One Westminster Social Prescribing service
March 2021 – March 2022
(A preventative approach to Population Health)

The Team

- 4 x Mental Health Social Prescribers
- 8 x PCN Social Prescribers
- 1 x Social Prescribing Resources Officer
- 1 x Head of Social Prescribing

Key to the Westminster Social Prescribing service

Addressing health inequalities by supporting people with social needs that impact on their wider determinants of health. We use a preventative approach through an ongoing extensive relationship using the "what matters to me approach" to tailor support to the individual. The VCS organisations are key partners in delivering the Social Prescription.

We start at the beginning

Recruitment process – selection – workshop – matching and retention

Prioritising Wellbeing

Clinical psychological support – peer support, thread to discuss casework with non-identifying features, HSP input into groups, escalating process, loneliness , Mental health

Patient journey

Initial contact, ONS4, triage, making a plan together, researching, encouraging, activity take up, handholding into service, embedded in the service / activities, Discharge

Average patient waiting list

12 people for up to 3 weeks, first contact is with the first week of being tasked. An AcCurx message or most accessible way to contact the patient to let them know the referral has been received and the Social Prescriber will be in touch.

Caseload, capacity and waiting lists

Through out the year all SPs were working at capacity caseload of 30 to 35 people a month and occasionally near capacity. All operated waiting lists for sometime through out the year. The south with the most extensive waiting list.

Imperial Community Group Placement

MEDICAL STUDENTS RESEARCH FINDINGS

(October 2021 - January 2022)

Interview with patients

Patients were largely overwhelmingly positive about the support they received from their service.

Social prescribers were identified as being immensely supportive and empathetic, serving as advocates for patients beyond the scope of the support received by GPs, focusing on social needs.	The variety of support offered is very evident. Patients value the Social Prescribers' wealth of knowledge and connections.	Many patients identified the fact that before their first session they had poor understanding of social prescription, with the medical professionals not fully addressing the purpose of social prescribing on referral.	Patients felt that it should be a service that more people know about and can utilise.

Patient Record Analysis

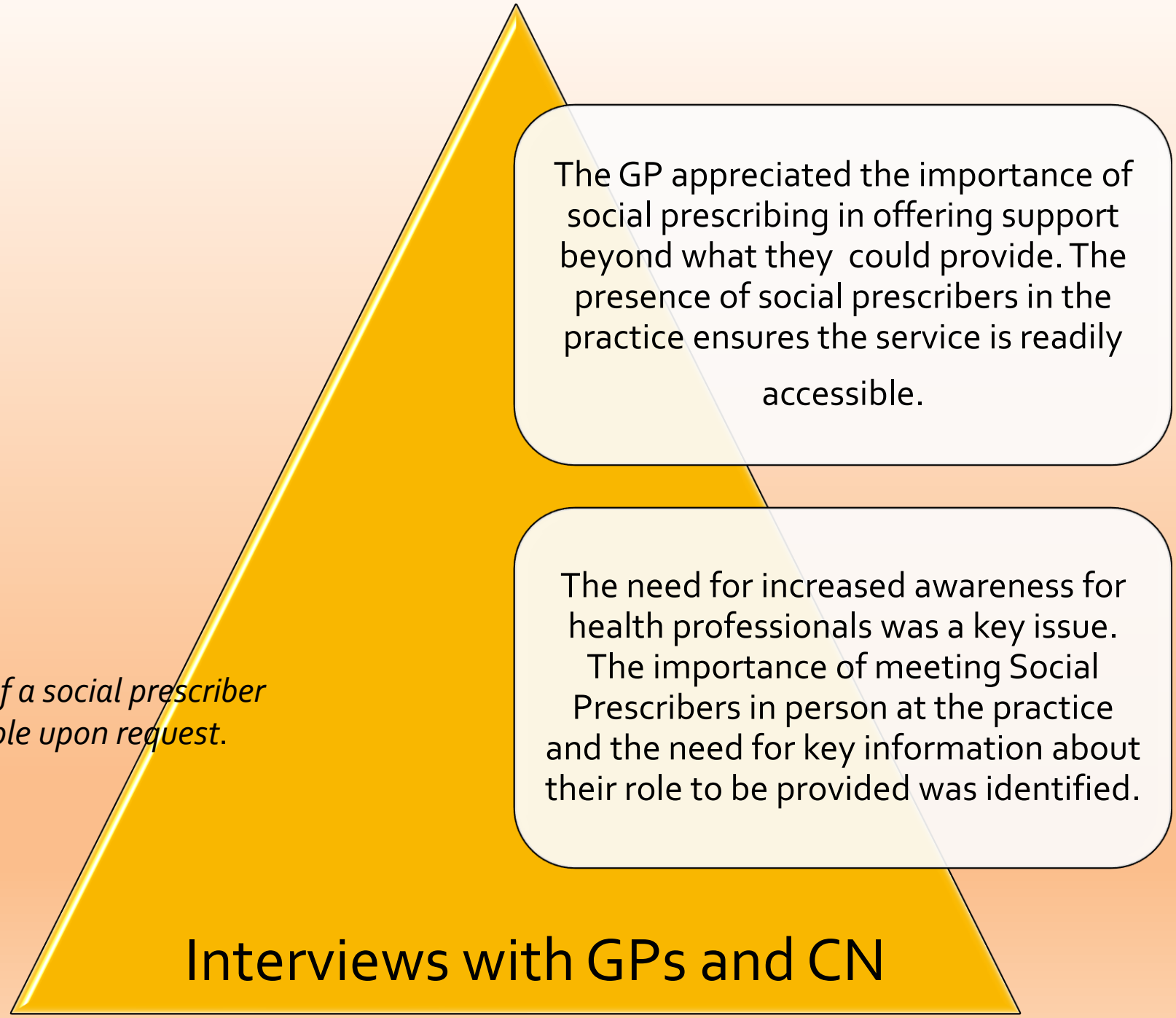
- Invaluable insight into the complexities of cases brought to the Social Prescribers
- Highlighting the variety of issues that patients need addressed.
- Wide variety of services and resources the Social Prescribers utilise.

