

The Voluntary, Community & Social Enterprise (VCSE) Sector's Role in Supporting Social Prescribing

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VCSE role in Health, Wellbeing & Care

- ‘VCSE sector has significant expertise that is invaluable in helping us achieve improvements across the health, social care and public health system’ *Department of Health, NHS England and Public Health England*
- Support focus on early intervention, prevention & self care/management – NHS & LA (Care Act)
- Key to NHS strategic shift - acute care > prevention, community based care & support & self management



Joint review of role of the VCSE sector in improving health, wellbeing and care outcomes & partnerships

Department of Health, Public Health
England, and NHS England



The VCSE supporting health & wellbeing and tackling inequalities

No wrong door -The sector's strength lies in its holistic, community-embedded and personalised approaches.

Track record of trust – local people trust us!

VCSE organisations **promote understanding of the specific needs of their communities.**

Its **diversity, flexibility** and level of **innovation** helps it reach and support those **hardest to engage**

Builds **emotional resilience** and promotes **self-care** and **independence**

Facilitate **asset based approaches** and **co-production**

Expertise of **lived experience** in designing more effective, sustainable **services**

VCSE Review

Investing in partnerships for
health and wellbeing



NHSE Five Year Forward View



NHS England Commitment:

“ We will work collaboratively with the voluntary sector and primary care to design a common approach to self-care and social prescribing, including how to make it systematic and equitable”

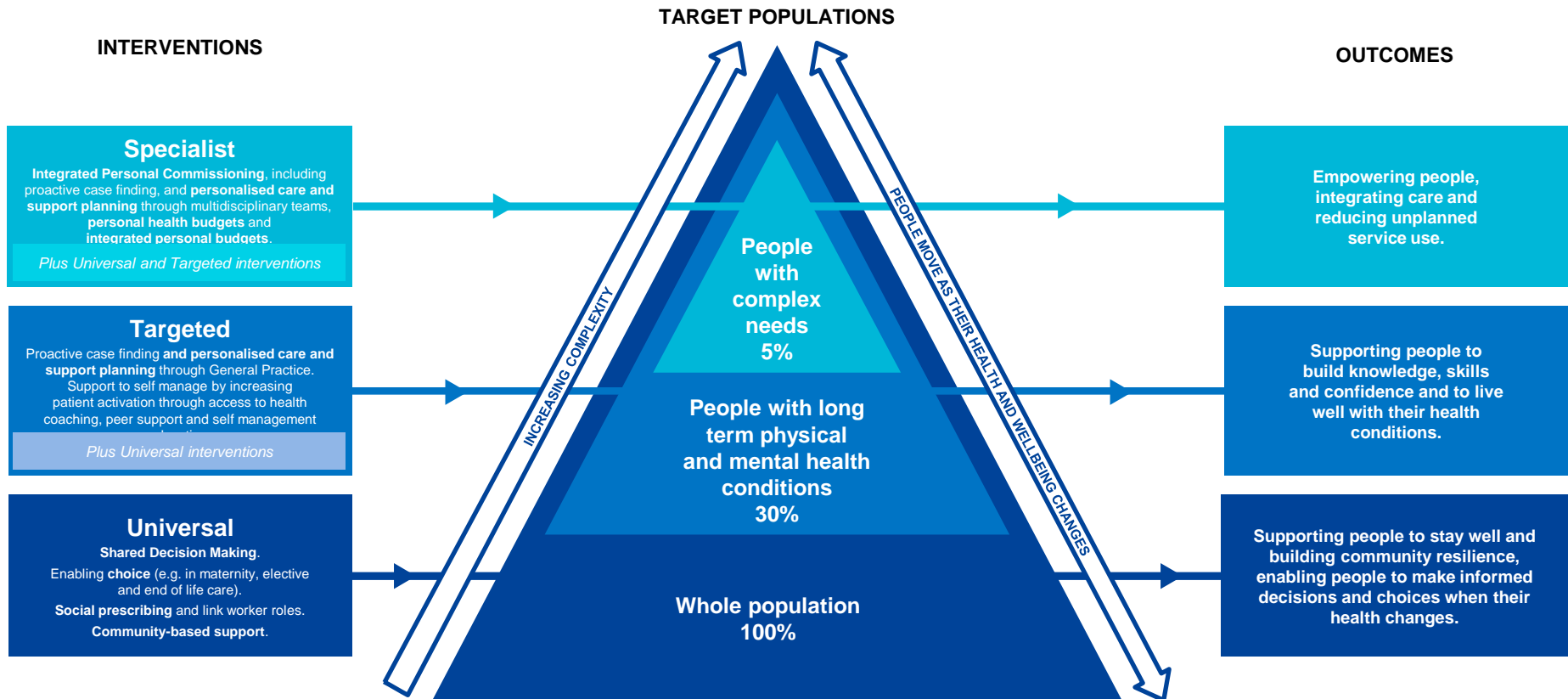
(p.45 Next Steps for the Five Year Forward View)

