Community Action Norfolk

Social Prescribing VCSE Provider Prospectus

West Norfolk and Breckland Areas

Contents

Introduction

This document is designed to provide information to voluntary community and social enterprise (VCSE) organisations wishing to provide 'living well workers' as part of the roll-out of Social Prescribing in the West Norfolk and Breckland District Council areas.

Community Action Norfolk is managing the delivery of Social Prescribing in these areas and is seeking to appoint VCSE organisations to deliver the day to day activity of the Social Prescribing service.

Community Action Norfolk will be working with Norfolk County Council, West and South Norfolk Clinical Commissioning Groups, Breckland District Council and Kings Lynn and West Norfolk Borough Council in the appointment and management of this programme.

Background

Social Prescribing, sometimes referred to as "community referral", is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services.

Recognising that people's health is determined primarily by a range of social, economic and environmental factors, Social Prescribing seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health.

Those who could benefit from Social Prescribing schemes include people with mild or long-term mental health problems, vulnerable groups, people who are socially isolated, and those who frequently attend either primary or secondary health care.

There are many different models for Social Prescribing, but most involve a Link Worker or Navigator (in our model these are referred to as Living Well Workers) who works with people to access local sources of support. Social Prescribing schemes can involve a variety of activities which are typically provided by voluntary and community sector organisations. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports. There is emerging evidence that Social Prescribing can lead to a range of positive health and well-being outcomes. However, robust and systematic evidence on the effectiveness of Social Prescribing is very limited.

Norfolk and Waveney's Sustainability and Transformation Partnership plans include the objective of developing Social Prescribing across Norfolk.

As part of this, two years-worth of funding to deliver a Norfolk wide Social Prescribing service has been allocated by Norfolk County Council from the Improved Better Care Fund and Public Health, totalling £950K per year. Principles for the development of Social Prescribing across Norfolk are:

- Delivered at scale, accessible to patients from all GP practices across Norfolk.
- Able to take referrals from Norfolk County Council.
- Work with voluntary sector and district councils, acknowledging their expertise in this area.
- One approach to evaluation built in from the start.
- Asset based – utilise existing resources, including those from Local Authorities and existing community groups and voluntary sector.
- Build on the existing learning and enthusiasm from current projects .
- Acceptable and trustworthy to clients/patients and referrers.

Social Prescribing is being developed on a Clinical Commissioning Group (CCG) locality basis across Norfolk. This is designed to enable delivery to be tailored to local needs and build on local assets. Local delivery models will still be part of a countywide programme with a shared evaluation process.

Through discussion with local partners in the Breckland District Council and Kings Lynn and West Norfolk Borough Council areas (all of West Norfolk CCG and the Breckland part of South Norfolk CCG) Community Action Norfolk will be managing the delivery of Social Prescribing.

As part of this, Community Action Norfolk will be appointing VCSE providers to deliver the day to day activity of the Social Prescribing programme.

Alongside Social Prescribing, Norfolk County Council is currently commissioning a range of services to address Social Isolation. Whilst these services are separate, there will be some overlap and providers of both services will be required to work together to achieve the best possible outcomes for residents.

Service Overview

The Social Prescribing programme across Norfolk is still very much under development. As such the model of service delivery and client journey will develop throughout the lifetime of the programme. Providers are expected to work with Community Action Norfolk and partners to develop and improve the Social Prescribing service, making changes to operational activities and systems where necessary. Based on current discussions the anticipated model is:

Living Well Workers will take referrals from primary care and adult social services as well as other partners.

Within Breckland and West Norfolk areas Living Well Workers will be attached to a GP cluster(s) (see Appendix C). They will normally take referrals based on the client being a patient of a GP within that cluster. However, Living Well Workers may also be assigned clients from other areas to manage workloads and mitigate absences.

The primary function of the Living Well Worker role is that of being a "social prescriber". Working closely with a wide range of partners including GPs and other healthcare professionals. The Social Prescribing service aims to address non-medical issues that may be causing or exacerbating health problems (e.g. debt, poor housing, mental ill health, social isolation, etc). The post holder will advise and support individuals on a 1:1 basis, with the aim that they will experience improved health and wellbeing. This is time limited, which encourages self-service and empowers them to take charge of their next steps. Living Well Workers will undertake, where necessary, a limited number of follow-up visits with the client in person or remotely (projections suggest an average of five total).

