

Northamptonshire

Health and Care Partnership



Social Prescribing at scale across Northamptonshire

EAP Health & Wellbeing and Vulnerable People –

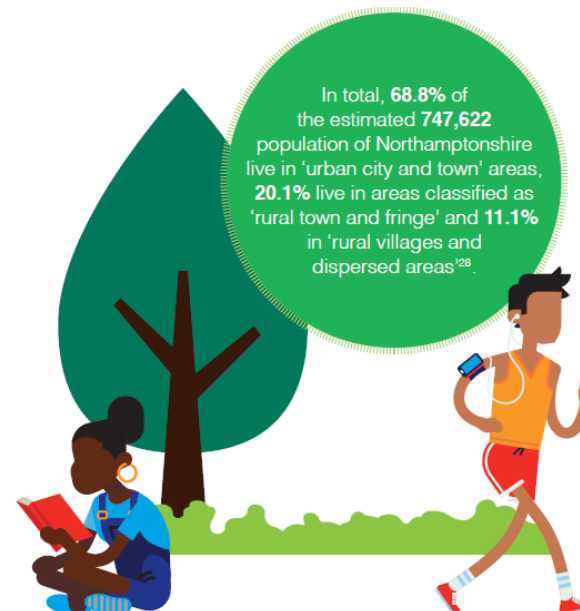
– Stuart Mallett

Our population challenge

Our county is home to nearly 750,000 people, who all lead different lives, have different views of the world and have different health and care needs. It is important to recognise that as our population ages and changes, our care services and processes need to change with them. Our NHS and social care system is not currently able to meet the level and complexity of demand and need within our population. Because of this, we are changing our ways of working, to support the needs of our communities today, and to plan for the needs of our citizens tomorrow.

The changing needs of our population

- We expect the overall population of Northamptonshire to grow 4% by 2024 and 7% by 2029 – above the national average. The biggest increase will be in older people aged over 65 – a 27% increase by 2029. Older people are more likely to be frail or have long-term health conditions.
- We also expect a 6% increase in the number of school age children by 2024. Children have particular health and care needs so we need to make sure we are giving them the best possible start in life.
- People living in deprivation are more likely to experience poorer health and wellbeing. In Northamptonshire, more than 105,000 people are living in the 20% most deprived areas of the country.
- People living in the poorest parts of Northamptonshire have a shorter life expectancy and will live 13 fewer years in good health than in richer areas
- Our county has high rates of unhealthy behaviours such as smoking, poor diet and lack of physical activity, and this also shapes local need for health and care services
- We have high levels of unwarranted clinical variation that leads to worse outcomes for some in our population



Social Isolation

The proportion of people who use health and social care services in Northamptonshire who report that they had as much social contact as they would like (44%*) is similar in Northamptonshire compared to the national average (46%).

Only 1 in 3 (32%*) adult carers in Northamptonshire also reported they had as much social contact as they would like.

Source: MEL Northamptonshire Mental Wellbeing Survey 2016 Final Report 18th May 2016.

