Hertfordshire

NHS
Herts Valleys
Clinical Commissioning Group

‘Social Prescribing’

Connecting People for Health

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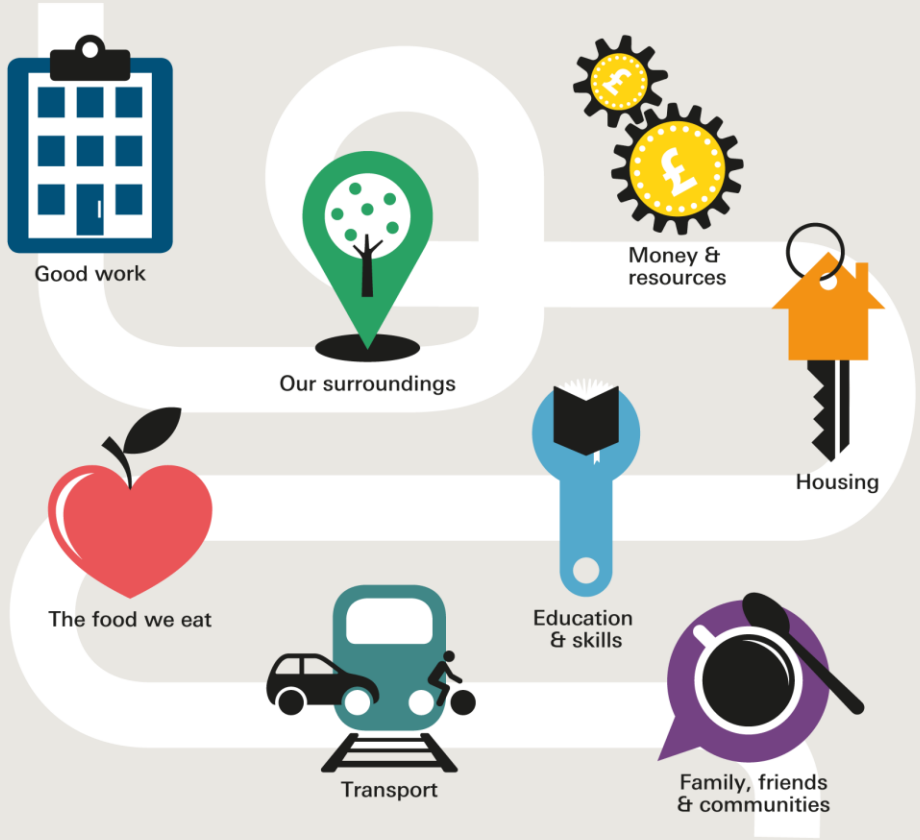
HertsHelp

Not Rocket Science

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

The Health Foundation

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

Loneliness Strategy: A Connected Society

- …'social prescribing' will allow GPs to direct patients to… tailored support to help people improve their health and wellbeing, instead of defaulting to medicine
- …funding will be provided to connect patients to a variety of activities…reducing demand on the NHS and improving patients' quality of life

UNIVERSITY OF WESTMINSTER

Making sense of Social Prescribing

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http://westminsterresearch.wmin.ac.uk/19629/

Patient and Doctor In Same Boat?

Hertfordshire and West Essex Sustainability and Transformation Partnership

Mirror image

- He's struggling but how can we get into that in 10 minutes?
- Anyway I don't know what may be out there to help…

- We both know I'm struggling but how can I admit that?
- Anyway I doubt there's support…or I'd have found it by now…

