Activity 3 - What should Social Prescribing look like in Stoke-on-Trent and North Staffordshire?

Full Summary

	What
	• Wellbeing hub and social hub – "where professionals/patients people go for information" (phone or online) • Navigator link worker (possible vol sector) • Co-located link workers – should be trained - SP navigations 'coordinaters' 'enablers' • Two way relationship between person and hub – bear in mind that it can be 'complex lives' as much as 'complex needs' and communities of interest are relevant • The same for Stoke-on –Trent and North Staffordshire?? • Local footprint • Flexible to individual depending on person's needs (buddying) • Volunteer champions – localised, GP linked, • Volunteers from multi -cultural areas and engaging other groups on awareness • Proactive system - needs to be before they see GP • Coming together infrastructure - Community resilience • Prescriber model • Prescription (e.g. dietary advice/ lifestyle/befriending) • Data Collection with data collection, outcomes and feedback • Must be done in collaborative way to avoid postcode lottery
	Who – Target Group/Criteria
	• Work needed on access criteria and referral routes (Fire and Rescue Service, etc) • People that go to GP for company / Loneliness lack of confidence – link to health literacy • Target Group; High need, identifiable patients • Long-term conditions • Frequent attendees • Low level anxiety • Target patient group
	Where
	• Impact should be 'Middleport' – community model • Do in ward GP clusters? Or 5 community hospital sites - could they be early adopter sites? – locality models • Early adopter sites based on community hospitals • Non-medical / access children's centres / via employers • Where / face to face / local - 1 or 2 access place per locality – GP practice, community centre, networks • Access roots in – libraries, pharmacists, dentists • Framework of referrers as wide as possible • Where to advertise/make information available to everyone - schools, social media, supermarkets, noticeboards in the community, community groups/networks • Part of the GP practice – because communication sharing is so important
	How
	• Practical system of achieving – need to make it as easy as possible • Learn from people who have done this elsewhere • Needs support - value and grow

- Demographics need to dictate
- Provider must have resources (money), resources / people to deliver, useful information about the person
- Personal Health Budget – can this be used for social prescribing?
- Creative finance option
- How to access
- Self-referral -persons own recognition
- Referral process – Community practitioners / GPs (PCSO's / Fire Service) – connected up
- Referral process which is easy to refer in, co – designed, prescription should follow with no duplication of information
- Single point of access – depending on what it is? An area
- Cross referrals between agencies
- HV/Health care professionals in community
- Social prescribing – education and training for all healthcare staff
- x number of paid link workers across GP locality
- All the information needs to be available in different languages
- Manage gaps in services and activities available to people – important the charities get together, communicate, deliver activities together and share information. They can add value and benefit if they 'manage the market' and provide different activity/service groups to the community – might improve funding.
- Awareness of capacity of the services link workers are signposting to
- Careful not to overwhelm them – third sector
- Need a relationship with the GP's/link workers who prescribe to us
- Access to community development funds for new local activity
- As broader network as possible
- Multi-agency
- Use current assets
- Support groups / befriending service
- Volunteers for different conditions (personal interests)? Would this work better?
- Good links between volunteers and professional workers
- Need the "space" to deliver the activity –knowledge of hubs / buildings
- Dedicated info / knowledge base e.g. VCS hub
- Accessibility – rural issues / other barriers

Social Prescriber Role

- Navigator – central point , for those needing support and help
- Not an 'add on job' it's a profession
- Prevention role
- Person centred – think outside the box
- The Person - Ask them! LISTEN, Support them to do it!, Do it!, Feedback/Celebrate
- Face to face , Telephone, Flexible approach to meet persons needs
- Face to face
- Should offer choice of face to face / personal contact
- Digital aspect for those who have the ability to find info out/interactive
- Using tech for increased accessibility e.g. 'live chat'
- Use of tech e.g. facetime
- Noticeable difference within, GP practices – feedback to the 'navigator'
- Takes time to unpick real need

	• Time to understand and listen (guided conversation) • Offer guided conversation • Decide with the person • Need longer (40 mins) than the GP 10 minutes • Pull in support where required • Support to access community/ groups • Support people to access services – hand holding Signposting to safe places and spaces/ framework for link worker, knowledge, training • Relationship building between GP and voluntary sector • Embedded – creates greater knowledge • Meet with others locally – share ideas and knowledge • Knowledge of activities in local areas/hubs • Feedback / review - localised navigators feeding into a hub specialist knowledge coordinated • Know what's going on across area • Need to know what's going on across the patch but also very locally too • Understand the city • Supporting roles to help prescribers • Prescriber and link worker – need a skilled link worker • Link workers – passion, enthusiasm 'enablers / coordinators' -co located, known to all practices across localities and common meeting places • Personal skills of link worker • Shared intelligence around target groups • Backed up by technology to hold data e.g. Staffordshire connects
	Data Collection and Sharing
	• Proportionate and appropriate • Referral process – needs to be really simple • From multiple sources GP, Social care • Group feel needs to review the evidence and working models – not reinvent the wheel • Sample data sharing • One single client management system / so it is tracked and monitored • Before/after quality of life questionnaire • Opt in system for the individual – to all services at the beginning is key - needs to be carefully worded. • Communication - online sharing, information of groups or gate way telephone number / centre point – link like VAST • 'supported' by a database