Bassetlaw
Place-Based
Partnership

BCVS
Bassetlaw Community and Voluntary Service

#WorkingTogether

Social Prescribing in Bassetlaw

Contents

Acknowledgements:

We would like to thank all Bassetlaw Place Based Partnership members, including VCSE organisations working to support Bassetlaw residents, for their contribution to this review. In addition, we would also like to thank Nottingham and Nottinghamshire Integrated Care System colleagues for the warm welcome to the Nottinghamshire System.

Executive Summary

Social prescribing is a process to help people make positive changes in their lives and within their communities. The need for this process is ever more critical in 2022 as the UK emerges from the impact of the COVID-19 pandemic on communities. It comes at a time of accelerating financial difficulty for many, with cost of living crisis despite record numbers of job vacancies and low unemployment.

The Bassetlaw Social Prescribing Service

In 2016/2017, the Bassetlaw CCG commissioned a Social Prescribing Service pilot delivered through BCVS to support patients aged over 65 who were socially isolated. At this time, Social Prescribing was still in its infancy across the country and Bassetlaw CCG worked closely with BCVS to develop this support for patients. Based on the acknowledged success of the pilot, BCVS quickly extended provision of this service to all Bassetlaw GP registered patients in 2019. This voluntary and community sector-based model has subsequently been further enhanced by the placing of specialist advisors in both ED and the Discharge Team at Bassetlaw Hospital. Long-term conditions support is provided through Bassetlaw Action Centre via its Health and Wellbeing Coach and specialist support for 11-25 year olds is being offered through The Centre Place.

A collaborative 'Place-based' approach is well developed in Bassetlaw. Strategic health and social care systems have changed this year as Bassetlaw has joined the Nottingham and Nottinghamshire Integrated Care System from 1st July, having previously worked through the South Yorkshire and Bassetlaw Integrated Care System.

Key Highlights

This Impact Review highlights the success of the Bassetlaw model of Social Prescribing across the three Primary Care Networks that cover the district – Retford and Villages, Larwood & Bawtry, Newgate and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. Key elements include:

- Patient needs and voice are assessed and inform all aspects of support provided.
- A holistic approach to supporting patients is adopted in all cases, with wide ranging and informed referrals into stakeholder and VCSE services.
- Both at a Primary Care and hospital level, Social Prescribing Link Workers are demonstrating the effectiveness of the model by reducing and in some cases preventing demand for clinical services.
- Social Prescribing Link Workers are fully integrated and employed in the voluntary and community sector.

Stakeholder Views

Members of the Bassetlaw Place Based Partnership were interviewed as part of this impact review. There was strong recognition that BCVS punches well above its weight and is a 'trusted voice', integrated effectively across the community.

Stakeholders feel that the Social Prescribing service is efficiently managed and see it as flexible and adaptive to a changing series of priorities and demands across the Place.

A key element of the service overall is the integrated delivery alongside Primary Care and acute care within the Hospital Emergency Department setting. Stakeholders highlighted that this was being used effectively to manage demands across the health and care system.

Supporting mental health and wellbeing are core aspects of the Social Prescribing Link Worker remit and stakeholders recognised the major role the service will play in responding to the issues caused by the cost of living crisis locally.

> "Having Link Workers embedded in the voluntary and community sector is a responsive and agile way of working."
>
> Locality Director - Bassetlaw Placed Based Partnership

Forward Focus - Building on Strengths

This impact review has allowed all stakeholders to reflect on the Social Prescribing work to date in Bassetlaw and the success of the approach that has been adopted. It has also enabled all partners to identify areas of future focus which will form part of forward work plans at a Place level.

The review has highlighted a number of strengths and areas for development. **These have been grouped into three key areas:**

1 Engagement and Integration Strengths

- Robust and diverse place-based ecosystem centring patients and the VCSE sector.
- Engagement with wider Social Prescribing networks in Nottingham, Nottinghamshire and nationally.
- Regional and national recognition of good practice in Bassetlaw demonstrated through regular invitations to present in national fora.
- Regularly engaging with Nottinghamshire Public Health priorities and working with Adult - Social Care to ensure that Link Workers are up to speed with developments in regulated care.
- Positive engagement with Bassetlaw District Council on critical issues such as housing, adult social care and financial inclusion.

Forward Focus

- Full integration into NHS systems, including patient IT systems, particularly in order to manage risk elements around frequent/high intensity/Mental Health users.

2 Systems Development Strengths

- Patient voice central to service development and fed in via weekly SPLW meetings.
- Proactive targeting of vulnerable residents and focus on PCN identified population health management priorities.
- Development of innovative ways to manage rapidly growing caseloads in a cost effective way.
- Learning from the Digital and Health Literacy pilot feedback informing local, place-based developments.

Forward Focus

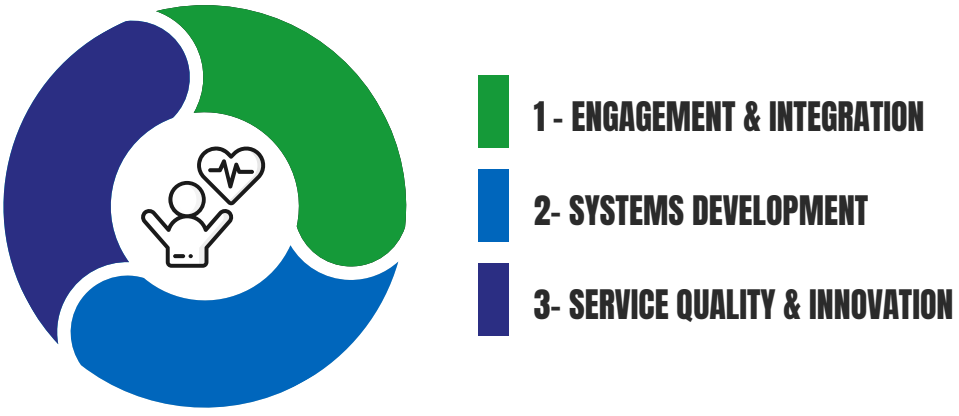
- To strengthen cycle of SPLW PCN quantitative data feedbacking back into asset and service development.

