Report title	**Social Prescribing Service Update**
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Department	Community Services
Exempt	No

Purpose of report:

For Information

Synopsis of report:

This report provides an information update on the Social Prescribing Service, run by the Council, over the last 12 months. It includes information on how the service runs, the employee breakdown, data on referrals and case studies from residents.

Recommendation(s):

None. This report is for information.

1. Context and background of report

1.1 This report provides an update on the Social Prescribing Service that is being delivered by the council.

1.2 Social Prescribing addresses the non-medical needs that affect people's health and wellbeing. It provides a person-centred, holistic approach to supporting residents to find support and services in the local area that could improve their wellbeing and quality of life.

1.3 The Team is made up of 4 Social Prescribing Link Workers (SPLW).

1.4 2 SPLW are funded through the Better Care Fund (BCF) via the North West Surrey Alliance. These SPLW cover COCO and SASSE 2 Primary Care Networks (PCNs). 1 SPLW is paid directly from the BCF by Runnymede Borough Council. All of these SPLW are employed on permanent contracts. The fourth SPLW is paid through a grant received into the Housing Business Unit to support with the Cost-of-Living Crisis. This is a one-time payment and so this employee is employed on an 18-month fixed term contract (FTC).

2. Report and, where applicable, options considered and recommended

2.1 SPLW receive referrals into the service from Health and Social Care Professionals, including GPs and Adult Social Care (ASC). Referrals are allocated and triaged with all referrals being contacted within 10 working days on initial referral.

2.2 Referrals are provided through a referral form that provides basic information, along with any risks the SPLW needs to be aware of. The types of reasons that referrals are made into Social Prescribing are:

- Specialists in Benefits/Budgeting advice
- Counselling services and other support groups for emotional needs (bereavement, low level mental health)
- Runnymede Borough Council Housing Team for tailored housing advice
- Local opportunities for social interaction (lifelong learning, Social Centers, activity groups)
- Exercise referral schemes (exercise programs at local leisure centers)
- Practical help (cooking, transport, shopping)
- Information how to best remain independent at home at (alarms & telecare devices, Meals at Home, Homelink Handy person Service)
- Support around disability/impairment and specialist support groups
- Employment support

2.3 Once a referral has been triaged and allocated, a SPLW will contact the resident via telephone. At this point they will gather any additional information they need. If appropriate, they will arrange to visit the resident at home or meet them at a local community space, such as a day centre. Residents have access to up to 6 sessions with a SPLW. Each session is structured around the residents aims and objectives set out in their referral and initial phone call. The SPLWs take a holistic approach and create a person-centred plan with them. The SPLWs are very flexible about where they meet the residents, for example, if they are living alone and struggling with social isolation, they will offer to meet them at their local day centre for their appointment. The appointment will include a tour of the day centre, meeting the staff and joining in an activity if appropriate.

2.4 The overall aim of the service and role of the SPLW is to empower individuals to take control of their health and wellbeing and find a way to achieve their personal goals. This can come through signposting and referring onto local services and support. The service is more complex than this though, supporting residents to gain the skills and confidence to have ongoing positive wellbeing.

2.5 The GP surgeries covered under the COCO and SASSE 2 PCNs are:

- Chertsey Health Centre
- Ottershaw Surgery
- Crouch Oak Surgery
- Ford Bridge Surgery
- Grove Medical Surgery
- Knowle Green Surgery
- Orchard Surgery
- Virgina Water Surgery

2.6 The below table shows the number of referrals into the service over the last 12 months.

	Oct 22 – Dec 22	**Jan 23 – March 23**	**April 23 – June 23**	**July 23 – Sept 23**
No. of referrals	150	204	199	144

2.7 In the last 12 months “low level mental health and wellbeing support” has been the highest referral reason with 307 referrals. This is followed by “emotional support” with 283 referrals and “remaining independent at home/practical help” with 259 referrals. The table below shows all referral reasons, with the corresponding number of referrals over the last months.

