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Social Prescribing Maturity Framework

A Quality Improvement Tool for Integrated Care Systems

Version 2.0, 6 February 2023

Contents

1. Introduction

This Social Prescribing Maturity Framework is a resource for leaders across Integrated Care Systems (ICSs) and Primary Care Networks (PCNs) to strategically embed, plan and deliver social prescribing at neighbourhood, place and system level.

It is designed as a simple self-assessment quality improvement tool, not as a performance management tool. It aims to support those involved in the leadership, development and delivery of social prescribing to address health inequalities and tackle the wider determinants of health and wellbeing together.

This framework is aligned to broader NHS England policy commitments, contracts and guidance that relate to social prescribing, community approaches and tackling health inequalities, including:

- NHS Long Term Plan
- Network Contract Directed Enhanced Service (DES) Contract Specification – Primary Care Network (PCN) Entitlements and Requirements
- Network Contract DES – Personalised Care
- NHS operational planning and contracting guidance
- Partnerships with the Voluntary, Community and Social Enterprise Sector
- Working with People and Communities
- Social Prescribing Link Worker Workforce Development Framework
- Core20PLUS5 – An Approach to Reducing Health Inequalities

Thank you to all stakeholders who have helped to co-produce this framework, including representatives from:

- Integrated Care Systems
- Primary Care Networks
- Regional Heads of Personalised Care and their teams
- National Voices
- National Academy of Social Prescribing
- National Association of Voluntary and Community Action
- National Association of Link Workers
- NHS England colleagues

Why social prescribing?

Social prescribing and community-based support is part of the NHS Long Term Plan commitment to make personalised care business as usual across the health and care system. Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths and needs. This happens within a system that makes the most of the expertise, capacity and potential of people, families and communities in delivering better outcomes and experiences. Personalised care takes a whole-system approach, integrating services around the person. It is an all-age model, from maternity and childhood through to end of life, encompassing both mental and physical health support.

This represents a new relationship between people, professionals and the health and care system. It provides a positive shift in power and decision-making that enables people to feel informed, have a voice, be heard and be connected to each other and their communities.

Personalised care is implemented through the Comprehensive Model of Personalised Care. The Model was co-produced with a wide range of stakeholders and brings together six evidence-based and interlinked components, each defined by a standard, replicable delivery model. These components are:

1. Shared decision making
2. Personalised care and support planning
3. Choice including the legal 'right to choice'
4. Social prescribing and community-based support
5. Supported self-management
6. Personal health budgets and integrated personal budgets

The deployment of these six components will deliver:

- whole-population approaches, supporting people of all ages and their carers to manage their physical and mental health and wellbeing, build community resilience, and make informed decisions and choices when their health changes

- a proactive and universal offer of support to people with long-term physical and mental health conditions to build knowledge, skills and confidence to live well with their health condition

- intensive and integrated approaches to empower people with more complex needs, including those living with multi-morbidity, to experience co-ordinated care and support that supports them to live well, helps to reduce the risk of becoming frail, and minimises the burden of treatment.

Social prescribing is an approach that connects people to activities, groups, and services in their community to meet practical, social and emotional needs that affect their health and wellbeing, the wider determinants of health. Social prescribing link workers (SPLWs) support people by connecting them to this community support, including specialist advice services and arts and culture, physical activity, and nature and green activities. They are based in PCNs and other settings. They develop trusting relationships with people, starting with what matters to them, building on individual strengths and introducing people to community support.

Social prescribing is an **all-age, whole population** approach that works particularly well for people who:

- have one or more long term conditions

- need support with low level mental health issues

- are lonely or isolated

- have complex social needs which affect their wellbeing

2. How to use this resource

This resource can be used by ICS and Integrated Care Board (ICB) leaders to identify priorities for collaborating, improving and delivering social prescribing in an area, building on shared PCN-level plans to deliver the social prescribing and proactive social prescribing elements of the PCN Network Contract DES. This shared planning will also support PCNs to address wider system population health needs in a more joined-up way and allow systems to pool resources for improvement.

