East of England Social Care

Social Prescribing Action Learning Group

19th July 2021

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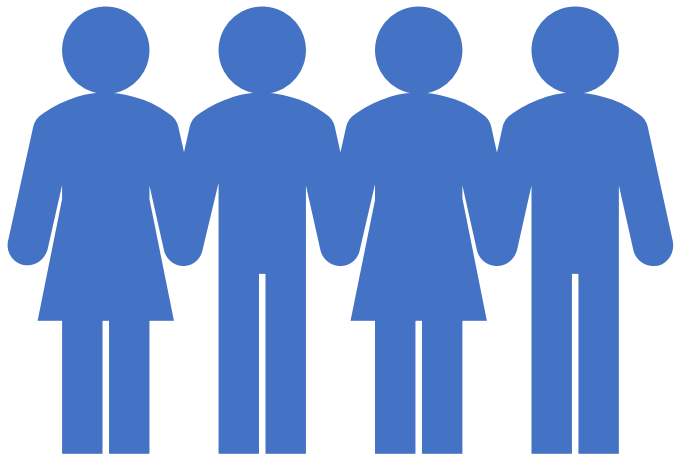


Social Prescribing is...

...a process to help people make positive changes in their lives and within their communities by linking people to volunteers, activities, voluntary and community groups and public services that help them to:

- feel more involved in their community
- meet new people
- make some changes to improve their health and wellbeing

BUT IT'S PERSONAL

Why social Prescribing – for the system?

- A part of personalised care and support planning –– Gives people more choice and control

"No decision about me without me"

- Reduces health inequalities – long-term conditions, support with mental health, loneliness, complex needs.
- Reduces pressure & assists in demand management in General Practice, A&E social care & other services
- Supports self-care, self-management and prevention, personal & community resilience

Personalised care and social prescribing in the NHS Long Term Plan

‘There is not a pill for every ill’

Simon Stevens

Long Term Plan: 5 major practical changes to the service model

1. We will **boost 'out-of-hospital' care**, and finally dissolve the historic divide between primary and community health services.
2. The NHS will **redesign and reduce pressure on emergency hospital services.**
3. **People will get more control over their own health, and more personalised care when they need it.**
4. **Digitally-enabled primary and outpatient care** will go mainstream across the NHS.
5. Local NHS organisations will increasingly **focus on population health** and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere.

Long Term Plan commitments

- 1.39. **We will roll out the NHS Personalised Care model across the country, reaching 2.5 million people by 2023/24 and then aiming to double that again within a decade**.

- 1.40. As part of this work, through **social prescribing** the range of support available to people will widen, diversify and become accessible across the country. Link workers within primary care networks will work with people to develop tailored plans and connect them to local groups and support services. **Over 1,000 trained social prescribing link workers will be in place by the end of 2020/21** rising further by **2023/24,** with the aim that **over 900,000 people** are able to be referred to social prescribing schemes by then.

A new primary care workforce

13 additional reimbursable roles:

- Clinical Pharmacist
- Pharmacy Technician
- Social Prescribing Link Worker
- Health and Wellbeing Coach
- Care Co-ordinator
- Physician Associate
- First Contact Physiotherapists
- Dieticians
- Podiatrists
- Occupational therapists
- Mental Health Practitioner
- Paramedic
- Nursing Associate

"By 2024 [all the above roles] will have become ***an integral part of the core general practice model throughout England*** *– not just 'wrap around' support that could instead be redeployed at the discretion of other organisations."*

