Going Local: Our End of Year Report for 2022/23

What is Social Prescribing?

Please watch the two videos below for an introduction to SP:

What is Social Prescribing? Social Prescribing and Me

How Social Prescribing can help local communities

Social Prescribing (SP) presents the NHS, local authorities and communities with an opportunity to help people make use of existing community services, resources and facilities which can help them manage or overcome social factors. By increasing people's active involvement with their local communities and finding the right support, they can feel more empowered to take control of their lives.

The SP approach aims to reduce pressure on Primary Care clinicians, improve people's lives through access to services, strengthen community resilience, reduce health inequalities, and meet the needs of our diverse communities. Social Prescribing can help to transform the NHS into a more person-centred, cost-effective, and preventative healthcare system - by addressing the social determinants of health and promoting healthy lifestyles. SP can improve the patient experience by providing people with a holistic approach to healthcare, tailored to their specific needs - while helping to build stronger links between healthcare and communities, by connecting people with local services.

Many GPs report that they spend significant amounts of time dealing with the consequences of poor housing, debt, stress, loneliness, and physical inactivity. It has been shown that 20% of people visit a GP with non-medical needs (The Low Commission Report). A recent study has shown that depression medication is less effective if a person has employment or housing issues (Buckman et al, 2022). Studies have also shown that social isolation significantly increases a person's risk of premature death from all causes, to a comparable level of smoking, obesity, and physical inactivity. See the National Academy for Social Prescribing (NASP) website for further evidence for SP.

Socially prescribed activities often fall into four main categories. Please see below for a more detailed breakdown:
Advice & Information / Arts & Heritage / Natural Environment / Physical activity

Going Local: Social Prescribing in Adur & Worthing

Going Local started in 2016 with a team of 3 operating across a targeted section of the Adur & Worthing community. In 2023 the team consists of 7 trained Social Prescribers and 1 Team Leader - working as part of the Communities & Wellbeing Team at Adur & Worthing Councils.

When supporting people, the Going Local Social Prescribers dedicate time and focus on 'what matters to me' and take a holistic approach to an individual's health and wellbeing, empowering them to take autonomy and control of their lives. The team develops strong relationships with local voluntary sector organisations, community groups and statutory services - and make appropriate and supportive referrals for individuals who wish to establish connections for practical and emotional support.

Referrals to Going Local can be made from a wide range of agencies; including GP surgeries, allied health professionals, local authority services and voluntary community organisations. People can also self-refer into the service.

The service is coming to the end of a period of 5 year funding, with this cycle finishing in March 2024. During this year the team is developing a business case to secure ongoing funding, and there will be an increased focus on gathering quantitative data and demonstrating the value of SP.

Service delivery

In the year 2022/23 **1209** people were referred into our team. This saw a 10% increase in referrals when compared to referrals from the last financial year. In Q4 2023 (January 23 - March 23) we saw **374 referrals -** this is an increase of 30% on a typical quarter and shows how busy the last few months have been.

Going Local continues to offer a flexible way of working, giving the people we support the choice of holding our sessions over the phone, on a video call, in an outside space, in community spaces (and in some cases back in GP surgeries). We are also able to offer home visits to those who are recognised by their GP as being housebound. Social prescribers actively encourage people to access their community.

The team has been managing caseloads on average of 70 - 80 people per FTE SP. This is higher than the service capacity that was set at 50 cases per FTE SP - and is a product of the increasing referral numbers and the ongoing complexities attached to the typical case. People are referred into the service on average with 2 separate needs - following the initial triage call

the person and the SP identify on average 3 - 4 needs that they would like to focus on. This would then require multiple sessions to address. This average number of sessions a person engages with is 4 - 5 appointments.

As a result, the team currently has a waiting list (depending on the PCN area in Adur & Worthing) of 1 - 4 weeks. We have worked on a number of procedures to support this.

What we have put in place to help manage the increased demand

We have developed a **Pathways Procedure** to ensure people accessing the service are directed to the right support as quickly as possible. This has been circulated to all GP surgeries and other key partners for use. Once someone is newly referred to Going Local (while awaiting contact from the SP) they are sent a list of relevant services to explore in the interim. This will allow for more streamlined work with the SP. We are recognising that some of the more typically urgent areas of need (housing, finances) are now already underway when a person has a triage call with a SP - freeing up the session time to focus more on establishing new social connections. This tool will be an ongoing benefit to Primary Care as the direction of travel is towards an increased focus on signposting. This tool goes hand in hand with the Cost of Living Leaflet that the Councils developed to support our communities struggling with the rising cost of living - this will be attached to the report.

