This assessment tool supports the implementation of recommendations in the NICE guideline on mental wellbeing and independence in older people

National Institute for Health and Care Excellence endorsed this assessment tool July 2017

User Guide: Social Prescribing Tool

This user guide has two sections. The first section is aimed at the social prescriber who will use the social prescribing tool in delivery. The second section is aimed at commissioners and providers of social prescribing services and can be utilised to establish a framework of key components, of which a social prescribing service should provide within communities.

Guidance for Social Prescribers

The social prescribing tool has been designed for use within an individual's home environment. Completing the tool in this setting allows the social prescriber to gain a comprehensive understanding of how the individual is managing within their own home setting. In some cases, the individual may prefer to meet within a community or health setting. The social prescribing tool can be used in any environment the individual feels most comfortable to talk. However, best practice would be for use within the individual's home setting.

The social prescribing tool is completed twice, once as a baseline assessment and then as a follow up assessment after an interval of typically six weeks. Users of the tool will find that either 'Y' or 'N' is made bold and underlined in each answer section. The bold and underlined 'Y' or 'N' answer indicates the positive outcome to that question in the social prescribing tool and scores three points, whilst the non-highlighted answer would score zero points. (Please refer to the picture below). Once all questions on the tool have been answered, the points can be added together and the resulting score would be the individuals total 'wellbeing score', for that social prescribing assessment.

A high score indicates that a person is content with their life, with all their health and wellbeing needs met, whilst lower scores indicate that the individual has areas of their life which they would like to address.

Being active | Baseline | 2nd Assessment

1. Can you manage your household chores e.g. cleaning, gardening, shopping or laundry? — Baseline: **Y** — 2nd Assessment: **Y** N

Consider: (e.g. due to physical health / motivation / skills)
If no, do they appear at risk of personal decline in regards to their independence and/or mental wellbeing?
- Refer to social services/ medical or mental health support/ GP.

Action Plan

2. Do you manage with cooking, preparing meals or personal cares? — Baseline: **Y** N — 2nd Assessment: **Y** N

Consider: (e.g. due to physical health / motivation / skills)
If no, do they appear at risk of personal decline in regards to their independence and/or mental wellbeing?
- Refer to social services/ medical or mental health support/ GP.

Action Plan

3. Can you get out and about e.g. walking / bus / car / taxi? — Baseline: **Y** N — 2nd Assessment: **Y** N

Consider: (e.g. mobility / confidence / travel cards/ recently have had to give up driving)
If no, do they appear at risk of personal decline in regards to their independence and/or mental wellbeing?
- Refer to social services/ medical or mental health support/ GP.

Action Plan

4. Do you feel that you are getting enough physical activity? — Baseline: **Y** N — 2nd Assessment: **Y** N

Consider: (e.g. stress balls / chair exercise booklet / walking schemes / creating connections / exercise on referral)
If no, are there any issues / barriers?

Action Plan

5. Do you feel that you would benefit from any lifestyle advice? — Baseline: Y **N** — 2nd Assessment: Y **N**

Consider: (e.g. improving diet / eating habits, stopping smoking, drugs & alcohol support)
If yes, are there any issues / barriers?

The bold answers score 3 points for the individual's health & wellbeing score. The answers to the questions will in some cases be bold for **yes** but in other cases bold for **no.**

The social prescribing tool consists of five sections based on the New Economics Foundation (NEF) Five Ways to Wellbeing, (New Economics Foundation, 2008), with each section containing five questions in support of the recommendations within NICE Guidance NG32.

Under each question, social prescribers will find important services to consider in relation to an issue or problem identified in the life of the individual. These services, as well as other similar services you may have available locally can enable the individual to realise their full potential and social prescribers should inform the individual of these options.

If questions generate a negative response and highlight barriers to the individual reaching their full potential, the tool offers a space under each question for social prescribers to note down any issues or barriers.

The third section of the question is the action plan, where social prescribers can note any actions agreed with the individual. The notes written in this section will contribute to an overall action plan.

See example from the tool:

Give - Money & further support

3. Do you want information or support with employment or volunteering? Y **N** Y **N**

Consider: (Volunteering for RVS / Local NHS Trust / 3rd Sector / www.do.it.org / Job Centre / Adult Education / Intergenerational activities)

If yes, are there any issues/barriers?

If the above question, during a baseline assessment, identifies that an individual has an interest in volunteering, the chosen answer would be 'Y'. Since this answer identifies a need, the role of the social prescriber is to use, where appropriate, the prompts provided under the question to suggest services which might be beneficial to that individual and jointly agree an action plan.

