Divisions Affected - All

Oxfordshire Health & Wellbeing Board
6 October 2022

Social Prescribing in Oxfordshire

Report by Interim Corporate Director of Adult Social Care

RECOMMENDATION

1. **The Health & Wellbeing Board is RECOMMENDED to**
   (a) Note this report which sets out
   - the current landscape of Social Prescribing in Oxfordshire
   - the opportunities to develop and extend reach and impact across public health, health, social care, and community priorities
   - next steps and a potential governance route to assure delivery

   (b) Approve the recommended approach to develop an implementation plan for Social Prescribing in Oxfordshire
   (c) Note the proposed governance approach for this work

Executive Summary

2. This paper updates Health & Wellbeing Board on the development and implementation of Social Prescribing in Oxfordshire.
3. Social prescribing is a priority in local and national strategy.
   (a) At a national level the NHS has developed a model of Social Prescribing that will support people identified by GPs and others initially in primary care and then elsewhere in the NHS. This being rolled out nationally in line with a *Social Prescribing Maturity Matrix* which is currently out for consultation. This will provide a framework for good practice when adopted. Primary Care Networks are separately required to deliver Social Prescribing in line with the national Network Contract.
   (b) In Oxfordshire, the development of Social Prescribing is a priority in the Joint Health & Wellbeing Strategy as a means of *Improving Health by Tackling Wider Issues.* Specifically, it was one of the areas of focus for the Health Improvement Board to meet its aim to *Create healthy communities where people of all ages can maintain and improve their health as they live, learn, work, and socialise*
4. Oxfordshire has developed local initiatives that build on the broad model of Social Prescribing. These include the Council Led *Oxfordshire Way* and schemes that have grown out of our response to the Covid Pandemic such as *Move Together.*

5. There is considerable potential to develop these national and local programmes into a model that creates resilient and engaged communities which enable people to *maintain and improve their health.* Social Prescribing has a key part to play in this.

6. This paper
   (a) Sets out the current landscape of Social Prescribing in Oxfordshire
   (b) Identifies the opportunities to develop and extend reach and impact across public health, health, social care, and community priorities
   (c) sets out next steps and a potential governance route to assure delivery
   (d) Seeks approval from Health & Wellbeing Board for the direction of travel

What is Social Prescribing and what is the situation in Oxfordshire?

7. The King's Fund has defined Social Prescribing-in the NHS context-as follows:
   (a) Social prescribing, also sometimes known as community referral, is a means of enabling health professionals to refer people to a range of local, non-clinical services. The referrals generally, but not exclusively, come from professionals working in primary care settings, for example, GPs or practice nurses[1].
   (b) Recognising that people's health and wellbeing are determined mostly by a range of social, economic, and environmental factors, social prescribing seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health.

8. The NHS Social Prescribing approach (as set out in the national Maturity Matrix-see below 20-25) is linked to Population Health Management approaches: identifying people at risk of poor health and/or health inequalities (either by screening, proactive case finding or when they approach with a health problem) and then working with them in a different way to create individual person-centred plans which look for different ways of managing their health needs better. This is the NHS model:

The Social Prescribing Link Worker sits in the Primary Care Network and works to create the "tailored plan" within a "common outcomes framework".

The model recognises that this is a new discipline, and that workforce and outcomes definition needs to be developed; and that delivery of the Social Prescribing outcomes will be contingent on somewhere to support people towards (community groups/capacity) and on strong partnership arrangements, especially where Social Prescribers identify unmet need and gaps in local community provision.

9. In Oxfordshire 19 out of 20 Primary Care Networks now employ Social Prescribing Link Workers either directly or via voluntary and community sector organizations. Overall referrals are increasing from 2020/21 to 2021/22 and a change in the age profile:

(a) In 2021/22 there was a total of 7,552 patients referred to Social Prescribing in Oxfordshire. Almost two thirds (62%) of patients referred were female and 38% were male.

(b) Between 2020/21 and 2021/22 there was an increase in the number of younger people and a decrease in the number of older people referred.