Social prescribing is listed as one of the ten high impact actions in the General Practice Forward View



Comprehensive Model for Personalised Care

All age, whole population approach to Personalised Care

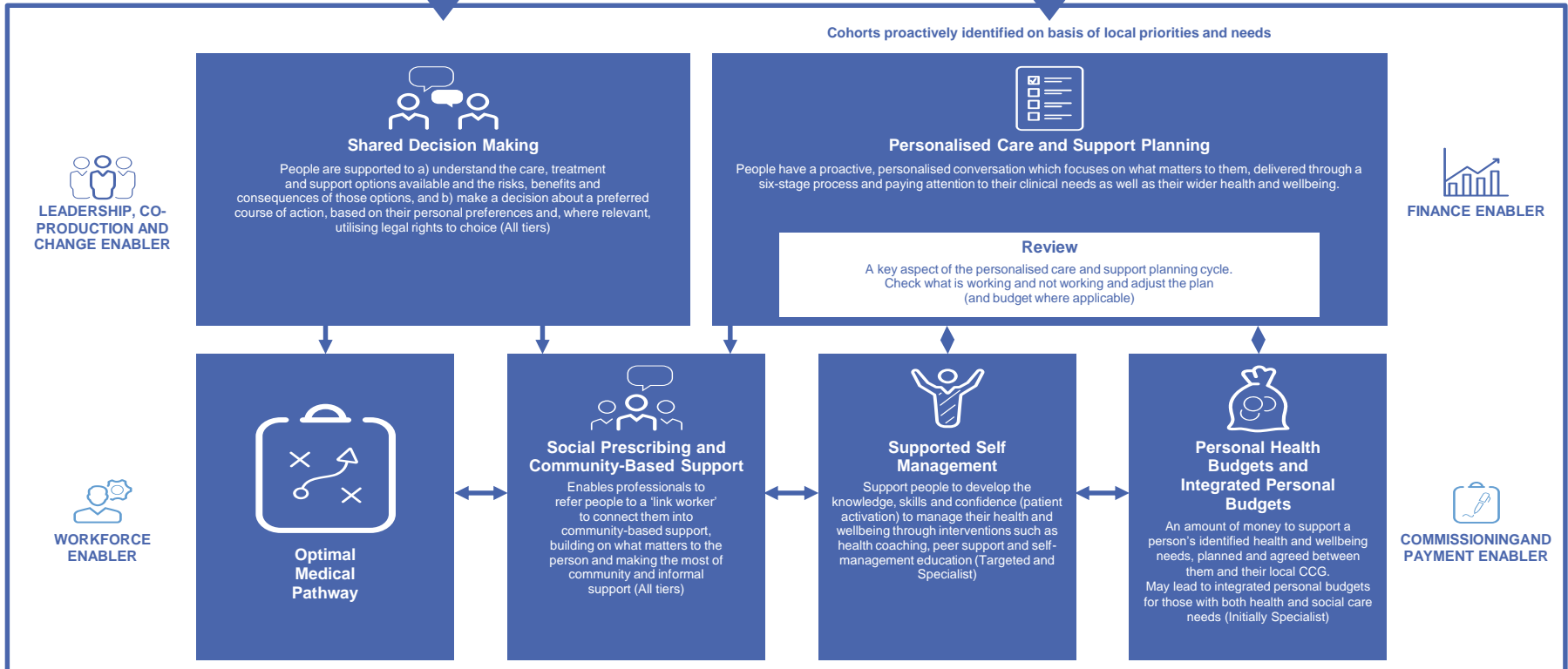


Personalised Care Operating Model

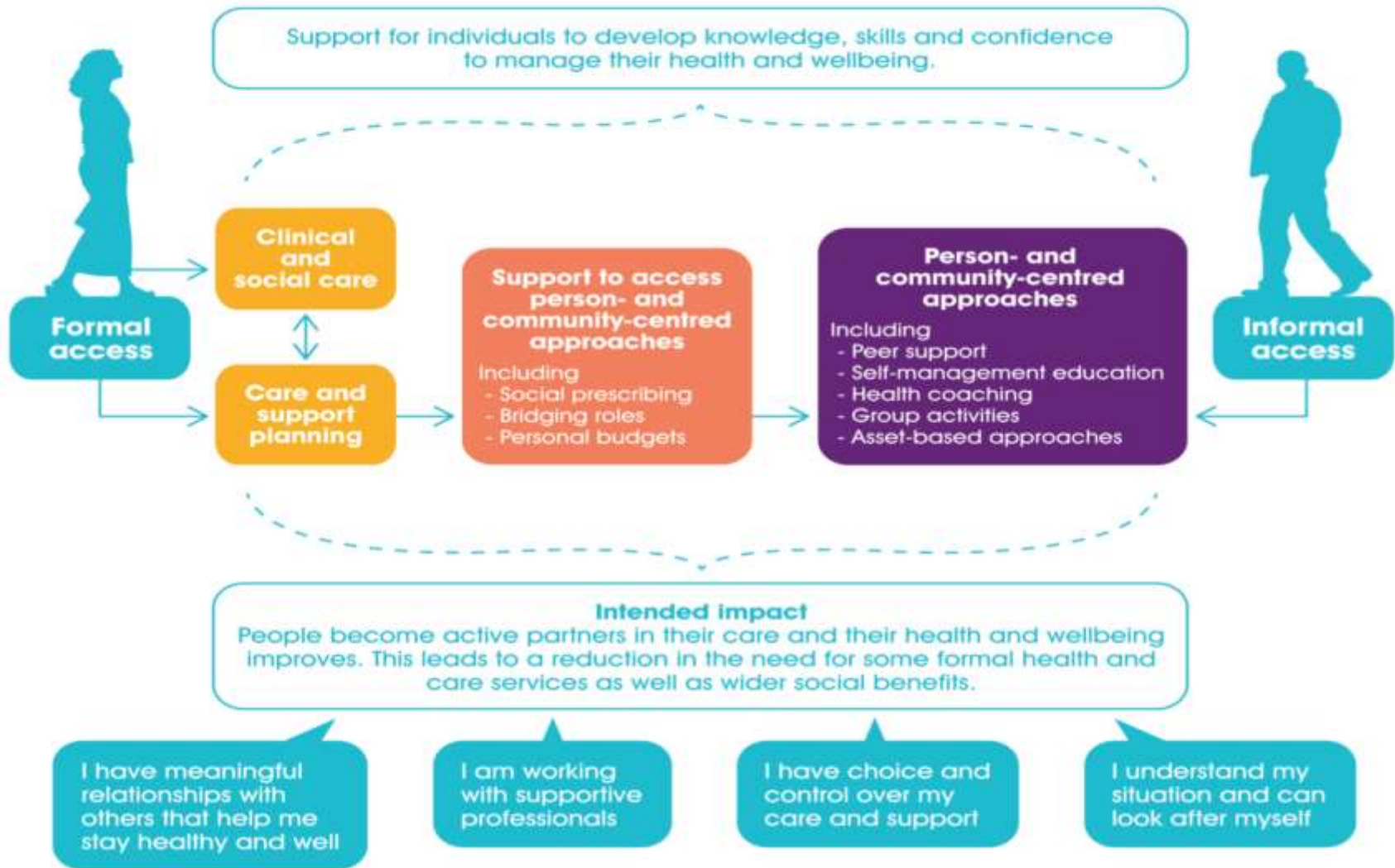
WHOLE POPULATION
when someone's health status changes