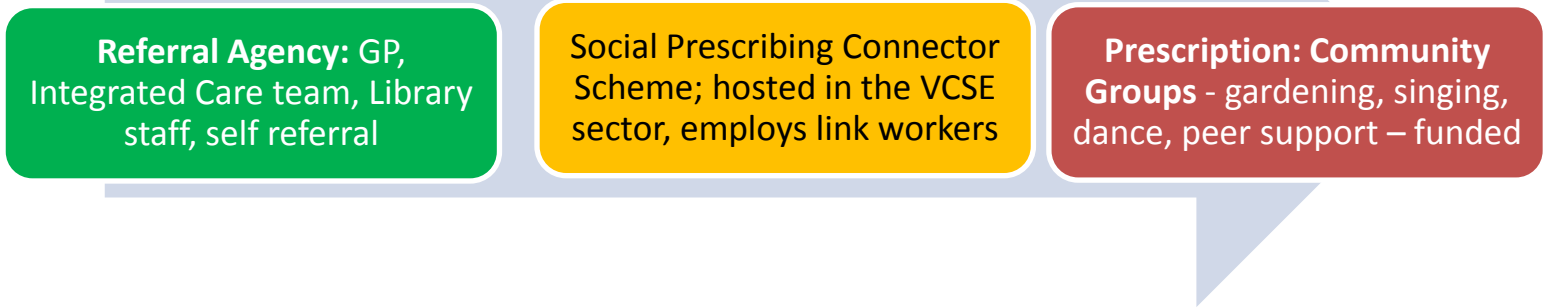
A Healthier Future

Improving health and care in Hertfordshire and west Essex

Social Prescribing Models

NHS England

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 'community link workers/ navigators' – employed by GP practices or federations of 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.

Asset-based community development

- Our aim: ***to enable all GPs across England to refer to a link worker service***, connecting people to community support.

- This only works where the voluntary, community and social enterprise groups are nurtured and supported.

- We need to fund VCSE groups to receive referrals, not just the connectors.

Access to thousands of community groups in Herts

- ✓ **Web** – Hertshelp.net
- ✓ **Text** – HertsHelp to 81025
- ✓ **Email** – info@hertshelp.net
- ✓ **Skype** - HertsHelp
- ✓ **Minicom** on 0300 456 2364
- ✓ **Fax** 0300 456 2365
- ✓ **Telephone** 0300 1234 044 or **Text** HertsHelp to 81025
- ✓ **Face to Face advice** – arrange on 0300 1234 044
- ✓ **Advocacy** – via professional referral
- ✓ **Communication Toolkit** - BSL, Makaton, Braille Service

HertsHelp

0300 1234 044

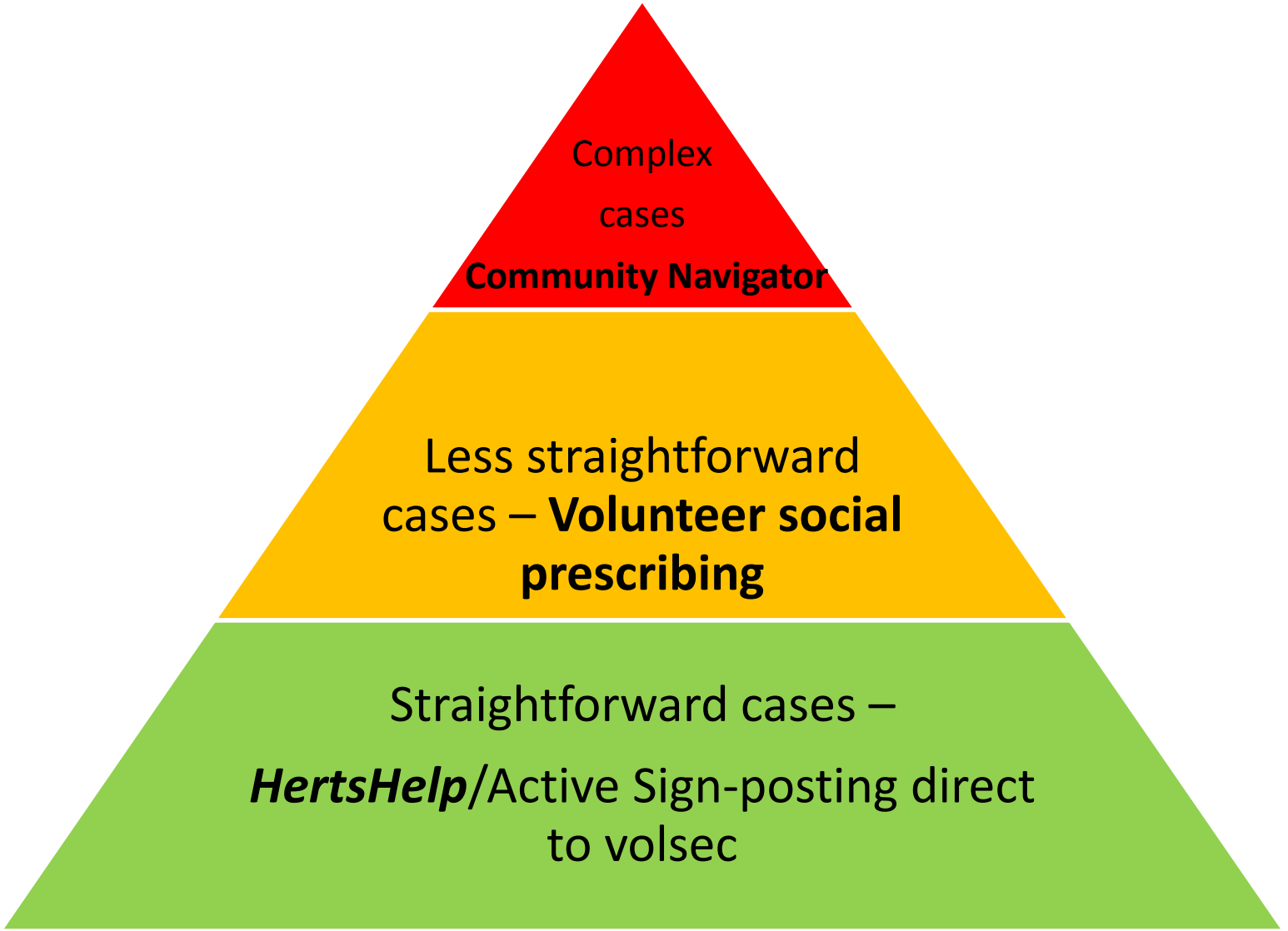
How does it work in Herts?