3 Service Quality & Innovation Strengths

- Responsive partnership which addresses gaps in services locally through asset development - for example face to face befriending, community transport, Bassetlaw Financial Inclusion Network, Community Gardens etc.
- Active workforce training, development and mentoring, including support for Social Prescribing Link Workers and Hospital Based Link Workers own physical and mental resilience.

Forward Focus

- Mainstreaming Green Social Prescribing to include learning and what works from all pilot areas including the South Yorkshire and Bassetlaw pilot and Nottinghamshire Pilot.



The Bassetlaw Social Prescribing Quality Improvement Cycle

As highlighted in this Impact Report, the approach to social prescribing in Bassetlaw is one of a valued **Place Based Approach** and the diagram above demonstrates the ecosystem and reach of social prescribing when supporting patients.

1. Introduction

Social prescribing is a process to help people make positive changes in their lives and within their communities. The need for this process is ever more critical in 2022 as the UK emerges from the impact of the COVID-19 pandemic on communities. It comes at a time of accelerating financial difficulty for many, with cost of living crisis despite record numbers of job vacancies and low unemployment.

In 2016/2017, the Bassetlaw CCG commissioned a Social Prescribing Service pilot delivered through BCVS to support patients aged over 65 who were socially isolated. At this time, Social Prescribing was still in its infancy across the country and Bassetlaw CCG worked closely with BCVS to develop this support for patients. Based on the acknowledged success of the pilot, BCVS quickly extended provision of this service to all Bassetlaw GP registered patients in 2019. This voluntary and community sector-based model has subsequently been further enhanced by the placing of specialist advisors in both ED and the Discharge Team at Bassetlaw Hospital. Long-term conditions support is provided through Bassetlaw Action Centre via its Health and Wellbeing Coach and specialist support for 11-25 year olds is being offered through The Centre Place.

A collaborative 'Place-based' approach is well developed in Bassetlaw. Strategic health and social care systems have changed this year as Bassetlaw has joined the Nottingham and Nottinghamshire Integrated Care System from 1st July, having previously worked through the South Yorkshire and Bassetlaw Integrated Care System.

The Bassetlaw Place-Based Partnership is a mature and strong partnership, which values and involves the Voluntary and Community sector at every level. This was further strengthened during the pandemic, with BCVS leading on providing emergency response work to support local people when isolating.

This Impact Review aims to highlight the success of the Bassetlaw model of Social Prescribing across the 3 Primary Care Networks that cover the district – Retford and Villages, Larwood & Bawtry, Newgate and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.

The Bassetlaw Place-Based Partnership is a mature and strong partnership, which values and involves the Voluntary and Community sector at every level.

Bassetlaw Place-Based Partnership

BCVS Bassetlaw Community and Voluntary Service

Case Study

Place Partnership Wider Priorities - Mental Health

Having recently moved back to the area, the patient had subsequently lost their job and was experiencing depression and loss of confidence.

Following a referral from the GP to the Social Prescribing Link Worker, a holistic assessment was carried out and a referral was made to Connect to undertake a benefits review to ensure correct benefits were being accessed. A referral was also made to Bassetlaw District Council to ensure the correct council tax charge was in place, following the change in employment status. Referral also made to Insight (Talking Therapies) to support with low mood/loss of confidence. The Link Worker also outlined possible social activities - Men in Sheds was discussed, but at this point the patient lacked the confidence to consider this.

Over the following 5-month period, through consistent phone and face to face support, the Link Worker established that the patient was interested in gardening and woodwork. Despite initial reluctance to engage, the patient's motivation to engage in social activities improved and a supported introduction to a Gardening Group at Oasis Community Centre was facilitated and the patient has continued to attend.

Outcomes as a result of the Social Prescribing intervention

- Patient in receipt of correct benefits
- Patient received appropriate reduction in council tax
- Reconnection back into local community
- Reduced social isolation, resulting in improved confidence

2. Bassetlaw Context

Approaches to Social Prescribing and specifically the employment of Social Prescribing Link Workers varies across Nottingham and Nottinghamshire. Bassetlaw is unique in its approach in having its Social Prescribing service managed through BCVS, bringing its VCSE infrastructure expertise to the fore of its service offer.

