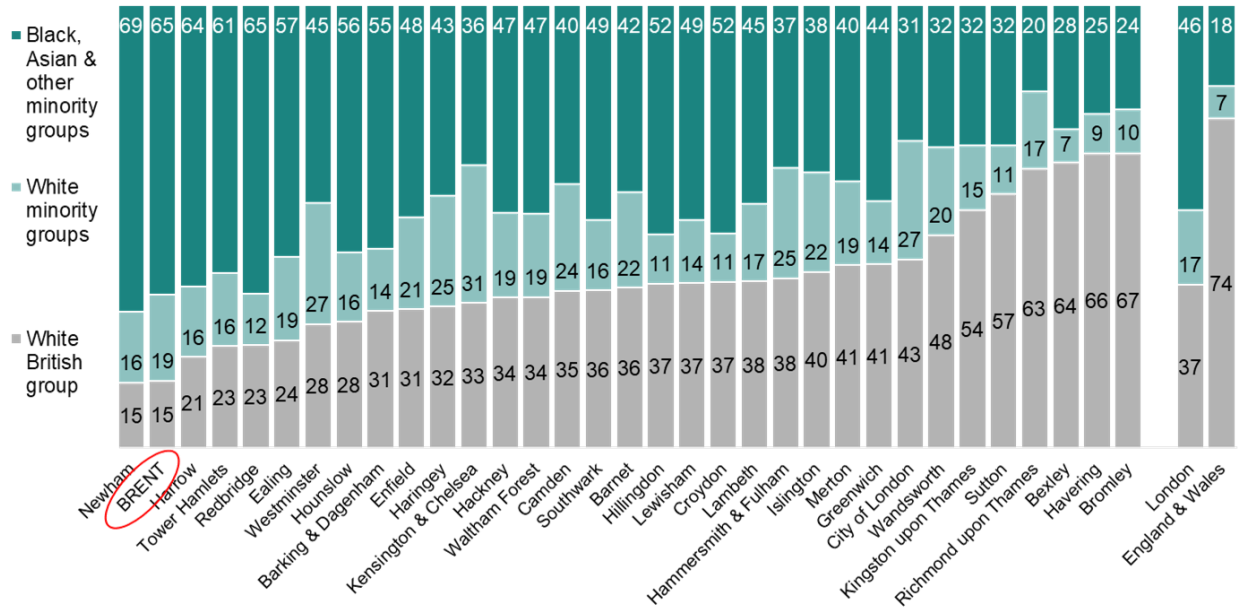
[16] Office for National Statistics, How life has changed in Brent: Census 2021
[17] ibid

population will continue to rise by another 17% between 2020 and 2041.[18] This growth in population is set to place greater demands on Brent's health and social care system. In January 2023, 463,894 people were registered with a Brent GP practice[19], which gives an indication of current demands on Brent's primary care system.

In Brent males have a life expectancy of 80.4, whereas women's life expectancy is 85.0, this is higher than the national average of 79.0 years for males and 82.9 years for females.[20] Brent's Health Life Expectancy figure, which is the number of years a baby would expect to live in a state of 'good' general health was 64.0 years for males and 68.6 for females; higher than London averages of 63.8 for males and 65.0 for females. Whilst this data suggests that Brent's general population is in good health, the local authority knows that there are specific groups of residents who are more likely to have poorer health outcomes and therefore require specific attention and intervention.

Brent has one of the most ethnically diverse populations in the country, the majority of its population (85%) are from ethnically diverse groups, and it has the second highest percentage of BAME residents in London, as highlighted in Figure 4.

