York VCSE Assembly

Social Prescribing in York

Wednesday 6 July 2022

Welcome

Alison Semmence
Chief Executive, York CVS

Humber and North Yorkshire
Health and Care Partnership

Stephen Eames CBE, Chief Executive

https://www.youtube.com/watch?v=u07cg1-8Xbc

Primary Care Link Workers
Social Prescribing in York

Ways to Wellbeing
Growing Social Prescribing

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Social Prescribing: The York Model

Christine Marmion-Lennon
Deputy Chief Executive, York CVS

The journey so far…

Ways to Wellbeing

Feb 2016: 12-month social prescribing pilot starts (York CVS & PMG, 1 social prescriber)

Jan 2018: W2W expands (3 social prescribers, 3 medical groups – PMG, Haxby, YMG)

Mar 2020: New (current) model, i.e. W2W no longer in primary care - moves into secondary care services

2021: Pathway to Recovery project starts – an MDT approach to support mental health recovery

Primary Care Link Workers

2019 NHS Long Term Plan - https://www.longtermplan.nhs.uk/
https://www.england.nhs.uk/personalisedcare/social-prescribing/

Jul 2019: new GP contract (England)
https://www.bma.org.uk/media/1496/bma-social-prescribing-guidance-2019.pdf

Feb 2020: First PCLWs employed in York as part of the NHS Long Term Plan

Social Prescribing – the principles

Supports individuals to take greater control of their own health

- Person Centred
- Holistic
- Non-medical support
- What Matters to Me and asset-based approach
- Person involved in making decisions to improve their health and wellbeing

A community-centred approach to health

- Recognises the importance of the communities we live and work in, and the social networks we belong to
- Promotes health and wellbeing
- Reduces health inequalities in a community setting
- Connects people to local community assets AND strengthens local community assets

Health inequalities

- Evidence that people's health and wellbeing are determined mostly by a range of social, economic and environmental factors
- A new approach to population health and use

Reduce pressure on statutory services

- By directing people to more appropriate services and groups
- Helping people have more control
- Helping people to live well longer reducing A and E admissions and hospital stays

The York Model

Encompasses the Holistic Approach

What Matters to Me

A **multi-agency** approach

NOT a sign posting Service

ALWAYS
Person Centred
Asset Based

Open door policy on discharge from the service

Helping to **identify barriers** and overcoming them

Building Relationships

Attending groups with patients

Connecting and **collaborating** with the **VCSE and Statutory Services**

NOT Support Workers

GREEN Social Prescribing

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Anthony Heard
Programme Manager, Green Social Prescribing

Humber and North Yorkshire Green Social Prescribing Programme: Working with our Social Prescribers

National and local context:

Humber and North Yorkshire Health and Care Partnership

GREEN Social Prescribing

smile health

- One of 7 ‘test and learn’ sites across England looking at how to embed Green Social Prescribing (GSP) into communities in order to:
  - Improve mental health outcomes
  - Reduce health inequalities
  - Reduce demand on the health and social care system
  - Develop best practice in making green social activities more resilient and accessible
- Green Social Prescribing Programme sits with the Humber and North Yorkshire Health and Care Partnership’s Voluntary, Community and Social Enterprise Leadership Programme. Being delivered by the Lead Provider – HEY Smile Foundation and overseen by a GSP Steering Group. Funded until March 2023.
- Reports to the National Green Social Prescribing team and is feeding in to the National GSP Evaluation Team who are looking at ‘Preventing and Tackling Mental Ill Health Through Green Social Prescribing’. Collaborative of Sheffield, Sheffield Hallam and Exeter Universities.

Department for Environment Food & Rural Affairs | NHS | Office for Health Improvement & Disparities | National Academy for Social Prescribing | NATURAL ENGLAND | THE NATIONAL LOTTERY | SPORT ENGLAND | Department for Levelling Up, Housing & Communities | Department of Health & Social Care

Green Social Prescribing – what is it?

