connected communities

Sustainability toolkit for community signposting services

NIHR | Applied Research Collaboration North West Coast

University of Lancashire

Purpose of this toolkit

This **hyperlinked toolkit** (including navigation panel on left-hand side (***A***)) is designed to **guide service managers** in sustaining & evaluating community signposting services.

It offers **practical steps**, key **considerations** & **evidence-based approaches** to help support delivery of services in **meeting the needs of local communities**.

How to use this toolkit

The toolkit is structured into five sections, each addressing a key area for sustaining effective community signposting services:

Section 1. What is the problem?

Section 2. Why are community signposting services needed?

Section 3. What are community signposting services?

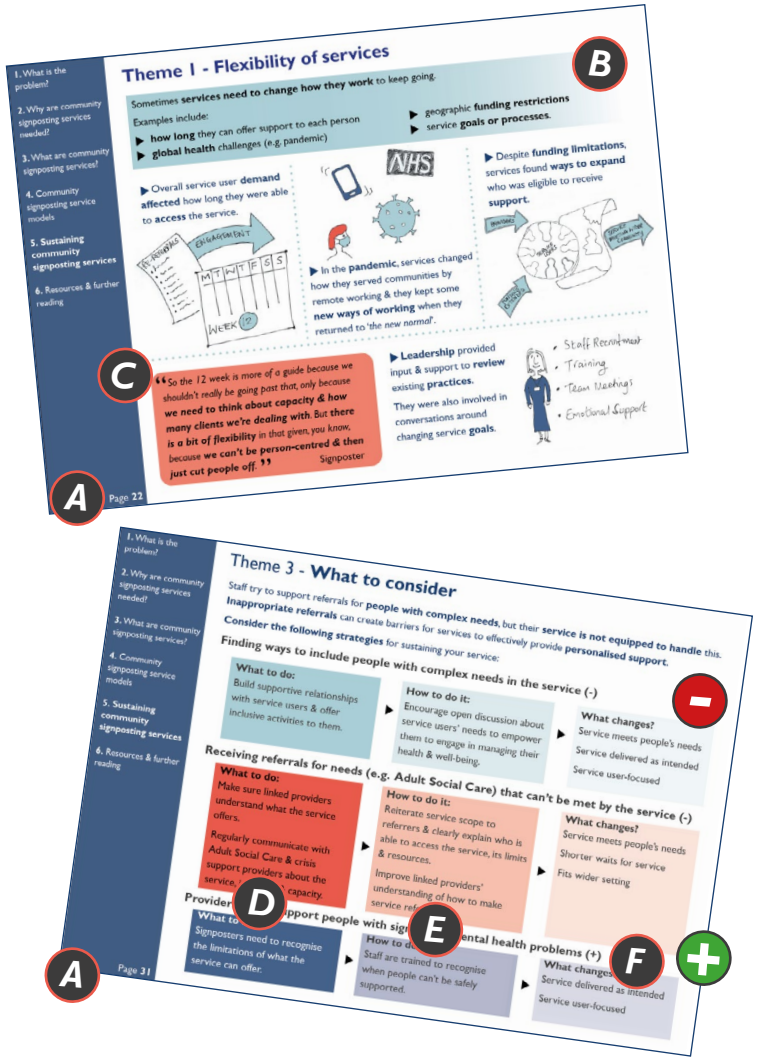
Section 4. Community signposting service models

Section 5. Sustaining community signposting services

This section addresses the common challenges that services face, how they overcome them, the opportunities to sustain their service through five detailed themes (***B***) with quotes (***C***) & what to consider: What to do (***D***), How to do it (***E***), What changes? (***F***).

There is also guidance on **how to evaluate** your service at the end of this section.

Section 6. Resources & further reading



Ways services have found to respond to opportunities (+) & challenges (-)

The Connected Communities research project

What is the research?

This research project is about **community signposting services** that use people known as signposters.

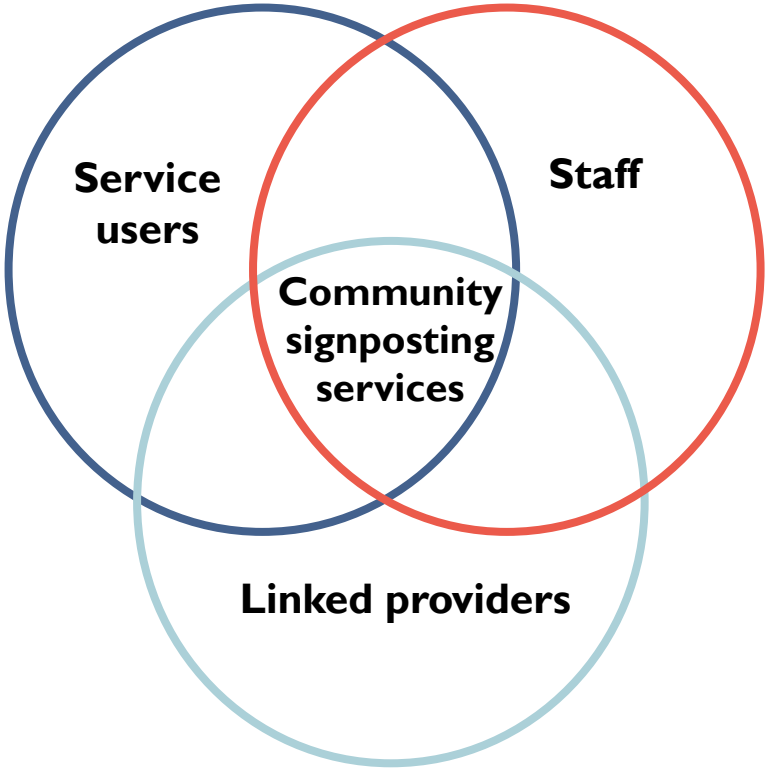
Signposters **link** people up with different kinds of **help & activities in the community** where they live.

Researchers from the University of Lancashire wanted to find out **how people feel** about using or working with community signposting services & understand **how these services can work best.**

The information in this toolkit will **help other people sustain similar services** in different communities.

Who did we do this research with?

The team spoke with **service users**, **staff** (including signposters) & **linked providers** (people who refer service users in & out of the service).



How did we do the research?

The research team worked with **three existing community signposting services** as case studies.

These services were **identified from** National Institute of Health and Social Care Research **Applied Research Collaboration North West Coast members**.

They are representative of a local group of community signposting services & they work at **different intensities** (referral volumes & staff).

The team wanted to know about:

- what things **affect** how services are **set up**
- how they **work** with other services
- how they are **funded** & **staffed**
- how these services can **adapt**.