Figure 4: Population by ethnicity, London Boroughs & the City, 2021



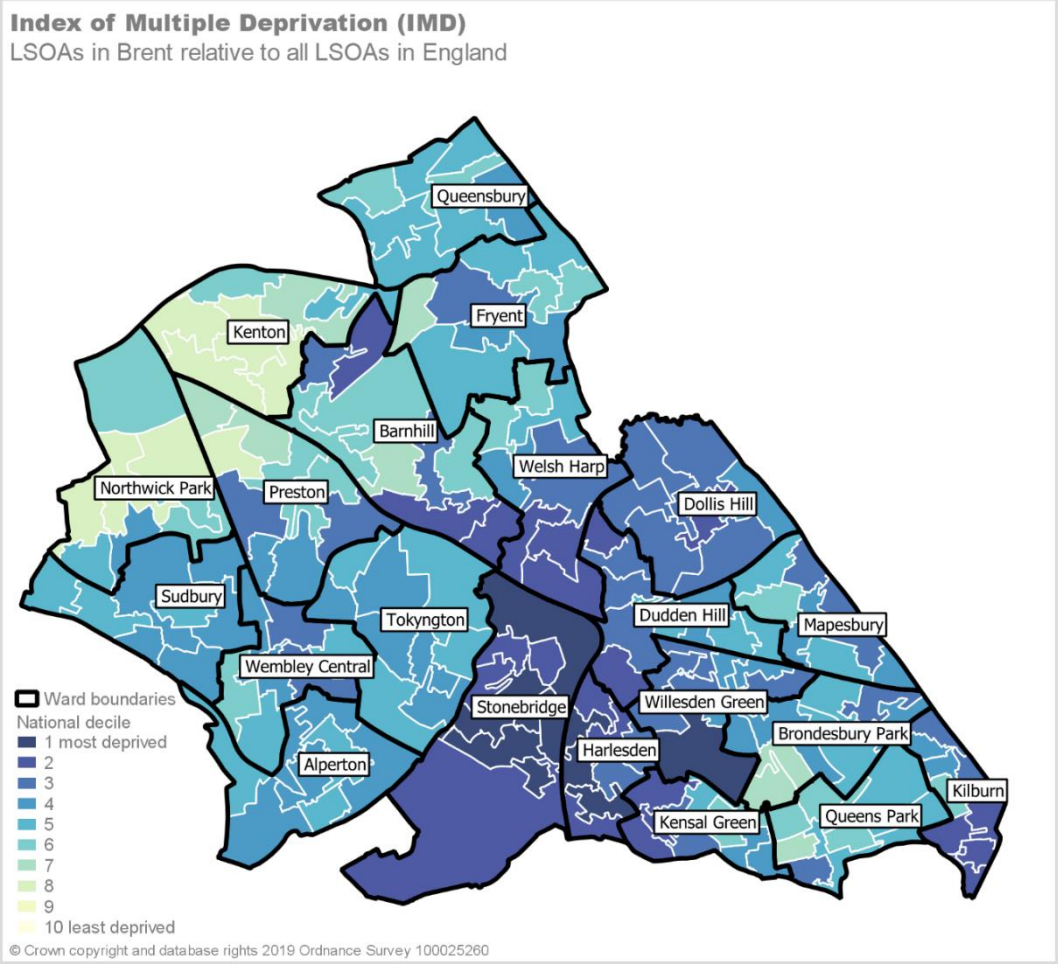
Brent Council recognises that its diversity is one of its key strengths, however it also acknowledges that its residents are more likely to be impacted by health inequalities as a result. Health inequalities are avoidable, and unfair, systematic differences in how groups of people access and experience healthcare. It has been found that a person's ethnic background can impact on their access and experience of healthcare, or cause differences in behavioural risks to health such as smoking, or

[18] Brent Council (2021), Population Change in Brent
[19] NHS NW London (2022), Number of people registered with a Brent GP
[20] Office for National Statistics (2021), National life tables – life expectancy in the UK: 2018 to 2020

their wider determinants of health such as housing, education and employment.[21] The impact of health inequalities on Brent's ethnic communities was highlighted by the Covid-19 pandemic, which saw deprived and ethnic communities overrepresented in Covid-19 mortality rates. Brent Council are proactively addressing health inequalities through its Brent Health Matters programme which works with and in Brent's communities to improve health outcomes for communities impacted by health inequalities. In order for social prescribing to effectively address health inequalities, the community interventions that residents are referred into must be diverse, culturally appropriate and reflect the needs of Brent's diverse population.