Humber and North Yorkshire Health and Care Partnership

GREEN Social Prescribing

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Source: Nature on Prescription Handbook (University of Exeter)

Our Programme in Humber and North Yorkshire:

Humber and North Yorkshire Health and Care Partnership

GREEN Social Prescribing

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Scoping:

VCSE-sector: who is already delivering GSP activities? What do they do? Where are they? How are they funded? Who do they work with? Are they connected to healthcare pathways? Do they monitor the impact of their activities? What capacity do they have? What enablers and barriers are there to supporting referrals from healthcare? What support and training needs are there to facilitate better connection to healthcare pathways?

Social Prescribing Services: Who delivers the service? How can people access it? How is impact monitored; how is information on local VCSE organisations stored? What enablers and barriers are there to referring in to VCSE groups delivering GSP activities? What training and support needs are there around increasing awareness and understanding around the health benefits of being outdoors and connected to nature.

Mental Health Services: How does GSP fit in to current service provision e.g. through Community Mental Health Teams; IAPT services; Early Intervention; Recovery Colleges.

Wider potential of GSP: What other healthcare priorities could GSP support: Physical health e.g. Type-2 Diabetes, heart disease; Waiting Well; Post-surgery support.

Our Programme in Humber and North Yorkshire:

Humber and North Yorkshire Health and Care Partnership

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Growing Our Own

- £200,000 of NHS Charities Together funding aligned with the programme. 11 projects funded from April 2022.

- £150,000 through the GSP Programme Fund put out to VCSE sector Autumn 2021:

    - 54 eligible applications received.
    - 20 projects shortlisted by Independent Grants Panel on 17th January 2022.
    - All funded projects will support our wider work to understand the impacts of GSP on individuals, connect with Social Prescribing services and feed data in to the national evaluations programme.

Hook Manor Project – credit Liz Allen

Funded Projects:

Humber and North Yorkshire Health and Care Partnership

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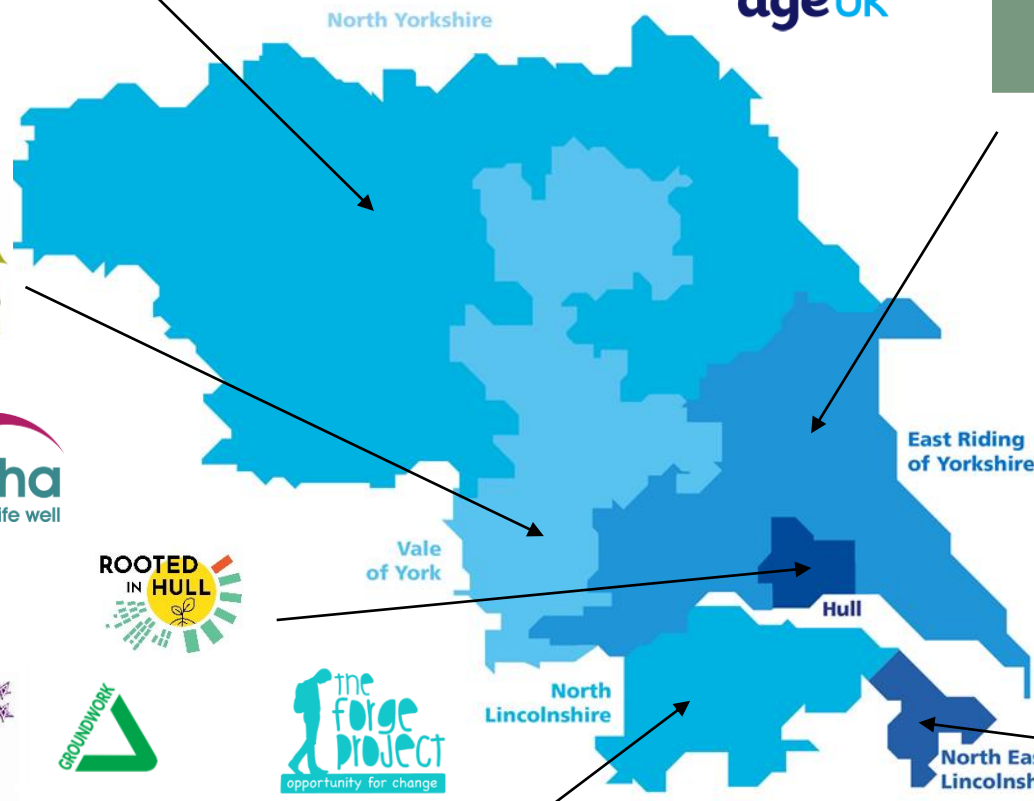