Patient Record Analysis

- Evidently the service provides support to people from a diverse range of backgrounds.
- Cases are often complex, with new issues arising as others near resolution – mental health was an underlying issue identified in some capacity in virtually every case, challenges with living situations were another common source of referral.
- Cases are driven by action plans outlaid by Social Prescribers continuously throughout the referral – ensuring high degree of efficiency.
- The plans going forward are characterised by collaboration and discussion between the Social Prescribers and their patients, ensuring the agenda is realistic and tailored to patients' needs.
- Collaboration and communication with other Social Prescribers and line manager was evident, and key to achieving the correct support for patients.

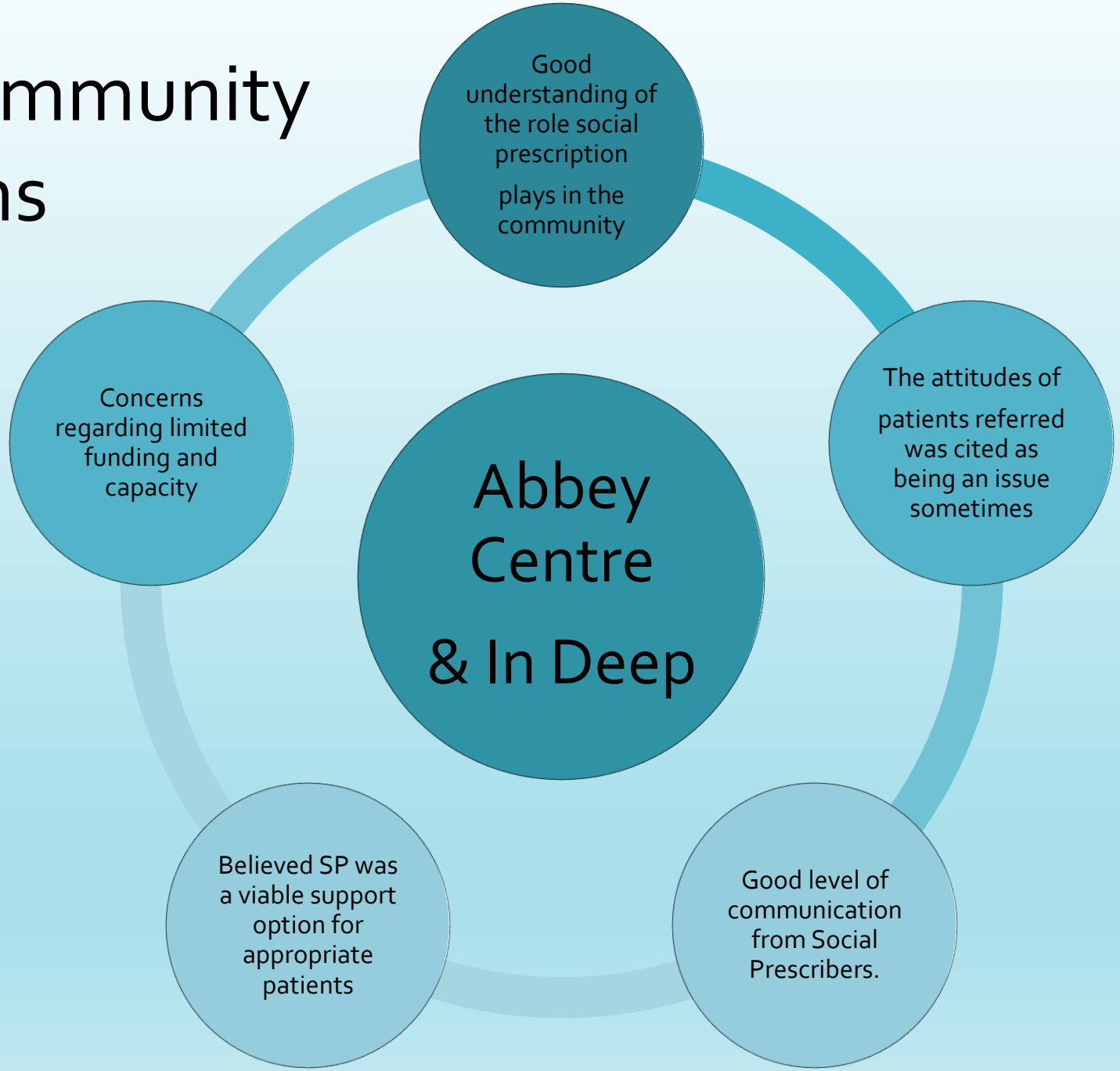
Patient Record Analysis

- Success rates are also attributed to the web of collaboration between the Social Prescribers and the network of organisations into which they refer the patient.
- Social Prescribers are incredibly persistent in terms of following up both patients who are not engaging, as well as external organisations who may not be dealing with cases in a timely manner.
- In dealing with living situations particularly, the primary challenges encountered are related to the capacity and bureaucracy of statutory services – they are often slow to respond and cannot offer patients adequate support – this means that patients are sometimes removed from the borough.
- There was evidence of patients being prematurely discharged when they left Westminster and/or transferred to a new GP practice not part One Westminster's network.
- Social Prescribers sometimes do not have the remit or authority to support with some statutory issues in its entirety – especially regarding housing technicalities.



The day in the life of a social prescriber document is available upon request.

Survey of Community Organisations



Key factors in the support offered

Support is open ended and last for as long as the person needs Social Prescribing support.

On average people stay between 3 and 6 months. With 4 months being the overall average through-out.

Same Social Prescriber – through out the process – they don't need to re-tell their story – it's a relational role which creates the avenue for a piece of work to start and finish.

Staff team all from person centered care backgrounds and from various communities and languages.

Caseloads are between 30 and 35 per month- we have found this need so the revised down to 30 maximum to ensure the best service.

Investigating what matters to the community

Social Prescribing Development Specialism

Activities and interventions in Social Prescribing (2021-2022)

- Health Coaching pilot
- Yoga workshop
- Attending fayres to promote Social Prescribing
- Producing Clinicians leaflet & Patient leaflets
- Sharing good practice and learnings with other Social Prescribing services nationally
- Head of Social Prescribing speaking on platforms as key note speaker about the Social Prescribing service

AWARDS

Westminster Community Mental Health Hubs Social Prescribing CNWL NHS Foundation Trust. Awarding body - PPiMH Awards"