Section 1. What is the problem?

The UK population are leading **increasingly isolated lives**.

Our **ageing population** means **more people are living with health problems**.

Other things like poverty, feeling isolated, being treated unfairly or feeling left out can seriously affect a person's health & way of living.

These problems don't have to happen – they come from how society is set up.

Clinical care alone can't address health challenges like **loneliness & mental health.**

People **struggle** more at **work** & in their **daily life** when they **don't have social connections.**

Loneliness is increasing across all age groups, but **older adults are particularly affected.**

1 in 5 GP appointments are for non-medical problems: **Social activities could reduce GP visits** by up to **2.5-3%** each year (2.8-3 million appointments).

Signposting services can help to **blend health, social & community organisations** working together.

Taking part in **social & cultural activities** can **make life better** than healthcare by itself.

Health inequalities

Disadvantaged people are more likely to experience mental health problems due to the health inequalities (**structural differences in living circumstances**) they face & they are less likely to access services to get help.

Services based in communities offer a way to help with this issue.

Differences in environmental, social, & economic **circumstances = health inequalities**

Socio-economic factors (e.g. poor housing, poverty & unemployment) are linked to **poor mental health.**

In the UK, **1 in 6** people are affected by common **mental health problems.**

Disadvantaged people are more likely to be **impacted** by their **mental health** than others.

They are **less likely** to **access services** & **benefit** from them.

Community-based approaches provide more **appropriate** & **effective** ways of improving people's health & well-being.

Struggling with mental health/ loneliness

Accessing community-based services

Improvement in health & well-being

Section 2. **Why are community signposting services needed?**

The **NHS** is under **pressure** to meet **patient needs** with **limited resources** & staff.

The 2025 **NHS 10 Year Health Plan**'s key reform objectives aim to **reduce pressure** & **help sustain the NHS** by:

Shifting care from hospitals into the **community** + **Shifting focus** from treatment to **prevention** = **NHS** becomes **more sustainable** with **less pressures**

How can we reduce this pressure?

There is a growing shift towards person-centred care. This type of support focuses **beyond clinical treatment** & on **social connections**, **community support** & **non-clinical care**.

When there is **collaboration** between healthcare, voluntary, community, faith & social enterprise (VCFSE) sector organisations, it helps to **reduce impacts** from social determinants of health.

These collaborations can potentially **improve health & care outcomes** for communities.

Community signposting services can help in the following way:

Providing **personalised support** for people experiencing poor **mental health** & **loneliness** → **Linking people** with community groups & **encouraging them** to form **social connections** = **Community signposting services**

> "*we get a lot of* ***referrals who are completely not suitable.*** *[...] We've had referrals from the likes of* ***Adult Social Care*** *who, without sounding rude,* ***just need to tick a box*** *and need to tick that they've done something for this person. So* ***people who have complex needs,*** *which* ***we are not equipped to deal with at all.***"
>
> Staff member

Section 3. **What are community signposting services?**

Community signposting **services** help people connect with the right kind of local assistance & activities in their community.

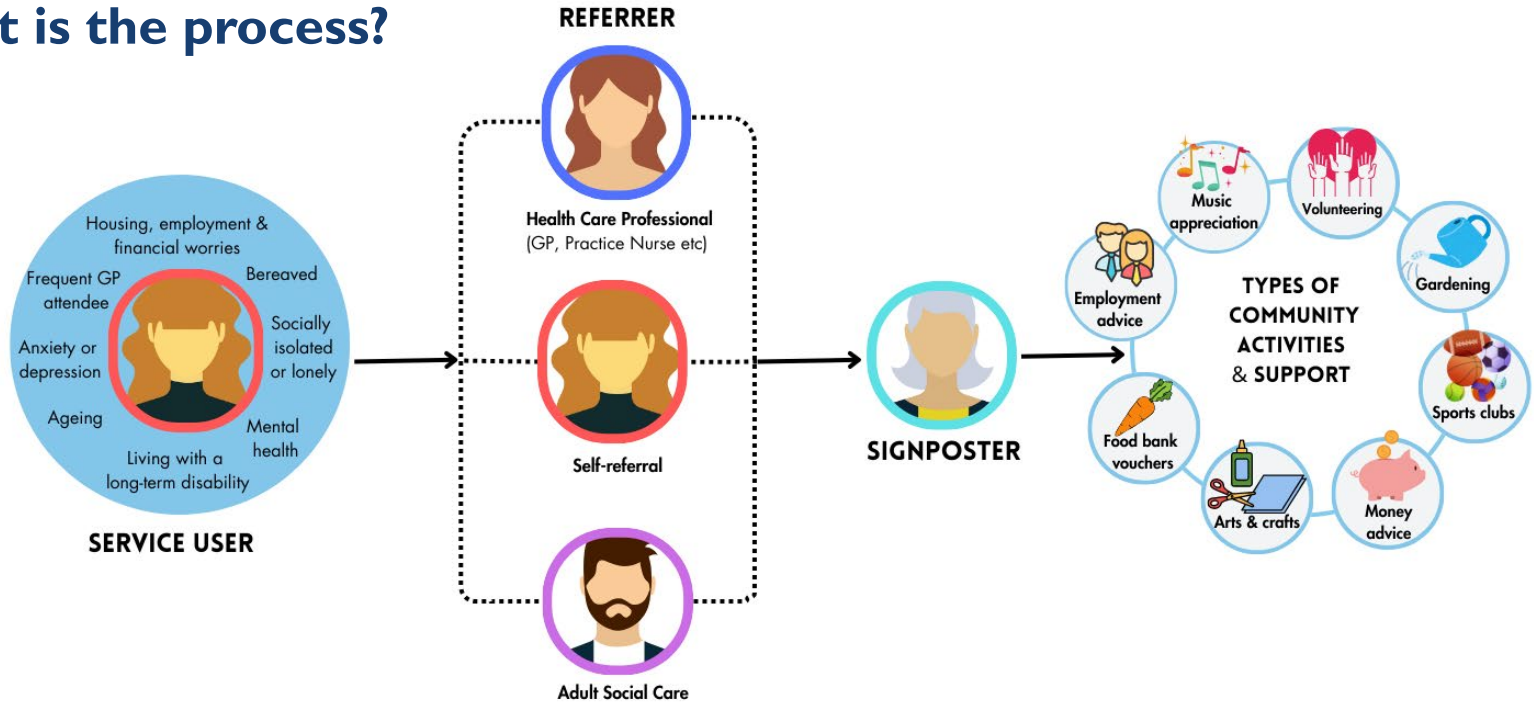
These services **focus on what a person needs to move forward in their lives**, by providing non-clinical, practical & social support to help improve people's health & well-being.