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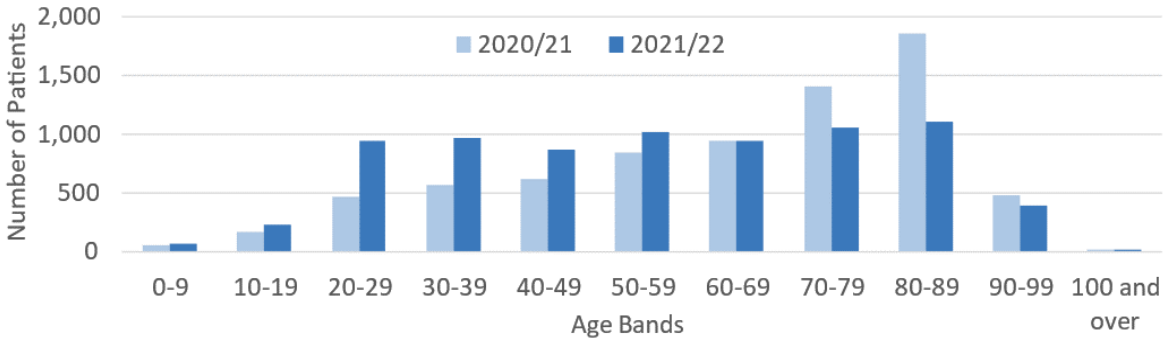

10. In the *Oxfordshire Way* the Council has developed a similar Social Prescribing approach in respect of people with an identified need for social care. Focussing on a strengths-based support model, staff employed by Age UK Oxfordshire help people identify what is important to them, identify what they can do or where they can go which will make a difference to their health and wellbeing, and "walk with them" when getting started or following up is difficult:

We have developed a compelling future narrative and roadmap for the transformation of Adult Social Care and the role it will play within our communities - The Oxfordshire Way

11. NHS Social Prescribing and the Oxfordshire Way are at this point mainly working with a "known" population: people already supported in primary or adult social care, or people identified via case-finding and/or population health management approaches. However, Oxfordshire also has Social Prescribing-like services that support a more preventative approach with people who are not "on the statutory radar". This broader approach to prevention can be described as
    (a) *Preventing people from becoming disconnected from their own resources, natural supports, and communities so that need fewer or no formal service interventions*
    (b) In 2021/22 the Council and the then Clinical Commissioning Group commissioned work to explore prevention within communities. This identified the key role played by *community connectors* who
        (1) Work with people who are "less connected than most"
        (2) Undertake activity that helps people think about their lives, strengths, and aspirations
        (3) Then use this insight to help people connect with other people, organizations, activities, services in their communities
        (4) And may help people to use and develop their skills and talents to better contribute to and have a positive impact on their community
    (c) This definition of community connectors" may cover the work undertaken by NHS Social Prescribers and the Oxfordshire Way, but may also cover a wider range of community organizations (see 12-13).
    (d) Community Connectors may also include unpaid community-based individuals and groups who may be in some ways better-placed to signpost, support and enable communities to respond to the needs of individuals. This represents an informal capacity with considerable potential to increase reach and impact of commissioned services.
12. An example of this approach is *Move Together.* This is a supportive pathway for people across Oxfordshire to become more active. Coordinated and delivered by Active Oxfordshire in partnership with Oxfordshire's District Councils, the pathway ensures that people get the right support to become active and improve their health (both physical and mental) and wellbeing. The initiative grew out of work that was previously focussed on diabetes management and was developed and has been funded short-term from the Covid Pandemic response. Move Together both works in a Social Prescribing model (developing personalised plans with individuals, identifying ways to get more active, walking with them on that journey) and additionally acts as a specialist resource for other Social Prescribers and other referrers.
13. The Council commissioned a snapshot survey of Social Prescribing in the County in July 2022 which confirmed that Oxfordshire has several examples of good practice and a significant amount of coverage
    (a) There are more than 125 full-time equivalent people working in community connector/social prescribing roles
    (b) This includes 45 staff working in Primary care 19 of the 20 primary care networks
    (c) There are social prescriber roles working in community and acute NHS settings as well as in primary care, including supporting people living with cancer and long-term conditions and around smoking cessation

(d) There are people working with specific client groups, e.g., adults with a learning disability and/or autism, people with mental health problems presenting to primary care, tenants of housing providers, victims (and potential perpetrators) of crime

(e) There are specifically focussed approaches: e.g., covid funding supported activities that help people get back into physical activity; debt and finance; citizenship and contribution

14. The commissioners of these services range across Council Public Health and Adult Social Care; NHS England (social prescribing); the NHS Integrated Care Board (additional social prescribing across City Primary Care Networks); District and City Councils; specific housing providers; Oxford University Hospital NHS FT; Oxford Health NHS FT. Many of these initiatives have grown out of the Oxfordshire response to supporting vulnerable and isolated people and communities during the pandemic.

