Oxfordshire
Clinical Commissioning Group

Report for the Health Improvement Board, 13th September, 2018

Social Prescribing in Oxfordshire

1.0 Context

Social prescribing was highlighted in 2006 in the White Paper '*Our health our care our say'* as a means of promoting health, independence and access to local services. The objectives of social prescribing also support the principles set out in subsequent NHS policy documents, including '*The NHS five year forward view'* (2014), which promotes a focus on prevention and wellbeing, patient-centred care, and better integration of services, as well as highlighting the role of third sector organisations in delivering services that promote wellbeing. More recently, the *General practice forward view* (2016) has also emphasised the role of voluntary sector organisations – including through social prescribing specifically – in efforts to reduce pressure on GP services.

(King's Fund, 'What is Social Prescribing?)

1.1 Definition

There have been several definitions of Social Prescribing. The King's Fund (2017) describe social prescribing as a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. White and Salamon (2010) define social prescription as being 'preventative, social, non-medical, flexible, demand-led and evidence-based.'

Social prescribing seeks to address people's needs in a holistic way, recognising that people's health is determined by a range of social, economic and environmental factors. It aims to improve mental health outcomes for patients; improve community well-being and reduce social exclusion (Bungay et al, 2010). It also aims to support individuals to take greater control of their own health.

The beneficiaries of social prescribing are varied, but mostly it is targeted at people with "social, practical or emotional needs" (Brandling & House 2007, Brown et al 2004) and the schemes are typically provided by voluntary or community sector organisations (King's Fund 2017).

1.2 Evidence

There is increasing evidence that social prescribing can have positive benefits to patients in terms of emotional, mental and general wellbeing and levels of depression and anxiety. For example, a social prescribing project in Bristol found

improvements in anxiety levels and in feelings about general health and quality of life.

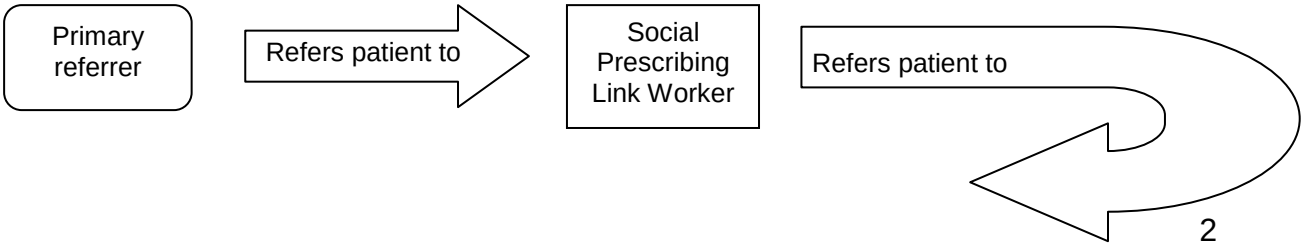
It has been estimated that 20% of patients consult their GP for what are primarily social problems (*Torjesen,2016)* and the Low Commission (2015) reported that 15% of visits to GPs were for social welfare advice. There is evidence that social prescribing schemes may lead to a reduction in the use of NHS services. A scheme is Bristol showed reductions in GP Practice attendance rates for most people who had had a social prescribing intervention. In addition, a scheme in Rotherham showed that for more than 8 in 10 referred patients who were followed up three to four months later, there were reductions in NHS use for accident and emergency (A&E) attendance, outpatient appointments and inpatient admissions.

However, robust and systematic evidence is limited and most studies are small scale and qualitative with self-reported outcomes. The cost effectiveness is also difficult to determine, however, economic analysis of the Rotherham project suggested that it could pay for itself in 18-24 months in terms of reduced NHS costs.
(King's Fund, 'What is Social Prescribing?)

2.0 Social prescribing models

The University of Westminster 'Making Sense of Social Prescribing' states that 'schemes will be and should be different in different areas. Despite the differences, there are essential ingredients that successful social prescribing schemes have in common.' One of these essential ingredients is the link worker. This involves the primary referrer (usually a healthcare professional) referring patients to a link worker (who can have varying job titles such as Practice Care Navigator; co-ordinator etc). The link worker uses motivational interviewing and action planning to co-design a non-clinical social prescription that will aim to improve their health and wellbeing and use services provided by the voluntary and community sector *(Social Prescribing Network).* Funding for all projects in Oxfordshire (apart from South West) has been to enable recruitment of the link worker post(s).

Onward referrals can be to a variety of activities and services which are usually provided by voluntary and community sector organisations. Examples include volunteering; arts, such as singing and dancing; gardening; befriending; lunch clubs; benefits advice and a range of sports and physical activity initiatives. The link worker will follow up with the patient to ascertain their take up of the referral and if not, explore the barriers. Sometimes the link worker will accompany a patient to a voluntary sector group or initiative for the first time.



