Community First Yorkshire

Social Prescribing and Community-based Support

Guide and Toolkit for North Yorkshire`s Voluntary and Community Organisations

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1. Introduction

This Social Prescribing Toolkit has been produced by Community First Yorkshire to provide an overview of what social prescribing is and how voluntary and community sector organisations can best prepare themselves to respond to referrals from the health and social care system.

Social prescribing is not new to North Yorkshire. Voluntary and community sector (VCS) organisations have a long established role supporting and improving the lives and wellbeing of people in our communities. North Yorkshire County Council (NYCC) has invested in social prescribing for some time through the Living Well service. The difference now is that NHS England has developed an approach to social prescribing with funding through GPs to appoint link workers who have a role to support and help people access non-medical help and interventions.

The aims of the toolkit are:

- to consolidate information available to guide and support social prescribing in North Yorkshire
- to set out the changes within the wider health sector and reason for introducing the approach
- to outline the process for referral and what role different organisations have in the health and social care system
- to detail what VCS organisations should have in place to respond to referrals and the resources they will need
- to provide a toolkit/checklist to self-assess readiness and where to go for resources and support.

This document incorporates information taken from various sources, most notably the **NHS Summary Guide to Social Prescribing**. The NHS Summary provides more detailed information.

The toolkit will evolve over the next few months with the notable impact of Covid-19, and increased call upon community-based support as people start to re-engage in social and connecting activities. It is designed to be a changing source of information and practical resources.

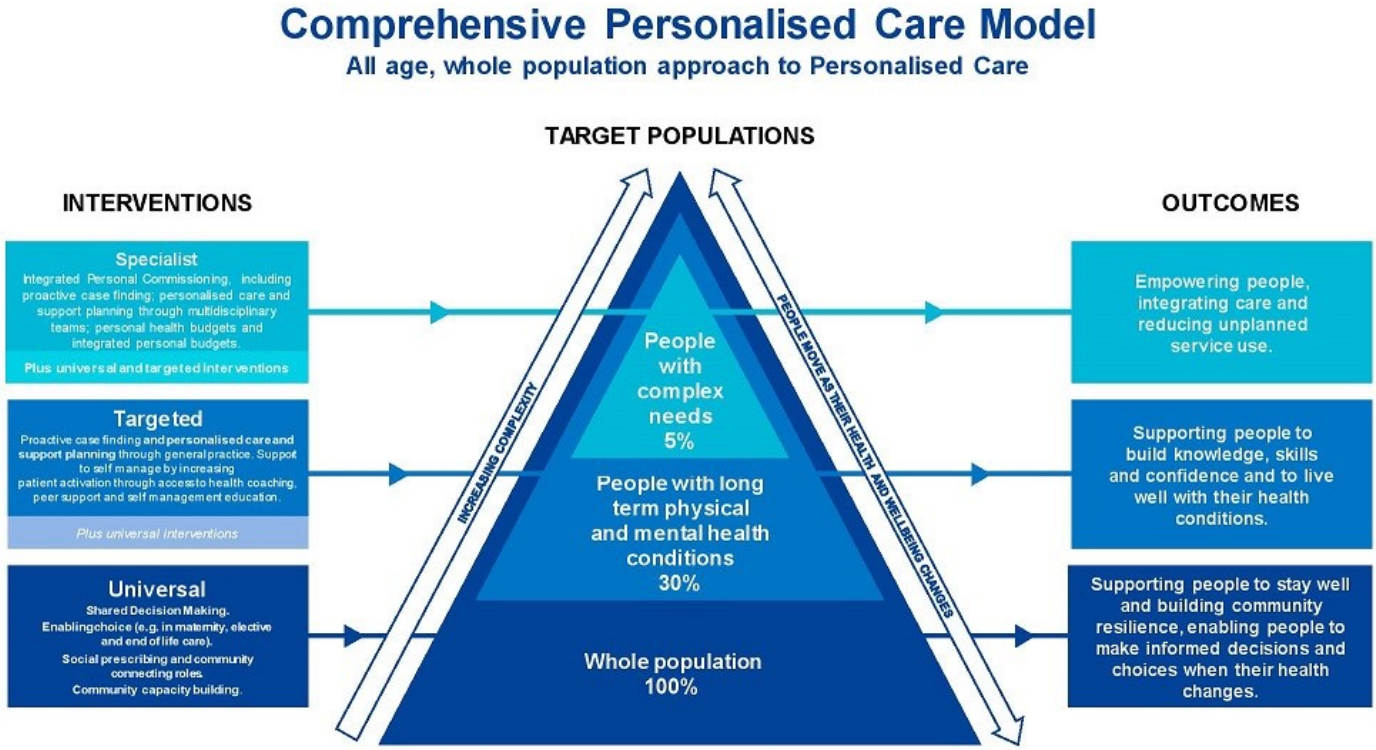
If you find there is anything missing from this guide which would be useful for others, please contact **communitysupport@communityfirstyorkshire.org.uk** and we will look to update the version.

