Community and Wellbeing Committee
9 October 2018

SOCIAL PRESCRIBING UPDATE

Head of Service/Contact:	Ian Dyer, Head of Operational Services
Urgent Decision?(yes/no)	No
If yes, reason urgent decision required:	
Annexes/Appendices (attached):	**Annex 1 -** Epsom and Ewell Outcomes Dashboard **Annex 2 -** New Model Social Prescribing 2018-2019
Other available papers (not attached):	

Report summary

This report provides a background of Social Prescribing, and an update on the delivery of the service in the Borough.

Recommendation

(1) That the committee notes this update report and endorses the continuation of the Social Prescribing service.

1 Implications for the Council's Key Priorities, Service Plans and Sustainable Community Strategy

1.1 This initiative of Social Prescribing promotes our corporate priority of 'Supporting our Community', by promoting healthy and active lifestyles, especially for the young and elderly

2 Background

2.1 Social Prescribing (sometimes called 'Wellbeing Prescription') is a framework for local GPs and healthcare professionals to refer patients to non-clinical services that can help meet their needs.

2.2 It is an innovative and growing movement, with the potential to reduce the work load and the financial burden on the NHS, particularly within primary care.

2.3 Social Prescribing takes into account that people's health is determined primarily by a range of social, economic and environmental factors, and seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health.

2.4 These needs are increasingly being regarded as factors intrinsic to a happy, healthy, and productive life.

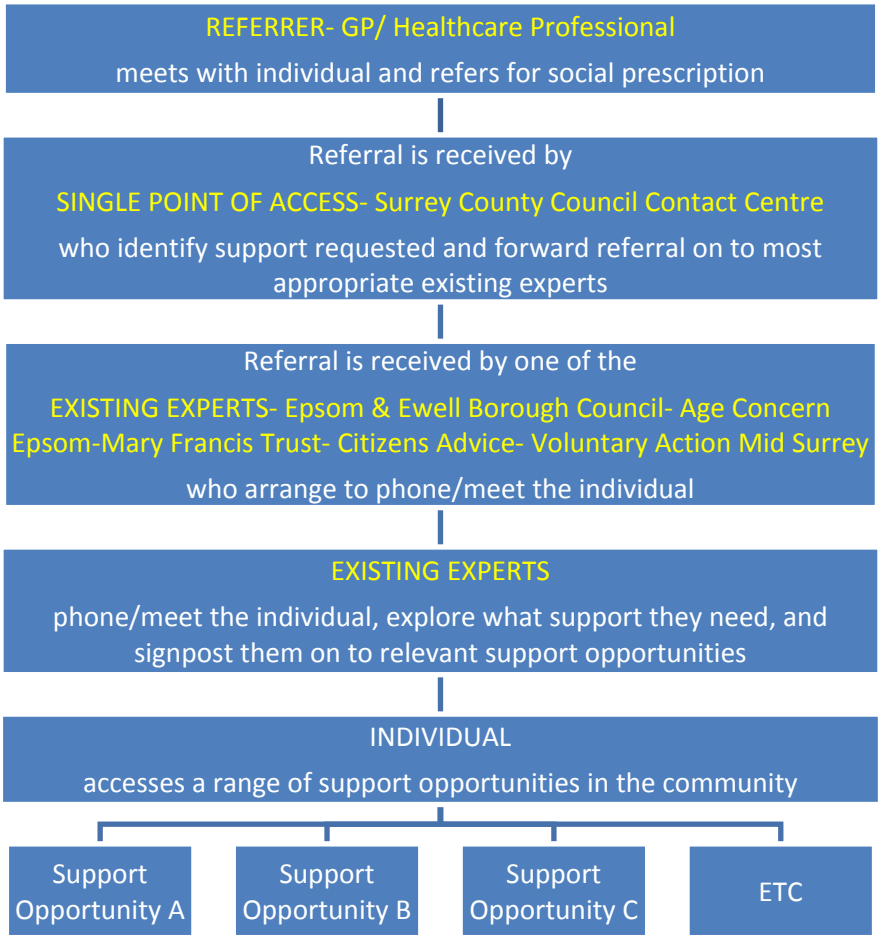
2.5 Social Prescribing came about due to a growing recognition that a person's health is not simply determined by their medical status. The fulfilment of social, emotional and practical needs also play a role in helping a person to be fully active and engaged in society. These requirements, which are of a personal nature, cannot be solved by a prescription filled by a chemist.

2.6 The rationale for this approach derives from the strong evidence base that demonstrates how health outcomes are socially determined, i.e. heavily influenced by the conditions in which people are born, grow, live and age.