Who delivers these services?

A **key part of these services** is **the 'signposter' role** (e.g. link workers, social prescribers, community connectors or neighbourhood coaches).

Signposters **listen to people**, help them **identify their needs & strengths** to **guide them** towards the best **available support in their area**.

What is the process?

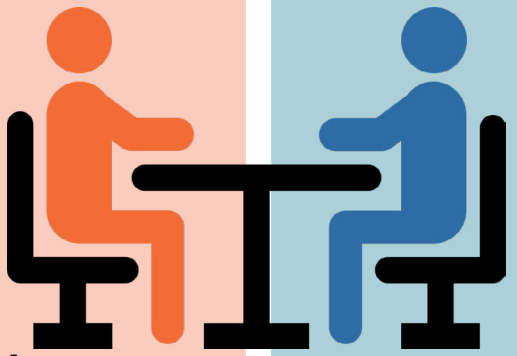


Who can community signposting services help?

These services **signpost adults to access help** who:

- Feel **socially isolated** & want to connect with others
- Are facing **practical challenges** like housing, finances or transport
- Need **emotional support** for their mental health
- Want to improve their **physical health** through community activities
- Have mild to moderate **mental health problems** but don't need clinical treatment
- Need help to find **local services**

People can **still access other** health & care **services at the same time**, such as community mental health teams.



Community signposting services help people by:

- **Identifying** their strengths & support to use them.
- **Linking** to local groups & activities of interest (e.g. gardening clubs, music appreciation events).
- **Signposting** to specialist services (e.g. housing support, debt advice, food banks).
- **Encouragement** joining local activities (e.g. arts & crafts, talking groups, or tai-chi sessions).
- **Supporting** people to develop confidence & recognise their strengths.
- **Addressing** skills gaps or access to training (e.g. IT classes, volunteer opportunities).

The level of **help can vary** from quick **one-off signposting to ongoing tailored support** over several weeks.
The services aim to **empower individuals to take positive steps forward** in their lives.

Section 4. **Community signposting service models**

Our research has shown there are **three different levels of signposting service intensity**:

Each service intensity has a **different structure**, **level of support** & **way of working** with service users.

Understanding these models can help organisations provide services that **match local community needs**.

We outline these service models by explaining how they **work & interact** with other services & systems.

Who runs these services?

Services are provided with **structural & funding support** by a **range of operating organisations**:

Local authorities

Community health services

Primary care services

Structural & funding support for services

Structural support

Local authorities	Triaging referrals Use of community centres where available Promotion at community events	**Community health services**	Making some direct referrals Providing room space for delivering activities Marketing & promotion between services	**Primary care services**	Making direct referrals only Office space (i.e. room in GP surgeries) Access to software & systems Induction to role training

Funding support

Local authorities	Limited funding (2 signposter roles) Additional applications made for external grant funding (e.g. digital literacy projects)	**Community health services**	Funding a range of signposter roles & support teams (e.g. social inclusion) Supporting linked providers to apply for additional activity funding	**Primary care services**	Funding signposter roles (30+ social prescribing link workers) GP practices provide some additional funding for small projects (e.g. neighbourhood groups)

Characteristics of different signposting service intensities

Signposting service intensities	Low-intensity service	Medium-intensity service	High-intensity service
Referral source	Self referral	Self referral or by a Health Care Professional	Health Care Professional
Duration of use by service user	Up to 12 weeks	As required to move on	Up to 12 weeks
Signposter role name	Connectors	Pathways Advisors	Social Prescribers
Additional service support	Volunteer 'Champions'	Volunteers	Community Mental Health Teams
Funder	Local authority (Public Health department)	NHS Trust	Primary Care Network/ Integrated Care Board

The next section (Section 5) presents key themes found for community signposting services & the ways services found to respond to **challenges (-)** & **opportunities (+)**:

Flexibilities ***Collaborative working*** ***Supporting complex needs***

Available resources ***Reviewing impact***

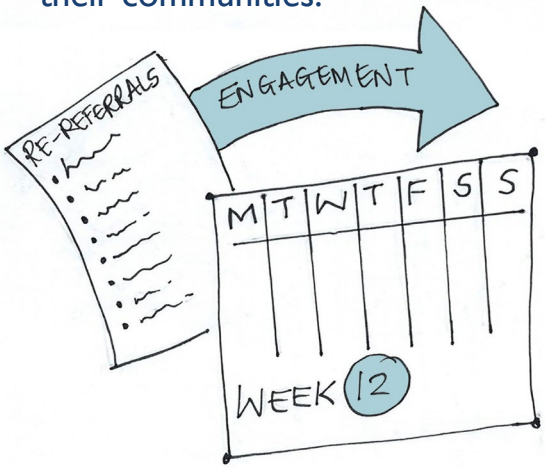
Section 5. **Theme 1 - Flexibility of services**

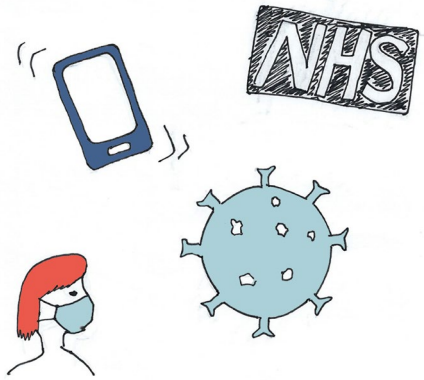
Sometimes **services need to change how they work** to keep going.

Examples include:

- **how long** they can offer support to each person
- **global health** challenges (e.g. pandemic)
- geographic **funding restrictions**
- service **goals or processes**.

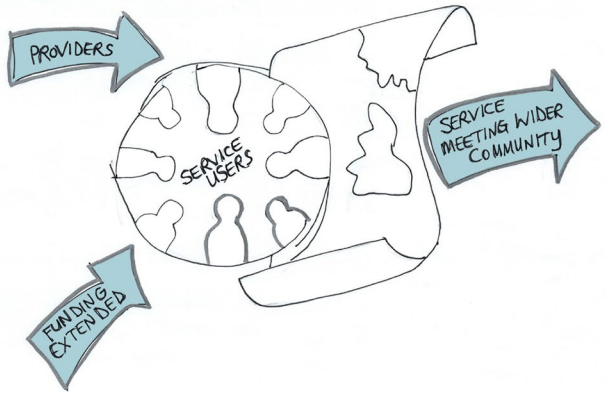
▶ Long **waiting lists create pressure for services** to support their communities.





