# LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of the Lincolnshire Sustainable Transformation Partnership

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| Report to | **Lincolnshire Health and Wellbeing Board** |
| Date: | **1 December 2020** |
| Subject: | **Social Prescribing** |

**Summary:**
This paper updates the Health and Wellbeing Board on the following:

- Evaluation of outcomes of the Social Prescribing "proof of concept" funded through the Health and Wellbeing Fund/Better Care Fund between 2017 and 2019.
- Update on successful delivery of services since 2019 (including Covid response/support) with the introduction of funding for Social Prescribing Link Workers through NHS Primary Care Networks (PCNs) and Mental Health Transformation Fund.
- Update on future ambitions, current risks and opportunities for the Social Prescribing Service.
- Recommendations to the Board to seek its support and influence across the health and care system to agree commissioning intentions to provide sustainability and future expansion of the service.

**Actions Required:**
Recommendations are made to the Board on the following areas:

1. To review and reflect on the progress made in social prescribing funded from both original proof of concept and new funding streams and to 'sign off' completion of the proof of concept project.
2. To review ambitions for the service/new national expectations against the current risks and mitigations outlined in the paper.
3. To review what further support and influence the Board can provide across all organisations to further commit funding in order to mitigate short-term risks as the Social Prescribing Link Worker model grows in maturity, but also to review how as a system Lincolnshire supports community development initiatives to ensure there are services and activities available for Social Prescribing to refer to (particularly in light of impact of Covid-19).
4. To delegate future responsibility to the Personalisation Board to monitor further updates on this service and agree the Personalisation Board will in turn report by exception back to the Health and Wellbeing Board as required.

## 1. Background

Over the last three years since the Health and Wellbeing Board first awarded £369,016 '*proof of concept'* funding for Social Prescribing, significant progress has been made in the strategic ambition as outlined in the Joint Health and Wellbeing Strategy (JHWS) and in the NHS Long Term Plan to create an embedded Social Prescribing Service.

The employment of Social Prescribing Link Workers (SPLWs) was originally commissioned through this funding with Lincolnshire Community Voluntary Service (LCVS) and Voluntary Centre Services (VCS). The addition of further NHS funding streams through Primary Care Networks (PCNs) Additional Roles Reimbursement Scheme (ARRS) and Mental Health Transformation funding in 2019 and 2020 has meant the social prescribing service has grown to a dedicated workforce of 27 individuals working across the county. Over 1700 referrals have been made and 24,000 activities/interactions have been facilitated in the first half of this year alone.

Throughout the period the proof of concept project ran, the national interest, evidence base and expectations for Social Prescribing as a preventative health care solution increased significantly. National expectations from NHS England/Improvement particularly through Primary Care Network and Personalisation agendas are that Social Prescribing is now supported by ICS/STPs to become a fully integrated service offer spanning across health and care organisations.

With the impact of Covid-19 the service has adjusted and reacted speedily to the changing context of how interactions with participants are completed. It is not without recognition from across sectors that social prescribing has played an instrumental role in supporting individuals and communities' health and wellbeing through this difficult period. It is anticipated like so many other health and care services that the regular contact and support given to individuals will continue to be critical through the winter months. There is an expectation of significant demand for Social Prescribing services into next year and beyond.

The aim of this report is provide all members of the Board with a progress update of the outcomes delivered for the funding pilot, but also to highlight and seek the Board's support for next steps to ensure we collectively build upon this offer and make it fully sustainable in future years. The current service position while in receipt of funding through the NHS is not without vulnerability both in terms of the viability of its operating model, but also its strategic development to thrive and actualise the full outcomes expected. This report will apprise the Board of these risks; where current mitigations have been made to date and where further support is required.