Brent is also home to some of England's most deprived communities. According to the 2019 Indices of Deprivation, the most recent measure of deprivation nationally, Brent was the 79th most deprived local authority in England out of 317. However, as shown in Figure 5, Brent has a number of Lower layer Super Output Areas (LSOAs) that are in the most deprived percentile. These areas of high deprivation are concentrated in Stonebridge, Harlesden and Kilburn, and one area in Stonebridge is in the top 5% of the most deprived LSOAs in England. This shows that there are significant levels of deprivation within the borough, and it is likely that deprivation has increased since

Figure 5: Brent Index of Multiple Deprivation Map by Pre-2022 Wards



[21] The Kings Fund (2022), What are health inequalities?

2019, with the cost-of-living crisis impacting significant numbers of the borough's residents.

Research has shown there is a strong relationship between socio-economic factors and health outcomes. The findings of the Marmot Review (2010) were key in highlighting the impact that social factors such as welfare, and housing can have on health outcomes. Socio-economic factors are also key sources of health inequalities, in England the least deprived 10% of men have a life expectancy that is 9.4 years higher life expectancy than the most deprived 10% of men, for women this figure is almost 8 years.[22] There are a number of socio-economic issues in Brent that could be contributing to poorer health outcomes for residents. Firstly Brent, like much of London is experiencing significant issues with housing supply, overcrowding and affordability of housing[23]. It has been shown that poor quality housing can have a negative impact on health outcomes, leading to residents requiring medication for mental health issues, poor sleep, and increases in depression and stress. Rising energy and food costs as a result of the cost-of-living crisis is also negatively impacting Brent resident's health, with many residents not eating enough nutritious food and not being able to stay warm in their homes. The cost-of-living crisis' impact on the population's health is not yet widely known, though it is likely to have a significantly damaging impact on health outcomes for many residents. This is why social prescribing is particularly important in areas with high levels of deprivation, where residents are more likely to present to GPs with welfare, or housing issues that are contributing to their overall ill health. It is therefore important that social prescribing is developed so that Brent's most vulnerable residents are able to access support through social prescribing.

[22] The Kings Fund (2022), What are health inequalities?

[23] Brent Council (2020), Recommendations from the Brent Poverty Commission

Findings

Extending access to social prescribing:

As stated previously social prescribing is currently being delivered in primary care settings in Brent, with a social prescribing scheme consisting of a referral from a GP to a link worker who refers the patient onto non-clinical community services. Whilst primary care patients are benefitting from the holistic person-centred approach of social prescribing, having a solely primary care model reduces the potential impact social prescribing could have for Brent residents. It is argued that a primary care model of social prescribing is not sufficient for Brent as it only allows residents who are registered to a Brent GP to access these services,[24] excluding residents who are not registered with a Brent GP. The exact number of Brent residents who are not unregistered with a Brent GP is not recorded, however as of January 2023 463,894[25] people were registered with a Brent GP, a higher figure than the Census' estimate of Brent's population in 2021 of 339,800.[26] A number of factors could account for this, such as residents from other boroughs registering with Brent GPs and population underestimates in London during the 2021 Census[27]. However, ultimately there are still significant numbers of residents in Brent who are excluded from social prescribing.

Whilst there are multiple reasons why a resident may not register with a GP, the work undertaken in the community by the council's Brent Health Matters programme found there are Brent residents who mistrust Brent's health services, which prevents them from accessing healthcare. Brent Health Matters' work found that some residents who mistrust health services are also more likely to be impacted by health inequalities. It is therefore even more important that these residents can access social prescribing opportunities that are culturally specific and diverse as part of Brent's approach to tackling health inequalities.

The Task Group believes that the Brent Integrated Care Partnership should lead the development of a social prescribing approach for Brent that could be used by all partners involved in social prescribing. As part of this approach, it is important that any widening of social prescribing compliments and supports the excellent ongoing work in primary care. The social prescribing offer in primary care is distinct as link workers can raise any clinical needs back to the patient's GP. Therefore, a widening of social prescribing should focus on supporting residents who are not registered with a GP and require non-clinical support. The local authority knows that these residents go elsewhere to access support within various settings or 'access points' in the borough, so, there is a key opportunity to extend social prescribing into these 'access points' so residents who are not registered with a GP can also benefit from social prescribing. The Brent Integrated Care Partnership believes that ICP partners and health and social care staff should be enabled to practice social prescribing approaches as part

[24] Evidence session 2
[25] NHS NW London (2022), Number of people registered with a Brent GP
[26] Office for National Statistics (2022), How the population changed in Brent: Census 2021
[27] The MJ (2022), Inaccurate Census could cost Londoners

of their work, and within the local authority the Adult Social Care Front Door, Family Wellbeing Centres and Brent Hubs have been identified as key 'access points' where social prescribing should be extended to meet the needs of residents who are not registered with a Brent GP. As part of the development of a Brent social prescribing approach partners should work together to ensure that all residents have the opportunity to benefit from social prescribing.