Closer Communities
Supporting families. Changing lives.

opencountry
out there together

carers plus YORKSHIRE

RAINCLIFFE WOOD COMMUNITY ENTERPRISE

Scarborough & District age UK

Mires Beck Nursery

Roots and Shoots Bridlington Community Allotment

TCV The Conservation Volunteers

York Bike Belles

St Nicks The Green Heart of York

Vale of York Athletic Community

THE VALE OF SNAITH ACTION GROUP
Promoting Walking to Residents and Visitors

smile foundation

mha Live later life well

NAVIGO

ROOTED IN HULL

Goodwin Development Trust

GREEN FUTURES

Community Triumph Ltd.

Hessle Road Network

GROUNDWORK

the forge project
opportunity for change

CLIMB 4

FARAWAY CIC
UNIQUE MINDS

HULL FC FOUNDATION

HULL KR

Voluntary Community & Social Enterprise Alliance North Lincolnshire
Volunteer Hub

HWRA

HUMBER & WOLDS RURAL ACTION

Your Place

Work to date: Partnering with Social Prescribers

Humber and North Yorkshire Health and Care Partnership

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Clinical Cohort data collection:

We are following a cohort of individuals with mild to moderate mental health on their GSP journey to better understand:

- Who accesses GSP
- How are they referred in to Social Prescribing services / GSP
- Why are they being referred
- What activity do they get involved in
- How long do they stay in that activity
- What impact does taking part in the activity have on their wellbeing and mental health.

Credit Valkyrie Wilderness Workshops

Investment in Social Prescribing

Humber and North Yorkshire Health and Care Partnership

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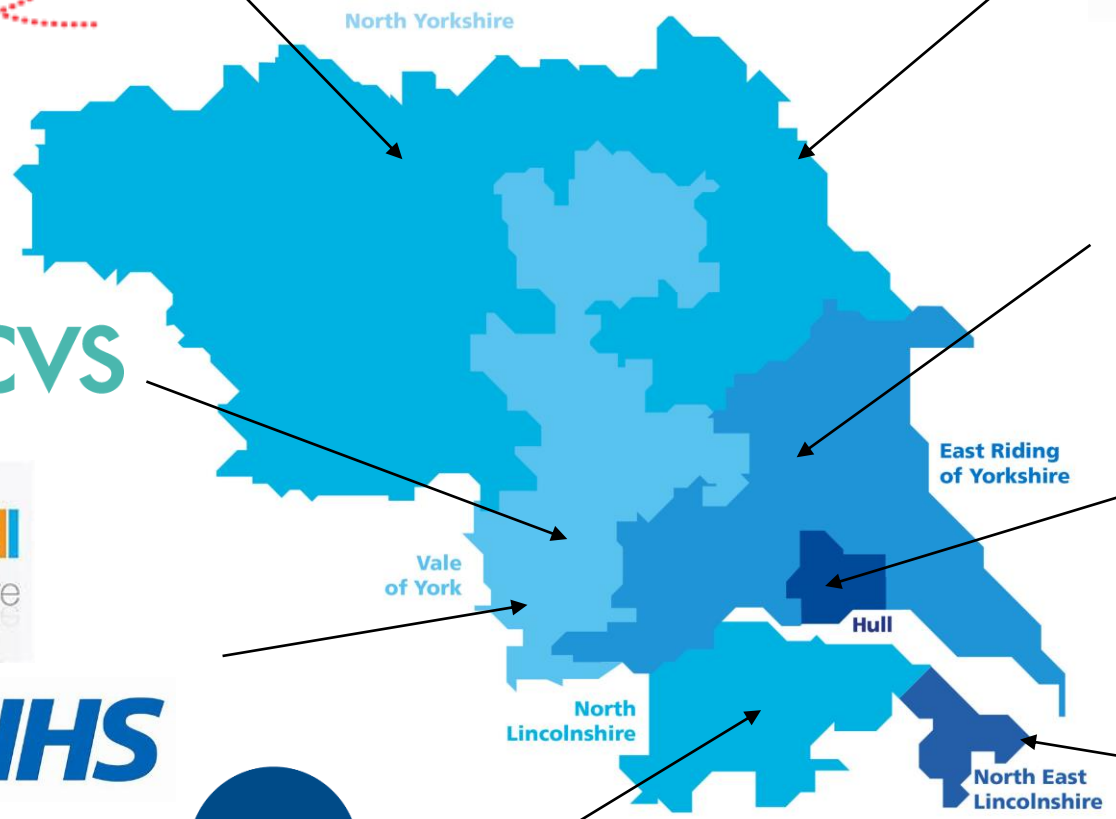

