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

Jane Hartley Chief Executive VONNE
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.
NHSE Five Year Forward View

Six principles for engaging people and communities

1. Care and support is person-centred: Personalised, coordinated, and empowering
2. Services are created in partnership with citizens and communities
3. Focus is on equality and narrowing inequality
4. Carers are identified, supported and involved
5. Voluntary community and social enterprise, and housing sectors are involved as key partners and enablers
6. Volunteering and social action are key enablers
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

**INTERVENTIONS**

**Specialist**
Integrated Personal Commissioning, including proactive case finding, and personalised care and support planning through multidisciplinary teams, personal health budgets and integrated personal budgets. 
*Plus Universal and Targeted interventions*

**Targeted**
Proactive case finding and personalised care and support planning through General Practice. Support to self-manage by increasing patient activation through access to health coaching, peer support and self-management.
*Plus Universal interventions*

**Universal**
Shared Decision Making
Enabling choice (e.g., in maternity, elective and end of life care). Social prescribing and link worker roles. Community-based support.

**TARGET POPULATIONS**

- People with long term physical and mental health conditions: 30%
- People with complex needs: 5%
- Whole population: 100%

**OUTCOMES**

- Empowering people, integrating care and reducing unplanned service use.
- Supporting people to build knowledge, skills and confidence and to live well with their health conditions.
- Supporting people to stay well and building community resilience, enabling people to make informed decisions and choices when their health changes.
Personal Health Budgets and Integrated Personal Budgets

An amount of money to support a person’s identified health and wellbeing needs, planned and agreed between them and their local CCG. May lead to integrated personal budgets for those with both health and social care needs (Initially Specialist).

Supported Self Management

Support people to develop the knowledge, skills and confidence (patient activation) to manage their health and wellbeing through interventions such as health coaching, peer support and self-management education (Targeted and Specialist).

Social Prescribing and Community-Based Support

Enables professionals to refer people to a ‘link worker’ to connect them into community-based support, building on what matters to the person and making the most of community and informal support (All tiers).

Personalised Care and Support Planning

People have a proactive, personalised conversation which focuses on what matters to them, delivered through a six-stage process and paying attention to their clinical needs as well as their wider health and wellbeing.

Shared Decision Making

People are supported to a) understand the care, treatment and support options available and the risks, benefits and consequences of those options, and b) make a decision about a preferred course of action, based on their personal preferences and, where relevant, utilising legal rights to choice (All tiers).

Review

A key aspect of the personalised care and support planning cycle. Check what is working and not working and adjust the plan (and budget where applicable).

Optimal Medical Pathway

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

Support for individuals to develop knowledge, skills and confidence to manage their health and wellbeing.

---

**Clinical and social care**

**Formal access**

**Care and support planning**

**Support to access person- and community-centred approaches**

- Social prescribing
- Bridging roles
- Personal budgets

**Person- and community-centred approaches**

- Peer support
- Self-management education
- Health coaching
- Group activities
- Asset-based approaches

---

**Intended impact**

People become active partners in their care and their health and wellbeing improves. This leads to a reduction in the need for some formal health and care services as well as wider social benefits.

---

I have meaningful relationships with others that help me stay healthy and well

I am working with supportive professionals

I have choice and control over my care and support

I understand my situation and can look after myself
Asset based approaches and health creation

- Community
- Social prescribing
- Supported self care
- Formal care
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:

Good work

Our surroundings

Money & resources

Housing

The food we eat

Education & skills

Transport

Family, friends & communities

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

References available at www.health.org.uk/healthy-lives-infographics

© 2017 The Health Foundation.
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’

Referral Agency: GP, Integrated Care team, Library staff, self referral

Connector: Community navigator or ‘link worker’, employed in the VCSE sector

Prescription: Community Groups - gardening, singing, dance, peer support – funded

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


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 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
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’

• 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:
Jane Hartley Jane.hartley@vonne.org.uk @VONNEjane