

‘Social Prescribing’

Opportunities and Challenges

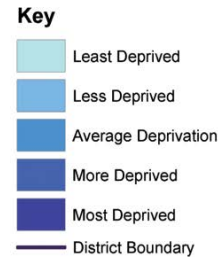


David Evans
Director of Commissioning
Ed Knowles
Assistant Director of Integration
Herts Valleys CCG

A long way from home...



- Population – 600,000
- 4 NHS Localities
- 5 District Councils
- 1 Local Authority
- Strong and diverse voluntary sector
- 60 GP practices
- Mixture of providers including acute, community, mental health and private organisations
- Overall health of the population is higher than national average but we have an ageing population to support



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IMD 2010 data derived from Department for Communities and Local Government.

So what *is* social prescribing?

1. **Health referral** – GP, nurse, consultant, physio
2. **Link person** – ‘co-producing’ support plan
3. **The prescription:** service/s and connections in community

Key community service in West Herts =
Community Navigator Service

For people who don't need face to face support ***HertsHelp*** provides key service



Why is it needed?

- **Average GP consultation = 10 minutes – shortest in developed world?**
<https://www.theguardian.com/society/2017/feb/07/gps-consultation-times-too-short-for-complex-cases-says-doctors-leader>
- **Long-term conditions make up 50% of GP appointments** www.england.nhs.uk/ourwork/ltc-op-eolc/ltc-eolc/house-of-care/
- **Empowerment is not easy** ‘Consultation length is directly linked to a doctor's ability to augment their patient's perception of their own empowerment...’
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4311338/>

Why is it needed (2)...

- People go where they go – ‘the lights are always on in (A&E) (**anti-nudge?**)
- 20% GP face-to-face time on non-medical issues
www.citizensadvice.org.uk/Global/CitizensAdvice/Public%20services%20publications/CitizensAdvice_AVeryGeneralPractice_May2015.pdf
- 15% GP time spent on ‘welfare’ issues
<https://www.lowcommission.org.uk/>
- Risk of missing up to 20% of what matters most to patients if don’t start with that question
<http://journals.sagepub.com/doi/abs/10.1177/1534735414555809>

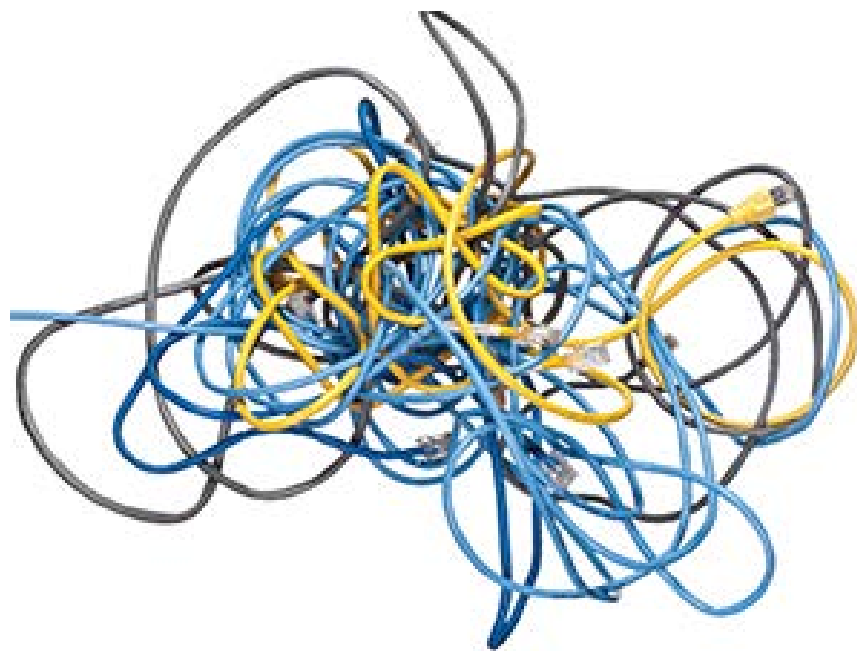
The Gloomy Bit

- Increasing demand
- Shrinking resources
- Staff shortages
- Tighter eligibility for social care – prove how vulnerable you are!
- Less prevention
- Less time to empower
- Charities poorer...



‘Wicked’ problems

- Fragmented services
- Health and social care very different
- Lack of integration between statutory and voluntary sectors
- System incomprehensible even to itself



The Hopeful Bit



- Things simply can't go on as they are
- New partnerships to create change - *Sustainable Transformation Plans (STPs)*
- New focus on prevention and putting patient at the centre (Five Year Forward View)
- Passion about social prescribing!