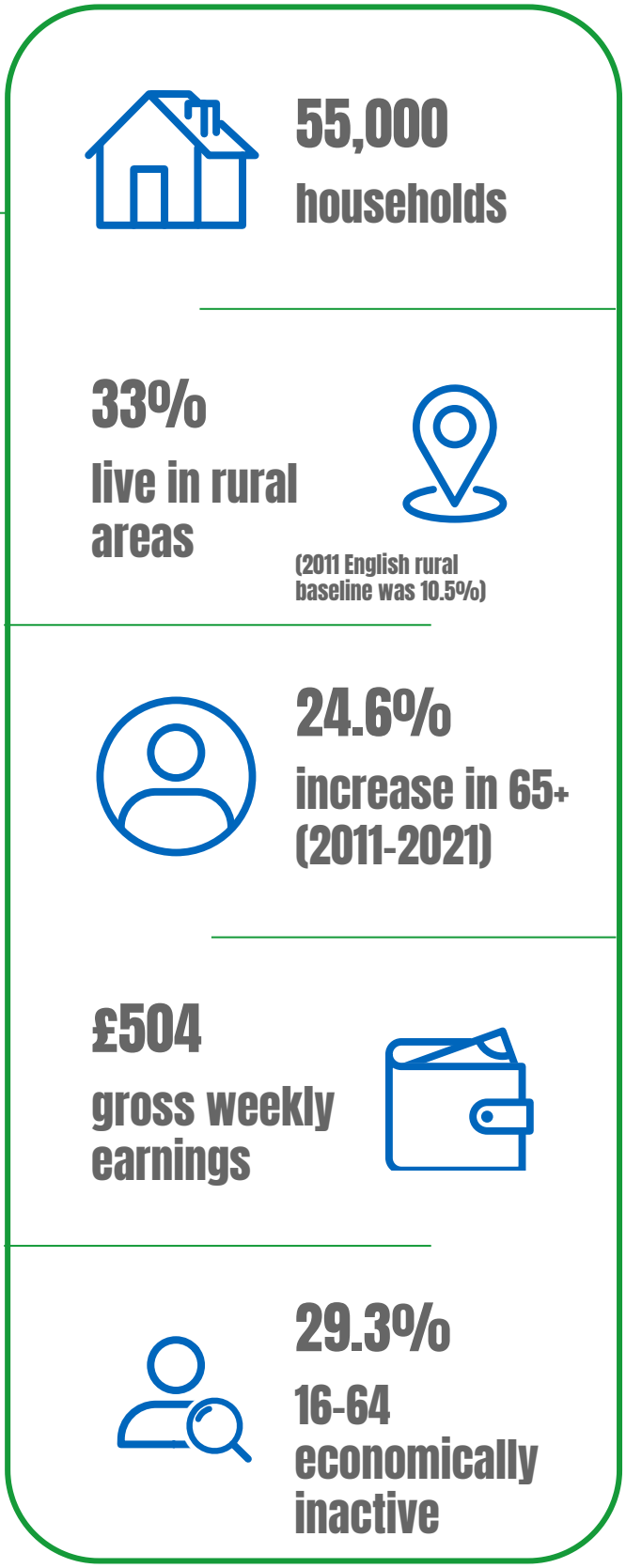
Bassetlaw Context

Bassetlaw has some 55,000 households spread across a large area of contrasting market towns, urban residential areas and rural villages. Over a third of the population live in rural areas and poor public transport links present significant challenges for local communities. As stated in the Introduction, although local and regional government boundaries place Bassetlaw in Nottinghamshire and the East Midlands, its geographical proximity to Yorkshire and the Humber impacts the District economically, socially and culturally.

Census 2021 figures show that the population size has increased by 4.4% since 2011 to 117,800 in 2021. During this time there has been an increase of 24.6% in people aged 65 years and over, a decrease of 1.1% in people aged 15 to 64 years, and an increase of 2.4% in children aged under 15 years.

The Annual Survey of Hours and Earnings 2021 highlights that Bassetlaw is in the bottom quartile of Local Authorities for Gross Weekly pay – ranked 301 out of 307. This means that at 2021 data, Bassetlaw residents were earning a Gross Weekly figure of just £504.

Economic activity rate at 70.7% is over 6% less than the Nottinghamshire rate and 8% less than the national figure. Correspondingly, 29.3% of the 16-64 age group are economically inactive in Bassetlaw, almost 6% higher than the Nottinghamshire rate and 8% higher than the national rate for England.