As outlined at the end of this report the evidence base of the impact Social Prescribing can have is strong (as described in the Joint Strategic Needs Assessment) where it is demonstrated it can deliver against targets for all age groups, all levels of need and for both physical and mental health needs. It is uniquely positioned to support and bring together service offers across statutory and voluntary sectors. It is a perfect example of how future ICS workforce can work together to deliver holistic care across clinical and non-clinical pathways as well as serving as a preventative service stopping many hundreds and ultimately thousands of people in the county requiring access to more expensive treatments, medications or care.

## 2. What is Social Prescribing?

Social prescribing enables professionals across health and care, wider statutory and community organisations to refer people to a range of local, non-clinical services. 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.

In 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. For

many people the experience of social prescribing becomes an alternative to receiving a traditional medical prescription and successfully prevents/delays deterioration in physical or mental health.

Social prescribing also aims to support individuals to take greater control of their own health through shared decision making, personalised care and support planning and builds on what matters to them. Social Prescribing is a key priority for the health and care systems following the publication of the NHS "*Universal Personalised Care*", where it is identified as one of the 6 components of the model. It is for this reason that it is our suggestion that Social Prescribing going forwards is monitored on behalf of the Health and Wellbeing Board by the newly established Personalisation Board (alongside reporting as necessary to NHSE/I for specific areas of the funded workforce).

Additionally of note is that a Personalisation service specification originally included in the 2020/21 Primary Care Network Contract Directed Enhanced Service (DES) included social prescribing; however following a consultation period with the British Medical Association and review of the DES nationally this was delayed for implementation until 2021/22. It remains a key component for delivery and further details of the new specification are expected in coming months.

Social prescribing works through different levels of support. This ranges from simple signposting e.g. from a GP receptionist/care navigator or a person is provided with dedicated support from a trained Social Prescribing Link Worker. A Social Prescribing Link Worker's key role is to work with a person to help restore and build confidence and offer practical support over a number of days/weeks. Link workers and participants work together to find them new connections and interests and ultimately build back a participant's skills and resilience for the future. A combined workforce help to refer, signpost, support and deliver activities along this integrated pathway.

## 3. Development of the Local Model

In 2017 the Health and Wellbeing Board awarded £369,016 of non-recurrent funding to the Neighbourhood Working Programme to support the development of a social prescribing / community connector's concept in Lincolnshire. The proof of concept commenced in the summer of 2018 in Gainsborough. The impact at a Neighbourhood level was almost immediate, and was extended across the County with additional short term funding from GP Federations, CCG's and Better Care Funding. The funding supported the employment of 18 WTE Social Prescribing link workers (including senior roles), equating to 23 posts. All posts were employed and managed by Voluntary Centre Services (VCS) and Lincolnshire Community Voluntary Service (LCVS).


When Health and Wellbeing Fund/Better Care Funding came to an end in 2019 it was with support from Lincolnshire CCG through each PCN (as relevant) that existing staff employed through VCS/LVCS were retained. New contracts began with no disruption to the service provision.

The PCN ARRS Scheme includes Social Prescribing Link Workers as one of 12 new roles that are part or fully funded by NHSE/I which should be embedded into local MDTs over the next 4 years. The 14 PCNs in Lincolnshire have all retained or recruited to at least one Social Prescribing Link Worker under this scheme. The number of workers recruited to, is for each PCN to self-determine within a set annual budget for all 12 roles, which updates every April. PCNs have the flexibility to engage link workers themselves, or to work in partnership with existing local social prescribing connector schemes to provide social prescribing services. PCNs can use whatever contractual arrangements work best at local level to facilitate these partnerships.

On behalf of the 14 PCNs the CCG has two contracts in place until March 2021 with LCVS and VCS to passport PCN funding monitored through a shared outcome based specification. Through additional national funding secured through the Community Mental Health Transformation Project additional Social Prescribing Link Workers in Boston, Gainsborough, Grantham and Lincoln were recruited to and these posts are also contracted by the CCG to LCVS/VCS for a further 2 year period. There is potential for a further 7 Social Prescribing Link Workers through Mental Health Transformation Fund Bids for a next wave starting next year.