30% OF POPULATION
People with long term physical and mental health conditions

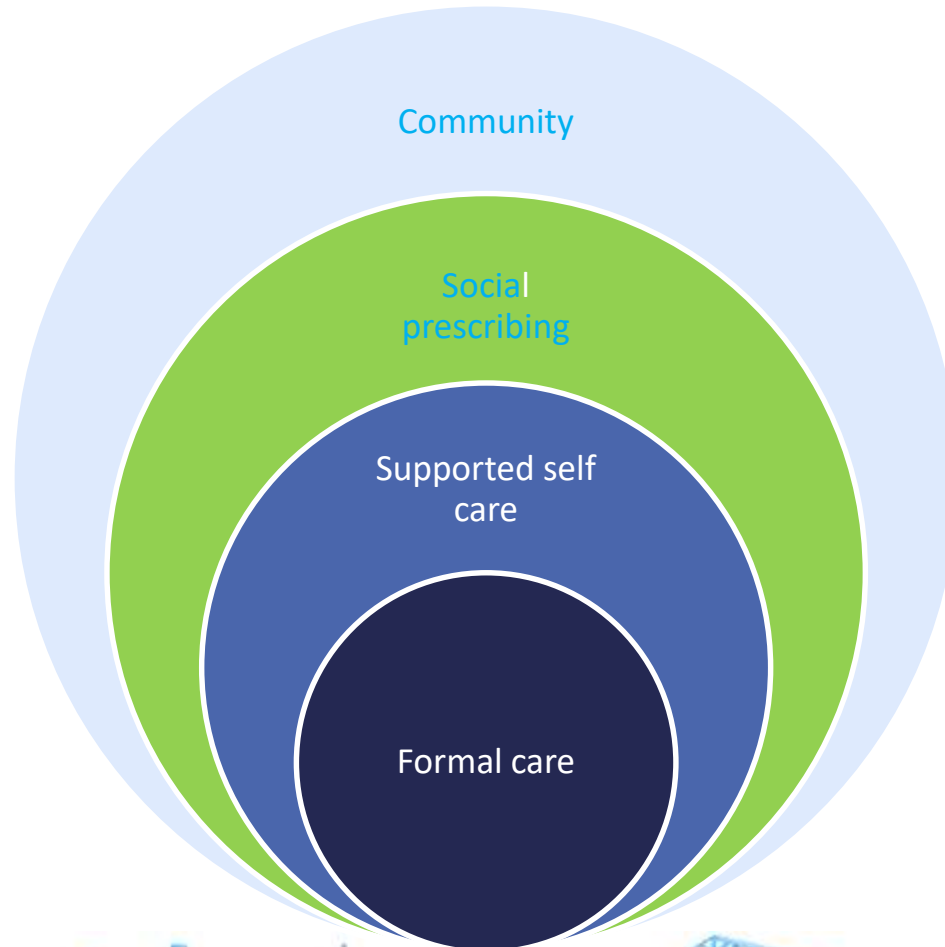
Cohorts proactively identified on basis of local priorities and needs



Person and Community-Centred Approaches



Asset based approaches and health creation



The High Impact Action:

Social Prescribing

Why Social Prescribing?

- Reduces pressure on General Practice and A&E
- Improves support for people with wider 'social' needs
- Reduces health inequalities – for those who use the NHS the most, complex needs