Personal Wellbeing



Source: Northants scores from ONS Personal Wellbeing 2019 Northamptonshire Data

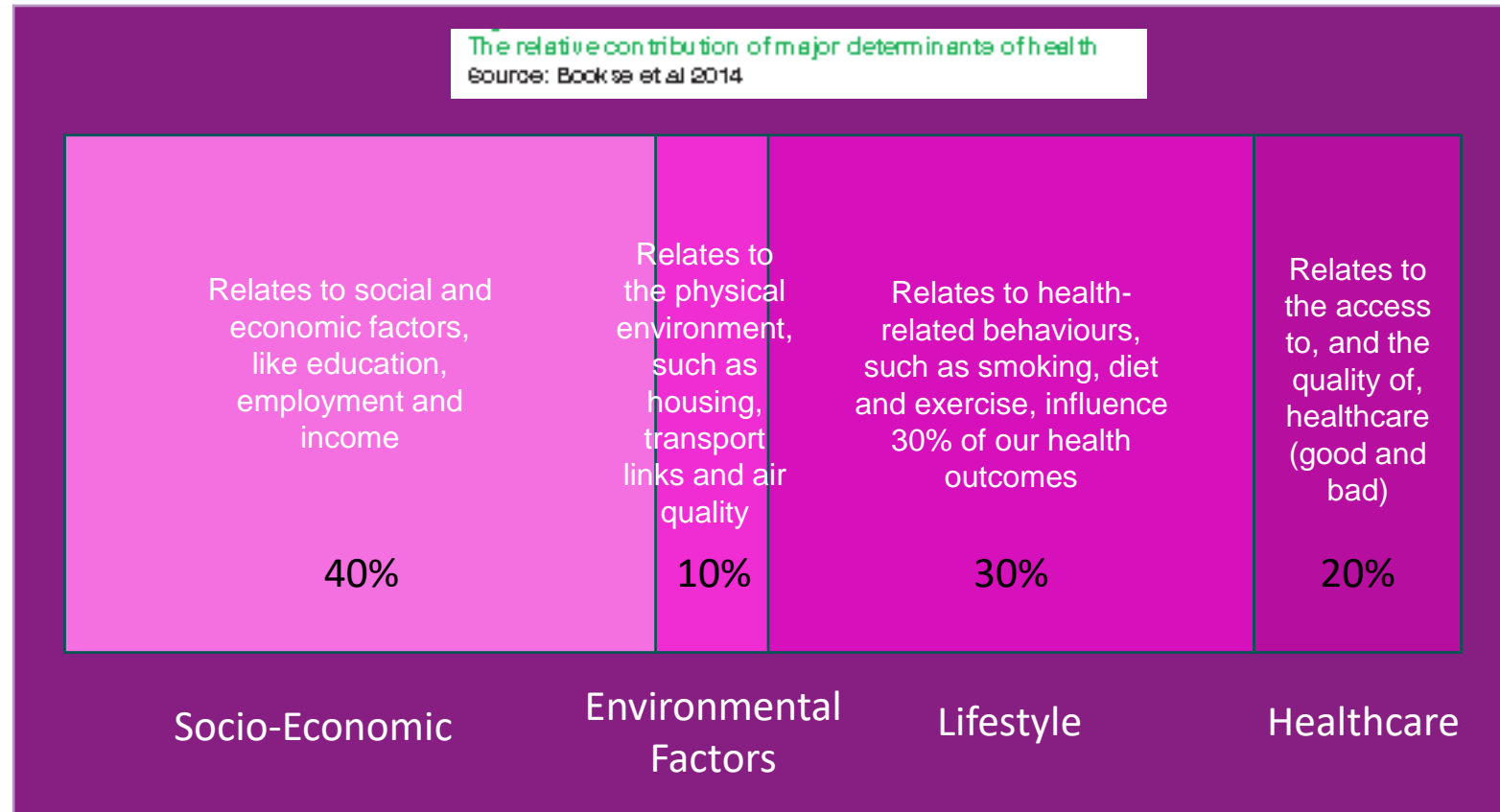
Wider determinants challenge

Our health is determined by our genetics, lifestyle, the healthcare we receive and our wider economic, physical and social environment. Although estimates vary, these wider determinants of health have the largest impact.

To enable our communities and residents to truly flourish, we need to understand what drives our health and wellbeing. The circumstances in which people are born, grow, live, work and age provide the foundations for people to live healthy or unhealthy lives.

To make sure that our towns, villages, communities and economy are all having a positive impact on health and wellbeing, and not limiting residents' ability to thrive, we will look to 'left-shift' our health and care provision and can employ a "Health in all Policies" approach.

