Chichester Social Prescribing year one evaluation report July 2018 – July 2019

Background

- A partnership project between Rural North and Chichester Local Community Networks with Chichester District Council
- Jointly funded for two years (2018 – 2020) by Chichester District Council, Chichester and Rural North Chichester (RNC) GPs, Clarion Housing, A2 Dominion, Friends of Midhurst Community Hospital and Chichester City Council
- 4 Community Referrers employed by Chichester District Council within the Wellbeing team in the Communities, Housing and Benefits Division.

Year One Statistics

- **596 referrals** - the team are embedded within the practice teams and have received referrals from GPs, Proactive Care and other practice staff.
- These referrals are for **Benefits Advice, Money and Debt Advice, Housing Advice, Social Isolation, Employment and Training and Lifestyle.** Many clients were referred for multiple reasons which made the referral more complex.
- **393 of these clients** have a long term health condition, **282** of these clients have a mental health component to their health condition.
- **Over 34% (202) of clients** were referred to the service with housing issues, **76% (153) of these clients** were also reported to having long-term health conditions.
- **53% of all referrals with housing issues** also had a mental health condition.
- **64% of all referrals with housing issues** were tenants of Hyde Housing Association.

Positive Outcomes

- **100% positive outcomes from Patient Evaluation Data; 79% clients** found the service to be "Very Useful", **21% clients** found the service to be "Useful"
- Hyde Housing Association have recognised the support provided to their tenants and have contributed funding to pilot a new part time Social Prescriber post focusing on Housing Association tenants.
- The team have identified gaps in local services detailed on p19/20
- Additional funding secured to the service and highlights achieved for the year are detailed on p20
- The team is contributing to the development of the Sussex wide Social Prescribing network sharing experience and learning with others

Introduction

The Chichester Social Prescribing service launched in July 2018 with 4 FTE Social Prescribers working across all GP practices in the Rural North and Chichester Local Community Network areas. The boundaries align with Chichester District Council but include Pulborough Medical Practice. The service is funded for 2 years initially 1st July 2018 – 30th June 2020 in partnership with Chichester District Council, Chichester and Rural North GPs, Clarion Housing, A2 Dominion, Friends of Midhurst Community Hospital, WSCC and Chichester City Council. This report details the activity and outcomes achieved by the Social Prescribers during their first year.

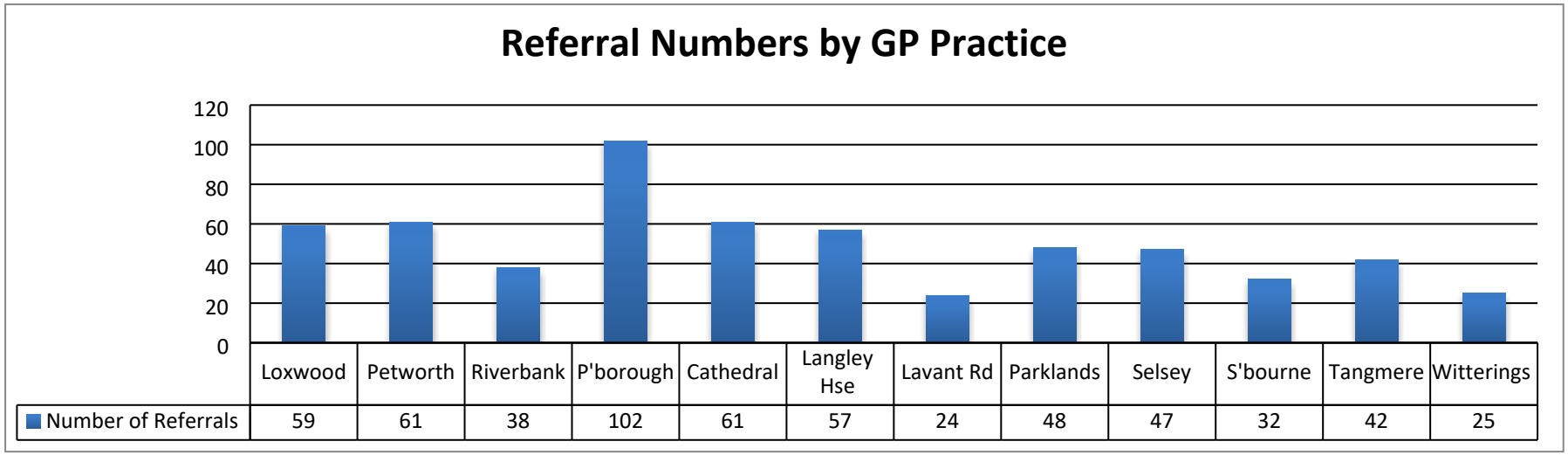
Client referral activity

In the first year (1st July 2018 – 30th June 2019) the service received 596 referrals to the service from GPs and medical professionals across the LCN areas as shown in Figure 1 p3. There were 260 referrals received from practices in the Rural North (referred to as RNC) and 336 from the Chichester practices.

Around 15% of referred clients (90/596) did not go on to take up service for various reasons, including that their issue may have become resolved or the referral may have been deemed inappropriate. The team has continually worked hard to build close working relationships with services and feedback to the services about the appropriateness of referrals if necessary. This has led to a reduced number of inappropriate referrals being received as the Social Prescribing service has become established.

The total number of recorded sessions lost due to clients not able to attend their booked sessions was 87. This could be due to the complexity of the clients that the service supports, as many of the reasons given for these missed sessions included health complaints and transport issues. The approximate service response time from referral to first contact made with client was 6.5 days and the average length of Social Prescribing intervention was 92 days (around 3 months). The results show an average of 4 sessions were provided per client including on average, 2 in clinic appointments, 1 home/community visit and 1 phone consultation.

Figure 1: Graph to show referrals numbers received by Social Prescribing Service in year 1 listed by GP Practice.



Referrals are fairly consistent across the practices bearing in mind the population of the Rural North area is much smaller than Chichester, also some practices are bigger than others and as such have more GPs and staff to make referrals.

The reduced number in the Rural North area could be due to the Social Prescriber for Midhurst and Petworth being absent from post since March 2019 due to sickness.

The reasons given for referrals are listed in Figure 2 below. The total number of reasons given for client referrals equals 1170, demonstrating that many of those 596 clients were referred for multiple reasons and as such have a level of complexity to them. Isolation features in 53% of referrals and was often combined with other confounding factors such as complex issues associated with housing, benefits and mental health issues.

Figure 2: Graph to show referrals numbers received by Social Prescribing Service in year 1 listed by reason for referral.