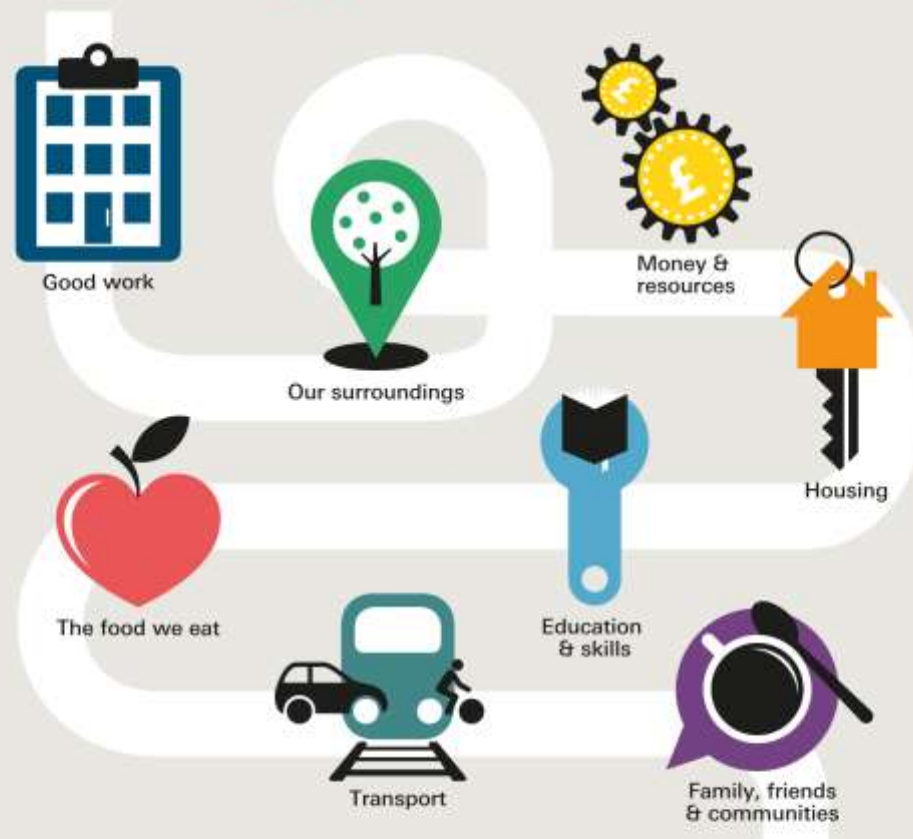


What makes us healthy?

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





Five ways to wellbeing



Why Social Prescribing

- 'I've got six things wrong with me, I'm on 10 different drugs, I've been in and out of hospital for years, but the biggest problem I suffer from is 'four-walls-itis'
- 'As a local GP social prescribing has been one of the most significant improvements in my ability to care for my patients in recent years. The noticeable improvement in people, who have been struggling with long term problems both mental and physical that had seemed to have reach the end of what medicine could offer them, is remarkable.'



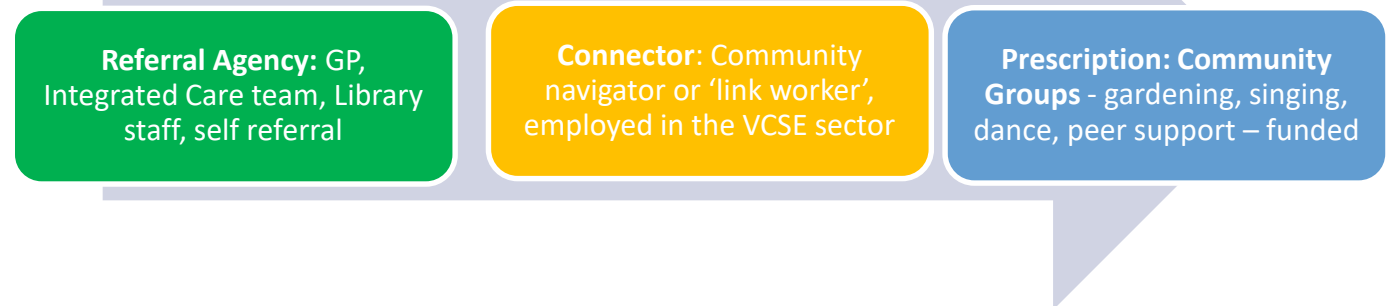
Social Prescribing Connector Scheme Definition

‘Enabling healthcare professionals to refer patients to a link worker, to co-design a non-clinical social prescription to improve their health and wellbeing.’



