Shropshire Council | NHS Shropshire Clinical Commissioning Group | Shropshire together

**Health and Wellbeing Board**
**14th January 2021**

# HWBB Joint Commissioning Report – Social Prescribing

**Responsible Officer**
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## 1. Summary

1.1 This report provides an update on the Social Prescribing offer and development in Shropshire. It describes the programme and recent progress, as well as progress in developing the Children and Young People's Social Prescribing Programme. Referral data can be found in Appendix A.

1.2 Social Prescribing is an important programme in our system that supports people to take control of their health and wellbeing and improving their chances of preventing ill health. It is a collaboration between Primary Care Networks, Public Health and the Voluntary & Community Sector (VCSE). The programme benefits a range of referral and delivery partners including Primary Care, Social Care, Job Centre Plus, the VCSE, Libraries, Sports and Leisure and more.

## 2. Recommendations

2.1 The HWBB note and endorse the progress.

## REPORT

3. **Risk Assessment and Opportunities Appraisal**
(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

3.1. The HWB Strategy requires that the health and care system work to reduce inequalities in Shropshire. All decisions and discussions by the Board must take into account reducing inequalities. Covid 19 has shone a light on inequalities and requires all of our services to further risk assess individual risk and to support the population who are at increased risk of ill health due to Covid 19.

3.2. The schemes of the BCF, including Social Prescribing and other system planning have been done by engaging with stakeholders, service users, and patients. This has been done in a variety of ways including through patient groups, focus groups and ethnographic research.

## 4. Financial Implications

There are no financial implications as a result of this report.

## 5. Background

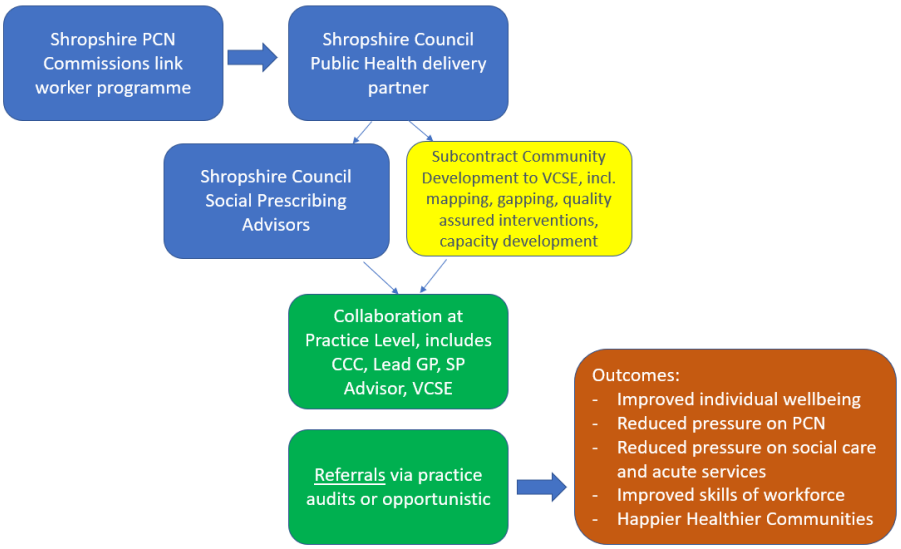
Adults Social Prescribing Programme

5.1. Social Prescribing is a programme of referring people to support in their community that empowers them to take control of their health and wellbeing.

5.2. Through non-medical 'link workers' who give; time, focus on 'what matters to me' and take a holistic approach, motivational interviewing and behaviour change techniques, a person is supported to connect to community groups, activity of interest, and statutory services for practical and emotional support.

5.3. Public Health, the Voluntary and Community Sector and Primary Care have been working collaboratively for 3 years to develop and roll out a model that supports people in the community where they live. This model is preventative in its approach as supports people with their emotional wellbeing and supports them to have the confidence and motivation to take positive lifestyle decisions. The model started in 3 practices in Oswestry and was soon joined by 8 additional practices; the programme is currently being rolled out across all Shropshire PCNs.

5.4. The diagram below describes the delivery model:




5.5. During Covid, the programme has made adjustments to support people on the telephone or online. Primary Care has worked alongside Public Health to make the changes needed to continue to support people through Social Prescribing and the offer has been extended to support the Clinically Extremely Vulnerable.