Feedback from Primary Care Networks has been varied, with some strong advocates for this type of model particularly when the link workers are embedded in GP practices (pre covid), this makes access much simpler and they are seen as key members of the local MDT's. It becomes challenging when 1 link worker covers a number of GP practices because they are less visible and the relationships are harder to develop.

Further detail about the progress and outcomes generated by the current service offer delivered through Lincolnshire Community Voluntary Services and Voluntary Centre Services to date can be found in **Appendix A**. This includes links to videos of case studies where participants explain the impact social prescribing has had on their lives.

## 4. Lincolnshire's Ambition 2020 onwards

NHS England/Improvement has outlined the following expectation for local ICS partners to formulate a Social Prescribing Strategy where:

*"Local partners should work together, building on existing social prescribing practice to achieve the following:*

- *enable every PCN to employ directly or contract for social prescribing link worker services, as a key part of their multi-disciplinary team*
- *build on existing local social prescribing schemes, avoiding disinvestment in current schemes or duplication, and enabling all social prescribing link workers (wherever they are employed) to work together as a wider team across the local area*
- *recruit new additional social prescribing link workers (using the national funding available to PCNs, via the Network Contract DES) to support expanding social prescribing services across PCNs*
- *work together with local partners to nurture the diversity of community assets, support VCSE organisations and community groups, including religious and faith-based groups through development support".*

A Social Prescribing Working Group has been established which brings together leads from PCNs, CCG, Local Authorities and Voluntary Sector to coordinate the development of a local Social Prescribing Strategy and to monitor progress with the service. The group is working together to find the best local arrangements for embedding social prescribing services in PCN footprints and that, regardless of the engagement model, link workers will collaborate in local areas, to overcome isolation of staff, make best use of limited resources and develop strong connections with local diverse communities and partner agencies. By being integrated into a

multi-disciplinary team on a neighbourhood basis Social Prescribing Link Workers can draw on a deeper pool of knowledge and experience, which will add value and efficacy to the role.

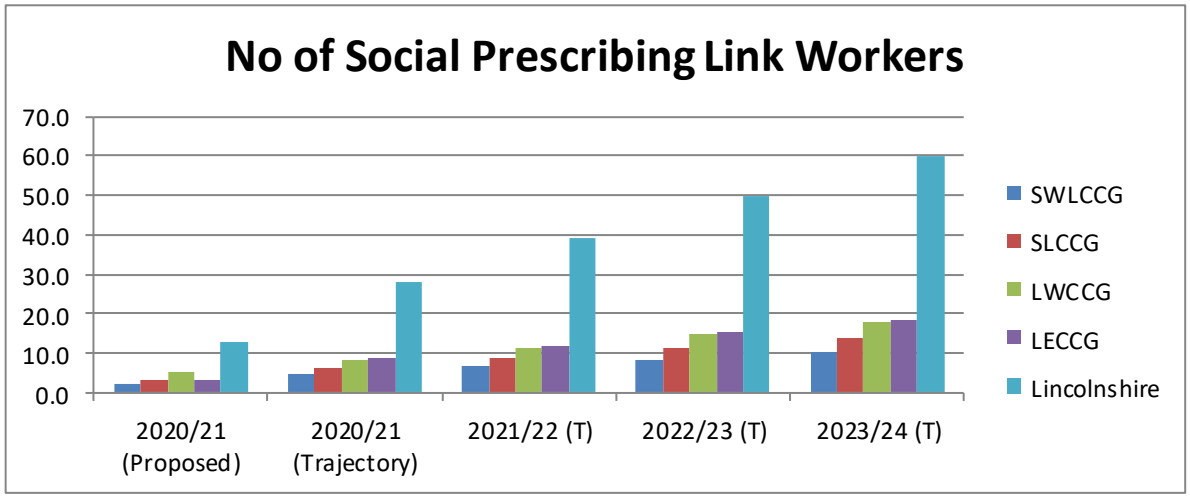
Lincolnshire's aim is to have a co-produced, digitally enabled social prescribing offer at the heart of communities that will support local populations. It will have a virtual offer and will join the various commissioned and non-regulatory services together, within a funding envelope that will enable local community services (VCSE) to thrive and flourish – meeting the requirements of local populations 2020 onwards.

