Proactive Social Prescribing

Respiratory Health Report **2025**

yorkcvs

Primary Care Link Workers
Social Prescribing in York

Humber and North Yorkshire
Health and Care Partnership

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Let's discover...

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What is the Respiratory Proactive Social Prescriber (PSP)?

The Proactive Social Prescriber (PSP) works across Primary Care Networks (PCN's) in York, proactively reaching out to individuals with respiratory conditions and tailoring support to their unique needs.

The PSP role is multi-faceted and acts as a direct link between the patient and the surgery team, bridging critical gaps between health and social care, significantly reducing waiting times for long term condition (LTC) reviews and improving confidence in healthcare provision.

An integral part of the approach is to connect to and develop successful working relationships with the wider clinical team, linking in across all York PCN's working collaboratively with healthcare professionals such as respiratory nurses and Mental Health Practitioners (MHP).

Report by Proactive Social Prescriber - Simon Daglish

What is the Respiratory Proactive Social Prescriber (PSP)?

The PSP works closely with the VCSE and health and social care sectors to encourage the person to access and engage in local community services. This approach supports the development of positive relationships, so people feel connected and invested in their local community.

The PSP prioritises what matters to each person, addresses challenges they face and supports them to develop a mutually agreed personalised care plan, leading to increased confidence when managing their own health. Through an initial phone call, the PSP offers to meet people in a way that is accessible, familiar, and safe for them, either over the phone or through face-to-face meetings.

During the two-year initiative the PSP proactively engaged with 111 people across York's primary care networks.

Who does the PSP reach?

People with long term respiratory conditions who:

- are at high risk of non-elective admissions to hospital
- are isolated and don't have formal or informal support
- are residents from socially deprived areas
- are individuals on low income
- have been lost to or disengaged from health provision

What does the PSP offer?

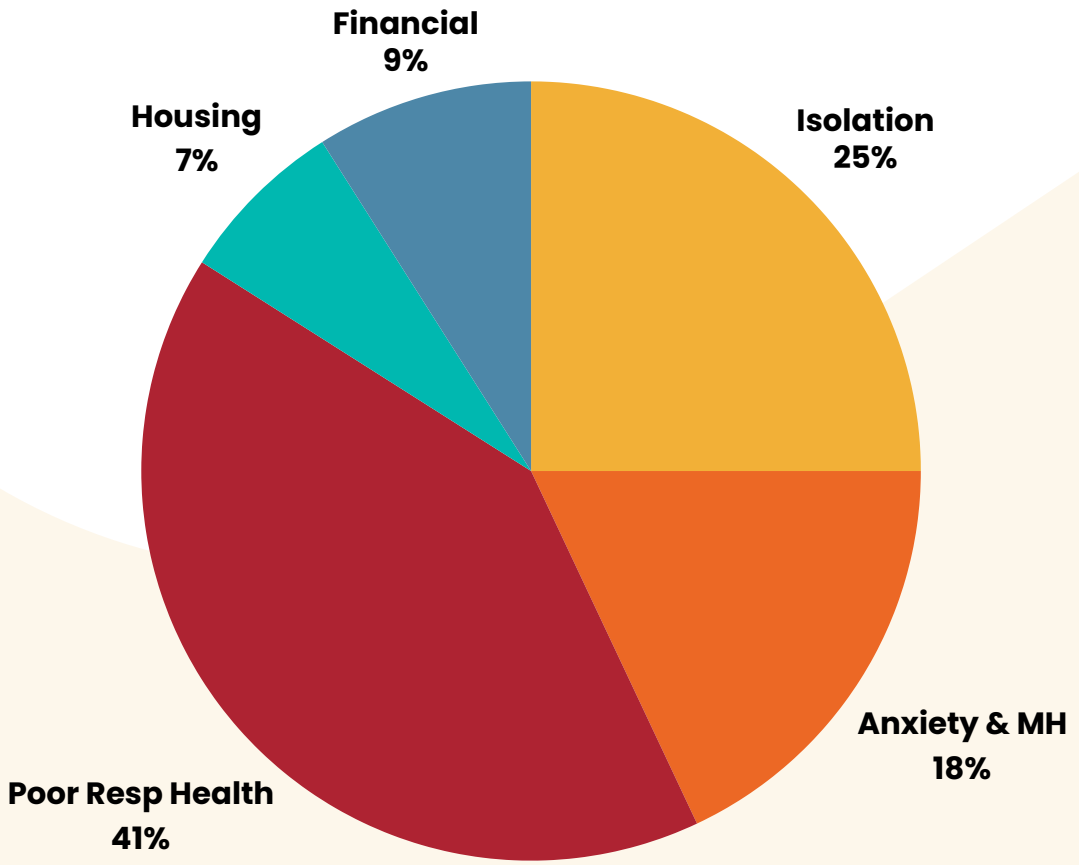
- Development of a person-centred support plan
- Support with loneliness and isolation
- Referral to physical health and exercise groups
- Support for people with complex social needs
- Supported referrals to Local authority and DWP benefits support
- City of York Council housing applications and repairs
- Budgeting, debt and financial support
- Exploring gaps in provision and develop strategies with VCSE groups

