Age UK Oxfordshire Social Prescribing model, currently working alongside GP Surgeries in SE Oxfordshire

Summary of Model

The model builds on the existing work of the Community Information Network (CIN), a service funded by Oxfordshire County Council to work within communities countywide to connect people to local services and support that will help them to retain their independence and live life to the full. The model has taken learning work undertaken by the CIN team in acute hospital settings (John Radcliffe and Horton sites) to relieve winter pressures by supporting discharge. It is a model of person-centred, flexible, partnership working that is strongly embedded within local communities

The model is currently operating alongside GP Practices in the South East GP Federation. It effectively builds **additional, dedicated capacity** into the Community Information Network to forge a link with local GP Practices.

The model provides **a named, dedicated Community Networker/Social Prescriber for each 'cluster' of GP practices**, working closely with the practices, taking referrals directly from GPs and other members of the primary health care team as well as some 'self-referrals'. This includes an element of appointment based drop-in sessions in the surgery as well as supporting patients in their homes or in other community settings, as required. This networker/prescriber would have strong local and wider knowledge and be based within the community.

Because it builds on the existing Community Information Network infrastructure, it is a cost-effective model, with the potential to deliver 'added value'.

Background

- Social prescribing involves empowering individuals to improve their health and wellbeing and social welfare by connecting them to non-medical and community support services. It is an innovative and growing movement, with the potential to reduce the financial burden on the NHS and particularly on primary care.

- The King's Fund has estimated that 19 - 20% of patients present with a social problem. Social problems require social solutions. Social Prescribing helps to find the right social solution for the person.
- An umbrella term, it has shown a positive impact on well-being through creative arts, volunteering, social links and community transport.
- A robust evidence base has not yet been established and this is a national priority, but the evidence that exists suggests this is a promising avenue of support to formal health & social care.

Aims and objectives of the service

The service aims to enable GPs and frontline health and social care professionals, to connect patients with the support they need to co-design a non-clinical social prescription to improve their health and wellbeing.
The service will:

- Develop personalised solutions which focus on social, emotional and practical needs in order to reduce isolation and improve resilience, quality of life, mental/emotional health, motivation, ability to manage home and self-care, employability, levels of activity, access to entitlements and advice
- Have simple referral and feedback processes
- Operate seamlessly with primary health as an integrated part of the locality
- Deliver cost-effective interventions which reduce pressure on health and social care services
- Provide a strong link between voluntary and community sector organisations and primary care, to strengthen collaboration, knowledge sharing and growth of community assets

Individual Outcomes (dependent on individual goals)

- Reduced social isolation
- Improved sense of wellbeing
- Improved ability to manage home/self-care
- Employment or fulfilling occupation

- Improved knowledge of services and supports available
- Entitlements secured

System outcomes

- Improved access for health practitioners to information about voluntary and community resources
- More creative solutions through collaboration
- Productivity gains for health and social care practitioners
- Development of community assets in response to needs identified
- Reduction in unnecessary use of health and social care services

Outcomes will be monitored using quantitative and qualitative measures.

Dedicated Community Networker

Age UK Oxfordshire's Community Networkers are effectively 'community connectors' (sometimes called link workers, social prescribers, care navigators, health advisers in other models). They are non-clinical staff with a thorough knowledge of the resources available to support people in their local community, from the voluntary, community, statutory and private sector. They have the personal skills to engage and motivate people they work with, to support them to identify what they would like to achieve and to connect the person with the resources to help them do so. This can range from providing information and advice, signposting to organisations and activities, arranging practical help (eg cleaners, gardeners, pendant alarms), identifying opportunities for the person to volunteer themselves, through to several visits in which the Community Networker builds a trusting relationship through which the person gains confidence to try a new activity, with the support of a link volunteer. The Community Networker uses their judgement in each case to vary the level of support so that the person remains in control of as much as possible, although they will make referrals on their behalf, encourage and support where appropriate.

Community Networkers also provide advice to health colleagues about voluntary and community sector services, which may be helpful for people they are supporting.

Interventions

The primary role of the Community Networker is to engage with the person referred in such a way that they can identify together what support the person needs, consider options and put in place solutions, by connecting them to existing provisions which may often be from local community or voluntary services, but also from the private or statutory sector. The Community Networker will make use of an appropriate tool to gather relevant understanding of the person's needs, eg the Guided Conversation, which uses a semi-structured conversational approach helpful for engaging the participant and opening up depth of discussion. Community Networkers also liaise with family or key friends, and other practitioners to understand context, contribute to collaborative approaches, support carers, and ensure key information is fed back.

