East of England Citizens Senate

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30th September 2020

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"

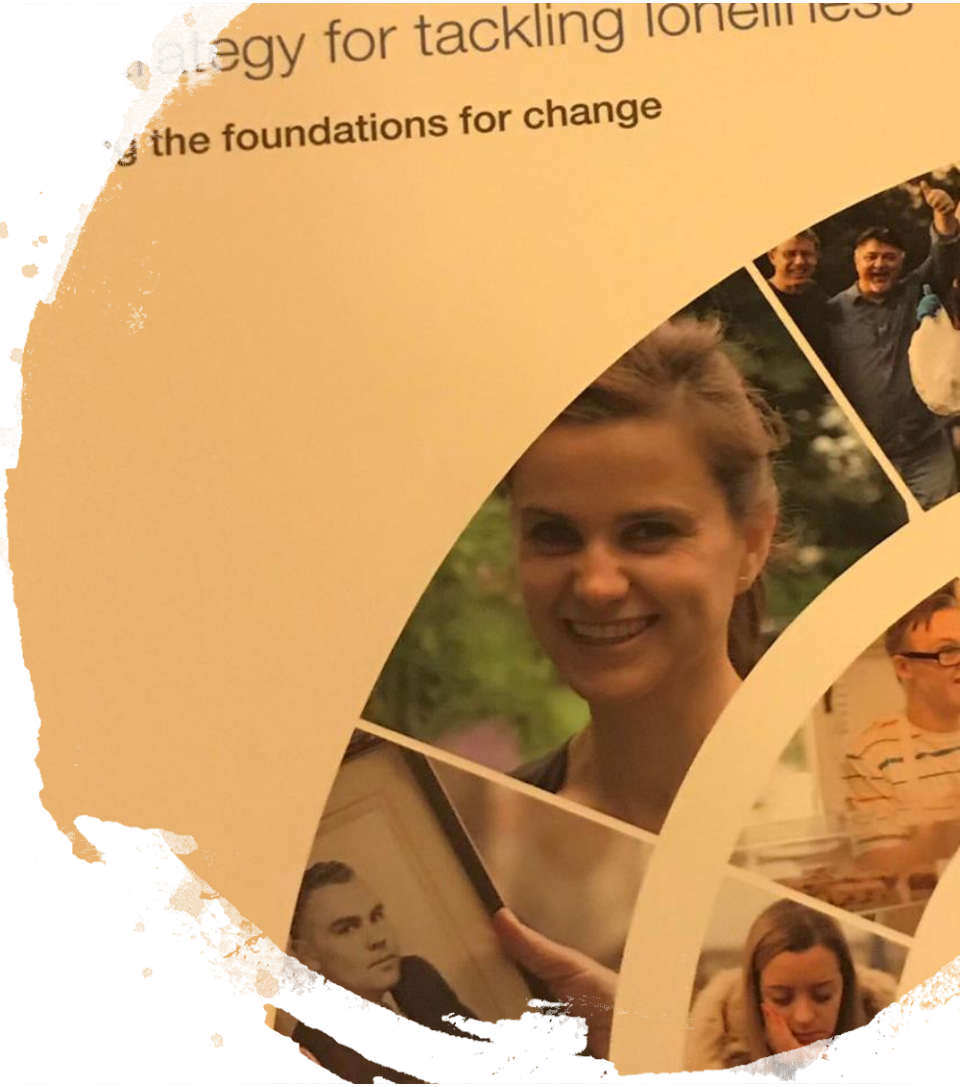
- Reduces health inequalities – long-term conditions, support with mental health, loneliness, complex needs.
- Reduces pressure & assists in demand management in General Practice, A&E social care & other services
- Supports self-care, self-management and prevention, personal & community resilience

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.