Depending on how social prescribing develops there is also an opportunity in the future to build social prescribing approaches into other council services, such as customer services and libraries, it is also possible to consider extending social prescribing approaches into softer 'access points' such as community and faith groups, which could address a different group of residents' support needs through social prescribing approaches.

Recommendation 1:

Recommendation 1: It is recommended that Brent's social prescribing model is widened from NHS primary care settings, to enable ICP partners, front line social care and selected front-line council staff to use social prescribing approaches. The Brent Integrated Care Partnership should lead in developing a social prescribing approach for Brent, where partners work together to ensure that all of Brent's residents have the opportunity to benefit from the holistic approach of social prescribing, as a way of further tackling health inequalities in the borough.

The Task Group recognises the good work in developing social prescribing in primary care and sees the benefits that using a holistic approach can have in improving health outcomes for Brent residents. However, it is known that there are Brent residents who are not registered with a GP and therefore cannot currently access social prescribing services. These residents may not be registered with a GP due to historical barriers to access for residents impacted by health inequalities, or because some Brent residents may be mistrustful of traditional health services.

The Task Group believes that the Brent Integrated Care Partnership should drive the development of a Brent social prescribing approach that is available to all Brent's residents. This would ensure every resident can benefit from the holistic approach used in social prescribing and would help to address the unmet health needs of resident's who are currently excluded from accessing social prescribing. Existing health and social care staff within the Brent Integrated Care Partnership and staff in selected local authority 'access points' should be enabled to use social prescribing approaches in their work as part of the Brent social prescribing approach.

Developing an equitable social prescribing offer

Social prescribing as an intervention in healthcare seeks to address a person's non-medical issues that contribute to a person's overall health. Therefore, its ability to make an impact is increased in areas with higher levels of deprivation, as these residents are more likely to need support with welfare and housing. As indicated in the above IMD, Brent has a number of areas with significantly high levels of deprivation; for residents in these areas, it is important that there are sufficient opportunities to access social prescribing services. Furthermore, the significant health inequalities in Brent have highlighted the need for healthcare interventions that are community specific, targeted and diverse for Brent's communities. As health inequalities are often intersectional, residents who experience health inequalities due to their ethnic background are also more likely to be affected by deprivation, which further highlights how vital effective social prescribing approaches are for Brent's communities. It is likely that even more Brent residents will require support as a result of the cost-of-living crisis, so partners must ensure that there is sufficient resource allocated to effectively support these residents.

Currently the ability to make social prescribing referrals is dependent on the availability of a link worker at a GP practice in the primary care model. The time each GP practice is allocated with a social prescribing link worker is decided at Primary Care Network level and is currently being allocated based on needs of the practice. There are currently 32 social prescribing link workers in Brent who work within its 51 GP practices. It is clear that there are large demands on social prescribing link workers which are expected to increase as social prescribing continues to develop. An increased demand on social prescribing link workers could therefore hinder PCNs ability to provide sufficient social prescribing resources to GP practices in areas of high deprivation, as social prescribing is impacted by the same funding and workforce pressures as the rest of the health and social care sector.

