GP Support Service	Community Connect (includes GP support)	Community Connections (includes GP Support)
Who for – People 18yrs and over support to live as independently as possible **Focus** – people experiencing crisis in housing related issues i.e. housing, benefits, health, debt management, Employment/Education/Volunteering etc. **Referral** – GP, Self, Adult social care and hospital discharge staff	**Who for** – People 50yrs and over, support to live at home as independently as possible. **Focus** – reducing social isolation and loneliness. **Referral** – GP, Adult social care, self and hospital discharge staff	**Who for** – People 18yrs, supporting connecting activities. Has an arts focus. **Referral** – GP and self
Area covered – Designated GP practices: Weston – New Court, Longton Grove and Tudor Lodge. Winscombe and Banwell Weston General Hospital and patients returning from other local hospitals.	**Area covered** – open to all GP practices across North Somerset, to include regular sessions at: Backwell, Weston Town Road; Long Ashton Surgery; Mendip Vale – Langford, St Georges and Yatton; Portishead Medical group and Harbourside; Worle Surgery, Riverbank and Cedars; Clevedon Medical Centre and Sunnyside; Nailsea, Tower House; Pill Hayward Family Practice; Winscombe Medical Practice; Locking Castle Medical Centre; Town Hall, Weston and Castlewood, Clevedon – adult social work teams.	**Area covered** – Designated GP practice. Weston – Locality health centre, For all healthy living centre, Bournville to include Graham road and Clarence park practices.
Social Prescribing Services (SPS) and their processes for developing and accessing, will continue to progress across Bristol, North Somerset and South Gloucester (BNSSG). These three services make up our current North Somerset contracted Social Prescribing offer, promoting early intervention, self-care and prevention.		
Access – Open, all the above three services can be contacted by people themselves within areas covered above. They have their own publicity material for this purpose. Focused, taking referrals from GP practices above (and social work teams – for over 50s community connect service), supporting early intervention and prevention activities through signposting and/or a social prescription. Intermediary, referred on from initial SPS to more appropriate SPS, i.e. housing, older people etc. Or referred into SPS from other health, social care, VCSE organisations/groups.		
Contact – Zoe Dunster; 07703 187811 Karen Disney; 07814 131101 Email - gpsupportteam@alliancehomes.org.uk Office hours – Mon to Fri, 9am – 5pm	**Contact** – Terri McCartney; 01275 888803 / 01934 888803 Email – communityconnect@curo-group.co.uk Office hours – Mon to Fri, 9am – 5pm	**Contact** – Julie Ellis; 07936 846873 / 01394 427426 Email – Julie.ellis@forallhlc.org Office hours – Mon to Fri, 9am – 5pm

Support levels –

For individuals – using 5 step process

For communities – using ABCD

Level 1 – Initial (individual)
Signposting. Immediate/short term information and advice. (1-4 weeks)
Typically step 1 of 5 step process below.

Level 2 – Intermediate (individual)
Signposting plus light touch/minimal support to access (2-6 months)
Typically steps 1-3 of steps below. May use step 4.

Level 3 – Complex (individual)
Social prescription – enabling plan. Likely to go through all 5 steps and ebb and flow.
6 – 9 months + * This is not a support worker role. Complex = overseeing single/multiple life changing triggers needing timely, accessible, supportive social connections.

Asset based community development (ABCD)
Building community capacity – developing groups/activities, to signpost/social prescribe into.

5 Step process Which steps and how many used is determined by individual needs as above. Process uses Strengths-based approach to include Active Listening and Conversational Assessment methods.	1) 'Postcard' Assessment guide, identifying info/advice needs – informing signposting 2) Social Prescribing providers keep (identify support level) or inter- refer as necessary 3) Time 4 TEA. Conversation guide to identify triggers, enablers and actions to reduce social isolation and/or loneliness element of need if present	4) Wellbeing Spiral – guide to identifying when unhealthy behaviours have a significant 'back story' that needs addressing in first instance, i.e. an unhealthy behaviour used for emotional pain relief. 5) 5 Ways to Wellbeing plan
Strengths-based approaches include: • being 'hope-inducing', recognising the power of hope; • working collaboratively with people based on reflective conversations, encouraging them to make sense of where they are & to make meaningful choices i.e. what's working, what needs changing & how would I like to be supported;	• drawing on a person's resources, abilities, strengths, skills, talent and connections; • acknowledging that people are more than their care needs, are experts in their own lives and take the lead in their own care i.e. 'What matters to me';	• incorporating conversational assessment principles, 3 conversational model etc. **NB.** The 3-conversations model has links with the 3 levels of support we have identified and the 5-step process.
Impact Assessment Methods used for individual's– informed by level of support; customer satisfaction surveys, 5 ways to wellbeing outcomes, ONS Wellbeing scale (Locally, working on a Strengths-adjusted version of scale more in line with SOCIAL prescribing) Wellbeing spiral progress, case histories, KPI'S, etc. Community Development Impact Assessment methods for ABCD work, to be agreed.		
Support offered Level 1 and Level 2. (Level 3 referred into Alliance Housing-Community Support where complex/longer term support required) **Staffing** x1 full time equivalent	**Support offered** Level 1 Level 2 Level 3 ABCD **Staffing** x 6.5 full time equivalents (levels 1-3) X 2 full time equivalents (ABCD)	**Support offered** Level 1 Level 2 ABCD **Staffing** x 1 full time equivalent (Part time social prescriber and part time ABCD – arts)

