Scoping a feasible and fit-for-purpose model of "Social Prescribing" for Latrobe Valley

Draft report for the Latrobe Health Assembly Board, V1

Prepared for: Latrobe Health Assembly

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Larter Consulting acknowledges the traditional custodians of the lands on which we work.

Contents.

Executive summary.

This Stage 1 scoping study sought to explore the feasibility of introducing a social prescribing program in Latrobe Valley and identifying the conditions necessary for trial.

This report provides the recommendations that emerged from that study.

Social prescribing enables primary health providers to address the wider social determinants of health by referring patients whose health is affected by non-medical factors (such as housing, financial stress or loneliness) to a range of community-based services, with the support of a link worker. Much of the experience and evidence base about social prescribing emerges from the United Kingdom and New Zealand. There is exciting evidence emerging such as improved individual wellbeing and quality of life; reduced need for hospital and GP care and improved provider satisfaction; and increased volunteering and use of community assets.

Social prescribing is relatively new in Australia, however we found that the sentiment about trialling social prescribing in the Latrobe Valley is very positive and its introduction is awaited with great anticipation.

This study comprised a literature scan, brief data review of PHN needs assessment and POLAR data, community resource mapping exercise and consultation, supported by a Working Group. Consultation included the general practice sector (and some other health services); the community; and community sector stakeholders.

The key lines of enquiry for the consultation were to identify the conditions required to successfully engage general practice in social prescribing, and the enablers and barriers for community engagement. Community consultation had a specific focus on groups of people who are likely to benefit from a social prescribing program based on the experience of international programs (for example, people living alone, living with complex mental health and or multiple comorbidities and/or disabilities; experiencing financial distress; lonely older people including men; socially isolated people, among others).

Recommendations for Stage 2

We recommend:

- That the Latrobe Health Assembly invests in trialling a social prescribing model in Latrobe
- A neighbourhood-based approach, with options identified for trial site partnerships (general practice and a community service partner) in each of the four large townships
- A phased approach to trialling models across the Valley: phase one trials across 1-2 sites; and phase two trialling some new model elements in new neighbourhoods including a youth model; and phase three focused on expansion, with increased referral pathways and options for supporting other general practices to become involved. Scaling after phase one will require significantly increased management and evaluation support.

- Latrobe Health Assembly choose to trial either one or two of these sites (Churchill, and either Moe or Traralgon), for 18 months in order to compare different model elements (for example, location of dedicated worker; clinical or non-clinical worker; different priority patient cohorts) and to understand system and community implications during establishment and as demand increases. It is important each site develop their own localised program to fit their local community context
- That the Assembly maintain alignment with work of the Gippsland PHN and Latrobe City Council, with a particular focus on identifying emerging opportunities for Council roles in social prescribing
- That a rigorous external evaluation be conducted including an economic evaluation such as a cost benefit analysis, and the development of a business case for sustainability.

Costing estimates for program management and site administration are included in the report.

A diagram of the recommended neighbourhood-based model is on the next page.

Comments on terminology:

- The term "social prescribing" is used to describe the model. While suggestions were made for other options, the recommendation is to keep using the term when formally communicating about the work to align with current and national advocacy and evaluation efforts
- The term "Dedicated Worker" is used throughout the report to signal the role of a social prescribing link worker.

SOCIAL PRESCRIBING: Neighbourhood-based trial sites, testing proof of concept

Social Model of Health | **Community Script** | **Community Referral** | **Latrobe Connect**

1 Identify town-based, 'Basic Referral Pad'

- [ ] Library Groups
- [ ] Neighbourhood House
- [ ] Walking Group / Park Run
- [ ] Community Lunch
- [ ] Crisis Relief, Food Bank
- [ ] Volunteering
- [ ] Community Garden
- [ ] Older Activity Groups
- [ ] Multicultural Friendship Group
- [ ] Vocational / Learn Local
- [ ] Men's Shed
- [ ] Singing / Choir
- [ ] Creative
- [ ] Sports
- [ ] Street Games
- [ ] Peer Support (eg disability)
- [ ] No Cost Activity Guide
- [ ] Financial Counselling
- [ ] Play Group
- [ ] headspace
- [ ] Youth Space

5 SOCIAL HEALTH CHECK screening

GENERAL PRACTICE

GP | NURSE

External referrals:
- Ambulance
- VicPol
- Community health
- CHSP
- Discharge planners / Hospital concierge

DEDICATED WORKER
(Community Connector?)
(CO-LOCATED AT GENERAL PRACTICE & COMMUNITY PARTNER)

3 Educate General Practice about local referrals

2 Works with groups to be welcoming and inclusive

RELATIONSHIP
- Humanistic
- Destigmatising

CO-PRODUCE PERSON-CENTRED 'PRESCRIPTION'

PSYCHOSOCIAL NEEDS ASSESSMENT
- PROM-driven KPIs
- Strengths-based

ENABLING COACHING

IDENTIFY LOCAL TRANSPORT SUPPORT

SOURCE LOCAL BUSINESS VOUCHERS

BANK OF VOLUNTEERS
- Welcoming
- Driving
- Companion

4 Prioritise cohorts for trial

1 FREQUENT ATTENDEES
- Frequent 12-19 visits/year
- Very high 20+

\+

3 - 4 from:

2 LIVING ALONE
3 BEREAVED
4 DEPRESSION
5 COMPLEX MENTAL HEALTH
6 AGE 50 - 65 PREMATURE AGEING
7 MULTIPLE CHRONIC DISEASE
8 ELDERLY
9 NEWCOMERS
10 SINGLE / YOUNG MUMS
11 RELATIONSHIP BREAKDOWN

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Latrobe Health Assembly | Shaping The Valley

Governance Group (eg neighbourhood-based community connections network) and Community Voice

About this report

This is a brief summary report of the *Scoping a feasible and fit-for-purpose model of social prescribing for Latrobe Valley* Stage 1 project in order to provide recommendations to the Latrobe Health Assembly Board.

The project approach comprised:

- Rapid literature scan
- Local general practice data review
- General practice consultation
- Community consultation
- Community sector stakeholder consultation
- Social prescription mapping (activities/programs/interventions; gaps and opportunities)
- Working Group (see Appendix A for membership)

This report provides:

- Brief situation analysis
- Key themes and insights from consultations
- Recommendations
    - Key elements of proposed model for trialling
    - Options for selection of innovations trial sites
    - Outcomes Framework example

Introduction and situation analysis.

- Literature review
- Latrobe Valley community needs
- Local GP data review

Long history of experience in UK and in New Zealand with promising outcomes

Social prescribing has a strong 25-year history in the United Kingdom, emerging from initial focus on reducing social isolation in ageing populations, and community renewal / rehabilitation programs after industry closures. The UK has just embedded SP into primary care strategy and invested in 1100 new social prescribers, one per primary health network

New Zealand is also known for its innovative approaches with the “green prescriptions” program for improved physical activity, with a focus on increasing activity for sedentary people. General Practitioners provide brief advice with exercise on prescription through community walking, exercise and nutrition. (Green Scripts in New Zealand: GP would write green script and link worker within sports trust would coach; funded by national pharmaceutical scheme)

In Victoria, we have a history of trialling similar type interventions since the 1990s with a focus on physical activity and wellness, including Active Script (focus: physical activity) and Lifescripts (focus: smoking, alcohol, physical, nutrition, weight). Key lessons from local experience was: (1)

the need to have a dedicated worker who could provide motivation, support and ongoing review (2) the need for prescribed activities to be free or affordable, and (3) that General Practitioners need conversation scripts to support sensitive conversations.