15. The providers included in-house staff and a range of voluntary and community sector providers including Active Oxfordshire, Age UK, Citizens Advice North Oxfordshire, SOFEA, Oxfordshire Mind, Oxford Hub and District and City hubs

16. The common themes across these different Social Prescribing approaches are a focus on addressing key risks to long-term health and wellbeing outcomes

(a) Combating isolation and increasing the sense of connectedness

(b) Mental wellbeing

(c) Physical wellbeing, especially physical activity

(d) Practical resources that can address specific risk factors (eg debt advice, housing issues, fuel and other forms of poverty) which contribute to the wider determinants of ill-health

17. The range of different models for Social Prescribing in Oxfordshire are built around key inputs

(a) Need for good quality, accessible, information and advice that can support self-help and act as a touch point for professionals and other referrers

(b) Co-produced, person-centred approaches to planning: what is important to the individual and how do they meet their individual challenges

(c) Practical support and navigation to enable people to access community resources when they cannot do so themselves

(d) Community resources and social capital that people can use to help them develop and achieve their personal plans

Opportunities to develop Social Prescribing and community connectors

18. Social Prescribing is key in the delivery of a range of local plans and initiatives

(a) Delivering the Oxfordshire Health & Wellbeing Strategy and addressing those health inequalities identified in the Joint Strategic Needs Assessment. Focussed social prescribing and community development approaches help people manage risks arising from the wider determinants of health and support the development of community resources. By identifying what is important to individuals we can better engage them in managing their own health. Social Prescribing can help inform and deliver our approach to Healthy Place Shaping especially in terms of identifying gaps in localities and opportunities to develop community capacity.

(b) Delivery of key system initiatives that assure "right care, right place, right time" as set out in the Better Care Fund plan and the system urgent care Integrated Improvement Plan. This will help manage demand on our health and care services
    (1) Supporting primary care with at risk populations, especially in terms of physical activity and mental wellbeing
    (2) Providing person-centred alternative forms of support for people who are at risk of hospital admission, or who have recently been discharged from hospital and are being supported by health and care in "virtual wards". A strengths-based assessment has been shown to reduce the demand for care by identifying the things that are important to the person, and which may be provided outside of formal NHS or Council care
(c) Improving our response to Carers, to people with mental health problems, to people living with learning disability and/or autism; helping with practical issues as well as building up that individual resilience to deliver 16b above.
(d) Developing our information and advice offer Live Well Oxfordshire to increase the options and resources available to the public and to social prescribers
(e) Increasing community capacity, social capital and capability and the ability of our communities to "grow their own" in terms of the things that will help keep the local population connected and well. This forms a key part of the Oxfordshire Better Care Fund 2022/23 plan
(f) The NHS Maturity Matrix model for Social Prescribing (see below 20-25) highlights the need to create a feedback loop on gaps in community provision and to use that data to support the development of the model and community development

19. There are opportunities to extend the range of options in the community by working to build links between Social Prescribers and arts and cultural groups and organisations, and to groups and organisations helping people access and connect to green spaces. The resources that people might use to help them *maintain and improve their health* are often already there: Social Prescribing connects people and resources to unlock that potential.

NHS Social Prescribing Maturity Matrix

20. This sets out a good practice framework for primary care networks, places (here, Oxfordshire), and systems (here Bucks, Oxfordshire and Berkshire West Integrated Care System).
21. The Maturity Matrix is a good practice and developmental model. Currently, Primary Care Networks are required under the Network Contract to *provide the [PCN's] patients with access to a social prescribing service.* During 2022/23 Primary Care Networks are required to design and implement a targeted programme to proactively offer and improve access to social prescribing to an identified cohort with unmet needs.
22. Both the NHS Maturity Matrix and the requirements of the NHS Network Contract include various opportunities and risks for the wider development of Social Prescribing in Oxfordshire
23. The key risk is that NHS Social Prescribing and the wider Oxfordshire offer develop in parallel in a way that is inefficient and creates confusion. The NHS

model, the Oxfordshire Way and the other forms of community connectors all have

(a) A working relationship and may be working in some instances with the same people