Systems should use this tool to self-assess social prescribing system maturity. They should do this in partnership with local partners including regional personalised care teams, PCN leaders, local authority colleagues, the Voluntary, Community and Social Enterprise (VCSE) sector, hyper-local community organisations and patients and the public with lived experience.

System leaders may wish to do this by:

- Assessing social prescribing maturity against the domains below to stimulate discussion with system partners
- Build consensus across system partners on areas for collaboration, development and improvement to create an ICS social prescribing strategy that expands on PCN-level shared local plans for social prescribing.

Organisations within the system may also wish to use the tool to assess their own maturity in developing or delivering good practice social prescribing, and to prompt ideas on areas for collaboration, development and improvement.

Systems should be conscious that different partners have different levels of influence and should create suitable opportunities for engagement with appropriate timescales; for example, by setting up a system social prescribing steering group with additional engagement for specific topics alongside a route for feedback from grassroots organisations, and a route to seek the opinions of those with lived experience.

Systems should, where possible, identify resource requirements and/or system capacity to undertake the self-assessment and consequent actions for improvement ahead of beginning assessment. This will support smaller organisations working in the system to understand the likely resource burden and where they can add maximum value and focus decision-making on actions for improvement that are realistic given current pressures in the health and care landscape.

Systems should also endeavour to link their social prescribing priorities to broader NHS priorities and requirements, including (but not limited to) population health management, tackling health inequalities through Core20PLUS5, reducing demand on NHS services and delivering proactive and preventative care.

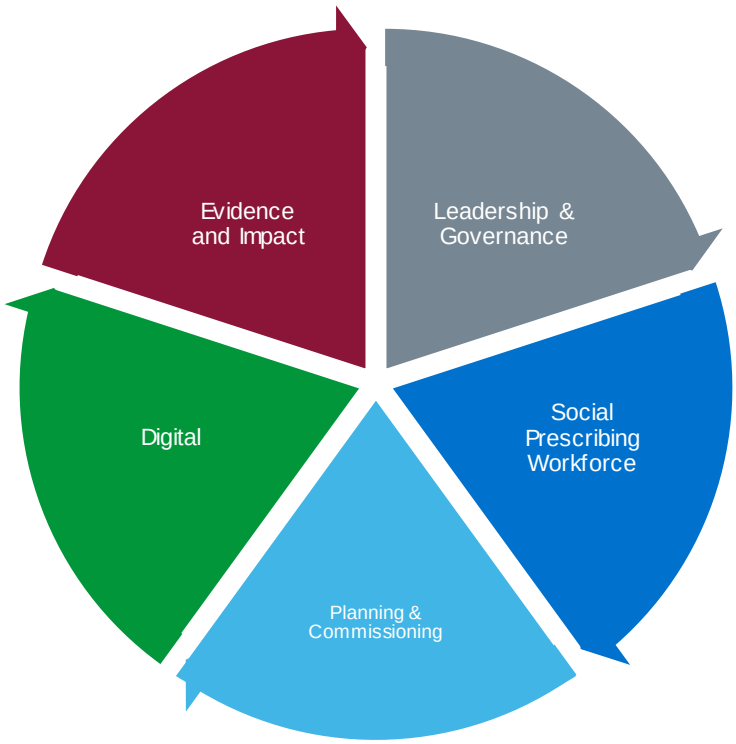
Monitoring and reporting

We suggest that the tool is used to monitor progress in addressing system priorities at least every six months, with system partners working to set new priorities together at least annually to enable social prescribing to deliver maximum impact for people and communities.

As a self-assessment tool, there is no requirement to report findings to NHS England or performance against identified priorities for improvement. However, systems may wish to design an implementation plan and internal reporting system to monitor improvement with identified timescales.

3. Social prescribing domains

5 features of mature social prescribing delivery are described in this document, with each domain containing a description of maturity.



