Social Prescribing in West Norfolk - update

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Introduction to Social Prescribing

- **Prescribing non clinical services** - Enable GPs, nurses, adult social care and other primary care professionals to refer people to a range of local, non-clinical services.
- **Holistic Approach** - Addresses people's needs in a holistic way - supporting individuals to take greater control of their own health and increase their Independence.
- **Benefits** - Works on issues that may impact now or in the future on people's health and wellbeing, such as:
  - Benefits and Debt
  - Employment
  - Family & Relationship
  - Fitness
  - Housing
  - Loneliness
  - Memory problems
  - Approaching needing Social Care Support
  - Caring responsibilities
  - Immigration
  - Low Mood or Low Level Anxiety

What does the service offer?

Living Well Workers – support people up to five times

Community Resources - Normally involves a link worker who helps people access local sources of support often provided by voluntary and community sector eg:

- Volunteering,
- Arts activities, hobbies
- Group learning,
- Befriending,
- Cookery and healthy eating
- Sports
- Steps towards employment
- Sign posting on to other organisation and support group

Norfolk wide project

- **Funding** - Social Prescribing is now live across Norfolk. There is two year funding from Norfolk County Council, funding provided by the Improved Better Care Fund.
- **County Approach** - In each locality a slightly different approach is being taken in order to respond to different local needs
- **Key outcome** - Key goal is to help reduce unnecessary demand on front-line health and social care services. Helping to manage the demand but improved outcomes for people.

Locality lead organisation

- **South Norfolk District** – South Norfolk District Council lead- linked to Early Help structure
- **North Norfolk District** - North Norfolk District Council lead - linked to Early Help structure
- **Broadland and Norwich District** - AGE UK lead (working with Shelter, Equal Lives, MAP, CAB) – quality assured advisors
- **East District** – DIAL (with GY and W MIND) – GP reception staff trained as care navigators able to triage and refer on to other services where GP not most appropriate
- **West and Breckland District** – Community Action Norfolk leads (with a partnership of local VCSE providers)

Service Delivery and Evaluation

- **Target group** - Support adult over 18 years old.
- **Time limited support** - Time limited support to encourage independence and empower individuals to take charge of their life.
- **Referral Routes** – These are accessed through a referral from:
  - GP/ Integrated Care Coordinators in each practice through locally agreed mechanisms
  - Adult Social Care, Front Door – Tel: 0344 800 8020
- **Shared set of outcomes** with overall evaluation by NCC and Public Health.
- **Workers role**- **Living Well Connectors** – their role will provide:
  - **Holistic Approach** - One to one holistic person centered approach – base on their needs
  - **Community Connections** - wider range of other organisations/groups/ activities/advice and monitor the progress of these connections.

Approach in West

- **‘Living Well Workers**’ (LWWs) hosted at each partner organisation to support patients.
- **GP cluster groups** - LWWs hosted by our partners and assigned to each cluster of GP surgeries locally :
  - King’s Lynn: West Norfolk MIND
  - Swaffham: Family Action
  - Fens: Homegroup
  - Coastal: West Norfolk Carers
- **Referrals routes**
  - **Health - C.A.N**. and are automatically sent through to appropriate LWW
  - **Social Care** - referrals via the NCAN system

Latest news – Where are we now in West Norfolk

- **West LWW posts have been recruited to** – starting to see referrals come in.
- **Induction programme underway** – ongoing training for staff
- **Increasing links in with GP** - LWWs are going round GP surgeries to establish connections and build awareness and relationships
- **Local governance in place –** involving key partners
- **County Group** – Lead by Norfolk County Council
- **Michelle Paterson** - Social Prescribing Lead Commissioning Manager

Presenting reason for referrals

- **Referrals on the increase**
- **Top 5 presenting reasons for referrals**
  - People raising Housing needs
  - People with Mental health conditions
  - People who are Social Isolated
  - People with Dementia and/or memory loss
  - People with specific health conditions

Next Steps?

- **Improve communication –** in localities and across the county (including linking to social work 3C's model)
- **Build links with GP's** - Continuing to build relationships with GPs, encouraging referrals
- **Establishing a feedback loop with GPs** – working out how we update referrers with info about the outcomes for individuals
- **Continuing to train** and develop LWWs
- **Review outcomes** – locally and across the County
- **Further develop partnerships** – with local organisation
- **Outcomes** - Central approach to outcome framework