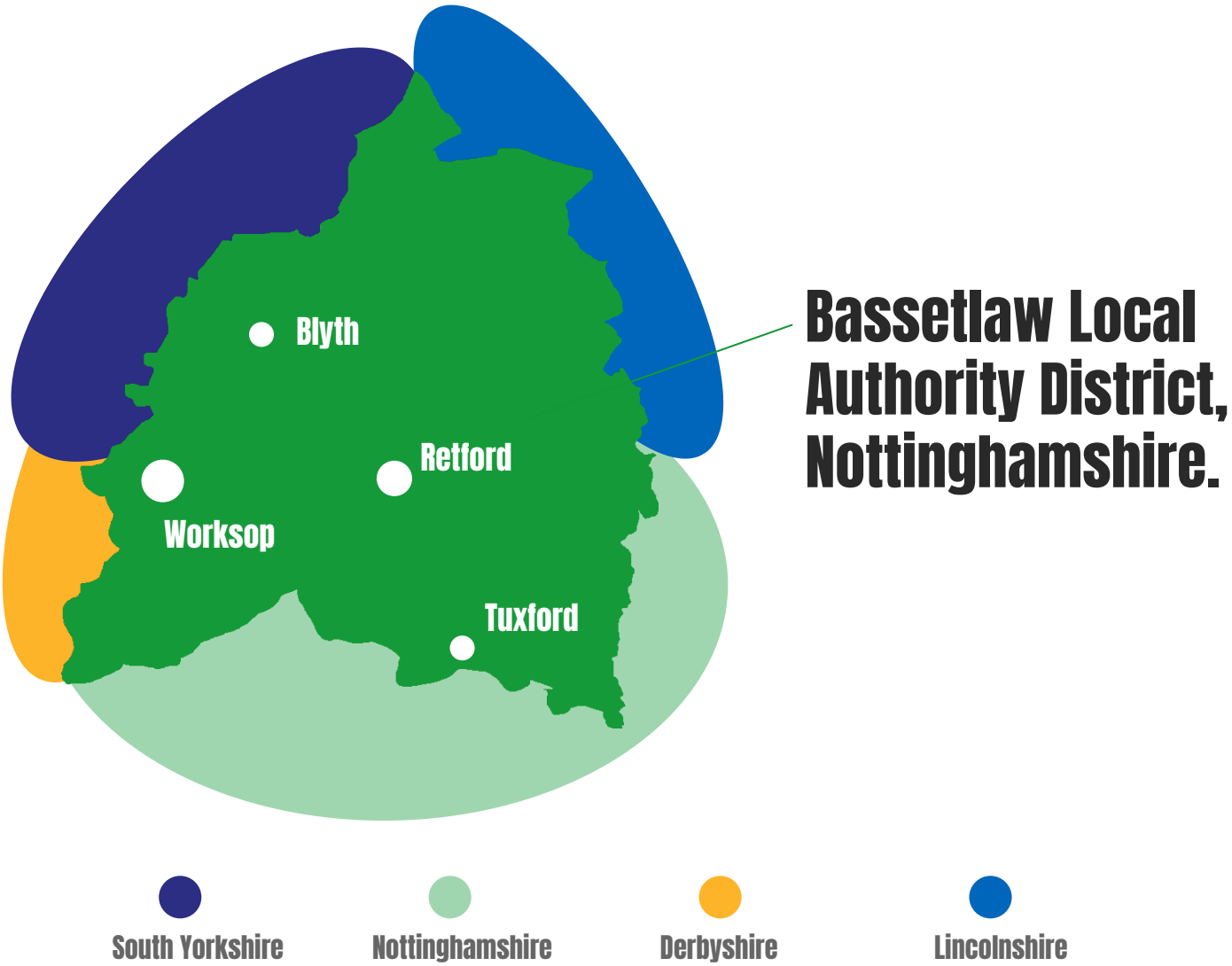


The low level of earnings can be attributed to the fact that 15.7% of those in employment work in elementary occupations, almost 6% higher than the Nottinghamshire and national position.

The health of people in Bassetlaw is varied compared with the England average. About 16.2% (3,205) children live in low income families. Life expectancy for both men and women is lower than the England average. Life expectancy is 8.7 years lower for men and 6.9 years lower for women in the most deprived areas of Bassetlaw than in the least deprived areas.

7550 of Bassetlaw's residents (approx. 6.44%) were advised to shield during the pandemic and this proportion of the local population is significantly higher than the England average (3.99%), and is the highest percentage across the East Midlands and South Yorkshire.

The Index of Multiple Deprivation 2019 ranked Bassetlaw at 106 out of the 317 Local Authorities in England, making it within the 35% most deprived areas nationally, although the detail of the District shows that 7.1% live in the top 20% of least deprived areas within England and 21.4% live in the 20% most deprived areas. This issue is highlighted in the Joint Strategic Needs Assessment 2020 which stated that health inequalities remain a priority in the District, with many residents having less healthy lifestyles and consequent poorer health and wellbeing outcomes.



Partnership and Place Approach

Strong partnerships and collaboration at Neighbourhood, Place and System level are the norm in the District. Bassetlaw Place Partnership is made up of Nottingham & Nottinghamshire Integrated Care System, BCVS, the three PCNs, Nottinghamshire County Council, Bassetlaw District Council, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Healthwatch Nottinghamshire and Nottinghamshire Healthcare NHS Foundation Trust.

The Place Partnership is working towards the shared goal of improving the health of people in Bassetlaw.

There is a strong focus on tackling health inequalities and support for those with mental health concerns or those who are particularly vulnerable.

Place Partnership Wider Priorities (with current areas of focus)

Sustainability

Increase Green Social Prescribing and Physical Activity
Reducing our Carbon footprint
Reducing Air Pollution

Same Day/ Urgent Care

Transformation of Same Day Urgent services to meet clinical need
Improving confidence for self care/management
Provide urgent care to th20% most deprived population

Children, Young People & Maternity

Reducing Obesity
Meeting the mental health and wellbeing needs of C&YP
Improve best starts and uptake of prevention initiatives to support heathy children and healthier adulthood

Mental Health

Meeting health needs of people with severe mental illness
Reducing Suicide and self-harm rates
Reducing mental health related hospital admissions
Reducing levels of GP recorded levels of depression & anxiety

Reducing Health Inequalities

20% most deprived population focus- COVID vaccinations, access, opportunities, prevention initiatives, awareness campaigns
Costs of living crisis initiatives
Reducing smoking rates
Improving access for those at risk of experiencing increased inequalities Improving early cancer diagnosis

Working Inclusively

Increasing digital confidence and competence
Improving Frailty patient outcomes
Reducing social isolation and loneliness

Case Study

Place Partnership Wider Priorities - Reducing Health Inequalities

The patient presented at ED with low mood and suicidal ideation due to poor social support and circumstances at home. Initial referral stated that the patient required support with care, shopping, cleaning and possibly a referral for a food parcel. The patient is an insulin-dependent amputee and their PA had recently obtained alternative employment, at short notice, leaving the patient to attempt to function independently. Assistance needed included day to day tasks such as shopping, topping up credit for electricity and general assistance.

The Link Worker arranged for an urgent food parcel through the Food Bank and discussions also took place regarding a longer-term solution to obtaining food supplies. The patient agreed for a referral to Bassetlaw Action Centre for their home support service and a weekly online shop was put in place. The Link Worker also spoke with the patient's Social Worker who made a referral to the Promoting Independence Team, with the aim of getting the patient a new mobile phone and to set up a face-to-face shopping and cleaning service. The Link Worker progress chased this referral through Notts County Council and the outcome was a Promoting Independence Worker started three weeks following the initial referral. Over the three-week period, the Link Worker contacted the patient every three days, and this also included facilitating credit onto their gas and electric account via the Energy Team at Bassetlaw Citizens Advice Bureau. It was also agreed that the energy supplier would visit the patient's property to ascertain if they could change the meter payments into direct debits.

From the outset of the initial referral, six different services were involved with the patient which have resulted in the patient being able to live independently in an accessible property, with a working mobile phone, a regular food shop, cleaning and information to ensure that the patient has the ability to access heating and electricity.

Outcomes as a result of the Social Prescribing intervention

- Patient assisted to receive urgent food and home support
- Patient received help with energy supply
- Patient assisted to live independently

3. Social Prescribing in Bassetlaw

BCVS and Social Prescribing

Social Prescribing forms part of BCVS' strategic focus on **Groups, People, Voice.**

An established team of Social Prescribing Link Workers is in place, with 6 of these focusing on Primary Care and 3 focusing on hospital-based services – ED and Discharge. Team members bring previous expertise from a range of other roles including working in housing support, MIND, Citizens Advice, Community Mental Health/Social Services/Dementia support. The team provide a direct link to community groups and a shared local knowledge, resulting in being a 'trusted voice' that provides information, does not turn people away or pass them round. The model operated is one of face to face open access and all the Social Prescribing Link Workers have extensive current knowledge of wider VCSE support available in the District and good understanding of pathways for patient signposting and support.