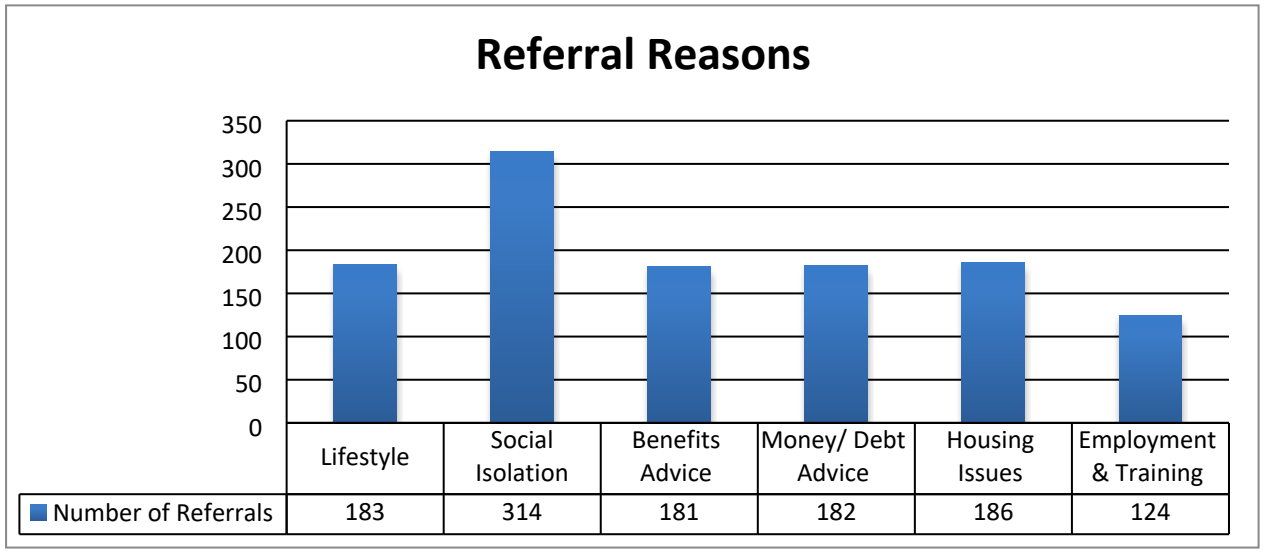
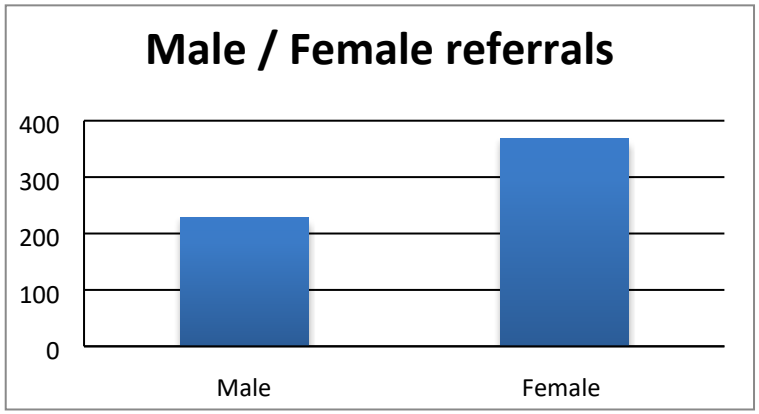
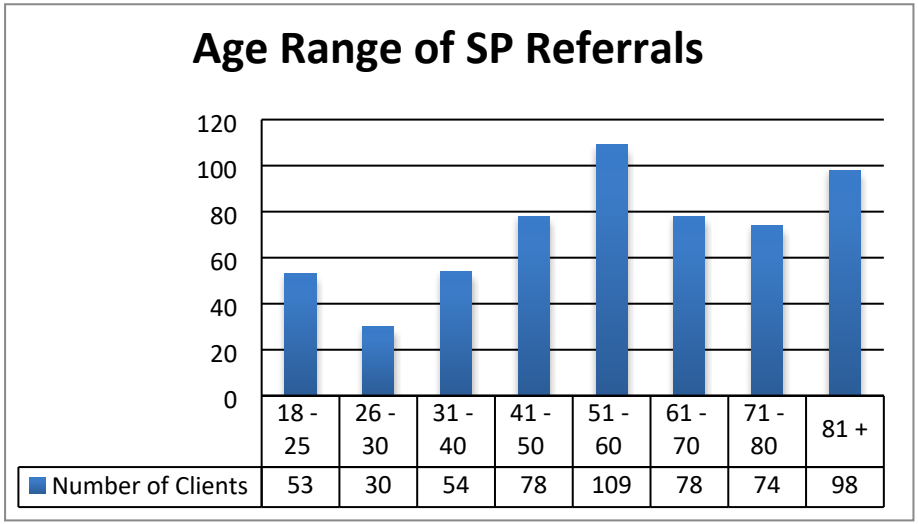


Figure 3: Graph to show referral numbers received by Social Prescribing Service in year 1 listed by gender.



An overview of the gender of clients referred to the service is shown in Figure 3. The percentage split across the patch was 38% Male to 62% Female clients. This was relatively the same in the individual area. This male / female split is common in frontline services as for many reasons, often women appear to be more open to support and are more comfortable discussing issues while men have been shown to be harder to reach or engage with services.

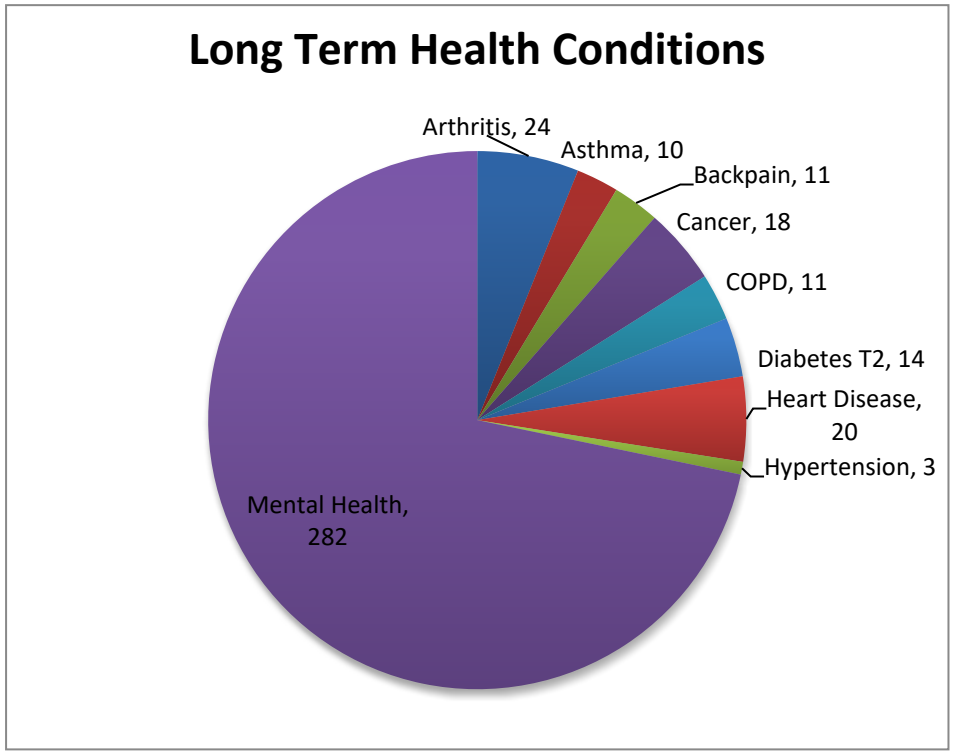
Figure 4: Graph to show age range of client referrals received by Social Prescribing Service in year 1



An overview of the age range of referrals received by the service is shown in Figure 4. Of the referrals received by the service, the youngest client was 17 and the oldest client was 98 which indicate the large client demographic the service covers. The average age of clients was 58 years old, which is often a time when clients are considering major changes in their lives such as retirement. Additionally many people around this age are struggling to manage care of their parents and grandchildren, whilst also dealing with their own challenges and health concerns (Figure 5).