There are 6 strands to our strategy;

1. Information and Advice (Level 1)
2. Embedding social prescribing (Level 2 & 3)
3. The Digital Platform – co production
4. A simple way to access – to included commissioned services
5. Support for community groups
6. Integrated Volunteering Approach

As a health and care system recognising the importance and value of a flourishing and thriving VCSE is also key to meeting this ambition, over the next 4 years as the service expands, working in partnership with commissioned services, but recognising that the real value of this approach is people being able to access a whole range of VCSE offers including those small to medium size groups.

As described earlier the evidence base for Social Prescribing continues to develop and expand. NHSE/I are hoping to see over 1000 social prescribing link workers recruited to nationally during 2020/21 and the development of our local Social Prescribing Strategy includes a target that over the next four years there are 60 SPLWs in employment. The NHSE/I trajectory in order to realise full impact of the service this is the calculated number of roles required based on the Lincolnshire population.




It is the findings from the Social Prescribing Working Group discussions that development of these numbers may not be realised solely by the employment of new Social Prescribing Link Workers via PCN funding (predicted scoping shows PCNs are expecting to recruit up to 10-20 more posts in this four year timescale).

It can however be achieved by examining how existing posts across commissioned services deliver (even in part time equivalents) to this model. It is recognised that within the county a huge range of formally commissioned and informal agencies and groups are facilitating social prescribing either through referrals or direct service provision. Wellbeing Lincs, One You, Age UK Community Connectors Scheme and Carers First services all have aspects of social prescribing as part of their offer for example.

It must be remembered that Social Prescribing is a much wider concept than just the practical operational delivery of Social Prescribing Link Workers.

It is our strategic intention that an integrated offer supported across voluntary and statutory services would enable a fast-tracking to the target number of workers in a shorter time span which would enable faster realisation of outcomes. To aid this facilitation it is proposed that a strategic lead for Social Prescribing is employed (with accountability to the Voluntary Executive Team VET) on an 18 month post using identified NHS Charitable Funds and possible match funding to this from statutory sector organisations.

With strategic backing from the Health and Wellbeing Board the development of a common specification will be developed from April 2021 where all organisations employing social prescribing link workers will be expected to work to a common competency framework, with supported supervision and training and integrate as part of a Multi-Disciplinary Team (MDT). Further complementary posts will be employed directly by GP Practices through the Additional Roles Reimbursement Scheme (ARRS) - such as Health and Wellbeing Coaches and Care Coordinators. The service will be monitored against a Social Prescribing and Community Based Support Outcomes Framework.

**5. Overview of Risks and Proposed Mitigations**

In the short term, the social prescribing working group recognise that additional capacity and resource is required to bring the five strands of the strategy together over the next 12 months, building a model that is scalable, sustainable and the envy of others.

The PCN ARRS scheme has presented both an opportunity to continue the service provision initiated by the proof of concept funding, but has additionally brought risks. Primarily this is for three reasons:

- Funding is only committed to/drawn down on an annual basis (national rules);

- The posts are 'in competition' with the other 11 roles which are also valued and prioritised for recruitment by PCNs and;

- In the short-term the model has become dependent on the coordination between 14 PCNs to all commit to the same county-wide model of provision. In order to deliver a service that covers its on-costs such as management, training, travel expenses there is a 'break-even' point where the service can/can't be provided on a cost neutral basis by the voluntary sector.

LCVS and VCS are working collaboratively to develop a whole cost recovery model which can be communicated to all PCNs plus a recorded webinar to demonstrate outcomes to date and how on costs and developments of the service are covered. There is a short window of opportunity to complete this task in the lead up to Christmas before PCNs make renewed commitments in April 2021.