BCVS believes that by working in this way, the following strengths have developed:-

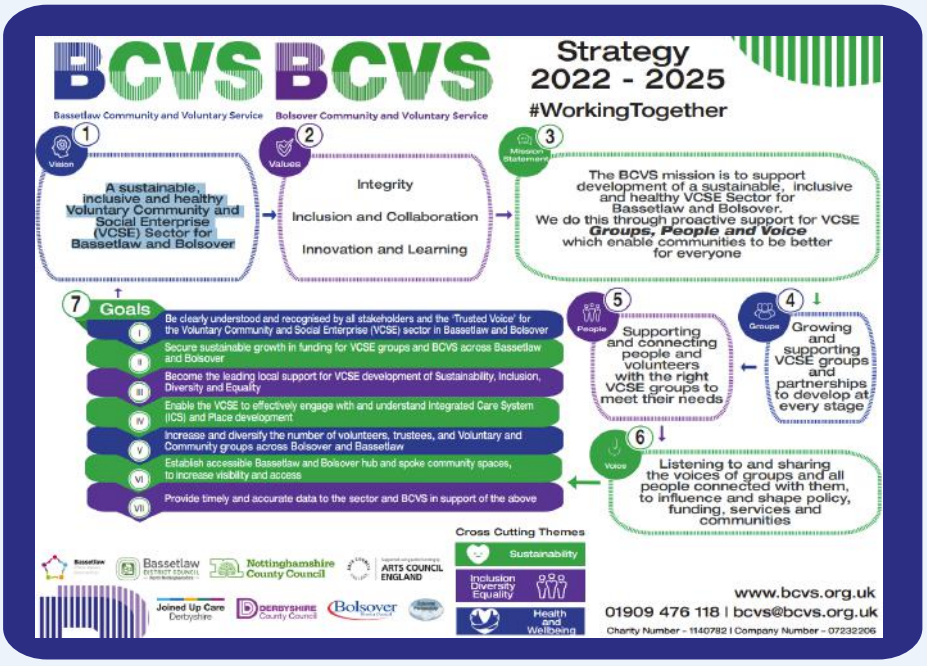
- Direct third sector connectivity into multiple stakeholders which builds on historic strong relationships with the health sector.
- Stronger strategic relationships and more regular conversations - BCVS is now 'expected to have a seat at the table'.
- Have a stable team with complementary skills sets.
- Take local insight and data to inform understanding at a Place Partnership level.

"Bassetlaw has a long history of very strong partnership working which has resulted in a partnership support ecosystem which is agile, responsive, and provides impactful support for our local population.

BCVS and the wider Bassetlaw VCSE sector sit at the heart of the social prescribing model with BPB partners and are critical to the success of the model.

Social prescribers provide two-way pathways of support and intelligence both for patients and to inform and support VCSE asset development across Bassetlaw in response to need and patient voice. We are proud of our track record and look forward to sharing our model and learning with new partners across the Nottingham and Nottinghamshire ICS."

CEO - BCVS



'A sustainable, inclusive and healthy Voluntary Community and Social Enterprise (VCSE) Sector for Bassetlaw and Bolsover'

The BCVS Vision

https://www.bcvs.org.uk/strategy

Case Study

Place Partnership Wider Priorities - Children , Young People & Maternity

The patient was referred by his GP – he is a single male parent who was experiencing domestic violence and was very worried about safety of his children who live with his ex-partner. Abused as a child herself, the mother had re-established contact with the perpetrator/family member, and he was a frequent visitor to the house.

The patient had asked for child protection mediation - safeguarding referrals had already been made. He was trying to get custody of the children but did not have a good relationship with child protection mediator and asked for support to present his concerns as he became angry and felt that he was not being believed.

The Social Prescribing Link Worker requested support from a male domestic abuse counsellor and spoke to the mediation service on his behalf of the patient. Counselling for the patient and support for the children to talk in a safe space was also put in place. The Link Worker also checked that legal advice was being accessed, and signposted to NSPCC support and local groups to help with the patient's mental health. As the children were too young to access local counselling, details were provided for the CASY based in Newark, who offer counselling to young people from age 6-25yrs.

"Just wanted to say a huge thank you. You were a real stepping stone to fixing our family life. Our quality of life is 100 times better than it was ... "

Outcomes as a result of the Social Prescribing intervention

- Parent and children received counselling
- Child Protection mediation established shared custody and gained an injunction to keep the mother's previous abuser away from her house when the children were there.
- Notes on the children's medical records to make primary care staff aware
- Notes on school records to make staff aware that the children's father was the victim not perpetrator of domestic violence.

As detailed in the information below, the team have worked with almost 3000 patients in 2021/22 and have made almost 3500 onward referrals for support.

A further demonstration of the integration of BCVS involvement in health and social care support is its inclusion in the Bassetlaw Provider Collaborative, which is working on the challenges of meeting current demands on front line services.

Total number of patients supported by Social Prescribing Link Workers during 2021/22 (all employed by BCVS)	**2,991**
• Primary Care Network Link Workers (4.4 FTE)	**1,654**
• Bassetlaw Hospital Link Workers - ED and Discharge (1.7 FTE)	**283**
• BCVS-based Link Worker/North Notts Support Partnership (1.0 FTE)	**376**
• Dementia Advisor - patients and carers (1.0 FTE)	**278**
Onward referrals/prescriptions	**3,462**
VCSE organisations/groups providing support from referrals	**109**
Volunteers supported	**151**
Total number of patients supported by Young Persons' Social Prescribing Link Worker during 2021/22 (1.0 FTE employed by The Centre Place)	**198**

Children and Young Peoples' Social Prescribing

Specialist social prescribing support for children and young people who are patients of GP practices in the Retford and Villages PCN is provided by The Centre Place, a Worksop based charity.

