scie social care institute for excellence

in collaboration with Integration and Better Care Fund

Better Care Fund resources

Social prescribing – linking with primary care

Scheme

Who?

Central Bedfordshire Social Prescribing Service

Bedfordshire Rural Communities Charity (BRCC)

What

This project enables GPs, nurses and other primary care professionals to refer people via social prescribing (SP) to a range of local, community-based, non-clinical services via a community wellbeing champion (CWC).

Why?

Twenty per cent of patients consult their GP/health care professional for a social problem (Citizens Advice report). By supporting people to access local voluntary and other services, SP can help people to be healthier, more confident, more independent and

more connected to their community.

The benefits of SP can include:

- reduction in GP appointments
- reduction in patients' reliance on other NHS services
- better integration of services and joined-up working.

When?

The project started in August 2018 with the first wave of 10 GP surgeries in November and December 2018 followed by another 2 GP surgeries in January 2019.

How?

In first three months, the team of three full-time and two part-time staff:

- established relationships with Bedfordshire Clinical Commissioning Group (CCG) SP lead
- established relationships with primary care
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In addition, in August and September the team:

- recruited five CWCs
- engaged in an extensive community asset mapping exercise
- identified gaps in services and started setting up groups
- built relationships with community groups.

The CWCs then started a health coaching course.

October 2018

- GP practice meetings and increased engagement work
- referral form on SystmOne.

November 2018

- first wave of GP practices launched
- CWCs completed health coaching course.

December 2018

- next wave of GP practices launched
- further multidisciplinary team work in surgeries to increase referrals.

January 2019

- two further GP surgeries launched NHS email.

Challenges

- Capacity within the voluntary and community sectors may be insufficient to cope with the rising demand.
- Some initial resistance from GPs. Some practices were slow to make referrals.
- There is an increase in the number of referrals with complex needs (multiple issues needing number of individual referrals) – service capacity, staff turnover risk.
- NHS email account issues have impacted initially on the engagement of primary care and referrals.

Impact

It is early on in project, but we can identify:

- 10 GP practices participating since November 2018
- two further GP practices engaged in next rollout phase
- 138 referrals in an eight-week period (complex, multiple needs).

Case study

Mr S, a 73-year-old retired policeman, was referred for a specialist paramedic (SP) assessment by the community matron. He has Parkinson's disease and speech and mobility issues. He was at that time depressed, socially isolated and was not taking his medication.

Although he had been very active and sociable, he had lost touch with friends, stopped going out, had experienced some falls, needed help washing and dressing and was too frightened to move out of his chair. His wife who cared for him was stressed and depressed. Mr S came to the SP assessment with his wife. He said his dreams and wishes were to be:

- socially active
- confident to play snooker and pool
- to speak louder with more confidence
- to walk with his wife and dog.

The social prescribed interventions were:

- introduction to a coffee morning group and a 'Men In Sheds' group (Good Neighbour Scheme)
- joint visit to disability resource centre for walking aids – client booked visit
- discussion of occupational therapy assessment (home adaptions – getting around safely, easing carer's duties); CWC met with community matron and arranged referral
- CWC spoke to local Parkinson's advisor, offered home visit and Parkinson's group information in Leighton Buzzard (exercises to help with speech) (client booked visit).

These interventions helped Mr S to gain confidence and to lead a much fuller life.

View all practice examples link 1

link 1 | https://www.scie.org.uk/integrated-care/better-care/practice-examples