(b) All rely on the continued development of community capacity and social capital

(c) All need an up to date and comprehensive information and advice resource

(d) And so, they **must** develop in a co-ordinated way

24. The key opportunities are that

(a) For the NHS model: that there are existing partnerships, pathways, and resources (especially around community capacity) that can be deployed to support patients of primary care; there is knowledge and resource on good practice and workforce development. There is an opportunity at both primary care network and ICB place level to do this once and drive greater value and impact by building on what is already there

(b) For the Oxfordshire approach to social prescribing: there are opportunities around building partnerships with primary care networks; building our understanding of unmet need; developing outcome measures and the means of capturing them; developing system data on impact.

25. The roll out of NHS Social Prescribing will be led by the ICB and there are some features that are specific (case finding, feedback into the patient's record) to that model. However, there are opportunities to work in partnership across this and the other initiatives to create a wider offer to our population if we work together across health and care and other partners to align our programmes and approaches.

26. The key features of the Maturity Matrix are set out below.

	Leadership & Governance	Workforce	Planning & Commissioning	Digital	Evidence & Impact
Neighbourhood (Primary Care Networks)	• Named SP lead in practice • Partnership working • Governance processes in place	• Access to high quality supervision • Access to IT • Population Health Management used to identify beneficiaries	• Unmet needs are identified routinely	• Access to GP IT systems • Use of prescribed codes identified & used in patient record	• ONS 4 evaluation tool used • Opportunities for feedback from individuals
Place (Oxon)	• Named SP lead in place • There is a co-produced SP plan • Governance in place	• Plan to develop the workforce • Cross sector working encouraged • Partnership working to ensure support services availability	• SP developed with partners • Unmet need shared across partners • SP built into clinical & care pathways	• Development of SP digital systems • Up to date service directories	• Leaders work with neighbourhood & system partner to capture ONS4 data
ICS (BOB)	• Senior Officer in place for SP • Links to & support for Voluntary sector • Senior Officer works across sectors & localities to produce a BOB SP strategy	• Frameworks used to inform recruitment & development for SP Link Workers • Peer support networks developed across • Focus on SP Link Worker retention	• Unmet need data gathered to inform planning • Population Health Management informs commissioning • SP- strategy includes long term investment plan for voluntary sector	• ICS has capability to link datasets between all health sectors • People can self-refer to SP using digital technology	• Benefits realisation model in place • Routine collection of data that shows impact of SP on health and social care services

Next steps

27. The Deputy Director, Integrated Commissioning has established a *Promoting Independence and Prevention* group that has brought together Public Health, District Councils, NHS, primary care, voluntary and community sector (including Social Prescribers), and Adult Social Care to develop ideas and practice around prevention and community capacity and capability. The PIP group is well-placed to link the development of NHS Social Prescribing and other strands and is leading the following initiatives
    (a) Development of Community Capacity, social capital and our information and advice offer
    (b) Development of pilots in Primary Care Networks that bring together local NHS and other Social Prescribers together with other services (such as Carers Oxfordshire, Dementia Support Service) to
        (1) Build local relationships and develop understanding of what is available within the local community
        (2) Improve approaches to referral and co-ordination
        (3) Identify gaps in local provision
        (4) Identify good practice and opportunities to increase impact and efficiency
        (5) Inform the local implementation of the NHS Social Prescribing Model in line with the Maturity Matrix framework
    (c) Further mapping that particularly considers the role of City and District Council hubs; the commissioning and resourcing routes for Social Prescribing and opportunities for alignment of these; wider opportunities around arts and culture, and access to green spaces
28. There is a need to bring the ambition, activity and plans set out in this paper into one place. This is endorsed by the partners within the PIP group. As local Place systems and structures develop it is proposed that
    (a) The PIP group led by the Deputy Director, Integrated Commissioning develop an approach to the implementation of Social Prescribing in Oxfordshire across health and care. This would include a review of the membership and scope of the group and should consider the opportunities for co-production with our wider community
    (b) The PIP group develop a plan and report into the most relevant Place forum. This will be confirmed when NHS and LA Place governance arrangements are more developed

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Annex: Nil

Background papers: Nil

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October 2022