Surgery Referrals

In two years, the PSP made **88 respiratory review requests** by direct tasking, often resulting in medication changes and increased confidence in inhaler therapy.

Several other referrals and requests were made for the following: Pulmonary rehabilitation, ordering rescue packs and referrals to the Mental Health Practitioners.

Of the 111 people who engaged in PSP the graph shows the priorities identified with the individual before agreeing to a personalised plan.



Community Referrals

The PSP made 184 supported community referrals for the duration of the project.

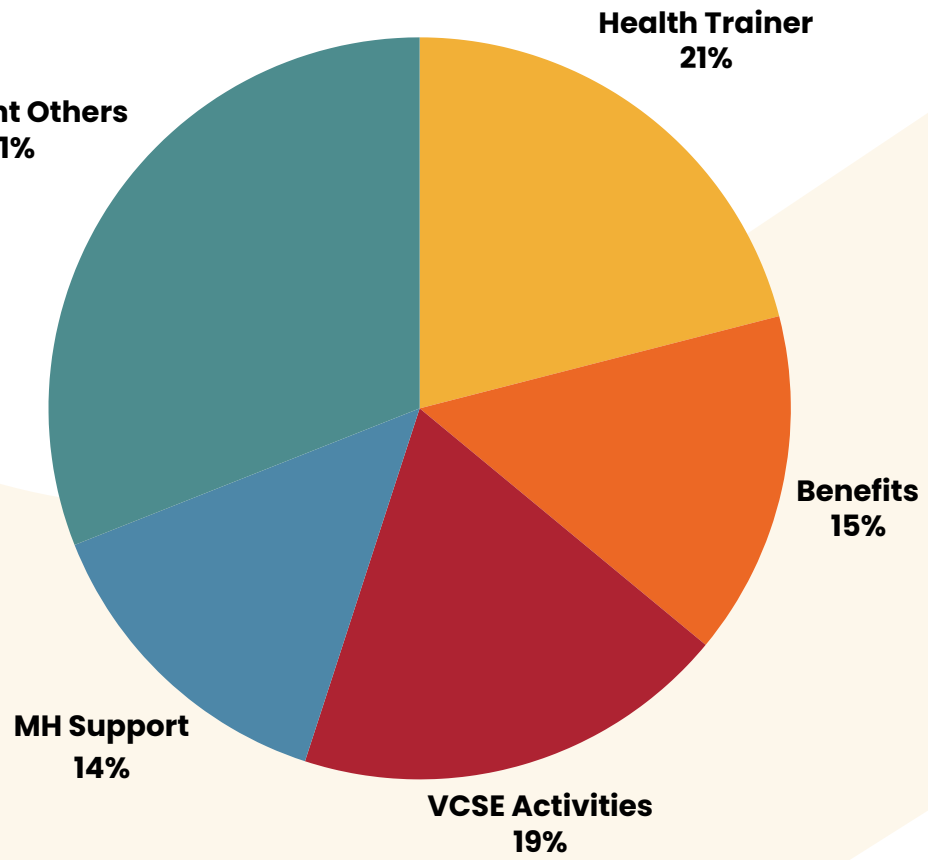
- Access to community support and groups
- Health and Social Occupational Therapists (OT)
- Physiotherapy referrals
- Smoking cessation, alcohol and weight management
- Supported employment and return to work
- Volunteering opportunities
- Council tax support
- Bereavement support
- DWP employment support
- Food and fuel vouchers

Partnerships

The PSP collaborates with community-based organisations across the health and social care and VCSE sectors, examples from the project include:

- City of York Council Housing
- York Carers Centre
- York in Recovery
- YSJ Converge
- Health Trainers
- Puffin Group
- Menfulness
- Cuppa and Chorus
- Employment support (DWP)

Priorities



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What were the challenges?