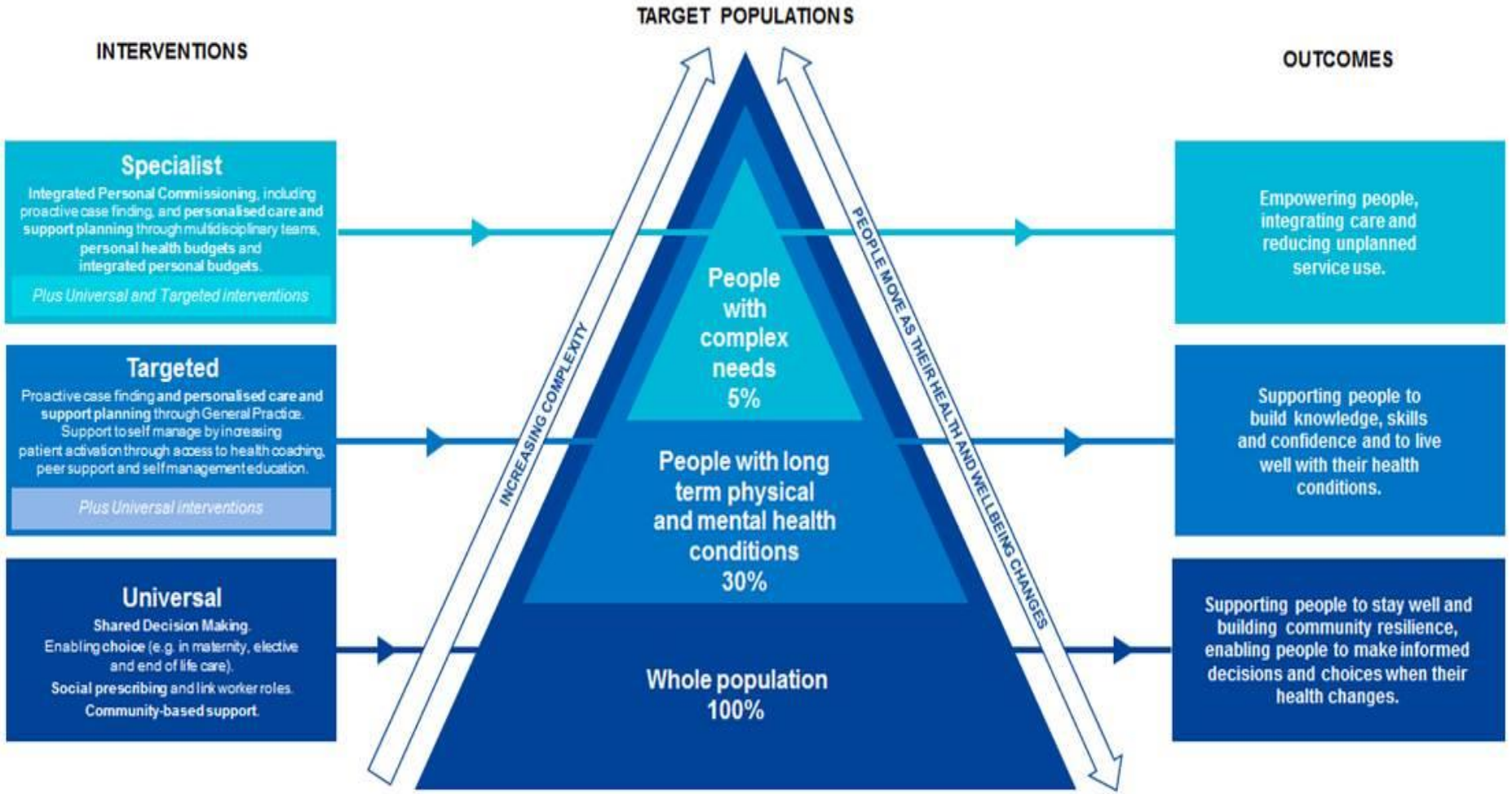
The NHS Long Term Plan

#NHSLongTermPlan / www.longtermplan.nhs.uk

Five Year Framework for GP Contract Reform

Comprehensive Model for Personalised Care

All age, whole population approach to Personalised Care



Personalised Care Operating Model

NHS

WHOLE POPULATION
when someone's health status changes

30% OF POPULATION
People with long term physical and mental health conditions

Cohorts proactively identified on basis of local priorities and needs

Shared Decision Making and Patient Choice

People are supported to a) understand the care, treatment and support options available and the risks, benefits and consequences of those options, and b) make a decision about a preferred course of action, based on their personal preferences and, where relevant, utilising legal rights to choice.

(All tiers)

Personalised Care and Support Planning

People have proactive, personalised conversations which focus on what matters to them, delivered through a six-stage process and paying attention to their clinical needs as well as their wider health and wellbeing.

Review

A key aspect of the personalised care and support planning cycle. Check what is working and not working and adjust the plan (and budget where applicable).

Optimal Medical Pathway

NHS @ home

Support people through the use of technology to better self-manage their health and care at home, including care homes. Encompassing personalised interventions with the addition of a technological tool.

Social Prescribing and Community-based Support

Enables all local agencies to refer people to a 'link worker' to connect them into community- based support, building on what matters to the Person, and making the most of community and informal Support. (All tiers)

Supported Self Management

Support people to develop the knowledge, skills and confidence to manage their health and wellbeing through interventions such as health coaching, peer support and self-management education. (Targeted and Specialist)

Personal Health Budgets and Integrated Personal Budgets

An amount of money to support a person's identified health and wellbeing needs, planned and agreed between them and their local CCG. May lead to integrated personal budgets for those with both health and social care needs. (Initially Specialist)

LEADERSHIP, CO-PRODUCTION AND CHANGE ENABLER

WORKFORCE ENABLER

FINANCE ENABLER

COMMISSIONING AND PAYMENT ENABLER

Five Year Framework for GP Contract Reform

- NHS England will provide funding directly to primary care networks (PCNs) for a new, **additional social prescribing link worker to be embedded within every PCN multi-disciplinary team**, through the Network Contract Direct Enhanced Service (DES).
- Starting from July 2019, at **100% reimbursement** of the actual on-going salary costs, up to a maximum amount (£34,113) GP Contract Reform, section 1.26. The percentage will neither taper nor increase during the next **5 years**, giving networks maximum confidence to recruit to the full.
- Existing practice suggests that many PCNs may **choose to fund a local voluntary sector organisation to employ the link workers on behalf of the network**. The contractual arrangement will be for local areas to decide, but the funding will be routed via the Network Contract DES.
- Funding will also be available to **all PCNs** across England, including local areas where link workers are already embedded in primary care multi-disciplinary teams.

Referral
Via a single point of access

NHS

WHAT MATTERS TO ME

PERSONALISED CARE

Social prescribing link worker

- Mental health needs
- Lonely and isolated
- Long term conditions
- Complex social needs

Link to

- voluntary sector
- community
- other statutory organisations
- wellbeing activities

Health and wellbeing coach

- Low motivation
- One or more long term conditions
- Physical & mental health needs
- Low confidence

Link to

- confidence
- knowledge
- skills
- self-management
- behaviour change

Care coordinator

- Needs information
- Uncoordinated care planning
- Frail/ Elderly
- Multiple appointments