Caseload per full time worker annually = 100-250 approx. Depending on level of support needed. i.e. levels 1, 2 and 3. **NB.** A workers caseload will need to be adjusted if one worker is employed in a dual role of Social Prescribing work with individuals (building individual's capacity) and Asset Based Community Development work with communities (building communities capacity) i.e. facilitating the maintenance of existing/setting up of new and sustaining community activities/opportunities. **Contact for further Social Prescribing Information – heather.whittle@n-somerset.gov.uk**

Community Connections

Our current Social Prescribing offer in North Somerset. Reflecting developments that have taken place so far (May/June 2019)

Glossary of terms – roles, approaches etc.

A) Community Navigator/Signposter/Village Agent etc. (level 1 in Pathway) – providing health or wider related information and advice on services, activities etc to improve health and wellbeing, using local knowledge and resource directories.
Who is it for? – works best for people who are confident and able enough to make use of info etc given on their own or with 'light touch' support.
How is it delivered? – directly face-to-face, telephone, email, post etc
Current Signposting services include – North Somerset Council Care Connect, Council Connect and On-line Directory. Voluntary, Community and Social Enterprise (VCSE) sector Info and Advice services. The 3 local Social Prescribing services identified in Pathway and imminently the PCN link worker services.
Minimum skill set - 1) Trained in Information/Advice provision.

B) Wellbeing link worker/PCN Link Worker etc (levels 2 and 3 in Pathway)
A person who; works with individuals, giving people time, focusing on 'what matters to me'. They connect people to VSCE and statutory services to help people make their chosen life style changes to improve their health and wellbeing.
Minimum Skill set - 1) Strengths-based working to include Active Listening and Conversational Assessment 2) trained in Information, advice and Support giving 3) Understanding of; a) The 5 Ways to Wellbeing and use in creating a 'What matters to me' tailored plan, b) Social Isolation and Loneliness Triggers, c) Emotional Pain Relief behaviours-Wellbeing Spiral, d) Impact Assessment methods, e) Health/self-care model, Social/strengths model as appropriate to role.

C) Community Development Link Worker (Supporting Communities in Pathway)
A person who; works with Communities using Asset Based Community Development (ABCD) methods to build community capacity, to provide activities to socially prescribe into.
Minimum skill set - 1) Strengths-based working to include Active Listening and Conversational Assessment. 2) Understanding of ABCD methodology. How the VCSE sector works to include, fund-finding, supporting sustainability, impact assessment etc.

D) Strengths-based approach – looks first at what person and community around them CAN do. Strengths = elements that help people deal with life challenges, to include;
- their personal resources, abilities, skills, knowledge, potential etc
- their social network and its resources, abilities, skills etc
- community resources, capacity of local Voluntary/Community/Social Enterprise groups (VCSE) etc

