Social Prescribing

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Social prescribing – addressing people's needs in a holistic way

GPs and other health care professionals can refer people to a range of local, non-clinical services, supported by a link worker or connector

Regional Social Prescribing Facilitator Role

Support the embedding of social prescribing link workers with all primary care networks across the region, as part of the NHS England personalised care programme.

This includes:

Supporting local system leaders

Acting as a social prescribing champion for the region.

Being the main point of contact for the regional social prescribing networks

Support local system leaders to understand how social prescribing fits within a wider personalised care approach.

Supporting opportunities to embed social prescribing across local health and care systems.

Facilitating regional social prescribing workshops, to share good practice and provide peer support and challenge

Models of social prescribing (Kimberlee, 2015)

SOCIAL PRESCRIBING AS SIGNPOSTING

- Online access to community activities
- Direct signpost from GP practice
- Emerging evidence base
- Leaflet in the GP practice
- No link worker

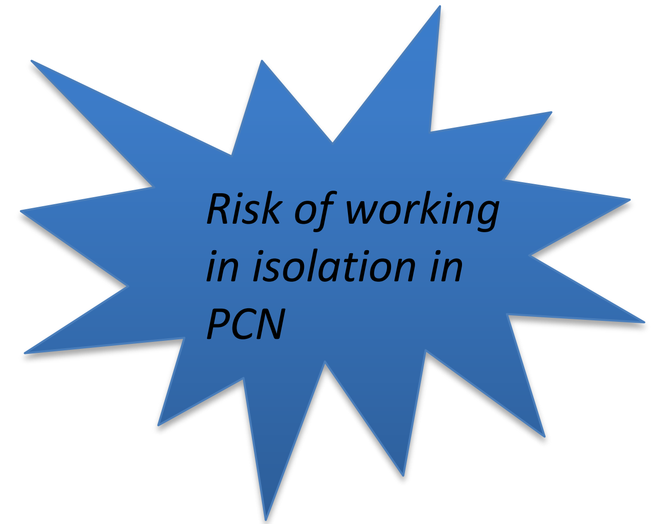
SOCIAL PRESCRIBING LIGHT

- Run by the voluntary sector to refer people to other activities delivered by the voluntary sector
- To address a specific need of vulnerable patients
- No direct links with GP practices

Models of social prescribing (Kimberlee, 2015)

SOCIAL PRESCRIBING MEDIUM

- Link worker or advanced care navigator
- Health focused (nutrition, diet, CBT)
- Signpost to voluntary sector and/or self-help groups
- Not focused on beneficiary needs in a holistic way



SOCIAL PRESCRIBING HOLISTIC

- Direct primary care referral to SP provider
- SP provider is local and employs link workers
- Link worker follows a 'holistic' approach (centred on person's needs)
- No limits on number of sessions. These depend on person's need

Silk painting and Wired for Wellbeing Micro-Commissioned

Ways to Wellness' Social Prescribing

Ways to Wellness

Ways to Wellness uses a personalised, comprehensive, long-term social prescribing approach to help people aged 40 to 74 years living with certain long-term conditions in the west of Newcastle upon Tyne

- Our overall aims are to (a) improve the health and wellbeing for 10,000 patients living with LTCs and, as a result; (b) reduce NHS costs related to those patients' care.
- Over the past 4 years, Ways to Wellness has received over 6,000 referrals, of which:
  - approximately 4,600 clients have engaged on the service for an average of 18-19 months
  - clients set an average of 4 to 5 goals and develop action plans for goals
  - 60% of clients are signposted on to other services or activities, when aligned with their goals
- Over 30 (26 FTE) Ways to Wellness Link Workers are employed across a local charity and a social enterprise and are currently working with approximately 2,900 clients
- NHS data and academic research* shows that patients referred have a high level of complexity, including historical use of hospital services, co-morbidity, anxiety and depression, and multiple social and economic issues (including debt, housing problems, low income and unemployment)

Impact measurement

1. Hospital costs and activity impact measures
   - Ways to Wellness has demonstrated reductions in hospital costs of over £1.2 million in 2017/18. The annual net savings for the CCG in 2017/18 was approximately £440,000.
   - The 2018/19 non-elective activity has been halved for the Ways to Wellness cohort
2. Wellbeing improvements
   - The average patient improved 3.1 points (11%) – more than double target
   - Clients move from describing themselves as, "finding out how they can improve things in their life to feel more in control", to "making changes", or even "managing their lives pretty well".

http://waystowellness.org.uk

*http://bmjopen.bmj.com/content/bmjopen/7/7/e015203.full.pdf

Measurement

- AWC – modality
- Leeds practice

What does good social prescribing look like?