▶ In the **pandemic**, services changed how they served communities by remote working & they kept some **new ways of working** when they returned to '*the new normal*'.

▶ Despite **funding limitations**, services found **ways to expand** who was eligible to receive **support**.



> "*So the 12 week is more of a guide because we shouldn't really be going past that, only because* ***we need to think about capacity & how many clients we're dealing with****. But* ***there is a bit of flexibility*** *in that given, you know, because* ***we can't be person-centred & then just cut people off****."* Signposter

▶ **Leadership** provided input & support to **review** existing **practices**.

They were also involved in conversations around changing service **goals**.

Theme 1 - **What to consider**

Community signposting services need to **work flexibly** & **continually adapt** to support service users.

Consider the following strategies to help make use of opportunities & avoid similar problems in your service:

Providers have flexibility to meet community needs (+)

What to do:	How to do it:	What changes?
Encourage staff to adapt what the service can offer.	Staff work to provide what the community needs as it changes.	Service includes everyone Service meets people's needs

Being flexible in how long services can work with a person (+)

What to do:	How to do it:	What changes?
Encourage flexibility in support duration.	Adjust processes to extend or reduce support duration as needed.	Service includes everyone & meets people's needs Service delivered as intended & can be kept going Shorter waits for service

Flexible use of available space (+)

What to do:	How to do it:	What changes?
Change use of available physical space to deliver activities.	Consider using existing/other spaces differently as needed (e.g. group activities).	Service meets people's needs Delivered as intended Service user-focused

Technology can support service users' engagement at the start of working with them (+)

What to do:	How to do it:	What changes?
Offer different communication options to service users.	Provide choice of phone/video calls to engage with service.	Service includes everyone Service meets people's needs Service user-focused

Theme 1 - **What to consider**, continued

Service fits within existing healthcare structure (+)

What to do:	How to do it:	What changes?
Build relationships with existing healthcare staff.	Promote the service & make it fit within existing referral systems.	Shorter waits for service Service can be delivered in practice

Expanding service reach to wider community (+)

What to do:	How to do it:	What changes?
Be aware of where service users live to be able to reach them. Discuss with & convince funders to expand service user eligibility to access service.	Improve access for people struggling to attend services due to where they live. Demonstrate public health benefits of expanding access.	Service includes everyone Service meets people's needs

Leaders support service improvements (+)

What to do:	How to do it:	What changes?
Leaders guide service developments & 'go the extra mile' beyond their daily tasks to sustain the service as a whole.	Leaders engage in service improvements, evaulation, extending access & filling resource gaps.	Shorter waits for service Service can be kept going

Fitting in with national policies, priorities & guidance (+)

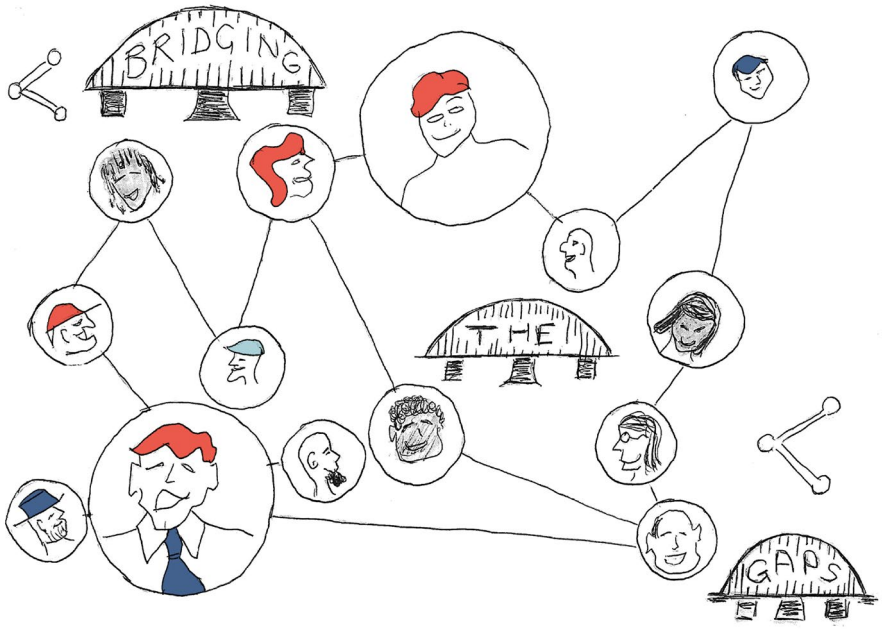
What to do:	How to do it:	What changes?
Service changes to fit in with national policy & guidance to meet funding requirements.	Leaders guide service changes to fit with national priorities.	Service meets people's needs Service can be kept going

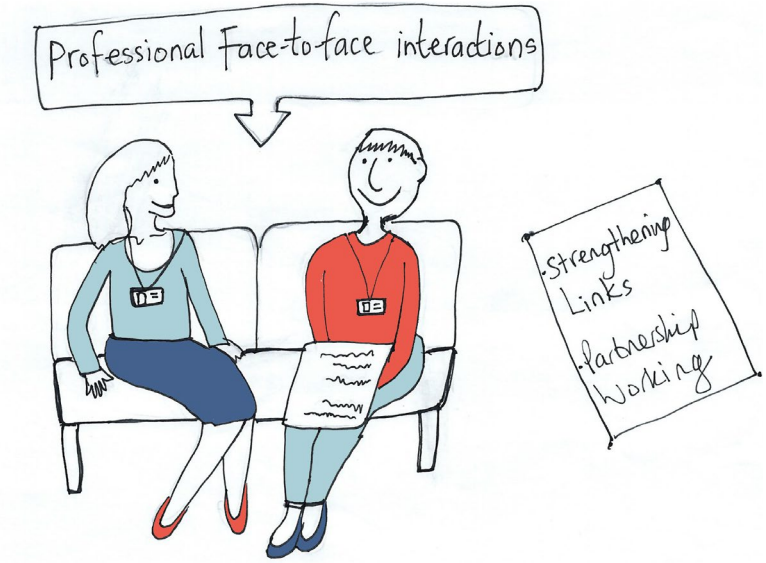
Theme 2 - Collaborative delivery

Working together allows providers to **engage** with & **appropriately support** service users in better ways.

This can be done by collaborating in **trusted places in the community** to **address issues** & **service gaps**. Doing this can **reduce competition** between providers.

▶ Providers **networked & shared information** to **identify service gaps** in what was available to support service users locally, & find ways to **address the gaps**.