2.7 General practitioners and practice nurses and other frontline healthcare professionals are well placed to identify suitable people for referral using a Social Prescription.

2.8 In April 2017, Epsom & Ewell Borough Council began participation in a one year pilot for Social Prescribing. This model was a non-financial model and only delivered the service as our business as usual with no extra on costs. (see **Annex 1*)***

2.9 **Epsom and Ewell Year One Pilot flow chart**



3 Update

3.1 The pilot method in year one worked well with people who are more activated and willing to start helping themselves. However, it was noted in a number of cases that the person receiving the social prescription was not taking up the services being offered to them. In these 'lowly activated' cases the person may have benefited from a little extra help to support them with engaging in with the services prescribed.

3.2 Surrey Downs Clinical Commissioning Group (SDCCG) and Surrey County Council (SCC) in partnership recognised this issue. They have offered funding for a pilot of one year to the Districts and Boroughs in their catchment area to employ a Link Worker to support these lowly activated cases.

3.3 The funding for the Link Worker role is from an under spend by SDCCG within their 2016-17 financial year. Epsom & Ewell Borough Council have been offered £30,000 to take part in the pilot. As of September 2018, we engaged a Link Worker on a one year fixed term contract.

4 Delivery of the Epsom and Ewell Social Prescription pilot

4.1 When a person is identified, the healthcare professional will forward the prescription to Surrey County Council's Customer Services department, which will triage each prescription and forward it to the existing organisation that can offer the service that will fit the individual needs. (see **Annex 2**)

4.2 These services vary widely, they potentially could include sports, leisure and art activities, or interventions that focus on skills development, education or improvement to the environment in which they live.

4.3 The aim of the Social Prescription is to improve the person's health and wellbeing by giving them direction to services that can help. This helps enable them to self-manage their health and welfare and become aware of the resources available to them within their local community.

4.4 The Community and Wellbeing Team will accept social prescriptions within the Wellbeing Daycare + Centre as part of their day to day activities.

4.5 An example of Social Prescriptions received by EEBC would be for the following:

- Basic living concerns (e.g. home maintenance, adaptations)
- Being healthy for over 55's (e.g. exercise, weight loss and healthy eating)
- Has recently fallen or is at risk of falls
- Emotional wellbeing e.g. lonely, low mood, dementia support, carers support and use of our community and wellbeing centre.
- Social isolation e.g. social activities, transport, meals, community alarm and Community and Wellbeing Centre.

4.6 The role of the Link Worker is to work with the person to understand what matters to them and to link them with the appropriate support to help them to support themselves. The Link Worker acts as a signposting service, spending time with a person, working out together their needs and goals. Most of this is carried out through telephone conversations.

4.7 The Link Worker will only work with the person for a maximum period of 6 weeks. If the person is still lowly activated after this time this will be reported back to the referrer as they may need higher levels of support through the health sector.

4.8 In practice, the level of engagement with people will depend on the individual support needed when they are referred. Some people may already have a good level of readiness to make a change. In this instance, the person may only need to speak with the Link Worker once or twice, and can be easily referred to a local services for support.

4.9 In some cases were the person needs additional support, the Link Worker will work on a one-to-one basis directly; this will take place within the Wellbeing Daycare + office or at a public place such as a cafe.

4.10 If needed, the Link Worker may accompany the person on their journey through different organisations, motivating and giving support to individuals to make the changes that they want to achieve.

4.11 For people with social, emotional or practical needs the role of the Link Worker is to empower them to find and design their own personal solutions, i.e. 'co-produce' their 'social prescription', often using local services provided by us and the voluntary and community sector.

4.12 The Link Worker will work at the person's own pace, supporting them to drive much of the journey themselves. The aim of this approach is that it leads to a time in the future where the person has the confidence and the life skills to move on without support.

4.13 This is where having a wide knowledge of local services and community groups is important, as the responsibilities of the Link Worker's role is to have knowledge of what services are available in the local and wider community.

4.14 As a council much of what we provide supports the health and wellbeing of the community. We are also well placed due to our local knowledge of services and groups to signpost people to what is available within the local community.

4.15 For example, people may need information, such as welfare or housing advice. Alternatively, people may wish to try a new activity, undertake or increase physical exercise and enjoy the outdoors and nature or become involved in an arts based project.

4.16 The Link Worker will monitor and report all of our cases and outcomes to the SDCCG through quarterly reporting.

4.17 Each existing expert (Epsom & Ewell Borough Council, Age Concern Epsom, Mary Frances Trust, Voluntary Action Mid Surrey and Citizens Advice are the providers in the current model, see **Annex 2**), will be responsible for their own reporting and monitoring.