Joint Winners of Primary and Community Mental Health Care 2021

Recognised as scheme of good practice London wide

Social Prescribing Manager of the Year 2021 – Finalist

Awarding body National Association of Link Workers

By Bromley by Bow, London Plus and other social prescribing services London wide

What are we measuring

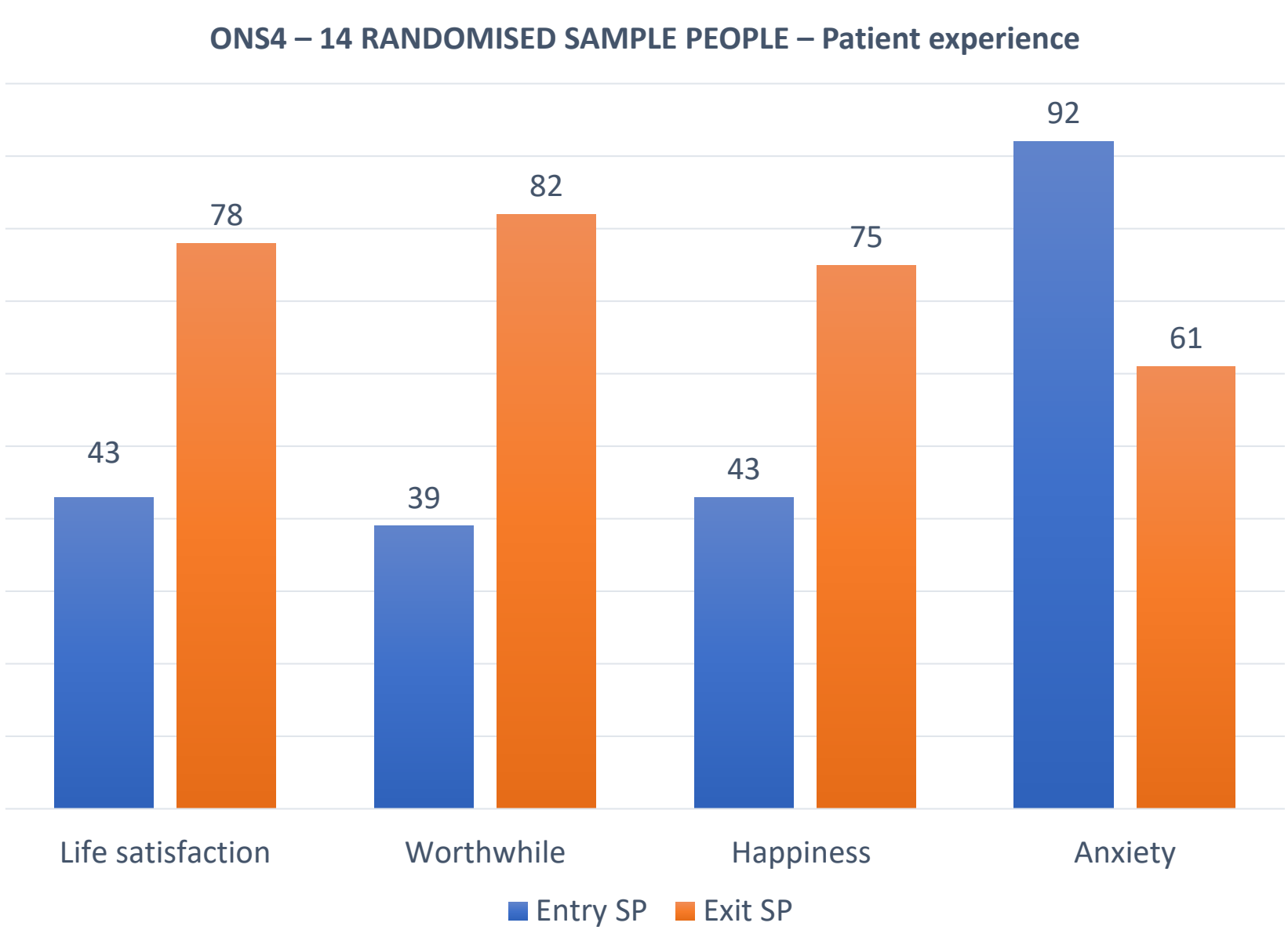
- People
- Service
- Community Groups
- Other sectors we interact with, eg Statutory

