Social Prescribing: The National Context

James Sanderson
November 2018
@JamesCSanderson
Comprehensive Model for Personalised Care

All age, whole population approach to Personalised Care

People with long term physical and mental health conditions
30%

People with complex needs
5%

Whole population
100%

INTERVENTIONS

Specialist
Integrated Personal Commissioning, including proactive case finding, and personalised care and support planning through multidisciplinary teams, personal health budgets and integrated personal budgets.

Targeted
Proactive case finding and personalised care and support planning through General Practice. Support to self manage by increasing patient activation through access to health coaching, peer support and self management education.

Universal
Shared Decision Making. Enabling choice (e.g. in maternity, elective and end of life care). Social prescribing and link worker roles. Community-based support.

TARGET POPULATIONS

OUTCOMES

Empowering people, integrating care and reducing unplanned service use.

Supporting people to build knowledge, skills and confidence and to live well with their health conditions.

Supporting people to stay well and building community resilience, enabling people to make informed decisions and choices when their health changes.

Increasing confidence
Staying well
Building community resilience
Enabling people to make informed decisions and choices when their health changes.
Personal Health Budgets and Integrated Personal Budgets
An amount of money to support a person’s identified health and wellbeing needs, planned and agreed between them and their local CCG. May lead to integrated personal budgets for those with both health and social care needs (Initially Specialist).

Supported Self Management
Support people to develop the knowledge, skills and confidence (patient activation) to manage their health and wellbeing through interventions such as health coaching, peer support and self-management education (Targeted and Specialist).

Social Prescribing and Community-Based Support
Enables professionals to refer people to a ‘link worker’ to connect them into community-based support, building on what matters to the person and making the most of community and informal support (All tiers).

Optimal Medical Pathway
WHOLE POPULATION
when someone’s health status changes

30% OF POPULATION
People with long term physical and mental health conditions

Cohorts proactively identified on basis of local priorities and needs

Shared Decision Making
People are supported to a) understand the care, treatment and support options available and the risks, benefits and consequences of those options, and b) make a decision about a preferred course of action, based on their personal preferences and, where relevant, utilising legal rights to choice (All tiers).

Personalised Care and Support Planning
People have a proactive, personalised conversation which focuses on what matters to them, delivered through a six-stage process and paying attention to their clinical needs as well as their wider health and wellbeing.

Review
A key aspect of the personalised care and support planning cycle. Check what is working and not working and adjust the plan (and budget where applicable).

Personal Health Care and Integrated Personal Budgets
An amount of money to support a person’s identified health and wellbeing needs, planned and agreed between them and their local CCG. May lead to integrated personal budgets for those with both health and social care needs (Initially Specialist).

Supported Self Management
Support people to develop the knowledge, skills and confidence (patient activation) to manage their health and wellbeing through interventions such as health coaching, peer support and self-management education (Targeted and Specialist).

Social Prescribing and Community-Based Support
Enables professionals to refer people to a ‘link worker’ to connect them into community-based support, building on what matters to the person and making the most of community and informal support (All tiers).

Optimal Medical Pathway
WHOLE POPULATION
when someone’s health status changes

30% OF POPULATION
People with long term physical and mental health conditions

Cohorts proactively identified on basis of local priorities and needs

Shared Decision Making
People are supported to a) understand the care, treatment and support options available and the risks, benefits and consequences of those options, and b) make a decision about a preferred course of action, based on their personal preferences and, where relevant, utilising legal rights to choice (All tiers).

Personalised Care and Support Planning
People have a proactive, personalised conversation which focuses on what matters to them, delivered through a six-stage process and paying attention to their clinical needs as well as their wider health and wellbeing.

Review
A key aspect of the personalised care and support planning cycle. Check what is working and not working and adjust the plan (and budget where applicable).

Personal Health Care and Integrated Personal Budgets
An amount of money to support a person’s identified health and wellbeing needs, planned and agreed between them and their local CCG. May lead to integrated personal budgets for those with both health and social care needs (Initially Specialist).
A model for social prescribing

Social Prescribing Link Worker
Employed to give time
Part of primary care network team
and local social prescribing connector scheme

What matters to me
Create a tailored plan

Collaborative commissioning and partnership working

Outcome

Support Group

Community

Workforce development

Easy referral from all local agencies
Shared decision making

In 2017/18 SDM was embedded into:
• Musculoskeletal elective care pathways in 13 CCGs
• Respiratory elective care pathways in 8 CCGs

Personalised care and support planning

• 75,914 people had a personalised care and support plan by March 2018
• Over 180,000 people supported by integrated, personalised approaches

Enabling choice

• 83% of CCGs have now completed Choice Planning and Improvement self-assessment
• Of these, 80% also now have a patient choice improvement plan

Social prescribing & community-based support

• 68,977 referrals in 2017/18
• 331 link workers employed in local areas

Supported self management

• 84,766 patient activation assessments delivered in total
• 8,229 people attended group-based or peer support activities
• 16,000 people had self-management education or health coaching

Personal health budgets & integrated personal budgets

• 28,040 PHBs by March 2018
• 83% up year-on-year in 2018-19 to date
• 15% jointly funded with social care
• 42,565 Personal Maternity Care Budgets delivered by July 2018 across 36 CCGs

Significant delivery of Personalised Care
The difference personalised care makes

To people’s experiences

- 86% of people said they achieved what they wanted with their PHB.
- 77% of people would recommend PHBs to others with similar needs.
- There is extensive evidence of improved wellbeing, satisfaction and experience through good personalised care and support planning.
- 75% of people who booked hospital outpatient appointments online felt they were able to make choices which met their needs.

To people’s outcomes

- People and professionals consistently overestimate treatment benefits and underestimate harms. Shared decision making helps reduce uptake of high-risk, high-cost interventions by up to 20%.
- In one area 83% of people were able to die in a place of their choice, against a local average of 26% because of personalised care at end of life.
- There is emerging evidence that social prescribing leads to a range of positive health and wellbeing outcomes, including improved quality of life and emotional wellbeing.

To the workforce experience

- Personalised care and support planning has been shown to improve GP and other professionals’ job satisfaction.
- 59% of GPs think social prescribing can help reduce their workload.

To the system

- PHBs provide an average saving of 17% on direct costs of conventional CHC packages for home care, and indirect savings of £4,000 per person per year.
- Integrated Personal Commissioning (IPC) in one area resulted in 15% reduction in delayed transfers of care and 10% reduction in A&E attendances.
- Integrated Personal Commissioning in one area led to a reduction of 50% in A&E presentations in people with substance misuse problems.
- Evidence has shown that those with the highest knowledge, skills and confidence through supported self-management had 19% fewer GP appointments and 38% fewer A&E attendances than those with the lowest levels of activation.

www.england.nhs.uk
Our objectives

Commitment: By 2023, government will support all local health and care systems to implement social prescribing connector schemes across the whole country, supporting government’s aim to have a universal social prescribing national offer available in GP practices

A connected society, a strategy for tackling loneliness

Objectives:
• Map all social prescribing connector schemes across England - Dec 18
• Publish best practice guide alongside the Long Term Plan - Dec 18
• Launch an online social prescribing platform – Dec 18 *
• Develop regional social prescribing networks and regional steering groups – Dec 18
• Publish Common Outcomes Framework for social prescribing – Dec 18
• Pilot new accredited learning programmes for social prescribing link workers - 2019
• Learn from good practice in enabling all local agencies to refer to social prescribing – 2019

* Achieved ahead of schedule. For sharing resources and discussion. Join by emailing england.socialprescribing@nhs.net