Opportunities

- Activists are influencing policy makers
- Patients and referrers value it
- Evidence of demand reduction
- Community helped to play more active role (health champions/volunteers)
- Reduces pathologizing and disempowering effects of 'transactional care'



National Social Prescribing Network (NSPN) – UK

- 1,000+ members
 - 300+ projects
 - NHSE support
 - National Clinical Champion for Social Prescribing
- Dr Michael Dixon



Parliamentary launch March 2016 (Dr Michael Dixon co-chair of NSPN left, Dr Marie Polley of Westminster University right, pictured with then Care Minister, Alistair Burt MP)

Herts and W Essex STP's vision

Our Ambitions

Support our patients and population to live well and stay well for as long as they can. Where they do have healthcare requirements, our aim is to provide them with the tools to manage their own health and wellbeing independently.



Patient supported to move to less interventional support

Incentives for the system

- Growing evidence base of prevention of demand (better use of services) and improved health outcomes
- Fills gaps (between services and between citizen and services) – health inequalities
- Humanizes the ‘offer’ and makes it work for the individual
- Makes people feel valued

Jamie



- Alcohol and mental health problems
- Ulcer on foot, plus disability
- Rough sleeper
- GP supporting with mental health and pain
- Life in chaos - needs support with housing issues
- Often comatose in the street due to alcohol - public call ambulance
- Presenting at A&E 21 times pa

Outreach to Jamie

- Identified as 'frequent attender' at A&E
- Invited to 'navigator clinic'
- Declined range of support
- Persuaded to accept referral to:
 - Housing Officer (with help)
 - Night Light (crisis intervention)
 - GP Practice Nurse to dress ulcer (saving time for A&E)
- Built relationship with navigator



Jamie's view

Jamie attends A&E less, though it is early days...



“The Community Navigator has helped me to access support from my GP and to complete housing forms as I am dyslexic but she has also listened to me when I am having a really bad day as often that’s all I need. This has made me feel hopeful and I can’t thank her enough...”

Incentives for GP

- Time saved and better health outcomes
- Increase links with community (part of the team)
- Better medical care possible
- Better signposting reduces pressures on whole team including reception
- Reduction in poverty improves health
- Helping family carers access support elsewhere
- Simpler partnership across health and social care
- **Example:** Community Linking Project East Gateshead https://www.youtube.com/watch?v=Gsl_jznoXrA

Incentives for user

- **Not** – ‘you can’t see a doc’, **but** ‘why would you want to see a doc when you can...?’
- Treatments can’t provide friendships and self-value
- Volunteering can be the way back to work
- Volunteering is good for your health



*"My territory had been my bed
- now I am walking to the
shops, and even the people I
meet nod and smile now - it's
like I belong to the community"*
Service-user

Incentives for social care



- Prevention possibilities
- Increasing resilience and wellbeing
- Manages demand
- Simpler working across health and social care

*“I have been working in this locality for over 14 years and I was simply not aware of the range of community organisations available, but the Community Navigator does, and this has benefitted my service users greatly” – **Social Worker***

Incentives for hospitals

- Preventing attendance
- Preventing admission (diverting)
- Preventing low level need patients getting 'stuck/stranded'
- Supporting discharges that stick
- Preventing 'frequent attenders' coming back for non clinical reasons



The Rotherham Model

www.varotherham.org.uk/social-prescribing-service/



IMPACT (Independent evaluation by Sheffield Hallam University)

- In-patient spells reduced by **11%**
- **17%** drop in A&E attendance for all patients
- For under 80's, now receiving long term support from voluntary and community groups:
 - **51%** drop in-patient stays
 - **35% fall** in A&E attendances

Incentives for Ambulance Service: Bexley Mind

- <http://mindinbexley.org.uk/wp/wp-content/uploads/2017/06/Social-Prescribing-in-Bexley-Pilot-Evaluation-Report.pdf>



- In relation to 81 clients, 47 calls to ambulance service were made in the six months **before** social prescribing
- 20 calls were made in the six months **after** the referral - a reduction of 56%.

Good value for the system

- Risk stratification/targeting clients who cost more than/have worse outcomes than they need to
- Keep expensive services at the centre – **not** first point of contact (active signposting)
- Create healthier communities
 - Volunteer social prescribers
 - Asset based community development
 - A culture of building, valuing and maintaining networks
 - It's about relationships locally – not structures

Making sense of Social Prescribing



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<http://westminsterresearch.wmin.ac.uk/19629/>

Evaluation Data

A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications

Polley, M., Bertotti, M., Kimberlee, R., Pilkington, K., and Refsum, C.

[**http://westminsterresearch.wmin.ac.uk/19629/**](http://westminsterresearch.wmin.ac.uk/19629/)

Partnerships across the Atlantic

- It's happening here!
- Country Roads in Portland have implemented *health champions* in partnership with ***Altogether Better***
- Social prescribing as a framework to pull together primary care and community based programs into an integrated network

EveryOne
Matters.





Thank you

David Evans

Director of Commissioning

david.evans@hertsvalleysccg.nhs.uk