Harnessing these combined statutory and community assets into an integrated service offer that is both accessible and sustainable in the long-term is our key ambition for Social Prescribing and is a key component of our developing Social Prescribing Strategy. Facilitating in particular targeted interventions for people according to needs e.g. social prescribing for people with alcohol/substance misuse issues, prescribing for participants who are homeless, support for younger people. Widening the menu of choices offered through social prescribing and also the accessibility for all groups to be in receipt of services is vital.

## 6. Conclusion

We have highlighted through this report how the Social Prescribing Service has come a long way in the last three year period based purely on a range of non-recurrent funding. It is our proposal that it is now time to mainstream and commit to social prescribing as a service across our system. We have moved beyond proof of concept and the model already brings together a huge range of organisations to deliver the holistic care for individuals' health and wellbeing.

Gaining acknowledgement and commitment from senior leadership to prioritise social prescribing (so it is not sat on the periphery or a 'nice-to-have') but seen as integral service in care provision is our aim and challenge. We need to keep building on the model, making it gain further traction and recognition as service delivering a broadening offer to more people.

Gaining strategic leadership input into the oversight of the development of a Social Prescribing Strategy where we can move the provision under a sustainable funding stream is a key priority. It requires acknowledgement this is not just about PCN funding for Social Prescribing Link Workers, but it is about how mental health, social care, housing, the VCSE sector etc work together and bring funding together so we are not relying on one funding stream.

As demonstrated by the frequent referencing to social prescribing in both national guidance but also local strategies we will need strategic support to help harness this together (via the proposed strategic role or via other ideas we haven't yet considered). We would like to invite the Board to consider the detail of this report and welcome their strategic input/steer and guidance on their thoughts, to help shape our strategy and specification.

## 7. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Groups must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

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| The development of Social Prescribing is integral within the ambitions of the updated *Joint Health and Wellbeing Strategy (JHWS)* and features in all of the priority area action plans. The *Joint Strategic Needs Assessment* (JSNA) evidence base is regularly consulted upon to reflect which areas of need and which target population groups and areas of the county we should prioritise social prescribing services against. It is with regard to this specifically that targeted work on social prescribing for people with mental health needs was prioritised as one example. |

## 8. Consultation

The local Social Prescribing Steering Group is keen to continue to work in collaboration and partnership with colleagues from across the system and where appropriate co produce aspects of the service with people, such as already happened with support from EveryOne to coproduce the new Social Prescribing digital platform.

## 9. Appendices

| These are listed below and attached at the back of the report | |
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| Appendix A | **Lincolnshire Social Prescribing Service Update Report from Voluntary Centre Services (VCS) and Lincolnshire Community and Voluntary Service (LCVS)** |

## 10. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were use in the preparation of this report.

This report was written by Sarah Stringer (CCG Transformation Manager East Locality) and Kirsteen Redmile (STP Lead Change Manager Personalisation) who can be contacted on 07557 938447 or 07580 677466 or sarah.stringer4@nhs.net or kirsteen.redmile1@nhs.net

**Appendix A**

**Lincolnshire Social Prescribing Service Update Report from Voluntary Centre Services (VCS) and Lincolnshire Community and Voluntary Service (LCVS)**

# Lincolnshire Social Prescribing Service Update Report – April-September 2020

Voluntary Centre Services (VCS) and Lincolnshire Community and Voluntary Service (LCVS) work in partnership to offer a county wide social prescribing offer to all 14 Primary Care Networks (PCN's) across Lincolnshire, as well as to meet the needs of the new Mental Health Transformation projects in Boston, Gainsborough, Grantham and Lincoln.

Over the past year there has been a period of expansion of the service with 11 new Link Workers recruited to meet the demands. Across the county, there are currently 27 Link Workers, 8 being directly aligned to the Community Mental Health Transformation Projects (CMHTP) all Link workers offer 1:1 support and advice to individuals, supporting them to connect with their community, helping to reduce social isolation and improve their health and well-being.