The current interest in Australia emerges from a combination of factors. These include:

- Ongoing policy interest to improve response to social determinants of health
- Continual strengthening of promising outcomes from the UK that NHS has in 2019 invested in social prescribing as part of their Long Term Care strategy, investing in 1100 new social prescribers, translating to one per primary health network

Social prescribing has arrived in Australia during last two years. There are a number of trial sites nationally implementing a number of different approaches to testing proof of concept in local contexts. This includes testing: concept acceptability, community appetite and readiness, required partnerships, service system.

For example,

IPC Health, Deer Park

- Funded by North Western Melbourne Primary Health Network and delivered in community health general practice setting (IPC Health, Deer Park campus) in a partnership with Australian Health Policy Collaboration at Victoria University and Brimbank City Council. A Wellbeing Coordinator sits within community health, $125,000 for 12-month trial

Mt Gravatt, Ways to Wellness Social Prescription project

- Ways to Wellness Social Prescription project is being implemented by Mt Gravatt Community Centre, with the support of the local community and a working group, are addressing social isolation and loneliness in Mt Gravatt and surrounding suburbs. Two project models are being trialled:

  (a) Community Link Worker model focuses on community client referrals (funder: Department of Communities, Disability Services and Seniors); and

  (b) Holistic Health model with a health care link worker co-located at local general practices, receives client referrals through the general practices and other medical and health organisations (funder: Department of Social Services). Funding $213,631 for one link worker

Gold Coast 'Plus Social' "Not your ordinary prescription"1

- Funded by Gold Coast PHN and delivered by Primary & Community Care Services, Plus Social specifically targets support for people living with more complex mental health issues to improve confidence and wellbeing; increased social connectedness; with three main components:

[1] https://gc.pccs.org.au/plus-social/

- Clinical care coordination between GPs, psychiatrists and allied health workers
- Connections to a range of local community services and social groups, and
- An after-hours community-based space, The Hub, where clients needing support can come after hours and where many of our social groups will run.

Our Neighbourhood, Australia Post

- Neighbourhood Welcome Service is a new community initiative to make neighbourhoods more welcoming places for people who have just arrived (moving to Australia, settling in a new neighbourhood), and for those who just need a little extra help (e.g. major life transitions, loneliness, social isolation and ageing). Uses Neighbourhood Welcome Service Community Connectors to help people connect with their neighbours, local businesses and essential services. People receive a Neighbourly Welcome and a Welcome Pack from the post office. When people visit a Welcome Space they can talk to a Community Connector, about the neighbourhood and how they can get involved.

RACGP & Park Run

- An emerging collaboration with social running organisation Parkrun to support all GPs to prescribe this activity

3840 Our Learning Future

- In the Valley, project 3840 Our Learning Future employed a "Neighbourhood Learning Links Coordinator" to identify and recommend pathways for learners to further education and/or employment, and facilitate and design courses to match local needs. The 12-month collaborative and community strengthening initiative was auspiced by Berry Street and supported by a Partnership Advisory Group comprising Department of Education ACFE, Berry Street, Federation Training, Gippsland Employment Skills Training G.E.S.T, Workways, Department of Health and Human Services and Latrobe City. The Coordinator role aligns with how a social prescribing link worker role might operate and be received.

At the moment, Australian appetite is being driven by individual primary health networks, individual health services and/or community services (e.g. Neighbourhood Houses), academia, and representative stakeholder bodies such as RACGP, and Consumers Health Forum of Australia.

First national roundtable was recently held (November 2019) hosted by RACGP, Consumers Health Forum of Australia and Health System Sustainability partnership centre (National Health and Medical Research Council) to formulate recommendations to policymakers and system managers, funders and commissioners, and service deliverers.

Literature review

A systematic, nationally scaled and locally implemented approach to social prescribing in Australia could lead to:

- preventing and managing physical and mental illness
- shifting the focus from illness to wellness
- increased consumer enablement and self-management
- decreased demand for health services
- greater value care
- fewer silos between health and community services
- increased joy and decreased helplessness
- decreased isolation and loneliness
- stronger communities.[2]

What we know

Most of the experience and evidence base about social prescribing emerges from the United Kingdom and New Zealand.

- At individual level, there is evidence to support
    - improved patient care outcomes, patient satisfaction and experience
    - including
        - Improved wellbeing, quality of life
        - Improved confidence, self-empowerment
        - Reduced anxiety, depression symptoms
- At systems level, there is evidence to support:
    - Improved overall efficiency of delivering population level care, including
        - Reduced need for GP visits
        - Reduced used of prescription medication
        - Reduced Emergency Department visits
    - Improved provider satisfaction
    - Increased integration between health and community support sectors
- At community level, there is evidence to support:
    - Increased volunteering
    - Increased use of community assets

What we don't know

In the Australian, Victorian and Latrobe Valley contexts, there is currently insufficient collection of data and experience to answer the following lines of enquiry:

- Acceptability of the concept in Latrobe Valley – by target community cohorts
- Acceptability of the concept in Latrobe Valley – by community

[2] RACGP & Consumer Health Forum of Australia, Roundtable November 2019, Stimulus Paper

- How to implement under conditions that make it feasible for general practice to participate (i.e. non-billable activity for small business operators operating in tight funding environments)
- What policy environment is required
- The funding supports available to support sustainability

Latrobe Valley community need

The Latrobe Health Advocate has been engaging community members across Latrobe Valley for 18 months to identify community priorities for health and wellbeing. The top three priorities identified are: mental health; access to services; social inclusion.

- People talked about the importance of having mental health support services that are approachable, professional and sympathetic
- Latrobe communities have also identified the barriers that the stigma associated with poor mental health can create. They have described their vision for mental health to become an everyday topic of conversation that is talked about as openly as physical health issues such as the common cold or flu
- Social inclusion is often discussed when people talk about improving mental wellbeing in Latrobe. People have talked about the benefits of community activities where there is a common interest that brings people together alongside an opportunity to connect and socialise. People have talked about the benefits of community groups which provide good opportunities to bring people out and help them to connect

The Advocate is also currently exploring access to general practice and other health services in response to feedback about:

- Difficulty accessing GPs due to booked out, too expensive or only in the area temporarily
- High GP turnover and long waiting times prevent seeing same doctor and continuity of care which impacts on establish a relationship of trust
- Local practices turning patients away daily
- Inappropriate ratios: "There may be enough doctors in Latrobe per person, but there are not enough doctors per problem"

Local GP data review

We accessed data available on Latrobe Valley from Gippsland PHN Needs Assessment 2019-2022.