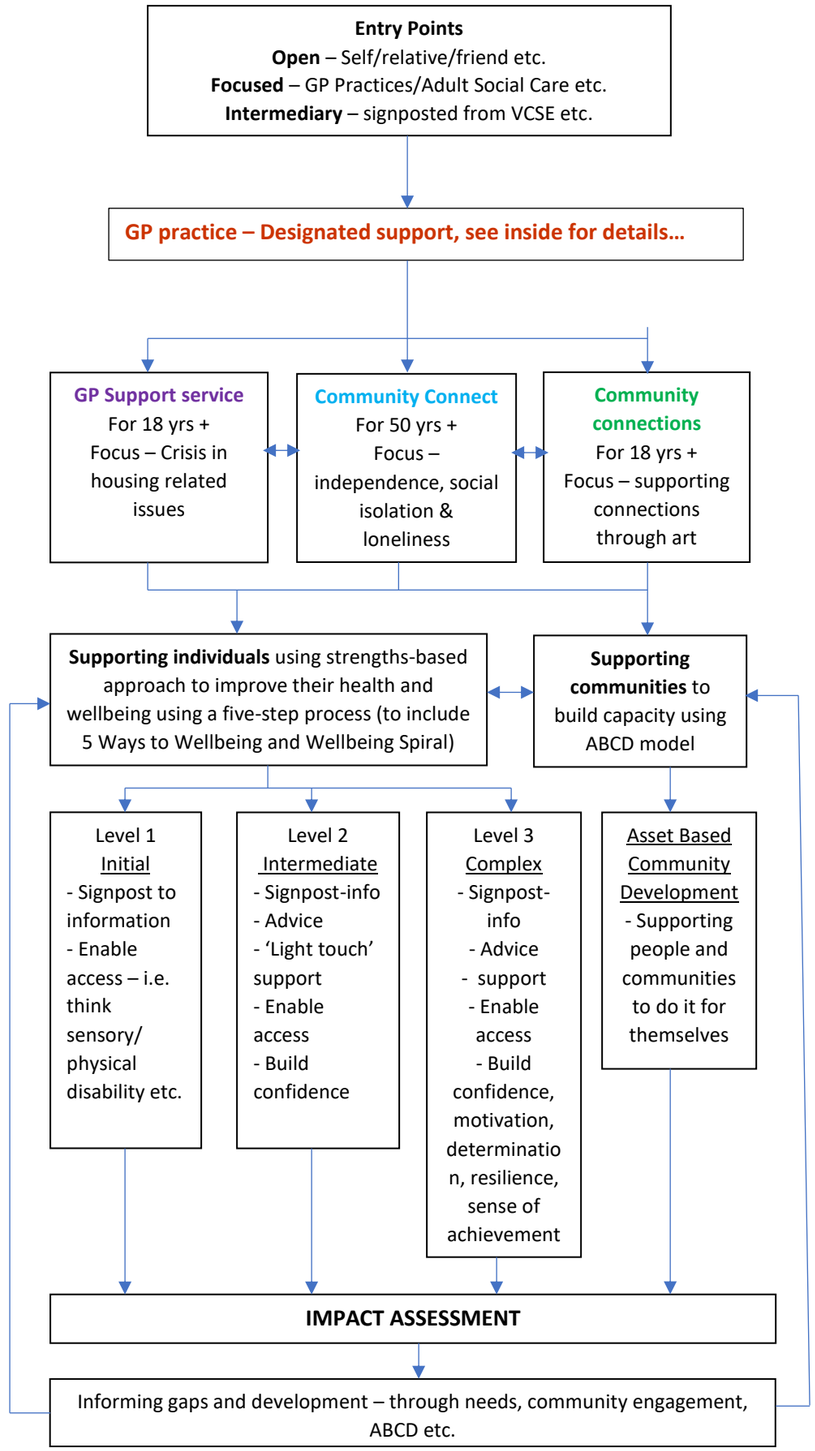
E) Ten Social Isolation and Loneliness (SI&L) triggers
Bereavement, Loss affecting body image, disability, memory changes, lost social network, significant changes in a) relationships b) Lifestyle, cultural deprivation, fear, trapped in unhealthy relationship/s.

F) The Wellbeing Spiral
Assessment guide to identify use of 'unhealthy behaviours' for emotional pain relief i.e. increased drinking, smoking, shopping causing debt etc to cope with stress. Guide used to determine first line of support i.e. Social Prescription or PCN health prescription.

Contact for further information – heather.whittle@n-somerset.gov.uk

Community Connections

Current Social Prescribing Service (SPS) Pathway



Community Connections

Promoting Early Intervention and Prevention in North Somerset. Using a strengths-based approach enabling people and their communities to improve 'what matters to them'.

Glossary of terms – Framework and Services.

1. Social Prescribing: Bristol, North Somerset and South Gloucester (BNSSG) agreed Framework (informs pathway) Framework consists of 5 activity areas;
1. Service entry points 2. Signposting 3. Social Prescribing-link worker support 4. Asset Based Community Development (ABCD) 5. Creative Impact Assessment

2. Social Prescribing Service (SPS) – two elements;
a) Individuals -**A Connecting people to communities service**, providing a non-medical referral option which may operate alongside clinical/social care, into VCSE services to improve health and wellbeing.
b) Communities - **A Connecting communities to people service** – Asset based community development, identifying needs and gaps in activities/opportunities provision and supporting development and sustainability.
Both use a 'what matters to me' **strengths-based approach**, recognising that people's health and wellbeing is determined primarily by a range of social, economic and environmental factors.

Who is it for? – It can work for a wide range of people to include those;
- with long term conditions - with complex social needs affecting wellbeing - who are socially isolated and/or lonely (see E. Ten Triggers)
- carers - using unhealthy behaviours as emotional pain relief i.e. drinking, smoking, shopping-debt etc.

How is it delivered? – variations in delivery to meet specific needs/local priorities. As a minimum will use the Social/Strengths based model of support and processes used will be evidence based, which locally will include;

a) **The 5 Ways to Wellbeing' model**; 1. Connect with people around you 2. Be active 3. Learn – keeping an active, interested mind 4. Take notice, seeing the joy in life 5. Give – your time, words, presence etc
b) **A Strengths-based approach**, using **Active Listening** and **Conversational Assessment.**
c) Impact Assessment methods

3. Social Prescription – has 2 symbiotic elements to make SPS work
a) Individual's needs - assessment, options offered, actions, goals/outcomes etc, to include identifying VCSE and statutory sectors potential provision in addressing needs, using The 5 Ways to Wellbeing.
b) Community Resources to deliver on individuals needs
Locally the VCSE sector is not equipped to deliver on the fast-developing Social Prescribing Services (SPS). VCSE sector will need support to receive the significant increase in social prescribing referrals.

4. Primary Care Network – Health Link Worker Service
Uses Self-Care model, promoting independence in managing individuals' health needs.
5. North Somerset Social prescribing Co-production group. Multi-agency group working in partnership to develop co-ordinated SP services.