A specialist Young Persons Social Prescribing Link Worker helped almost **200 young people in 2021/22**, with the majority of referrals to the service to help young people with anxiety, low mood, low self-esteem/confidence, panic attacks and self-harm.

The case studies below give a brief insight into the type of support provided:-

A 15-year-old was referred to Young Persons Social Prescribing Link Worker by her GP. This followed numerous appointments with regards to her mum's belief that she was struggling with anxiety and re-engaging with school post pandemic. Referrals had been made to CAMHS by the GP but not been accepted by them.

The individual disclosed that she was struggling with school, smoking both cigarettes and cannabis and had a fluctuating relationship with her mother. Both she and her mother suggested that she was dyslexic but when asked for a copy of the diagnosis, it was not available.

With agreement, a referral was made for support around smoking and cannabis use. The Link Worker also liaise with school around specialist learning support. Regular contact was made with advice around her mood and a referral made to Talkzone for counselling. Advice was given around a needs assessment under SEND and an application was made. In addition, a visit to a post-16 provider was facilitated, which offered a small and nurturing environment where the individual could re-sit Maths and English at a functional level and work on her personal and social development.

Talkzone contacted the individual for counselling, however she felt that she no longer needed it and began working with a family support worker from the Family Service. Input was also provided by the Link Worker to a forward action plan.

An 18-year-old who was referred by his GP due to anxiety and related physical symptoms. The individual disclosed a difficult home life and questions about his sexual orientation. He had attended A&E feeling suicidal and disclosed physical assault by a family member, along with challenging relationships within the family.

The individual had a part time job but had been signed off - he was hoping to attend University in the following September but was worried about how he would manage.

Discussions about counselling took place, however waiting list times meant that support was unlikely to be available until after he was due to leave for university. Medication for low mood was prescribed and information about support through Mind and mentoring was also passed on. The Link Worker provided supportive listening sessions which resulted in the individual feeling able to speak to his family about his sexual orientation, change his living arrangements between family members and return to work.

Health and Wellbeing Coaching

Another dimension of the Bassetlaw Social Prescribing Ecosystem is provided by Bassetlaw Action Centre which employ long-term condition health and wellbeing coaches who support patients in the Retford and Villages Primary Care Network area. Two case studies detailing this work are set out below.

The patient was referred to the Health and Wellbeing Coach working through the Bassetlaw Action Centre in Retford for support.

He had suffered a recent heart attack and was very anxious about returning to work. The patient initially presented with anxiety and concerns re the fact that he felt unable to go on walks or on holiday.

He was supported through the Health and Wellbeing Coach to manage his anxiety better through talking, including with his family. He was also encouraged to recognise the need to self- manage his health and increase exercise/activity through daily walks. He also achieved a phased return to work which was due to his improved confidence.

The patient was referred to the Health and Wellbeing Coach for support with weight loss and managing anxiety.

They were highly anxious and socially isolated as a result of this. The Health and Wellbeing Coach supported the patient to increase their time spent outdoors through attending walking groups and other social groups.

These measures resulted in weight loss due to increased activity and increased confidence to self-refer to insight (talking therapies). In addition, the patient applied for a number of jobs and as part of the measures to reduce social isolation.

Health and Wellbeing Coaching Model - Bassetlaw Action Centre

Bassetlaw Social Prescribing Model

This impact review has highlighted the following elements which makes for a highly successful social prescribing model. These elements have been defined through analysis of systems reporting and interviews with stakeholders and practitioners.

VCS Integration – social prescribing link workers and health and wellbeing coaches employed and fully integrated in the voluntary sector. This creates a direct feedback loop of patient voice and needs into community and asset development

Positive Practice Relationships – work with and receive referrals from GPs, Care Coordinators, Receptionists, District Nurses, OTs. Take part in PCN meetings.

Shared Understanding - GPs entering practice have an understanding of the benefits of Social Prescribing, including registrars shadowing during GP training.

Dementia/Long Term Health Conditions – have filled gaps in provision left by national charities and worked with local charities/groups to establish dementia cafes/sessions and a community facilities.

Public Health – have promoted a range of services at events and contributed to COVID-19 support by delivering food parcels and medications.

Non-judgemental - no limits on number of sessions to help patients or prescriptive support, patients are increasingly self-referring.

Responsive – personable, meet people in the community/in their homes, provide holistic help. This often develops into supporting a whole family as opposed to just one person.

Wider Health and Social Care Engagement - engage with social services, pharmacists and other parts of the health and social care system.

Support for Families - both specific children and young peoples' support and wider family support available locally.

Hospital Based Advisors – working in ED and in Discharge to help patients in a holistic way.

Case Study

Place Partnership Wider Priorities - Working Inclusively

Patient was referred from GP - has epilepsy aggravated by stress. The situation was an extended family living in cramped social housing with stretched family relationships which has led to volatile situations and police involvement. The family had rent arrears and the eldest child was not in mainstream school due to stress and anxiety. Support had been provided on and off over a lengthy period as circumstances have changed, however support from previous referrals has not been sufficient and other issues have arisen.

The housing situation was the first priority and following support from the Link Worker, the family were placed in emergency accommodation waiting to be processed through the homelessness/ housing systems. The patients' partner was referred for support with finding a job to increase family income. A referral was also made for debt management support in connection with the rent arrears. A referral was also made for a family food parcel suitable for the emergency accommodation facilities. Info given about Too Good to Go food app plus the Bassetlaw Cost of Living booklet was sent to patient along with information from North Notts College to support their child currently not in school. Further assistance will be provided with furniture and equipment for a home.

"My children are so much happier - when we get a house they want to grow flowers for you."