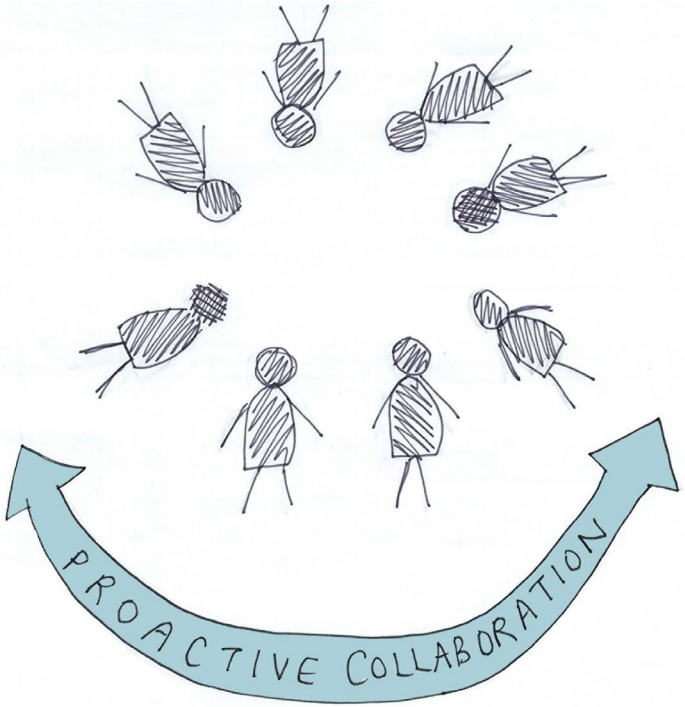
▶ When providers can **meet together**, they can **better support** their community.

> *"it's so important as a Community Connecter to **build good relationships with the groups we work with**, to **always be out & about**, speaking to these groups, maybe attending the groups & just building good relationships with the ones who run it."*
>
> Signposter

Theme 2 - Collaborative delivery - continued

▶ Providers can **engage better** with service users when they make use of **trusted places in the community** (e.g shopping centres, supermarkets or pharmacies).

▶ Providers who **share responsibility** in **delivering support** for service users have **less competition** between services.



*"we also help get some projects off the ground if we **identify gaps.** That's probably one of our main things is looking at the community & **seeing what our service users need**, & what's not necessarily there. And if we can, try to **help organisations** be able to **deliver it**. So, my colleague recently got a PTSD support group set up with [Linked provider] & that's been brilliant. So it's like things like that are great because **we can see things happening in real time as to when we see an issue** & then hopefully we can find funding."* Signposter

Theme 2 - **What to consider**

Collaboration between services is important as it allows people to **work together**, share **responsibility & help** each other. This can **improve service delivery** & **support service user outcomes**. **Consider these strategies**:

Providers work together to strengthen community links & develop service (+)

What to do:
Involve community in developing service.

Build & strengthen good working relationships to collaborate effectively & support services.

▶

How to do it:
Collect and use feedback from community to develop & keep service going.

Work with providers, use community spaces, set up regular stakeholder forums & pass on learning from training.

▶

What changes?
Service includes everyone & meets people's needs

Service can be kept going

Service user-focused

Shorter waits for service

Providers collaborate to identify & fill service gaps for more effective service delivery (+)

What to do:
Actively offer support between providers to work towards common goals & solve known problems together.

▶

How to do it:
Create strong relationships between providers to address service gaps through support & training, obtain funding & keep service going.

▶

What changes?
Service includes everyone

Service meets people's needs

Service can be kept going

Sharing workspaces & systems for referrals helps providers to respond quickly (+)

What to do:
Set up shared working spaces & use existing referral systems to embed the service with partners.

▶

How to do it:
Communicate together in shared spaces & create a more helpful referral process with other providers.

▶

What changes?
Shorter waits for service

Can be delivered in practice

Theme 2 - **What to consider**, continued

Signposters regularly promote service & are aware of community resources (+)

What to do:
Maintain provider relationships to have a shared vision of community support.

Encourage people to access service by promoting & delivering it in public spaces.

Keep community resources database up to date.

How to do it:
Make notes of available activities/opportunities, & share knowledge with the community.

Partner with trusted community spaces to connect with people, promote & deliver the service

Strengthen community awareness through marketing & volunteers.

What changes?
Service includes everyone & meets people's needs

Can be delivered in practice

Service can be kept going

Service user-focused

Staff & volunteers with lived experience help to keep them in the workforce & support better service user outcomes (+)

What to do:
Employ staff who have lived experience, offer appropriate role development & put in place volunteer roles in the service.

Provide full support to service users by working together.

How to do it:
Recruit people who have lived explerience for staff roles & volunteers from the community/ previous service users.

Work together to solve support issues for service users.

What changes?
Service includes everyone & meets people's needs

Shorter waits for service

Service can be kept going

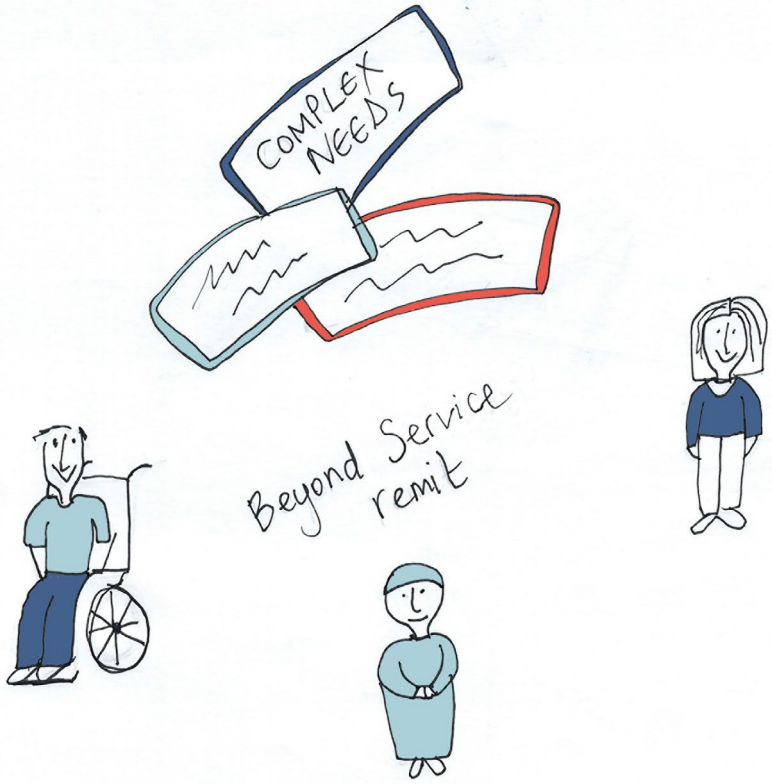
Service user-focused

Theme 3 - Challenges meeting people's more complex needs

People often have **complex personal needs**. For example: intense social isolation, vulnerability, trauma, and severe depression.