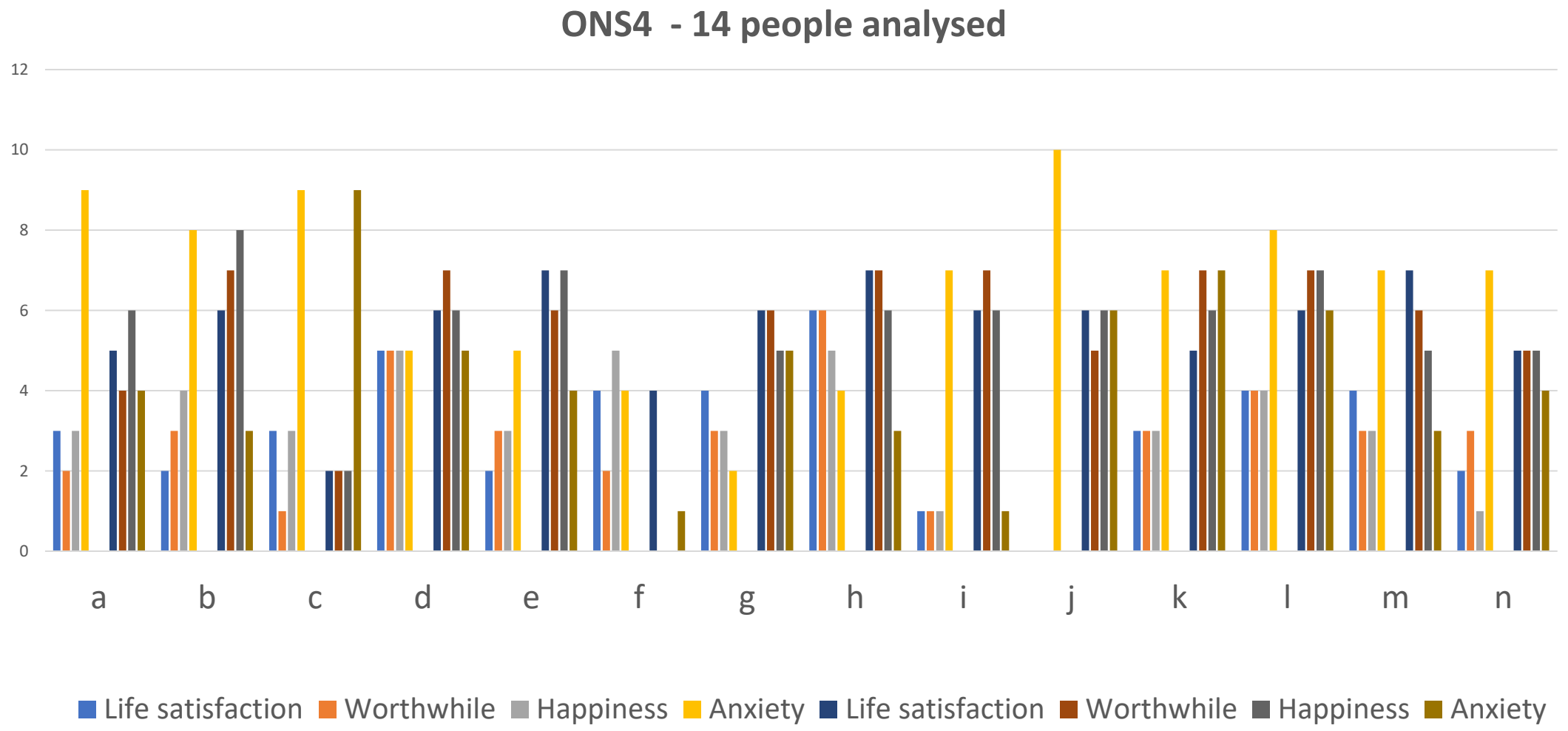
Outcomes

Outcomes frame work and measuring tool feels natural and a part of the conversation ONS4

Outcome

- Life became worthwhile by more than double the amount for people.
- A significant reduction in anxiety was had. And when looking at the individuals, some people had a reduction of half the anxiety
- All scores improved significantly with Life satisfaction and Happiness improving by nearly 40% more.



