

Social Prescribing Pilot in Worcestershire, working with Primary care and the Voluntary and Community sector

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INTRODUCTION

To release more time to care for patients, the 10 high impact actions in the GP Forward View highlighted the role of 'Social Prescribing' in using referral and signposting to non-medical services within the community that increase well-being and independence. In 2016 the Worcestershire Health and Well-being Board held an event to focus upon prevention, self-care and creating resilience in the population to tackle the wider determinants of health and work towards reducing health inequalities. Historically, uptake from primary care has been variable in similar programmes. This event and subsequent partnership work resulted in the creation of a jointly funded social prescribing pilot from 2018-19 supported by the Worcestershire CCGs and Public Health Directorate at Worcestershire County Council. Teams of GP Practices were invited to apply to take part in a one year pilot to test the model of social prescribing as presented by the National Social Prescribing Network. The pilot allowed the employment of a 'social prescriber' role, working across a group of GP practices. The social prescriber engaged patients 1-2-1 to explore health and wellbeing concerns, using a person centred approach to produce advice and guidance, signposting to local services, groups or clubs for ongoing support.

AIM

The main purpose of the pilot was to test the model of social prescribing in a primary care setting across Worcestershire. To embed prevention through a 'Social Prescriber' role, to act as the 'bridge' between primary care and the variety of community assets and provide information to improve health and well-being.

METHODOLOGY

The pilot was administered by the CCG with support from a multi-agency steering group. There were eight expressions of interest and six pilot sites were chosen, which maximized the amount of funding available and a wider reach of service. The pilot attempted to be all encompassing for the population and did not have specific referral criteria, however, it was recommended that the service should support the following:

- Anyone over the age of 18
- Registered with a Worcestershire GP
- Multiple, non-medical needs
- Socially isolated, vulnerable and/or other emotional needs
- Living with long-term conditions
- Frequent attenders in primary care

Public Health led on the evaluation of the pilot, taking a Donabedian approach to healthcare service quality, reviewing the structure, process and outcomes. This included the use of the shortened Warwick-Edinburgh Mental Well-being Scale (SWEMWBS) to measure change in individuals well-being following a social prescription. For the purpose of this pilot only Health Care Professionals within the selected practices could refer.

Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2008, all rights reserved

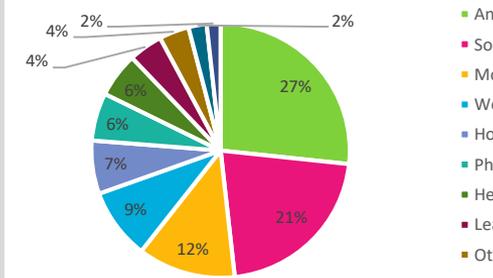
RESULTS

The total spend for one year of the pilot was £170,986 covering 43 of the 63 practices in the County. Following award, five of the six pilot sites chose to work with a voluntary and community sector provider to deliver the programme on behalf of the grouped practices. Data presented is representative of each of the pilot sites and uses the data submitted to Public Health from each of the pilot providers. There are some inconsistencies in data reporting and quality, which suggests statistical uncertainty.

In the one year pilot, 1,414 patients were referred into the programme, of these, over 900 were seen 1-2-1 or received telephone consultation. Providers reported a small number of patients (110) who did not attend or refused the service. The pie chart below shows the reason for referral of which, one or several reasons could be identified. The most common reason for referral was; anxiety, stress, depression or low mood. Followed by social isolation and money, debt or finance. 61% of patients were female, and were aged between 18 years to over 90 years old, with the highest proportion aged between 45 and 64 years old.

Using the shortened Warwick-Edinburgh wellbeing scale, 237 people had wellbeing scores recorded at initial referral and at a follow up call or appointment. Of these, just under 75% of entrants to the programme (73.2%, n.175) had an increase in SWEMWBS score suggesting improved sense of well-being. The median score was 5 (range improvement of 1-21). (Graph 3)

Data provided through EMIS by 8 GP practices suggests that, following referral to social prescribing, a reduction in the number of GP appointments was evident at both 6 and 12 months from referral. (Graph 1). Although further monitoring over time is needed to see if this positive trend continues.

