



Social Prescribing

**Wellbeing and Health VCS Open Forum
February 2011**

Report prepared by NCVS

1 Introduction

On 17 February 2011 the Wellbeing and Health VCS Open Forum held a workshop event on Social Prescribing. The purpose of the event was to:

- Establish a voluntary and community sector perspective on social prescribing and in particular the idea of local hubs led by a lead provider.
- Gauge the level of interest from delegates to become part of such a mechanism, both as local providers or as a lead organisation.
- Consider alternatives to the lead provider hub model.
- Develop recommendations for future action.
- Produce a report containing those recommendations and subsequently use it to contribution to multi sector debate and decision making through the Wellbeing and Health Partnership.

This report is based on the output from the workshops on that day. The presentations made are available on NCVS website

<http://www.cvsnewcastle.org.uk/forums/hccf/adultwellbeing.htm>

2 A definition of Social Prescribing

A means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector (VCS).

3 Benefits of Social Prescribing

To patients	Improved health and wellbeing Supports health and lifestyle change Improved self esteem and confidence Offer of accompanied visits More specialised local knowledge Speed of referral Allows time to be heard.
To GP practice	Reduces frequent practice attendance More appropriate use of GP time Easy referral Provides links between the VCS and primary care Increased range of practical services Encourages and supports self care.

Cost saving Decreased reliance on GP's
 Decrease in clinical prescribing
 Decreased need for acute services

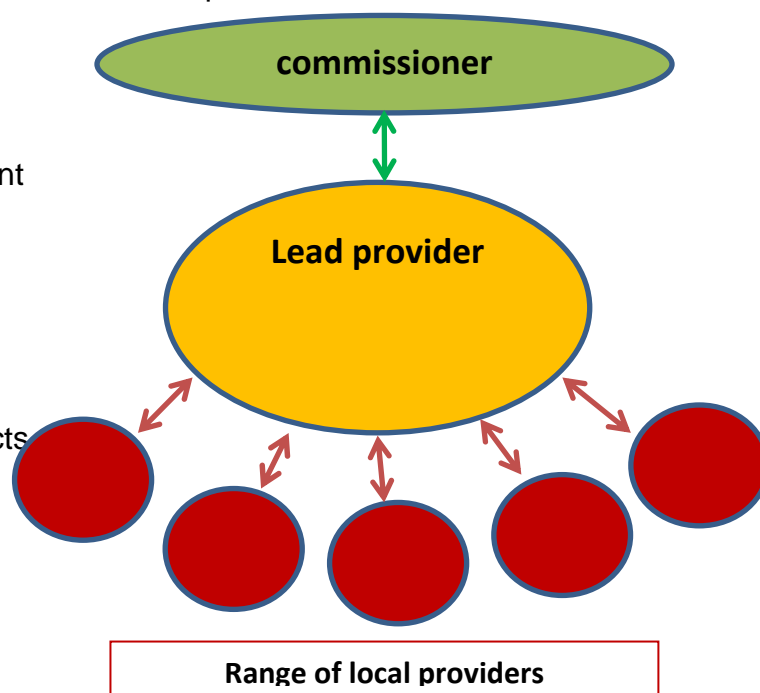
4 Commissioning – The idea of a Hub

The idea of local hubs arises from the need to provide easy access for referrers to local services, ideally through a single point of contact, but which draws together a wide range of service providers.

The main structure put forward for a hub is the lead provider model. Illustrated below:

Key features

Single point of access and assessment
 Single contract for commissioners
 Managed capacity
 Credible and visible
 Lead provider model provides ability
 to manage a range of sub-contracts
 Focus on VCS providers
 Focus on disadvantaged areas
 Captures local intelligence
 Easier signposting
 Easier monitoring of outputs/outcomes



As an alternative to geographically based hubs, it may be possible to create one based on a particular theme (such as employability or physical activity) or communities of interest or identity (such as BME or older people).