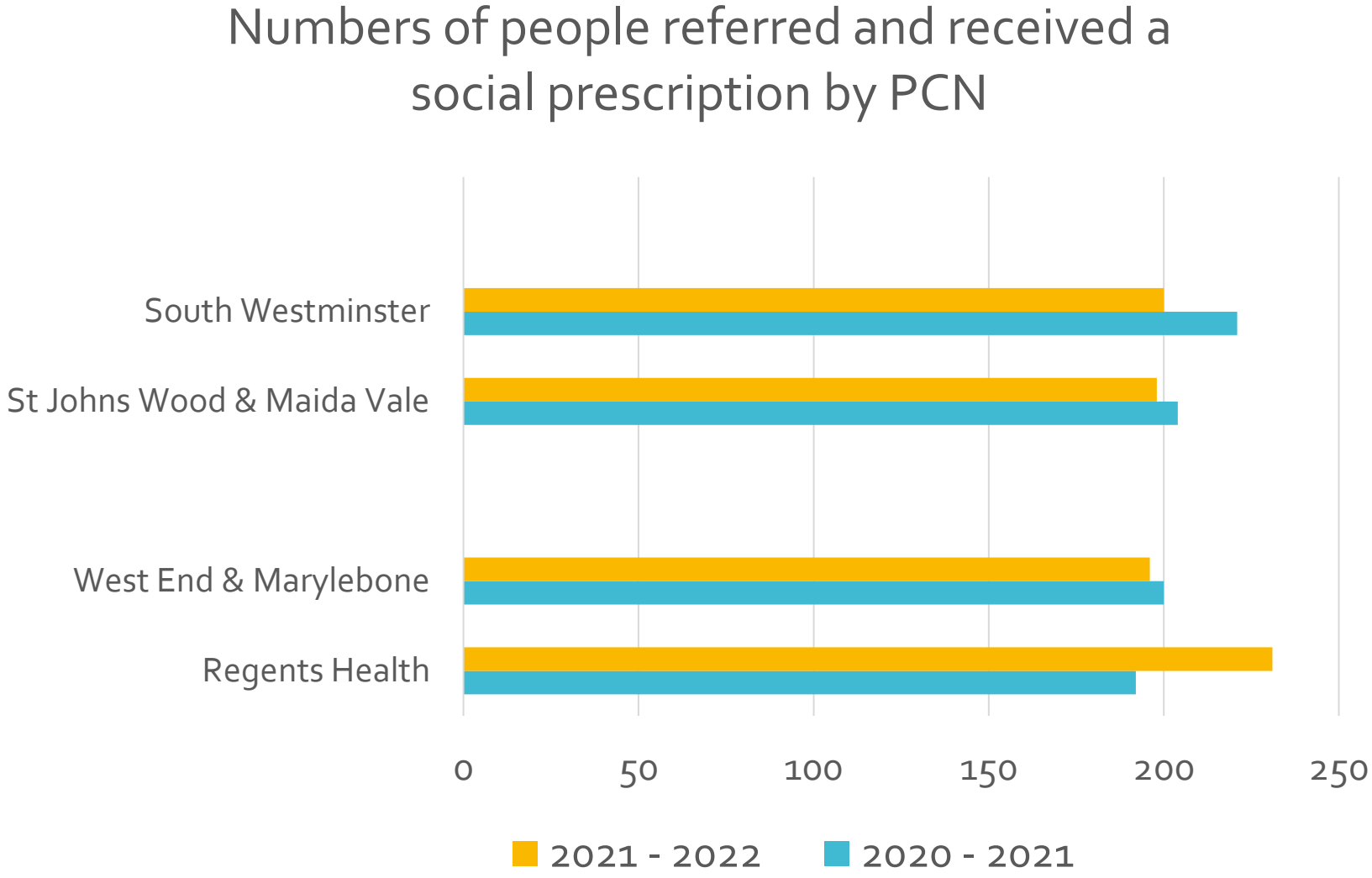

ONS4 - 14 people analysed
12
10
8
6
4
2
0
a
b
c
d
e
f
g
h
i
j
k
l
m
n
Life satisfaction
Worthwhile
Happiness
Anxiety
Life satisfaction
Worthwhile