The document is available on the Community First Yorkshire website **www.communityfirstyorkshire.org.uk**

2. National health and social care context

Social prescribing and community-based support is part of the **NHS Long Term Plan**. It is part of the overarching vision for 'Personalised Care', taking a whole system approach by integrating services around the person.

Personalised Care means people have choice and control over the way their care is planned and delivered, based on 'what matters to them'. This means a comprehensive whole population approach. The model brings together a wide range of service providers and stakeholders.



www.england.nhs.uk/personalisedcare

The model has six inter-linked components, with social prescribing and community-based support as an integral part:

1. Shared decision making
2. Personalised care and support planning
3. Enabling choice, including legal rights to choice
4. Social prescribing and community-based support
5. Supported self-management
6. Personal health budgets and integrated personal budgets.

Social prescribing enables all local agencies to refer people to a link worker. When social prescribing works well, people can be easily referred to local social prescribing link workers from a wide range of local agencies, including GPs, local authorities, pharmacies, multi–disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social car services, housing associations and voluntary, community and social enterprise organisations. Self-referral is also encouraged.

Link workers include a range of workers and job titles such as wellbeing advisor, community connector, community navigator, community health worker, community health agent or health advisor. Whilst the names may be different, the core elements of the roles remain the same, hence the generic 'link worker' term. These link workers operate closely with and within the 16 primary care networks (PCNs) in North Yorkshire. Details of the PCNs can be found at **Healthwatch North Yorkshire**.

Link workers:

- are attached to GPs and PCNs, made up of GP practices, where they take referrals from a range of local agencies
- are employed by the GP practice/PCN or are roles contracted out to link worker providers
- are proactive in developing strong links with all local health and social care, and other support agencies to encourage referrals into the social prescribing system, recognising what they need to be confident in the service to make appropriate referrals
- identify the wider issues that impact on a person's health and wellbeing, such as debt, poor housing, being unemployed, loneliness and caring responsibilities
- work with individuals to co-produce a personalised support plan
- meet people on a one-to-one basis, making home visits where appropriate, build trust with the person, provide support
- work with the person, their families and carers to consider how they can all be supported through social prescribing
- actively support access and provide the link to services and activities to improve health and wellbeing
- are a source of information about wellbeing and prevention approaches

NHS Long Term Plan commitments:

- Roll out of the NHS Personalised Care model across the country, reaching 2.5 million people by 2023/24 and then aiming to double that again within a decade.
- Through social prescribing the range of support available to people will widen, diversify and become accessible across the country. Link workers within PCNs will work with people to develop tailored plans and connect them to local groups and support services.

3. What is social prescribing?

The **Health Creation Alliance** describes health creation as the process through which individuals and communities gain a sense of purpose, hope, mastery and control over their own lives and immediate environment. When this happens their health and wellbeing is enhanced. The alliance and its partners have found people need three things to be well: confidence; connection and control.

Social prescribing is a local mechanism to help people to become more confident, connected and in control of their lives and this in turn helps them to be well. Sometimes referred to as community referral or introduction, social prescribing is when GPs, nurses and other primary care professionals like a 'social prescriber' introduce people to a range of local, non-clinical services, often run by local community organisations or charities. This introduction helps people to access opportunities which enable them to reconnect socially with others through a range of activities

such as local craft making, walking groups, food growing projects, local support groups for people with chronic conditions or volunteering.