5.6. Additionally, the system has invested in Winter Pressure Link Workers who are employed by Age UK. These Link Workers work primarily with those who are vulnerable (including the Clinically Extremely Vulnerable), offering help at home, befriending, shopping and a variety of other support offers to keep people well this winter.

Data

5.7. A robust data set has always been collected and monitored as part of the programme. This has included referral (referral data from across the PCNs can be found in Appendix A), and outcomes data including the Patent Activation Measure (PAM), used for people/ patients with long term conditions; Measure Yourself Concerns and Wellbeing (MyCaw), used for all people/ patients; and the Dejong Gierveld loneliness scale.

5.8. The 2018/19 Westminster University Evaluation found that:

- The service is aligned to national best practice identified by the Social Prescribing Network and NHS England
- 134 people recruited into the evaluation. 105 completed pre & post

- **A reduction of 40% in GP appointments**
- Improvements in Measure Yourself Concerns and Wellbeing (MYCaW) concerns
- Support included behaviour change and motivation
- Changes translated into improvement in weight, Body Mass Index, Cholesterol, blood pressure, levels of smoking and physical activity
- **High patient satisfaction – suitable times, venue and ability to discuss concerns with the Adviser**
- Unmet needs were supported beyond the remit

5.9. A more recent look at the data for the South East and South West PCNs found that: Across all practices in Shropshire there are 133 SP clients with baseline and follow-up data for the MYCaW concerns. 71% reported an improvement in their Concern 1 and 67% reported and improvement in their Concern 2; with 51% voicing an improvement in their wellbeing; and 55% with an improvement on their loneliness score.

5.10 Additionally, where the service has audited patients for pre-diabetes, the service has captured data on HBA1C. The details and results are as follows:

- ❖ Baseline measure = HbA1c recorded by surgery and identified in audit prior to invitation to Social Prescribing
- ❖ Follow-up measure = HbA1c recorded by surgery at follow-up – falling between 3 and 12 months after baseline measure
- ❖ 64 Social Prescribing clients with before and after HbA1c measures by Feb 2020 of whom:
  - 56 showed a reduction in HbA1c of between 1 and 7 mmol/mol
  - 40 patients reduced their HbA1c to within normal range

NB: it's important to note that some patients will have also accessed the National Diabetes Prevention Programme – the two programmes work hand in hand.

Development

5.11 Since the implementation of PCNs across Shropshire, the service has worked with the SE and SW PCNs, and subsequently the North and Shrewsbury PCNs to embed the service across the Shropshire Council area.
Key information:

- ❖ It is an integrated service with the voluntary and community sector
- ❖ Over 1100 referrals to date
- ❖ The service is up and running in all practices in the SE and SW
- ❖ Recruitment for additional social prescribing advisors is complete for the North and Shrewsbury PCNs and roll out has started in both areas
- ❖ Additional practices have started the service in the North and additional practices to start in January for the Shrewsbury PCN
- ❖ The community development element is delivered by Qube, RCC and Ludlow Hands Together
- ❖ The Mayfair Centre in Church Stretton deliver social prescribing advising for the Church Stretton Practice
- ❖ Additional to this model, Winter Pressure Link Workers are being trialled across Shropshire to support winter pressures and the impact of Covid.

Recognition in national publications or websites

- https://www.kingsfund.org.uk/publications/social-prescribing
- LGA Website – presentation by Jo Robins and Lee Chapman
- National Healthwatch website – report by Healthwatch Shropshire

## 6.0 Social Prescribing. Children and Young People – Update

6.1 We are working on a project to bring social prescribing to the children and young people of Shropshire, starting with the South West of Shropshire in Ludlow and Bishops Castle.

6.2 This will look at events and activities that would enable young people to engage, motivate, gain confidence, grow as individuals, set and achieve goals, manage their mental health and inspire.

6.3 The project will rely on us engaging with young people on the right level and with the right technology to ensure we reach the young people that need the project and getting them to participate so that the programme is designed to meet their needs.