	Level of Maturity	Definition of Maturity
1	Emerging	This element of social prescribing is underdeveloped and not currently a priority to develop further across the ICS
2	Developing	This element of social prescribing is under discussion but not yet in active development
3	Maturing	This element of social prescribing is in active development and in the process of being implemented
4	Embedded	This element of social prescribing is fully embedded and will be sustained even in the event of a change of operational or strategic leadership

4. The Maturity Framework

Neighbourhood						
	Description		Maturity			
			1	2	3	4
Leadership and Governance	**1.**	**Leadership**				
	a)	There is a named **Social Prescribing Champion** in every GP practice, who can support SPLWs and help staff understand how social prescribing can address the wider determinants of health				
	b)	**All patients can access a social prescribing service** across the PCN, in line with the PCN Network Contract DES				
	c)	SPLWs **work proactively with identified cohorts most impacted by health inequalities,** aligned to the Personalised Care Network DES service specification proactive social prescribing element				
	d)	PCNs work with local partners, including community groups and services to build **trusting relationships** and finding creative ways to support social prescribing and community development together				
	e)	All PCN staff, including clinicians, receive **training about social prescribing** and personalised care roles, which could include training from the Personalised Care Institute (PCI) on supporting SPLWs to deliver social prescribing				
		Shared Local Social Prescribing Plan				
	f)	There is a co-produced **PCN-level social prescribing plan,** which feeds into the ICS/ICB social prescribing strategy. It includes recruitment, how SPLWs can work to deliver the PCN Network DES requirements, and how local partners will work together to map and develop community activities and services. It supports social prescribing beyond primary care, in community and secondary care settings to promote integration and transformation. Local partners may include VCSE organisations, social care and local authorities, housing, statutory advice services, early years and education, and the emergency services				
		Governance				
	g)	The PCN has **governance processes** in place for social prescribing delivery, including service quality, safeguarding, contractual requirements for supporting social prescribing workforce and information management				

		Where the social prescribing service and/or SPLW is contracted to a partner agency, this includes a Memorandum of Understanding (MoU), data sharing agreement and data protection impact assessment				
	h)	There is a **named person in the PCN**, who is responsible for creating and monitoring the shared local PCN plan to improve social prescribing. This includes working with others to feed into wider place-based and ICS social prescribing plans				
Social Prescribing Workforce	**2.**	**Support for SPLWs**				
	a)	Each SPLW has a **maximum caseload of 200-250 people per year depending on case complexity**. SPLWs can give time, hear what matters to people and build a shared plan to connect them to community support				
	b)	All SPLWs have access to **high quality supervision**. SPLWs employed through the PCN ARRS have access to regular workplace supervision and monthly clinical/professional supervision, with an appropriate professional and peer supervision delivered at place by the ICS or region, as outlined in the PCN Network Contract DES				
	c)	SPLWs and their supervisors use the **Social Prescribing Competency Framework contained within the Workforce Development Framework** to understand the role and guide professional development				
	d)	SPLWs can take up training opportunities to support professional development, as outlined in the **Social Prescribing Workforce Development Framework**				
	e)	SPLWs have training and access to appropriate **IT equipment** and **case management IT systems**				
	f)	SPLWs regularly attend **primary care multi-disciplinary team (MDT) meetings** and contribute to joint case working				
		The SPLW Team				
	g)	The PCN creates a **social prescribing team e.g. 3-4 SPLWs** driven by PCN population health need and that that allows them to meet the Investment and Impact Fund (IIF) incentives threshold without exceeding caseload maximums				
	h)	The team provides an **all-age universal social prescribing offer**, including specific SPLW role(s) for children and young people 0-25 years				

