Health and Adult Social Care Overview and Scrutiny Committee **12th July 2021**	**Item**

Social Prescribing

Responsible Officer **Penny Bason, Head of Joint Partnerships**
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1. Summary

1.1. Social Prescribing is an important programme in our system that supports people to take control of their health and wellbeing and improve their chances of preventing ill health. Social Prescribing Advisors (or sometimes called Link Workers) give people time, focusing on 'what matters to me' and taking a holistic approach to people's health and wellbeing. They connect people to community groups and statutory services for practical and emotional support.

1.2. Social Prescribing programmes also support existing community groups to be accessible and sustainable, and help people to start new groups, working collaboratively with all local partners.

1.3. Social prescribing works for a wide range of people, including people:

1.3.1. with one or more long-term conditions
1.3.2. who need support with their mental health
1.3.3. who are lonely or isolated
1.3.4. who have complex social needs which affect their wellbeing.

1.4. When social prescribing works well, people can be easily referred to Social Prescribing Advisors from a wide range of local agencies, including general practice, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise (VCSE) organisations. Self-referral is also encouraged.

1.5. The Shropshire model described in this report is an integrated programme and 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.

1.6. The model is an integrated programme that works in line with Shropshire Council's Organisational Principles, specifically; putting Shropshire back into the community, focussing on outcomes for customers, using data and intelligence, and continually improving performance.

1.7. This report provides an update on our Social Prescribing offer and its development in Shropshire. It describes the programme and recent progress on the Adult programme, as well as progress in developing the Children and Young People's Social Prescribing offer.

2. Recommendations

2.1 The HOSC note and endorse the progress.

REPORT

3. **Risk Assessment and Opportunities Appraisal**
   3.1. (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)
   3.2. As a health and care system we work to reduce inequalities in Shropshire. All decisions and discussions 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.

4. Financial Implications

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

5. Background

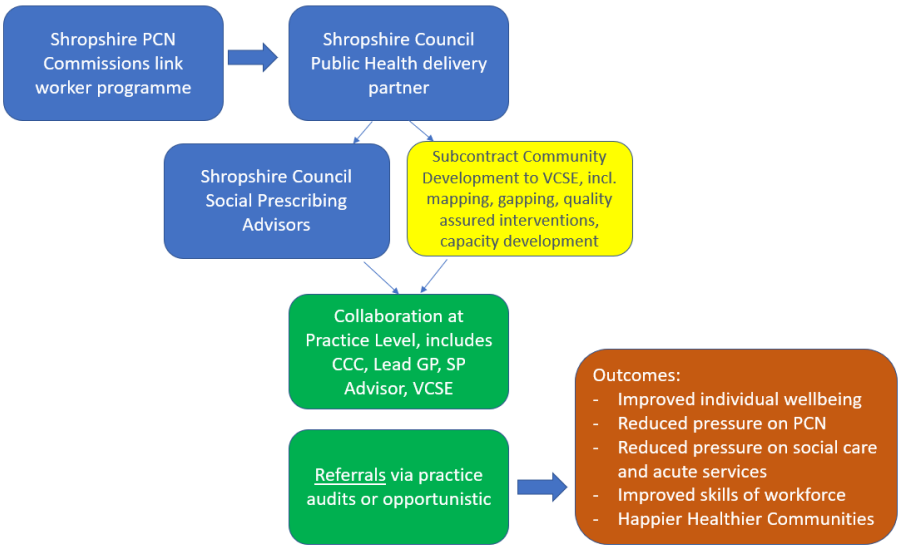
Adults Social Prescribing Programme

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. 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.

5.2 Social prescribing in its broadest sense has been happening in our communities for many years. Our vibrant voluntary and community sector working with public services support people in communities with non-clinical approaches with great success. In recent years the NHS and Local Authorities have been keen to recognise this work and encourage its development. By formalising Social prescribing across services, there becomes a greater offer of community support for people, as well as increased understanding and recognition of the work of our community and voluntary sector partners.

5.3 In Shropshire, Public Health, the Voluntary and Community Sector and Primary Care have been working collaboratively for over 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; it 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; in 2020-21 the programme was rolled out across all Shropshire PCNs and GP practices.

Diagram 1 below describes the delivery model:



5.4 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.

5.5 Additionally, the system has invested in Winter Pressure Link Workers who are employed by Age UK. These Link Workers work through the winter months, 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

5.6 A robust data set has always been collected and monitored as part of the programme. 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, are deployed to ensure that the programme is delivering positive outcomes.