Heartbeat
Connecting health and care communities

Scarborough & District age UK

NHS Humber Teaching NHS Foundation Trust

yorkcvs

LivingWell in North Yorkshire

mind for better mental health Hull and East Yorkshire

forum

Selby Town PCN PRIMARY CARE NETWORK

NHS

citizens advice North Lincolnshire

NAVIGO

Our different models:

Humber and North Yorkshire Health and Care Partnership

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One Social Prescribing Link Worker funded to co-ordinate the GSP cohort work for a day a week.

- Full service aware of the work. Funded staff member can take eligible referrals from whole Link Worker team.
- Gathers all the data with the referral and connects with GSP provider.
- Is developing further links with local providers of 'green' activities.
- Sharing local 'green' offer with all Social Prescribing staff at York CVS for non-cohort referrals who could benefit.
- Engaging with GPs and Mental health workers in surgeries to establish further referral pathways in to GSP.

Willow weaving – credit St Nicks

Our different models:

Humber and North Yorkshire Health and Care Partnership

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forum

mind for better mental health Hull and East Yorkshire

Two Green Social Prescribers funded (50% GSP Programme and 50% Forum) to work 15 hours a week each on the cohort work. Seconded from HEY Mind but working for Forum through the Social Prescribing team.

- Set up a single referral point from HEY Mind in partnership with the Peer Support and Recovery Workers.
- Phased approach. Began by visiting GSP providers to understand offer and practicalities around making a referral. Used this to develop communication pathways and create 'cheat sheets' on activities to share with potential referrals.
- Cyclical approach to 'recruitment'. Attend Peer and Recovery groups at different time points to introduce GSP and recruit.
- Offer structured 'buddying' support if needed. Can attend first session, then half of second session.

Cheat sheet example:

Humber and North Yorkshire Health and Care Partnership

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Rainbow Community Garden

What they do?

Really relaxed atmosphere here. They grow vegetables and salad crops in the ground and raised beds. They maintain the crops, ponds, trees, shrubs and wildlife areas and you can also get involved in crafting, painting, wood burning and wood etching. You can try anything you choose on the day.

When do their sessions run?

Mon-Thursday 10-11:30 or 1-2:30. Wednesday is the quietest and Thursday the busiest.

Who's the main contact person / leader of the group?

This is Brenda. Really knowledgeable and has been keeping the site going for several years. She will know when to expect you and will meet you at the gate.

This is Emma – She is so friendly and supportive. Emma will also know when to expect you and meet you at the gate.

Our different models:

Humber and North Yorkshire Health and Care Partnership

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LivingWell in North Yorkshire

Selby Town PCN PRIMARY CARE NETWORK

NHS

Working with all Social Prescribing staff within the Selby Town and Tadcaster and Rural Selby PCNs – Social Prescribing Link Workers; Health and Wellbeing Coaches; Care Co-ordinators; Wellbeing Link Workers.

- All Social Prescribing staff have been trained in the data recording process and can identify and recruit individuals to take part.
- Different staff members can have different beneficiaries they work with. For example one staff member is working a lot with carers and is hopeful GSP can be a way to support them.

Barriers:

Humber and North Yorkshire Health and Care Partnership

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General Barriers:

- Complex cases coming through to Social Prescribing. Cost of Living Crisis having a huge impact. Often, an individuals wellbeing needs have to be prioritised. There may be other issues around housing and finances that are ahead of GSP.
- Transport / rurality
- Myths surrounding 'what is green'
- Communication – maintaining this both ways
- Time needed to visit groups, take part in an activity, alongside discussing practicalities.