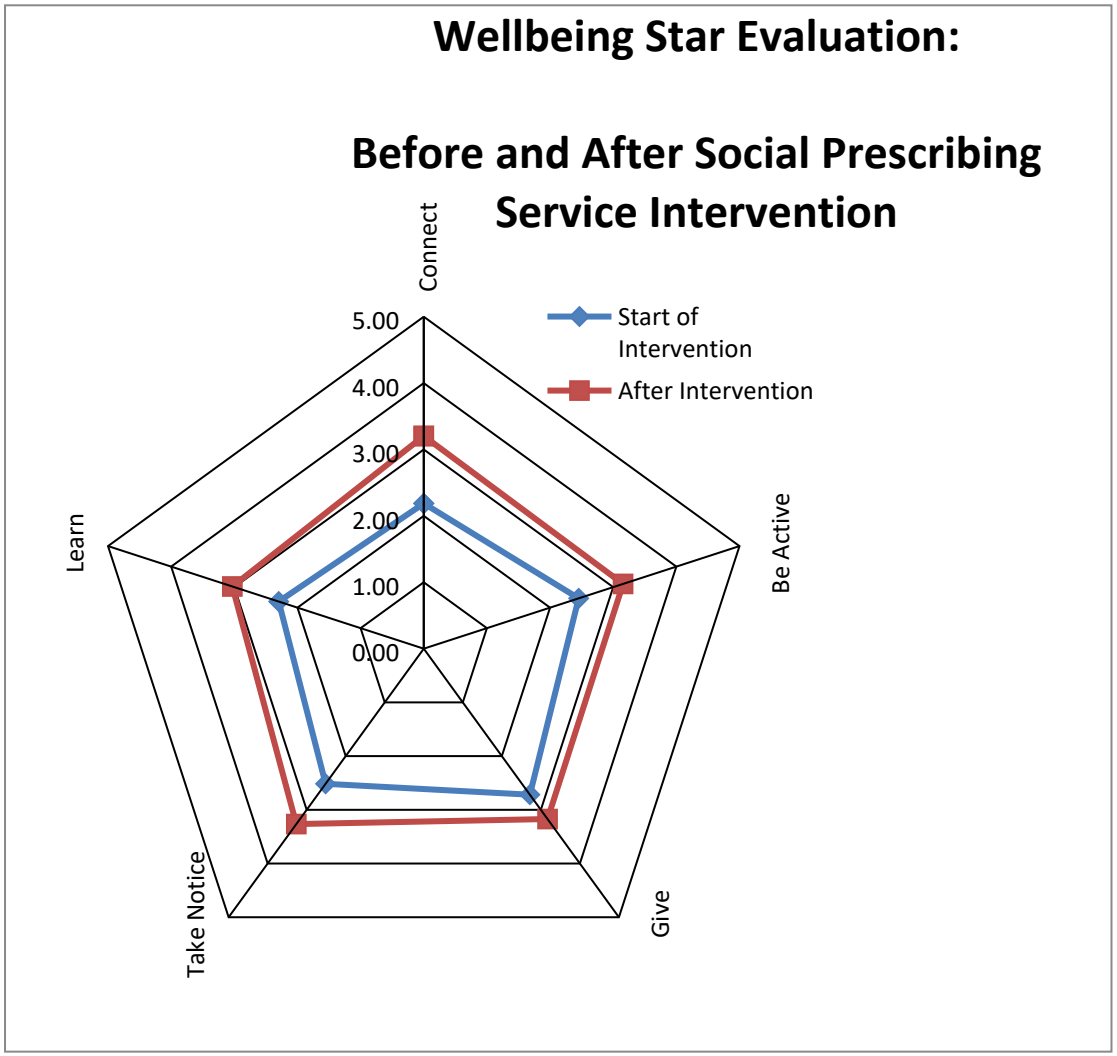
Over 66% (393) of clients referred to the Social Prescribing service in the first year were recorded as having a Long Term Health Condition. Health conditions can present a barrier to accessing services, such as challenges with transport and communication which make the cases more complex. The Social Prescribers have all become very skilled in creative person centred problem solving to assist clients to overcome these barriers where possible. Examples include assisting a client with learning disabilities and sight issues to access therapies by escorting them to check they were a good match with the service and then assisting the client to apply for a bus pass so that that they could travel there with another attendee. Another example is assisting clients by accompanying them on their first visits to a service and then arranging transport from within that service to pick them up for future visits. This works really well as once relationships are forged clients are often able to be supported in other ways by community groups and their members

Figure 5: Graph to show referrals recorded as having a long term medical conditions



282 clients were referred to the service had a mental health condition and whilst they were not referred for support with their mental health it adds a layer of complexity to the case. Examples include agoraphobia, anxiety disorders, bi-polar, depression, eating disorders, PTSD and split personality disorder. Dementia has also been included as it impacts on a person's mental health and ability to cope and of course some people have more than one long term condition.

Figure 6: Wellbeing Star evaluation



One aspect of the Social Prescribers role is to support the client to improve their resilience and self-efficacy.

Figure 6 shows before and after Social Prescriber intervention self-assessed wellbeing scores, using the Wellbeing Star tool. The Wellbeing Star measures change using the 5 ways to Wellbeing, Connect, Be Active, Give, Take Notice and Learn.