Link to

- community services
- secondary care
- mental health teams

New roles in Personalised Care

Health and wellbeing ooach	Care coordinator	Social prescribing link worker

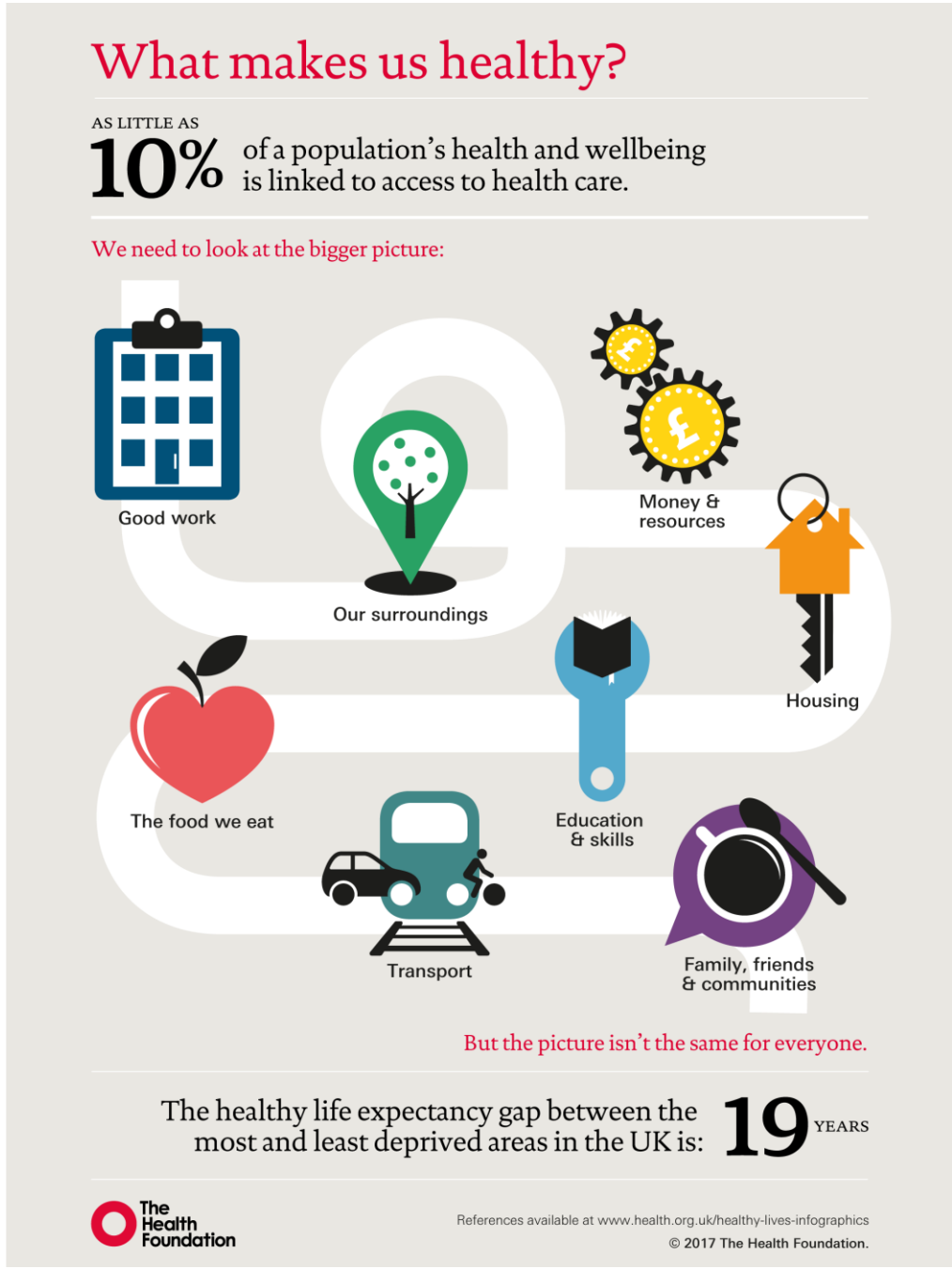
• **Focus on people with long term conditions or poor health** or with risk factors for developing an LTC
• Work with people in a coaching relationship and using a structured framework over a number of sessions to **help them to work through a health related problem or problems**.
• **Help people to find their own solutions** and to build their knowledge, skills and confidence in living with their condition and dealing with challenges and ups and downs.
• Work with people one to one or in small groups
	• Proactively identify and work with people to **provide coordination and navigation of care and support** across health and care services.
	• Manage a caseload of patients, **acting as a central point of contact.**
	• **Bring together all the information about a person's identified care** and support needs and explore options to meet these within a single personalised care and support plan.
	• Review patients' needs and **help them access the services and support they require** to understand and manage their own health and wellbeing, referring to social prescribing link workers, health and wellbeing coaches, and other professionals where appropriate.
	• **Support people in preparing for, or follow-up, clinical conversations** with primary care professionals (to enable them to be actively involved in managing their care/ be supported to make choices that are right for them).
		• **Address the wider issues** that affect people's health & wellbeing
		• **Take a person-centred approach**, **to identify what matters to the person**
		• **Connect people to:**
		  ○ practical, social and emotional support within their community; and
		  ○ activities that promote wellbeing e.g. arts, sports, natural environment; and
		  ○ positive people, positive places and positive things
		• **Identify and nurture community assets** by working with partners such as VCSE, local authorities and health.
		• **Tend to work with** people experiencing loneliness, complex social needs, mental health needs or multiple LTCs.

Why social Prescribing now?

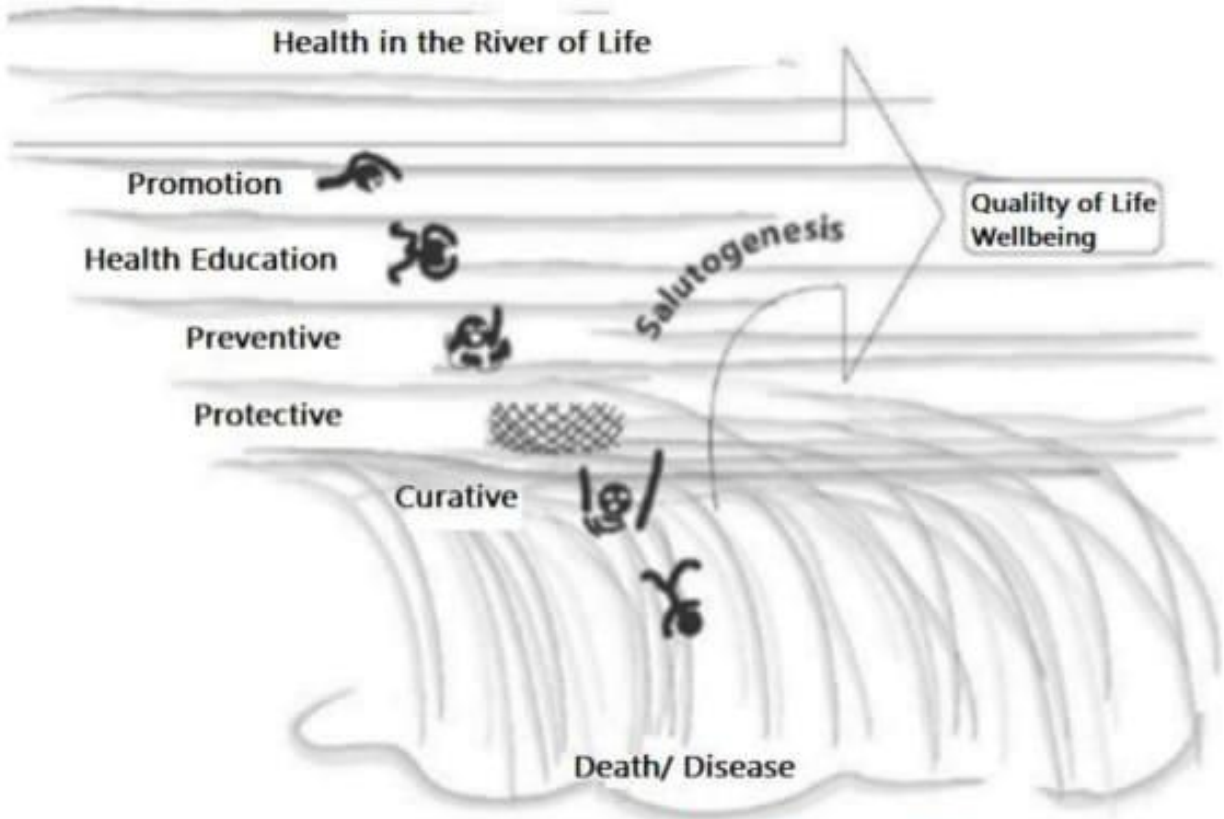
GP Five Year Forward View


Any questions?