Some funding will be made available to support providers of the services Living Well Workers refer to, where referrals are making a significant impact on their delivery. The details of this are still to be developed.

Living Well Workers will collect required information from the client to meet reporting and monitoring needs, following up to understand service user outcomes where appropriate.

A more complete job outline is include in appendix A

Specification

VCSE providers will be required to undertake the following:

- As part of a partnership of providers, deliver the service outlined above.
- Directly employ 'Living Well Worker(s)' based on the number of Lots awarded, either as a new post or as an adjustment to the role of an existing staff member.
- Support any clients referred to the Living Well Worker in a holistic way within the ethos of the Social Prescribing model and in order to achieve the best possible outcomes for residents.
- Co-operate and liaise with Social Prescribing, Social Isolation and other providers in the development and delivery of the Social Prescribing services.
- Collect, collate and provide in an agreed and timely manner those aspects of client and delivery data outlined in Appendix D and any reasonable additional monitoring requirements.
- Participate in joint training, development meetings and other events
- Abide by any shared policy on the support of clients, the management of client information, lone working and other arrangements that may be necessary.
- Support the overall promotion of the Social Prescribing service across Norfolk including participation in events, use of their organisation's networks and engagement work with colleagues in primary care to help embed the service.
- VCSE providers will be required to assure Community Action Norfolk that individuals undertaking the Living Well Worker role meet the requirements of, and are able to carry out the tasks within the job description contained in Appendix A.
- VCSE providers will be required to meet all minimum organisation criteria outlined in Appendix B

Lots available and applications

Appointments will be made as a two stage process. The first stage is the completion of the Expression of Interest form. The second stage will be a panel interview.

We anticipate awarding providers funding in Lots of £14,000 to provide a 0.5 full time equivalent (FTE) Living Well Worker. Based on current models we would expect each 0.5 FTE Living Well Worker to support at least 100 clients per annum. This will be reviewed as the service develops and during an initial period of service mobilisation volumes are expected to be lower.

Individual providers may apply for and/or be awarded more than one Lot. However, in making appointments, we will be looking for a mix of providers both geographically and in terms of client specialisms.

We expect to award six Lots in the Breckland area of South Norfolk CCG and six Lots in the West Norfolk CCG area. 12 Lots in total.

In your Expression of Interest form please indicate the minimum and maximum number of Lots you are interested in providing. Also indicate which GP cluster areas you are willing to cover.

Shortlisted organisations will be invited to interview. After the interview stage, Community Action Norfolk, in discussion with partners, will issue offers to successful providers. Offers may include further negotiation of the number and composition of Living Well Workers hosted by each provider to meet the overall objectives of the programme.

Selection Criteria

In evaluating submissions Community Action Norfolk and partners will look at the following criteria:

- The ability to meet the minimum organisation criteria.
- Experience of successful delivery of similar services.
- The overall track record of the organisation.
- The robustness of systems for ensuring quality of service delivery and reporting.
- The overall geographic and specialist mix of providers within the programme.

Appointment timeline

Timeline may be subject to change.

Element	Date
Expression of Interest form and prospectus distributed. Published on CAN website, emailed to all VCSE organisations on CAN system. Partners asked to share.	01/02/2018
Briefing session – open to potential bidders	16/02/2018 1500 Swaffham Community Centre. Email office@communityactionnorfolk.org.uk to book your place
Deadline for submission of the Expression of Interest form	0900 26/02/2018
Shortlisting	w/c 26/02/2018
Interviews	w/c 5/03/2018
Offers/negotiation – based on panel discussions it is likely we will go back to providers with offers that may change/combine/scale their proposals.	12/03/2018 – 23/03/2018
Service Level Agreements issued – CAN will issues SLAs to providers based on their agreed offer and their mobilisation will begin.	26/03/2018

The deadline for submission of the Expression of Interest form is 0900 26/02/2018 and should be emailed to office@communityactionnorfolk.org.uk

SLA and payment information

- SLA's will initially be for 12 months with the option to extend.
- Performance will be reviewed every three months.
- Payments will be staged:
    - 30% on signing the SLA.
    - 30% after 3 months of the Living Well Worker(s) being in place.
    - 30% after 9 months of the Living Well Worker(s) being in place.
    - 10% after 12 months of the Living Well Worker(s) being in place.
- Payments will be made subject to satisfactory performance and provision of required reporting data.

