Social Prescribing Update (Community Services, Jill Moody)

Synopsis of report:

To provide the Committee with an overview and update of the Social Prescribing Service currently being delivered by Runnymede Borough Council.

Recommendation(s):

None: This report is for information.

1. Context of report

1.1 Social Prescribing addresses the non-medical needs that affect a person's health and wellbeing, by connecting them to statutory and community groups and services for support.

1.2 Runnymede Borough Council (the Council) has been delivering Social Prescribing to its residents since April 2018.

1.3 Initially, the Council secured funding to employ one Social Prescribing Link Worker (SPLW) through the Better Care Fund via the North West Surrey Alliance. Since 2019 funding for two more SPLW became available through the Primary Care Networks (PCNs).

1.4 PCNs are groups of GP practices usually covering a population of around 30,000-50,000 people.

1.5 As part of the NHS Long Term Plan funding is available to PCNs to deliver Social Prescribing as a key component of the plan to help prevent illness and tackle health inequalities by addressing the wider determinates of health. The PCN funding is currently planned for 5 years until the end of March 2024 for the provision of SPLWs aligned to their GP Practices.

1.6 The Corporate Head of Community Services identified Social Prescribing as a project that could be developed as part of the Council's work within the North West Surrey Health Alliance and to demonstrate the Council's ability and commitment to supporting the wider health and social care agenda.

1.7 As a result of this project being approved, North West Surrey boroughs are now delivering Social Prescribing on behalf of and in partnership with PCNs.

1.8 Although it is not intended that this project generates income for the Council, it is possible that there might be an increase in uptake of other Council services as a result of referrals through Social Prescribing which could lead to a small increase in income through those services. However, the primary purpose is to ensure that individuals receive appropriate support to meet their needs, whether this is through Council, statutory, voluntary and community sector services and to improve residents' health and wellbeing as a result.

1.9 This report intends to provide an update of the Social Prescribing service that is being delivered by the Council.

2. Report

About Social Prescribing – the process

2.1 Social Prescribing is a way to address the non-clinical factors that affect a person's health and wellbeing. These factors are known as the wider determinates of health. They include socio-economic, cultural and environmental conditions, such as appropriate housing, social connections, employment and financial stability as well as personal lifestyle factors and they have a profound impact on a person's physical and mental health and wellbeing.

2.2 Social Prescribing Link Workers (SPLW) are able to give people greater time and support with their non-medical needs, where a clinician's time might be limited. This enables them to take a holistic approach and explore the factors that might be affecting a person's health wellbeing and to focus on what matters to them.

2.3 The Social Prescribing team receive referrals from Health and Social Care professionals, including GP's and Mental Health teams. There isn't a direct route to self-refer into the service but individuals who have previously been referred and discharged from Social Prescribing can refer themselves back at a later date if they need further support. Otherwise, they are advised to seek referral though their GP or other health or social care professional.

2.4 The referral form contains details of the referrer and the referred person and the reason for referral. The list below is used on the referral form and will give an indication of the types of reasons that referrals are made to Social Prescribing:

- Benefits / budgeting advice
- Emotional support (including bereavement, relationships etc.)
- Family Support
- Housing options advice
- Low-level mental health and wellbeing support
- Opportunities for Social Interaction
- Physical activity
- Practical help (cooking / transport / shopping)
- Remaining independent at home (careline, meals, handyman etc.)
- Support around a disability / impairment

2.5 The referral form is emailed to the team, where it is allocated to an SPLW according to the GP practice where the resident is registered. The BCF funded postholder generally receives referrals via the Homesafe Plus, hospital discharge platform.

2.6 Once a referral is received the SPLW will make contact, usually by telephone for an initial discussion. This conversation is usually an introduction to the service and to establish the type and level of support required. Sometimes this will enable them to signpost or refer the person on to the appropriate services straight away, but an assessment will be made as to whether the

patient requires more support and if a face-to-face appointment is more suitable to explore this in more detail.

2.7 Sometimes a face-to-face appointment is simply more practical because, for example, the client is hard of hearing or would like a relative to be there, but it is often very helpful to meet in person, especially in more complex cases. Sometimes meeting in person helps an individual feel more comfortable to open up about the issues they are facing and the support they may need. It can also give the SPLW valuable insights into how the person is coping.

2.8 Face to face meetings can be arranged at the person's own home or at a community venue. This enables the SPLW to tailor their approach to the resident. For example, they may want to see how a person is managing if they live alone, or to encourage a person to meet at a community a venue to help them gain confidence and enjoy going out. Having such flexibility also helps officers to consider risks identified within the referral forms.

