

Appendix 1: Social prescribing models

Area	How it is run	Description on offer
Culm Valley Integrated Centre For Health Social prescribing model	Health Facilitator with training in motivational skills	<ul style="list-style-type: none"> • Being a face to face health resource for patients referred by other professionals (particularly GPs) and self-referred • Provides advice on exercise, nutrition etc..., demonstrate means of self-care such as the free on line Thought Field Therapy programme (rather like CBT) and signpost to voluntary organisations or self-help groups • Acts as catalyst for these self-help/self-care groups, which includes groups for:- <ul style="list-style-type: none"> ○ Specific disease areas - e.g. patients with heart disease, diabetes and fibromyalgia. ○ Specific needs - e.g. “Knit and Natter” group for the socially isolated, Creative writing, printing and book reading groups for patients needing directed activity/socialisation. ○ Specific form of activity, often led by patients themselves, such as the Amblers Walking Group and Community Gardening Group. • Acts as the interface between local voluntary statutory agencies and individual patients and the surgery itself. This includes awareness of all local voluntary and statutory agencies, directing individual patients to them as necessary and working with individuals involved in them • Acts as the “face” of health promotion at the surgery/Integrated Centre with a room marked “Health Facilitator”, wearing an appropriate badge and being very much part of the “scenery” in the waiting room, café and other public areas of the Integrated Centre with advertised and availability in the waiting room and café. Her presence together with a range of self-care activities in the surgery (e.g. patients measure their own blood pressure/weight/BMI on an automated machine and can directly access Calm Zone – thought field therapy) extends the message and ethos of self-care to patients visiting the surgery (90% of registered patients will visit the Centre during the year) and community
Way to Wellness	Ways to Wellness holds the contract for developing the offer for and contracts for	Ways to Wellness is for people with certain long-term health conditions, aged 40 to 74, who attend GP practices within the pre-existing NHS Newcastle West Clinical

	social activities, training for link workers and raises funds and contracts with social investors and manages the referrals and data	<p>Commissioning Group area (now part of Newcastle Gateshead CCG).</p> <p>The eligible long-term health conditions are:</p> <ul style="list-style-type: none"> • Chronic breathing difficulties (COPD) or Asthma • Diabetes (Type 1 or Type 2) • Heart Disease • Epilepsy • Thinning of the bones (osteoporosis) • Any of the above with depression and/or anxiety
East Riding of Yorkshire	The Council has developed partnership with local GPs and leisure services and libraries	Direct referral by GP to exercise on prescription, Live well programme and books on prescription. This was seen as the most pragmatic approach and is funded by public health.
Blackburn with Darwin	Volunteering on prescription with project officer, care navigator and recovery support officers	<p>GP, social care or other council teams refer to CVS led 2 social prescribing volunteering scheme. One programme is aimed at people with drug and alcohol and the other is for people with mental health problems.</p> <p>Project officers link them with the most appropriate volunteering opportunity with the help of community navigator or recovery support officer</p>
Luton Council	In house social prescribing using the existing infrastructure in place – exercise on referral, volunteering. Care navigators were employed. The programme is funded by public health, better care fund and DCLG	<p>GPs refer to community navigator with patients setting on the goals and preference activities and the navigators arrange 12 week prescription. Patients are given smart cards which they scan when they attend activities so that the progress can be tracked and measured. The patient returns to community navigator after 12 weeks to have an assessment and progress towards self-care.</p> <p>The programme now has 20 accredited providers covering 5 areas- social activity, volunteering, physical activity, wellbeing and mental health, information advise and guidance.</p>

		Some of the services are run by the Council and some run by external organisations.
Rotherham	Voluntary Action Rotherham in partnership with 20 organisations have five social prescribing workers funded by CCG	<p>Integrated case management led by GPs and including social workers and other health professionals refer to social prescribing workers.</p> <p>The social prescribing worker visits the patient at their home to carry out a guided conversation with the patient and work out what prescription to offer. The prescription can be anything between 8-16 weeks which can include a range of activities such as metalwork clubs for men, range of exercise clubs. Patients can continue with activity after the prescription ends.</p>
Cotswold District Council		
Tower Hamlets	Tower Hamlets has a history of providing social prescribing in two GP practices, the Bromley-by-Bow Centre and the Mission Practice. In 2016, Tower Hamlets Clinical Commissioning Group funded an 18 month roll-out of social prescribing across the borough with the local GP federation, Tower Hamlets GP Care Group, acting as lead provider organisation. The service is delivered by 10 Social Prescribers (9 WTE) through Tower Hamlet's 8 GP Networks. Each GP	The range of needs Social Prescribers have supported clients with demonstrates how holistic the service is (for example, 24% clients presented with weight management issues, 21% with low level mental health needs, 16% with social isolation, 13% with housing issues and 13% with financial concerns) and the high number of onward referrals and signposts (2,034) to a large range of organisations (333 activities across 279 organisations) in the borough highlights the breadth of services available to primary care users through social prescribing. Nearly a quarter (22%) of clients receiving an onward referral or signpost were given 3 or more referrals.

	practice has a named Social Prescriber.	
Merton	<p>CCG and Public health funded a pilot with 2 GP practices with link worker at each practice.</p> <p>The existing service model involves employing a 'link worker' known as a Social Prescribing Navigator working at each respective practice two days a week. The link worker is visible to the primary care team, and encouraged to be seen as a fully integrated member of the practice team. The post holder has been given appropriate training on EMIS, and has a wealth of local knowledge about services available in the community, as well as strong links to community and volunteer organisations. The post holder is an employee of Merton Voluntary Service Council (MVSC) and is supported by this organisation</p>	<p>The referral is made when a GP refers a patient to the service and the Social Prescribing Navigator books a one-hour initial consultation. At this consultation the navigator offers strategies to self-manage the patient's problems by either:</p> <ol style="list-style-type: none"> 1) Sign posting – directing patients to non-clinical services / self-directed advice; 2) 1:1 Assessment service where needs are complex. 3) Assisting with form filling, benefits eligibility checks, and initial engagement in counselling. <p>Some other interventions include:</p> <ol style="list-style-type: none"> 1) Improving stability of home and family life; 2) Promoting better mental health and resilience; 3) Relationship guidance; 4) Volunteering; 5) Social connectedness to reduce isolation. <p>The patient is offered a follow-up appointment and the navigator records notes directly into the patient record.</p>