Appendix A: Living Well Worker Job Description

VCSE providers will be required to assure Community Action Norfolk that individuals undertaking the Living Well Worker role meet the requirements of and are able to carry out the tasks within this job description:

Job Purpose

The role of the Living Well Worker is to support the provision, coordination and development of Social Prescribing; supporting individuals and families to access support within their local community from community, voluntary and public-sector organisations.

The Living Well Worker will contribute to the wider early help and prevention approach, by supporting the development of strong, resilient and sustainable communities.

Social Prescribing

The primary part of the role is that of being a "social prescriber". Working closely with a wide range of partners including GPs and other healthcare professionals. The Social Prescribing service aims to address non-medical issues that may be causing or exacerbating health problems (e.g. debt, poor housing, mental ill health, social isolation, etc). The post holder will advise and support individuals on a 1:1 basis, with the aim that they will experience improved health and wellbeing. This is time limited, which encourages self-service and empowers them to take charge of their next steps.

The post holder will help service users to identify their social, well-being and health goals and to locate resources such as voluntary groups, support services and activity clubs within their community that can assist the individual to achieve those goals. This requires the post holder to gather information and to understand what resources are available within the community and to signpost or refer people to these resources.

The role requires close working with health and social care providers to maximise the individual's potential to reduce or delay more formal packages of care and to reduce demand in primary care and other statutory services.

Main duties and responsibilities

- Offering 1:1 holistic assessments by face to face, telephone, email or video calling (or any other digital platform) to proactively identify the needs of the individual or family.

- Build relationships with staff from primary care and broader health and social care services so that staff are familiar with the concept of Social Prescribing, understand how to access Social Prescribing and feel confident to do so.

- To deliver support through a person-centred approach with the service user enabling them to identify a suitable solution and make informed choices.

- Where appropriate, and with the service user's consent, supporting individuals to represent their interests to third parties.

- Support connections to local groups and voluntary organisations by providing information and supporting attendance to activities and events.

- To work with individuals to improve their confidence, knowledge and skills to maintain their independence.

- To forge strong links with local voluntary and community sector providers of health and well-being activities to promote access to services for people.

- To work closely with health and social care teams, attend relevant meetings and provide information and feedback on Social Prescribing.

- To use appropriate systems for the referral of clients to other services and follow the policies and procedures associated with their use.

- To report on any gaps in community resources that become apparent when carrying out Social Prescribing.

- To support voluntary sector organisations to develop new community-based programmes and activities which aim to improve health and well-being and promote self-help.

- To promote and raise awareness of local opportunities available

- To create opportunities and social networks for individuals and families to meet, connect and thrive through building positive, supportive and enabling relationships.
- Improve awareness of opportunities for residents to participate in, and have a say in their local community.
- To forge strong operational links with the local Help Hubs and other appropriate partners to effectively reach out to and engage with individuals, and families through a range of activities.
- To maintain expertise in identifying and undertaking continual personal and professional development.

- To assist with meeting project targets as relevant at the time, and to ensure high-quality record keeping, monitoring, and project evaluation.
- To maintain satisfactory records of all work undertaken in line with information governance policies and procedures, contributing to the collection of monitoring information and preparation of progress reports.

- To act on all safeguarding concerns about individuals in accordance with the local procedures.

- To undertake any roles or tasks that are consistent with the level of the post and fall within the scope of the role thereby ensuring that the overall business and operational priorities of the project are delivered in a timely and effective manner.

- To understand the importance of social welfare issues as a non-medical determinant of health and maintain key relationships with accredited advice

- To develop a working knowledge and ability to address entitlements to benefits and social welfare issues.

Use a range of behavioural change techniques such as motivational interviewing and strength-based approaches to help service users determine and achieve their goals Whilst every effort has been made to outline all the main duties and responsibilities of the post, the role of the Living Well Worker is a newly created post and may be updated as the service and role develop.