The Community Networker or a volunteer may provide short term support to make sure that the person can follow up the opportunities identified, eg by phoning to see how a visit went, or by accompanying on the first visit to a new event. The Community Networker or a volunteer may provide short term practical support eg to get someone started on following exercises at home, to show them how to use a microwave etc where they do not have any friends or family who can help.

Referrals

There is a simple process for busy practitioners to refer to Community Networkers, without the need to determine exactly what the person requires. The Community Networker provides a single point of contact with the voluntary sector as they will elicit what the person requires and connect them with the relevant services. Referrals can be made direct to the Community Networker by email, telephone or in person. The networker will become known to the practice(s) team as a 'pop-in' culture will be encouraged to collect referrals in person, feedback to GPs, support practice initiatives eg coffee mornings, themed information events etc.

Scope and scale

The service works with adults over 18 who are registered with a GP practice which is within the area covered by the Primary Care Network. Following an initial phone call, a face-to-face visit(s) is arranged be this in the clients own home, GP surgery or neutral community setting. It is a challenge to estimate potential demand, as this remains largely untested. However, the levels of activity experienced by GP care navigators

and Community Networkers in Oxford City as well as our own social prescribers working with the South East Federation of GP Practices suggests that there may be considerable un-surfaced demand throughout the county.

Growing community assets and funding for 'prescriptions'

The success of social prescribing through a Community Networker is dependent on the capacity of suitable services in the community. There are many schemes and opportunities available, but there are also gaps and shortages. Many people would like companionship through a volunteer visiting them at home, and in some areas this is available through Good Neighbour Schemes, befriending schemes, or faith groups. However, demand significantly outstrips supply in most areas. The social prescribing scheme needs to have strong links into communities and voluntary sector organisations so that it can seed and nurture developments where it identifies gaps. It needs to have capacity to work with others to explore innovations such as time-banking, intergenerational work and mutual befriending, which could strengthen the impact of its work over time.

The Community Networkers will be part of Oxfordshire's Community Information Network which stimulates and supports growth of community activities and networks. Community Information Networkers also offer a less intensive version of social prescribing to individuals, which is public facing for referrals, and targeted primarily at people who do not yet have major health needs, and are able to follow up on information and resources they are signposted to.

Monitoring and evaluation

Given the challenges of measuring the impact of a largely preventative initiative in a complex system, we would welcome the opportunity to agree the measures and data sharing across the wider system at the outset. Case studies, self-assessments of wellbeing before and after intervention, and surveys of health staff will also be gathered.

Age UK Oxfordshire (AUKO) 'social prescribing' or 'community connectors' model

'Community Connectors': AUKO employs a countywide network of 'community connectors' or **social prescribers**, who use 'guided conversations' to understand people's aspirations & needs and support them to access a diverse range of community support. There are three teams of 'connectors', a **generic team**:

 # Community Information Network: (funded by OCC)

And **two specialist teams**:

 # Carer Support Service: (funded by OCC & OCCG) *taking Direct GP referrals via Emis / nhs.net)*

 # Dementia Support Service: (funded by OCC & OCCG) *taking Direct GP referrals via Emis / nhs.net)*

The outreach teams are underpinned by our **Information Hub (incl CIN Directory) & Advice Helpline,** which is charitably funded.

Helping people maintain their independence (our own services):

Digital Connect (IT support); Footcare; Homeshare; Home Support Options;

Oxfordshire Specialist Advice Service (welfare benefits support).

Helping people maintain wellbeing and enjoy life (our own services):

Community Activities & Opportunities (CD); Late Spring Bereavement Support Groups; OxBEL lite; Phone Friends;

Carers' Wellbeing options; Carers' Support Groups; Dementia Support Groups;

Generation Games (*direct GP referrals via Emis / nhs.net*).

Non- AUKO connections (too numerous to mention):

Arts activities; befriending; Citizens Advice; Local Day Services; LA Services (housing, social care etc); falls pathway; Good Neighbour Schemes; IAPT; legal advice (wills, LPA etc); Oxfordshire Mind Wellbeing courses; Pension Service; physical activities; social activities and connections; support groups (LTCs); transport options; faith groups; WFF; Housing Associations; Health Services (OT, Falls Prevention etc); etc etc