- **Low engagement** from people using the initial introductory text due to lack of digital confidence or access and general feedback was they could not understand the information or found it overwhelming. People stated that they preferred face to face meetings, initial home visits and community visits often produced a broader range of provision across the cohort.

- **Less face to face visits** and community inclusion referrals, over winter months, due to aggravation of long term condition's, COVID and flu anxiety. During this period the majority of support was phone based and there was a significant reduction in face to face visits.

- **Socio-economic barriers** including 'cost of living' and reduction in welfare benefits resulting in people being unable to afford or access travel to health appointments. People from the cohort stated they had no option but to choose between 'heating and eating'.

- **Social isolation** was prominent in the cohort; people would stay in a routine at home due to the severity of their condition and lacked confidence in attending activities due to social anxiety or lack of community connections.

Identifying gaps in provision

- During the implementation of the respiratory health initiative, part of the PSP role was to identify gaps in provision and work pro-actively with other organisations and/or individuals to try and bridge the gap. For example, some patients were unable to attend an existing exercise and social club, because of its location and limited capacity. Working collaboratively with York St John (YSJ) active* the PSP was able to set up an exercise and social group called Eazy-Breathe to provide achievable breathing-based exercise and reduce social isolation. The PSP and YSJ active facilitator were able to secure funding to ensure that this was free to join, and the group is now well established and continues into 2025.

- The PSP initiative addresses challenges such as digital exclusion, which are often overlooked but can significantly impact health outcomes. The PSP identified the issue with digital exclusion, this resulted in the PSP working with a local charity that supports York residents through “Digital cafes”, which can help people navigate health links sent by GP surgeries and other specialist health services.

You can come in at any level, the exercise can be adapted.

I can do everyday tasks a lot easier now.

The whole group is really friendly, thank you for making me feel welcome today.

*York St John (YSJ) active is a team of fitness professionals that offer a high quality, inclusive and sustainable service for students, staff and the wider community.

Case Stories

Mrs A is a retired lady in her early seventies, who struggles daily with her COPD and several other long-term conditions impacting on her daily life. She lives in Social Housing and has no formal or informal support. Her breathing had recently deteriorated and she explained she has been isolating due to poor health, her breathing problems and arthritis in legs being the main issue to her mobility. Mrs. A. is only in receipt of state pension and often uses Food banks or chooses between 'heating and eating' due to cost of living.

Successfully supported applications to the respiratory nurse for a COPD review resulting in a change in medications and increased confidence in her inhaler regime. A referral was also made to OT for replacement rollator and an environmental assessment or her property for adaptions and stairlift etc. Supported applications for 'Attendance allowance' and 'Pension credits'. Engaged in several community visits due to increased mobility following successful referrals.

Mrs A

Mrs A

Simon is a little treasure, I have been trying to ring the surgery to thank him for everything he has done, I have been successful in getting attendance allowance which has made such a difference, it has changed my life and has made my days so much easier, without having to worry about making ends meet now.

He is my little fairy, that has changed my life, a lady turned up and brought me a brand new 'walker' which I thought was strange until I spoke to Simon, and he said this was his doing too, I couldn't believe how quick it all happened, I wouldn't have known I could get any of this, it has made such a difference and changed everything, Simon has been a godsend.

Simon, you've done it again, I can't believe it, I can't believe that someone I don't know has done so much for me, there are people out there struggling to pay their bills and pay for food, I can't believe I have been lucky enough to have found you. You've gone overboard with your help, it's amazing what you have done, and it has totally changed my life. Any time you have 30 minutes, I will take you for a coffee, a nice Christmas one, it's the least I can do, now I can afford one.