Lead provider issues

The role of lead provider would be a key one in this model and the following points needs to be taken into account:

- A robust knowledge and understanding of the skills and capacity of local providers would be essential, which may favour the idea of a lead organisation being identified from the local area.
- The lead provider would need a process for ensuring fair distribution of work.

- There are risks for the lead provider in being responsible for the quality of local providers.
- Who would oversee lead provider quality? GP commissioners would seem the obvious candidate, but they would lack the knowledge.

Alternative Models

It is important to not simply assume the lead provider model is the best option. Any feasibility study should consider alternatives. These include:

- A broker model in which the lead is not a provider and therefore independent.
- A consortia model. The leader provider/sub contractor models make it possible for the lead to provide most or all of the services. A consortia structure would offer some protection against this for local providers.
- Could GPs refer directly to individual groups through an information system? This could be a modified broker model where the independent agency manages the information system.

General unanswered questions about a social prescribing hub

- Could wider based (citywide +) organisations be commissioned to work with local groups, and how would they link into geographical hubs?
- How can we ensure smaller local VCS take part and not be squeezed out? The involvement of small local groups is essential.
- There are lots of groups already supporting vulnerable people into services, not just health trainers. How will they fit in?

5 Referrals and referrers

Alternative pathways

This report, and the workshop event, was based on a proposed relationship between GPs and a local grouping of providers. However it is possible that this may be too restrictive in terms of who can refer into a hub and that we need to consider multiple pathways into services.

The logic behind the notion of multiple pathways addresses the need for early intervention. GPs may not see an individual until the issue is well advanced. It is important to the idea of preventative action that unnecessary medicalisation is avoided.

Possible alternative pathways include:

- Self referrals
- Health and Wellbeing Boards
- Local community projects, who are more likely to identify people rather than GP's

Managing provision to an individual

In many cases individuals will need more than one intervention from more than one provider. How this is managed matters because there is a danger of services not being joined up. Whatever model is used it should recognise that multiple interventions need to be seen, and managed, as a journey for the individual.

Who would do this? Would the individual always have to go back to the GP? Or could the hub play a role, either as advisor to the GP or potentially provide case management for the individual to a range of services?

Referring to the right services

A hub would have a crucial role to play in ensuring the right services are accessed. GP's won't know what's out there and hubs would be the logical place to hold that intelligence, perhaps in the form of a database and a website on which providers could list themselves.

6 Funding

How the interventions will be commissioned will have the biggest impact on whether VCS organisations, particularly the smaller ones, will be able to take part. For this reason it is important that the sector is involved at commissioning level (GP consortium) to ensure it is appropriate to the sector and to local providers.

The kind of issues that would need to be addressed in designing a commissioning method include:

- Payment by results and/or in arrears would be a serious barrier.
- Block funding to a hub is one model, but the size of such a contract would have to be appropriate, and clarity about accountability and where the risks lie.
- If the money follows the patient how would that work? A method that incorporates the minority who hold personalised budgets would have to be devised. Funding based on individuals also fails to recognise that organisations and activities need funding (spot purchase versus block funding).
- There is a danger that a commissioning model involving engagement with a hub could be quite expensive in both money and time (GP time, lead assessment and monitoring).
- What if any charges might the GP make? For example for letters of referral?
- What happens if individuals fail to attend? Would the provider still be paid?
- Any commissioning model would need to be able to make minor payments. Some local providers will only need relatively small amounts of money (say refreshments and room booking for an event).

- Commissioning should be proportionate to the organisation and the activity being purchased. This will also help to ensure a smoother and more cost effective service.

7 Monitoring, evaluation and intelligence

Monitoring performance

Ensuring quality of service would be the responsibility of the lead provider. This will be easier to manage if local providers have an agreed methodology for recording and evaluating their activities for feeding back to the lead provider.

The benefits of non-medical interventions are harder to measure because it is mostly about how individuals feel. Whilst monitoring will need to include numbers of people through the door etc, it will be more important to gather feedback from recipients of services about the quality and efficacy of support.

