North East Locality Group

Oxfordshire
Clinical Commissioning Group

Locality Commissioning Meeting – North East

Date of Meeting: **9.5.18**					**Paper No:** **3**
Title of Paper: **Social Prescribing Update**					
Is this paper for	**Discussion**		**Decision**		**Information** ✓

Purpose of Paper:

To provide practices with information on progress in establishing a social prescribing scheme for the locality

Action Required:

Practices to note and provide feedback on the following:

1. Which patients would benefit most from social prescribing? Are the current inclusion/exclusion criteria appropriate?
2. What would remind you to refer a patient to the social prescribing scheme?
3. Would Making Every Contact Count (MECC) training be helpful for clinical and non clinical staff in your practice?
4. How would you want to measure success?

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1. Background

A proposal for a Social Prescribing scheme has been developed by Citizens Advice North Oxfordshire and West Oxfordshire in partnership with Cherwell and West Oxordshire Disrtict Councils for patients living in the North, North East and West Oxfordshire localities. The proposed scheme was submitted to seek national funding from the Department of Health VCSE Health & Wellbeing Fund, with local commitments from OCCG and the district councils to contribute to funding in Years 2-4 of the scheme.

Details of the scheme and the pathway that patients will follow once they have been given a social prescription need to be developed in detail with practices and the voluntary sector. It will be based on the principles agreed with localities and described in Appendix A. Where practices already have social prescribing in place the scheme will be flexible so that it can integrate with existing processes.

2.0 Progress Update

- The proposal has been shortlisted by the national fund but we are still awaiting an outcome of the bid for funding.
- A steering group has been established to set up the scheme and includes practice manager and GP representation
- An advisory group of voluntary organisations, community groups and patient representatives is being set up to advise on development of the scheme.
- Meetings have been held with Maggie Dent and OCCG locality co-ordinators to agree how best to enable GPs to co-design the scheme.
- A request has been submitted to the CSU to produce a simple EMIS referral form
- Cherwell District Council has completed an asset map to identify relevant community groups in the district.
- Pat Wood, chief executive of Citizens Advice, North Oxfordshire, has attended receptionist training sessions to provide an update on plans to set up a social prescribing scheme.

3.0 Scheme Co-Design

In order to develop the scheme so that it meets the needs of local patients, GP input is required into the following:

3.1 Patient Cohort

Proposed inclusion criteria:
Patients who are presenting in primary care with social, emotional or practical needs. The service will be targeted at patients who are lonely or socially isolated and inactive. These may include people with long term conditions, carers, or those with a disability as demographic data indicates that these individuals are at higher risk of social isolation. Patients with higher social needs (debt, poor or insecure housing, family problems) are also more likely to have poorer health and wellbeing

Proposed exclusion criteria:
Patients with high level mental health or dementia needs or those already engaged with services offering motivational coaching such as the Go Active scheme for diabetes patients will not be included in the scheme.

Q1:Which patients would benefit most from social prescribing? Are the current inclusion/exclusion criteria appropriate?

3.2 Encouraging Referrals

The scheme will succeed or fail dependent on the numer of referrals received. An EMIS referral form is being developed to make this process as easy as possible for GPs. Referrals will also be taken from other services and patients and carers will be able to self-refer.

Q2: What would prompt you to refer a patient to the social prescribing scheme?

Making Every Contact Count (MECC) training can help to prepare frontline staff and volunteers who have regular contact with the public to understand what they can potentially do in the context of an opportunistic conversation to help the person to better take care of their health and wellbeing.

Q3: Would Making Every Contact Count (MECC) training be helpful for clinical and non clinical staff in your practice?

3.3 Evaluation

A number of potential performance measures have been proposed to assess the effectiveness of the scheme:

- measures of physical activity
- measures of social interaction
- patient reported improvement in mood .
- reduction in use of primary care services
- increase in the number of people accessing local community and voluntary services and the impact on their capacity to respond
- qualitative feedback including success stories to be shared (with patient's consent)
- satisfaction with the service

Q4: How would you want to measure success?

4.0 Next Steps in GP Engagment in Co-designing the Social Prescribing Scheme

- We would ike to hold a one hour discussion at the July locality meetings – inviting relevant representatives from the voluntary sector and district councils to review and agree the proposed patient pathway for the scheme.

- We would like to identify 3 or 4 'pathway practices' who would be willing to test out the new pathway from September 2018.

- Regular updates on progress with mobilization will be provided at loicality meetings.

5.0 Concluding Remarks

Practice representatives are requested to consider the four Questions highlighted and provide feedback at the May locality meeting.

Appendix A: Proposed Social Prescribing Model

Principles of the Scheme

- The scheme will focus on the needs of a clearly defined cohort of patients in both a targeted way and opportunistically.
- There will be an attractive, easy route for referrals
- There will be a low level of barriers to being involved:
- People will not need to be 'fit enough to engage' or need lots of medical screening
- People will be encouraged to get involved in activities that match their interests – they may promote physical exercise or simply social integration.
- If the voluntary activity involves a cost, vouchers will be provided so that the initial sessions are free. Voluntary groups to be reimbursed this cost.
- Referrals will be made to activities that are self-sustaining once patients have engaged in them as they will be part of the current offer provided by local voluntary organisations
- The intervention will provide motivational coaching and support to engage patients, signpost them to activities and motivate them to continue until their activities have gained momentum and patients will continue with them un-prompted
- Digital support will be a central part of the scheme to support patient activation and adherence
- Volunteers, including volunteer drivers, will be recruited to provide additional support for up to four months, to support people to access community based activities
- The service will link with other services to sustain health improvement such as patients exiting weight loss programmes and IAPT services including talking space
- The scheme will have a robust evaluation with clear performance measures
- The scheme needs to operate for at least three years in order to provide the voluntary sector with the confidence that they have the resources and time required to invest in building up their capacity
- In both localities the scheme will prioritise those populations with high social needs and high health inequalities