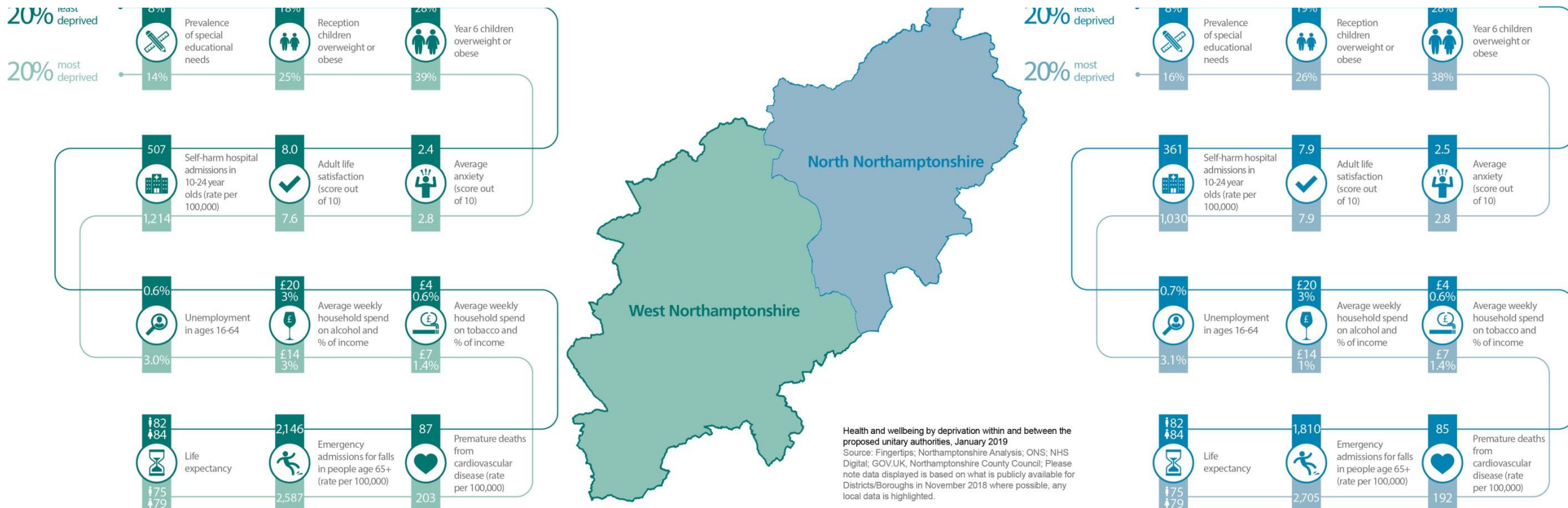
By taking a 'Health in all Decisions' approach, across our ICS, we can create environments that support and encourage our population to make positive health choices



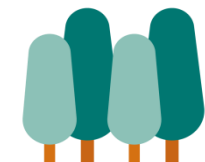
The NHS will need to support the broader economic and social development agenda

Health inequalities challenge at place

Where you were born in Northamptonshire makes a difference to how long you are likely to live. A male in Northamptonshire can expect to live an average of 80 years and a female an average of 83 years. This is similar to the national average. However, males born in the most deprived part of Corby have an average life expectancy of 73 years, compared to males born in the wealthier area of Spratton who live an average of 83 years. Similarly, females born in Corby Central live to an average age of 78, while others born in Towcester Mill live to an average age of 87. **The diagram below shows the differences in life expectancy and lifestyle risk factors at place level (North & West Northamptonshire). Whilst noting the figures appear to be similar at this level, as described in the example above the variation and differences become larger when comparing at Locality and Neighbourhood level.**



**How can we help people
to help themselves and
bend the trend from
medicalisation to
socialisation?**



What is Social Prescribing?

What is Social Prescribing?

Social Prescribing (or 'Community Referral') is a way for practices to refer patients with social, emotional or practical needs to a wider range of non-clinical and local services to support patients.

Who is Social Prescribing for?

There is no defined list of who you should prescribe for, but several recent pilots in the UK have benefited patients with these characteristics:

- History of mental health problems
- Frequent GP clinic attendees
- Two or more Long-Term Conditions (LTCs)
- Socially Isolated
- Untreatable or poorly-understood LTCs (e.g. chronic fatigue, IBS)
- Patient not benefiting from clinical or drug treatment

What are the benefits?

- A better outcome for the patient
- Less use of GP appointments
- Clinicians can focus on medical issues
- Increase of the range of services offered in and outside the practice
- A more 'holistic' care package for patients in need
- More cost-effective use of practice resources



What kinds of services are available?