- Latrobe residents report higher use of GPs, ED, community health services, pharmacists
- Community averages 6.5 GP attendances per person per year
- 90.1% of attendances at GPs are bulk-billed
- Hospital admissions rates are high for Latrobe residents (443 per 1,000 people)
- Emergency department presentation rates in Gippsland are high (398 presentations per 1,000 people)

- 19/100 people report high or very high isolation (in Gippsland)
- 43% of all survey respondents reported problems getting an appointment with a GP during business hours
- Economic factors are an important consideration for many people in accessing services, especially for people with low socio-economic status.
- Community input shows that access to health services is most difficult for people with social or financial worries, parents and people with a disability. Main barriers are cost, long wait times and transport, while not feeling comfortable accessing a service and lack of information about available services are also relevant, especially for some groups. Access to GPs was the top health issue in interviews

For the purpose of patient identification (i.e. selecting priority groups for inclusion in the program or for the trial period, for example), there are some additional data sets available for extraction and analysis from Gippsland PHN, to be reviewed once trial sites are selected. For example:

- What proportion and with what frequency do youth access general practice? (in order to understand whether general practice provides an adequate referral opportunity for young people into social prescribing)
- Patient visit frequency to general practice according to: low (1-3 visits); occasional (4-5 visits); above average: 6-11 visits, frequent: 12-19 visits; very high: 20+ visits per year
- Patient numbers with multiple chronic diseases (focus on three or more), including identifying proportions of chronic disease comorbidities
- Data on chronic disease by patient activity
- numbers of patients within chronic disease categories and their level of visit frequency
- Identifying patients at high risk of hospital admission based on general practice data

Consultation and stakeholder engagement: Key themes and insights.

The following sections summarise the key themes from the following stakeholder groups:

- General practice
- Community
- Community sector stakeholders

General practice consultation; community health care consultation

There are 27 general practices in Latrobe Valley, which includes sole practitioners and corporate practices (for example, Medical and Aged Care group which owns four practices). There are currently approximately 76 general practitioners practising in the Valley, including registrars.

This project consulted with 10 general practices, 22 individual General Practitioners and 13 nurses (including chronic disease, diabetes educators, aged care, Nurse Practitioner) to explore feasibility of social prescribing model in the Valley.

Key themes and considerations included:

Key theme	Comments
"Social patients"	• GPs report seeing that social patients (alternately referred to as "reassurance" or "TLC") range between 15% to 80% of daily patient visits (one practice in Churchill identifying up to 80%, which reports many pain management patients)
GPs (and nurses) lack awareness of community resources & supports	• GPs want more support for their patients, but many do not know what is available in the community. GPs reported referring to nurses where non-clinical referral was necessary. Many doctors and nurses were not familiar with local voluntary, community, social enterprise. Several were not familiar with concepts such a neighbourhood house or men's shed. Some nurses reported not knowing where to send patients for food or crisis relief to access a meal
Concept awareness	• The large majority of GPs and nurses were not familiar with the social prescribing concept. Not all GPs engaged with the concept or agreed that GPs should be involved in non-clinical or social care
Role of nurses in social prescribing	• Nurses expressed significant support for the concept; nurses are often already providing this referral but don't necessarily have

	access to the community connections, information, and not supported for this work. One nurse reported: "the patients see the doctor and then see the nurse and tell them what's really going on".
Identifying patient cohorts	• Some example patient cohorts identified for participation, include: social patients; pain patients; people aged 50 to 65 (a group which is prematurely ageing in the Valley but who do not yet qualify for funding supports for 65 years and over)
Barriers to patient participation	Some GPs expressed concern about • the financial stress faced by patients who cannot afford their medication or their children's' medication, or cannot afford to eat) • patients with behavioural difficulties being referred to community activities unsupported by a worker; can lead to group disruption
Existing social prescribing activity	• Tanjil Place Medical operates a walking group from its premises twice per week, with good engagement success. The group has led to social connection outcomes which include: friendship, lunches, Christmas events, isolated patients participating (for example, in family violence situations)
Community health setting	• LCHS integrated primary health team supported the introduction of a model, identifying key target cohorts within district nursing, dental services, and other allied health services
Cost incursion to general practice	• General practices operate in small business environments, with multiple and competing pressures. The general practice sector across the Valley is under pressure with long waiting times, and insufficient doctors to support the complexity and multi-morbidity • Time and costs likely to be incurred include: nursing time as key general practice lead; nursing/mental health worker time for supervision/mentoring/debrief (one hour per week); GP and nursing time for training (in-kind during clinical education); patient management software adjustments to embed Social Health Check tool; patient identification; active patient recruitment; participation in evaluation

The minimum conditions of participation for general practice in a social prescribing model include:

Key theme	Comments
Funding & reimbursement	• A dedicated worker is required to deliver the program. In considering the types of patients that are best placed to participate and that will benefit the most, an enabling and coaching service is the key gap. The dedicated worker must be resourced to provide the time required to support patients in person-centred, flexible and responsive manner • The model must be sustainable and not subject to short-term funding cycles.
Sustainability	• The model needs to be based in a well-resourced setting with appropriate systems, practice support, resources and governance in place (i.e. there was reluctance expressed about locating the model in community structure such as a Neighbourhood House which can be too resource-constrained and unstable). Some GPs expressed engagement fatigue with well-meaning programs which are limited by funding cycles.
Dedicated worker	• Any dedicated link worker has to be based out of general practice or based onsite some of the time in order for general practice to engage in the model.
Systems and feedback loops	• The program must have: simple referral form and process; minimal wait list; information feedback loops which communicate back to primary care provider and communicate outcomes of activity

Latrobe Valley community consultation

The community consultation was specifically designed to include community members who are most likely to need and/or benefit from social prescribing; experience loneliness and isolation; experience barriers to participation. The recruitment process included a number of different public and private settings, using direct approach and community group invitations, across four townships (Churchill, Moe, Morwell, Traralgon).

The consultation process included a combination of quantitative surveys and qualitative community conversations, resulting in 130 conversations and 80 completed surveys.

Community conversations were held at venues such as:

- street side, park benches; Opportunity stores; Shopping centre food courts; Bus and train stations; Food and crisis relief centres; Libraries; District Nursing clients; English

language conversation class; Laundromats; Work for the Dole program; Multicultural friendship groups; English language conversation class; Magistrate's Court; Skate parks; Street Games; Health service waiting rooms (general practice; community health)

The key questions posed to community members to

- How much do you know about your local community and voluntary services? (list of some local activities, groups, services)
- Has your doctor ever told you to (list of some community activities, groups, services)
- What's most important to you? (general interests and values)
- What matters to you? What are you interested in? (comprehensive list of community activities, groups, services)
- Thoughts on the concept, on terminology, on GP role in social prescribing
- What would make you more likely to engage in activities/services/ groups in Latrobe Valley which could improve your health and wellbeing? (list of participation barriers and enablers)

Key themes and considerations included:

Key theme	Comment
Patient identification	• A high number of people living alone and living very complex and disadvantaged lives contributed to the survey. A high proportion of people reported living with multiple stressors, living with poor mental health, relationship breakdown, chronic conditions, high drug and alcohol use, and financial distress, but most of all, living with constant stress • People were very willing to speak openly and honestly about their life circumstances (and many reported not having many people to speak to, personal and professional, about these challenges) • Many people make the connection between social determinants and their health, speaking of the impact of stressors on their wellbeing • Bereaved people spoke of their loneliness and difficulties in maintaining social connection • New residents to the Valley described the challenges in connecting with community, isolating experience
Reflecting on general practice	• While some community members reported having a regular or family doctor, a majority reported not having a regular GP. Many also reported: "GPs don't listen"; "GPs don't care too much"; "They just want to throw medication at it"