1. **Health referral** – GP, nurse, consultant, physio etc (usually electronic) – but also social care, housing etc
2. Triaged by ***HertsHelp***
3. **Community Navigator** – 'co-producing' support plan
4. **The prescription**: service/s and connections in community

Key social prescribing service in West Herts = **Community Navigator Service**

For people who don't **need** face to face support ***HertsHelp*** provides the help

Scaling social prescribing with support of local GP-practice-based volunteers



Starts with the person – not the condition

"I had a lady that was invited to a breast screening, who refused to go. So I offered to go with her, and waited with her in the waiting room. Now I know, that next time she is invited she'll go because she'll know what to expect, because it's not the frightening thing that she thought it was".

University of Hull/ Hull York Medical School ***Survey***

- 3,000 people with type 2 diabetes
- Loneliness, stigma, embarrassment, blame, guilt
- Feel they're seen as burden on NHS

'If you have type 2 people think it is your fault, that you haven't looked after yourself properly."

'At Christmas or going out for a friend's birthday it isn't easy to cope with not being able to eat the same food, the same birthday cake as everyone else. So instead – you just don't go out."

What matters to the patient (**My Care and Wellbeing** form)

"Meeting other people who are in similar situations and the incredible warmth and supportiveness of all the "staff" who made it so much more possible to be positive and optimistic about the future."

"…I have never had the chance [before] to discuss myself holistically; to really stop and consider all my needs, physically, mental and spiritual. THANK YOU FROM THE BOTTOM OF MY HEART."