This means community signposting services sometimes get **inappropriate referrals** from **Adult Social Care** and their **staff haven't got the skills** to support people with mental health problems **beyond the service's remit.**

▶ Staff find it **difficult to fully support** people's **complex needs**.



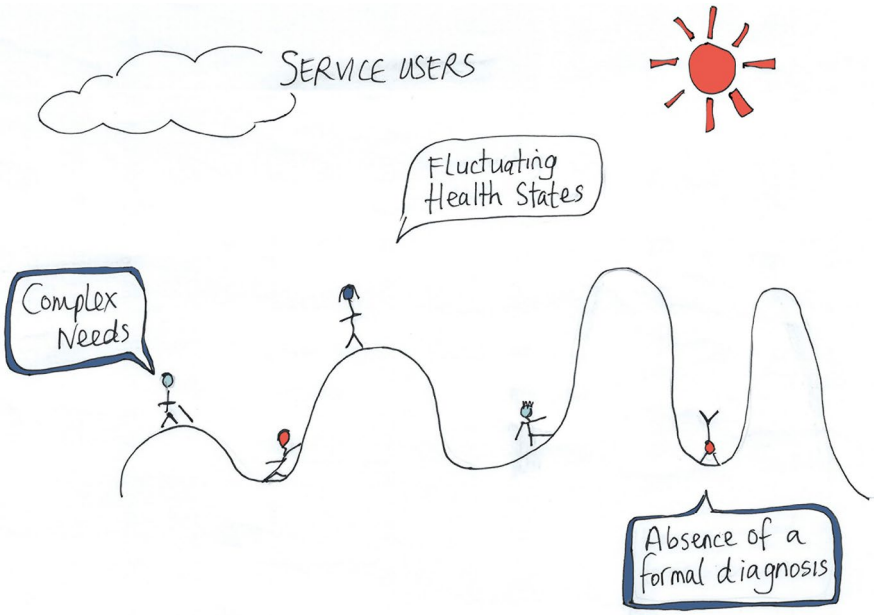
▶ Staff working with Adult Social Care sometimes get **inappropriate referrals** that are **difficult** for them **to support**.

> *"Sometimes we get **really inappropriate referrals** where the person needs social care or **more intense support than what they could receive from us,** but we try and **refer them on to the right people**. I'd do like a care-line phone call with them and **try and get them the support.**"*
>
> Signposter

Theme 3 - Meeting people's more complex needs, continued

"*We're working with* ***people with mental health needs****, and it* ***should be low to moderate mental health.*** *But what we are finding increasingly is because there's* ***long waiting lists for counselling****, it's* ***hard to get into secondary mental health services****. We're finding that* ***people are coming to social prescribing as a holding [area]****, so that is something we are having to be very careful of and* ***making sure that we don't become mental health practitioners*** *because that's not our role,* ***we're not trained in mental health****."*

Signposter



▶ Staff are **not equipped** to support people with **significant and/or undiagnosed mental health problems** in their community signposting service.

"*we're trying to balance and* ***manage some very unwell people that probably aren't suitable*** *for social prescribing.* ***What they need is psychology services****, but they just* ***do not have capacity or that person doesn't meet the criteria****, so therefore will not be supported and then* ***you've got to try and find them other things*** *that are probably only just going to stick a plaster on the issue… I'm* ***just sticking a plaster on a problem, not actually helping to resolve one.***"

Signposter

Theme 3 - **What to consider**

Staff try to support referrals for **people with complex needs**, but their **service is not equipped to handle** this. **Inappropriate referrals** can create barriers for services to effectively provide **personalised support**.

Consider the following strategies for sustaining your service:

Finding ways to include people with complex needs in the service (-)

What to do:	How to do it:	What changes?
Build supportive relationships with service users & offer inclusive activities to them.	Encourage open discussion about service users' needs to empower them to engage in managing their health & well-being.	Service meets people's needs Service delivered as intended Service user-focused

Receiving referrals for needs (e.g. Adult Social Care) that can't be met by the service (-)

What to do:	How to do it:	What changes?
Make sure linked providers understand what the service offers. Regularly communicate with Adult Social Care & crisis support providers about the service, its scope & capacity.	Reiterate service scope to referrers & clearly explain who is able to access the service, its limits & resources. Improve linked providers' understanding of how to make service referrals.	Service meets people's needs Shorter waits for service Fits wider setting

Providers try to support people with significant mental health problems (+)

What to do:	How to do it:	What changes?
Signposters need to recognise the limitations of what the service can offer.	Staff are trained to recognise when people can't be safely supported.	Service delivered as intended Service user-focused

Theme 4 - Service resource availability

Providers have to find **ways to keep working** with **limited resources**:

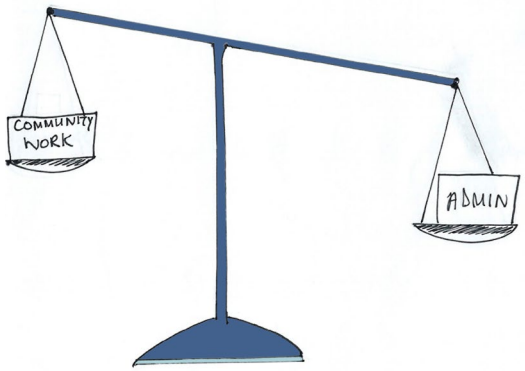
▶ **time**: they switch resources to **juggle service demands** & encourage service users to use other providers (like crisis centres) outside of working hours

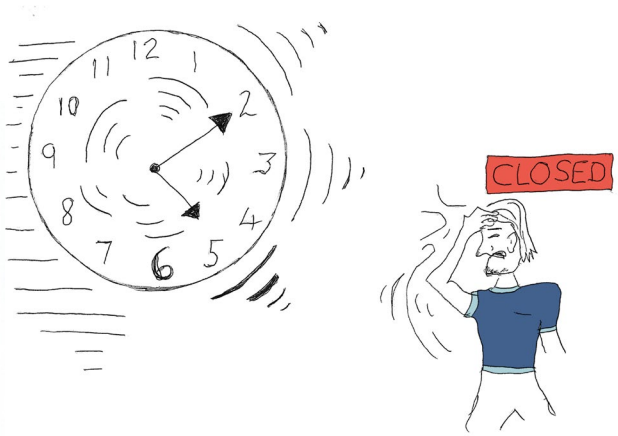
▶ **money**: funding is **time-limited** & has **attached expectations** for use

▶ **workforce**: staff are encouraged to access **online & in-person training** where available (sometimes through other providers) & they use **previous experience** to apply for **new job opportunities** to stay employed by their service

▶ **data**: staff manage workloads & targets with **existing technology** which has **limited functions** & **access**.