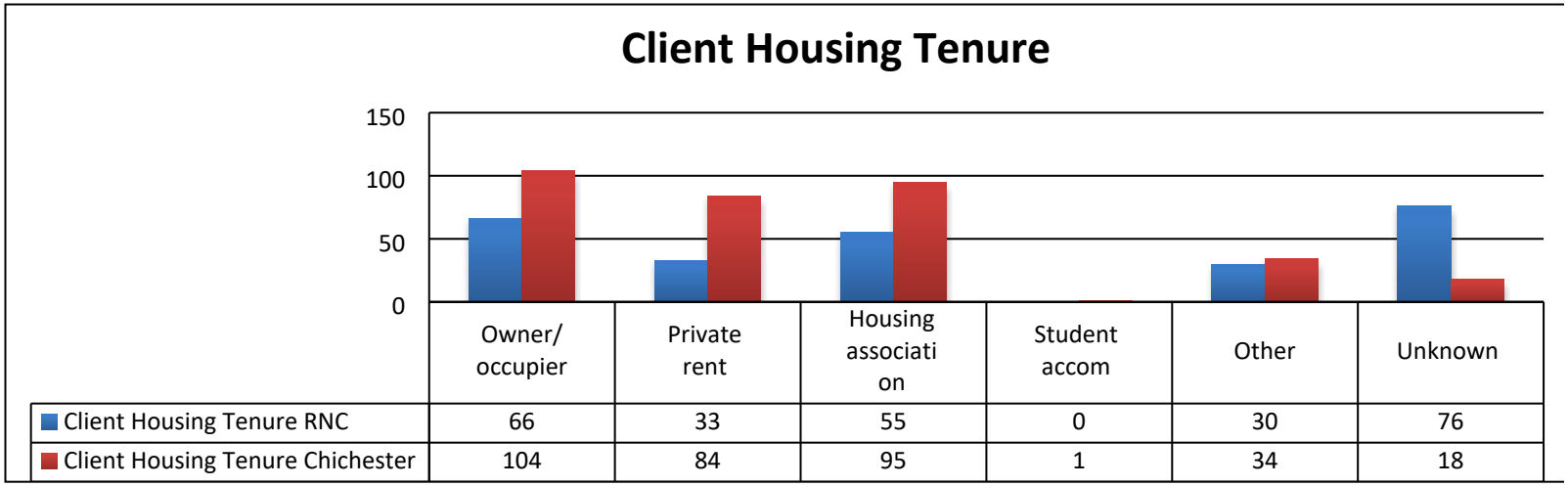
The data sample for this graph was from 64 respondents, which is around 10% of the clients seen in the first year. Whilst the sample size is small and it is promising to see the small positive improvement, it is important to recognise that clients then go onto reach more long term personal goals within the local community and support services.

This small incremental change reflects how the input by the Social Prescriber is the starting point for change and that real long term change occurs in stages over a longer period of time.

Housing Issues

An overview of the housing tenure of clients is provided in Figure 7. Just over a third of referrals received by the Social Prescribing service were for clients presenting with housing issues, these clients often had a mental health issue as well. Ways in which the Social Prescribers have supported clients with housing issues include referrals to Occupational Therapists for adaptations needed to the property (such as installation of wet rooms), assistance with hoarding, assisting clients with the effects of neighbourly disputes, assisting clients to access support for repairs and damp issue, assisting clients with benefit claims and applying to charities for assistance with purchasing furniture. The Social Prescribing Team have developed strong links with the Housing Team at Chichester District Council and attend regular meetings to discuss cases where consent to share has been provided. In cases of dealing with Housing Association providers demonstrating consent to share can be a little more complex, although in many cases where this has been established the Social Prescribers have been able to work with the Housing Association to resolve the issues, occasionally acting as intermediaries between the housing benefit department and the Housing Associations.

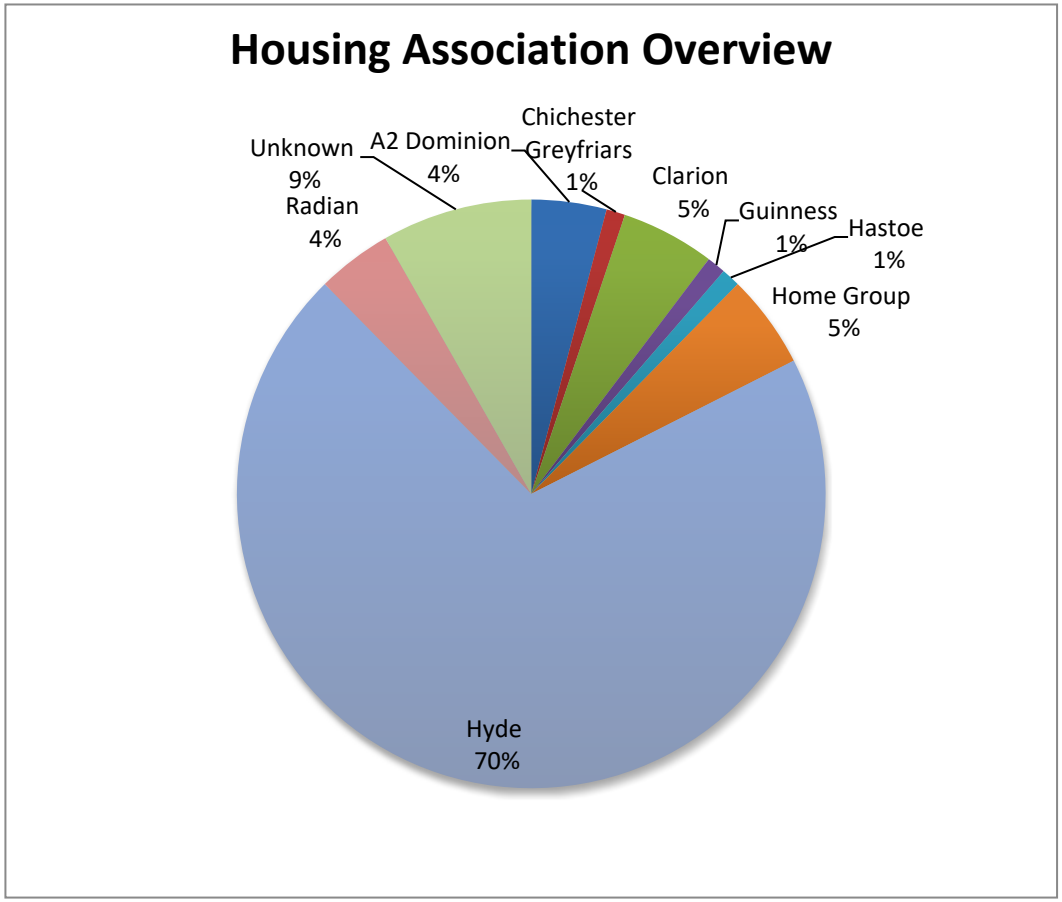
Figure 7: Graph showing housing tenure of Social Prescribing clients referred in year 1



	Owner/ occupier	Private rent	Housing association	Student accom	Other	Unknown
Client Housing Tenure RNC	66	33	55	0	30	76
Client Housing Tenure Chichester	104	84	95	1	34	18

76% of clients who were referred for housing issues were also reported to have a Long Term Health condition. Half of these were a mental health condition, of these 38% lived in Housing Association properties, 31% private rentals and 15% other (including those who are homeless or staying with friends or family). The remaining 16% was made up of clients reported as owner/occupier, unknown or living in student accommodation.

Figure 8: Graph showing overview of housing associations tenancy of Social Prescribing clients in RNC and Chichester referred in year 1



Housing Association	Number of Clients	%
A2 Dominion	6	4
Chichester Greyfriars	1	1
Clarion	8	5
Guinness	1	1
Hanover	2	1
Hastoe	1	1
Home Group	5	3
Hyde	96	64
Radian	4	3
Saxon Weald	13	8
Southern Housing	1	1
Unknown	12	8

Clearly the majority of social housing properties are owned by Hyde. The team at Hyde have recognised this and have contributed funding to pilot a new part time Social Prescriber post focusing on Housing Association tenants.