The High Impact Action: Social Prescribing Models

1. Referral to a commissioned 'one-stop connector service'



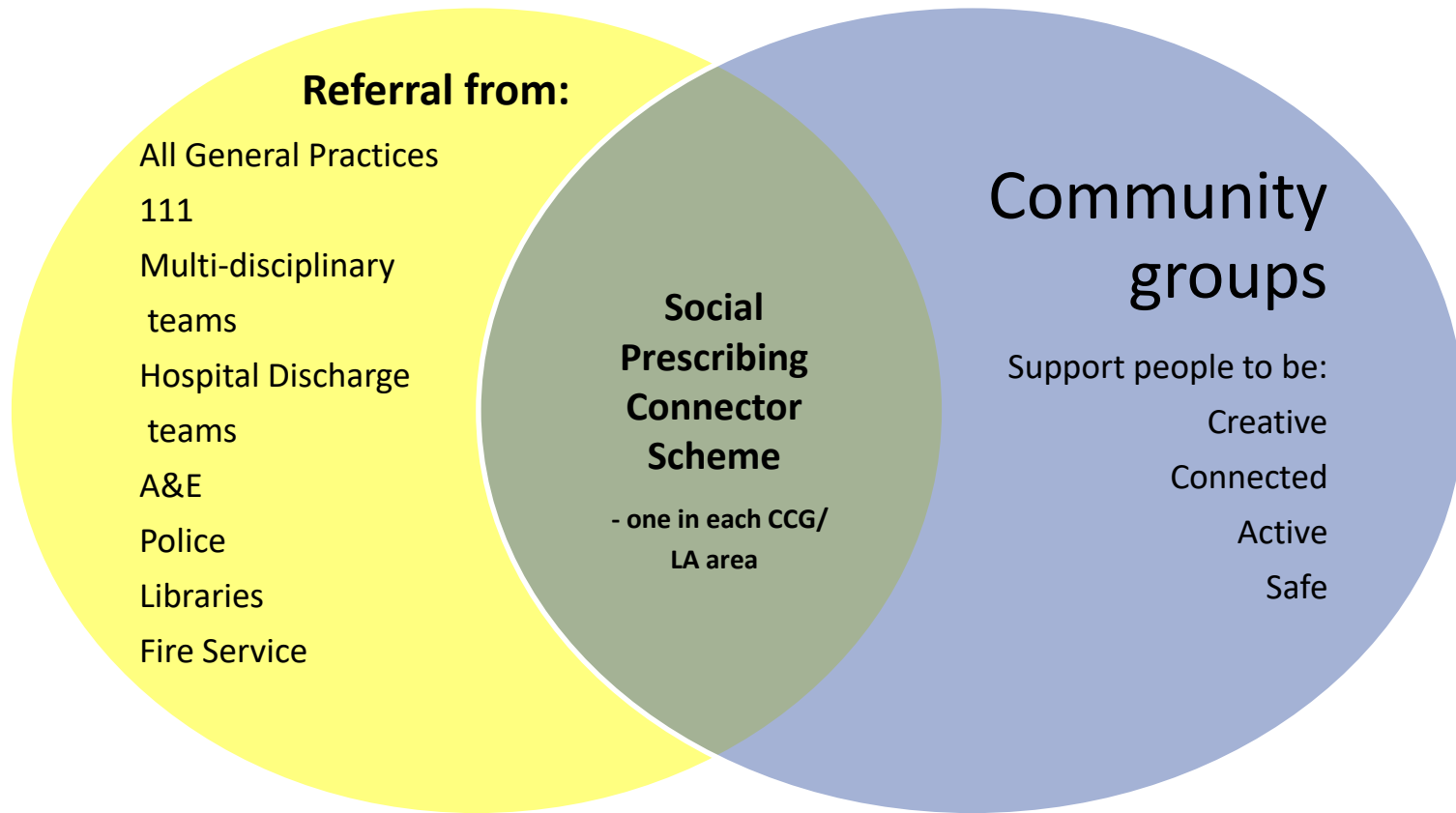
2. **Collaborative Practices:** GP surgeries as community 'hubs', invite citizens in to work collaboratively, as 'health champions'.

3. **In-house 'link workers/ navigators'** – employed by GP Practices.

4. **Active Signposting:** 'Care Navigators' in GP practices, having different conversations with patients, signposting them to community support, as well as pharmacy, physiotherapists and care providers.