Loneliness & Social Prescribing

Published October 2018



“Part of the work we have to do is to change the way we think about public services. For example, the expansion of social prescribing across the country will change the way that patients experiencing loneliness are treated. Recognising that medical prescriptions alone cannot address the root causes of loneliness, it will invest millions of pounds in ways of connecting people with community support that can restore social contact in their lives. As such, it will also play a critical role in the prevention of ill-health which I have made a key priority for our long-term plan for the NHS”

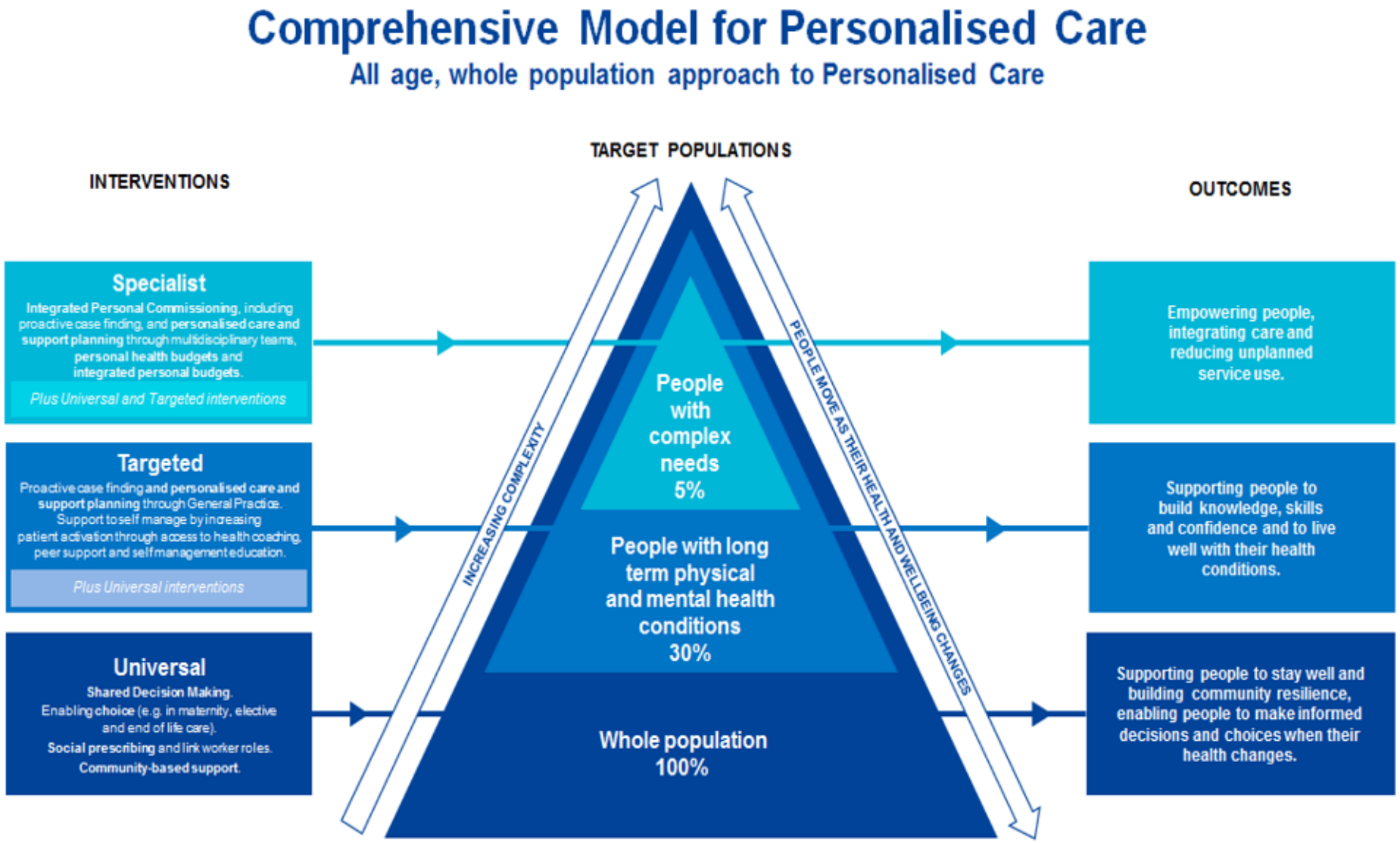
Theresa May

Social Prescribing in the NHS England Long Term Plan

Published January 7th 2019

“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.”