Salutogenic Social model of health -



Salutogenic Social model of health -

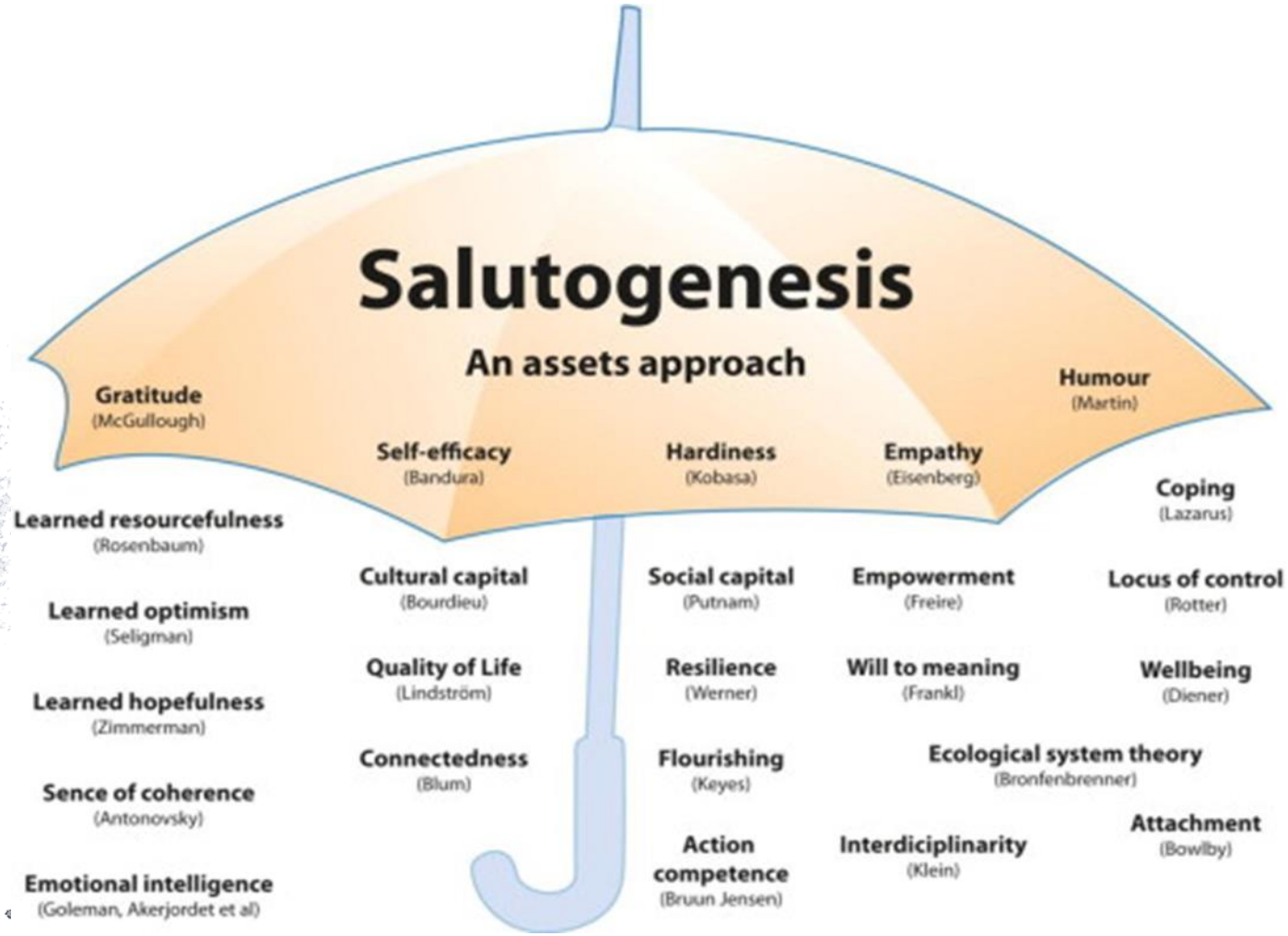


Salutogenesis is a medical approach focusing on factors that support human health and well-being, rather than on factors that cause disease (pathogenesis).

25

Drawing: Bernt Lindström Graphic: Jonas Jernström

Salutogenic Social model of health -



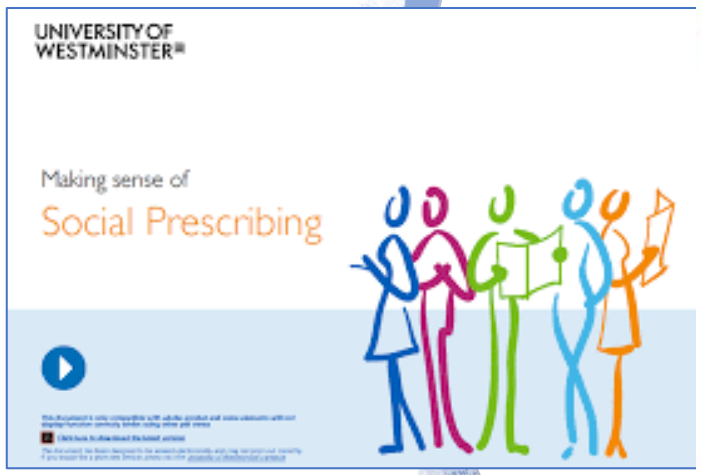
Why social Prescribing – for me?

Focus changes from

"What's the matter with me" to ***"What matters to me"***

- Strengths rather than deficit
- Builds on existing assets
- Connects me to my communities
- Offers me a greater choice of opportunity & help that's non-medical
- Meet new people and make new relationships including volunteering
- Build my self-responsibility, take control, engaging, empowering
- Improve my health and well being
- More enjoyable and/or rewarding

What makes a good social prescribing model?



Social Prescribing Link Worker

- 6 to 12 sessions modelling – can be more or less depending on the person
- Conversation based – 50m/1hr slots – don't overload
- Home visits
- Health coaching approaches
- Well being plan – goals,
- Personalised care approach
- Not traditional PC consulting approach
- Community capacity building

Refer who?