A **Service Timeframe** of 3 months has been introduced this year to help maintain the flow of referrals through the service. This timeframe is in line with SP framework advice from NHS England. Previously people would access the service for up to 6 sessions, however this could happen over any length of time. While the open-ended flexibility was useful, we were aware of people being held on caseloads for longer than necessary. The new timeframe is helping both the SP and the person to hone into their reasons for accessing the service and meaningfully engage with the time they have. In the next Quarterly Report we will show the impact this has had on the rate in which cases are being closed.

The **Care Coordinator role** is being trialled within the Lancing & Sompting PCN. The role was developed due to SPs needing to spend one full day per week triaging new referrals in an attempt to manage the volume of new cases. Due to complexity of the average case, it can take in excess of an hour to complete the necessary triage procedure - which includes urgent onward referrals.

For this PCN area we have seen a reduction in waiting times from 4 weeks prior to the introduction of the role, to 1 week until contact. This has enabled the primary SP working alongside the CC (Holly) to increase the number of weekly appointments available to her caseload. The role has also allowed the winding down of existing cases - Holly's caseload has already reduced by 21%. Holly's caseload is still exceeding the ideal number of cases held by a full time SP (50) - however, the CC role has only been active for 6 weeks and we anticipate this benefit will continue to be seen in the coming months.

The role has helped the SP's at L&S PCN by ensuring they have more time to look into community groups to expand our service offer. The role has also reduced feelings of

overwhelm due to the size of caseloads being impossible to manage - and people are now able to engage with a more responsive service. The indepth triage call with the CC can ensure that only those patients identified as benefiting from ongoing sessions as assigned to a SP. In the CC's other duties at the PCN, an additional benefit is gained from the learning and experience of working as part of the SP team - enabling them to better direct patients to the right place.

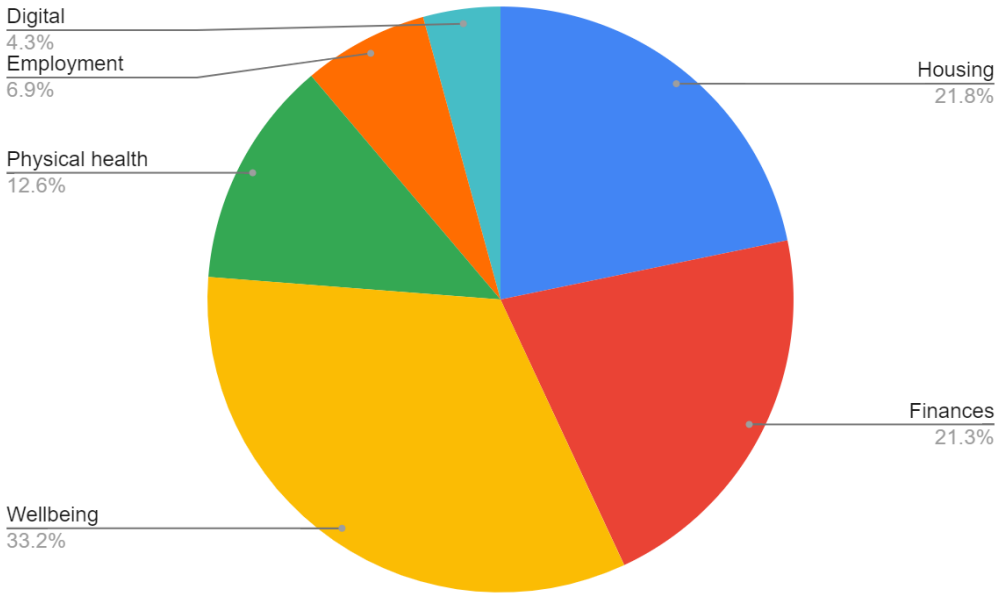
Over the next few months we will collate further data to present the full benefits the CC role has on the working practice of the SP.