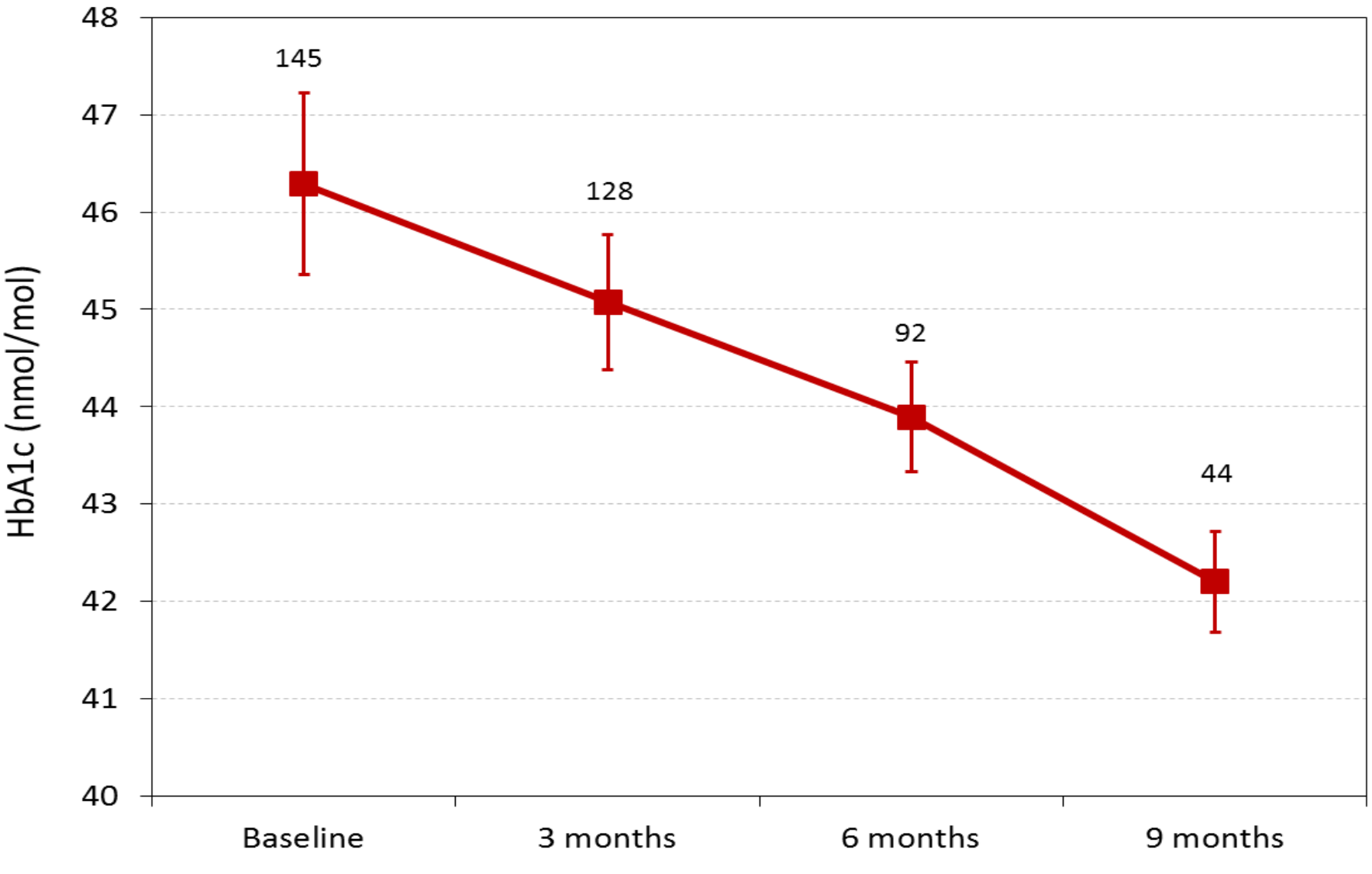
"The most important aspect is the change in the way I think about myself and the compassionate caring I had - I couldn't have made these changes without support and I found the group work especially valuable."