What good social prescribing looks like – for people

- people, their families and carers know about social prescribing and can be easily referred
- builds on 'what matters to me' and is based on a person's abilities, needs and preferences
- support to take the first steps, such as an introduction to community groups
- people develop knowledge, skills and confidence
- people can self-refer
- develop sense of belonging that comes from being part of a community, social group and activity
- promotes physical activity, improves mental health and can reduce loneliness and anxiety.

What good social prescribing looks like – for communities

- communities are stronger and more tolerant, and more people volunteer
- communities understand the power of social prescribing and making connections in reducing health inequalities and social isolation
- communities are aware of how social prescribing encourages development and increases community assets and informal support
- communities work to ensure services are fully accessible to all, including those in greatest need
- communities recognise the NHS, local authorities and statutory service alone cannot meet everyone's needs
- VSC organisations are supported to receive referrals and deliver services
- communities support people who participate in social prescribing, improving their confidence and ability to manage their own wellbeing.

What good social prescribing looks like – for the health and social care system

- social connector schemes are available locally and collaboratively commissioned
- social prescribing link workers are attached to GPs and PCNs
- there is a clear and easy referral process for all agencies involved, helped by the availability of directories (as listed in Checklist B later in this guide)
- link workers have strong knowledge of local community groups, map community assets, recognise gaps in community provision and encourage asset-based community development
- link workers complement, and connect to, other relevant approaches in the local area, such as active signposting or local area coordinators.

Model for social prescribing

NHS England has engaged a wide range of stakeholders, including people with lived experience, GPs, social prescribing link workers, local authority commissioners, Clinical Commissioning Groups (CCGs) and the voluntary and community sector, to set out the key elements of what makes a good social prescribing scheme and what needs to be in place locally into one diagram.

1. Collaborative commissioning and partnership working
   - all partners build it together
   - local relationships matter
   - the VCS is involved from the start.

2. Easy referral from all local agencies
   - a wide range of local agencies are able to refer to social prescribing in order to coordinate support around the person and encourage partnership working
   - informed decision-making happens before referral to social prescribing to ensure people can exercise choice, they know what to expect from social prescribing, and that it is right for them
   - easy referral with local GPs.

3. Workforce development
   - link workers need suitable support and training
   - the wider workforce has an understanding of social prescribing to enable appropriate referrals.

4. Link workers employed to give time
   - fundamental feature of good social prescribing
   - reduce health inequalities by addressing the wider determinants of health

- increases people's active involvement with their local communities
- link workers typically work with people through 6-12 contacts over a three-month period
- typical annual caseload of up to 250 people.

5. What matters to you?
   - what matters to the person – they have a simple plan reflecting their priorities, interests, values and motivations
   - community groups and services the person will be connected to
   - what the person can expect of community support and services
   - what the person can do for themselves, in order to keep well and active.

6. Support for community groups
   - to plan ahead, for social prescribing to be embedded across all local areas
   - funding - shared investment fund bringing together all local partners, commissioning, small grants, enable people to use their Personal Health Budget (PHB) to pay for support in the VCS
   - making safe referrals, ensuring both people and link workers are safe, includes appropriate insurance, safeguarding, lone working, first aid (including mental health first aid), data protection, DBS checks, food safety and working with vulnerable citizens.

7. Common Outcomes Framework locally driven
   - impact on the person
   - impact on the health and care system, evidence suggests GP consultations reduce by an average of 28% and Accident and Emergency attendances by 24%, data will test this
   - impact on community groups, will identify growing 'confidence' through the NHS regular survey of community groups and identify development needs.

4. Safe referrals and quality assurance

Link workers will:

- Identify diverse local community services, groups and VCS organisations in the local neighbourhood and beyond.
- Create an easy to read 'menu' of diverse local community groups and services, which can be used to explain what support is available locally.
- Build in regular catch-ups with local community groups and VCS organisations, to check what capacity they have for new people and to overcome any challenges.
- Include small, informal community groups in connecting people through social prescribing, which may not have formal policies and procedures.
- Where needed, arrange to go with the person to their first community group session. Support them to get through the door, get settled and feel comfortable.
- Where there are gaps in local community activities, encourage commissioners and local infrastructure agencies to support the development of diverse new community groups.

The referral process and quality assurance will improve the connections between health, social care and the community, facilitating more effective integration of local services.

Quality assurance is a delicate balance, which must be proportionate and take a common-sense approach. Voluntary organisations and community groups involved in social prescribing should have appropriate arrangements in place to ensure that people have a safe and positive experience.