To ensure that social prescribing is effective in addressing health inequalities it is important that resources and funding are allocated equitably so residents who are most in need can access adequate support. Partners know that deprived residents and those impacted by health inequalities are the residents who need this holistic and person-centred support the most and will have the most significant positive impact on their health. It is therefore important that social prescribing resources are allocated equitably across Brent and focus attention in areas with the greatest need. NHS guidance on Network Contract Directed Enhanced Service (Network DES) has outlined guidance on promoting proactive social prescribing through community development.[28] It is stated that by 31 March 2023 PCNs must design and put in place a targeted programme to improve access for an identified cohort with unmet needs. This means it must review which residents are part of this cohort and extend the offer of social prescribing based on the cohorts needs.[29] As part of this work in primary care,

[28] NHS England (2022), Network Contract Directed Enhanced Service
[29] NHS England (2022), Network Contract Directed Enhanced Service

there is an opportunity for the Brent's social prescribing approach to be informed by the findings of this piece of work in primary care. This will assist the Brent social prescribing approach in focusing its efforts and resources in areas of Brent with high levels of deprivation, where residents may have unmet needs. The Task Group believe that the Brent social prescribing approach must be more proactive in listening and responding to Brent's communities when allocating funding and resources, which could be implemented through consultations, community engagement and proactive analysis of demographic information to ensure the social prescribing approach adapts as Brent changes. This would be influential in ensuring there is an equitable social prescribing offer across the borough that meets the needs of residents and address the health inequalities faced by Brent's communities.

Recommendation 2:

It is recommended that there is an equitable social prescribing offer across the borough that explicitly addresses deeply entrenched and intersectional health inequalities, that listens and responds to communities, and ensures funding is allocated by areas of Brent with higher levels of deprivation.

The Task Group believes that social prescribing resources and funding should be weighted towards areas of Brent with higher levels of deprivation. Throughout the Task Group's work partners have outlined that social prescribing is particularly important for residents living in areas with high levels of deprivation. The Task Group also know that residents living in areas of high deprivation are more likely to be impacted by health inequalities. It is therefore vital that these residents are supported by sufficient resources, especially in the context of a cost-of-living crisis which is continuing to have a detrimental impact on the health of our deprived residents.

Social prescribing in primary care currently allocates resources based on GP practice need at PCN level. There is an opportunity for Brent's social prescribing approach to be developed so that it is guided by residents' needs and focuses its resources and funding for in areas of the borough with higher levels of deprivation, where residents are more likely to be affected by health inequalities. Ensuring that the approach listens and responds to Brent residents' is essential in developing an equitable social prescribing offer that tackles Brent's deeply entrenched health inequalities.

Developing more joined up working between partners involved in social prescribing:

The Task Group found that there is an opportunity to develop more joined up working between partners involved in social prescribing. Partners identified an issue that the

opportunities in Brent's community and voluntary sector are not always being fully utilised by existing social prescribers. A number of issues could be contributing to this, including a lack of local knowledge amongst some social prescribers, which hinders their ability to learn and acquire knowledge of new opportunities as they arise. This lack of knowledge is likely due to the fact that link workers have busy caseloads and spend the majority of their time with patients, which affects their ability to engage with the community and voluntary sector. Developing greater joined up working would give link workers an outlet to learn more about the opportunities in the community and voluntary sector and communicate gaps within the current offer that could be filed by developing new opportunities.

Brent Council officers also did not think that the local authority was utilising its services as well as it could be for social prescribing opportunities[30], they also questioned whether the council had been proactive enough in thinking about how its services could address current gaps in social prescribing opportunities[31]. There are also some services such as libraries, who are not currently connected to existing NHS frameworks. This hinders link workers' ability to make referrals into these services, which in turn limits link worker's ability to refer patients into diverse and community specific opportunities in the community. It is therefore important that the council works more proactively to connect its services with NHS systems to achieve better outcomes for residents.

In Brent, there have been some good examples of joined up working between Primary Care Networks and council services to share understanding and work more collaboratively; this has enabled link workers to navigate council services more effectively to better advocate for their patients. However, this is not currently standard practice in council services, so there is still work to be done to develop working relationships between partners involved in social prescribing. At the evidence sessions partners expressed a collective view that there is not a complete picture of all the social prescribing opportunities available in Brent. To address this, partners involved in social prescribing should come together to share knowledge on available social prescribing services and develop more joined up working to benefit Brent residents. In practice, the Brent Integrated Care Partnership could lead on bringing partners together by sponsoring a working group that meets to share knowledge on social prescribing opportunities and best practice, and develops a borough-wide approach to working together for Brent residents on social prescribing initiatives.