In addition benefits to individuals should be subsequently measurable by GPs in terms of increases in health and wellbeing, reduced frequency of visits and less in clinical intervention. It is therefore crucial that the burden of monitoring should be shared between commissioner and provider and also be proportionate to the activity.

Measuring impact

Case studies and stories are a powerful way of illustrating impact because they describe actual benefits to real people

Cost savings also need to be calculated. This is a lot harder because it requires an assessment of what cost would have been incurred for an individual if the non clinical intervention had not occurred. However there are models for doing this. A major evaluation of the Supporting People Fund was able to establish cost savings, and it is possible that this and other methodologies could be investigated and a suitable one chosen that all providers could use.

Tracking

Tracking individuals has always been a major problem because it is both difficult and expensive, a mechanism for doing this needs to be explored.

8 Recommendations: future action/next steps

- It is vital that public sector support, particularly by GP consortiums, for the hub idea and that they would engage with it, is established before the ideas can be developed further
- We would then need to consider how much resources are needed and where the funding would come from.

- Alternatives to a lead provider hub model should be explored. This would be a useful discussion to have with GP consortium and should include the identified issues relating to how referrals are made and how providers are paid.
- Monitoring and evaluation techniques should be explored to determine the best models. This should include qualitative as well as quantitative information and techniques for tracking individuals.
- Nearly 60% of VCS were more than city wide geographically. Given that a central plank of social prescribing is the idea of local hubs, it is clear that to take this further we need to engage smaller local groups in the idea.

Appendix 1 Evaluation

40 delegates attended. 12 evaluation sheets were returned

Question 1 – What is the key thing you will take away from today?

- The wider viewpoint and information from others
- A range of opinions and informed presentations on social prescribing
- There's a lot to think about!
- Food for thought
- Being connected is vital to confront new ways of working
- Social prescribing is an opportunity for VCS to play an important part in developing improved services for vulnerable people
- There are good foundations for a future model for Newcastle
- Local may well not work
- Lots of models of social prescribing. Still need community activities funded for people to directly access
- Clarified thoughts on social prescribing through discussion
- Everyone is very worried about their finances but interested in this model
- A couple of extra lbs from the muffin! The willingness of VCS to grasp the nettle. The naivety of open sharing of “commercial information”, the private sector don't do it.

Question 2 – What do you think should be the next steps?

- Wider information for the VCS on the new structures in the NHS and how they fit into the blueprint for the city (e.g. JSNA)
- Further local consultation/steering groups
- More brainstorming about how it would work in order to present something cohesive to Denise Pickersgill
- Take back to team and new CEO so we can begin to plan ahead
- Obtain as much feedback as possible from those involved today
- NCVS test support for it to influence commissioning and monitoring processes
- Firm up the model with a bit more detail
- Get commitment to the principle from major funders, NHS North of Tyne and Adult Services (and from minor funders, police, probation, housing education)

- Ensure NCVS is at the centre of provider arrangements
- Notes on other groups ideas would be helpful
- Work up some different models
- Establish the lead provider network and the qualifying criteria for participation

Question 3 – What worked about the event?

- A lot of good discussion
- Good representation and networking
- Good mix of people. Great muffins
- People talked, discussed ideas
- Informal approach is preferred
- Clear exposition of the concept of social prescribing and where it lies at present by Chris Drinkwater
- Enable people to share perspectives on the same issue – hopefully leading to more cooperation in future
- Good networking
- Lots of time to discuss the issue
- Working in groups
- Networking

Question 4 – What would you have changed about today?

- May have been good for a social prescribing representative in attendance
- Nothing
- Could have been a full day event given the scope of the subject
- Nothing
- Nothing, it was a good start
- The overheads didn't match many organisations parameters
- A presentation that provided different models of social prescribing
- Facilitated workshops would have been helpful
- Screen

Question 5 – Is there anything that NCVS can do to help and develop your organisation in the coming year?