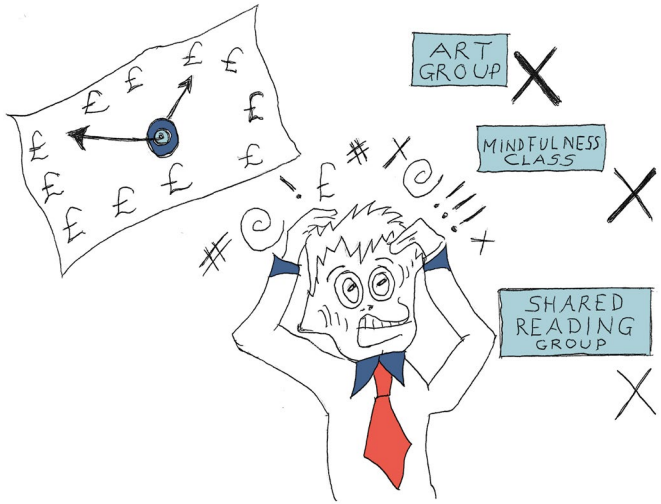
▶ Providers have to juggle competing demands, & they deal with this by **allocating other resources** to keep their service going.





▶ Services are **limited by** their **opening hours**. If service users need **support out-of-hours**, they have to **be signposted elsewhere** when the service is closed.

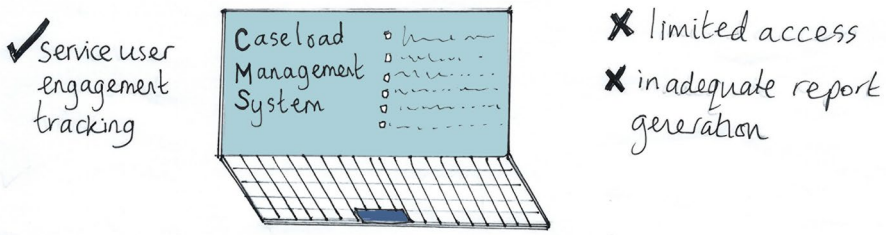
▶ Providers worry about the **availability** & **use of funding** affecting operation of the service.



Theme 4 - Service resource availability, continued

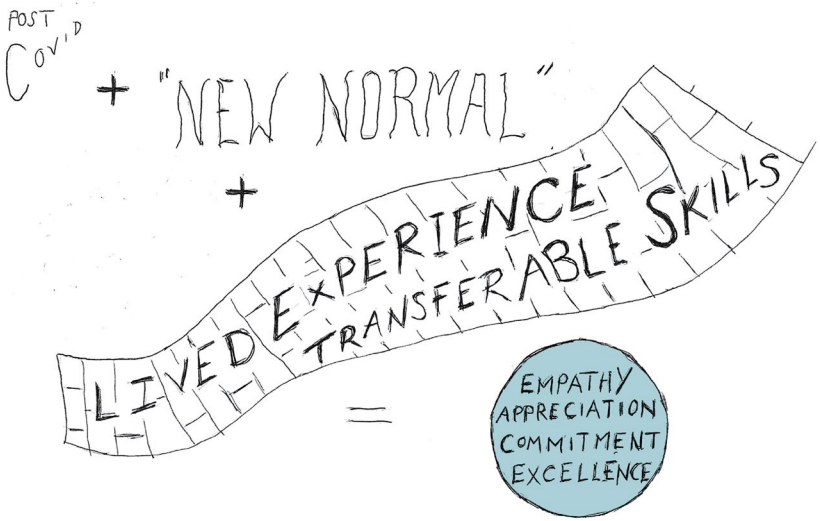
▶ Providers **promote training opportunities** (online/in-person) for basics & additional **ways of supporting service users**.

> *"as part of our **mandatory training**, we have an online training package coverings safeguarding, equality, diversity, and health & safety. The Make Every Contact Count training & suicide prevention is usually in-person. Either people [here] deliver that or other voluntary organisations locally.*
> *Me and [Linked provider], we deliver some behaviour change stuff. There's a wide range, so **there's a mix of online and in-person training. Most of it's funded** as well, which is good. I think if there was a gap, we'd be able to find the funding to do the training we needed."* Linked provider



▶ Providers **use technology** that **they already have** to manage their workloads & targets, which allows **follow-up** & **supports engagement**, but they are **limited** by **access & functionality**.

▶ Many staff joined their service after the pandemic began & used **previous work experience** to apply for opportunities which supports **career journeys** & **keeps staff in the workforce**.



Theme 4 - **What to consider**

Providers have to find ways to keep **working effectively** with their **limited resources**. Making better use of **existing resources, time & training** can help staff to do this. **Consider the following strategies** for your service:

Staff freely manage their own time & workload to make sure the service runs smoothly (+)

What to do:	How to do it:	What changes?
Give staff workload flexibility to manage their own tasks & responsibilities (include admin).	Support staff to complete & prioritise key tasks to manage their own workload (e.g. admin days).	Service can be kept going

Offer staff accessible & flexible training to meet their needs (+)

What to do:	How to do it:	What changes?
Provide staff access to appropriate & regular training opportunities to improve available service support. Offer flexibility in workloads for staff to develop new skills.	Make sure all staff in the workforce keep their skills up to date. Recognise training gaps & use existing resources or appropriate providers to fill them. Share learning with others to overcome limited training access.	Service includes everyone & meets people's needs Service can be kept going Shorter waits for service Service user-focused

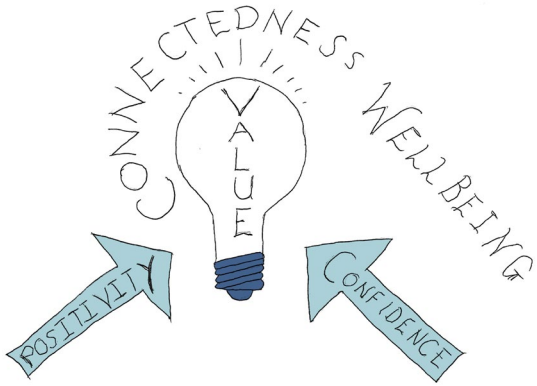
Providers access existing technology to support service user engagement (+)

What to do:	How to do it:	What changes?
Allow records to be shared between providers & get information about community resources to support service user engagement.	Find & share appropriate information (through community database & connected record systems) to personalise service user support.	Service meets people's needs Shorter waits for service Service can be kept going Service user-focused

Theme 5 - Understanding how services make a difference

Both service users & staff feel **the community signposting service makes a difference to themselves & others** in the community & they are **enthusiastic** about it.