- 25 – 40% of patients present with social issues
- DES states to be a member of the MDT - not the whole picture
- Discrete groups of patients – carers, parents, LTCs,
- Can be from any practice staff not just GPs
- Over time from any agency – police, social care, housing, DWP, self-refer
- Issues – self-esteem, loneliness, financial, employment, volunteering, lifestyle, activity, advocacy, lower level mental health,
- Earlier the prevention the better. Culture and behaviour change

Some of the opportunities and challenges

Opportunities

- ARRS – 3 personalised care roles (social prescribing link worker, health and wellbeing coach, care coordinator; part of the wider primary care workforce expansion
- Mixed model (nationally, regionally, locally) – different employment models; ‘hosted’ by VCSE organisation, embedded as part of wider PCN team
- Local flexibility, national framework
- Personalised care – national, regional and local support offer
- Relevant to all patients, appropriate for some
- Referral based service, but also an opportunity to support a more targeted approach to help address local priorities (PHM approach)
- Runs through NHS Long Term Plan, embed in clinical pathways
- To engage more closely with local communities

Challenges

- Integrating and embedding personalised care roles as part of primary care
- Interface between the 3 roles (and new primary care MH practitioner role)
- Understanding social prescribing
- Supervision and support - SPLWs
- Workforce retention
- Equipment and access to healthcare record (VCSE hosted SPLWs)
- Balancing flexibility and staying true to the model of personalised care
- Time for SPLWs to focus on the ‘what matters to me’ conversation, and be able to provide focused support to a caseload of patients (200-250 patients/SPLW/year)

Where do people actually go? (Pre-Covid)

- **GPs** – 20+ % GP face-to-face time - non-medical issues
- 8-10 min consultations
  (shortest in developed world?)
- 50% of appointments LTCs
- ‘Consultation length linked to doctor's ability to empower people’

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4311338/

Where do people go? (2)

- 15% GP time on ‘welfare’ issues
  https://www.lowcommission.org.uk
- *‘the lights are always on in A&E’* (eg lonely people more likely to use)
- Can miss 20% of what matters to patients if don’t start by asking that question…

http://journals.sagepub.com/doi/abs/10.1177/1534735414555809

Is *this* what public services do?

‘If you want to get somebody to do something, make it easy. If you want to get people to eat healthier foods, then put healthier foods in the cafeteria, and make them easier to find, and make them taste better. So in every meeting I say, “Make it easy.”

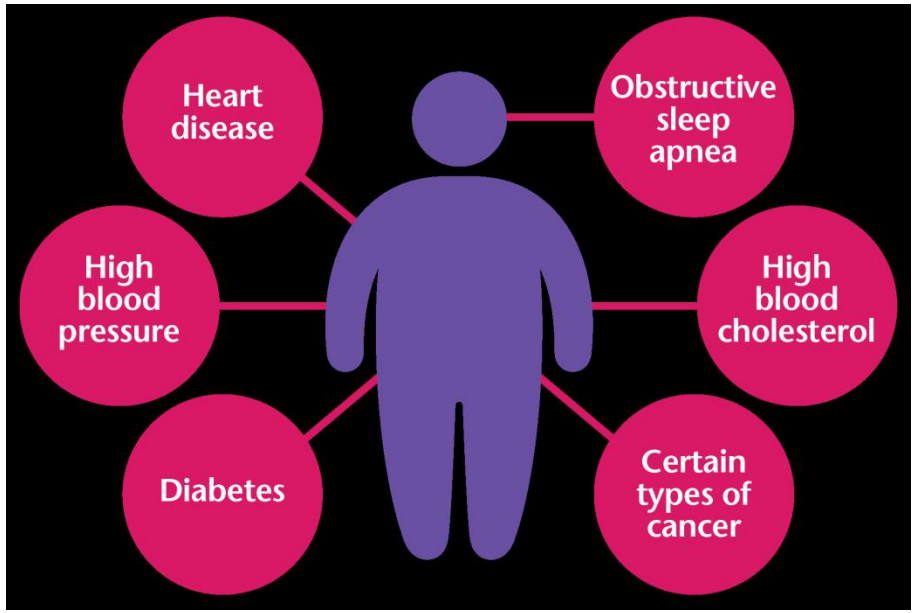
Richard Thaler, Economics, Nobel Laureate 2017

Obesogenic Culture?

Martin McShane, NHSE, 2015:

"These figures are a stark warning and reveal the increasing cost of diabetes to the NHS.

"We've said it before and we'll say it again, it's time to get serious about lifestyle change. Prevention is better than treatment for individual health as well as the health of the NHS."