	i)	The team works with Population Health Management leads to connect with and **proactively support groups impacted by health inequalities**, to deliver the Personalised Care Network Contract DES proactive social prescribing element and aligned to the Core20PLUS5 framework				
	j)	The team **welcomes volunteers including people with lived experience of social prescribing**, who can help to introduce people to community groups and support social prescribing within their communities. Volunteers have support, training and expenses paid.				
	k)	The team works closely with local **Patient Participation Groups,** people and communities, to build wider understanding amongst the public about the value of social prescribing. This should include how they can get involved in delivering social prescribing, such as volunteering or setting up new activities or groups.				
	l)	Social prescribing apprenticeships are considered to provide with access to funded training and create employment opportunities reflective of the community				
		PCN Workforce Planning				
	m)	**Demand for social prescribing is monitored** across population groups to ensure that people impacted by health inequalities and those who have long-term conditions can access social prescribing quickly, without long waiting lists				
	n)	The PCN routinely **submits workforce returns to system and/or region** to build understanding of the social prescribing workforce and local capacity				
Planning and Commissioning	**3.**	**SPLW Role**				
	a)	**Unmet community needs** and gaps in services are routinely identified by SPLWs and shared with commissioners at neighbourhood, place and ICS levels				
	b)	SPLWs have enough time to build trusting relationships with **local community groups and services,** supporting them to be accessible and sustainable. Good practice indicates that up to 1 day per week is spent on community development				
		Planning				
	c)	All partners are involved in the **planning and design of local social prescribing services** and community activities				

Digital	**4.**	**Digital Data Systems and Processes**				
	a)	SPLWs have **access to GP IT systems** to ensure appropriate recording and coding of referrals, which is a mandatory requirement in the DES				
	b)	Appropriate **SNOMED codes are always used** for individuals referred to social prescribing, as required by the PCN Network Contract DES				
	c)	Data is recorded in line with the mandated **Social Prescribing Information Standards** and **Minimum Data Set** requirements				
	d)	PCNs can access clear processes to **re-identify system level de-identified data**, to support social prescribing case management				
		Digital Enablers				
	a)	Digital processes support **inter-operability** between GP IT systems and social prescribing software supplier systems				
	b)	**Information sharing agreements** are held between local health, care and VCSE partners to enable sharing of social prescribing data				
	c)	The social prescribing team has access to an up-to-date digital **local community services directory,** including national services				
Evidence and Impact	**5.**	**Role of SPLWs**				
	a)	**SPLWs use the ONS4 tool** and other appropriate outcome measures before and after social prescribing support, to help individuals track their progress and show impact				
	b)	SPLWs routinely create opportunities for **feedback** from individuals about their experience of social prescribing and perceived outcomes from social prescribing				
	c)	The social prescribing team contributes to understanding impact on individuals through collection of local data and development of consent-based **case studies** and personal stories				

Place						
	Description		Maturity			
			1	2	3	4
Leadership and Governance	1.	**Leadership**				
	a)	There is a **named social prescribing lead** in the locality Integrated Care Partnership (ICP) who works with all partners and the ICS Senior Responsible Officer for social prescribing, to review shared local plans and join up work across areas to pool resources. This includes monitoring progress, using this Maturity Framework				
Social Prescribing Workforce	2.	**Locality Development**				
	a)	Local commissioners work with social prescribing providers to consider **full cost recovery** for organisations hosting SPLWs including management, training and supervision costs				
	b)	Commissioners use the **Social Prescribing Workforce Development Framework** to take a strategic approach to developing the SPLW workforce				
	c)	**Cross-sector working is actively encouraged**, with other connector roles within mental health services and secondary care. This includes taking referrals from all local agencies, including social care, emergency services and NHS 111, local authorities, statutory advice services, etc.				
	d)	The locality ICP works with PCNs, SPLWs and VCSE partners to ensure there is an **adequate supply of community activities and practical and emotional support services** to meet the health needs of the population that SPLWs can connect people to				
Planning and Commissioning	3.	**Identifying Need and Mapping Provision**				
	a)	PCN leaders routinely share social prescribing data and intelligence with place-based commissioners, funders and providers, finding collaborative solutions to gaps in provision				
	b)	SPLWs work with other agencies to create, maintain or contribute to a **directory of community services,** including national support services and statutory services				