Case Stories

Mr B is a 62-year-old man with severe COPD who lives alone in social housing, was previously his wife's primary carer until she passed away. Mr B is on benefits due to incapacity to work because of the severity of his long-term condition, he sleeps downstairs on his sofa and doesn't have a downstairs bathroom. Since his wife's passing and significant deterioration of his COPD, he reports very low in mood and isolates himself, describing his typical day as staying in his lounge with the curtains shut, he doesn't go out unless his 2 friends visit but has no family or formal support.

Successful supported applications for PIP, re-assessment for Universal Credit and work capability and Blue Badge and OT assessment resulting in Stairlift for upstairs access.

Mr B

Mr B

You can go ahead and give yourself 5 stars, I couldn't ask for better, the help you have given me is priceless, with my health and with money, when my wife passed away, I was on my bones with money and have no idea how to do these applications, or where to start. I am getting out more because of the blue badge. You have been a 'gent' all the way, I wish you the best of luck and thank you for saying I can self-refer, I might take you up on it in the future.

Case Stories

Mr C is a 61-year-old man with several long-term conditions including, severe arthritis of lower limbs and spinal stenosis, COPD and obstructive sleep apnoea. Mr C was previously very active but due to deterioration in his conditions he is unable to mobilise without crutches around the home and drives everywhere to access the community. He averages 2 to 4 hrs sleep a night and is unable to use the stairs at home safely, his weight has increased due to inactivity resulting in severe pain and limited mobility, he is therefore more isolated within his home. Mr C is a long-term smoker and wants to stop but doesn't feel motivated to change anything currently.

Successful supported referrals to Healthwise for swimming therapy and Health trainer for Smoking cessation.

Supported CYC occupational therapy referral, resulting in environmental assessment and stair lift.

Mr C

Mr C

Thank you for all the help, I have been 2 months without smoking and still go to the swimming, it's all made a difference and the stairlift will change my life, it will be the first time I have slept in a bed in nearly 5 years, and upstairs too, I wouldn't have had a clue about all these things, thank you

Case Stories

Mrs D is a 69-year-old lady who lives with her husband, they have lost their only son last year. Mrs D and her husband were her son's primary carer when her health deteriorated. Mrs D sleeps downstairs in her chair due to her pain, severe mobility issues and the severity of her long-term conditions which include lung cancer, bowel cancer and COPD. Mrs D isolates and is unable to access many community areas due to the severity of her conditions, 6 months prior her application for attendance allowance (AA) and a blue badge was refused before engaging in PSP.

Successfully supported applications for Attendance Allowance and Pension credits.
Supported referral to OT for environmental assessment and adaptions at home.
Successful in blue badge following referral and supported application.

Mrs D

Mrs D

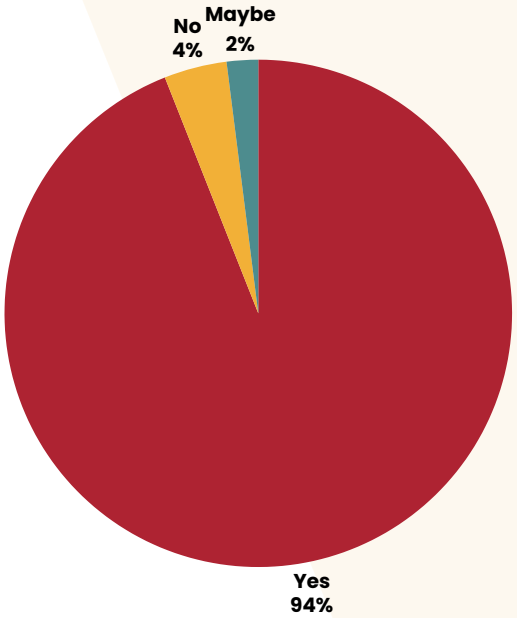
I can't thank you enough, the blue badge has helped so much, I'm getting out a lot more now.

I've never had benefits, I didn't know I was entitled, nobody helped or told me, you had better stay and not go, I don't know what we would do without you.