This means a comprehensive whole population approach:



Why social Prescribing now?

GP Five Year Forward View

Why social Prescribing – for me?

Focus changes from

"What's the matter with me"

to

"What matters to me"

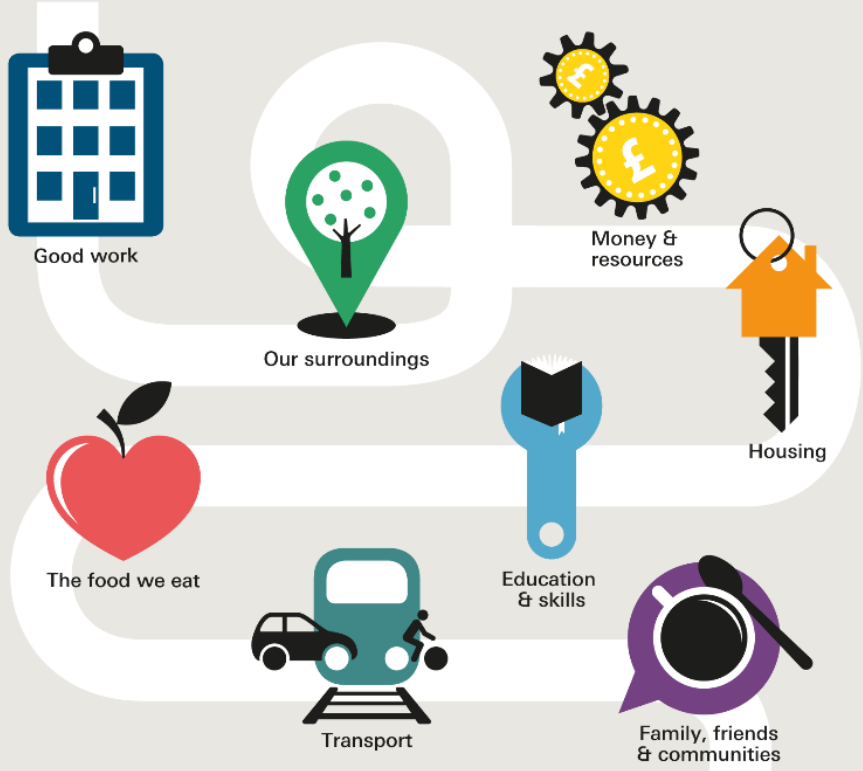
- Strengths rather than deficit
- Builds on existing assets
- Connects me to my communities
- Offers me a greater choice of opportunity & help that's non-medical
- Meet new people and make new relationships including volunteering
- Build my self-responsibility, take control, engaging, empowering
- Improve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

Social model of health

What makes us healthy?

AS LITTLE AS **10%** of a population's health and wellbeing is linked to access to health care.

We need to look at the bigger picture:



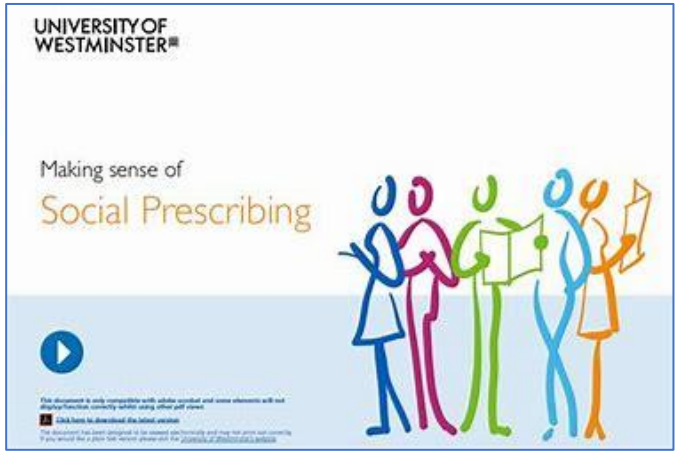
But the picture isn't the same for everyone.