2.9 As a result of the discussions held, a person-centred plan will be agreed with the individual. The SPLW may signpost and/or refer the individual to the services or organisations that they have agreed would be beneficial. The SPLW will offer additional support to access these services where required.

2.10 An important part of Social Prescribing is to have an extensive and ever-growing knowledge of the support and services that are available in the borough including statutory, council, voluntary and community groups. This also lends itself to knowledge of gaps in service provision which is helpful in planning asset development within the borough.

2.11 It is the role of the SPLW to empower individuals to take control of their own health and wellbeing but depending on many factors including the complexity of the case and the service user's confidence, the SPLW may need to offer additional support to help the individual to gain the skills needed to take control of their wellbeing later on in the process.

Social Prescribing Resource

2.12 In Runnymede there are currently 3 x full time SPLW, whose roles cover different geographies and patient cohorts.

2.13 The table below shows the SPLW, the region they work in, how they are funded, the area of work they are allocated to and the GP practices they cover. The Social Prescribing team is managed by the Runnymede Borough Council, Health and Wellbeing Manager.

SPLW	Region	Funded by	Allocated to	Practices covered
SPLW 1	Runnymede	BCF	HSP	All Runnymede practices
SPLW 2	SASSE2 PCN	SASSE 2 PCN	SASSE 2 PCN	• Knowle Green Medical Practice • Fordbridge Medical Centre • Grove Medical Centre • The Orchard Surgery • Packers
SPLW 3	COCO PCN	COCO PCN	COCO PCN	• Crouch Oak Family Practice • Chertsey Health Centre

				• New Ottershaw Surgery

2.14 Patients registered at the Hythe Medical Centre in Runnymede receive the same service via Spelthorne Borough Council due to the PCN cluster they are within. Referrals are not received for residents of Englefield Green by the GP practice, given their Social Prescribing resources are managed within the Frimley Health footprint. However, where an Englefield Green or Egham Hythe resident is referred as part of a Hospital Discharge plan, the BCF funded post will provide the service directly.

Social Prescribing outcomes

2.15 The tables below show the Social Prescribing referrals received for the previous financial year and this year to date.

The total referrals for the last 12 months from October 2021 to September 2022 = 702

Social Prescribing Referrals April 2021 – March 2022		
Q1 (2021)	Apr - Jun	169
Q2 (2021)	Jul - Sep	126
Q3 (2021)	Oct - Dec	135
Q4 (2022)	Jan - Mar	215
TOTAL Q1-Q4 (2021-22)	**Apr 21 – Mar 22**	**645**

Social Prescribing Referrals April 2022 – September 2022		
Q1 (2022)	Apr - Jun	197
Q2 (2022)	Jul - Sep	155
TOTAL Q1-Q2 (2022)	**Apr 22 - Sep 22**	**352**

2.16 As mentioned below in point 2.18 one of the benefits of installing a software package to manage Social Prescribing referrals and caseloads, would be the ability to better record, evaluate and report on outcome measures.

2.17 In the meantime please see the following case studies, from Runnymede Social Prescribing service users. Their names have been changed for anonymity.

Social Prescribing case study 1 - Peter

Peter was referred to Social Prescribing by his GP for low-level mental health and wellbeing support. He is a carer for his mother who is fully dependent on him and has dementia. He was struggling financially and emotionally. The Social Prescribing Link Worker (SPLW) was able to help by referring Peter for a carers assessment through Adult Social Care, and for financial support to Citizens Advice. Peter was also awarded some money to help with respite care from the GP carers fund that his SPLW nominated him for. Peter said that the Social Prescribing service provided him a lifeline. When he felt he had hit a brick wall it saved him. Knowing he had someone that cared enough to support him and that he had someone to turn to gave him a new

lease of life. Peter said that Social Prescribing changed his mind set from having to cope alone to knowing he can reach out because there is help available.

Social Prescribing case study 2 – Sam

Sam was struggling with her mental health and wellbeing when she was referred to Social Prescribing. She also suffered from work stress and was on long term sick leave. It was identified that Sam was awaiting a diagnosis for autism so her Social Prescribing Link Worker (SPLW) signposted her to Surrey Recovery College which offers courses on Understanding Autism and the Surrey National Autistic Society's ASSIST service for more tailored 121 support. Over the course of 7 months and 14 appointments, the SPLW supported Sam to engage with mental health support in the community and got her back into artwork and attending a local art group. Sam was encouraged to manage her own wellbeing by using self-help information and resources, which proved to be very successful. She was also referred to the Richmond Fellowship (the local employment support service) and with their support Sam was able to leave her stressful job and move to reduced hours in a different workplace where she feels much more appreciated and settled. Sam sent the following feedback to her SPLW "Thank you for all your support. I'm still receiving support from Richmond Fellowship as I find my feet in the new job….and I am so grateful to both of you."