"Ideally, I'd like to have taken part in as many activities as possible as to talk confidently as to what is involved, but it really is a question of time. As I'm working from 5 practices a week, my time is spread thinly"

- Accessibility – many could benefit from community-based green activities but may be excluded from traditional week day activities due to work / family commitments.

Cohort Barriers:

- Participant information sheet and consent form – wordy / sounds heavy.
- Criteria set as working age. Lots of older people access SP.

Enablers:

Humber and North Yorkshire Health and Care Partnership

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We have allocated resource to this – primarily TIME:

- Capacity to visit / connect / build relations with providers of 'green' activity.
- Providing buddying support.

"She felt really grateful I was able to support her because she was so anxious in the morning that without me being there, she doesn't think she would have gone".

Producing easy to read materials on groups to bring the activities to life for first time referrals.

An understanding and enthusiasm across the Social Prescribing landscape that outdoors and in-nature activities have a key part to play in good health and wellbeing.

Community allotment – credit Open Country

Operational team:

Humber and North Yorkshire Health and Care Partnership

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- Head of Smile Health: Victoria Winterton. Operational oversight for HEY Smile Foundation.
- Programme Manager: Anthony Hurd (FT).
- Clinical Lead: Dr Hannah Armitt (PT 1.5 days a week).
- Programme Assistant: Morena Morris (FT)
- **Contact:** Anthony Hurd ah@heysmilefoundation.org

Subscribe to our GSP newsletter by emailing GreenSP@heysmilefoundation.org

Beverley Westwood – Credit Aimée Crosley

Green Social Prescribing in Humber and North Yorkshire

GREEN Social Prescribing

https://www.youtube.com/watch?v=MC8mPb6_scg

Primary Care Link Workers
Social Prescribing in York

Ways to Wellbeing
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Proactive Social Prescribing

Lucy Kitson
Team Leader, Primary Care Link Workers
York CVS

Aims

- **Diabetes** – Improve Health and Wellbeing of people living with NIDDM in lower Socio economic areas of York

- **SMI** – To increase attendance at annual reviews and ensure continuity of care.

Primary Care Link Workers
Social Prescribing in York

How did we identify the patients?

- Information sharing agreements
- Partnership work with York CCG and Public Health York - CCG and Public Health York ran searches for:
  - Diabetes - identified 400 people between the age of 55-65 living in area of highest deprivation CCG and PCN's ran searches for SMI people – this info was correlated by Nimbus.
  - SMI – Identified 294 people within 2 PCN's who had not responded to texts and letters inviting them to their annual review.

What did we do with the patients?

Diabetes cohort intervention 1:

- A Working Group developed a script for the Social Prescribing Link Workers to use, baseline and post intervention, including Wellbeing scores and Managing Diabetes Scores.
- Proactive phone calls made to explore motivation, personal wellbeing barriers to healthcare and self-management.
- Supported booking appointments for blood tests, blood pressure and weight and nurse review if not had their annual review.
- Personalised Support – What Matters to Me conversations follow six month post intervention

What did we do with the patients?

SMI cohort intervention 2:

- Design intervention myself, CCG and York Nimbus project leads
- CCG ran searches and information sharing agreements were implemented across two York PCNs
- Contacted patients with SMI who had not engaged before
- Our team contacted 294 patients over a period of 5 weeks to build trusting relationships and support them to attend their SMI appointments, helping to overcome barriers

Outcomes

Diabetes cohort intervention 1 – early findings (full findings post June 2022):

- The results so far has shown that Social Prescribing is an ideal mechanism to help people gain confidence and knowledge accessing the local community networks and VCSE, along with statutory services in managing their diabetes.
- Identified barriers to services (retinal screening, Blood tests)
- Patients now contacting our team in the first instance for support with Social Needs and Wellbeing
- Patients were taken onto Link Workers active caseloads
- Case Study

Outcomes for the end of the Project:

- More people living in the early stages of Diabetes in York are supported to live healthier lives
- More people living in the early stages of Diabetes in York receive optimal primary care management

Outcomes

SMI cohort intervention 2:

- 137 people attended for their SMI review both F2F and Home Visits due to Social Prescribing input.
- Around 200 people were supported by Social Prescribers in regards to lifestyle advice such as stopping smoking, reducing alcohol intake by connecting to support within the VCSE and Statutory Services.
- These calls often resulted in our Social Prescribers taking these patients onto their active caseloads for support regarding issues such as housing and finance. Each patient was given our Link Worker direct line to call if they needed non-medical support in the future.