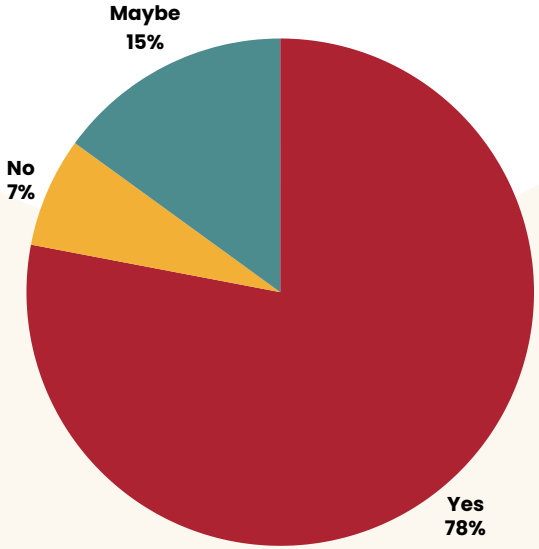
Feedback

at the time of the report

Of the completed feedback forms post working with the Proactive Social Prescriber, the following results were collected:



Q1: **94%** of patients stated the PSP helped them to set goals that were important to them.



Q2: **78%** of patients felt more in control of their health and wellbeing following support from the PSP.

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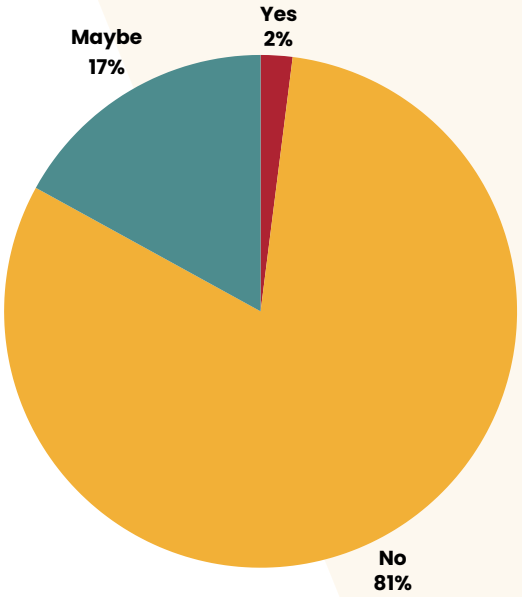
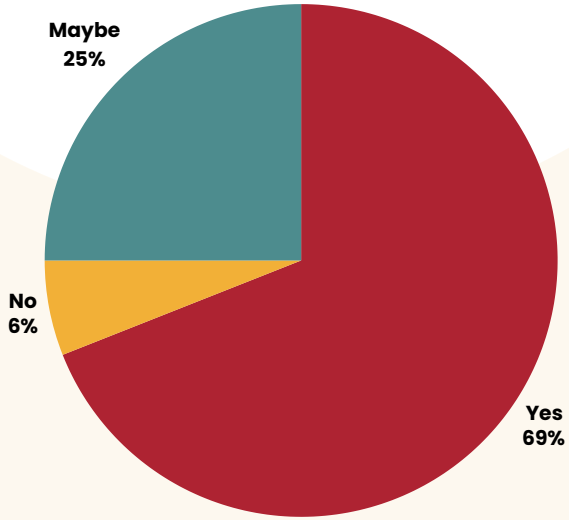


Q3: **81%** of patients stated they would not have been aware or accessed the support without PSP intervention.

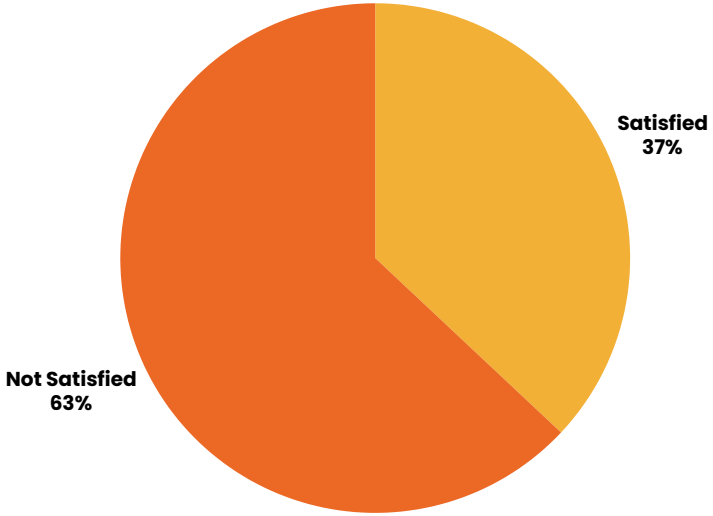


Q4: **69%** of patients felt they could manage their health more effectively since engaging with the PSP.