Happiness
Anxiety

Referral numbers for Social Prescribing service

March 2021- March 2022

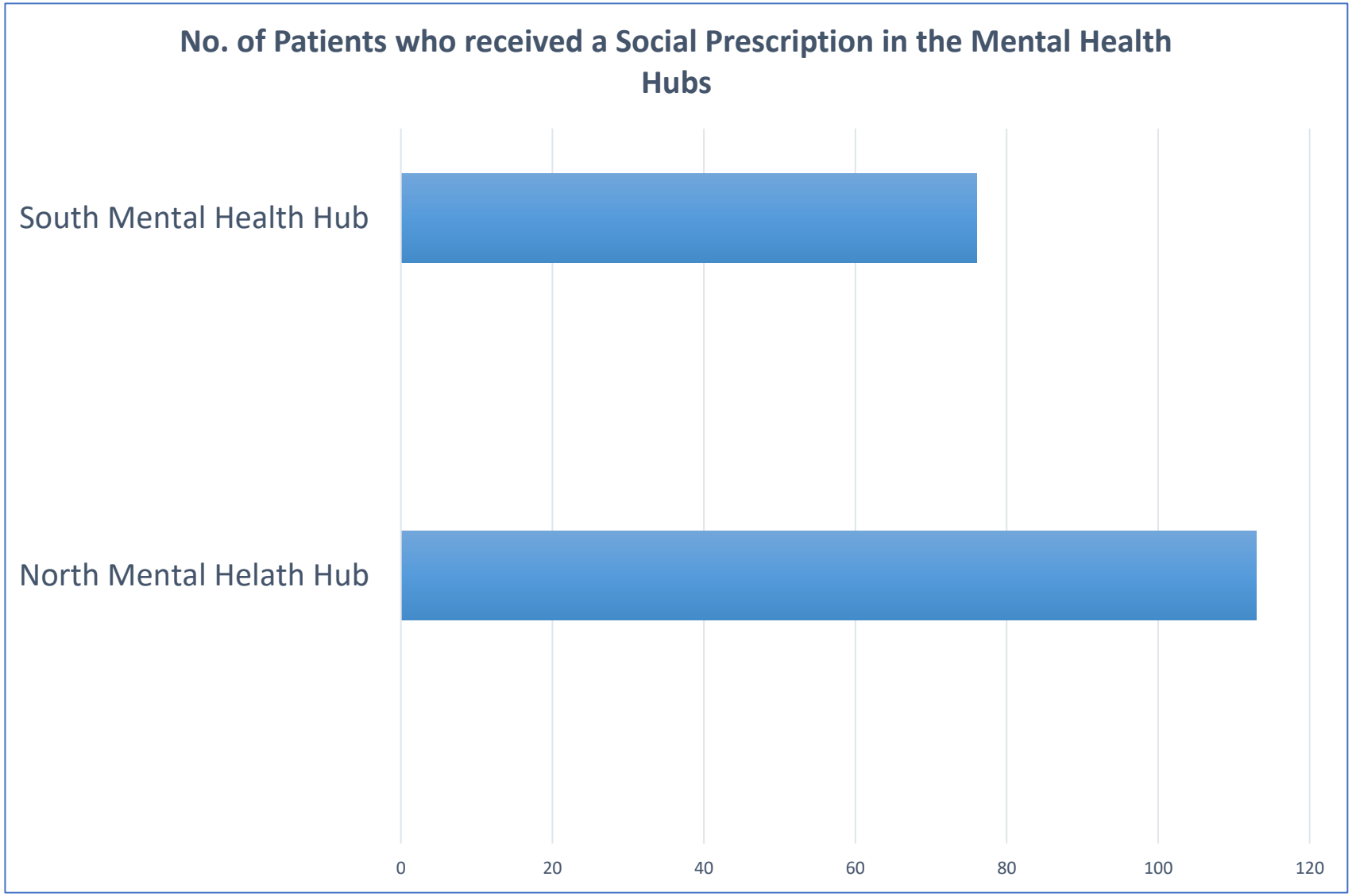
Breakdown of numbers are available for individual surgeries.

