1. Progress Update - Social Prescribing

The H&WBB have previously received and endorsed the social prescribing model for Shropshire, supported the business case, and subsequent proposals for expansion. They also endorsed the future ambitions presented to the Board in November 2018.
This paper summarises local progress, (including key points from the independent evaluation) and provides a national update following the publication of the NHS Long Term Plan which gave a clear commitment to social prescribing. Some key points to highlight are:-

- The Shropshire Model of Social Prescribing has been externally evaluated by Westminster University, the National Network for social prescribing (specifically on the model and the outcomes) and feedback is summarised below, this includes qualitative data and quantitative data. The fuller detail is contained in the slide set attached and the components of the local model are found in appendix 1.

- The Shropshire Model of Social Prescribing mirrors the NHS England national guidance specifically in relation to the role of the link worker role (and is distinctly different to other local roles that focus on sign posting).

- Shropshire has been identified as an exemplar site by the National Network and the NHS England team and as such is being invited to participate in regional strategic events and national conferences.

2. The Evaluation Brief for Westminster University

- **Westminster University commissioned to carry out an evaluation of the 'demonstrator site' – 4 GP practices in the north of Shropshire**

- **To understand why the programme was being used and how well the components worked together**

- **To develop a robust service using best practice in development and data collection**

- **To assess the impact of key measures being used on patient outcomes**

- **To understand the impact of the service using a range of validated tools and measures (qualitative and quantitative)**

3. Feedback From the External Evaluation Report, Phase 1 (2019) - Highlights

3.1 "The development of this particular social prescribing service is innovative for several reasons ":-

1. Very few existing social prescribing services have a prevention focus to them, therefore there is very little existing learning to go on (the Shropshire model is part of the wider Healthy Lives programme) .
2. Targeting health and social problems known to have a bigger impact on the population
3. Identification of those at risk and those with low agency
4. Use of data to target and pro-active identification of those at risk – one way is via practice records, and opportunistically, via adult social care teams, GP's, voluntary sector, Job Centre, libraries
5. No additional budget was available to implement social prescribing, therefore integrating existing resources and knowledge was essential.

6. The application of a multidisciplinary team approach (involved many professionals- adult social care, community enablement, data system lead, Help2Change e.g. social prescribing advisors, operational locality leads)
7. Extensive scoping with key organisations and people across the system to identify best fit for social prescribing with tried and tested methodology
8. Iterative and systematic approach to development of the programme
9. The model has it's roots in the Health and Well-being Strategy – move from fixing disease to a more collaborative way of promoting and maintaining health

3.2 The Role of the Social Prescribing Adviser

The role of the **social prescribing adviser**, based in primary care or the community which allows time with the individual (1 hour) and includes a structured goal based discussion according to the person's needs with follow up. This is aimed at those who are unlikely to take up services or activities through signposting alone and without one to one support and aimed at those with low agency.

The session also includes reliable and valid measurement tools as part of the one to one session and at 3 month follow up and is targeted at those most likely to achieve health gain including those with lifestyle issues and long term conditions. The outcomes can be tracked and are reported.

Additionally practice records can be audited to identify larger cohorts of people at risk. The functions of the role are in line with the national guidance from NHS England on the role of the link worker.

3.3 Some Patient Feedback

"Knowing that the SP Advisor had said to me "I'll see you in 3 months and we'll see how we're going". That actually was a very good incentive. I've been to things like Weight Watchers but the Advisor was taking the trouble to see me, giving me one to one, which I think is very important, I didn't want to let her down anymore than I wanted to let myself down."

"I think I'd been to the doctors about my cholesterol and the issue of weight came into it, which I had been aware of for some time, but really done nothing about it."

Follow up calls to check the client had followed up actions –
"if they hadn't persisted I'd have just forgotten about it. If it had been just one visit to the surgery I'm sure there would have been a very different outcome"

"I think partly the attraction of it was that there was somebody who was happy to talk about my problem and also say I can give you an hour."