Person Specification

Detailed below are the type of skills, experience and knowledge that are required of applicants applying for the post. The "Essential Requirements" indicate the minimum requirements, and applicants lacking these attributes will not be considered for the post.

The points detailed under "Desirable Requirements" are additional attributes to enable the applicant to perform the position more effectively or with little or no training. They are not essential but may be used to distinguish between acceptable candidates.

Personal Skills/Characteristics	Essential	Desirable
Experience		
Experience of supporting individuals and / or families on a 1:1 basis	✓	
Experience of delivering coaching, motivational interviewing or similar behaviours change approaches		✓
Experience of working directly with people within or with the voluntary, community or health sector in a paid or voluntary capacity		✓
Experience of monitoring and evaluation	✓	
Experience of building relationships and working in partnership with a variety of organisations and individuals		✓
Qualifications & Training		
Basic skills at level 3	✓	
Coaching or mentoring qualifications		✓
Ability to demonstrate continuous improvement and self-development	✓	

Training in behavioural change technique such as motivational interviewing.		✓
Special Skills/Knowledge		
Knowledge of the wider determinants of health, including social, economic and environmental factors		✓
Knowledge of social welfare advice		✓
Understanding of issues around mild to moderate mental health needs.		✓
An understanding of community development approaches to health and well-being issues		✓
Ability to express oneself effectively verbally and in writing at a range of levels and with a variety of partners and stakeholders	✓	
Knowledge and ability to utilise IT systems including word-processing skills, email, internet use.	✓	
Knowledge of voluntary and community services in Norfolk and/or how to find out about local services and how to support people to access them	✓	
Understanding of personalisation and the skills required to support individuals to make informed decisions about their health and wellbeing		✓
Personal Qualities		
Ability to maintain effective working relationships and a positive attitude towards collaborative work with peers, colleagues and other professionals. Proven ability to interact with people in a way that inspires trust and confidence. Ability to motivate and influence others.	✓	
Energy, commitment and ability to lead and finish work.	✓	
Ability to organise, plan and prioritise on own initiative, including when under pressure and meeting deadlines.	✓	
High level of written and oral communication skills.	✓	
Ability to work flexibly and enthusiastically within a team or on own initiative.	✓	
Knowledge of and ability to work to policy and procedures	✓	
Personal Circumstances		

A satisfactory Disclosure and Barring Service (DBS) check	✓	
Willingness to work flexible hours when required to meet work demands	✓	
Other Requirements		
Access to own method of transport to be able to travel across the locality on a regular basis	✓	