The following table sets out the principles which underpin quality assurance for social prescribing.

Quality Assurance Principles	
1	Social prescribing supports people to make informed choices about engaging with community groups and VCS organisations.
2	PCNs cannot be held responsible for the choices and actions that people take after being connected to community groups and VCS organisations. This is down to personal choice for the person.
3	Link workers (on behalf of PCNs) can make basic quality assurance checks, using the prompt sheets provided, to ensure they are not connecting people to community groups and organisations which they consider to be unsafe.
4	The prompt questions on Checklists A and B, later in the document, are designed to develop constructive conversations between the link worker and the VCS organisation or community group and building trusting relationships. They should help to build confidence and be inclusive, to celebrate informal groups and, wherever possible, enable them to be involved.
5	This process should not be used in a rigid way to exclude smaller groups because they do not have formal policies. Many small, volunteer-led community groups, such as knit and natter, café conversations and meeting in the local pub, provide excellent informal peer support. It would be unrealistic for them to have formal policies and procedures. The link worker should have constructive conversations, using scenarios, to help group members think about how they safeguard group members and vulnerable people.
6	Proportionality is required, as is taking a common-sense approach.
7	Where a safeguarding concern is raised by the person, a volunteer or staff member, there should be clear procedures for dealing with this swiftly and appropriately.
8	The process will improve the connections between health, social care and the community, facilitating more effective integration of local services.
9	An essential ingredient of quality assurance is ensuring that community groups are diverse, inclusive and culturally sensitive.
Source: Personalised Care. Social prescribing link workers: Reference guide for primary care networks – Technical Annex	

5. Best practice Checklists A and B

Short self-assessment checklists have been produced in this document, detailing recommended best practice policy and governance requirements for organisations to have in place, as well as referral and management processes to work effectively with link workers. The checklists can be downloaded and used as working documents to record the resources organisations have in place and actions to be taken.[1]

Checklists A and B have been produced from national guidance and information from link workers about their expectations and practices:

Checklist A - Policies and governance

Checklist B - Referral and management. Relevant to all employees and volunteers.

It is recognised that many VCS organisations will have much or all of the good practices in place. Specific requirements and details of referral processes will vary across North Yorkshire depending on the link worker and their practices.

Checking what policies and procedures are in place against the requirements listed in checklists A and B will identify any organisational gaps and actions needed to meet the requirements. Organisations which have these policies and practices in place are best placed to engage with the health and social prescribing system, and develop overall operational practices. The checklists are intended as prompts.

Checklist A - Policy and governance requirements

Many voluntary organisations and charities that provide services will already have quality assurance policies and procedures in place, particularly where they employ staff.

Link workers will ask key questions of VCS service provider to ensure necessary policies for quality assurance are in place.

The self-assessment Checklist A**,** lists policy and governance documents and provides links to national and Community First Yorkshire resources which will help groups to establish how relevant the document is to the organisation and activities. The checklist also includes links to template documents. It is important to note a number of the requirements may not be applicable to every individual situation.

Checklist A provides an outline of the policies and governance expected from VCS organisations.

Checklist A - Policies and governance			
Requirement	**Is this relevant to us?**	**Evidence/ What we need to do**	**Help and further information**
Does your organisation have a governing constitution?	Does your group have a constitution which guides how the group/organisation operates?		**Example constitution from Community Impact Bucks**

[1] The website links for further information are correct at the time of publication.

Is your organisation registered with the Charity Commission?	If not, should it be?		**Register your charity with the Charity Commission**
Public Liability Insurance	Required for all organisations		
Safeguarding policy and procedures	Does your group have safe working practices and safeguarding in place?		**North Yorkshire Safeguarding Adults Board** **Safeguarding resources for your organisation on Community First Yorkshire's Community Gateway**
Risk assessments for lone working	Do you have workers including volunteers working alone?		**Lone working guidance from the Health and Safety Executive**
Confidentiality, Data Protection and Information retention,	Does your group keep information about members or people who are referred on paper files or online, and are General Data Protection Regulations adhered to?		**Guide to Data Protection** **Data Protection factsheet from Community First Yorkshire**
Health and safety risk assessments	Health and safety risk assessments should be carried out, for all activities, when starting new or making changes to activities and using equipment. Food handling certificates are needed if your group provides catering and refreshments.		**Health and Safety resources for your organisation on Community First Yorkshire's Community Gateway**
Equality and diversity	No one should be discriminated against on the grounds of race, age, disability, gender and the other protected characteristics covered by the 2010 Equality Act.		Equality is about being fair and making sure that everyone can fulfil their potential. Diversity is about recognising and valuing everyone's differences. Information **here** from Engage Learning may help you formulate a policy

Checklist B - Referral and management requirements
In addition to policies and other documents, link workers will ask key questions of VCS service providers to check processes and capabilities are in place to respond to referrals.