Social Prescribing – the Universal Offer

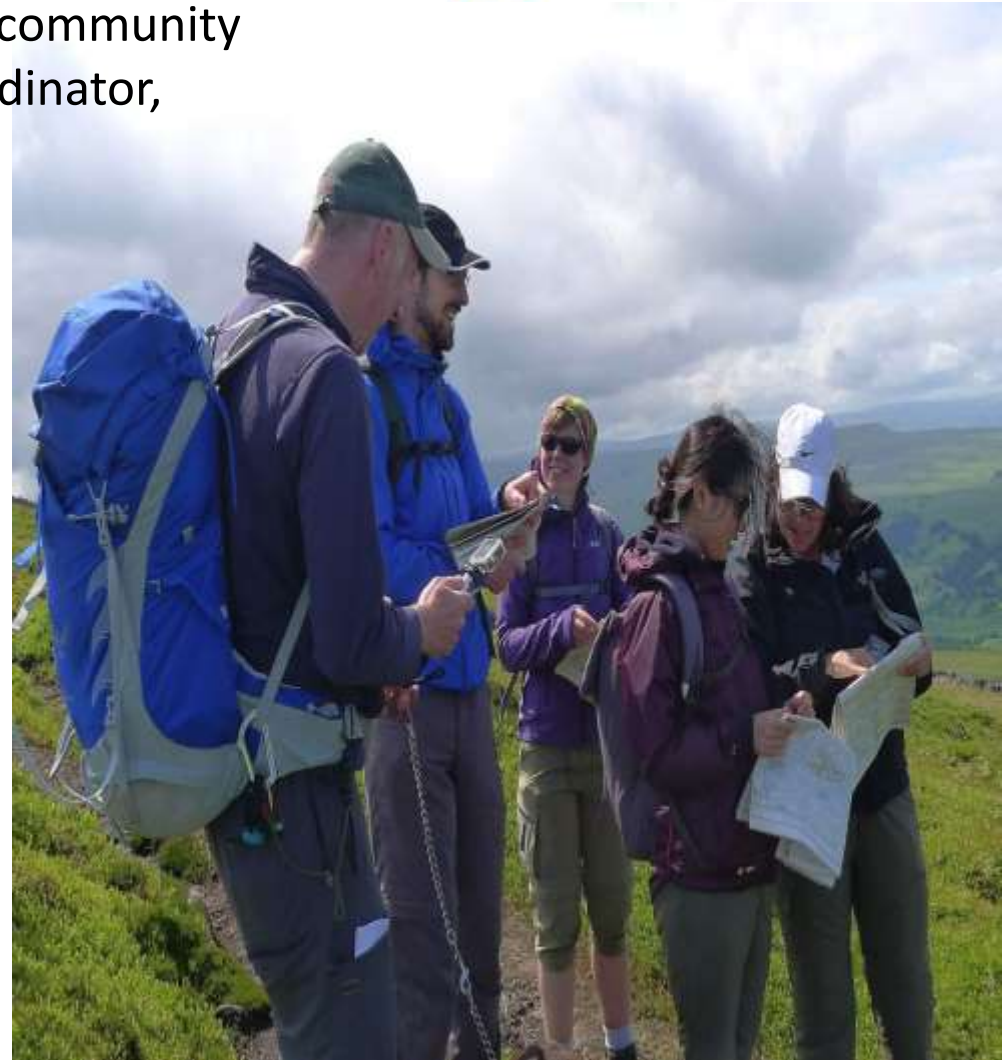


Social prescribing connector schemes enable referrals to Link Workers. Normally hosted in VCSE sector, commissioned by CCGs/ LAs. Link workers give people time, co-produce support plans and practically connect people to community groups. NHS England wants every local area to have a social prescribing connector scheme, which enables all GPs to refer people with wider needs.



Link Worker : health trainer, care navigator, community connector, community navigator, social prescribing co-ordinator,

- Link worker role isn't just signposting or navigating
- Builds relationship and empathy with patients
- Enabling and supporting a patient to assess their needs
- motivate and support individuals to achieve the change(s) that they want to achieve
- Co-producing solutions for them making use of appropriate local resources
- Provides continuity and support



Social Prescribing Activities

- Often delivered by smaller community groups at neighbourhood level
- THE VCSE at local level requires funding to sustain and to absorb increased demand via social prescribing



Hub & Spoke

Local Infrastructure orgs (local CVS/Development Agencies) can be a gateway/broker to community support groups & services and support social prescribing pathway



The challenges: the sector is struggling

- More demand for services & support
- Less money and fewer staff
- Core activity not funded through contracts
- Larger contracts /Gov Grant/EU programmes prohibitive to smaller VCS orgs
- Payment by results type contracts
- Procurement process prohibitive