GP survey data

A short survey about the Social Prescribing service was distributed to Practice Managers for completion by primary care staff. We received 21 responses of these 17 respondents said they had referred a patient to the service. Those that haven't referred do not see patients within their role and one respondent felt the options for referral were confusing.

How helpful has the Social Prescribing service been?

For you as a GP surgery

Very unhelpful= 0 somewhat helpful = 0 neutral = 1 somewhat helpful = 5 very helpful = 11

For your patients

Very unhelpful= 0 somewhat helpful = 0 neutral = 0 somewhat helpful = 6 very helpful = 11

Would you benefit from further training to understand the role and benefits of Social Prescribing for patients and practice staff?

Yes = 5 No = 13 Unsure = 3

Have you seen a reduction in attendance for non-medical concerns by patients following Social Prescriber input?

Yes = 5 No = 2 Unsure = 14

How far do you agree that the feedback you receive from your Social Prescriber, during and after intervention is sufficient?

Strongly disagree = 0 Disagree = 1 Neutral = 4 Agree = 12 Strongly agree = 4

Do you feel patients would benefit from our Social Prescribers having appropriate level access to the medical record?

Yes = 14 No = 3 Unsure = 3

If you are willing to provide a non-identifiable example and evidence of the change, please do so here

- Homeless patient support and encouragement to access services including specialist health care and services for homeless
- I have a number of patients who were frequent attenders who have been comprehensively "sorted out" by Jo F. She has helped my patients and also helped me. Great service!
- Some patients have reduced attendance after referral, some haven't reduced regular appointments. I have had some patients who have benefitted greatly with support re housing / benefits.
- Patients feeling much more supported by social prescriber, several mental health patients have found her input very valuable
- Have seen some reduction in some patient's visits, others no reduction
- Patient living conditions causing stress/alcohol related issues, helped with contacting agencies.

If you have any other comments about the social prescribing service, please tell us here

- We have been unlucky with not having a SP for quite some time. The initial stages were very positive and I am sure patients benefitted from the advice given
- The group I felt we were possibly not including enough were the isolated elderly, and those with dementia and their carers. Our social prescriber built up a really useful amount of knowledge around local services. It is a great shame she has not been well enough to be at work for the last few months. It also, sadly, emphasises the risks of lone workers when there is insufficient capacity in a service to cover ill health and maternity leave
- The social prescribing service has added a much needed level of support to primary care. Patients are happy with the service and we have worked closely together to improve patient outcomes. I believe it is vitally important that the social prescriber remains visible in general practice so that we are able to discuss concerns and support patients as one team
- For this to really work SP's need system 1 access

- Kate was fantastic when she was here, a highly useful and effective resource. Unfortunately we have been without a service for some time without her and this is has been a challenge. I'm aware that her replacement is now in post but the lack of service has been disappointing in the interim period
- Difficult to define what appropriate level access is but there would be benefit in them being able to write their update reports direct to the record without viewing the patient record themselves (but this would involve them being their own System One organisation) I believe the service may be providing too extensive a service to individuals and therefore over-stretching itself, e.g. completing paperwork with an individual rather than sign-posting them to a different service that can help them complete the paperwork
- More please!
- It would be nice to have emails sent to appropriate staff who are able to prescribe - or even come to a practice - with clear guidance of Who, What and Where - and maybe also have a public information site so that patients can ask the medical professionals to prescribe. I know of a few things that are available, although I have not prescribed to any (except Chichester Wellbeing - if that is included - to which I prescribe a lot.) But for aged, elderly and dementia care it's not clear - often patients have quite negative feedback of previous attempts at social prescribing too so when asked if they want help, for various reasons, will often say no. I would really appreciate some very clear signposting on how to socially prescribe - appropriate to my role, or at least what I might be able to suggest a GP could do
- Good to be able to offer this service and we have had positive comments from patient's referred into the service, only issue is very little feedback on the notes or face to face interaction with the social prescriber
- I don't actually know our Social Prescriber, I've never had any formal introduction

Next steps

Nationally Social Prescribing is growing; it is recognised as a valuable resource for Primary Care and is a key feature in the 2019 NHS 10 year Long Term Plan. Alongside working to secure additional funding officers are working with Coastal West Sussex Clinical Commissioning Group, GPs and the other Social Prescribing teams across West Sussex to develop a shared and consistent evaluation framework which will enable us to measure long term outcomes and value for money. In addition we will undertake the following actions.

- We will explore the possibility of the team having access to system one
- The Social Prescribers will attend practice meetings to help staff to better understand the role and benefits of Social Prescribing for patients and staff. In addition they will write a referral guide / pathway so that the referral process is clear
- We will recruit maternity cover for the Petworth / Midhurst Social Prescriber

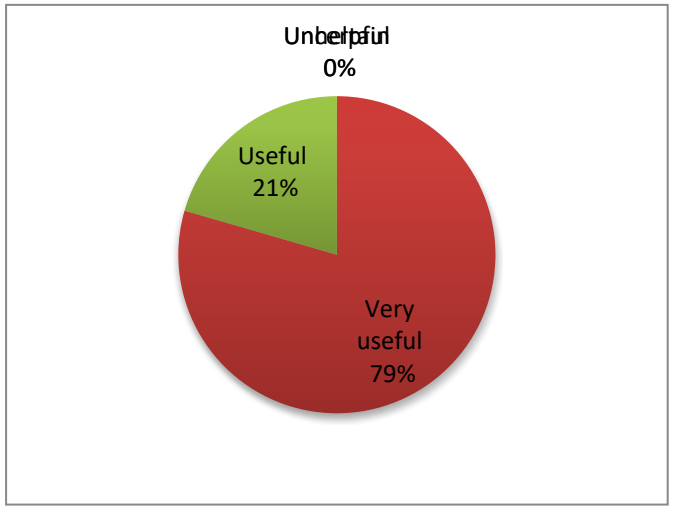
Patient evaluation data

10% of the year's total clients were selected to provide an evaluation of the service. This amounted to 60 people. 39 of these were successfully contacted by phone, 17 were not available after 3 attempts of calling, 2 people were emailed due to incorrect numbers (awaiting responses) and 2 people were unable to evaluate due to illness.

Evaluation Questions

How useful did you find the social prescribing service? We gave clients the options of: very useful, useful, uncertain, or unhelpful.

Figure 9: How useful did you find the social prescribing service?



31, (79%) Clients said that they found the service **very useful.** The remaining 8 clients said they found the service **useful** (21%).

How likely would you be to recommend a social prescribing session to a friend or family member?

We gave clients the options of: very likely, likely, uncertain, unlikely or very unlikely.

23 (59%) Clients said that they would be **very likely** to recommend us. The remaining 16 (41%) clients said they would be **likely** to recommend the service. None of the clients asked were uncertain or said that they were unlikely or very unlikely to recommend the service.