	• Most people cannot recall a doctor recommending community activity or participation; doctors often do not know what is available in the community • Others emphasised that many community members "don't know how to talk to GPs [about non-clinical or social issues…] don't know how to begin a conversation about some of their issues…they feel anxious, not empowered, think GPs don't listen or care…" • Some expressed concern that social prescribing might take away time from already-pressured appointments and that they preferred GPs concentrate on their medical issues only
Awareness of existing community assets	Community members reported • Not knowing much about local community activities (library, neighbourhood house, volunteering, social groups), and wanting to know more about what local activities are available • Several towns' Neighbourhood Houses are inconveniently located for people with transport accessibility issues (in particular, Morwell and Moe) • For some people with social anxiety, participation in groups can contribute to their feelings of stress which can be exacerbated by reported perceptions that some community groups can be exclusive or overly political
Conceptualising a social prescribing service	• The majority of community participants supported the introduction of a social prescribing model, however, many identified some key barriers to participation: transport; someone to go with; cost • Some older community members (65-70 and older) tended to more instinctively understand social connections as community involvement, and a distinct • Multicultural community members identified the need for social connection, employment skills, confidence building and language skills in order to develop foundational capabilities to integrate and contribute to the community
A dedicated worker with very specific skills who provides coaching/enabling support	• Community members reported repeatedly that a "prescription" alone from a GP was not enough; additional support from a worker was required for them to engage. One of the themes explored during conversations was the gap between receiving a "prescription" and following through to engage with the activity. People commonly reported needing: someone to motivate them, to accompany them to a group, and to follow up to reflect on experience

	• Two 'fishing' analogies were used several times: one to indicate that a person needs to be shown the skills rather than provided with the benefits; and the other, that you need to be able to demonstrate participation rather than to read about it or describe it. In both cases, the emphasis is on the worker demonstrating or modelling what participation and social connection can look like. • Community identified that a worker needs to: ▪ have the time for appointments to have meaningful conversations and get to know them and understand their strengths and hesitations ▪ have exceptional engagement skills ▪ have empathetic, respectful, empowering, non-judgemental approach based on principles of active listening and trauma-informed care
Referral contact points	• Some community influencers for disenfranchised people (and therefore potential referral sources) identified included: food / crisis relief workers; opportunity shop attendants; receptionist at general practice
Terminology	• In considering the terminology of "social prescribing', there was a tension between the formality of the term 'prescribing' (i.e. the patient expectation that a doctor prescribes a recommended course of action) and the influence and authority of a doctor who prescribes; and others' preference to make the focus on the community connection part of the model. Suggestions included: ○ community referrals; social service, community connection, social interaction, social awareness, community health, social support, social health, life empowerment, inclusive health, Helping Hand, a whole-approach, community connector, wholly connected, resocialise, community connection worker, social worker, social advocate, social coordinator, social mediation, life coach, life worker, services coordinator, Social Support Officer, community resources enabler/facilitator; social service; community involvement; social outing

A summary of the key results from the survey are attached in Appendix B.

- Key priorities and needs identified include (in order of priority):
  - **What's most important to you?** Talking with people, conversation; Being a bit more active; Having something meaningful to do with my time; Having a support group; Volunteering

- **Latrobe Valley Social Prescriptions. What matters to you? What are you interested in?** Health and wellbeing; working on my strengths, goal setting; walking group; relaxation / meditation; computer, internet, technology courses; cooking / nutrition

Service stakeholder consultation

Consultation with community sector stakeholders comprised a mix of individual interviews, group network meetings and a large public forum. A list of stakeholders consulted included in Appendix C.

Key themes and considerations included:

Key theme	Comments
Build on existing structures and previous experience	• For example, 3840 Our Learning Future project experience of using a community link worker to increase rates of education / vocational participation • On other relevant campaigns such as 'Hello' campaign and align with the findings of Latrobe Health Advocate's activity to improve social inclusion, such as current town-based inclusion project • Existing community structures like the libraries, Learn Local, neighbourhood/ community houses, community lunches, Park Run
Impact on community/ voluntary/enterprise sector is risk if not adequately resources	Concern about impact on community/voluntary/enterprise sector • The risk that some community sector resources may not be able to cope with the additional demand generated through social prescribing was identified. In particular, some Neighbourhood Houses expressed concerns about the ability to support additional community members • The need for community groups to be supported through training on creating safe, welcoming and inclusive environments, including for particular population groups (for example, the ageing; complex mental health), to support them to provide strengths-based and empowering environments
Community and care navigation portal	The need to have a community and care navigation portal for information in the Valley is significant • A strategic approach is required to avoid contributing to existing mix of portals, some of which are not well marketed. • Berry Street is currently trying to address this problem with development of Discover Local; Gippsland PHN is exploring a digital guide to non-clinical supports

Use of volunteers	• There is scope to involve volunteers in the model in a number of difference capacities, both to support program delivery and to role model community volunteering • The HandsUp Latrobe Valley program can provide organisational support to operate a volunteer program

Social prescription mapping.

This project sought to collate information on current activities, programs, groups and resources to identify what a Latrobe Valley prescription pad could look like. Following consultation with community and stakeholders, we sought to identify any gaps and opportunities for new "prescriptions" or community referrals.

The project collected information from:

- Community noticeboards and advertised community flyers at: shopping centres, community centres, libraries; store windows, Morwell Neighbourhood House community newsletter Latrobe Echo, No Cost Activity Guide
- Community survey questions on local community supports and stakeholder interviews

Existing databases of information include

- Latrobe City Council list of community organisations
- Latrobe City Council calendar of community events
- Libraries groups / events
- Neighbourhood Houses, Community Centres, Learn Locals groups and courses

It is important to note that both community members and healthcare professionals reported that they do not know what is available in the community.

An example list of the breadth of community groups and events available across the Valley, listed in different digital and hardcopy locations is included in Appendix D.

Recommendations for Stage 2.

This section summaries the recommendations for Latrobe Health Assembly Board to progress to Stage 2 with a social prescribing model, including:

- Recommendations for key elements of a trial model built on a neighbourhood-based approach
- Identification of four options for trial innovations site partnerships (general practice and community service partner) in each of the large townships
- Recommended phased approach to trailing, beginning with 1-2 sites for 18 months, before considering adding other trial models in other locations.

The following table summarises the recommendations for key components of the model, followed by recommendations on selection of trial innovations sites.

Key elements of a trial model

Key elements of the model	Comments
Objectives and outcome measures	The purpose of introducing social prescribing to Latrobe Valley is to: • provide a more holistic and personalised approach to health • support general practice to respond to social model of health (i.e. respond to social determinants of health) • reduce unmet needs which impact on health and wellbeing but cannot be met by clinical services • respond to top community needs and priorities identified by Latrobe Health Advocate: mental health, access to services, social inclusion The purpose of the trials is to test whether the model: • can be adapted to work for Latrobe Valley community and Latrobe Valley general practice, healthcare and community sectors in way that demonstrates benefits for community and services • provides benefits for individuals in: social inclusion, access to services, mental health • cost effectiveness and sustainability, assessing whether benefits can be demonstrated for primary health care sector in a way that costs can be absorbed once effectiveness is measured

Management and administration	Project lead role (0.6FTE, including some evaluation data collection, process, qualitative), potentially to be funded by Gippsland PHN and co-located between PHN, Council communities' team / sites (example, libraries) and Latrobe Health Assembly. Project governance supported by: Latrobe Health Assembly, Latrobe Health Advocate, Latrobe City Council, Gippsland PHN, With involvement of: Neighbourhood Houses Regional Coordinator, Libraries Regional Coordinator, ACFE Regional Coordinator, LRH Ambulatory Services, LCHS aged and community care or primary health
Neighbourhood-based approach	The site/s to work at very local level to identify • local priority needs populations for trialling • local activities / groups / services to establish collaborative community partnerships • options for local transport support • small business or service donations through vouchers/discounts, etc • co-designed patient-reported outcome measures (PROM) to be used to monitor implementation • a local fit-for-purpose model
Innovations trial sites	Four sites have been identified for participation (in Churchill, Moe, Morwell, Traralgon). The Working Group identified two competing priorities for selecting participating trial sites: (a) focus on one trial site to optimise measurement and learnings approach; or (b) trial a number of different sites, employing a different model at each site to test assumptions and different parts of the model. See discussion and table below
Management & administration	The Project Lead should be employed by Gippsland PHN, with potential co-investment by the Gippsland PHN. Location at the PHN will provide opportunity to optimise alignment with general practice strategic activities, provide access to data analysts and evaluation expertise and provide a pathway for sustainability.
Engaging general practice	Understanding of the general practice setting is critical to engagement, with reference to the operating structures, small business pressures, the staffing structures and whole-of-practice approach. General practice providers operate differently from community health and other local healthcare settings, and both the engagement of the trial site/s and the relationship-development with a dedicated worker needs to be sensitive to and acknowledge these.