[30] Evidence Session 2
[31] Evidence Session 2

Recommendation 3:

It is recommended that the Brent Integrated Care Partnership sponsors a social prescribing working group that bring partners involved in social prescribing together quarterly to develop a Brent approach to sharing knowledge, best practice and working together on social prescribing. This will ensure there is greater shared understanding of the numerous social prescribing opportunities in Brent and will increase partners' ability to effectively meet our resident's needs.

The Task Group found that there is currently not a comprehensive, real-time picture of all the social prescribing opportunities in Brent. This issue is currently hindering the effectiveness of social prescribing in Brent as not all services are connected into NHS frameworks and social prescribing link workers do not have the time to proactively research opportunities in the community and voluntary sector, which means that suitable opportunities for residents could be missed.

The Task Group believes that in order to develop more joined up working and information sharing on social prescribing between partners, the Brent Integrated Care Partnership should take ownership of bringing partners involved in social prescribing together to share information on social prescribing opportunities, best practice and adopt a shared understanding of how partners will work together on social prescribing. This will foster better information sharing and develop a Brent approach to working together on social prescribing. This will improve residents' experience of social prescribing, giving partners more knowledge on support in the community to refer residents into, therefore enhancing Brent's social prescribing offer by making it more diverse, targeted and community specific.

Improving data evaluation so that social prescribing develops in an evidence and needs based way

As social prescribing continues to develop nationally, there is a growing body of evidence that social prescribing can lead to a range of positive health and wellbeing outcomes.[32] However, social prescribing continues to be constrained by limitations in its ability to evidence its positive outcomes. Whilst many patients benefit from social prescribing, it is very difficult to attach any improvements in a patient's wellbeing to the impact of social prescribing alone. This is because the methods of measuring outcomes are qualitative and require patients to self-report their outcomes which means that results of social prescribing is subjective and are harder to evidence than outcomes in traditional forms of medicine. Furthermore, a recent study by the

[32] The Kings Fund (2020), What is Social Prescribing?

University of Westminster found that over half of the outcomes social prescribing can deliver are not being routinely measured in evaluation frameworks.[33]

Social prescribing outcomes data in Brent is currently measured using the Office for National Statistics measures of personal wellbeing, often referred to as the ONS4[34]. This measures a patient's personal wellbeing based on four questions, which are scored from 1-10. The four measures of personal wellbeing are outlined in Figure 6 below:

Next I would like to ask you four questions about your feelings on aspects of your life. There are no right or wrong answers. For each of these questions I'd like you to give an answer on a scale of 0 to 10, where 0 is "not at all" and 10 is "completely".	
Measure	**Question**
Life Satisfaction	Overall, how satisfied are you with your life nowadays?
Worthwhile	Overall, to what extent do you feel that the things you do in your life are worthwhile?
Happiness	Overall, how happy did you feel yesterday?
Anxiety	On a scale where 0 is "not at all anxious" and 10 is "completely anxious", overall, how anxious did you feel yesterday?

Figure 6: Four measures of personal well-being Source: Office for National Statistics

Patients are asked the ONS4 questions when they are first referred to a link worker and are then asked again once they have received their social prescribing intervention. The ONS4 data collected from Harness PCN areas indicate that on average a patients' personal wellbeing measures improve after a social prescribing intervention[35], and whilst this shows that social prescribing can improve a patient's wellbeing, it is impossible to attribute social prescribing as the only factor in any improvement. All four of the measures in the ONS4 are broad and can be influenced by external factors which may not be linear, for example, an improvement in a patient's ONS4 score for happiness could be due to them recently receiving good news that is unrelated to their social prescribing intervention. Therefore, whilst the overall improvement in ONS4 measures in the data from Harness PCNs is positive, using the ONS4 in isolation is not adequate in measuring social prescribing's impact.

It is therefore important that partners continue to develop and improve data collection and evaluation of social prescribing in Brent. It is essential as it gives partners insights on where social prescribing methods are working effectively and where it needs further development. For instance, Harness PCNs have identified that Arab patients and patients with disabilities are underrepresented in social prescribing data. They can use these insights to target and address this issue in current service provision. Therefore,

[33] University of Westminster (2020) What does successful social prescribing look like?
[34] Office for National Statistics (2018), Personal well-being user guidance
[35] ONS4 – Harness Data

improving data evaluation will positively impact health outcomes for Brent residents and would contribute to tackling health inequalities in the borough.