	c)	All local partners across place regularly **share data and intelligence about unmet needs with commissioners**, within information governance guidelines. This includes community groups, VCSE organisations, arts, nature and physical activity providers, and statutory services and agencies				
	d)	Data from **interdependent programmes** e.g. population health management, ambulance, secondary care, mental health and community health services is considered alongside social prescribing data to support planning and commissioning				
		Collaborating to deliver plans				
	e)	The ICP is aware of PCN-level shared local plan ambitions and works to **foster collaboration and pooling of resources** across place				
	f)	**Community grants** are widely available to local groups and VCSE organisations, to support the development of new community activities and services to address unmet needs				
	g)	The ICP works with commissioners to build social prescribing into **clinical and care pathways**, through commissioning of social prescribing interventions to support the self-management of people living with long term health conditions. This could include clinical pathways that form part of the Core20PLUS5 model				
	h)	**Community 'wellbeing hubs'** including community centres, libraries, leisure centres and spaces, shops and NHS estates provide accessible spaces for groups to meet and community development of unused land and buildings is encouraged				
Digital	**4.**	**Systems**				
	a)	The ICS/ICB contributes to the plans, procurement and implementation of **social prescribing digital systems** and supports all SPLW host organisations to implement them				
	b)	The ICS/ICB has access to **non-identifiable social prescribing activity and outcome data** extracted from digital systems, to inform planning and population health management				
		Enablers				
	c)	Where appropriate, **local community service directories** are up to date, accessible, link to national services and use				

		a common standard e.g. Open Referral UK for easy searching and identifying gaps in services				
	d)	There is practical support for people to **overcome digital exclusion,** for example, libraries providing digital equipment (phones, laptops) for people and helping them to learn how to use it				
Evidence and Impact	**5.**	**Gathering evidence of impact**				
	a)	Leaders work with Neighbourhood and System partners to support social prescribing schemes and SPLWs in PCNs to routinely capture data around **ONS4 impact data, social prescribing referrals and activity**				
	b)	ONS4 and local social prescribing data is routinely analysed to **shape future development work** and share learning about social prescribing				
	c)	All partners, including VCSE community groups and services are routinely invited to **feedback** how social prescribing impacts their work and to share informal evidence and intelligence, particularly on unmet needs				
	d)	Locality partners routinely draw on **population health data** and **data on health and care service utilisation**, to understand the impact of social prescribing, including on communities impacted by inequalities				

Integrated Care System						
	Description		Maturity			
			1	2	3	4
Leadership and Governance	**1.**	**Leadership**				
	a)	There is a named **Senior Responsible Officer** (SRO) for social prescribing within the ICP executive leadership team. They are responsible for the planning, delivery, monitoring and quality of social prescribing within the ICS area, including the social prescribing system plan				
	b)	The SRO supports the emerging **Voluntary Sector Alliance** to build effective partnerships and enable VCSE leaders to influence the social prescribing strategy				
	c)	VCSE leaders and other social prescribing providers are included in **leadership development programmes** across the ICS. There are opportunities for secondment, work shadowing and 'improvement challenges' across the sector				
	d)	Leaders support transformation by embedding **SPLWs beyond primary care**; within Hospital Discharge teams, Urgent and Emergency Care, Elective Care support and Mental Health Trusts				
	e)	Social prescribing is embedded within **clinical pathways**, by commissioning social prescribing activities to enable people manage long-term conditions, pooling or delegating resources to and from places where required				
	f)	**Social prescribing champions** are supported across the ICS, including primary, community and secondary care. They help people understand how social prescribing can improve outcomes, reduce system pressure and address inequalities				
		ICS Social Prescribing Strategy				
	g)	The SRO works with leaders across sectors and locality social prescribing leads to co-produce an **ICS social prescribing strategy** to address health inequalities. This brings together all the place-based social prescribing plans to facilitate a universal, all-age social prescribing offer across the ICS, using this maturity framework to identify opportunities for collaboration, improvement and development				
	h)	The social prescribing strategy describes how SPLWs can proactively support **population health management priorities**, connecting with health inclusion groups and				