4. Summary of Overall Findings From the Evaluation Report

- Patient reported outcome data is demonstrating statistically significant improvements in concerns.
- There is improvement in activation levels and wellbeing using the Patient Activation Measure (which is linked to linked to behaviour change, clinical outcomes and costs for delivering care)
- There are improvements in physiological changes – physical activity, weight, smoking
- Real life examples of changes in action and underlying reasons why the SP Service has triggered changes have been captured through questionnaires and feedback
- Significant reduction in GP appointments for participants at 3 month follow up
- **User feedback is positive – people are feeling heard and supported and needs being met not as a condition but as a person**

- The shift from theory to a developed service has been challenging but rewarding and positive learning experience – testing out, pause, reflect, act.
- Data collection ongoing to phase 2 to increase numbers in the evaluation.

Further detail can be found in appendix 2 and in the attached presentation

4. National Context NHS Long Term Plan – Social Prescribing

The NHS Long Term Plan, published on Monday 7 January 2019, includes commitments to personalised care, which includes social prescribing. The context for this is about broadening the primary care workforce along with other new roles.

To establish social prescribing link workers within primary care networks to help GPs and their teams refer people who would benefit to community programmes with the aim to put in place over 1,000 social prescribing link workers by the end of 2020/21, rising further by 2023/24,

The new link workers are in addition to existing link workers with funding for 1 link worker in each PCC Network to be 100% funded for 5 years, aligned clinically and geographically with a population of 30-50,000. The link worker will be part of a DES signed up by the PCCN and is part of the support to broaden the primary care workforce.

There is an expectation from NHS England that CCG commissioners, local authorities, VCSE leaders, and existing social prescribing schemes work with primary care networks to create shared plans for social prescribing at a place-based level, including looking at how they will build on existing social prescribing schemes.

Plans for the CCG's to have addressed this are due by 1/4/2019.

Locally we are well placed to support this development, with a clear model, which adheres to national good practice principles, supports gaps in the current system, achieves positive outcomes for people, and primary care that has been externally scrutinised, and evaluated and is innovative in its approach.

Appendix 1

Social Prescribing - The Shropshire Model – Key Components

- **Additional support** for primary care and adult social care
- Opportunity to **support** the voluntary sector – demonstrate impact
- **Time** with a Social Prescribing Advisor – trained in behaviour change and motivational interviewing – focus on the whole person, not signposting
- Improving well-being and health, reducing isolation
- **Governance** – reliable measures, validated tools, data, recording, reporting, monitoring, quality assurance of groups/activities receiving referrals .
- **Structured referral routes from GP, health professional, practitioner, voluntary sector, Job Centre, libraries**
- **Proactive identification** of larger groups of patients- those at risk of health conditions, those with social or behavioural factors that pose a risk, those existing health conditions, isolation and loneliness
- **External scrutiny** – Westminster University evaluation

Appendix 2

Summarised Points Relating to the Data From the Evaluation Report on Social Prescribing

Referrals to the social prescribing service were opportunistic and via an audit of CVD risk of medical records at 2 GP practices. 277 referrals were made between May 2017 – Oct 2018 and 89 people were recruited into the evaluation.

Evaluation participants were **highly satisfied** with the social prescribing service and reported positive experiences. These included **satisfaction ratings of 4.8/5** for suitability of times, convenience of venue and feeling able to discuss concerns with the social prescribing advisor.

MYCaW concerns identified a range issues that people urgently needed support with including lifestyle advice as well as social determinants of health and concerns that relate to adult social care. **Statistically significant improvements** in concern scores were achieved and participants appreciated talking through issues with the social prescribing advisor, being listened to, feeling supported, reassured and confident to put changes into action.

There was a **discernible improvement in agency for individuals**, which was demonstrated through the qualitative data. Participants particularly **valued the role of the social prescribing advisor**. **Changes in agency** were also **demonstrated through changes in PAM score.** Not only is this due to the 1:1 time with a social prescribing advisor, but their training in motivational interviewing amongst other things, and the support an individual receives to access an appropriate group when the time is right.

Patient activation was clinically significantly improved in 36% of participants at the 3 month follow-up and a shift up the activation levels was achieved. This is associated with **a reduction in health care utilisation and there for a reduction in costs for the health service usage.** There is no data yet to show if PAM scores are linked to a reduction in adult social care usage, although evidence collected in other social prescribing research projects is highlighting this to be so.

Two people quit smoking via the social prescribing service and **59%** of participants were **more physically active** at the 3 month follow-up.