The second assessment, usually completed at six weeks post baseline assessment, is an opportunity to identify any improvements within the individual’s life. Due to the implementation of the action plan to address areas of identified need, an improvement of scores will ideally be present at the second assessment. On occasion, there may be some negative changes resulting in a lower score, depending upon the individual’s life experiences between assessment dates. For example, following the baseline assessment individuals may have encountered bereavement, moved home or lost employment.

Questions within the social prescribing tool have been grouped together to facilitate a natural flow between sections. During conversation, you may find that responses from the individual cause you to skip between the different sections of the social prescribing tool. This will not affect the outcome and in most cases, is of benefit to the individual, who should be encouraged to discuss the varying aspects of their life as they please.

When considering how to score each question, consider the following, is there already a solution in place? For example, when completing question one in the section ‘Being active’ as shown below, the individual themselves may not be able to clean, garden or shop, but do they have a solution in place? If the individual already receives assistance to complete these tasks, whether this be via family, friends, carers, voluntary or paid for services, are they happy with the arrangement? If the answer is yes then you can mark ‘Y’ for this question.

Being active

1. Do you manage your household chores e.g. cleaning, gardening, shopping and laundry? Y N

Keep this in mind for each question, consider always if there is a solution in place which the individual is happy with. If the individual is looking for support, or to make a change to existing arrangements, then a negative response to the question would be awarded and an action plan put in place to support this identified need.

Guidance for Commissioners and Providers

NICE guidance has been used to inform this social prescribing tool. Please see older people: independence and mental wellbeing NICE guideline NG32. This section is aimed at commissioners and providers of social prescribing services, aiming to ensure that activities recommended as outcomes from the use of the social prescribing tool, to improve independence and mental wellbeing, are made available for communities to access. Data collected from the tool on the types of activities that are commonly referred to by social prescribers, should be used by commissioners and providers to identify the types of activities to fund in local areas.

Commissioners and providers also need to be aware of volunteering activities that meet the needs of local older people within their own communities, to ensure when volunteering has been identified as a goal, such opportunities are available. For example, www.do.it.org offers a wide range of volunteering opportunities nationwide.

Under each question there are services to consider which can improve mental wellbeing and independence in older people. The social prescriber who uses the tool can recommend services to improve mental wellbeing and independence in older people.

If group activities, one to one sessions and volunteering activities which are identified as a need are not available, commissioners and providers should consider either directly commissioning activities or providing community based grants to encourage such activities to become established.

To support the social prescriber to work effectively, commissioners and providers need to facilitate access to a directory of group and one to one social and support activities. This directory should be made available in both paper and electronic formats to increase access for all. An example of such a directory can be found here:

http://www.southwestyorkshire.nhs.uk/our-services/directory/live-well-wakefield/social-exercise-and-support-groups/

To support the needs of older people identified as being at risk of a decline in their independence and mental wellbeing, commissioners and providers would need agreed pathways to be prearranged to ensure that social prescribers have the ability to refer to appropriate agencies including social services, mental health services, general practitioners and fall prevention services.

When considering providing or commissioning a social prescribing service, a mapping activity needs to be undertaken to ensure sufficient group based activities are available within communities. Community activities need to include multicomponent elements, including singing programmes (in particular those involving a professionally led community choir), and creative activities including arts and crafts.

When considering providing or commissioning social prescribing services, the following groups of older people are recognised as having an increased risk of decline in their independence and mental wellbeing:

Risk Factors

Older people who/whose;

- partner has died in the past 2 years
- are carers
- live alone and have little opportunity to socialise
- have recently separated or divorced

- have recently retired (particularly if involuntary)
- were unemployed in later life
- have a low income
- have recently experienced or developed a health problem (whether or not it led to admission to hospital)
- have had to give up driving
- have an age-related disability
- aged over 80 years old

Due to higher risks of decline in independence and mental wellbeing, these keys areas to consider are included in the 'about you' section at the forefront of the social prescribing tool, so enabling social prescribers to have these primary risk factors at the start and forefront of the assessment. When any of the risk factors mentioned above are identified through the questions within the social prescribing tool, they may be addressed by an individual intervention for each life event. These risk factors can be considered for referral criteria in to a social prescribing service.

National Institute for Clinical Excellence, (2015) Older People: Independence and Mental Wellbeing. Available from: https://www.nice.org.uk/guidance/ng32 Accessed on [03/01/2017]

New Economics Foundation, (2008) Five Ways to Wellbeing. Available from: http://neweconomics.org/five-ways-to-wellbeing-the-evidence/?_sft_project=five-ways-to-wellbeing Accessed on [03/01/2017]