Next steps

2.18 With the growth and success of Social Prescribing comes a requirement to address the need for a case management system software package. The administration associated with the service is time consuming and inefficient for both day-to-day management and effective monitoring and evaluation purposes. There are software packages now available that have been designed specifically for social prescribing services, which have bespoke features and an ability to communicate with the GP systems among other advantages. Work on how this could be procured and paid for remains ongoing within North West Surrey.

2.19 Recruitment and retention of social prescribing roles has been a challenge for some time. This is partly because the roles are limited by the funding available to the PCNs and via the Better Care Fund. This has meant recruiting on fixed term contracts and on a pay grade that appears to be out of alignment with other regions and certainly doesn't reflect the complexities of cases that the SPLWs now work with and the value of the service that the SPLWs provide.

2.20 A paper will be submitted to the Local Joint Commissioning Group (LJCG) to request consideration for an increase in pay scale for SPLWs to reflect the expectations and value of the role and to level out regional variations.

2.21 There is also a need for training and career development opportunities for SPLWs. A consistent approach to accessing accredited training and the associated development opportunities is being sought by North West Surrey boroughs to provide a professional framework that enables SPLWs to progress personally and professionally within their roles.

2.22 The North West Surrey Alliance, has recently, at the request of the boroughs, committed to underwriting the risk of redundancy costs for the SPLW roles. This effectively means we are now able to offer permanent contracts to all existing staff and new recruits. This will potentially improve the quality of the recruitment process as well as providing greater job security for those SPLWs already employed on fixed term contracts.

2.23 There is currently a review being conducted of all Personalised Care roles in North West Surrey. These roles include SPLWs along with others such as with GP Care Coordinators and Wellbeing Hub Advisors. Similarities have been identified between these roles, so the review will seek to clarify and establish how each role effectively works within the system and with each other and to ensure consistency of service delivery and measurement of outcomes for residents.

3. Policy framework implications

3.1 The strategic focus of the forthcoming Health and Wellbeing Strategy is tackling the Wider Determinates of Health which underpins the work of the Social Prescribing service. The theme 'Working in partnership to tackle health inequality: To work with statutory agencies, voluntary, community and faith sector organisations, communities and residents to identify and tackle health inequalities and deprivation' is particularly relevant to this project.

4. Resource implications

4.1 The main resource implication identified is the continued management and support of the SPLW's that are employed by the Council. However, the service has been incorporated within the new Community Services structure and it is felt that there isn't a requirement for intensive line management support as the roles function with a reasonable level of autonomy.

5. Legal implications

5.1 None identified.

6. Equality implications

6.1 The Council is required to have due regard to its Public Sector Equality Duty with regard to delivering Social Prescribing.

6.2 The Council's Duty is stated under the Equality Act 2010 and is to have regard to the need to:

a) eliminate discrimination, harassment or victimisation
b) advance equality of opportunity between persons who share a protected characteristic and persons who do not share it
c) foster good relations between those who share a relevant characteristic and those who do not

6.3 Social Prescribing is implemented in accordance with the principles of the Council's Equality Objectives 2016 - 2020 (currently being reviewed and updated up to 2026) to maximise positive outcomes for all service users, including those with protected characteristics.

6.4 An Equality Impact Screening Assessment is currently being prepared, to be considered by the Council's Equalities Group and reported to this Committee.

7. Environmental/Sustainability/Biodiversity implications

7.1 It is recognised that as SPLWs are required to travel around the borough to attend appointments with clients and for meetings there will be an environmental impact associated with the use of their car. To mitigate this impact, they are encouraged to base themselves at a community hub building and to use Microsoft Teams and phone calls wherever possible, to reduce travel time. When they have joint visits and meetings with colleagues SPLWs routinely car share and are encouraged to continue to do so.

8. Conclusions

8.1 The North West Surrey model for the delivery of Social Prescribing is being successfully delivered to residents throughout the borough and is embedded within the Community Services offering at Runnymede Borough Council.

8.2 The service has been well received by both stakeholders and residents demonstrated by the level and quality of referrals and the positive feedback received from those supported by the service.

8.3 We hope to secure an increase in pay grade to encourage quality recruitment into these valuable roles and to be able to secure our currently employed and much valued team members. We will continue our work to provide a formalised framework within which to offer SPLWs opportunities for growth and progression.

8.4 Officers believe that this project serves as an example to prove the borough's ability and commitment to work with partners to successfully deliver a high quality service that delivers valuable health and wellbeing outcomes for our residents.

(For information)

Background papers

None Stated.