- Regents Health has the highest number of referrals into Social Prescription. Paddington Green Health Center, Connaught Square Practice and Lisson Grove.
- Though the smallest of patient population. WEM PCN utilises Social Prescription well.



An MHSP – Patient Discharge statement

"Ali is a 42-year-old Bengali gentleman who currently lives in his sister's flat with his wife and two children (both aged under 10). They share the space with his sister's family, so there are 10 people in the 3-bedroom property at present, and the family are at risk of homelessness. Ali has approached Housing and has been advised to find private rented accommodation. However, he is a waiter, and his income has been affected by the pandemic, so he is concerned that he will be unable to afford this. Ali explained that he does not have anybody he feels able to talk to at this stressful time. Ali also mentioned he was interested in starting an ESOL course. I have connected Ali with an advisor from Shelter for further advise regarding housing. I have supported Ali to enrol on Grand Junction's Community English for Beginner's Course which starts in September. I have put Ali in contact with Bengali emotional support."



Total number
1082 people
supported

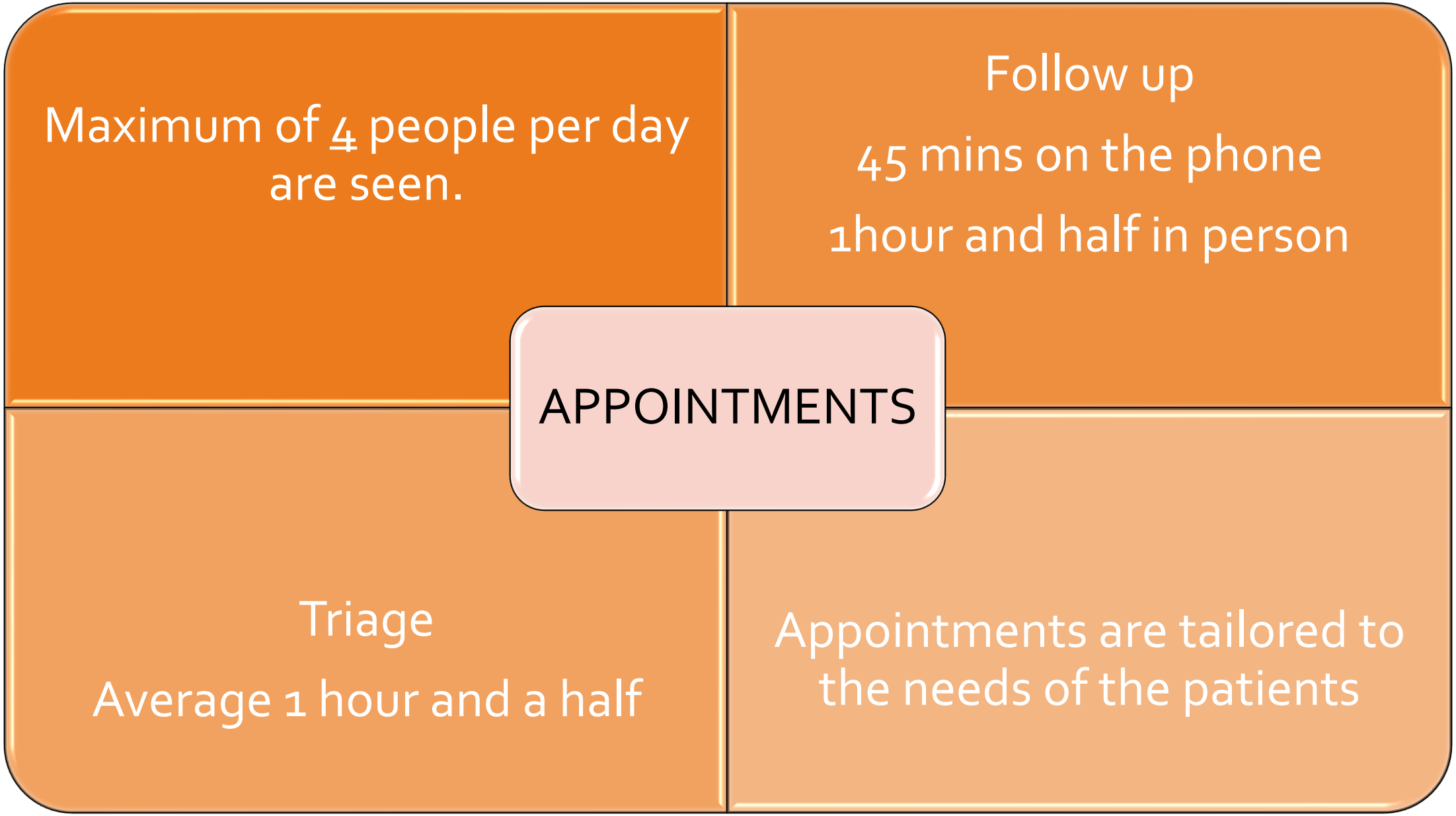
2021 - 2022

Who are the patients?

- Reflective of the communities living in the area based on Westminster ward profiles.

What are their main needs?

- Housing
- Mental health
- Welfare & Debt advice
- Loneliness


Maximum of 4 people per day are seen.
Follow up
45 mins on the phone
1hour and half in person
APPOINTMENTS
Triage
Average 1 hour and a half
Appointments are tailored to the needs of the patients

Patient feedback

“One of my clients left me a voicemail today. He has health issues and restricted mobility. I referred him to the food bank and for a fuel voucher. This morning he was in the dark and cold, he was extremely thankful for our help, saying he now has light. ” SP.

Case Study 2

- *MT is a 26-year-old female with a mental health diagnosis who is stable on medication.*

Needs

- social isolation
- interested in volunteering

  interested in part time employment

Intervention

- Employment specialist
- Online social groups – Women only