5.7 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

5.8 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.
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

5.9 Data analysis of the whole service was completed in March 2021 regarding referrals for those with low level mental health concerns or who those who felt isolated and lonely. The results demonstrated that good improvement in outcome scores for those who were referred for either MH difficulties or isolation and loneliness. Summary:

- Total of **667 patients** referred to SP between 01/04/2019 and 01/02/2021
- **211** patients **–** had both baseline and follow up data reported. Of these:
    - **70** patients had '**Mental Health difficulties'** as their part of their Referral reason 1,2,3 or 4.
    - **26** patients had '**Lonely/ isolated'** as their referral reason 1,2,3 or 4.
- For those patients who were referred for mental health difficulties, the analysis shows that patients who were referred to another service and those who were not, all improved (i.e. their scores decreased) on their concern 1 MYCaW score at follow-up when compared to their initial baseline scores.
- For those who were referred due to isolation/ loneliness, there was good improvement against their concern1 MYCaW score, and a smaller improvement in their MYCaW wellbeing score.
- Numerous positive comments were made about the Social Prescribing Service and the services where individuals were referred.

5.11 Summary of key information:

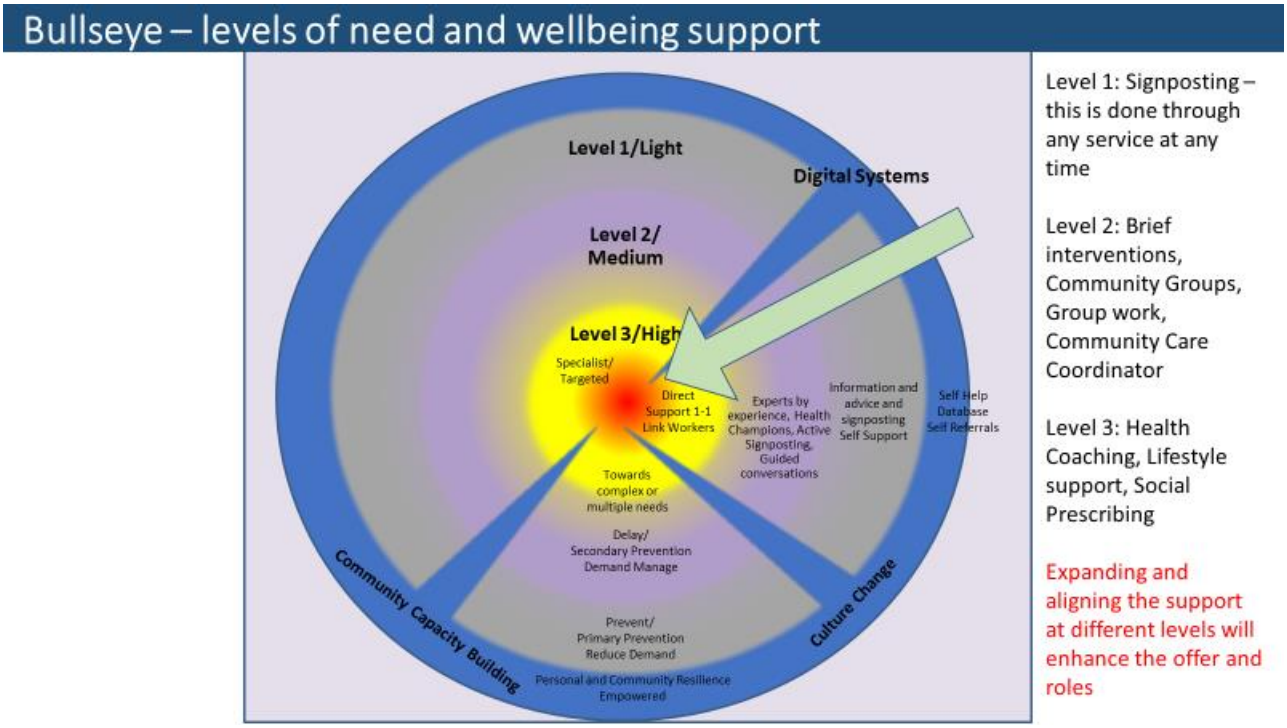
- ❖ Shropshire Social Prescribing is an integrated service with the voluntary and community sector, Primary Care, Local Authority and partners;
- ❖ There have been over 1642 referrals to date;
- ❖ The service is up and running in all GP practices in the Shropshire Council area which are part of the Shropshire PCNs;
- ❖ The service is preventative in nature, and it works with Primary Care Practice audits to proactively refer people who have health risk;
- ❖ The community development element is delivered by our VCSE colleagues, Qube, RCC and Hands Together Ludlow
- ❖ The Mayfair Centre in Church Stretton deliver social prescribing advising for the Church Stretton Practice;
- ❖ Outcome measures demonstrate improved health and wellbeing of those who participate in the programme;
- ❖ Additional to this model, Winter Pressure Link Workers are being trialled across Shropshire to support winter pressures and the impact of Covid.

Development

5.12 Since the advent 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.

5.13 In 2021/22 the service is working with Primary Care Partners to develop the model further, looking at how it can support more people and improve wellbeing. Primary Care Networks, through their contracts with NHSE/I, are able to provide services to those registered through their practices. In addition to Social Prescribing, the additional roles include pharmacists, physiotherapists, care coordinators, and health coaches. Public Health is very keen to work collaboratively with the PCNs and partners to develop multi-disciplinary approaches, to support people in Shropshire.

