# Social Prescribing in the East of England

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# What is Social Prescribing?

* Signposting?
* Care navigation?
* Community Navigators or Connectors?
* Linking people with their communities?

# What is Social Prescribing?

...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

# What is Good Social Prescribing?

- Allows all agencies to refer to an employed ***link worker***
- ***What matters to me*** not what is the matter with me
- ***Connect*** people to community groups and agencies for practical and emotional support .
- Collaborate with local partners to support community groups to be accessible and ***sustainable*** and help people to start new groups
- ***Asset based***
- ***Co-produced***

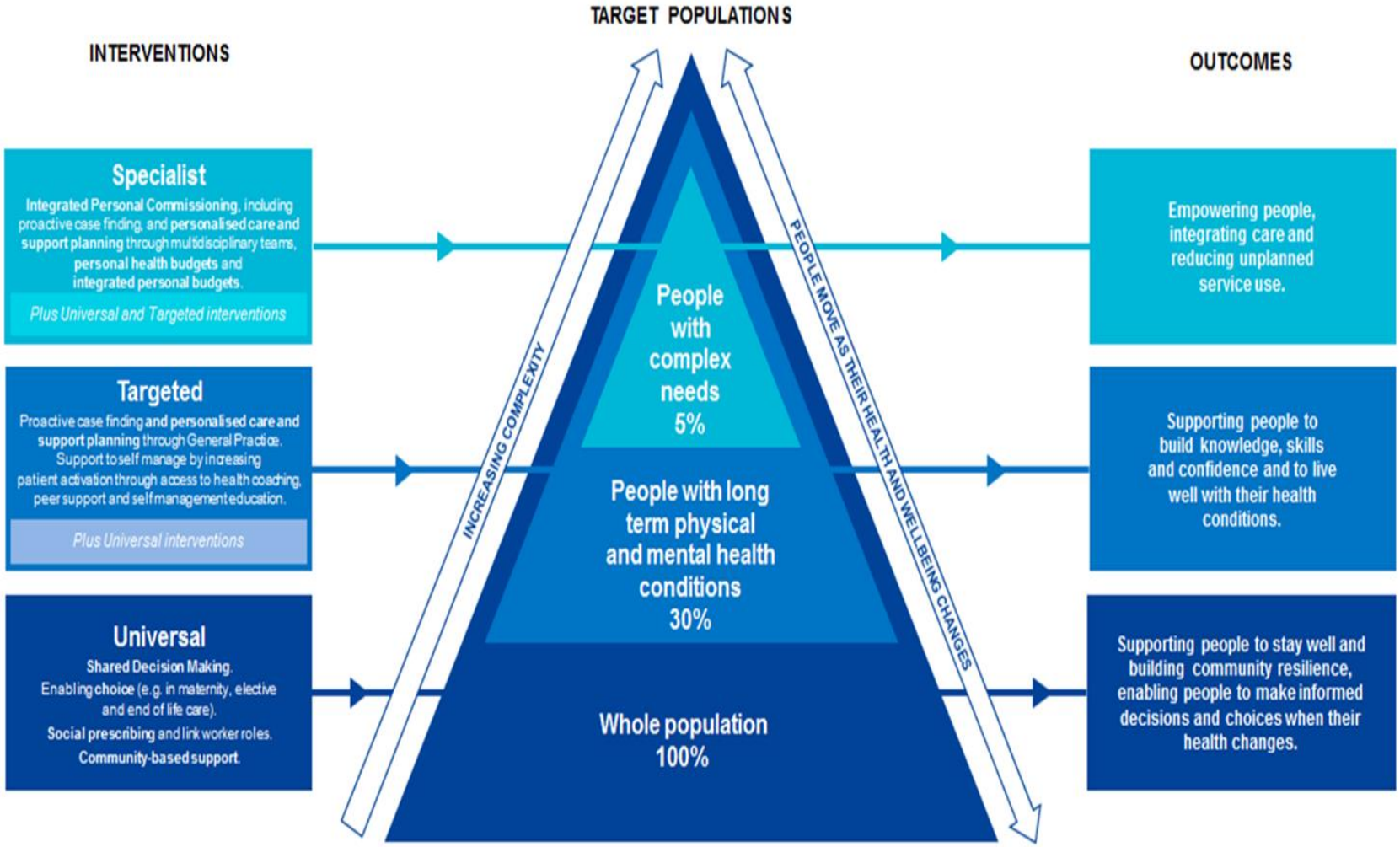

Easy referral from all local agencies
Workforce development
Common outcomes framework
What matters to me
Create a personalised plan
Support for community groups
Collaborative commissioning and partnership working
Social Prescribing Link Worker
Employed to give time
Part of primary care and local social prescribing connector scheme