	Working closely with GPHN to engage general practice is recommended. Only general practice sites that have expressed interest have been recommended, noting that the Churchill practice is a corporate clinic and additional time and resources may be required to engage. The participation grant funding should be a true reflection of the time and resources the practice is contributing as a trial site, with costs monitored during evaluation for costs analysis.
Principles underlying approach	The design of the trials and the objectives of implementation should be underpinned by the following principles which are key to optimal social prescribing outcomes: • A flexible, responsive, person-centred service delivery model which is destigmatising, strengths-based, empowering • The model should address a range of factors (social determinants) that impact on the wellbeing and social inclusion of community members, including housing, education, employment, income, financial distress, relationships, social connectedness, personal safety, trauma, stigma, discrimination, geography • The model should build on existing assets wherever possible (including community assets and projects assets such as Latrobe Health Assembly men's shed project) • The trial design should prioritise and invest in meaningful evaluation outcomes in order to inform: (a) any roll-out strategies for Latrobe Valley; (b) understand implications for sustainability; (c) contribute to Australia's evidence base and advocacy Also, the principles may take inspiration from Australia's recovery-oriented practice in mental health: • *Recovery-oriented approach*: i.e. embraces the possibility of wellbeing created by the inherent strength and capacity of all people. Maximises self-determination and self-management of wellbeing. Acknowledges the diversity of peoples' values and is responsive to people's gender, age and developmental stage, culture and families as well as people's unique strengths, circumstances, needs, preferences and beliefs • *Trauma-informed approach*

Dedicated worker	General practice and community members have both identified the need for a dedicated worker as a minimum condition of participation, whose key responsibilities include: • relationship-building and individual needs assessment • co-producing goals, actions, with strong follow-up • relationship management with health and community sector (existing Latrobe Valley community connections is ideal) • flexibility: appointment time; appointment location; repeat appointments and follow up Terminology • Some resistance to the local use of name "link worker" has been reported • "Community connector" or "community navigator" have been suggested and tested as acceptable by community • Other sites use: Wellbeing Coordinator (Deer Park); Community and Health Care Link Workers (Mt Gravatt); Social Prescription Link Workers; Neighbourhood Welcome Service Community Connectors (AusPost, Maribyrnong). The approach taken by Mt Gravatt trial site is to split the role into two positions: community link worker and health care link worker Qualifications and skills • A clinically-trained individual is not required (but would be feasible supported by adequate framework about approach). Key skills include: social/relational; coaching/motivational; community development • Sample position description is attached in Appendix E. Auspicing and support • The worker may be employed by the general practice/community health; community sector partner such as community centre; or key implementation partner such as GPHN or Council. It is a priority is to ensure funding to support and maintain their position should the employer be a third sector organisation. Social prescribing facilitates relationships being established, especially between the dedicated worker and the local community. The relationship and trust between a person and the worker can empower a person to take action to change their circumstances. These relationships take time to develop therefore continuity of funding is very important to ensure relationships can continue

	• The position must receive adequate supervision/debriefing/ mentoring Several people have expressed interest and have been identified as having 'community connection' skills required for this type of role during the consultation.
Identifying patient cohorts	Recommendation is that the trial site/s take a collaborative approach with the general practice and community partner to identifying the priority populations for trial. The aim is not to exclude but rather monitor demand management and evaluate the experience of different cohorts, including enablers/barriers to engagement. The site should prioritise for inclusion / activation: (1) High frequency GP visitors (using the two highest categories: Frequent (12-19 visits per year) and Very high (20+ visits), and (2) select 3-4 categories from the following, depending on local practice cohort and identified unmet needs: • living alone • bereaved • depression • complex mental health • premature ageing 50-65 years • multiple chronic diseases • elderly • newcomers • single / young mothers • relationship breakdown (3) Others may be selected as needed (for example, obese young people) **Approach to young people** Developing an approach to social prescribing for young people is a standalone model, partly informed by for example: young people's reduced use of general practice; youth-friendly engagement strategies; community resources and activities available to young people. Options to consider include: • including a youth-specific innovations trial site

	• delaying a youth-specific site until general trial learnings are understood Model options include: • including headspace on the foundational referral pad for site/s (nb: while referrals are generally for non-clinical community activities, headspace provides a holistic service across four key domains: mental health, drug and alcohol, vocational, general practice) • working with the Youth Governance Committee to develop a model based on the Latrobe Youth Space, for example, funding a dedicated worker or creating referral pathways
Timing and establishment **A phased approach to trial conditions and demand management**	Recommended trial period is minimum 18 months (6 months establishment, 12 months implementation). Such programs require adequate time to establish, especially in a general practice setting. Establishment phase to comprise: • relationship and trust building; awareness-raising and training; referral pathways, data and information management and feedback loops to be established A year of full implementation is the minimum to trial and understand learnings from: being embedded into general practice; engaging patient groups; costs analysis; impact on community sector. The key risk is demand management with concern that the service will be over-subscribed. Creating another waiting list service has been highly discouraged by all during consultation including the Working Group, and will act as barrier to participation. In particular, this can lead to rapid disengagement of disengaged/vulnerable/hard-to-reach population groups with the program. There should be no service demand or intake expectations which prioritise through-put. The recommendation is to assume a cautious and responsive approach to establishment, closely monitoring demand and capacity. There are a number of ways to stagger implementation to manage demand. Consider limiting • the patient groups targeted for inclusion, perhaps focusing on one group at a time • the referral sources for the first 12-18 months while the program establishes (perhaps general practice and self-referral)