Fig. 5 Examples of 'What has been most important for you?' (MYCaW form)
http://www.pennybrohn.org.uk/wp-content/uploads/2014/08/Polley_et_al_200770a9.pdf

Preliminary results on the use of a "Facilitated Social Prescription" to improve the health outcomes for those with Type 2 Diabetes and those at risk of Diabetes

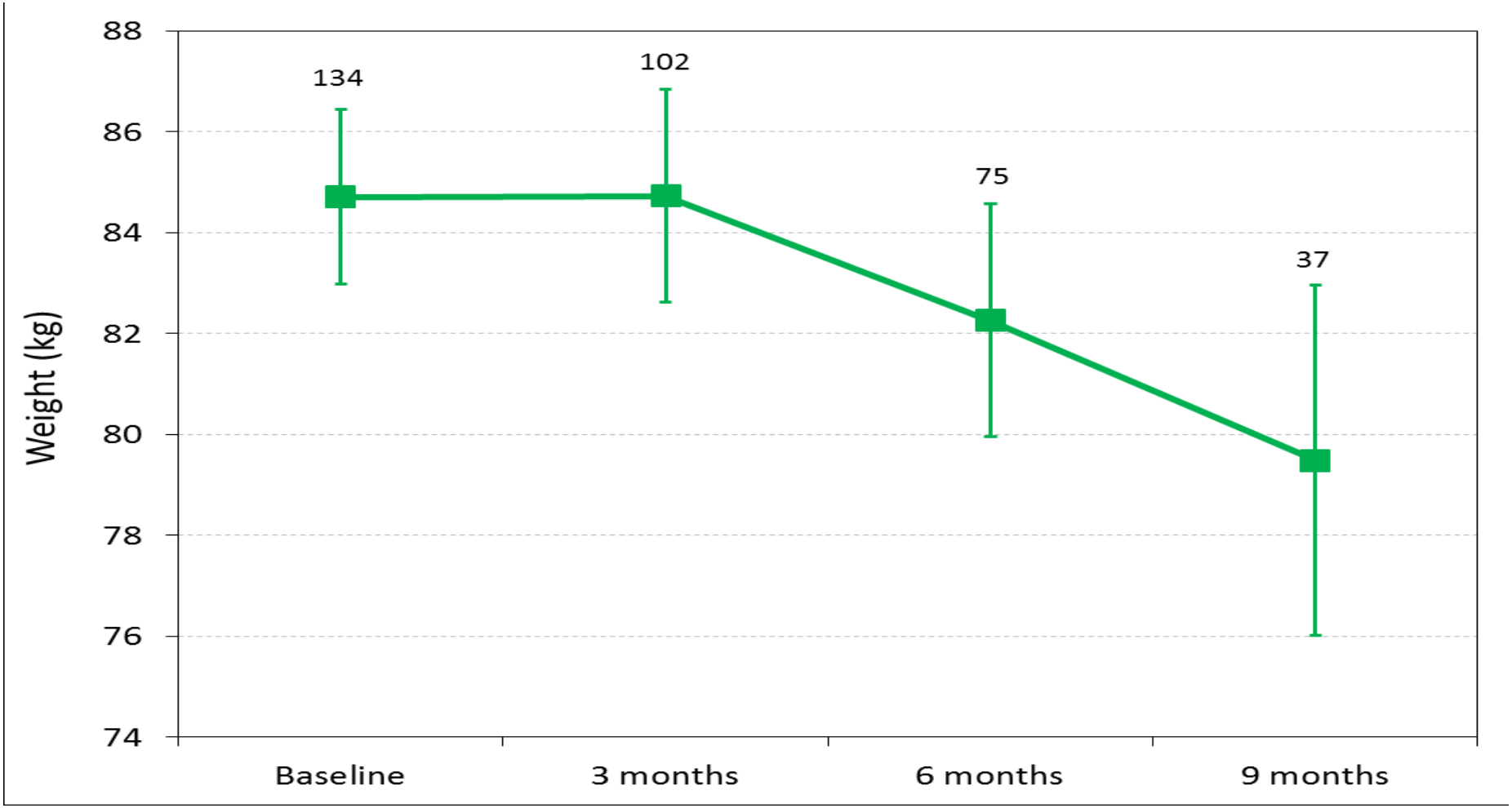
April 2015

Average (+/-SE) HbA1c levels over time

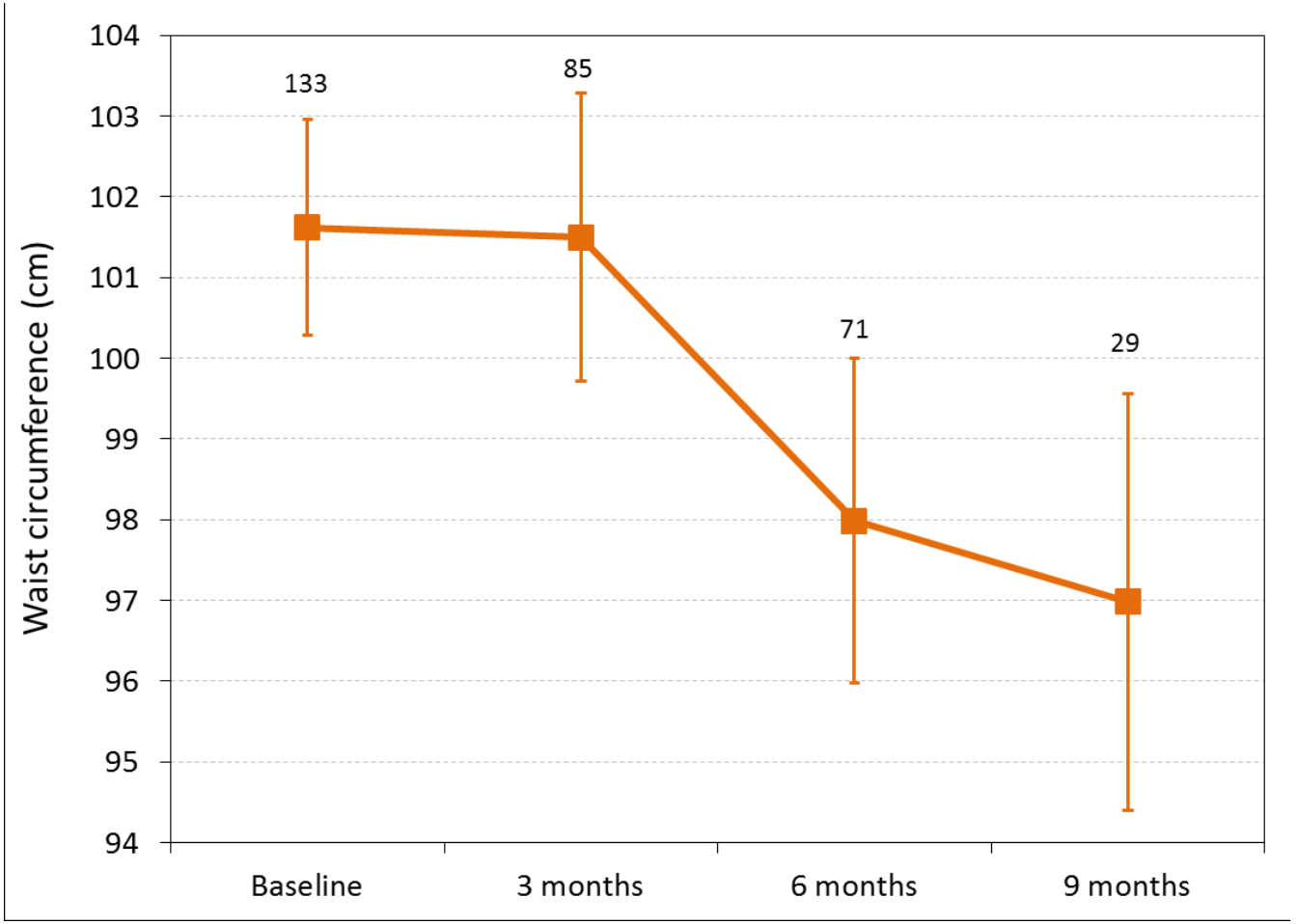


Weight change over time (average +/-SE)