Checklist B provides an outline of the referral and management expected from VCS organisations.

Checklist B - Referral and management. Relevant to all employees and volunteers			
Requirement	**Is this relevant to us?**	**Evidence/ What we need to do**	**Help and Further Information**
Information on on-line directories for link workers to access	Is your organisation listed on relevant on-line directories such as North Yorkshire Connect and local directories? Is the information current?		**North Yorkshire Connect**
Recruitment of new members of staff and training volunteers	How does your community group support new members of staff and volunteers and ensure that everyone is supported to build skills and confidence within the group?		**Volunteer support from Community First Yorkshire**
Awareness of local link worker	Does your organisation know who this is and made contact?		GP practice information
Process for handling referrals/new service users	Staff and volunteers know how to interact with clients and have a common approach to build empathy and support clients to engage in the service.		This will vary between organisations
Quality assurance and other requirements to monitor outcomes are in place	What new information might be needed and can be captured and reported on? Are you clear on what update information the link worker needs from you?		This will vary between organisations
Client experience feedback	Service users are encouraged to give feedback, for reporting and service improvements. We are able to respond to changes as a result of client or link worker feedback.		This will vary between organisations
Adaption and service changes can be implemented	Able to adapt and change to meet client needs. We have clear processes for staff to know how to make changes and record new processes and practices in work instructions used by staff and volunteers.		This will vary between organisations

Data capture system and impact measured	Data systems must be able to record and report using the same data fields as link workers. Data will include recording and holding information on the person referred as well as outcomes.		A way to measure mental wellbeing from Warwick Medical School

6. Client data and measuring impact

Client data

Each delivery organisation may have different data requirement approaches and criteria. Data to be captured will include details provided by the link workers of the person being referred. This will be determined by each social prescribing scheme and may include:

- Personal details: title, first name, family name, address including post code, home telephone. mobile telephone, email address, NHS number, date of birth, next of kin, demographics such as gender, nationality, religion etc
- Nature of the referral
- Requirements of the person being referred (not limited to but could include): What the person would like support with
- Consent and contact preference.

Data Protection

The Data Protection Act 2018 controls how personal information is used by organisations, businesses or the government. The Act is the UK's implementation of the General Data Protection Regulation (GDPR). Information and guidance can be found **here**.

Measuring impact

Models for measuring impact will be in place and link workers will advise VCS organisations about the measures and data needed for monitoring the impact of the referral on clients' wellbeing and health.

A regularly used approach to measure personal wellbeing is **Warwick Edinburgh Mental Wellbeing Scale (WEMWBS)**. On this scale, data has shown that 74% of people accessing socially prescribed activity reported an increase in wellbeing.

Other measures used for measuring personal wellbeing include ONS4; a personal wellbeing overview, details can be found on the **Office for National Statistics website**.

Everyone who is referred to a social prescribing link worker should be asked at regular intervals to give easy feedback about the impact of social prescribing on their personal wellbeing.

Measuring impact may also be taken from self-reported outcomes from surveying individuals:

- continue living in own home
- feel more confident in themselves
- have social contact with people they like
- pay greater attention to health
- take up/return to a new hobby.

7. Jargon busting health and social care

Some of the language and abbreviations within the toolkit may be new to you. If so, the following websites and list may be helpful:

www.england.nhs.uk/participation/resources/involvejargon
www.nhsconfed.org/acronym-buster?l=P

Clinical Commissioning Groups (CCG): organisations that replaced the NHS Primary Care Trusts a few years ago; they are led by GPs in a local area and are responsible for commissioning (allocating money to) local health services to deliver patient care.