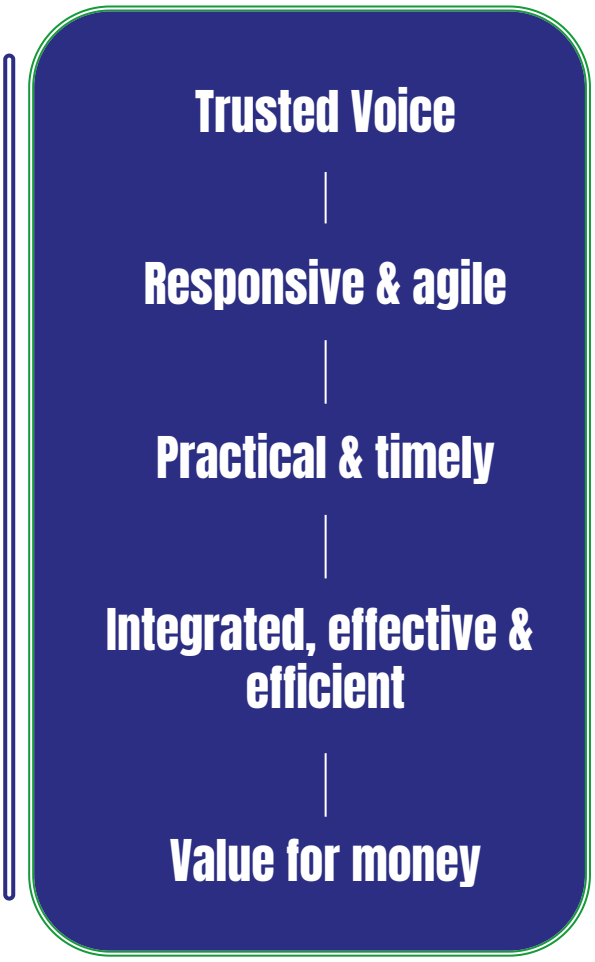
Outcomes as a result of the Social Prescribing intervention

- The family are away from the volatile and overcrowded previous property, safe in emergency accommodation and in the process of the housing system.
- The patients' partner is now fully supported by Working Win and much more positive about finding paid employment.
- Food parcel received and discussion had around alternative sources of affordable food. This includes Food Hubs, Too Good to Go app, veg box scheme and food van.
- Family now have the information from North Notts college to support home schooling for the eldest child.
- Working with the Money Advisor to deal with the housing debt.
- ONS4 scores have improved 100% across all areas of Life Satisfaction; Worthwhile; Happiness and Anxiety.

4. Stakeholder Views

As highlighted earlier in this Review, there is very strong support for the Social Prescribing Link Worker model in Bassetlaw. At a local 'Place' level, the view is that the following aspects are key contributors to its success:-

- Recognition that BCVS punches well above its weight, is **a 'trusted voice' connected to its community.**
- BCVS networking and information gathering is critical to making connections and developing solutions.
- Having access to timely information around benefit entitlement and financial insecurity support is critical.
- Practical ways of tackling loneliness and isolation through working with local groups and communities.
- Being aware of the nature of the geography of the District and the challenges this brings in each PCN.
- Good integration with other statutory and third sector stakeholders – 'trusted partners' working to co-design and deliver initiatives for the benefit of the District.
- Recognition from statutory partners that the VCS infrastructure has to be funded but equally that community support budgets have been reduced very significantly.
- **Effective and efficient service management by BCVS which is flexible and adaptive to rapidly changing priorities.**
- BCVS provides added social value by employing local people.
- Staff turnover is stable in comparison to other social prescribing services.
- **Development of the Hospital-based Link Workers is working well and is being used to manage demands on services in primary care, hospitals and mental health.**
- Recognition of the cost of living crisis and its impact on mental wellbeing which will translate into even more need for the service locally.
- Non health partners underlining what this service has achieved in Bassetlaw to date and that this needs to be borne in mind at a time of change in health structures, with a fresh emphasis on raising and maintaining awareness.
- The positive Green Social Prescribing work to date in Bassetlaw and the wider work in Nottinghamshire is demonstrating additional ways that the VCS can make an impact.



Stakeholder Feedback Chain

"Having Link Workers embedded in the voluntary and community sector is a responsive and agile way of working."

Locality Director - Bassetlaw Placed Based Partnership

"The Bassetlaw Social Prescribing Link Worker service is effectively integrated across the Place Partnership and the service is managed very well by BCVS, who are seen by Bassetlaw District Council as a Trusted Partner."

Head of Corporate Services - Bassetlaw District Council

Case Study

Place Partnership Wider Priorities - Promoting Sustainability

One of the Larwood Social Prescribing Link Workers was looking for a safe, outdoor space to be used to meet with Dementia patients and their carers as the COVID-19 pandemic meant that Dementia groups and engagement could no longer go ahead indoors. Through strong relationships with Bassetlaw District Council, the Willow Garden plot was identified, a community garden that sits in the heart of one of the most deprived areas of Worksop.

The large plot was largely neglected apart from one area where 2 volunteers were maintaining raised beds and a greenhouse. These volunteers were approached and asked to be involved with the wider regeneration of the plot and an ask was made of the wider community through a local campaign. The BCVS Volunteer Coordinator contacted a number of groups including the National Citizen Service who were keen to use the space as part of their summer activities supporting local young people. The VCSE Development Officer also supported with finding funding for projects and also advised with group structure and governance.

The NCS group work resulted in path creation, a bookstore, brought the BBQ area back to life, planted new areas, made raised beds. A young people from Transform training also tidied areas and helped with planting.

The Social Prescribing Link Worker leading the project sourced funding and arranged for a slabbed area to be built to enable ease of access for those with reduced mobility. Over a period of 3 months a group from a local school have transformed this newly paved area with flowerbeds and benches to make a really welcoming space.