Figure 10:
How likely would you be to recommend a social prescribing session to a friend or family member?

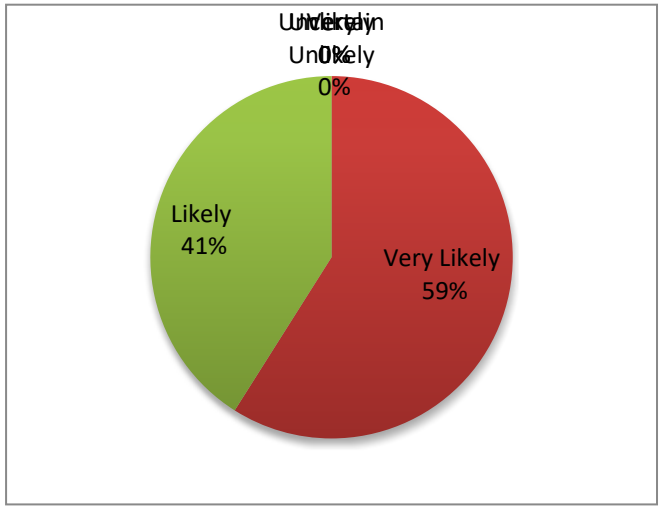
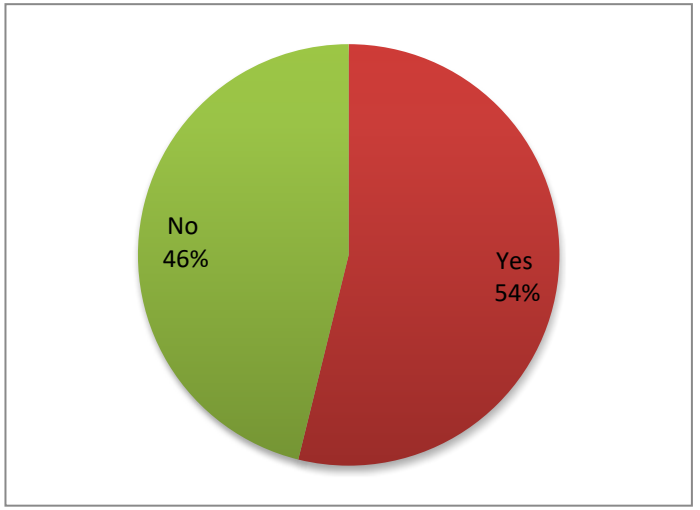


Figure 11:
Did the Social Prescriber refer you on to other services during your session?



Did the Social Prescriber refer you on to other services during your session? 21 (54%) Clients said yes and the remaining 18 (46%) clients said no. We then asked for some comments regarding the helpfulness of the referrals (if referred) and any reasons why no referrals were made. See Figure 11. Those responding 'no' included clients who had been signposted rather than referred on to other services as demonstrated by the client comments on referrals below.

Client comments on referrals:

"Didn't refer me but we spoke lots about my interests and how I could get more involved with them within the local community."
"Gave me a useful website that had lots of tools and links to help me out, I have used all of them."
"Referrals were very very helpful to me."
"I was referred to a company that fitted hand rails and mobility aids around my house to help me get around. It has really made a difference."
"I was referred on to 'Time to Talk'. Peter sorted it all out for me and was really helpful."
"No referrals but I was given lots of suggestions and it was left open for me to decide what was best."
"Referrals were useful and I got a lot sorted out in the house as a result of them."
'I was signposted to a few different services and Peter was really helpful with all the forms.'
'I was advised to start local clubs to get out of the house. I have started yoga.'

To finish the evaluation we asked an open question of 'Any other comments?'

"Freddie was lovely and so easy to talk to and really helped me engage more with my interests."
"Felt nice to know there was someone to talk to"
'Peter is a hero and is making a huge change to my life, shame there is a limit to appointments.'
'Peter was very friendly and organised and always rang before visiting to confirm'
'Freddie is an amazing bloke; I really appreciated all his help'
'Peter is an absolute top guy'
'Peter was brilliant, he went above and beyond to help us, including calling services and helping us to book appointments'
'Jo was so understanding and caring and really listened to me which I really appreciate'
'Freddie was brilliant, and as a result of his visits I am now getting back into work'
'We owe a lot to Peter. We couldn't have managed without him'
'Kate gave me a website with loads of useful tools and links to help – I have used all of them!'
'I was advised to join a few local clubs to help get me out of the house and I now volunteer at a SEND school'
'Freddie helped me to sort my grandson out – he has now moved out and resolved his drinking problem!'
'Peter helped me to move into a new house on the ground floor so that I can get around a lot better'
'Peter was so helpful and listened to me, the help came at just the right time and I am very grateful'
'The service was helpful and I felt that I was no longer alone'
'Only negative would be that I would've liked more sessions but I am aware that it can't go on forever.'
'Freddie was very enthusiastic and really keen but, through no fault of his own the service just wasn't suitable for my issue.'
'I didn't like the way some things were worded (patients wife had passed away). However I spoke to more to Freddie than anyone else and it was good to get stuff off my chest.'

Impacts on Community Groups

As there has been ongoing concern about the onward referral routes, mainly voluntary sector, coping with increased demand on services, several groups were asked for feedback and below is the feedback received:

Rotary Club of Chichester Harbour

Number of referrals you have received: 1 to 2 a month

Benefit of working with Social Prescribing service: we reach people and are able to help where we might not have done before without this system. Also referrals are by professionals, so we know they are genuine.

No negatives, very happy to continue working with SPs.

Age UK Horsham:

Number of referrals you have received? 5

Benefits of working with the Social Prescribing service: We have had some referrals for some vulnerable people who might otherwise not have known about. We have been able to assist them with welfare benefits issues.

Any perceived negative impacts of receiving referrals/working with the Social Prescribing service? No

How you might like things to progress working with the Social Prescribing Service in the future?

No specific observations. I think we have a constructive working relationship with Freddie Jones and anticipate that this would continue.

Onward referrals

The team made 1063 referrals to 225 different organisations; these are listed in appendix 1

Gaps in referral routes

Where the team have been able to identify gaps in community services it is important that Commissioners recognise that Social Prescribing is essentially dealing with individuals who are either falling through the gaps or are not able to access services due to increased eligibility criteria.

Benefits: Support for people with PIP assessments and appeals. Personal Independence Payment assessments are complex and time consuming and the majority of claimants require support to complete the forms. If they are not filled in correctly they are either rejected or go to appeal. The appeals are heard out of county in East Sussex or Hampshire and often people struggle with cost and transport to get there. There are Advocacy Services and CAB will provide some support but these have long waiting lists. There seems to be no service in place that meets the emotional needs of the client to support them through the process and the Social Prescribers have often found that clients report the process to be very traumatic. The change to Universal Credit has also caused numerous issues. Universal Credit applications can only be completed online and this can be a barrier for some claimants who are not proficient in IT. Some clients also have issues preventing them accessing the support available, eg transport. The Social Prescribers also often have to act as intermediaries between their client and their clients GP in order to access appropriate supporting documents.