These teams are supported by a small administrative team (3 FTE) and management teams who support the development of the programme at a strategic level.
In the first two quarters of 2020 (April-September) the countywide service has received over 700 new referrals to add to an existing caseload of 660 at the start of April. This level of referral is around 70-75% of our normal expected volume, based on the average quarterly referral rate over the previous 12 months.

Sources of referrals:

- GP practices 40%
- LPFT 25%
- Integrated Neighbourhood teams 10%
- Other VCSE organisations 4%
- Adult Social Care 3%
- Others include hospital and Well Being Lincs 7%

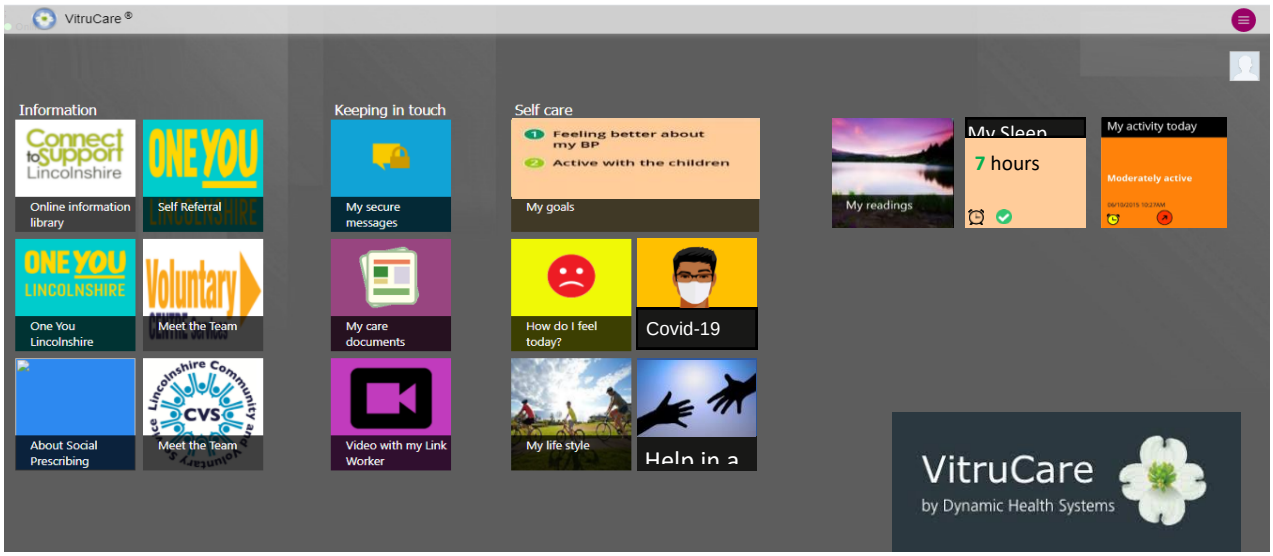
This demonstrates that social prescribing is about supporting PCN's the Neighbourhood Teams and their communities allowing access for all residents, truly demonstrating an asset-based approach to population health management.

The increase in referrals from LPFT demonstrates this is a referral route that has increased significantly as the COVID lockdown continues to impact the wider secondary healthcare system.

The Link Worker team have carried out almost 24,000 support activities during first half of the year, ranging from telephone calls, liaison with services, online MDTs as well as making use of the new Vitrucare video call (VCVC) platform. Vitrucare is a new co-produced digital platform introduced in early 2020 and fully developed by October 2020. The platform has enabled the link workers the opportunity to link and support participants virtually via the Video call to video call element, to date we have successfully made over 280 individual calls, with over 50 clients registered and regularly using VCVC. Both LCVS and VCS staff are fully trained and offering the platform to all participants.

The fully developed platform enables participants to work with their link worker, virtually or via secure call, to develop a suite of digital self-care tiles that support their own personal goals and well-being.