Developing services and policies together

- Many small organisations are struggling to make links with and gain acceptance among local GPs and commissioners.
- For health and wellbeing to be community-based and collaborative, statutory systems need to learn to work with the VCSE sector- large and small
- Co-production requires “mutual respect between commissioners and VCSE organisations”

The One Stop Connector Model

We know that:

- Nearly half of all Clinical Commissioning Groups (CCGs) are investing in social prescribing 'connector' programmes.
- Social prescribing is included in 75% of Sustainable Transformation Plans (STPs).
- 1 in 5 GPs regularly refer patients to social prescribing. 40% would refer if they had more information about available services (July 2017, GP Online Survey).
- All GPs are able to refer to social prescribing 'connectors' across Gloucestershire, Rotherham, Bassetlaw, City & Hackney, Dudley, Leeds, Halton and Tower Hamlets CCG areas



Impact

On the NHS: On GP consultation rates, A&E attendance, hospital stays, medication use, social care.

University of Westminster led an evidence review, looking at the impact of social prescribing on demand for NHS Healthcare.

Average of 28% less GP consultations & 24% less A&E attendances, where social prescribing 'connector' services are working well.

<https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network>



The 'Rotherham Model' **VONNE** voluntary organisations' network north east

- Voluntary Action Rotherham (VAR) on behalf of the CCG delivers 2 Social Prescribing (SPS) programmes.
- LTC programme works with all GP practices as part of the integrated case management approach. Patients are identified as part of the MDT, over 75's health check & GP discretion. Referred to a VCS adviser aligned to each GP practice. Operating since 2012. Over 7,500 referrals
- VAR is the contract body and acts as the Single point of contact and contracts with a range of VCS organisations
- Team of 11 includes 8 link workers who work at VAR as well as GP practices
- Funding comes via the CCG and is part of the Better Care Fund



What the evidence is showing us – impact on health & demand

- **Health and wellbeing** – Over 80% improvements for LTC patients and over 90% for MH service users. Over 72% of all SPS patients are referred on to a service to help tackle loneliness & isolation
- **Reduction in demand for services** – for the LTC service consistent reductions in use of services 6-11% reduction in non elective inpatient stays and 13-17% reduction in use of A&E services. MHS - over 50% discharge from services for those eligible for discharge review
- **Impact on GP time** – pilot study shows 28% reduction in face to face appts 14% reduction in telephone appts – findings are consistent with others across country. Helps patients manage symptoms, supports carers, impact on medication usage
- **Financial savings** – cost avoidance and return on investment plus significant additional benefits to patients/ users & sector



Social Prescribing – Learning Challenges/ Successes

- Truly person centred care needs a non clinical approach to sit alongside a clinical approach. Integrated care is often seen as health and social care service integration.
- It has developed organically/ locally and differently across the country – it can appear ‘messy’ it needs NHS/ CCG/ LA to have a leap of faith to really work differently.
- Funding/ money flows need to change to really support integration and innovation –Integrated Care Partnerships and Place Based working is key
- Link workers are vital and signposting can work but it is only as good as the VCS capacity to deliver and be signposted too. The VCS is not a sponge to soak up Public Sector cuts and increased demand



Challenges moving forward

How to enable the spreading of social prescribing but with limited funds

Supporting shared leadership - nurture bottom-up collaborative partnerships

We should **not assume the voluntary sector is free and always there** – build in support and funding. SP requires an asset-based approach

‘Link worker’ connector model is key – they have time to find out what really matters to people and connect them with community support

Building the evidence base – everyone measuring the same things – so that we can make long-term comparisons

We should not over-professionalise social prescribing – it’s about **human relationships – putting community and people at the centre**



What Social Prescribing means to patients

'Before social prescribing I was very isolated, shut off from the world, struggling to leave the house, lost , helpless battling every day to keep going. Nothing to live for, nothing to get up for, nothing to get ready for, nothing to do, nowhere to go. There's no point in being stuffed full of tablets if you have no purpose in life, this has given me a light to my life. Kerching!'



Resources

'Making Sense of Social Prescribing' - Guide

<https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network>

National Social Prescribing Network

email: socialprescribing@outlook.com

<https://www.westminster.ac.uk/social-prescribing-network>

NHS England – On Line platform & register for NE Events

Email: england.socialprescribing@nhs.net

North East Social Prescribing Regional Facilitator:

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