Engagement

6.4 Engagement has been made with organisations across Shropshire who will be key in providing a wide range of interventions to work with this project as it is not a one size fits all approach we are looking to provide.

6.5 We have planned engagements in the diary to increase the activities and this will be an ongoing programme to capture as wide a range of interventions as possible.

6.6 Further work is in progress to capture programmes and activities to ensure that the offer remains relevant.

6.7 Engagement with young people is currently taking place to ensure that we can communicate to understand their current needs, wants and what is missing from their life to help them achieve and move forward, this engagement has already shown us the impact that COVID has had over the last six months.

Mapping

6.8 Mapping of the interventions and activities is being produced to enable us to see at a glance what is available and where in the county this will fit and how we can use this for the children and young people's needs on going.

Specification

6.9 We have prepared a specification for the pilot of the social prescribing project. This works as a grant funding document to gather correctly the information about organisations and their proposals.

6.10 The specification also sets out what we know so far and what we are looking to achieve and our expected outcomes.

Next Steps

- Continue engagement with young people and professionals
- Appoint CYP Link Worker
- Publish specification/ tender

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| **List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)** |
| **Cabinet Member (Portfolio Holder)**<br>Cllr Dean Carroll, Adult Social Services and Climate Change |
| **Local Member**<br>n/a |
| **Appendices**<br>**Appendix A – Social Prescribing Referral data** |

Appendix A

## Social Prescribing Update – 15 December 2020 by Katy Warren, Social Prescribing Project Lead

**Data at 08/12/20 with increase since 03/11/20. New referrals since last update in red.** Please note: GP Practices have started their Social Prescribing service at different times, which is reflected in referral numbers.

Total number of referrals across all Shropshire Social Prescribing services: **1157 (increase from 1071)**

### North Shropshire

**Referrals** Total = 426 (increase from 406)

| **Breakdown of referring organisations:** | **Age ranges:** | **Reasons for opportunistic referral** *(can be referred for more than one reason)* |
|---|---|---|
| 105 Plas Ffynnon (31 opportunistic + 74 CVD audit)<br>132 Cambrian (31 opportunistic + 101 CVD audit)<br>4 Caxton<br>20 Ellesmere medical practice<br>19 Dodington Surgery (6 opportunistic + 13 CVD audit)<br>12 Wem & Prees (1 opportunistic + 1 pre-diabetes audit + 10 diabetes audit)<br>23 Adult Social Care<br>6 Pre-diabetes session (delivered by H2C)<br>1 Age UK<br>2 Mental Health Access Team<br>1 Mental health Social Work team<br>3 Early Help<br>5 Library<br>7 Help2Change/Public Health Team<br>48 Job Centre Oswestry<br>2 Job Centre Whitchurch<br>1 Qube<br>5 Enable<br>10 Oswestry Outpatients Physiotherapy<br>1 Designs in Mind<br>2 FPOC<br>2 Care Closer to Home<br>11 Shropshire Council calls to the shielded<br>1 Shropshire Council Covid-19 helpline<br>3 other | 18-19 10<br>20-29 25<br>30-39 31<br>40-49 39<br>50-59 73<br>60-69 126<br>70-79 96<br>80-89 25<br>90-99 1 | Lifestyle risk factors- 76<br>Long term conditions – 41<br>Mental health difficulties – 103<br>Risk of loneliness / isolation – 75<br>Carer – 5<br>Other – 9<br>Frequent attender – 9<br>NHS Health Check - 1 |

**People seen:**
367 people seen (increase from 350)

**Final follow ups (at 3-6 months):**
184 people have had final follow-up appointments (no increase)

## Shrewsbury

**Referrals**

Total = 299 (increase from 285)