Exercise/Healthy lifestyles

Self-Management programmes



Money Advice - debt, benefits, fuel poverty

Carer's Support



Dementia Support



Housing / Adaptations Help



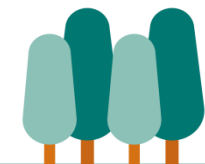
Social / Leisure Activities and Groups



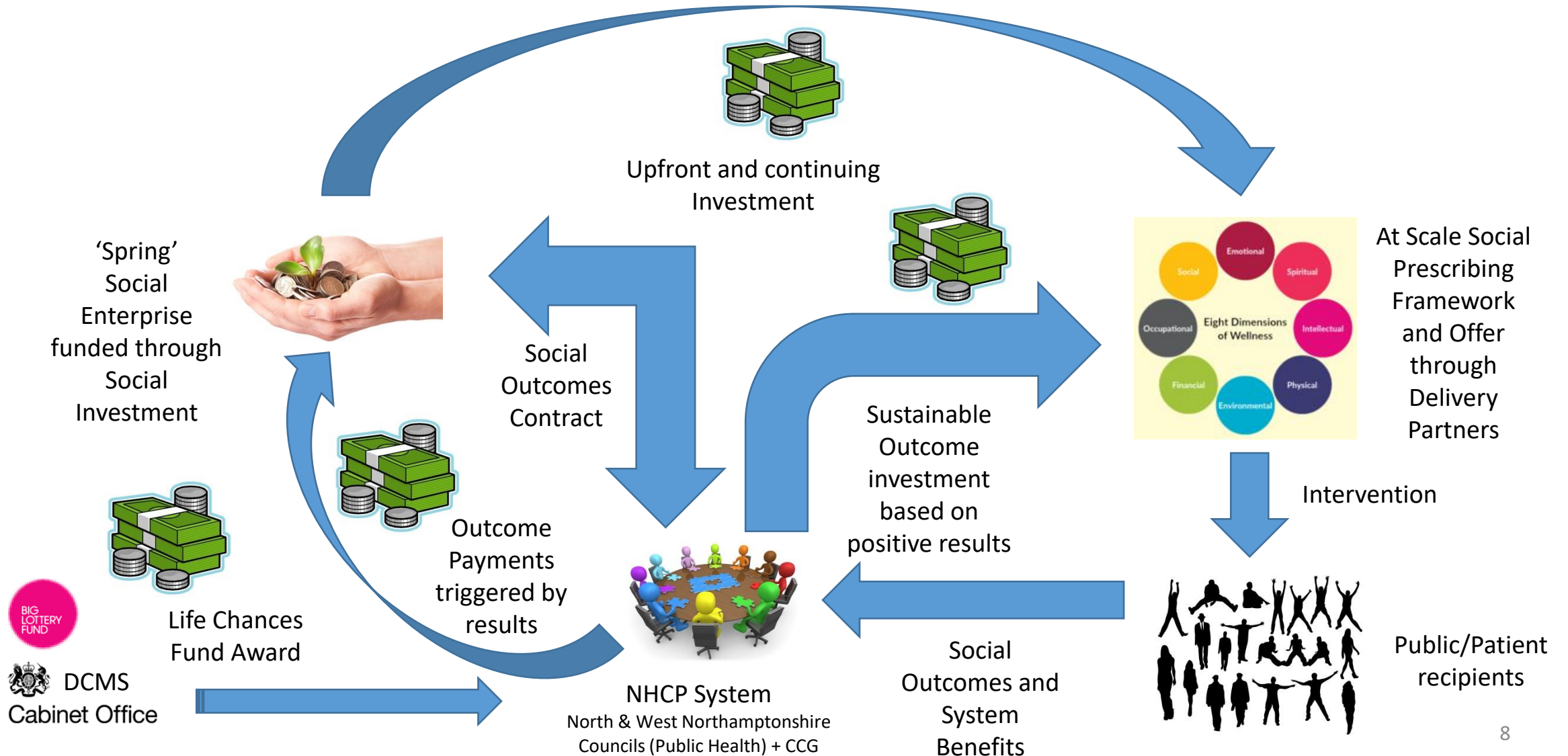
Transportation / Mobility



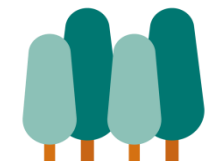
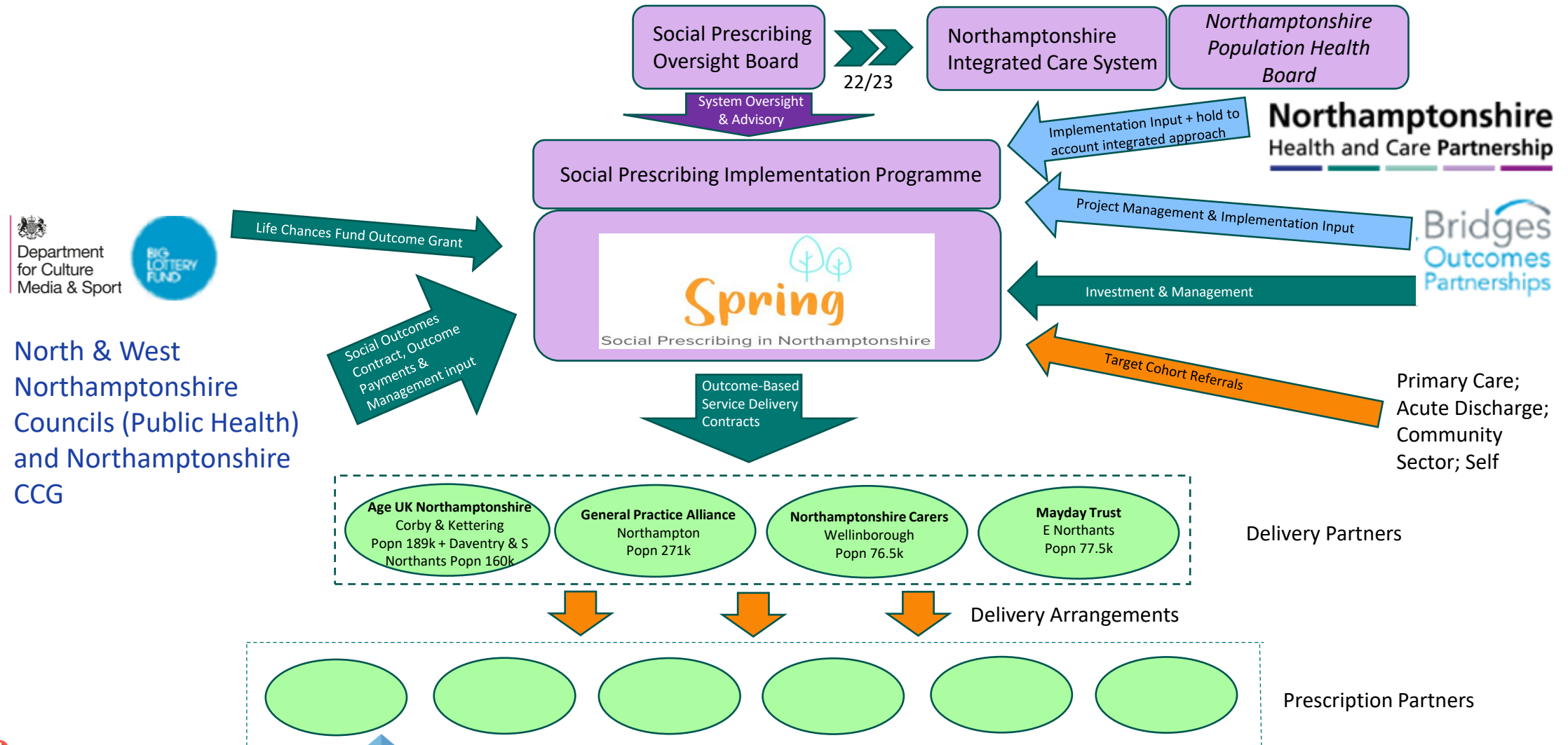
- Our programme will encompass a range of support, in the community and in some cases commissioned, to supplement mental and physical health and wellbeing prevention and treatment services through a wide range of non-clinical social, emotional or practical schemes.
- It is our objective to build sustainability and resilience in our communities and the VCSE sector through developing county-wide collaborative services that operate consistently and at scale.
- The necessary processes and actions to develop protocols and provide continuing and acceptable quality assurance to referrers is also in the process of being established.
- At the heart of our Link Worker-led framework will be a personal consultation and/or motivational interview.
- Our programme will be focused on those with greatest need and likelihood of benefiting. Our cohort focus is People living with Long Term Conditions; People with Mental Health and Wellbeing issues; Support for Carers; People living in social isolation and individuals affected psychosocially as a result of the current pandemic
- Our offer will involve sourcing a variety of schemes that are typically, though not exclusively, provided by VCSE organisations.