- Walking group set up by our SP service with 5 other people who had a mental health diagnosis.
- Found a friendship with one person.
- One Westminster's volunteer support programme

On Discharge

- Awaiting to start a mentoring role
- Join an in-person event at the Women's organisation she had joined online

Plan for next Year

- To create an appropriate social prescribing response to emergency needs and integrate this in the PCN's where we can see this is most needed. Rapid Responder SP roles.
- To move to a digital data capture programme integrated with S1.
- Introducing Senior Social Prescribers (April 2022)
- Re-review of structure in September 2022.
- Wellbeing Coaches in Regents Health PCN evaluation October 2022.

Gap in service

- Rapid responders for emergency needs
- Chat with a nice person – (Not befriending) – volunteer chatter / listener
- Strong relationship with the Care Coordinators
- Referrals from multiple pathways in the GP practice through out the borough.
- No alternatives when voluntary sector reaches capacity.

Students Assesment

Recomendations for improvement

1. Building on our collaborative relationship with health professioanls in the PCNS through providing more opportunities for all parties to understand what the needs are in both pathways.

Currently, Social Prescribers employ a variety of different methods to support PCNs understanding about SP and referrals.

<u>These include:</u>

- Posters
- Presentations
- Attending MDT & PCN meetings

2. Continue to support medical students education of Social Prescribing.

3. Changes to OW website to bring SP to the fore and créate a webpage.

One Westminster recommendations

1. To seek agreement to introduce 2 rapid responder SPs.

2. Strengthen Social prescription across all PCNs and MH Hubs. This will include OW providing bite sized information.

3. Further develop understanding and relationships across all of the PCNs and CMHT partners

4. To continue to promote the need for funding to follow the person into the social prescription activity or service in the VCS.

5. To support the development of services that meet gaps in current provision.

6. To successfully engage with all GP practices and Mental Health Hubs