5.14 Diagram 2 below, describes considerations for developing the model to support people at different levels of need. Working in a multi-disciplinary way will be part of a system approach to supporting health and wellbeing.



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

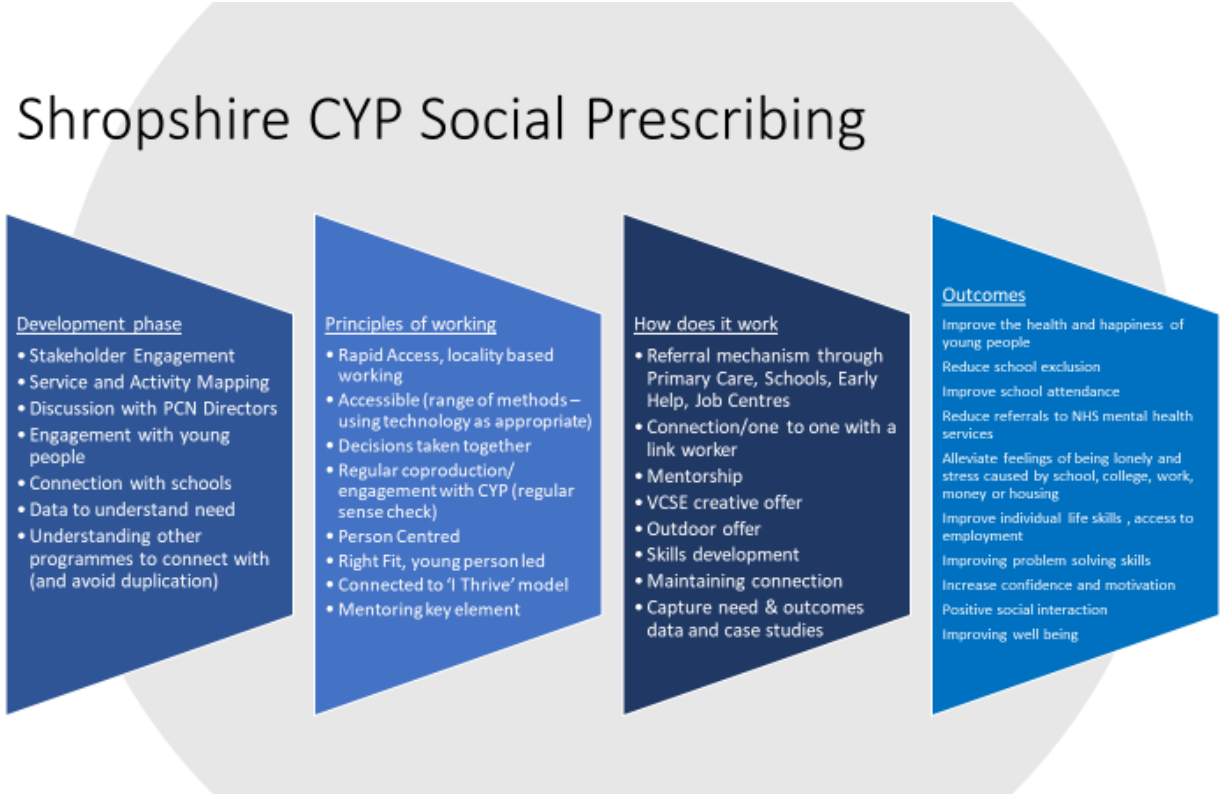
Social Prescribing. Children and Young People – Update

5.15 Through the South West Primary Care Network, a pilot programme to bring social prescribing to the children and young people (CYP) of Shropshire, starting with the South West of Shropshire, has started. Following in the footsteps of the adult programme, the CYP programme has been developed through engaging with local organisations, services and children. Two key components of the programme are to provide a link worker role to support CYP, and secondly to provide additional activity to enable young people to engage, motivate, gain confidence, grow as individuals, set and achieve goals, manage their mental health and inspire.

5.16 The programme aims to work collaboratively with Primary Care, the voluntary and community sector and young people, to help us understand what kind of support is having an impact on

children and young people's wellbeing. Both the one to one sessions with the Link Worker and the additional activity aim to provide feedback from young people.

5.17 The development of the service has been captured through the description below, in diagram 3.



5.18 The service is complemented by the additional activity, which has been commissioned by Shropshire Council. Four providers have formed the 'Provider Collaborative' who deliver different activity for young people in the south west. By forming a collaborative, the providers can work together to give young people the best opportunity to benefit from our offer. Bringing together partners who all have specific areas of interest and something different to enhance young people's experiences as well as the opportunity to continue to learn from each other is central to the idea.

5.19 The 'Collaborative' works together, collaborating with young people and increasing our awareness of the barriers and challenges young people are experiencing, with a focus on continuously improving outcomes through social prescribing lies at the heart of this collaborative. The group aims to share experience, resources & knowledge while also offering peer support to overcome some of the practical issues that are faced by young people living in our rural communities.

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) Cllr Dean Carroll Portfolio Holder for Adult Services, Health and Housing and Assets
Local Member n/a
Appendices – none.