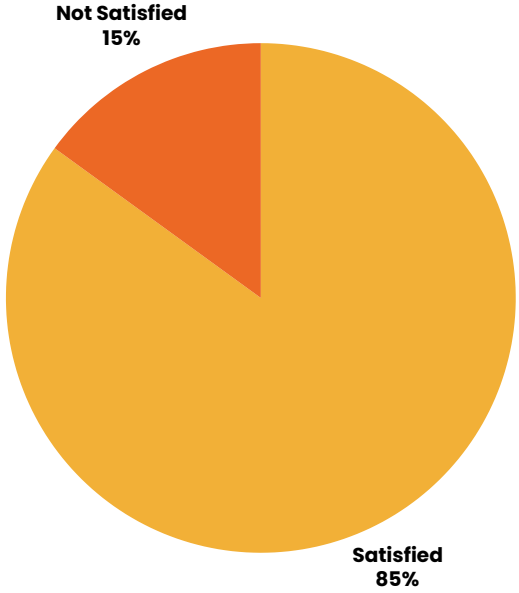
ON24 Scores

The following ONS4 data was collected prior to working with the PSP and following discharge from PSP support at the end of year one.

Before PSP support



After PSP support



Patients reported that overall, they were not satisfied with their life prior to working with PSP.

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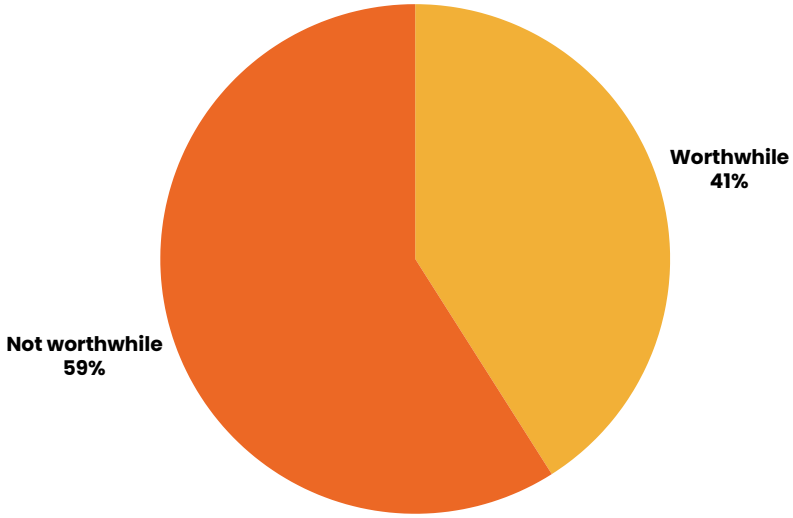
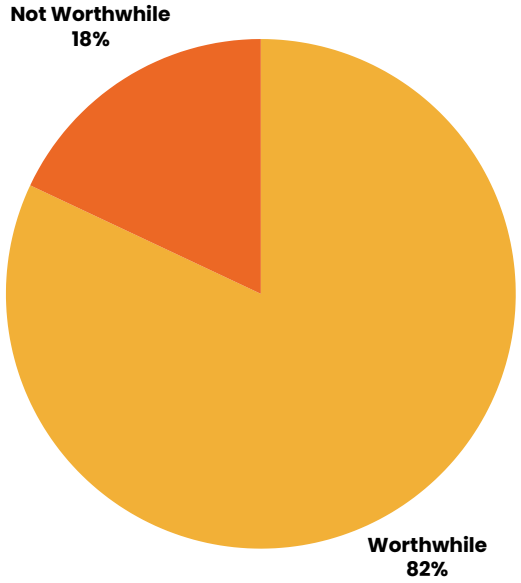
Before PSP support



Patients reported that overall, they felt things they did in their life were worthwhile

After PSP support



Patients felt the things they did in their life were more worthwhile after PSP intervention

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RESPIRATORY HEALTH INITIATIVE REPORTS 03/03/25

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