		those most impacted by health inequalities. The strategy is clearly linked to wider NHS priorities including ICS operational priorities, Core20PLUS5 and PCN Network Contract DES requirements				
	i)	The strategy supports **all SPLWs**, including ARRS-funded PCN roles, locally commissioned social prescribing schemes and those funded from other sources				
	j)	The strategy includes **commissioning local community activities and services,** such as (but not limited to) legal, welfare and financial advice, arts and culture, nature and physical activity support				
	k)	The strategy enables people to access social prescribing **beyond primary care**, in mental health, community and secondary care				
		Governance				
	l)	The **ICB oversees governance** for the ICS social prescribing strategy and is responsible for re-assessing priorities and delivery against plan(s)				
Social Prescribing Workforce	**2.**	**ICS Workforce Development & Planning**				
	a)	The **Social Prescribing Competency Framework** and **Workforce Development Framework** inform recruitment, training and supervision and peer support for SPLWs across the ICS				
	b)	The SRO works with all partners to ensure that all SPLWs (however they are funded) can access **peer support networks** across the ICS. The networks reduce isolation and enable SPLWs to share learning and good practice across localities. The ICS has a similar peer support network for practitioners delivering social prescribing activities, and clear links between the two networks				
	c)	The SRO works with all partners to promote **effective recruitment, training and development to improve retention** of SPLWs across the ICS. This includes analysing workforce returns to understand issues and challenges				
	d)	The SRO works with all partners to regularly assess SPLW **learning development needs** and coordinates a support programme to meet priority needs across the ICS				
	3.	**Identification of Need**				

	a)	Intelligence about **unmet need** is routinely gathered and shared from SPLWs across the ICS to understand gaps in social prescribing activities and services, including for local communities most impacted by inequalities				
Planning and Commissioning	b)	Social prescribing champions, local community leaders and VCSE organisations can routinely feed intelligence about **gaps in community support** and services up to system level, to inform planning				
	c)	The operating model and governance processes between System, Place and Neighbourhood enable business analyst teams across sectors to **share data to inform social prescribing commissioning**				
	d)	**Population Health Management** data informs commissioning of local community activities				
		Meeting Identified Need				
	e)	The social prescribing strategy includes a **long-term investment plan for sustainability of the VCSE sector** through market development, grants and contract-based commissioning. It supports the development of providers, infrastructure bodies and alliance bodies, as core parts of the local system				
	f)	Commissioning the VCSE sector to provide services and support is **accessible, consistent and timely**. There are small grants for community groups and voluntary organisations				
	g)	Partners are working together across the ICS to boost '**shared investment'** in local community activities and services, aligning community grant funds and bringing in external funding to support small, local community groups, most impacted by health inequalities				
Digital	**4.**	**Digital Systems**				
	a)	The ICS procures and uses a Health Services Support Framework (HSSF) **accredited social prescribing digital software supplier**, or an in-house solution with equivalent functionality and compliance to mandatory standards				
	b)	The ICS has the digital capability to **link datasets** between community, primary and secondary care services, which enables analysis of health and care service usage to inform planning				
	c)	The ICS has a digital mechanism to gather and report real time **social prescribing referrals, activities and outcome**				

		data. This data is routinely shared with VCSE and health and care partners				
		Digital Enablers				
	d)	The ICS aligns with local government to ensure commissioned community directories are resourced, up to date and hosted on an **open standard platform** e.g. Open Referral UK standard				
	e)	The social prescribing strategy includes plans for **digital inclusion** for its population, so that people can access the equipment and skills required to engage with digital social prescribing				
	f)	The strategy enables people to **self-refer to social prescribing using digital technology**, to promote self-management				
Evidence and Impact	**5.**	**Impact on the System**				
	a)	The ICS uses a **benefits realisation model** for social prescribing which includes measuring impact on individuals, communities and health and care service utilisation				
	b)	Impact reporting shows how SPLWs are supporting **communities most impacted by health inequalities**, using population health management data				
	c)	The ICS routinely collects social prescribing data related to **health and care service utilisation** which may include primary care attendances, 111 calls, A&E attendances, hospital admissions and social care packages				
	d)	The ICS values **independent evaluation** of social prescribing and supports local evaluation where possible. It actively supports all partners to draw on best practice and contribute to the emerging national and international social prescribing evidence base				

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