	• the 'community referrals' available for the first 12 months while the program establishes (i.e. focus on establishing foundational relationships with existing local assets from list in diagram above), without being exclusive (i.e. if a particular participant needs another activity, this will be supported). Key unknown factors impacting on demand include: • What proportion of community members will engage with program and how long trust and word-of-mouth will take to build • How much enabling or coaching will be required and resource implications • The resources required to deliver the non-linear and follow-up support reported by trial sites (i.e. participants may not find referral useful or may require additional coaching) For reference: Two trial sites completing first six months of operation have supported approximately 70 community members to connect to community with 1.0EFT.
Town-based "referral pad"	Refer to model diagram in Executive Summary Each trial site to develop and continue to review its own neighbourhood-based referral pad. This initial referral list comprises: • the key local community resources which general practice and community members reported they are not familiar with (e.g. library, neighbourhood centre, men's shed, Learn Local, volunteering opportunities • some key community services such as crisis relief, food bank, community lunch, domestic violence, which general practice identified needing for their patients • some general activity needs identified through community consultation: walking group, older activity groups, disability support, multicultural friendship group One example of an area-based referral pad being trialled in metropolitan Melbourne:

	https://ourneighbourhood.auspost/wp-content/uploads/2019/11/Local-Offers-and-Activities.pdf Other elements of a localised approach: **(a) Transport options** The dedicated worker will work with local partners and its project Community Connections Network to source and map a number of options to support transport for participants to travel to activities **(b) Local business support** The dedicated worker will engage local business and services who might contribute vouchers for participants to use (for example, swimming, transport, cinema, food, coffee, companion animal grooming, massage, etc)
Social determinants screening (Social Health Check tool) and psychosocial needs assessment	Two tools are recommended for use in innovations trial sites: a. Social determinants screening tool – in general practice b. Comprehensive psychosocial needs assessment – with dedicated worker **Social Health Check screening tool** Trial the use of a brief patient screening tool to (i) provide opportunity for patient to identify social determinants which may be impacting on their health, and (ii) seek permission for doctor or nurse to discuss any of these issues at a future appointment • Trial tool with existing patients to understand acceptability before rolling out to new patients. Tool designed to be very simple, fast, sensitive • Tool to be completed in waiting room while waiting for appointment • Tool to be developed can be adaptation of current work in progress in South Australia in developing asocial determinants check to be used in clinical settings[3] and Camberwell Assessment of Need Short Appraisal Schedule (CANSAS, a tool used for complex mental health, see Appendix F for example)

[3] Browne-Yung, K, Freeman, T, Battersby, M, McEvoy, RD, Baum, F (2018) Pilot Social Health History Screening Tool Research Project Questionnaire, Flinders University. https://doi.org/10.25957/5ba9793a8fcb5

	The trialling of a Social Health Check screening tool for social determinants is a key innovation for the proposed trial and will benefit from a partnership approach with clinical, policy and academic partners. **Comprehensive psychosocial needs assessment** This will be completed by the dedicated worker and will form the basis of co-producing goals and determining community referrals. The data will also be a key source for monitoring evaluation to determine changes in unmet need status over time. The tool should be a full psychosocial assessment with quality of life, strengths, goals; existing tools may be adapted.
Process and systems; data and information management	A key component of establishment phase is to establish data collection management for the service and identify the processes and pathways to integrate with general practice. Elements include: patient identification, referral (including criteria), demand management, interventions, tracking/monitoring, exiting, feedback loops to primary care
Local referral pathways	Recommendations for initial trial period is to begin and monitor internal referrals from general practice trial site • General Practitioner • Practice Nurse ▪ completing health assessments (75 plus health assessments MBS item ▪ chronic disease, mental health, aged care nurses, diabetes educators • Counselling, allied health • Social Health Check self-referral • Assertive practice marketing through patient identification to identified cohorts A protocol will need to be developed to respond to external queries in early phases. This includes an approach to referrals from other general practices. **Local referral pathways** Consider the following approach to staged referral introduction as service demand becomes clearer and adequately managed.

	Tranche 1 • Ambulance Victoria frequent-user case managers • Victoria Police including Proactive Policing and MHaPR (Mental Health and Police Response) program • Community health programs, including District Nursing • Hospital discharge planners, concierge role • Community Home Support Programme (CHSP) • Maternal, Newborn, Child Health (MNCH) nurses • Department of Housing *Tranche 2* Library workers, community centres, community workers, food/crisis relief workers, Council local laws and dept workers, Refugee Health Nurses, settlement workers, other community touchpoints (e.g teacher, elder, faith-based leader) **Developing new referral options** As the model develops, gaps in local community activities/resources/services will be identified. The dedicated worker may have the capacity to identify grant opportunities and/or support community organisations to establish new activities. This should be monitored through evaluation and alternative pathways to support be established through project governance (for example, Council).
Role of volunteers	Volunteers can provide wraparound support to the dedicated worker and the participating community members to provide a more holistic, person-centred service and to reduce some of the barriers to participation identified by community members. For example, volunteer roles can include: • welcoming services, companionship to activity, driving (including potentially a "volunteer uber service"), and may include enabling, coaching, depending on the skills of the volunteer There are two options to source volunteers for the model: a. self-administration which requires a Volunteer Coordinator role to be funded to sit alongside project lead role (or split role to create 1.0EFT), and utilisation of https://www.gippslandvolunteering.com.au/ portal

	b. partner with local organisation who hosts volunteers to create pathway, for example, Council and LCHS PAG volunteers, MiCare Friendly Visiting Volunteers HandsUp Latrobe Valley can provide management, risk management and governance support through coaching, toolkits, and network meetings hosted by Volunteering Victoria
Barriers to engagement	***Transport*** • Access to transport was identified as the primary enabler by community members for participating in activities/services/groups to improve health and wellbeing. • Recommendation is to take neighbourhood-based approach to identifying transport support, including: volunteers to drive; mapping local unused bus and vehicle options and entering into partnership with organisations to use vehicles; GP voucher; partnering to receive vouchers from community taxi alliance; VicRoads; Red Cross transport • Evaluation to monitor whether transport barriers are reduced once coaching/enabling is in place ***Enabling, coaching*** • Core component of flexibility to be provided by dedicated worker is enabling or coaching where necessary. This includes motivational interviewing, 'work' coaching, ***Cost*** • Recommend all referrals are to free or low cost ($2-$3) activity wherever possible
Terminology	Consultation yielded two opposing but strong views on terminology. One view held that "social prescribing" is too much aligned with clinical service and formalities / barriers and misunderstandings about its objectives. The other views held that the relationship and expectation in a doctor-patient encounter yields significant influence on the patient and therefore a patient is much more likely to act on "social prescription" advice. • Community referral was the most commonly identified alternative term by community members. • Some stakeholders have suggested that a brand (Latrobe Connect) might be better suited • Using 'scripts' rather than 'prescriptions' or prescribing'

	For the purpose of advocacy, continuing to align the model with the term "social prescribing" is recommended. Approaches used in other sites: • "A new prescription for life" (Deer Park, Melbourne) • "Plus Social", "Not your ordinary prescription" (Gold Coast) • "Ways to Wellness" (Mt Gravatt, Brisbane) • "Links Count" (Inala, Brisbane) • "Don't medicalise…socialise" (UK) • "No health care without social care" (UK) • "A prescription for life" (UK)

Social marketing strategy and materials	The key priority for a marketing and social communications strategy during the trial period is to test community engagement approaches, and a secondary priority to develop general practice and health sector communications to explain and promote the service.
	
	The materials will have limited exposure during the trial period however will produce some important data during the evaluation.
	
	The following components are recommended for trial development during establishment period. The purpose is trial testing rather than broad mass social marketing so a supplier should be found that can work flexibly within these parameters, ahead of a potential further roll out in a further phase.
	