At BCVS …

- Support
- Community Interest Company
- Wider provision
- Access to all

BCVS Services Available

Two distinct services commissioned by Bassetlaw CCG:-

- Social Prescribing (over 65s, socially isolated, clinical referral required into service, funded service)
- Community Advisor (age 16 +, open access or referral, signposting access and navigation service)

Bassetlaw
Clinical Commissioning Group

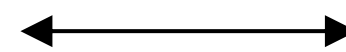
Community Advisor

Self-referral or Sign-posted

Aged 16 +

Community Advisor
(Speaks to patient face to face in surgery, at BCVS or via telephone)

Signposting and Navigation into appropriate service



Social Prescribing Service

Referral by Health Professional

Aged 65+ and socially isolated

Social Prescribing Advisor
(Undertakes assessment during home visit)

Patient receives funding to access social support service/activity (and transport, if meets criteria)

Community, Voluntary or other Statutory Services

Complex patients may be offered telephone review

Social Prescribing Advisor Review at 6 and 12 weeks

Bassetlaw
Clinical Commissioning Group

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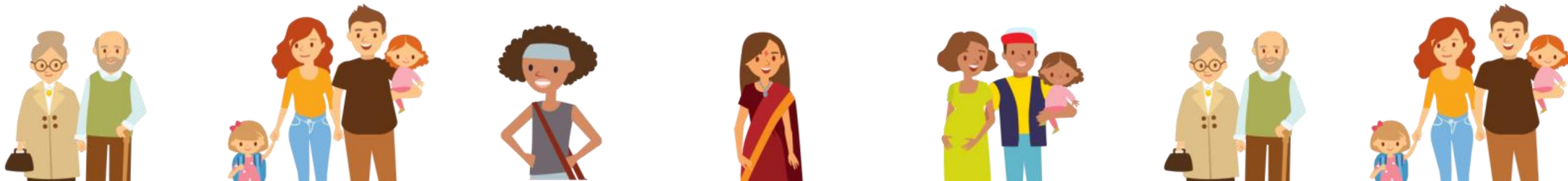
wakefieldcouncil
working for you

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Live Well Wakefield



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South West Yorkshire Partnership NHS
NHS Foundation Trust

What does the Live Well Wakefield Service do?

The Live Well service is available for people aged 18+ living in the Wakefield district. The service delivers:

- Stroke reviews, which are carried out through the Stroke Review Care Pathway
- 1:1 support with Live Well Advisors and Live Well Volunteers
- Self-management programmes, workshops and support.
- Small Grants

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Childhood experiences

Housing

Education

Social support

Family income

Employment

Our communities

Access to health services

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wakefieldcouncil
working for you

NHS
South West Yorkshire Partnership
NHS Foundation Trust

FIVE WAYS TO WELLBEING

connect take notice be active give keep learning

Micro-Commissioning Live Well Wakefield

Community asset approach

Complex interplay between community asset development and health related behaviour

Salutogenic approaches by including community development roles within social prescribing models S.Yorks / Wakefield / East Ridings

Do you know of other areas that use this approach?

In 2018/2019 our Small Grants Fund supported **25** projects, awarding a total of **£131,666,49**

East Ridings of Yorkshire
Network of Activity supporting Social Prescribing

- Community Link Workers (Navigator Role +) within all 30+ East Riding Practices
- All reception staff across ERoY GP practices trained to Actively signpost to Community Link Workers and MECC (plus another 6 services)
- Media Company produced local information videos for GP waiting areas to inform patients of the Community Link Worker service (and others) – planned for roll-out on LCD screens in 2019

- Link Worker (Practice Worker/Assessor)

Acts as the link between the referrer and the connector, responsible for assessing the individuals and coproducing an action plan.

- Community Connector (Navigator/Community Link Worker)

Proactively supports the individual to access appropriate services that help them in achieving their action plan and supports Builders to identify assets and gaps

- Asset Builder (Activator)

Maps, identifies gaps and helps communities to build assets that support local delivery of community services/assets

Key elements of Social Prescribing

From small acorns grow mighty oaks