3.0 Evaluation and Outcomes

Broadly, each project is collating data and using patient outcome measures (e.g. Warwick & Edinburgh Mental Well Being Scale). KPIs measured are generally: reduced GP appointments for non-medical reasons; reduced emergency admissions and reduced A&E attendance where applicable. However, there will be project specific variations.

3.1 Elemental software

This software offers the opportunity to develop an infrastructure that might enable a number of prevention initiatives to be managed and tracked, as well as acting as an embedded referral process operating from within the EMIS system. Elemental links with EMIS but is able to track patients through their pathway and have outcomes embedded within it, which are visible to clinicians using EMIS. It allows the referrer to see any goals set and whether these have been met. The licence cost is £20 per patient/service user and OxFed is piloting it as part of their Practice Care Navigator scheme.

4.0 Principles for Social Prescribing

As the Oxfordshire system moves towards an integrated care system it will be important to have a set of overarching principles for social prescribing that can be applied at locality or Practice level. Whilst recognising that all schemes should reflect local needs, OCCG has recommended a set of agreed principles to be used, which would apply to all social prescribing schemes.

Proposed principles include:

a) Analysis of local need and identification of cohorts most likely to benefit
b) Person related outcomes in terms of physical activity, mental wellbeing, connectivity with others, better able to manage their own health and wellbeing, better able to manage practical issues such as housing, money etc.
c) System related outcomes to include a reduction in non-elective admissions and A&E attendances, as well as a reduction in the number of visits to the GP.
d) Single system of evaluation against pre-determined outcomes.

e) Patients and stakeholders are involved in the scheme design to ensure it best meets patient need.
f) Scheme delivers value for money.
g) Robust information on the voluntary and community sector offers must be developed so that people can be appropriately referred on.
h) The voluntary/ community sector support to which the person is referred will not normally be funded through Social Prescribing.

5.0 Social Prescribing Schemes in Oxfordshire

Scheme	**Locality**	**Funded/ Model**
OxFed Practice Care Navigators (PCNs)	Oxford city	Funded by OCCG. Prime Minister's Challenge Funding (PMCF) for this project was initially for working with frail, elderly, housebound patients. It is now expanding to work with other adults who are identified as vulnerable and would benefit from Social Prescribing. The model follows the primary referrer referring to the PCN who makes onward referrals to the voluntary and community sector. This type of link worker would be part of the bronze/silver frailty pathway helping to build resilience.
Hedena Health (Barton surgery)	Oxford city	Practice funded. The project is delivered from Barton branch surgery which employs their reception staff member part time as a Social Prescribing Co-ordinator. The model follows the primary referrer who refers to the co-ordinator who makes onward referrals to the voluntary and community sector.
Chipping Norton Health Centre	North Locality	Practice funded. The surgery employs one of

		their reception staff part time as a Social Prescribing Co-ordinator. The model follows the primary referrer referring to the co-ordinator who makes onward referrals to the voluntary and community sector.
Cherwell/ West Oxfordshire (VCSE Fund)	North, North East and West Localities	Scheme initially funded by the PHE/ DH VCSE fund. Expected to start October 2018 Funding phases out with full contibution required from Yr 4 from OCCG and WODC and CDC. Citizens Advice will employ 1 Lead Navigator and 2 Community Navigators and recruit volunteer Link Workers to engage patients referred by identified referral sources and self-referrals.
Practice Care Navigators	South West Locality	Practice funded – mainly in Abingdon following PMCF pilot. Active signposting is in all the practices, where Care Navigators refer to relevant community information through use of the COACH website.
Age UK	South East Locality	CCG funded with non-recurrent funding (12 month project). Scheme expected to start September 18. The service will build 35 hours of additional capacity into the Community Information Network, which connects people to sources of support within their local community. The additional capacity will provide a named, dedicated Community Networker for each 'cluster' of GP practices, who will work closely with the practices, taking referrals directly from GPs and other members of the primary health care team.
Mind Wellbeing workers	Oxford city and South West locality	This will act as a social prescription model linking patients with mental health issues with appropriate

		wellbeing services which have a mental health interest. They will use Mind well-being link workers based in Practices who will also deliver short interventions where appropriate. In Oxford city the Elemental software will be used to track patients and outcomes.

6.0 Purpose of the Paper

Through this paper, OCCG is requesting the Health Improvement Board to:

- Ratify Social Prescribing as a means of supporting patients to improve their health and wellbeing through being better socially connected;
- Agree that a cross organisational approach is required, recognising that people's health is determined by a range of social, economic and environmental factors;
- Agree to the proposed Social Prescribing principles;
- Agree to monitor and review the progress and outcomes of Social Prescribing schemes in Oxfordshire.

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