Counselling therapies: Traditional counselling therapies are expensive and therefore unaffordable for many. NHS Time to Talk is time limited and has a long waiting list. It was found that a lot of the not for profit services still charge for their services in order to cover their costs which can be challenging for some clients to afford.

Handy man services: A low cost / free handyman service to carry out small maintenance jobs around the house. Some of the housing providers expect their tenants to do small repairs and maintenance themselves but it is the most vulnerable tenants that struggle with this.

Damp and mould: The Social Prescribing Service is seeing high numbers of people experiencing problems with damp and mould. Whilst some of this may be due to a lack of awareness from occupants about preventative measures, some of it could be associated with poor property

maintenance by housing providers. The impact of living in these circumstances increases the risk of long term health conditions and can impact on people's emotional wellbeing.

Transport: Community transport services, especially in the north of the district are lacking, people become isolated because they can't access services or community groups. There are some services available to assist with transport to medical appointments but very few to assist with social activities. There have also been many cuts in public transport, resulting in less frequent services and some areas being left without any service connections.

Activity for young people: Isolation impacts younger people as well as older people and there is a lack of social activity for this age range. Many young people are returning to the family home or have been unable to leave due to the shortage of affordable accommodation in the area. Transport can also be a particular issue for this age group. Aside from the lack of transport availability, cost can also be a barrier. Many of the youth clubs lack funding and succession planning to enable them to continue to provide a service.

Dementia services in the north of the district: Sage House in Chichester is an excellent service but there is currently little in the north of the district, although, Sage House have recently recruited a new post whose role it will be to develop outreach services in these areas. Some services are provided at the Grange Leisure Centre but transport can often be a barrier to people accessing this service. The Memory Assessment Service is experiencing high rates of referral resulting in delays in diagnosis. This can often impact on benefit claims, reviews and access to dementia specific services.

Support for people with mental health issues: Statutory services are clearly under pressure and therefore limited with the support they can provide. There have been a lot of changes in Voluntary and Community sector mental health provision, particularly for those under 65, which has left some areas of the Chichester District with little additional support. In central Chichester, Mind are no longer active for this age group and the impact of this is that Richmond Fellowship are now experiencing a marked increase in new referrals, creating delays.

Additional funding secured and highlights

- Positive working relationships with all GP practices have developed and the staff are embedded within the Primary Care teams
- Additional funding of £15,000 for a 1 year pilot has been secured from Hyde Housing Association to recruit a Social Prescriber to work specifically with Housing provider tenants starting in August 2019.
- Admin support has been recruited to ensure all client data is inputted and available for evaluation. This will free up Social Prescriber time

- Funding of £3,000 for two equine therapy programmes was secured from Chichester in Partnership and Chichester Rotary Club
- Funding of £1300 was secured from a local charity to fund a client's driving lessons, following a case of domestic abuse and relocation to rural location.
- Partnership working with Hyde to address extreme hoarding issues with one of their tenants and secure funding of £5000 for house clearance and deep clean. The client was then rehoused and a three bedroom property was then made available to a family.

Case studies

NB: All of the case studies used in this report are fully anonymised and are an amalgamation of the experiences of several clients. They do not directly relate to any one single individual and should not be interpreted as such.

Case study one

One of the patients is an elderly woman who moved to Chichester 2 years ago. She has struggled to make friends and was referred by her GP due to social isolation, having been diagnosed with depression.

Having met with her twice, it was clear that she was still struggling with her grief following her husband's death and she was agreeable to a referral to CRUSE for bereavement counselling. I also assisted her to make a claim for Attendance Allowance, as she was struggling to manage at home, due to a number of physical health problems.

I introduced her to the local University of the Third Age community and she has joined a poetry group. She also now attends a weekly lunch club at the local church.

She was awarded lower rate Attendance Allowance and now employs a cleaner and can take taxis to the U3A meetings. The bereavement counselling has started and, although emotionally difficult, she said that she now realises how much she had bottled things up.

I recently asked her GP to refer her for a hearing test as she is struggling to hear in the groups she now attends. This was acting as a barrier to effective participation. I attended one of her lunches and asked the organisers to make sure she is seated in the best position to hear people, when they are talking to her. The group are now going to install a hearing loop at the venue where several of the other members also said that they found it difficult to hear.

I worked with this lady for nearly 3 months and made 3 home visits, 2 community visits and several telephone sessions. I will now be closing the case and she reports that she is feeling “a lot happier with my lot”.

Case study two

This patient is a lone parent living with her young daughter. She is separated from her child’s father after a difficult history of domestic abuse. Her parents live locally but have limited time to support her with child care due to their own working responsibilities.

It unfolded during our sessions that she had developed issues with her mental health when she was a teenager resulting in her having to drop out of school and not finish her exams. As a consequence she was struggling to find her career direction whilst managing the responsibilities of being a single parent which had taken priority. Her long term goal was to take her exams and focus on her career development.

She had previously been working in a job where she had a real sense of purpose and community. Due to the nature of her domestic abuse she needed support in relocating and was unable to remain in employment.

As a result of being unemployed she needed to apply for Universal Credit which with the support of our sessions we were able to initiate.

She was then relocated to a new two bedroom house. As a consequence she was much further away from family support, friends and her new part time job. The issue of transport focused our sessions to explore local charity funding to support her to learn to drive. After finding a driving instructor we contacted a local charity who agreed to support with funding for lessons. Based on the principle that the average driver requires 45 hours’ worth of driving experience, we secured £1300.

In the process of working with this lady we also liaised/referred her to Family Support services, applied for free childcare and a leisure access card, signposted to local family support centre and Work, Information & Support Hub (WISH).

This patient has now established much better childcare through service and family support, is working extended hours in a new job, visiting her new local gym with a friend 3 times a week and continuing to learn to drive with the ongoing support from the charity.

The last word from the Social Prescribers

Life as a Social Prescriber – Jo Fishwick

The past year has passed in a flash. The role of social prescriber has been challenging, exciting, frustrating, heart-warming and sad but, above all, one of the most satisfying jobs I've ever had.

I came from a social work background and thought this role would be less stressful and, primarily about sign-posting people. The reality has been wholly different and, at times, I am working with people with such high levels of complexity, it is hard to know where to begin and I am very grateful for my previous experience and knowledge.

There have been many challenges so far – the sheer volume of referrals took us all by surprise, as did the complex nature of the issues that many of those people are facing. Working in different GP practices and therefore not having a permanent base can be trying at times. Frustrations at gaps in services and the impact of benefits changes on so many people's lives can be difficult to accept.

The positives, however, outweigh all of this. We have created a really effective, creative team from scratch and I have the utmost respect for my colleagues, whose humour, knowledge, support and kindness has been essential. The GP surgeries have also been overwhelmingly supportive of this new service.

Most of all, though, this role further bolsters my admiration for the immense resilience of people, who are facing unbelievably difficult and traumatic issues. It's a privilege to work, with them.