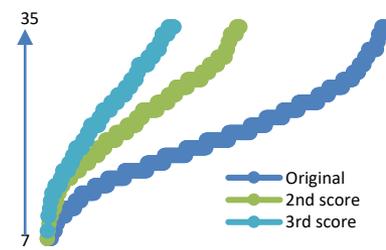


Graph 2: Reason for referral given by Health care professional

SUMMARY & CONCLUSION

Engagement and referral from GPs practices across the County in the pilot, has been higher than previous prevention programmes implemented. The data shows the service has been well utilised in referral by healthcare professionals and in uptake of the referral of patients, feedback from individuals and healthcare professionals has been overwhelmingly positive. Dr Fitton, GP Partner at Spa Medical Practice said; ".....there are a number of patients who I was seeing on a frequent basis who no longer feel the need to attend. I have also had a number of patients tell me how much they lovesocial contact that they now realise they have been missing for some time. Not only does this improve their mental health but I really feel this has a positive impact on their physical health too." Data returns submitted suggest that over 800 signposts have been made to a wide range of organisations, services and advice sources across the County. The improvement in SWEMWBS scores suggests that this has contributed to increasing wellbeing and independence. Where support to attend these groups is needed, social prescribing could be enhanced through peer led opportunities and befriending. Evaluation gathered to date is showing promising results for patients – but these must be monitored over time to have statistical certainty. The programme must continue to collect and strengthen the variety of data metrics recorded, with particular focus on outcomes for patients, now we understand the process to be acceptable. NHS England has made provision and funding for the employment of social prescribers in each Primary Care Network (PCN). Public Health and the CCGs are continuing to work in partnership, with the PCNs to implement these roles across the County using the guidance given by NHS England as well as the learning from this pilot.

Graph 1: Impact upon GP Appointments following social prescribing referral



Graph 3: Improvement in Wellbeing Score using Warwick-Edinburgh at intervention & follow up (7 lowest score 35 highest score)

ACKNOWLEDGEMENTS

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CONTACT INFORMATION

Lucy Chick: lchick@worcestershire.gov.uk

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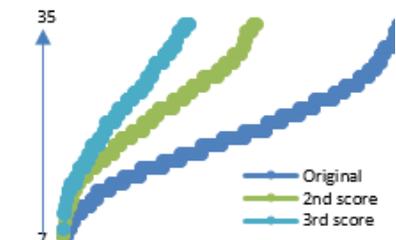
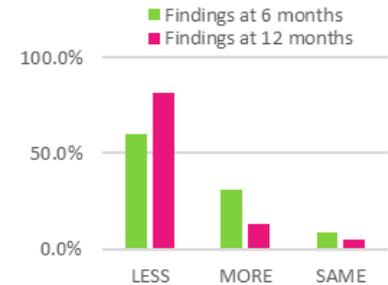
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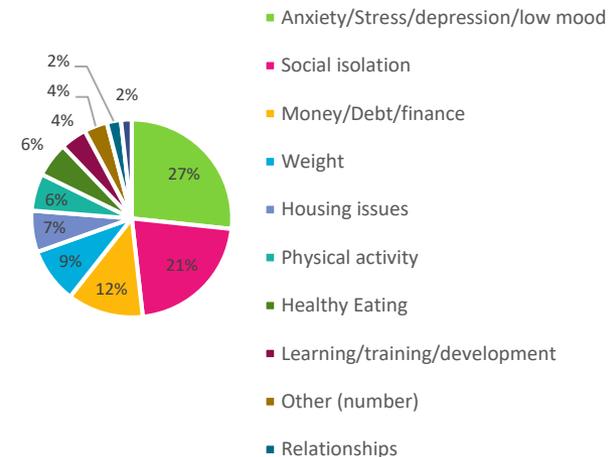
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