Below is a screenshot of a platform and the variety of tiles available to our Social Prescribing participants.




Tracy's video really captures how the Social Prescribing virtual VCVC element has transformed her life and supported her through her dark days of lockdown. https://vimeo.com/425830427
Since 23rd March 2020, the Link Worker teams have additionally supported 1,134 vulnerable individuals through check in and support telephone calls to support individuals to navigate the COVID lockdown. Support provided has varied from our basic check-in
and support call, offering basic signposting advice to ensure individuals can access basic supplies, through to regular weekly check in calls.

This video case study of Ann, an elderly lady in the Grantham area, who received a Check in and Support call and subsequent longer-term weekly calls from Naomi. https://youtu.be/fkeyAnkjXfs

The video https://youtu.be/QtfX2c5xLzk created between a GP, Neighbourhood Lead and Social Prescriber explains the activities that have taken place to support clients identified on vulnerable patient lists throughout the first 3 months of lockdown.
During the lockdown period we have continued to see positive outcomes for our clients, with over 250 new services accessed and individuals continuing to access lifestyle support through digital tools offered by One You, Citizen's Advice and smaller community groups.

Going forward, our Link Worker team are able to support individuals who would benefit from connecting to their community and continue to accept new referrals for social prescribing across the county. The Link Workers have adapted through the ongoing restrictions and found new ways to connect with clients, including socially distanced walks, video calls and even group chats, in line with current government guidance. Clear risk assessments have been developed protecting both staff and participants, to ensure that we can begin to reconnect individuals with the community in a safe way.

Types of activity could include social activities, interests/hobbies, peer support groups, dietary support, relaxation, exercise, voluntary opportunities or other lifestyle changes that could improve health and wellbeing.

In addition to providing support to individuals the wider VCS and LCVS teams are supporting local community groups to navigate the current challenges and are focussing on supporting the recovery of the community and voluntary sector as lockdown measures continue to fluctuate.

For many groups this means finding new ways of operating and delivering services, whilst providing ongoing support to their staff, volunteers, and clients. We anticipate there to be a period of significant change for the sector as the pandemic continues to have a catastrophic effect on those services that are now needed more than ever.
Nationally, there is an on-going project supported by Nottingham Trent University, Sheffield Hallam and NCVO, VCSE Barometer dashboard. tracking and recording national trends by producing a monthly barometer survey of the impact of Covid-19 on the voluntary, community and social enterprise (VSCE) sector.

The barometer paints a bleak picture, with 47% of organisations responding stating that they were unlikely to be operating this time next year: whilst 26% reported significant negative impacts on delivering objectives, this time next year.

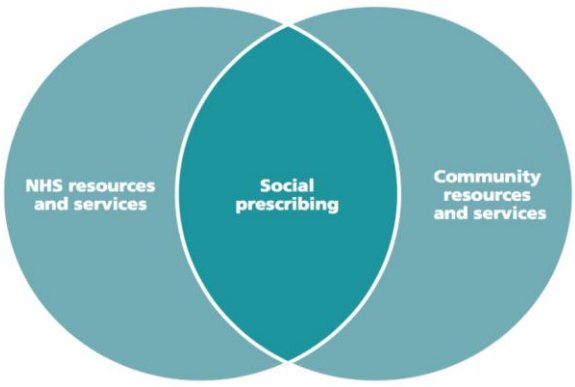
In a recent Lincolnshire report produced in the early stages of Wave 1 Lockdown, following a survey of all registered organisations the organisations that responded stating that "A significant proportion (almost half) of the survey respondents have faced a major reduction to their financial capacity (50% or more) – this is likely to get worse over the next 3 months."

The Impact of the Coronavirus on the Activities and Capacity of the Voluntary and Community Sector in Health and Care in Lincolnshire.
We recognise that our Social Prescribing offer is dependent on a strong and vibrant voluntary community sector (VCSE) if this provision ceases or reduces this will directly impact on referrals and ultimately the success of Social Prescribing across Lincolnshire.
East Lindsey PCN headed by Dr Ko and Dr Thomas and Neighbourhood lead Matthew Fisher recognised the correlation between a robust and sustainable VCSE sector and a flourishing Social Prescribing offer.