First year in review – Freddie Jones

Before working as a Social Prescriber I practiced as a Cardiac Rehab Specialist in the community. I therefore had little experience, or understanding of the social care, mental health, benefits, or housing systems and really had no idea of the complexities awaiting me.

As I was new to Social Prescribing, I felt there was only one way to be and that was to walk in the client's shoes; discovering what had brought them to this point, sitting with their isolation, facing the challenges and obstacles along the way and of course experiencing the means tests, thresholds and assessments they had to jump through to get the support and find a way out.

It's been a complete privilege to hear people's stories over the past year. Learning to be a part of that story for a very short but intensive period of time has been my biggest but most impactful challenge. I've learnt that the service people 'need' isn't always out there. Managing their expectations and looking first at their daily lifestyle choices has proven to be hugely important. Working with the Chichester Wellbeing team on this has been invaluable. They've been an

insightful resource of knowledge and experience, which has allowed us to shape the Social Prescribing service in our own way, whilst keeping the same principles and philosophies of 'empowering the client' to make their own changes.

What was believed to be a signposting service has become something far more all-encompassing. Carrying out this review has allowed us to understand that and feed it back where it's needed. I'm excited about what's still to come from Social Prescribing and very honoured to be at the forefront of it in Chichester.

Life as a Social Prescriber, One Year On- Peter Smith

One year ago, when I first took up the role of Social Prescriber the expectation was that we were to provide a signposting service, simply encouraging people to "join a Knit and Natter group or the local choir". However, it soon became apparent that the service is meeting a need much greater than this, people lead very busy lives, often becoming more and more isolated in doing so, as a consequence we struggle in dealing with the daily challenges we face let alone those we have carried for a longer period of time.

During the past year it has been a real privilege to work alongside a wide range of people supporting them in resolving issues such as housing, employment, isolation and debt management. However I am also deeply respectful of those who have disclosed more complex issues of historical sexual abuse, self-harm, long term mental health, bereavement and gender identity. Such issues can never hope to be resolved within the time limited support I provide but having those conversations and linking people in with the relevant professional support is of equal value.

But to return to that initial expectation as an analogy – perhaps what I have been providing for the past year is an opportunity for an individual to find their own voice (sometimes for the very first time) and join the local choir. These singing lessons begin within the initial assessment session often in a confused, frustrated or angry manner, but a session equally recognised as one in which the client is given the space to discuss the challenges they face and the support which may or may not already be in place.

My belief is that we all as individuals are equipped with the necessary resilience and self-efficacy to meet life's challenges; it's simply that we have lost sight of that fact; we have forgotten how to sing, Detached from their own voice we also lose contact with the chorus of the local community. Given the information, time and encouragement I am able to provide many people who initially announced that they "cannot sing a single note" eventually find themselves reconnecting with that voice.

Maybe, at the end of the day it is all simply about knitting and singing groups!

Appendix 1

	Most Popular referral/signposted organisations	Description	Number of Signposted Clients	%
1	Citizens Advice Bureau (CAB)	Free, confidential information and advice to assist people with money, legal, consumer and other problems	74	7%
2	Choose Work	Assisting Chichester District residents to move into or towards employment through coaching, mentoring, providing information, advice and guidance.	62	6%
3	CDC Wellbeing	Information and support services for things like getting your family fitter, dealing with stress, kicking a habit, or simply improving your general wellbeing.	55	5%
4	The Department for Work and Pensions (DWP)	Responsible for welfare, pensions and child maintenance policy. As the UK's biggest public service department it administers the State Pension and a range of working age, disability and ill health benefits	50	5%
5	Carers Support West Sussex	An independent charity supporting some of the 89,000 family and friend carers living in West Sussex.	47	4%
6	Time to Talk (TTT)	Talking therapies services in West Sussex	31	3%
7	Mind/Pathfinder	Mind is a mental health charity offering one on one support and group sessions such as out and about groups, music groups, badminton etc. The Pathfinder service is connected to Mind and provides information about mental health conditions, self-help tools, apps, help lines, useful websites	29	3%
8	Adult Care Point	Adult social care support	22	2%
9	Richmond Fellowship	A national mental health charity and one of the largest voluntary sector providers of mental health support in England	19	2%

10	Age UK	Information, advice and support for older people.	19	2%
11	CDC Housing Advice	Chichester District Council Housing Team provide housing advice to residents of the Chichester District	18	2%
12	Christians Against Poverty (CAP)	A Christian charitable company. It is a national organisation specialising in debt counselling for people in financial difficulty, including those in need of bankruptcy or insolvency.	15	1%
13	Prevention Assessment Team (PAT)	A multi-agency, multidisciplinary teams delivering a preventive service across West Sussex. The team includes health advisors (qualified health professionals); social care workers and support workers from the voluntary sector.	13	1%
14	Sage House	A bespoke, modern and functional community centre, where people can access the most up to date support, information and advice on Dementia	13	1%
15	Turn2us website	A national charity that helps people in financial hardship to gain access to welfare benefits, charitable grants and support services.	13	1%
16	U3A (University of the Third Age)	A UK movement of retired and semi-retired people who come together to continue their educational, social and creative interests in a friendly and informal environment.	13	1%
17	Frontline Liaise Debt Advice	Free Debt and Welfare Benefit Advice	12	1%
18	Homemove	Sussex Homemove is the lettings scheme for council and housing association homes in Adur & Worthing, Brighton & Hove, Chichester and Mid Sussex	12	1%
19	Impact Initiatives Advocacy	Advocacy service working with people with learning difficulties, people with an acquired brain injury, people with a physical disability or sensory impairment, and people on the autistic spectrum.	12	1%
20	Men's Shed	Men's sheds or community sheds are non-profit organisations that advise and improve the overall health of all men.	12	1%

21	Mind Advocacy	Advocacy service working with people with mental health conditions	12	1%
22	Tandem	A transport service in Midhurst area assisting people to attend medical appointments	12	1%
23	West Sussex County Council	Council Services often referred to for assistance with blue badge applications and bus passes.	12	1%
24	My Sisters House	Support for vulnerable women who are characterised by a range of issues including histories of physical , emotional and sexual abuse, drug and alcohol addiction, trauma, and mental health problems.	11	1%
25	Petworth Community Gardens	An established community garden in Petworth to enable local people with limited means to be able to access free fresh organic fruit and vegetables. Also aiming to promote healthy life styles, care for the environment, celebrate peoples abilities, deliver social and therapeutic horticulture sessions and be a place of play and learning.	11	1%
26	Vaac/ Vaac Do it Volunteering Service	Promoting and supporting Charities and Community Groups Across Arun and Chichester	11	1%
27	Rother Valley Together (RVT)	An activity and lunch club at The Grange in Midhurst offering fun and friendship, and supporting those who have difficulty in getting out and about independently.	10	1%
Total			620	57%

Over 57% of the 1063 referrals/signposting made in the first year went to these top 27 organisations, out of the total of 225 organisations referred/signposted to in the first year.