University of Hull
Hull York Medical School

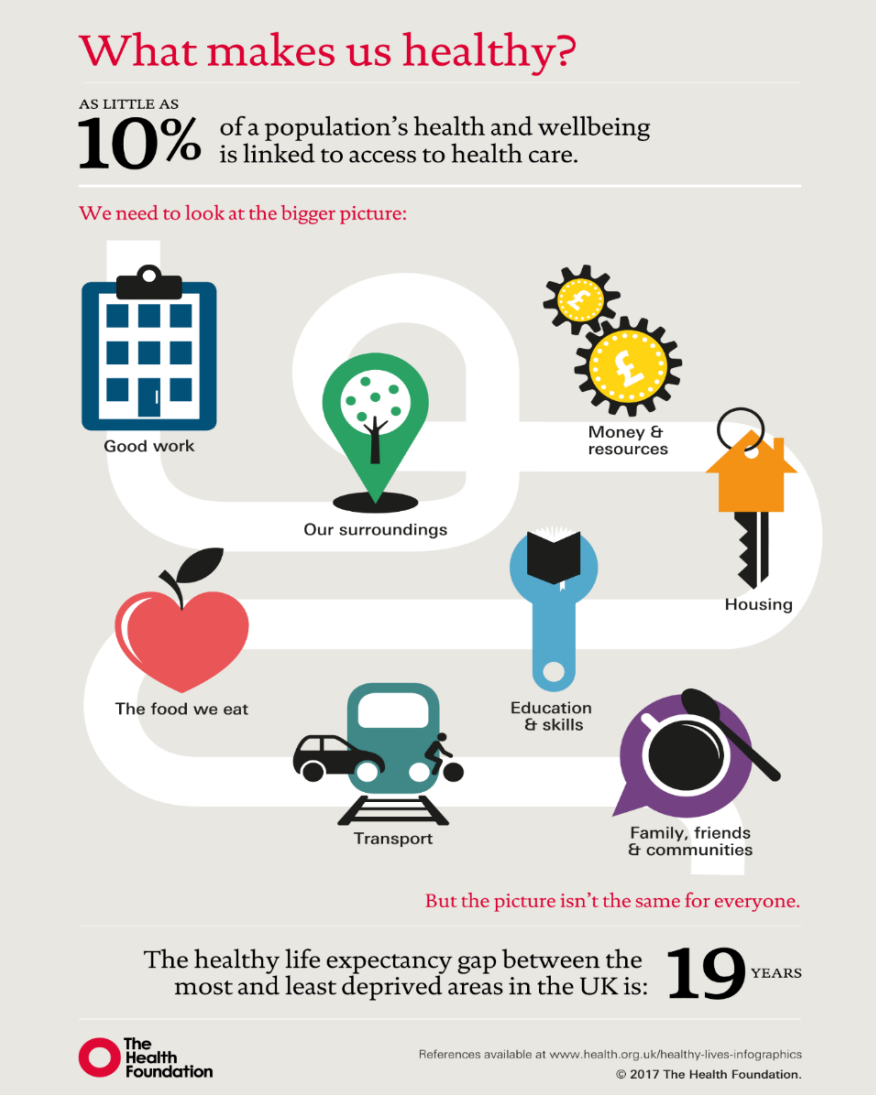
Empowering vs blaming patients

- Survey of 3,000 people with type 2 diabetes
- Loneliness, stigma, embarrassment, blame, guilt
- Feel they're seen as burden on NHS

'If you have type 2 people think it is your fault, that you haven't looked after yourself properly."

'At Christmas or going out for a friend's birthday it isn't easy to cope with not being able to eat the same food, the same birthday cake as everyone else. So instead – you just don't go out."

Covid = Syndemic



- Aggravating existing health inequalities
- Particularly BAME, digital exclusion, domestic abuse, isolation of caring, mental health…
- Impacting most on those with deprivation induced LTCs

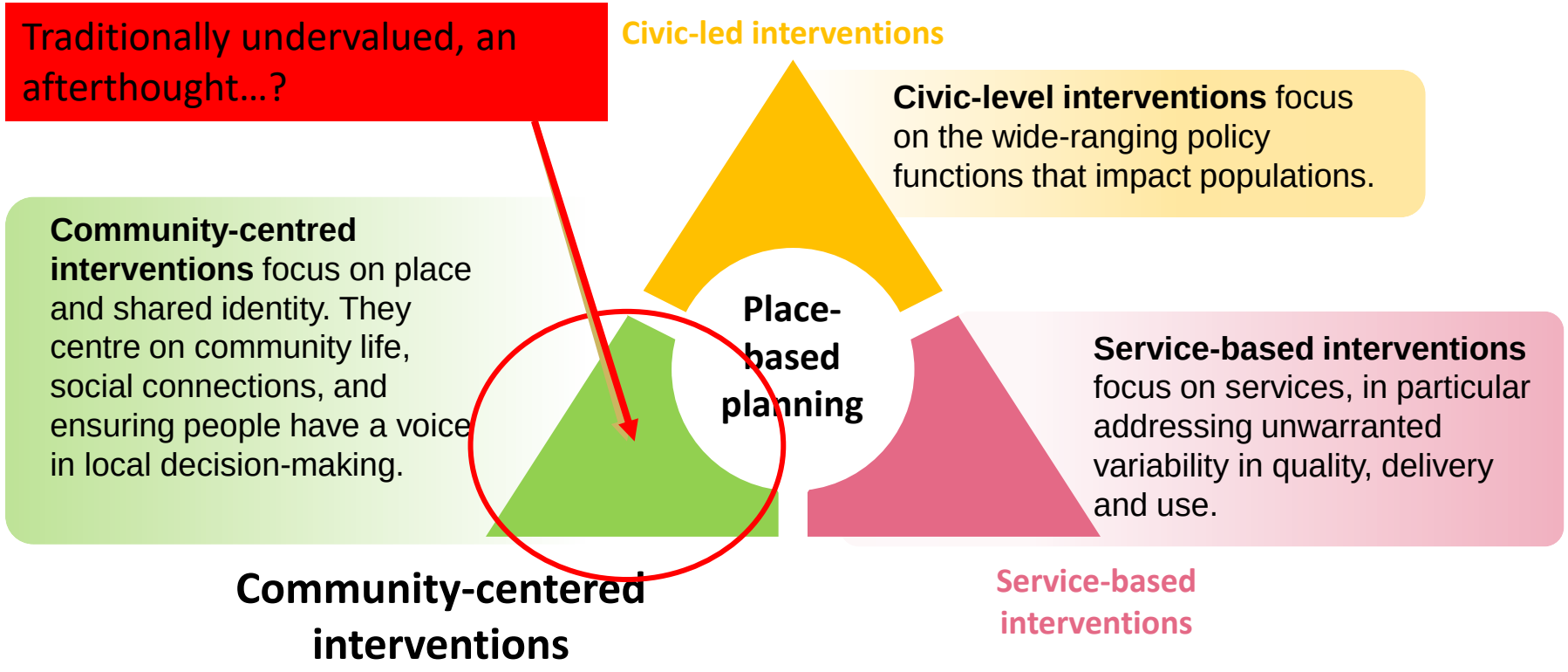
Key Opportunities social prescribing for Covid recovery

- System wide models of social prescribing –ICS and place based planning
- Health inequalities & population health management
- Green social prescribing
- Specialist models e.g. children & young people, maternity, ethnic minorities
- Secondary care – planned stay preparation, discharge, A&E
- Primary care expansion - more Link Workers
- Long Covid
- VCSFE – support including NHS Charities and NASP (National Academy of Social Prescribing)

Key Challenges for Recovery

- 10 years of austerity and worsening health inequalities
- Exhaustion of staff (statutory and voluntary)
- Economic consequences
- Social and MH consequences
- So many organisations seeing social prescribing as the “magical solution” to so many statutory pressures
- PCNs signing up to community/ social model of health and employing more Link Workers
- Financial constraints to model in funding of VCFSE

Population Intervention Triangle (PIT)



- PIT shows the main components of place-based interventions: **civic, community** and **service**
- Each have potential to independently make a quantifiable change at population level
- Joint working across interfaces between civic, service and community sectors can help the whole be more than the sum of its parts.

What are health inequalities?