| Breakdown of referring organisations: | Age ranges: | Reasons for opportunistic referral *(can be referred for more than one reason)* |
|---|---|---|
| 38 Claremont Bank Surgery (all opportunistic)<br>97 Marden Medical Practice (all opportunistic)<br>30 Radbrook Green Surgery (all opportunistic)<br>58 Severn Fields Practice (39 opportunistic; 19 pre-diabetes audit)<br>13 Shrewsbury Job Centre<br>13 Help2Change/Public Health team<br>7 Adult Social Care<br>5 Enable<br>7 Other<br>2 FPOC<br>1 Leaving Care Team<br>3 Shropshire Council Community Reassurance team<br>20 Shropshire Council calls to the shielded<br>1 Shropshire Council Covid-19 helpline<br>3 Shropshire Council follow-up befriending calls<br>1 Shropshire Council Food Hub follow-up calls | 18-19 2<br>20-29 31<br>30-39 28<br>40-49 43<br>50-59 79<br>60-69 58<br>70-79 35<br>80-89 15<br>90-99 8 | Lifestyle risk factors - 94<br>Long term conditions – 29<br>Mental health difficulties – 127<br>Risk of loneliness / isolation – 56<br>Carer – 6<br>Other – 9<br>Frequent attender – 1<br>NHS Health Check - 6 |

**People seen:**

278 people seen (increase from 268).

**Final follow ups (at 3 to 6 months):**

158 people have had final follow-up appointments (increase from 146)

## South-East Shropshire

**Referrals**

Total = 278 (increase from 257)

| Breakdown of referring organisations | Age ranges: | Reasons for opportunistic referral *(can be referred for more than one reason)* |
|---|---|---|
| 86 Albrighton Medical Practice (40 Opportunistic, 4 CVD audit, 42 prediabetes audit)<br>3 Alveley Medical Practice (opportunistic)<br>105 Bridgnorth Medical Practice (17 opportunistic, 88 prediabetes audit)<br>4 Broseley Medical Practice (opportunistic)<br>2 Brown Clee Medical Practice (opportunistic)<br>14 Cleobury Mortimer Medical Practice (opportunistic)<br>20 Highley Medical Centre (opportunistic)<br>5 Ironbridge medical Practice (opportunistic)<br>15 Much Wenlock Medical Practice (14 opportunistic, 1 prediabetes audit)<br>5 Adult Social Care<br>2 Care closer to home MDT<br>10 Shropshire Council calls to the shielded<br>1 Shropshire Council Food Hub follow up calls<br>1 Shropshire Council Welfare Benefits team<br>1 Shropshire Council calls to those with assisted bin collections<br>1 Enable<br>2 Help2Change/Public Health Team | 18-19 1<br>20-29 10<br>30-39 16<br>40-49 19<br>50-59 61<br>60-69 70<br>70-79 72<br>80-89 24<br>90-99 5 | Lifestyle risk factors- 35<br>Long term conditions – 8<br>Mental health difficulties – 80<br>Risk of loneliness / isolation – 29<br>Carer – 12<br>Other – 12<br>Frequent Attender - 2 |

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|---|---|---|
| 1 Rhodes Pharmacy, Albrighton | | |

**People seen:**
243 people seen (increase from 227)

**Final follow ups (between 3 & 6 months):**
93 people have had final follow-up appointments (increase from 90).

## South-West Shropshire PCN

**Referrals**
Total = 149 (increase from 118)

| **Breakdown of referring organisations** | **Age ranges:** | | **Reasons for opportunistic referral** *(can be referred for more than one reason)* |
|---|---|---|---|
| 62 Bishop's Castle Medical Practice (53 Opportunistic, 9 CVD audit) | 18-19 | 3 | |
| 14 Church Stretton Medical Practice (opportunistic) | 20-29 | 14 | |
| 7 Craven Arms Medical Practice (opportunistic) | 30-39 | 9 | Lifestyle risk factors- 42 |
| 29 Portcullis Surgery (opportunistic) | 40-49 | 20 | Long term conditions – 27 |
| 11 Station Drive Surgery (opportunistic) | 50-59 | 20 | Mental health difficulties – 73 |
| 6 The Meadows 5 opportunistic, 1 letter sent to patient) | 60-69 | 29 | Risk of loneliness / isolation – 38 |
| 6 Shropshire Council calls to the shielded | 70-79 | 35 | Carer – 5 |
| 7 Enable | 80-89 | 15 | Other – 4 |
| 2 Job Centre Shrewsbury | 90-99 | 4 | Frequent attender - 1 |
| 5 Other | | | |

**People seen:**
121 people seen (increase from 98)

**Final follow ups (between 3 & 6 months):**
49 people have had final follow-up appointments (increase from 42).