# Where does Social Prescribing fit in?

# Comprehensive Model for Personalised Care

## All age, whole population approach to Personalised Care

NHS England



# Personalised Care Operating Model

NHS England

**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

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 a proactive, personalised conversation which focuses 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)

LEADERSHIP, CO-PRODUCTION AND CHANGE ENABLER

FINANCE ENABLER

WORKFORCE ENABLER

COMMISSIONING AND PAYMENT ENABLER

## Optimal Medical Pathway

## Social Prescribing and Community-Based Support

Enables professionals 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 (patient activation) 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)

# Person Centred Care

* Shared decision making
* Supported Self management
  * Health Literacy/activation
* Personalised Care and Support Planning
  * Health coaching
* Social prescribing
* Personal Health budgets

# Mrs Smith

- 75 year old retired teacher
- History of type 2 diabetes, overactive bladder and COPD
- Lives alone, smokes and has a daughter who lives 20-minutes away
- Usually independent but, 4 months ago was admitted with pneumonia and stayed in hospital for one week.
- Overweight and struggles to walk long distances

- At her last annual review, Mrs Smith was offered additional medication to control symptoms and signposted to a local trainer
- This year she received a letter inviting her into the surgery for an appointment with a nurse trained in primary care support planning

# What matters to Mrs Smith ? Personalised Care and Support planning

First appointment

- Blood pressure, blood tests , a breathlessness assessment and other physical tests
- She was asked to think about what matters to her before the next appointment

- Results shared with a prompt about what matters to her.

# What matters to Mrs Smith ? Personalised Care and Support planning

At the second appointment Mrs Smith's priorities were discussed:

- Confused about when to use her rescue medications.
- wanted to get to shops without being breathless.
- Urinary symptoms made her anxious when she went out.
- As a result she had lost touch with friends, lost confidence and become less mobile.
- Socially isolated.

# What Matters to Mrs Smith? Shared decision making

- Not keen to take any medication for urinary symptoms. She was referred to the local continence service and signposted to Age UK
- Pulmonary rehabilitation was discussed but she was anxious about the long sessions and group setting.
- Diabetes medication and weight discussed. She was fed up with taking so much medication but didn't know what to do about it.

# What Matters to Mrs Smith? Supported self management

- The local continence service and Age UK provided guidance on managing her urinary symptoms.
- The rescue medication was discussed and Mrs Smith was given a clear, personalised **self-management** card about what to do if her symptoms got worse. She could refer to this if she could not recall what to do
- The exercise handbook for COPD provided by The British Lung foundation was reviewed.

# What Matters to Mrs Smith?
# Social Prescribing

- Mrs Smith realised that what really mattered to her was her loneliness and lack of confidence so she was referred to the practice Link worker
- The link worker asked her what her interests were and what mattered to her.
- Personalised care plan:
  - Illuminate (confidence for change programme and community)
  - Local walking group
  - Community Allotment.
- Follow up telephone call

# What Matters to Mrs Smith?

A review appointment was arranged in 6 months time:

- she could walk to the shops now and felt more confident in managing her breathing.
- She had also become involved in the local breath easy group and had found herself volunteering to teach others how to manage their breathing.
- She had only been back to the GP once.
- She had lost weight

# Things are moving fast

* Draft Common Outcomes Framework
* Draft link worker job description
* Draft Competency Framework and Toolkit
* New GP contract
  * Primary Care Networks of 30-5000 patients
  * One fully funded Social Prescribing Link Worker per network
  * But….

# Social Prescribing in the East of England

* 19 CCGs, nearly all with something
* Different models in different places
* East of England Social Prescribing Steering group
* 2 regional facilitators
  * sianbrand@livingsafeandwell.co.uk
  * tim.anfilogoff@nhs.net
* http://www.hwncambs.org.uk/
* https://www.socialprescribingnetwork.com/

# Thank you

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