	• Program marketing: brand, slogan
	• Program materials: prescription/referral pad
	  ○ Trial different approaches to the 'referral pads', using a coloured approach, both to differentiate from routine white pad, to capitalise New Zealand's success with "Green Scripts"
	• Community-facing materials (e.g. waiting room posters, brochure to be used in assertive patient mail out)
	  ○ Patients need confidence in having conversations with GPs and nurses about non-clinical issues and to understand role of dedicated worker
	• General practice-facing materials (e.g. posters, digital materials)
	  ○ GPs and nurses need confidence in having conversations about non-clinical issues; conversation scripts

Local governance	Each trial site to be supported by a neighbourhood-based 'Community Connections Network' (or existing alternative identified), comprising as a minimum: dedicated worker, nurse, Neighbourhood House / Learn Local, library, men's shed, crisis relief service, volunteering service, Park Run and community members. The group is to review progress and implementation barriers, promote the service and support community connections for the dedicated worker.
Community voice	The model needs to include an embedded mechanism for community voice, both for the trial phase and for ongoing delivery. As a minimum, this might include membership of the Community Connections Network and regular reflection on qualitative user experience conversations with the dedicated worker. (For example, the worker may have a KPI to demonstrate one example each month of how community feedback has contributed to service improvements.) The evaluation can include effectiveness of the community voice mechanism.
Partnerships	A priority during trial phase for each neighbourhood is to continue to identify place-based partnership opportunities. These may be health and fitness facilities; service clubs such as RSL, Probus or community clubs such as Italian-Australian club; community housing; or small / local businesses At higher-level, explore Valley-wide partnerships such as VicRoads, Australia Post, Latrobe Valley Bus Lines / Kindred Spirits Foundation, other philanthropic or corporate social responsibility driven by public value objectives. Others who have expressed active interest include: • Gippsland Legal Assistance Forum (GLAF) Djirra, Victoria Legal Aid, Gippsland Community Legal Service and the Victorian Aboriginal Legal Service • Monash School of Rural Health • Neighbourhood Houses Gippsland • Neighbourhood Houses Victoria • Latrobe Community Service Providers Network • Emergency Relief Network • Proactive Policing Unit, Gippsland • Ambulance Victoria Operations Community Engagement Liaison Coordinator, Gippsland

	Latrobe Health Assembly to consider establishing community of practice with other Victorian trial sites
Impact on voluntary / community resources sector	There was concern expressed by some community service organisations about managing the impact of increased referrals to their service or activities. There have been instances in the United Kingdom where social prescribing programs have failed because of inadequate support and resources to the voluntary / community service sector. The Working Group recommends that this is monitored closely during evaluation. An outcome of the evaluation may be an understanding of resource capacity segmentation of referral activities (for example, ready to go; requires some support; high-risk but can be supported subject to several conditions).
A comment on unintended consequences	One risk identified by community members is that a referral to social prescribing by a health practitioner may delegitimise their health problems, both internally and to others. Some community members expressed a 'co-dependency' on prescription medication to validate their experiences. Others, both community and GPs, noted that conversations about non-clinical needs that have not been initiated by the patient are outside of the scope of clinical service or intrusive. All of these issues and sensitivities need to be monitored and measured during evaluation to understand how people respond to social prescribing. While this issue was not identified during our consultations, medical practitioners in other sites reflect on a duty of care to patients, which may not easily be transferred to others. It will be important to develop appropriate referral and transfer protocols to mitigate these potential concerns.
Recommendations to key stakeholders	
DHHS	• Identify opportunities to support the local state-funded community services sector to grow into this model • Identify opportunities for sustainability after a trial period • Consider options for including program / activity / service information in a community services portal as part of contractual obligations for funded services across sectors such as housing, domestic and family violence support services, carer support, employment etc (i.e. to drive a

	Latrobe community navigation portal, single source of information) • Consider options for innovative social prescribing models when reviewing the Victorian public health and wellbeing plan 2019-23, and when providing guidance to agencies drafting their own plans • (Is there some support available to local neighbourhood houses and community centres to engage in the model?)
Latrobe City Council	• Identify opportunities for Council role in social prescribing • Identify alignment with the Council's Health and Wellbeing Plan, and how it could support that Plan's goals • Identify opportunities for Council to support local community / voluntary / enterprise sector to participate into this model • Explore opportunities to support the trial with Council-administered transport options, volunteer mechanisms, or community groups and events digital portal • Explore Council role in providing Welcoming and Friendly Clubs training to participating community referrals
Gippsland PHN	• Consider project lead to be employed by GPHN given their mandated role to support general practice, health planning, health system integration and commissioning services in line with national and local priorities • Support the engagement of local general practice/s as innovation trial sites, ensuring aligns with other GPHN priorities and activities • Support access to local relevant data to stratify patient groups and neighbourhood-based approaches where possible • Identify opportunities for trial alignment with the PHN's digital social prescribing tool to be developed • Identify opportunities to explore general practice 'frequent visitor' issues through research or commissioning • Consider developing a small place-based referral resource for non-clinical community supports for each general practice in Latrobe Valley (or Gippsland) i.e. each practice receives postcard with 7 most important/common community referrals
LCHS	• Support a trial site if appropriate • Support the development of referral pathways from general practice to community health programs and activities • Promote and market the program upon referral readiness

	• Build the capacity of NDIS Local Area Coordinators and Home Care Providers to improve opportunities for people with a disability and ageing people to actively participate in community activities through a social prescribing approach
LRH	• Identify opportunities to support social prescribing trial, introduction and sustainability • Support the development of referral pathways from discharge and ambulatory settings

Exploring trial innovations site options

The table below provides some trial site suggestions based on consultation with general practice and community sector. Each site provides the opportunity to trial a different model, as indicated in the comments.

Innovations site	General Practice	Community co-location partner	Comments
Churchill (4,568 pop)	**Hazelwood Health Centre**	**Churchill Neighbourhood Centre (employs worker)**	Option to trial community partner employing worker and high numbers of reassurance patients (up to 80%), pain patients This site would need to be supported by MOU between neighbourhood centre and general practice, which is also part of MACG corporate network (with 3 other practices in Valley), may require additional support to engage and sensitive to cost-benefit considerations
Moe (16,812 pop)	**Tanjil Place Medical (employs worker)**	**GEST**	Option to trial Learn Local partner site. Tanjil Place already runs successful walking group program, could explore other practice-initiated activities, high chronic disease and newcomers
Morwell (13,770 pop)	**LCHS (employs worker)**	**Morwell Library**	Option to trial community health setting or youth approach. No preliminary engagement from a general practice or community partner setting

			Option: can re-attempt engagement of 2 MACG corporate clinics at Mid Valley Shopping Centre, and forge relationship with Youth Hub
Traralgon (25,485 pop)	**Breed Street Clinic (employs worker)**	**Traralgon Neighbourhood Learning House**	Option to trial a clinician (nurse) in the role. Breed Street focus could also be ageing population, and premature ageing (50-65 years)

Overall recommendation is to focus investment into two sites for 18-month trial period, prior to trialling some other options in a trial phase two. Recommended options:

- CHURCHILL. Trial community centre-based worker with community centre in current high readiness and engagement, with manager with previous experience as Link Worker in United Kingdom. Multi-purpose site with child care, library, community garden, Men's Shed, community café and Learn Local adult education. Hub is currently seeking additional community engagement

and one of:

- MOE. Trial dedicated worker, non-clinician, employed by general practice and co-located at GEST Learn Local (neighbour site) with time onsite at Moe Library through MOU. Site has active chronic disease supports (two chronic disease nurses, two diabetes educators). Currently focus more on prescribing movement ('exercise scripts') than social activities. This practice is not bulk-billing, sees many lonely over 70 year olds, overweight younger people, many newcomers, ageing, socially isolated, housing stress, depression
  OR
- TRARALGON. Trial dedicated worker who is an existing nurse clinician at the general practice, which is co-located at Traralgon Neighbourhood Learning House. The practice has identified people ageing prematurely aged 50-65, 'Warfarin' patients, obese people and the 'baby boomer bubble' approaching retirement. Site has also expressed interest in prescribing 'food prescriptions' for appropriate foods

Comments

- MORWELL. Consider delaying trial in Morwell until evaluation can provide learnings for feasibility, adaptability and readiness in other Latrobe Valley sites. Project lead can spend time identifying possible trial site partners during this trial period. Alternately, engage LCHS to trial community health setting, with Morwell Library as potential co-location partner.
- YOUTH. Consider delaying dedicated youth trial until evaluation can provide learnings for feasibility, adaptability and readiness in other Latrobe Valley sites. The above

recommendations have included basic referral options to headspace and Youth Space for each site, and youth need, engagement, participation should be monitored during the evaluation for recommendations for phase two trial

Evaluation and outcomes framework

The purpose of a local Stage 2 trial is to understand if and how a model of social prescribing might operate in Latrobe Valley; the impact of such a model on: community health and wellbeing measures; the general practice sector; other parts of the health system; and the community sector. This understanding will contribute to a business case for further roll out.