In September, the PCN commissioned Lincolnshire's first ever Social Prescriber connector pilot; this role is led by an LCVS Community Development practitioner whose sole aim is to develop and support community capacity and resilience by including developing localised community hubs, similar to the successful Alford Hub : The Alford Community Hub

The community hub model enables and empowers local communities to develop their own groups and interests. The Social connector works closely with the PCN Social Prescriber Link workers ensuring they are aware and can support their local participants to access information and groups in their communities.

The model places social prescribing and health at the core of communities.



The last 12 months have been turbulent; PCNs being established, reform of CCG governance, COVID-19, evolving NHS guidance, development of viable IT solutions for integrated data management and outcome reporting and ongoing discussions around funding and contracts.

Management and coordination of the service has enabled resilient and continued services to expand ensuring safe and secure practices whilst participating in Community Mental Health Transformation teams (CMHT) and new collaborative project ideas such as Green Social Prescribing and NHS investment in Social Prescribing assets.

Both LCVS and VCS are committed to working in partnership and bringing significant NHS and other resources into the county, this will be reflected in the whole cost model which is being developed. They are committed to building and supporting partnership working, this has already been recognised at a national level with their involvement in the Mental Health Transformation projects.

In order to ensure, referral numbers meet PCN expectations and participants receive the best possible services, we need to link our referral platforms to other Lincolnshire systems, SystmOne, Emis, Mosiac, Rio and others, these need to be fully integrated and interoperable, offering real time solutions, reporting and monitoring. This project is being supported by a successful NHS England Annex bid; the funding will support the project management support and integration however the system purchase and running costs will need to be negotiated across the whole system.

There needs to be a firm commitment to Social Prescribing across the county, not just at PCN level but across all sectors including mandated service provision; in order to develop a single offer, contract security and stability will need to be reached; allowing both the staff and the model time to embed and mature. There will also be the need to share resources both at an operational level but also strategically, it is recognised that a Social Prescribing lead is needed to drive the system change and direction.

Social Prescribing is now embedded in the NHS offer, it forms part of the NHS's ten high impact actions (2016) and now is an integral part of the NHS DES and the Five-Year plan. Critical, is how we integrate our Social Prescribing offer with communities, other sector organisations and providers ensuring we can demonstrate the full impact whilst preserving and supporting our voluntary and community sector.

# Lincolnshire's digitally enabled Social Prescribing Model 2020

Name : **Sue**
Age 60
Job Title : Retired Teaching Assistant
Sue lives in a village in rural Lincolnshire with her Husband. She retired from her Teaching Assistant Role in the local school18 months ago due to health problems. Since this time Sue has become increasing isolated and misses her role in the local community which often leads her to feeling lonely, isolated and low in mood.

While visiting her GP's for a routine health check, as usual, Sue spends time talking to the GP's Receptionist about her love of crafting, the facilities she used at the school and how she misses the company and sense of accomplishment she gained from creating pottery.

During the visit to her GP's the Receptionist introduced Sue to Sheila, a Local Voluntary Digital Navigator. Shelia spent some time showing Sue the vitrucare digital platform and how Sue can use the connect2support tile to find out information about art groups in the local area. Shelia gives Sue her own access to the system that she can down load and use on her tablet at home.


Sue used vitrucare at home and found a pottery class in the next village. Sue makes contact with the group and attends the group on a regular basis. Sue notices, through self recording /tracking on the viturcare app, that since attending the classes her mood has improved and her motivation to take part in exercise has returned, in turn helping Sue control some of her health issues. Sue now looks forward to making pottery twice a week with her new friends. Vitrucare continues to target information towards Sue based on her postcodes and interests. Sue is also given a secure messaging functionally to link with her social prescriber.

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