What are our next steps?

- Continue to identify and address Health Inequalities including **Core 20 Plus 5**.
- Continue to work closely with the CCG (ICS) and Public Health York to identify future projects.
- Working closely with PH York to explore a population health model of Social Prescribing.
- Our team have been asked to continue to work with GP leads, Nimbus and the CCG to plan how these reviews will be carried out in 2022-23 and how Social Prescribing can continue to support these patients with early meetings taking place.
    - Learning Disability Reviews
    - Befriending Calls
    - Living Well with Pain Peer Support.
    - Green Social Prescribing Programme
    - **SMI reviews**
    - **Cervical Screening**

Mind the gap!

The Ways to Wellbeing approach

Emily Abbott
Team Leader, Ways to Wellbeing, York CVS

Mind the gap!

The Ways to Wellbeing approach

In a nutshell…

- Identifying need / gaps
- Testing ideas
- Creating opportunities
- Partnering with VCSE orgs
- Sustainability

But why?

Because...

Because this is what social prescribing is!

- It is **not** signposting
- It is not solely about the work we do supporting individual York residents
- It's about identifying gaps and then doing something about them
- It's about contributing to a strong local VCSE sector:
  - ✓ **because without it there is no community support for people**
  - ✓ **because without it there is no specialist peer support**
  - ✓ **because without it there are no volunteering opportunities**

Mind the gap!

The Ways to Wellbeing approach

Ways to Wellbeing
Growing Social Prescribing

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We'll look at two examples of gaps we identified, and then addressed:

Living well with persistent pain
- A structured peer support course

Cuppa and Craft
- A stepping stone scheme

Living well with pain

What do we mean by chronic pain?

Chronic pain is persistent pain that lasts more than three months, despite medication or other forms of standard medical treatment.

- It can be caused by health conditions like arthritis, or nerve damage linked to diabetes
- It can be the result of a specific problem that has often healed (e.g. shingles)
- It can also develop slowly, sometimes for no obvious reason
- It may come on months or years after an event or injury (e.g. a road accident or surgery)

Useful resources:

Home - Live Well With Pain
Home - Flippin' Pain (flippinpain.co.uk)

Living well with pain

Some context

- Persistent pain affects 30%-50% of people (flippinpain.co.uk)
- Persistent pain is the leading cause of disability in the world (flippinpain.co.uk)
- It's the biggest reason people in the UK see their GP

This is reflected in the high number of referrals we receive, to support York residents living with chronic pain

Our social prescribers support a lot of people living with chronic pain
They find it particularly hard to find local support and activities to help them

Living well with pain

Specialist training

A clinically-led training programme created and delivered by medics, people with lived experience and pain specialist clinical psychologists working in the NHS.

We wanted to:

- make sure we have the most up-to-date knowledge about chronic pain and its management
- learn what current best practice is
- equip our social prescribers to give the best support possible to people living with persistent pain

Living well with pain

Specialist training – what we learned

- The scientific understanding of pain has been transformed over the last 20 years (how our brains respond, how we process it)
- Pain and damage are NOT the same **(hurt does not always equal harm)**
- Persistent pain is often unrelated to any harm or injury
- It's important to be treated as an equal partner in your care
- Self-management can be empowering; people can take control – they just need to find the right way
- Everything matters: how we feel and think can affect how much pain we experience

Living well with pain

Why social prescribing? Because…

- Social prescribers support people to **take greater control** of their own health and wellbeing
- Social prescribing galvanises in people a change in status from passive recipient of NHS services, to **active participant and decision maker**
- Social prescribing addresses people's needs in a holistic way, recognising that people's health is determined primarily by a range of social, economic and environmental factors
- Social prescribing develops tailored plans led by the person, connecting them to local groups and support services; learning and volunteering opportunities and peer support networks

Living well with pain

Why social prescribing? Because…

Ways to Wellbeing
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Conventional health services are not equipped to help people manage their long-term conditions

But social prescribing is!