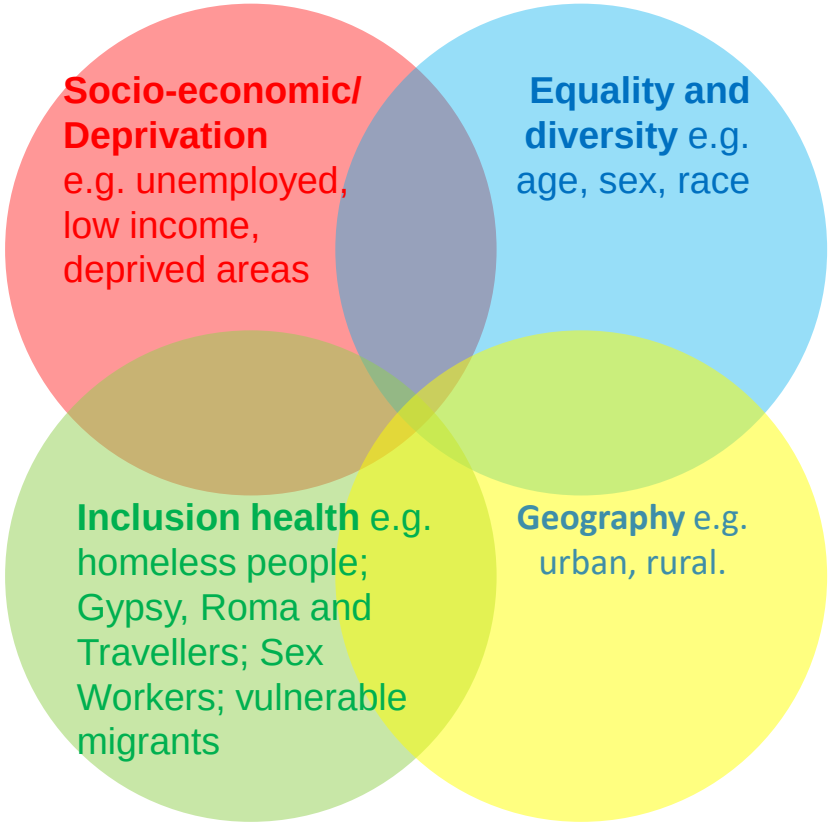
Unfair and avoidable differences in health across the population, and between different groups within society.

Arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.

Have been documented between population groups across at least four dimensions, as illustrated to the right.

Action on health inequalities requires improving the lives of those with the worst health outcomes, fastest.

Dimensions of health inequalities



COVID-19 APPEAL

Supported by NHS CHARITIES TOGETHER

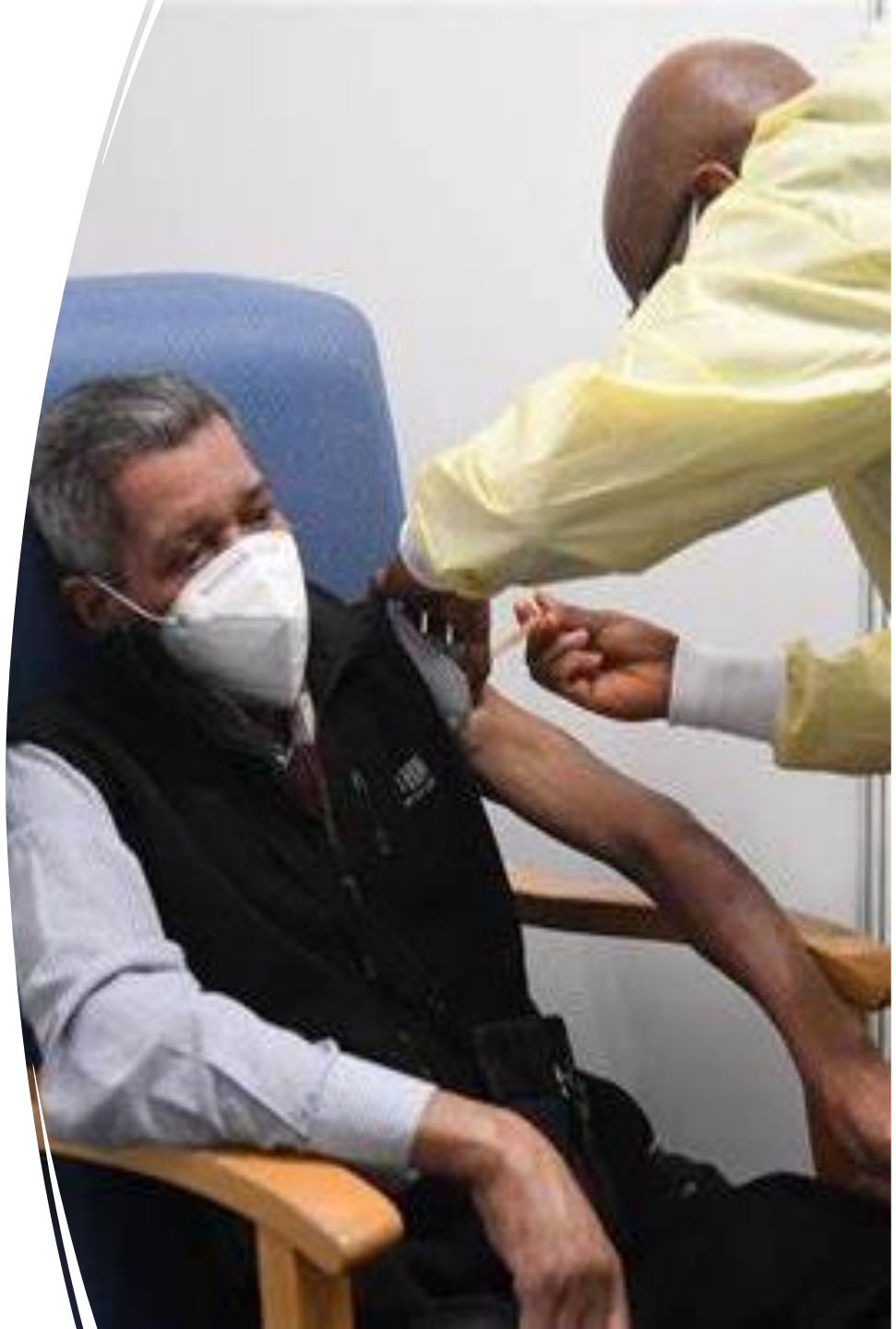
NHS Charities Together – Hertfordshire update