Community signposting services **collect engagement feedback**, but have **difficulty showing long-term impacts**.



▶ Providers demonstrate **passion & commitment** to delivering their service for service users.

▶ Providers **review involvement with service users** (before & after) to understand **if the service has met their needs** & also collect their feedback.

All services have **challenges demonstrating long-term impacts** for service users.

▶ Providers report **job satisfaction** & feel **confident about their service's aim**.

> *"It's all that **anecdotal feedback** and the **case studies**, & the seeing somebody after, [...]. **They definitely don't transform their life suddenly**, but it makes a little difference & that's all we can hope to do. [...] **all I have to do is** sit in with the clinic, or with the client, or **talk to a social prescriber to remind me that this is the power of it**, really. Because **the statistics, the reports & the data, they don't really say anything**."*
>
> Signposter

Service users indicate **positive service experiences** & are **thankful for the quality of service** they were provided with.

Theme 5 - **What to consider**

Collecting feedback is important in understanding how community signposting services can impact service users **during & after** their **engagement**. Some funding should be allocated to support collecting feedback.

This can also support **better practice** within the service by staff, volunteers & linked providers.

Based on our research, you might want to **consider the following strategies** to help make use of opportunities & avoid similar problems in sustaining your service:

Share data between providers to fully support people *during service engagement* (+)

What to do:
When commissioning services, explore subscribing to the same systems as linked providers. This makes data-sharing possible to track service users' engagement.

▶

How to do it:
Providers use shared reports to monitor service user engagement/delivery.

▶

What changes?
Service meets people's needs

Can be delivered in practice

Service user-focused

Improve service based on people's feedback *after service engagement* & share between providers (+)

What to do:
Create opportunities for service users to give feedback.

Share service user data between providers to improve services & review impacts on service users.

▶

How to do it:
Survey & provide supportive conversations to encourage service user feedback.

Track referral volumes & review impacts on service users to share findings with providers.

▶

What changes?
Shorter waits for service

Service meets people's needs

Delivered as intended

Service can be kept going

Service user-focused

Evaluating community signposting services

Why evaluate community signposting services?

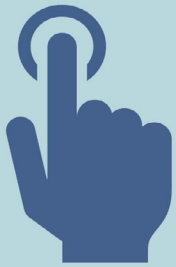
Evaluation is important to consider & **measure how successful community signposting services** are in improving **people's well-being & their ability to use** services.

It help services to **meet people's needs**, highlight **areas to improve** & **encourage best practice**.

Asking people to share their **lived experiences** can offer a more **complete understanding** of **service impacts**.

Collecting evidence for **outcomes & community impacts** can support services to attract **further funding**.

Click here for more information



How to collect evidence?

Evidence (data) can be collected using a **variety of methods**:

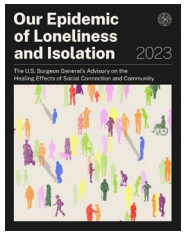
- monitoring attendance
- shared databases to track engagement
- informal feedback (e.g. thank you notes/emails)
- (pre- & post-) service use surveys
- case studies
- interviews & focus groups (with service users, providers & wider community)

Who can collect evidence to evaluate community signposting services?

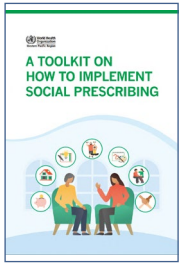
- Signposters
- Staff
- Operating organisations
- Funders
- Linked providers
- Volunteers
- Service user forums
- External research teams

Section 6. **Resources & further reading**

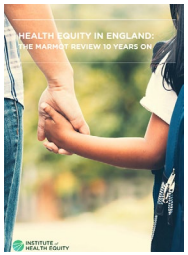
Fit for the Future: The 10 Year Health Plan for England (2025)
https://assets.publishing.service.gov.uk/media/6888a0b1a11f8599944091 47/fit-for-the-future-10-year-health-plan-for-england.pdf



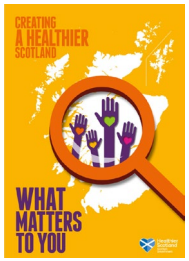
Our Epidemic of Loneliness and Isolation; The US Surgeon General's Advisory on the Healing Effects of Social Connection and Community (2023)
https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf



A Toolkit on How To Implement Social Prescribing (2022)
https://iris.who.int/bitstream/handle/10665/354456/9789290619765-eng.pdf



Health Equity in England: The Marmot Review 10 Years On (2020)
https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on



Creating a healthier Scotland (2016)
https://www.gov.scot/publications/creating-healthier-scotland-matters/documents/

Marmot Places. (2024). **Institute of Health Equity.** https://www.instituteofhealthequity.org/taking-action/marmot-places

Morris et al. (2022). **Community-Enhanced Social Prescribing: Intergrating Community in Policy and Practice.** International Journal of Community Well-Being. 5: 179-95

Husk et al. (2020). **What approaches to social prescribing work, for whom, and in what circumstances? A realist review.** Health & Social Care in the community. 28(2): 309-24.

Pescheny et al. (2018). **Facilitators and barriers of implementing and delivering social prescribing services: a systematic review.** BMC Health Services Research. 18(86):1-14.

Dayson C. (2017). **Policy commentary – Social prescribing 'plus': a model of asset-based collaborative innovation?** People, Place and Policy. 11(2): 90-104.

connected communities

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NIHR | Applied Research Collaboration North West Coast

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- The Life Rooms, Mersey Care NHS Foundation Trust - medium-intensity service
- Social Prescribing service, Sefton Council for Voluntary Service (CVS) - high-intensity service

Phase 2 focus groups with service users (including Adult Social Care) *(during 2025 to refine the toolkit content)*

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Or visit our team's website: NIHR Applied Research Collaboration North West Coast (ARC NWC) Implementation and Capacity Building Team (**IMPaCT**) at the University of Lancashire
https://arc-nwc.nihr.ac.uk/impact/meet-the-team/

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