- Good links with up to date progress
- No
- Keep us informed
- Continue to represent the VCS in terms of sectoral interest
- Continue to keep us informed of changes in the NHS and social care landscape
- Acknowledge the work done by organisations based outside Newcastle for the people of Newcastle and continue to keep us involved
- Keep on sharing information

Question 6 – Any other comments?

- It provided a good support service for us to share our funding woes with people in similar difficulties
- Thank you for ensuring VCS organisations are brought together

Possible actions

- Lots of comments about being kept informed and involved through NCVS information services, newsletters, e-inform and the Open Forum
- Things we could particularly concentrate on mentioned above would be changes in NHS and their impact on Newcastle
- A number of organisations reckoned they could be lead providers and a few suggested it could be NCVS
- Suggestion that potential lead providers could be brought together in a network

Appendix 2 Delegates (40)

Alice Thwaite	Equal Arts	Non-m/Reg
Anne Bonner	Riverside Community Health Project	Member/Local
Annemarie Norman	NIWE Eating Distress Service	Member/Reg
Barbara Douglas	Quality of Life Partnership	Non-m/City
Bob Dennis	Independent Living Zone	Member/SubReg
Bob Malpiedi	Newcastle and Gateshead Art Studio	Member/SubReg
Cath Scaife	NCC	Public Sector
Catherine Mackereth	North of Tyne NHS	Public Sector
Chris Drinkwater	HealthWorks Newcastle	Member/City
Clare Bethel	Newcastle PCT	Public Sector
Colleen Bitten	Addaction	Non-m/National
Donna Taylor	YMCA North Tyneside	Non-m/N-Tyne
Fiona Hill	Newcastle Libraries	Public Sector
Graham Bone	NCC	Public Sector
James Herbert	Mindful Employer North East (NHS)	Public Sector
Jan Thompson	North of Tyne NHS	Public Sector
Janet Heal	Age Concern Newcastle	Member/City
Jean Fraser	Newcastle Disability Forum	Member/City
Julia Perry	Mental Health Concern	Member/SubReg
Julie Marshall	CAOH	Member/City
Kate Neil	Norcare	Member/Reg
Kath Lohfink	National Trust Inner City Project	Member/SubReg
Leeanne Myers	Richmond Fellowship	Member/National
Lesley Clark	Norcare	Member/Reg
Linsley Charlton	HealthWorks Newcastle	Member/City
Meg Middleton	Sage Gateshead	Non-m/Reg
Mel Cartlidge	Newcastle PCT	Public Sector
Mike Bell	Mutual Inspiration	Non-m/consult
Mike Halsey	Key Enterprises	Member/?Reg
Morgan Hamilton	East End Health	Member/Local
Ollie Batchelor	Tyneside Cyrenians	Member/Reg

Pam Jobbins	NCVS	Staff/City
Peter Andrew	Key Enterprises	Member/?Reg
Pummi Mattu	NIWE Eating Distress Service	Member/Reg
Rachel Parsons	Carers Centre Newcastle	Member/City
Rob Bailey	Tyne Housing	Member/Reg
Sarah Mctimoney	Streetwise Young People's Project	Member/Reg
Susan Tron	Stepney Bank Stables	Member/City
Victoria Smyth	Taking Part Workshops	Non-m/Reg
Violet Rook	Newcastle LINK	Non-m/City

Analysis

32 VCS of which:

- 24 are NCVS members and 8 are non members
- 2 national, 12 regional, 4 sub regional, 10 city, 2 local, 1 North Tyneside

8 Public sector of which:

- 3 NHS
- 2 PCT
- 2 NCC
- 1 Newcastle Libraries.

Nearly 60% of VCS were more than city wide geographically. Given that a central plank of social prescribing is the idea of local hubs, it is clear that to take this further we need to engage smaller local groups in the idea.