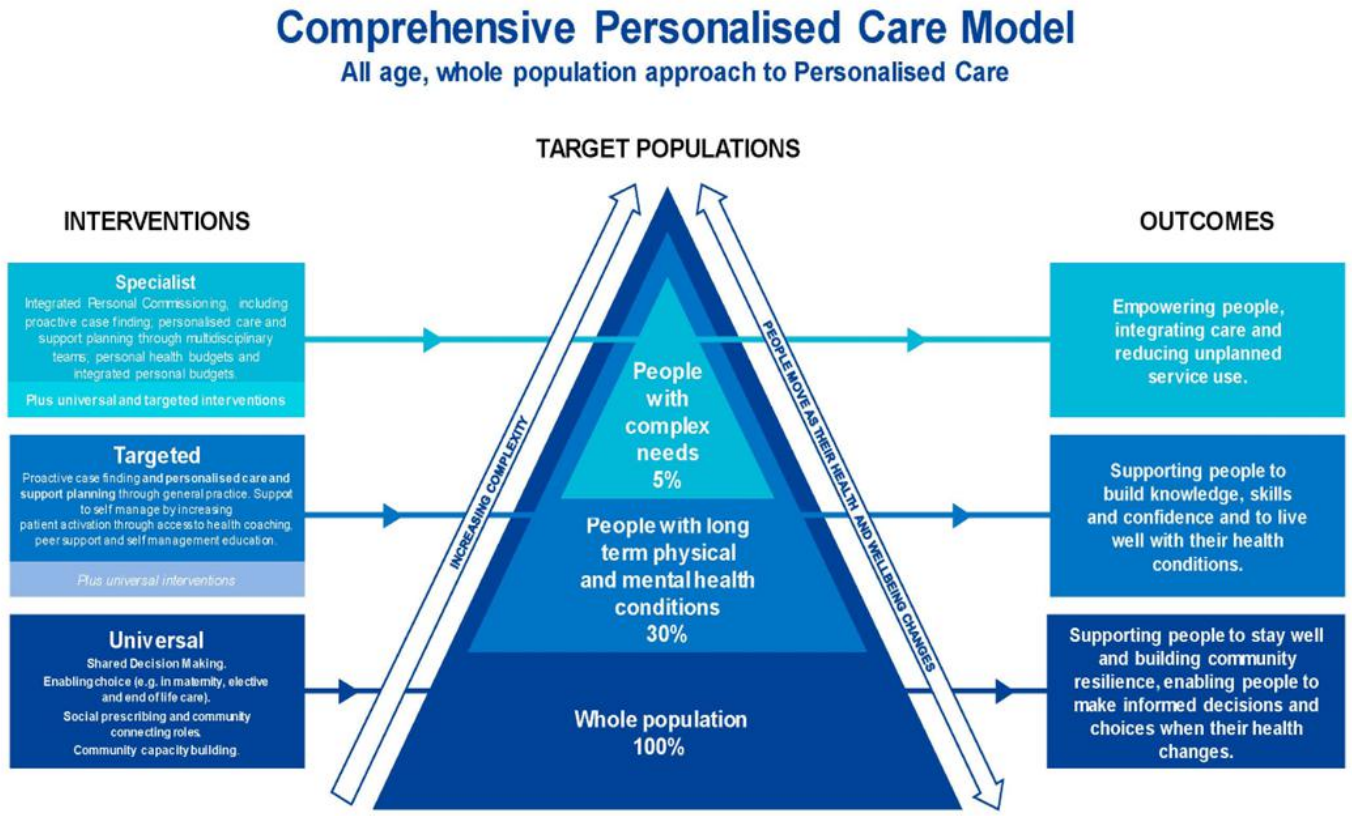
In Easter 2022, the BCVS Social Prescribing Link Workers and Volunteer Coordinator ran a week of events at Willow Community Garden to engage with local and wider community members.

Outcomes as a result of the Social Prescribing intervention

- Dementia patients and carers provided with safe outdoor space
- Significant volunteering opportunities for all ages created
- Opportunity for community to engage with green social prescribing

Appendix 1 - Social Prescribing Model

Social prescribing now forms a key element of NHS England's Comprehensive Personalised Care Model which establishes whole-population approaches to supporting people of all ages and their carers to manage their physical and mental health and wellbeing, build community resilience, and make informed decisions and choices when their health changes.



Social prescribing has a Link Worker at its centre who give people time, focuses on 'what matters' and takes a holistic approach to health and wellbeing. They connect people to community groups and statutory services for practical and emotional support. Link Workers also support existing community groups to be accessible and sustainable, and help people to start new groups, working collaboratively with all local partners.

Social prescribing works for a wide range of people, including people:

- with one or more long-term conditions
- who need support with their mental health
- who are lonely or isolated
- who have complex social needs which affect their wellbeing.

When social prescribing works well, people can be easily referred from a wide range of local agencies, including general practice, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and VCSE organisations. Self-referral is encouraged as part of self-management of health and well-being.

NHS England developed a standard model of social prescribing in partnership with stakeholders, which shows the key elements that need to be in place for effective social prescribing[1];

In the Long Term Plan, NHS England committed to building the infrastructure for social prescribing in primary care:

- 1,000 new social prescribing link workers in place by 2020/21, with significantly more after that, so that
- at least 900,000 people will be referred to social prescribing by 2023/24.

Social Prescribing Link Workers form an integral part of the multi-disciplinary teams in primary care networks (PCNs), are part of the additional roles in the five-year framework for GP contract reform and were included in the Network Direct Enhanced Service Contract for 2020/21. Further work to support Social Prescribing provision is via the National Academy of Social Prescribing and its Thriving Communities[2] programme. This is resulting in increasing evidence that the use of Link Workers is reducing the use of NHS services, including attendance at GP practices.

[1]NHS England Model of Social Prescribing - Social prescribing and community-based support. Summary guide, Published January 2019
[2]https://socialprescribingacademy.org.uk/thriving-communities/

Appendix 2 - Patient Voice

Of the patients who scored the support received from the Link Workers, 100% of patients gave the support offered **5 out of 5.**

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