In particular, there needs to be a focus on:

- Demand management and workload management, given the many dimension of the dedicated worker position description. For example, understanding FTE requirements per population catchment, and management, supervision resource support.
- Monitoring resource requirements for 'supported engagement' component, which will require worker to leave the office, have access to transport, access to volunteer support
- Monitoring and understanding the impact on general practice (example, with regards to impacts on "social patient" visits including MBS billing and changes to waiting times for appointments)
- Monitoring and understanding the impact on the community / voluntary sector (example, any unintended consequences and resource implications for referrals to different types of community settings)
- Analysis of ongoing costs and sustainability
    - including: costs of maintaining the referral database; transport costs
- Other lines of enquiry, including
    - whether transport barriers can be overcome by supported engagement approaches
    - whether levels of required supported engagement change over time
    - whether, longer-term, the model has the scope to address some of the general practice service access issues, for example: reducing waiting times; general practice continuity issues

This study recommends for the purposes of Stage 2 trial approach:

- An external evaluation, which is embedded and includes a developmental component
- An economic evaluation that will generate a business case for sustainability
- An outcomes framework to be co-designed by the participating trial site/s, with measures identified by: participating community members; general practice; and dedicated worker. A draft framework is provided as a starting point in Appendix G.

Measures of interest might include:

- Wellbeing, quality of life, reduced unmet non-clinical or psychosocial needs
- Confidence, self-empowerment
- Use of community resources

- Involvement in volunteering
- Frequency of GP visits
- Symptoms depression, anxiety
- Use of prescription medication
- Frequency of Emergency Department visits

Economic evaluation

We recommend that both a costing analysis and a cost-benefit analysis should be undertaken.

(a) Costing analysis

A costing analysis would determine the input costs incurred in order to achieve the program's outputs, while taking account of various public revenue sources that could meet those costs through existing schemes (such as the Medicare Benefits Scheme) and programs (such as the Australian Government Primary Health Network Programme and the Victorian Government Community Health Program). Important costing analysis elements include:

- General practice
    - Cost of engagement, training and resources
    - Cost of patient engagement and referral
    - Whether income from MBS items or practice nurse funding can partially subsidise this involvement, and to what extent
- Program management and Dedicated Worker/s
    - Cost of management
    - Cost of governance, including organisational partnership work
    - Salary cost of the Dedicated Worker/s
    - Training
    - Marketing and promotion
- Community sector / voluntary sector impact
    - Increased costs due to referral to the sectors, such as training additional volunteers
    - Increased staffing and maintenance costs due to additional use of community facilities

(b) Cost-benefit analysis

A cost-benefit analysis would compare the difference in effectiveness of different social prescribing trial interventions, and would also help determine whether the benefit of the investment outweighed the costs. Benefits are measured in monetary units, as are costs.

Important cost-benefit analysis considerations include:

- Savings to the health system due to the reduction in the need for face-to-face clinical services (GPs and hospitals)

- Whether enhanced client engagement in community activities delivered community and individual health and wellbeing benefits that more than offset costs identified in the costing analysis
- Identifying particular elements in different trial models that delivered benefits that significantly outweighed costs.

Program costs

Costs estimates in table below are for 12 months unless otherwise noted. The recommended trial period is ***18 months***.

	COST ($)	NOTES
OVERALL PROJECT COSTS		
Staff costs		
Project Lead (0.8 FTE for 2 trial sites)	100,000 + oncosts	Consider co-contribution from PHN
Volunteer Coordinator (0.4FTE for 2 trial sites)	35,000 + oncosts	
Infrastructure		
Office, IT	0	In-kind from PHN
Transport	5,000	
Communications/Marketing		
Development, design, printing, website	30,000	
Resources		
Tools development • Social Health Check screen • Comprehensive psychosocial needs assessment • materials printing	20,000	For a comprehensive partnership approach including clinicians and academic support
Governance group support	2,000	
Digital community portal		Use to be confirmed, or delayed
Evaluation costs		
Internal data collection	0	Part of project lead FTE
External evaluation	50,000	
Economic evaluations	30,000	
SUBTOTAL	**282,000 for 12 months**	

PER TRIAL SITE		
Staff costs		
Dedicated worker	85,000 + oncosts per site	1.0 FTE per site
Resources		
Transport	7,500 3,000	worker vehicle transport vouchers
Printing, materials	2,000	
Volunteers		
Administration, resources	10,000	
Training	5,500	HandsUp Latrobe Valley in-kind
Infrastructure		
General Practice site grant	33,000	(50,000 for 18 months, @10 hours/week) • HR & administration (for sites with employed worker) including supervision and debriefing • Nurse & Practice Manager time for systems establishment • Training time – GPs and nurses • Data extraction • Mail out / SMS campaign • Social Health Check implementation • Materials printing • Participating in the evaluation
Community groups		
Community partner	0	In-kind
Training	0	In-kind Council or Primary Care Partnership
Resourcing & support for participating community sector groups	0	In-kind, costs/impact to be monitored during evaluation
Funding to identify some gaps in community need	0	Dedicated Worker to identify grants opportunities
TOTAL	**146,000 for 12 months**	

Sustainability

At local level, an economic evaluation of the trial period will establish a business case for the model and in particular, for general practice engagement.

In the longer-term, sustainability considerations include:

- Current advocacy by RACGP, Consumers Health Forum of Australia, and National Medical Health and Research Council, amongst others, to include social prescribing in the MBS item number review (in the same way the program is funded in the United Kingdom, and through the prescribing scheme in New Zealand
- Other commonwealth advocacy is encouraging development of a mechanism to enable bundled payment arrangements between commissioners across the health and community sectors to support the establishment of link worker positions based in local health services
- Nationally, it is predominantly Primary Health Networks funding sites and aligning social prescribing outcomes with their investment strategies in: chronic disease; mental health; community wellbeing and resilience. Some PHNs are funding place-based trial collaborations (with community health, Council, academic partners, NWMPHN) while others are using commissioning levers to trial driving an increase in prescription of non-clinical supports though general practice (e.g. SEMPHN chronic disease funding). A national PHN community of practice has been established
- Locally, the Latrobe Health Assembly needs to explore what a place-based partnership would look like to support social prescribing, with support from DHHS, Latrobe City Council, Gippsland PHN, and LRH as minimum
- Locally, the trial and implementation needs to be aligned and coordinated with Gippsland PHN strategies and initiatives to prevent duplication, and drive sustainability within the general practice sector
- Other partnership opportunities are emerging as different sectors (for example, Australia Post) and philanthropic organisations (for example, Be Wise Foundation) begin to explore their role