Referral reason	No. of referrals
Low level mental health and wellbeing support	307
Emotional support	283
Remaining independent at home / Practical help	259
Opportunities for social interaction	251
Benefits / Budgeting Advice	232
Support around a disability / impairment	129
Loneliness / Social isolation	119
Housing Options Advice	97
Family Support	83
Physical Activity	76
Looking after someone else who couldn’t manage without them	28
Specialist advice	19
Basic living concerns	16
Being healthy	14
Has recently fallen or is at risk of a fall	13
Skills and job roles	3

2.8 Residents can be referred for multiple reasons, with 73% of referrals for more than one reason in the last 12 months. However, during appointments, even those residents who are only referred for one reason, it is common for other areas of support to arise and be discussed with the SPLW.

2.9 In the last 12 months, SPLW have supported residents for an average of 28 working days. It is vital for the service to spend quality time with each person to build trust and support them gain confidence to improve their health and wellbeing. The table below shows the number of sessions SPLW have had with clients, and the number of times this number of sessions has occurred over the last 12 months.

Session Number	Client Count
1 to 3	328
4 to 6	175
7 to 10	43
11+	16

2.10 Below are case studies from resident that the Social Prescribing team have worked with over the last 12 months. These case studies showcase the variety, support and scope that the service offers residents. Names have been changed to protect the identity of the case subjects.

Simon

Simon was referred to Social Prescribing by a GP at Chertsey Health Centre for low Level mental health & wellbeing support.

Simon disclosed that he was being made redundant from his job. He has a history of anxiety and depression. He felt he needed to work but had always been given work through friends or family, or employers who knew his history and who can accommodate his work ethic. He was in arrears with his housing association but had spoken to them to arrange paying back what he can. He had previously been told to apply for PIP but found the appeal process too stressful.

Using coaching skills and the GROW method, Simon set his goal to find new employment. The reality was he felt anxious about how to write a CV, applying for jobs and his lack of funds to pay for his car MOT. An opportunity was discussed with him to try Richmond Fellowship & applying for the Household Support Fund (HSF).

Simon was referred to Richmond Fellowship and worked well with them. He also received money from HSF to help towards his MOT and reached out to parents for financial help.

During follow-up sessions Simon was signposted to “we are with you” – IAPT service for CBT. A self-referral was made and an assessment was carried out before the case was closed. He was also referred to the Citizens Advice to assist with a PIP application.

Simon felt he was managing with the support he was receiving, and the case was closed to the service with the re-referral route was discussed if Simon felt he needed further input.

Chloe

Chloe was referred through Homesafe Plus because she was struggling with social isolation due to her osteoarthritis and social anxiety that was exacerbated by COVID lockdowns. She needed to make several trips to the pharmacy each week, causing her mental, emotional, and physical stress. Her days felt consumed by anxiety and loneliness. Upon hearing about Chloe’s difficulties, we devised a wellbeing plan together, keeping her preferences and personal strengths at the forefront of every discussion.

Chloe was signposted to the Surrey Coalition, who were able to donate her a tablet that she could use. From there, she used her newly learnt technology skills to get her prescriptions and food shopping delivered, saving her time and stress during the week.

This gave her a lot more-free time in the week to consider social interaction options. She was signposted to the local day centre, which she now attends twice a week and has found lots of friends with common interests. She now feels empowered to independently find support in her community by volunteering at a local charity shop, which she does once a week.

Following Social Prescribing intervention, Chloe now feels less lonely and anxious. From the support in the community to making use of technology to help support her day-to-day life, her quality of life has improved, and she regularly facetimes her family who live far away and feels re-connected to her local community.

David

David was referred to the Social Prescribing Team by his Surgery in SASSE 2 PCN. He had been struggling with mental health problems and was seeking support for this. He was also living with a friend but thought this was not sustainable for him. He was also at risk of losing his job and was unsure how to change his accommodation.

David had been financially abused by his live-in landlord and was struggling financially because of this and was not able to pay for repairs to his motorcycle. He told the SPLW that he struggles with depression and PTSD.

David was signposted to Citizens Advice Bureau and was able to get advice on what sort of benefits he can claim and what are his rights in terms of the financial abuse from his landlord. He was able to apply for PIP is in better financial situation.