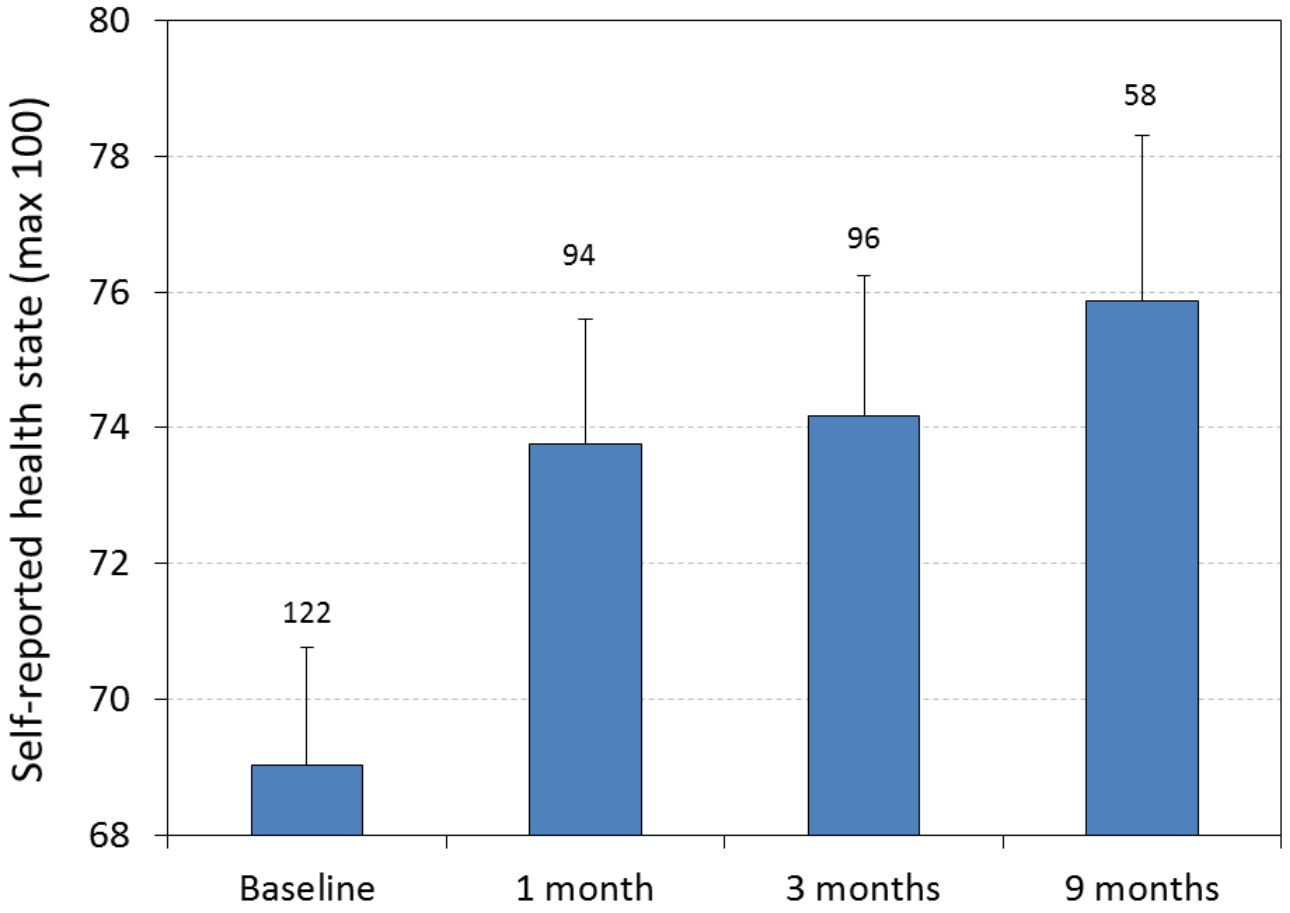
Significant reduction relative to baseline (p≤0.05), 6 + 9 m data not complete



Waist circumference over time (average +/-SE)



Average (+/-SE) Quality of Life Score (EQ5D)



Medicine in its proper place: part of the solution…

https://www.diabetes.org.uk/research/research-round-up/research-spotlight/research-spotlight-low-calorie-liquid-diet

DiABETES UK
KNOW DIABETES. FIGHT DIABETES.

Thanks for listening

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HertsHelp

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