The healthy life expectancy gap between the most and least deprived areas in the UK is: **19** YEARS

The Health Foundation

References available at www.health.org.uk/healthy-lives-infographics

Key elements of social prescribing in primary care networks



The NHS Long Term Plan
#NHSLongTermPlan / www.longtermplan.nhs.uk

Link workers in primary care networks

Social prescribing link workers will be **embedded within PCN multi-disciplinary teams** to;

- provide personalised support to individuals, their families and carers to take control of their wellbeing, live independently, and improve their health outcomes
- develop trusting relationships by giving people time and focusing on ‘what matters to them’
- take a holistic approach, based on the person’s priorities, and the wider determinants of health
- co-produce a simple personalised care and **support plan** to improve health and wellbeing
- introduce or reconnect people to **community groups and services**
- evaluate the individual impact of a **person’s wellness progress**
- record referrals within GP clinical systems using the national **SNOMED** social prescribing codes
- support the delivery of the comprehensive model of **personalised care**
- draw on and increase the **strengths and capacities of local communities**, enabling local VCSE organisations and community groups to receive social prescribing referrals.

Health & Well Being Coach

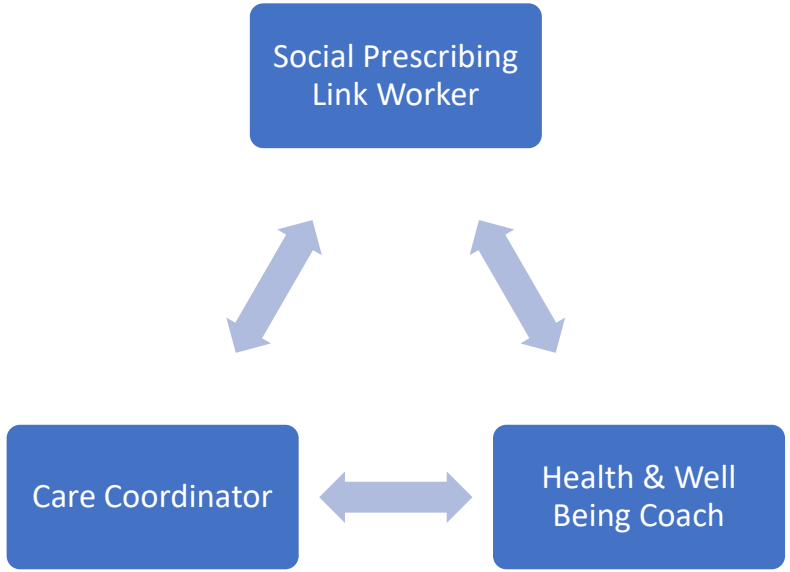
- Work with people with one or more long term conditions such as type 2 diabetes or COPD, or with risk factors for developing a long-term condition, providing support for issues such as weight management, managing chronic pain, living with depression, and anxiety.
- Work with people over a number of sessions to support them to develop their knowledge, skills and confidence to become active participants in looking after their own health
- Skilled in coaching, communication and behavioural change skills and are able to work alongside people (individually or in groups) at their starting point

Care Coordinator

- Proactively identify and work with people, including the frail/elderly and those with long-term conditions, to provide coordination and navigation of care and support across health and care services
- Work closely with GPs and practice teams to manage a caseload of patients, acting as a central point of contact to ensure appropriate support is made available to them and their carers
- Coordinating all the information about a person's identified care and support needs within a single personalised care and support plan, based on what matters to the person.

Role interdependencies

- First point of referral is Social Prescribing Link worker as single point of access
- Can refer to each other and good communication between 3 roles essential



Something to take away

Five Ways to Well-Being

THANK YOU FOR LISTENING

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