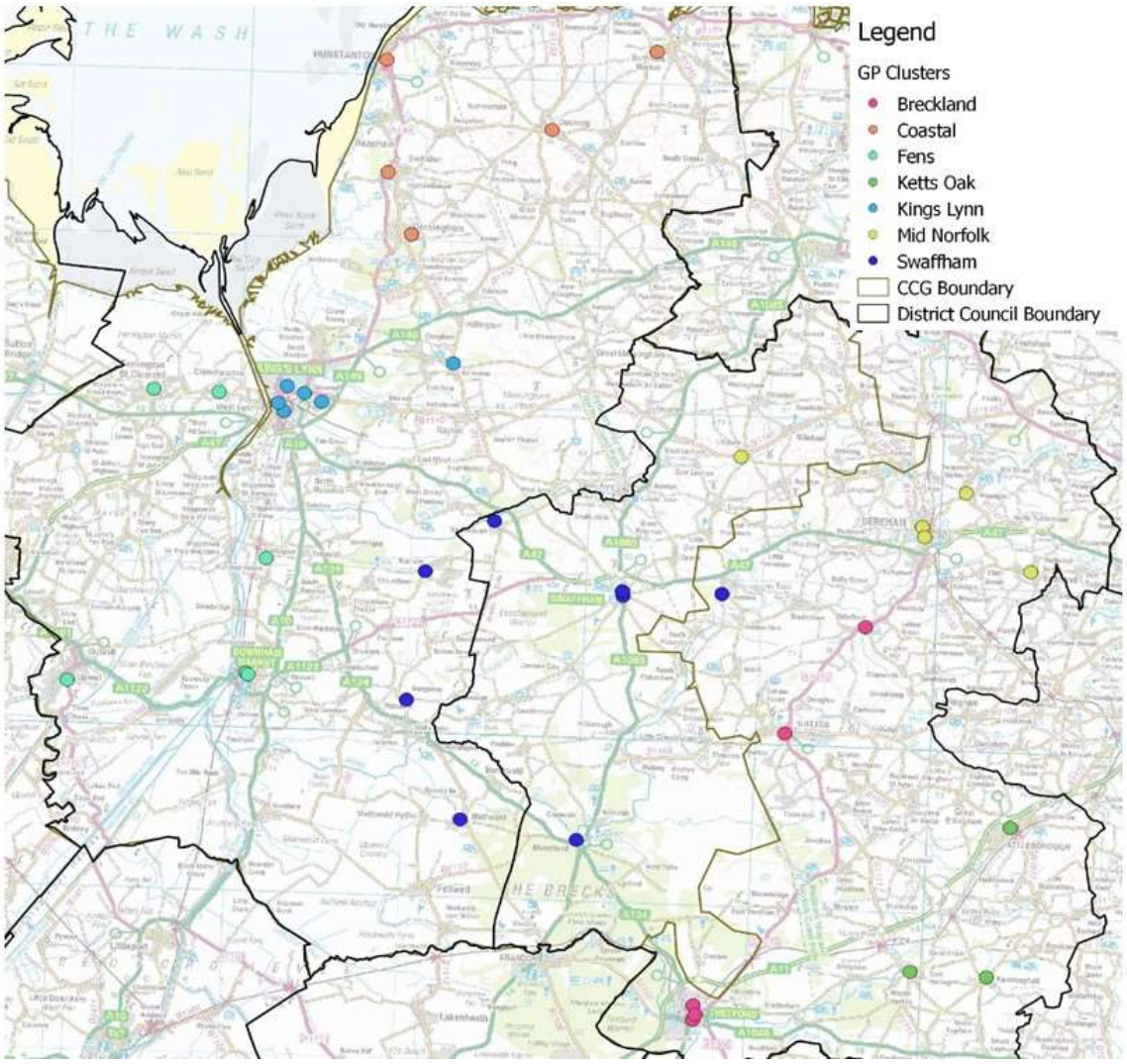
The salary for these roles is expected to be circa £19,500 FTE. Other funding being allocated to providers is to cover associated delivery costs.

Appendix B: Minimum organisation criteria

- Voluntary, community or social enterprise organisation with a recognised structure.
- Satisfactory Data Protection policy in place and actively used.
- Satisfactory Safeguarding policy in place and actively used.
- Satisfactory Health and Safety policy (including Lone Working) in place and actively used.
- Insurance cover in place to cover Social Prescribing activity
- Organisations currently meeting their statutory reporting requirements
- Organisations that have appropriate governing documents and governance procedures in place

Appendix C: Current GP clusters

These are the initial GP clusters proposed for social prescribing they are subject to final confirmation and may be change over time based on operational feedback and engagement with primary care.



Branch Name	Postcode	Approx List size	Assigned Social Prescribing Cluster
THETFORD HEALTHY LIVING CENTRE	IP241JD	11,262	Breckland
WATTON MEDICAL PRACTICE	IP256FA	12,687	Breckland
SHIPDHAM SURGERY	IP257LA	3,137	Breckland
SCHOOL LANE PMS PRACTICE	IP242AG	2,588	Breckland
GROVE SURGERY	IP242HY	12,722	Breckland
DOCKING SURGERY	PE318NQ	5,624	Coastal
HUNSTANTON SURGERY	PE365DN	7,000	Coastal
SNETTISHAM SURGERY	PE317PE	7,967	Coastal
ST NICHOLAS ENDOSCOPY UNIT	PE316GZ	16,450	Coastal