There are positive steps being taken to address issues with data evaluation at a North West London level, colleagues from the North West London Integrated Care System advised the Task Group that a new case management system called JOY has been procured which will enable social prescribing link workers to capture more patient data and provide a more comprehensive picture of social prescribing's outcomes in Brent[36]. The new system is being trialled in Westminster, Ealing and Harrow and will be rolled out across North West London. Whilst this will improve case management and data collection, it has its limitations as it would only be available for colleagues in primary care.

The Task Group's view is that more must be done to ensure that social prescribing develops in an evidence and needs based way. During its evidence sessions the Task Group heard that data on social prescribing activities in Brent was not being fully captured[37], it also heard that there was not a culture of information sharing amongst partners on social prescribing which reduces its effectiveness in Brent. There is not currently a borough wide picture of social prescribing's activities and outcomes due partly to the different models of social prescribing used by different PCN areas. However, some of these issues may also be due to a lack of an information sharing culture regarding social prescribing across the borough.

To move towards capturing further data on social prescribing the Brent Integrated Care Partnership should develop a whole Brent approach for collecting additional data from all partners across the borough on social prescribing activities. Collecting further data will enable the Brent ICP to better understand how social prescribing is developing in the borough and monitor behaviour change as a result of social prescribing. This will be key in creating a more joined up approach to data collection and evaluation amongst partners, which will benefit Brent residents and the community as a whole. It is imperative that any approach developed for collecting additional data compliments partners' respective reporting measures and sits alongside them as an additional ICP reporting mechanism.

To further the impact of this approach partners involved in social prescribing should be required to report all of their activity data regularly to the Brent Integrated Care Partnership's Health Inequalities and Vaccinations Executive Group, this will develop greater alignment of social prescribing across the borough and provide the Brent ICP with strategic oversight of social prescribing's impact in reducing the deeply entrenched health inequalities in Brent.

[36] Evidence Session 1
[37] Evidence Session 4

Recommendation 4:

It is recommended that the Brent Integrated Care Partnership develops a Brent approach to capture further activity data and develop an understanding of how resources are distributed. In order monitor behaviour change and the effectiveness of social prescribing in Brent. This approach should complement partners' respective reporting mechanisms and be used by all partners involved in social prescribing. This will further support the Brent Integrated Care Partnership to develop a joined-up approach to data collection amongst partners in the borough.

The Task Group believe that issues around data collection and evaluation are the key challenge for social prescribing's development locally and nationally. To improve data evaluation there must be sufficient data collected on social prescribing activities in the borough, which would show how social prescribing is developing and allow partners to monitor how social prescribing is contributing to behaviour change in the borough.

The Task Group believe that the Brent Integrated Care Partnership should develop its own approach to collecting further data from all partners on social prescribing activities in Brent. Any further data collected by the Brent Integrated Care Partnership would be separate and additional to the reporting measures that already exist for separate partners. The ICP's additional data collection should complement partner's existing reporting measures and be a standalone measure that develops a shared view amongst partners. This further collection of data, driven by the ICP will develop a joined-up approach to data collection and give the ICP strategic oversight of how social prescribing is evolving and changing resident's behaviour.

Recommendation 5:

It is recommended that social prescribing activities are reported quarterly to the Brent Integrated Care Partnership's Health Inequalities and Vaccinations Executive Group, to evaluate social prescribing activities for the borough. This will create greater consistency and alignment for social prescribing across the borough.

The Task Group believe a mechanism must be put in place which ensures social prescribing activities are reported across Brent. Currently there no overall picture of how social prescribing is developing across the borough, which risks there being inconsistency in the social prescribing offer across the borough which could negatively impact residents. Reporting social prescribing activities into the Brent Borough Based Partnership (ICP) will give the ICP to have strategic oversight social prescribing's development in Brent, which will promote greater consistency and alignment across the borough.