5 Financial and Manpower Implications

5.1 The funding of £30,000 covers the cost of the role of the Link Worker and expenses related to the role.

5.2 Referrals to services may increase our market share and revenue income

5.3 ***Chief Finance Officer's comments:***
Delivery of this service will be funded by SCC and SDCCG, no impact on EEBC budgets is anticipated.

6 Legal Implications (including implications for matters relating to equality)

6.1 All referrals that have been considered for the social prescription service will not be an issue with regards to equality as the service will to open to all with the Borough.

6.2 ***Monitoring Officer's comments:***
The funding from Surrey County Council will be subject to a legal agreement. There is a small risk that if the Council and Surrey do not agree the terms of the legal agreement, the Council would be liable for the funding of the Link Worker post from its own budget. The Council and Surrey have already had informal discussions regarding the funding so the probability of the agreement not being completed is small.

7 Sustainability Policy and Community Safety Implications

7.1 The Link Worker's role is covered by the appropriate disclosure and barring (DBS) checks which are needed for working with vulnerable people.

7.2 Training of the Link Worker includes, safeguarding, General Data Protection Regulations (GDPR), health and safety, lone working policy, Council policies and online induction training. The Link Worker will also have one day induction training with the other provides within the Epsom & Ewell Social Prescribing Group.

7.3 Additional training will be provided by the SDCCG. This will include Care Navigation and Making Every Contact Count training.

7.4 An outcome of our lone working assessment recommends that the Link Worker role should not visit people in their own homes. Where one to one meetings are requested, these will take place in the Wellbeing Daycare+ Centre or in a public place, such as a library or cafe.

7.5 If the people would like to be accompanied on their first visit to an activity or service with the Link Worker, the person will need to become a member of our Transport from Home service and use this transport to the event.

7.6 Where new organisations ask if they can be on our referral list we will ask for their standards of governance, health and safety, safeguarding and complaints policies and GDPR information. When an organisation cannot supply this information, we will not include it on a list of service for referral.

7.7 The Link Worker will receive monthly one to ones and there will be regular telephone surveys to measure the outcomes and satisfaction for the people they are supporting.

8 Partnerships

8.1 From a commissioning element we will be working in partnership with SDCCG and SCC.

8.2 Within the pilot we will be working with SCC, Age concern Epsom, Mary Frances Trust, Voluntary Action Mid Surrey and Citizens Advice.

8.3 During the pilot we will be signposting throughout the community, voluntary and faith sector within the Borough.

9 Risk Assessment

9.1 It should be noted that all Social Prescriptions first start with the healthcare professional. The responsibility that sits with SDCCG and SCC as mentioned in this report should also be noted.

9.2 Social Prescriptions, once prescribed are processed by SCC into a filtering system, which is then forwarded by them to the local expert best suited to deal with the case. Ensuring where each prescription is sent for action is solely the responsibility of SCC and SDCCG.

9.3 The pilot of the Link Worker ends in April 2019. If it is considered unsuccessful, prescriptions will cease being sent to the Link Worker for action.

9.4 We will only continue to accept social prescriptions as in the year one without a Link Worker as in paragraph 2.8.

9.5 Referrals that point to the Council services such as Meals at Home, Transport from Home, Home Improvement Agency, handy man service, Community and Wellbeing Centre will help to increase our market share and improve our income to support our services.

9.6 The funding for the pilot runs from April 2018 to March 2019. We engaged the Link Worker in September 2018 for a fixed term of one year, the role will end in September 2019. This gives us an exit strategy of 6 months to deal with the referrals received in the 1 year pilot.

9.7 The management of risks, safeguarding and governance is covered within the report.

10 Conclusion and recommendations

10.1 Only persons identified by GPs or other healthcare professionals will be accepted for the Social Prescribing.

10.2 SCC Customer Services triages the prescription to the existing expert within the Epsom and Ewell Social Prescribing group best suited to person's needs.

10.3 When a Social Prescription shows that support is needed from multiple services then the prescription will be forwarded to the Link Worker to review and support the person.

10.4 The Link Worker will support the person for a period of up to 6 weeks.

10.5 The Link Worker will monitor and report all of our cases and outcomes to the SDCCG through quarterly reporting

10.6 If no further funding is received after the one year pilot Epsom & Ewell Borough Council will no longer provide a Link Worker within this Social Prescribing model.

10.7 The Committee is requested to note the update contained within this report and endorse the continuation of the Social Prescribing service.

Ward(s) Affected: (All Wards);