Branch Name	Postcode	Approx List size	Assigned Social Prescribing Cluster
THE BURNHAMS SURGERY	PE318DH	4,569	Coastal
CLENCHWARTON SURGERY	PE344AH	5,044	Fens
TERRINGTON ST JOHN BRANCH SURGERY	PE344LZ	5,690	Fens
THE HOLLIES SURGERY	PE389JE	4,300	Fens
WATLINGTON MEDICAL CENTRE	PE330TU	6,210	Fens
UPWELL HEALTH CENTRE	PE149BT	9,385	Fens
BRIDGE STREET SURGERY	PE389DH	8,491	Fens
DR LOCK & PARTNERS	NR162AD	7,283	Ketts Oak
DR OXLEY & PARTNERS	NR172AF	17,028	Ketts Oak
KENNINGHALL PRACTICE	NR162EF	7,283	Ketts Oak
CAROLE BROWN HEALTH CENTRE	PE316GZ	12,613	Kings Lynn
CAROLE BROWN HEALTH CENTRE BRANCH	PE316GZ	7,000	Kings Lynn
FAIRSTEAD SURGERY	PE304SR	3,000	Kings Lynn
GAYTON ROAD HEALTH CENTRE	PE304DY	12,000 - 15,000	Kings Lynn
NORFOLK SURGICAL & DIAGNOSTIC CENTRE (NSDC)	PE305QX	12,613	Kings Lynn
ST AUGUSTINE'S HEALTHY LIVING CENTRE	PE302LB	21,533	Kings Lynn
ST JAMES MEDICAL PRACTICE	PE305SY	12,613	Kings Lynn
GRIMSTON MEDICAL CENTRE	PE321DW	4,636	Kings Lynn
SWANTON MORLEY PMS PRACTICE	NR204LT	8,744	Mid Norfolk
LITCHAM HEALTH CENTRE	PE322NW	3,291	Mid Norfolk
THEATRE ROYAL SURGERY	NR192EN	9,276	Mid Norfolk
MATTISHALL SURGERY	NR203QA	8,136	Mid Norfolk
ORCHARD SURGERY	NR191AE	9,943	Mid Norfolk
BOUGHTON SURGERY	PE339AG	3,247	Swaffham
MARHAM SURGERY	PE339HP	7,371	Swaffham
NARBOROUGH SURGERY	PE321TE	6,258	Swaffham
NECTON SURGERY	PE378EF	5,374	Swaffham
OAK FARM SURGERY	PE378EF	6,258	Swaffham
ST GEORGE'S HALL (FELTWELL SURGERY)	IP264NT	4,270	Swaffham
VILLAGE COMMUNITY CENTRE	IP265DP		Swaffham
MANOR FARM MEDICAL CENTRE	PE377QN	6,258	Swaffham
THE CAMPINGLAND SURGERY	PE377RD	6,051	Swaffham
HEATHGATE MEDICAL PRACTICE	PE377QN	8,339	Swaffham

Appendix D: Data collection requirements

The intention in taking a systemwide approach to Social Prescribing includes an objective to undertake a common approach to the evaluation of the Social Prescribing schemes in Norfolk. The final detailed criteria, frequency of collection for different data and formats for gathering information to enable the evaluation is still to be agreed with participating organisations in the Social Prescribing model. Some of the evaluation will entail tracking the use that individuals, who have been supported through Social Prescribing, make of other parts of the health and social care system.

The Living Well Workers and their employing organisations will be key to the process of gathering information for use in the evaluation. The list below details the sort of information that is likely to be required and the potential sources for that information. This is a long list and will be refined to the data which is going to be essential to evidencing activities and outcomes:

Information required	Prospective source
Demographic and needs - Age / gender / ethnicity / disability status / employment status / other needs factors (housing, income)	Referrer / Referral format / Living Well Worker
Identifying information to allow individuals use of other services to be tracked and measured – NHS no. and postcode	Referrer / Referral format / Living Well Worker
Numbers of people referred to LWW: Reason for referral; Type of intervention and support offered; Numbers referred onto other sources of help and activities ; Numbers who drop out of the process; Needs which could not be met.	Living Well Worker
Measure of wellbeing and follow up – Wellbeing improvement is expected to be a key outcome of social prescribing, so baseline data is required for comparison to follow-up.	Living Well Worker
Measure of self-efficacy – Self-efficacy is another key outcome which requires baseline data for comparison.	Living Well Worker
Measure of overall health (e.g. EQ-VAS) - Self-reported overall health rating at baseline will allow improvement to be tracked after completing the programme.	Living Well Worker

Case studies	Living Well Workers/ Referrers/ Community Providers
Unexpected outcomes	Living Well Workers/ Referrers/ Community Providers