NHS Charities bid (HWE) Nov 2020

PROPOSAL	Year 1	Year 2	Bid
1. Covid Recovery BAME workers (1 for E, 1 for W)	£100k	£100k	**£200k**
2. Practical support to BAME and other carers	£20k	£20k	**£ 40k**
3. Staying Connected (digital inclusion worker)	£50k	£50k	**£100k**
4. Enhancing work of Herts charities to address fuel poverty, cold homes, isolation	£7.5k per DC	£7.5k per DC	**£150k**
5. SP for YP in crisis at Watford and Lister Hospitals to connect YP to help in the community	£45k	Link to HCNS review	**£45k**
6. Digital inclusion and BAME engagement work (West Essex)	£89k	£89k	**£178k**
TOTAL			**£713k**

1. BAME Covid Recovery Workers

- Started 12 April
- Integrating with Social Prescribing and Advocacy ‘system’
- Supporting capacity building in BAME VCFSE
- Invited to participate in Central Watford Pilot
- naomi.duncan@cdaherts.org.uk
  rushna.miah@cdaherts.org.uk
  (West Herts)
- mercy.bwomono@cdaherts.org.uk
  (East Herts)



2. BAME Carers Breaks

- New BAME Breaks Coordinator being recruited (i/vs 21 June)
- Building on Carers' Urgent Breaks on prescription in West Herts
- Massive increase in carers identifying to primary care (3,250 in first quarter 2021)

3. Digital Inclusion

- Cindy Withey started 1 February 2021
- Corporate Social Prescribing to source equipment
- Socially prescribing where real impact on wellbeing
- Not just kit: volunteers to help with skills and support/data poverty etc…
- cindy@communityactiondacorum.org.uk

There are four main areas of this project
(a) access to equipment
(b) access to connectivity
(c) fear of using equipment
(d) skills in using the equipment

4. Winter

- £75k NHSCT monies distributed
- Mainly on digital and loneliness and additional volunteers
- Levered further £35k (DWP monies (food and fuel), MH monies, Dacorum BC monies)
- Will repeat winter 21-22

5. Young People's Mental Health Social Prescribing

- 3 day per week workers, 1 in WGH, 1 in Lister – both appointed end May
- Based with Watford FCT in West, Youth Connexions in East
- Will link those in crisis to support when they get home/prevent admission

Relationships/Social Capital are key

- More responsive and integrated (within and between sectors)
- Built new services very quickly:
  - 2-week discharge wraparound
  - Pathway - welcome home calls
  - Outreach to quarantined travellers, refugees etc
  - ***Community Help Herts*** countywide support with food, medicine, befriending all linked to Herts Help
- Working to direct small grants into neighbourhoods in partnership with PCNs and Local Authorities

Strategic Overview Framework for Building on Collaboration

No Wrong Door approach

- Access for all, especially those who need it most
- Supporting unpaid, family carers
- Volunteering
- All joined up through integrated commissioning of the VCFSE focused on ‘health creation’

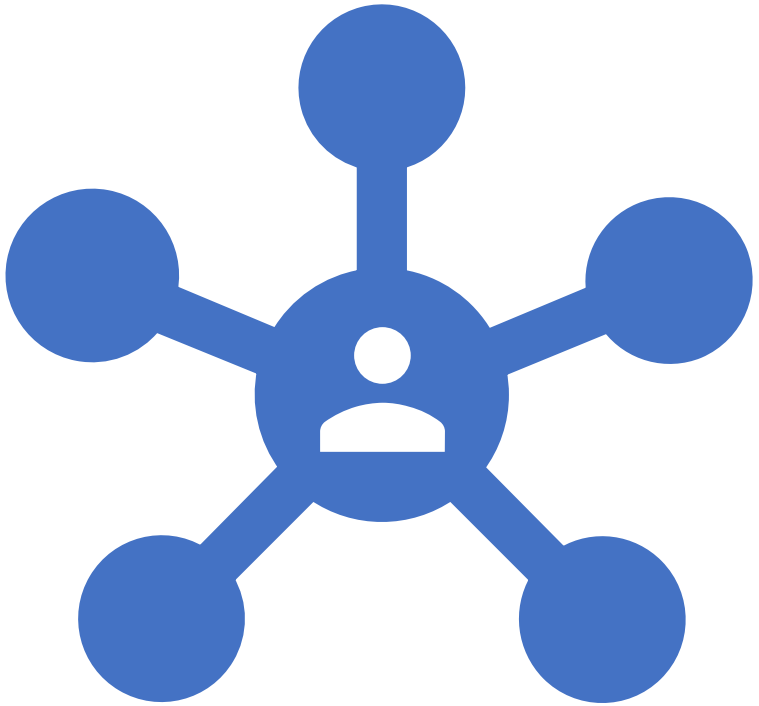
Key Players:

- Commissioners:
  - Prevention and Wellbeing Adults
  - Children’s
  - Complex Needs
  - Mental Health (Joint)
- NHS Commissioners
- District Councils
- Police and Crime Commissioner
- Herts Community Foundation…

Shared Plan for Social Prescribing

DES Network Spec 2021-22

B. 3.10 A PCN must work in partnership with commissioners, SP schemes, LA's and voluntary sector leaders to create a shared plan for social prescribing which must include how the organisations will build on existing schemes and work collaboratively to recruit additional SP LWs to embed one in every PCN and direct referrals to the voluntary sector.



Whole system needs to engage communities better

Top Tips for PCNs from Health Creation Alliance

1. Don’t wait until the Tackling Neighbourhood Inequalities DES kicks-in, start now.

2. Involve your local communities and local partners in shaping your PCN.

3. Make sure your PCN governance arrangements include people from diverse communities.

4. Share the process of developing your actions for tackling health inequalities with local partners.

5. Support member practices to work with communities as equal partners in pursuit of improved population health.

New Joint Strategic Commissioning Board (Herts): Health Creation & the Voluntary, Community, Faith and Social Enterprise Sector (VCFSE)

- Key Stakeholders Commissioning VCFSE sharing vision
- ICS, HCC, DCs, VCFSE, Police and Crime Commissioner, PH, MH and CYP commissioners etc – with independent VCFSE Chair
- Meetings with stakeholders to agree principles
- First meeting September 2021
- Focusing on recovery, integration and promoting wellbeing

Population Health Management

- Greater integration and synergy (build on Covid legacy)
- Strengths and gaps – particularly in relation to health inequalities and ‘recovery’
- Central Watford pilot: BAME males not managing diabetes (outreach with LW, BAME Covid recovery workers, Football Club, District Council etc)
- Young people’s mental health: developing CYP SP offer – preventing pathologizing of ‘normal teenage challenges’
- Working in partnership with PCNs and neighbourhood organisations

Opportunities & Challenges for Social Care & Social Prescribing

Discuss…….

Opportunities

Challenges


Any questions?

Thank you

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