- Social prescribing helps people learn new **self-management techniques**, new skills
- Introduces people to **communities of support** – much more longevity, sustainability
- **And if there isn't a community of support – social prescribing will help create one**

Living well with pain

Why social prescribing?

NHS Long Term Plan

- NHS LTP - 'through **social prescribing** the range of support available to people will widen, diversify and become accessible
- A different way of thinking about health and care in pain management is required
- Potential for community support to improve the experiences of people living with persistent pain
- Improving **prevention** of avoidable illness and its exacerbations, e.g. preventing / avoiding opioid addiction
- Need to create opportunities for volunteers to enhance ‘supported self-management’ of long-term health conditions
- Helping people live better lives with persistent pain needs an understanding of the individual experience, and person-centred management **this is what social prescribing is!**

Living well with pain

Shaped by lived experience

- **Via the pain training we brought in**
- **Via the 2 focus groups we subsequently ran**
- **Via the ongoing group**

Living well with pain

Sustainability

- **Financial**
- **Staffing**
- **Volunteers**
- **Participant numbers, not getting full etc.**

proud to be part of yorkcvs

York Art Gallery project

Ways to Wellbeing
Growing Social Prescribing

Primary Care Link Workers
Social Prescribing in York

What we are doing

York Art Gallery studio
First Friday of each month

An arts for wellbeing coffee group for local people being supported by social prescribers.

What was the need?

Social prescribers recognised a common theme - people anxious about leaving their home and interacting with new groups, people and places.

This is something which has increased hugely post-pandemic.

Identified a need for opportunities to introduce people to a group in a safe environment where they can meet with their social prescriber, be introduced to the group and meet others with this shared experience.

This in turn is a stepping stone to building their confidence in accessing further support across the city.

Transport Grant – filling anther gap

A major barrier for patients we work with is transport.

This can be for a number of reasons including financial, frailty and movement restrictions, and anxiety around getting around and using public transport.

40% of the groups participants have needed the transport grant and would have otherwise not been able to access the support of the group.

Case study

Peter

Peter was referred due to being isolated, increased alcohol consumption, poor diet and recent hospital admission. Suffering from reduced mobility on discharge. He previously socialised in pubs but had stopped this during the pandemic.

On visiting Peter, he was feeling emotional and had a number of issues relating to his employment, lack of any social activity since covid pandemic and his reduced mobility leading to difficulty accessing certain places.

One of the first steps for Peter was attending the group at York Art Gallery. He managed the journey by bus, and thoroughly enjoyed the group. In fact, he enjoyed it so much that he has decided to keep going even after returning to the workplace because of how it supports his mental health.

Feedback “ I was made to feel very welcome and had very good chats with others.
I am looking forward to the next time. I feel it will be a good avenue to help with my mental health.
Even after I return to work. I will still continue to go, and I am sure I will get approval from work."

Feedback

“I really enjoyed the art group and can't wait to go again! [after initially using a taxi from the transport budget] I feel confident to get the bus next time too. I have barely left my home in recent months and after seeing a couple of ladies at the group in wheelchairs I feel less self-conscious of my own limited mobility.”

(Participant feedback from our Cuppa and Craft sessions at York Art Gallery)

What's next?

Volunteers: we have now recruited 2 support positions and are hoping to introduce the other 3 applicants to more fitting roles

Next steps groups

Thank you

Ways to Wellbeing
Growing Social Prescribing

Keep in touch…

Primary Care Link Workers
Social Prescribing in York

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@PrimaryLinks

Ways to Wellbeing
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Tel: 01904 621133

Email: waystowellbeing@yorkcvs.org.uk

Address: York CVS, 15 Priory Street, York YO6 3ET

@W2WYork

Questions?

Round table discussions:

Question 1.

Through the work you are doing what gaps in services are you seeing?

Feedback

Round table discussions:

Question 2.

- **Would your organisation consider having a specialist social prescriber to focus on your particular client group/specific issues?**
- **What could that look like and who might you want to work with?**

Feedback /
Creating a shared plan

Next steps / Close