Healthwatch: Healthwatch North Yorkshire is available to help people find out about local health and social care services. They listen to what people think to help improve the quality of services by letting those running services and the government know what people want from care AND encourage people running services to involve people in changes to care.

Link worker: may also be called health advisor, health trainer or community navigator. They are not health professionals (like nurses or GPs) but they are trained to work in a social prescribing service helping the person who has been referred to them to find the right activity.

Link worker providers: across the county PCNs have considered which provider will best meet their requirements. There are a range of models operating that provide link worker support, including social care, health and VCS providers, and direct PCN employment. Some have decided not to invest in the link worker role for 2020/21. Link worker providers:

- Selby Town PCN and the four Harrogate PCNs (Heart of Harrogate, Knaresborough and Rural, Mowbray Square and Ripon and Masham) North Yorkshire County Council Living Well Service
- Whitby Coast and Moors delivered by Coast and Vale Community Action (CAVCA)
- Scarborough and Ryedale by Scarborough Care, Filey and Scarborough Healthier Communities Network
- North Riding Healthy Community PCN delivered by VCS leader group - Advocacy Alliance/Age UK/MIND
- Tadcaster and Selby PCN has employed its own link worker directly.
- Craven District, delivery of social prescribing falls with Modality and Wharfedale, Airedale and Cravendale Association WACA, a GP led alliance.
- As at August 2020 PCNs had not appointed link workers for 2020/21 in Hambleton South, Hambleton North and Richmondshire.

ONS4: the Personal Wellbeing Score (PWS) is based on the Office of National Statistics (ONS) four subjective well-being questions (ONS4) and thresholds.

PAM: The Patient Activation Measure is a validated, licenced tool that has been extensively tested with reviewed findings from a large number of studies. It helps to measure the spectrum of knowledge, skills and confidence in patients and captures the extent to which people feel engaged and confident in taking care of their condition.

PCN: Primary care networks. There are 16 primary care networks in North Yorkshire; each PCN is required to make an individual decision about their approach to delivering the link worker role. Some of the PCNs are working together on a co-ordinated approach – for example in Scarborough/Ryedale CCG area three PCNs are working together, and in Harrogate and Rural District with four PCNs working together supported by the Yorkshire Health Network.

Primary care: health care provided in the community (as opposed to in hospital, which is secondary care). Primary care includes GPs, community nurses and a range of other health workers such as community matrons, health visitors and mental health nurses.

Social determinants of health: the conditions in which we live and work that affect our health and wellbeing; these include our social networks (family and friends) as well as our access to education, training, work, shops and health services, and whether we feel safe on the street and have decent housing. All of these conditions have a big impact on our health and are skewed by poverty and wealth.

VCS: voluntary and community sector.

VCSE: voluntary, community and social enterprise.

8. Support and resources for community groups in North Yorkshire

If you are a voluntary or community organisation or a social enterprise in North Yorkshire, **Community Support North Yorkshire** provides expert advice and information to help with:

- funding and fundraising
- governance
- marketing and social media
- DBS training and safeguarding
- business and finance management
- recruiting and managing volunteers
- employment advice
- volunteer management
- volunteer recruitment
- volunteer policies
- training
- legal considerations.

To access or refer a group or organisation for support from Community First Yorkshire complete a simple **on-line enquiry form** at **www.communityfirstyorkshire.org.uk** or if it is easier email **communitysupport@communityfirstyorkshire.org.uk**

Organisations with volunteering opportunities can place their roles online using **Volunteering In North Yorkshire**. This is operated by Community First Yorkshire and people interested in volunteering can search the site for opportunities and apply online. Community Support North Yorkshire also provides resources and guidance for all aspects of good volunteer recruitment, management, motivation and retention as well as opportunities for training at **www.communitysupportny.org.uk**

To make sure local link workers, potential clients and others are aware of the services an organisation provides, register on **North Yorkshire Connect.** This is the community directory for the whole of North Yorkshire, offering local information from community and voluntary organisations. Groups need to register themselves for this free service. It also lists activities and things to do.

More local online directories are also in place and organisations can register with these, such as:

- **Where to Turn Directory:** a directory of regular community activities provided by the voluntary organisations across the Harrogate district, managed by **Harrogate & District Community Action**.
- **Compass EHUB: Compass** in Craven is third sector, social care and health together providing a connected and holistic service for the residents of Craven.