What does the Northamptonshire funds flow look like under our Social Outcomes Contract model?



Mobilisation Governance Structure (1/2)



Two tiers of partners:

- Tier One – Locality-based delivery partner – engaged via an outcomes-based service delivery contract
- Tier Two – Social prescription provider partner

Delivery Partners

Employ geographically distributed link workers, under a co-location model, under which a link worker may spend time within a GP practice or community hub. Link workers will be the point of access for beneficiaries, and will

- Provide an initial assessment and facilitate completion of the Wellbeing Star for self-help with Long Term Conditions
- Goal plan to determine the activities required from social prescription provider partners and initiate referrals
- Monitor patient progress and complete multi-stakeholder social prescription completion report and ongoing plan
- Assist in developing the knowledge base around interventions that work
- Support VCSE scale and capacity growth, co-creation and co-production through Asset-Based Community Development and increased volunteering

Provider Partners

In each PCN area we will look to have a network of social prescription provider partners that will receive referred clients and deliver the social prescription.

Provider partners will deliver specific support (one to one or in groups), eg:

- Exercise, Weight Management and Healthy eating
- Mental health, Anxiety, Stress, Depression & Low Mood and Social Isolation
- Smoking, Drugs, Alcohol and other Addictive Behaviour
- Debt/money management, Housing, Benefits, Employment and Volunteering

If there is an identified delivery need within a PCN, but there is no availability of that service, we would aim to make it available through partner development.





spring

SOCIAL PRESCRIBING
IN NORTHAMPTONSHIRE

Northamptonshire
Health and Care Partnership



Public Health
Northamptonshire



Spring's role in Northamptonshire

Individuals with **any long term health condition (LTC)** can access Spring. We will work with individuals for between **6 and 12 months**, depending on need...

...with the aim of helping individuals better manage their health by:

- Providing **holistic and person centred support** through our SPLW team.
- **Coaching and motivating** individuals in adopting healthier lifestyles and methods to better manage their LTC.
- Helping individuals to access **specialist services** and **community support**.
- Providing resources to facilitate better health through our **Well-being Action Fund**.

For example...

Person A:

- Started with telephone appointments to start building trust. After three appointments, A agreed to a visit at home, where she felt most at ease.
- With the support of Social Prescribing Linker Worker (SPLW), A set goals on her Wellbeing Star (WBS) which included looking for employment. Although A had previously been in employment, she had not attended a formal interview.
- The SPLW supported A to contact Mind which could help with her anxiety and interviewing techniques. Although her anxiety is still quite high, A is hopeful to overcome this with support and working on achievable goals.

Person B:

- Suffered a brain injury and moved to enjoy a quieter place to live, but now feels isolated. B would like to attend local social groups. One of his goals is to return to employment but would like help as has struggled to retain employment. He now feels that he has come to terms with his brain injury and is managing this quite well.
- Together with the support of the SPLW, B completed the WBS to explore his interests and see what employment support is available. He is working towards goals to reduce his isolation and improve his confidence.

Our goals...

Spring's success will be measured through 3 outcomes

1

Improve overall
wellbeing

2

Improve mental
health

3

Reduce
GP attendance

Questions

&

Discussion