He was also referred to a supported accommodation provider where his application was approved, and he is now waiting to be moved into supported accommodation. This was David's ultimate goal, and he was happy with the outcome.

He was referred to the foodbank whilst he was awaiting his PIP decision. David was also nominated for the Household Support Fund to get help to repair his motorbike. This was successful and meant that the repairs have been made and he can continue to commute to work.

Following successful signposting and referrals, David has been discharged from the service. David was very happy with the help from the service and would recommend to other residents. He found it especially helped that Social Prescribing could communicate with all the services and work as one team around the resident's needs.

Frank

Social Prescribing received a referral for Frank from Adult Social Care, requesting help/options with funding a mobility scooter.

Upon meeting Frank, there appeared to be other concerns than just the mobility scooter funding. He presented as very isolated due to mobility, meaning he was unable to even step outside of his own house without fear of falling. Frank was keen to find ways of socialising. He also disclosed that he is part-funding his care, which he is paying for out of his savings. Frank explained that he is worried about paying for transport to and from appointments and gave an example of a dentist appointment which costs him around £70 which includes the appointment itself and transport. Frank also explained that his energy bills are extremely high as his house has been rated as 'G' under the energy efficiency rating system.

The SPLW signposted a member of Frank's family who supports him to the Connected for Warmth scheme, which may be able to provide funded loft and cavity wall insulation to homeowners who have an energy efficiency rating of C or below.

Frank was signposted to his local day centre, and in doing so, has been able to arrange low-cost transport for him. He has now attended 2 sessions at the day centre, enjoying spending time with others, a nice hot lunch and winning bingo!

The SPLW has linked Frank up with a service called 'Care in Egham' who are volunteer-based and are sometimes able to help with transport to and from medical appointments. Thankfully, for Frank's most recent dentist appointment they were able to get a volunteer to him, meaning that he was able to save money compared to

previous appointments. Frank was very happy with this service and has reached out again for a future appointment.

Frank was also referred to the 'Time to Talk Befriending Service' and they have been able to match him with a volunteer who will now be visiting Frank once a week for an hour or so, to have a chat and a cuppa together.

The SPLW is currently in the process of applying to a local charity for funding for a mobility scooter. They have contacted a local mobility company who have been out to see Frank with one of their scooters which following a test he feels may be suitable for him.

3. Policy framework implications

3.1 The Social Prescribing Service supports the Health and Wellbeing Strategy. Particularly around the objectives of "working in partnership to tackle health inequalities". The Social Prescribing service directly support individuals' wellbeing and tackling health inequalities.

4 Resource implications/Value for Money (where applicable)

4.1 There are no resource implications that arise directly from this report.

5. Legal implications

5.1 There are no legal implications that arise directly from this report.

6. Equality implications

6.1 Social Prescribing support vulnerable residents in Runnymede and as such has a positive equalities impact on those residents who may be at a disadvantage due to having a protected characteristic. The service is implemented in accordance with the principles of the Council's Equality Objectives.

7. Environmental/Sustainability/Biodiversity implications

7.1 Whilst there are no environmental implications that arise as a direct result of this report it is recognised that a mandatory part of the Social Prescribing service is the requirement for Caseworkers to travel around the borough to visit clients in their home, and as such there is an environmental impact associated with the use of their car. To mitigate this impact, they are classed as mobile workers, and able to work from anywhere in the borough. For example, if the client's house is closer to their home, they will work from home before and after the visit

8. Risk Implications

8.1 Not applicable

9. Conclusions

9.1 The Social Prescribing service is successfully being run throughout Runnymede. Residents have access to a supportive, holistic, and person-centred offering that works to improve their health and wellbeing.

9.2 Over the next 12 months, working with the North West Surrey Alliance, the Wellbeing service would like to implement a new software system. This will support the service tracking data more efficiently and allow a greater overview of service performance.

9.3 Working with Community Services, over the next 12 months, the Social Prescribing service hopes to begin collecting and measuring feedback from residents. This will include a variety of wellbeing measures that measure the wider determinants of health. It will provide a way to measure the impact the service is having on residents' wellbeing before and after accessing the service.

10. Background papers

None stated.

11. Appendices

None.