The Task Group believe that social prescribing activities should be reported into the ICP's Health Inequalities and Vaccinations Executive Group, social prescribing is more important in areas with higher levels of deprivation as it can play a significant role in improving health outcomes for Brent residents who are impacted by intersectional health inequalities. It is therefore logical that social prescribing activities should be reported into this executive group, so that it can review the impact of social prescribing in reducing the deeply entrenched, intersectional health inequalities in Brent.

Appendices

Appendix A - Participants

The Task Group thanks the following participants who contributed to the report through their participation in evidence sessions held between October 2022 to December 2022:

- Tiffany Adonis- French - Head of Service - Access information and Long-Term Support, Brent Council
- Peter Baxter - Library Arts and Heritage Manager, Brent Council
- Mehrnoush Bakhasz - Team Manager: Social Prescribing Link Workers, Brent Mencap
- Dr Charlotte Benjamin - Chief Medical Officer, NHS North West London Integrated Care Board
- Yoel Berhane - Community Lead Brent Health Matters, Brent Council
- Germaine Brand - Managerial Lead – Kilburn Primary Care Network
- Claudia Brown – Director of Adult Social Services, Brent Council
- Thomas Cattermole - Director of Customer Access, Brent Council
- Laurence Coaker – Head of Housing Needs, Brent Council
- Caroline Evans - Senior Public Health Analyst – Brent Council
- Lorna Hughes - Director of Communities, Brent Council
- Fana Hussain - Assistant Director of Primary Care Brent Integrated Care Partnership
- Sophia Johnson, Citizens Advice Brent
- Caroline Kerby - Managerial Lead – Harness Primary Care Networks
- Cllr Promise Knight, Lead Member for Housing, Homelessness and Renters Security, Brent Council
- Dr John Liquorish – Deputy Director of Public Health – Brent Council
- Professor Sir Michael Marmot – University College London
- Anne-Marie Morris, Brent Carers Centre
- Ann O'Neil – Executive Director, Brent Mencap
- Cllr Neil Nerva, Lead Member for Adult Social Care and Public Health, Brent Council
- Joe Nguyen – North West London lead for social prescribing, NHS North West London
- Jackie Rosenberg – Chief Executive, One Westminster
- James Sanderson – NHS England
- David Sagman – Senior Social Prescriber, Kilburn Primary Care Network
- Javina Seghal – Director of Primary Care, NHS North West London
- Nipa Shah - Programme Director Brent Health Matters – Brent Council
- Tom Shakespeare - Brent Integrated Care Partnership Director
- Dr Melanie Smith - Director of Public Health, Brent Council
- Kristine Wellington, CVS Brent

Appendix B – Evidence Session Schedule

	Key Themes / Discussion Areas
Evidence Session 1 October 2022	Social prescribing and its expected benefits The national direction of travel for social prescribing How social prescribing is being delivered in Brent including the outcomes for delivery and patient pathways How developed social prescribing is in Brent in comparison to other NW London Boroughs The key health issues Brent seeks to address through social prescribing
Evidence Session 2 November 2022	The local opportunities for those who socially prescribe Primary care awareness and attitudes towards social prescribing Potential barriers to effective social prescribing for primary care professionals in Brent Equity in delivery of social prescribing in primary care across Brent Ensuring social prescribing is inclusive of vulnerable people, those with disabilities or complex needs Training and development of social prescribing link workers Funding of social prescribing in Brent
Evidence Session 3 November 2022	The local offer of social prescribing opportunities in Brent, including those provided by the local authority Benefits and opportunities for local organisations who receive social prescribing referrals Potential barriers to effective social prescribing in Brent for local organisations Potential barriers to involvement in social prescribing for organisations not currently receiving referrals How attractive and inclusive are social prescribing opportunities for Brent residents? (including vulnerable people and those with complex needs) Communication and awareness raising of social prescribing in Brent
Evidence Session 4	The role and effectiveness of link workers in connecting those who social prescribe with those who offer social prescribing opportunities

November 2022	Assessing the patient pathway in social prescribing How well connected are different aspects of social prescribing How could stakeholders involved in social prescribing in Brent work together more effectively Evaluating and monitoring social prescribing's outcomes Developing social prescribing in Brent with partners to fully realise its potential

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