Referral data for 2022/23

1209 referrals

- **Cissbury Integrated Care PCN** - 461 referrals
- **Central PCN** - 160 referrals
- **Coastal & South Downs Care PCN -** 204 referrals
- **Lancing & Sompting PCN -** 181 referrals
- **Adur Health Partnership PCN** - 203 referrals

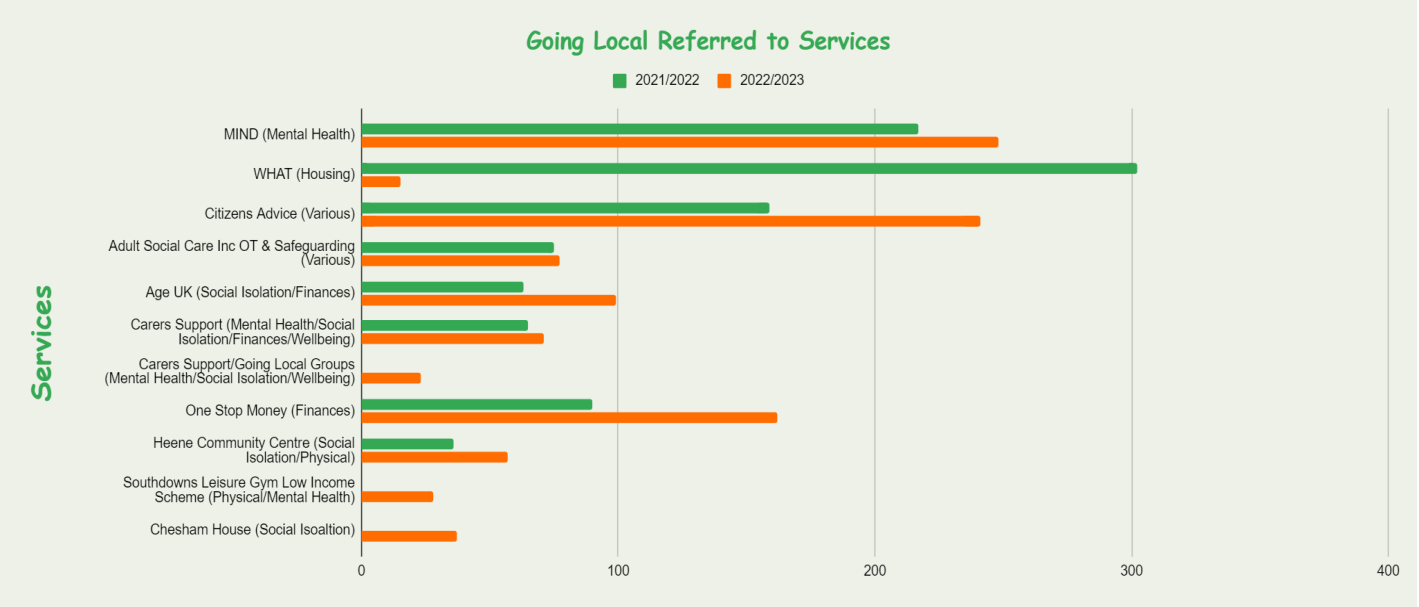
NB: The referral rates and corresponding waiting lists are reflective of the resourcing each PCN is funding.



Referrals reasons present at the point of referral

Housing	475
Finances	465
Wellbeing	724
Physical health	275
Employment	151

Digital	93
Total	2183



- **Referred to services comparison 2021/22 - 2022/23**

Across the service we made **3200 referrals in 2022/23** to a range of community groups, services and activities. This year we've observed that the primary concerns for our client base continue to be mental health issues, social isolation, finances and housing.

In 2021/22 the Wellbeing Housing Advice Team (WHAT) was our most referred to service for people with housing needs. At the start of 2022/23 this service was decommissioned. There are no similar services to offer this housing support. As a result Social Prescribers have taken on additional roles (for those struggling to do so independently) in providing support around form filling/advocacy - and this is now consuming a greater % of their time in an average week. The pressure around housing is a national challenge and relates to the reduction in affordable properties available and the rising cost of living.

The Going Local SPs help people find organisations and groups where the traditional route has become over subscribed, supporting people to navigate the system and find a suitable pathway. For example, Cruse Bereavement helps many people who have lost a loved one, but they now have a very long wait list. We have made good links with alternative provisions, including the HD Tribe Bereavement service.

If someone struggles to physically access their local community due to difficulties they may have leaving their homes, we can refer them to community transport services. Befriending services can also help those who are isolated or house-bound people by establishing a new positive connection and offering some social contact. Our team maintains an up-to-date awareness of the variety of services on offer and the key contacts to assist someone in accessing their services.

Social Prescribing can also provide 'lighter touch' interventions to make people aware of the great amount of resources available in the community. We often connect people with Church groups, as well as libraries, community centres, knitting, walking and gardening groups. Though diverse, often these more traditional groups do not have much of an online presence and may not be advertised on the usual networks, making them harder to find for an isolated person or someone digitally excluded.

Data from the people accessing the service

Using the data from our Wellbeing measurement tool (Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) © (the tool used by SP across West Sussex) we can show that a majority of patients who were asked the question 'I've been feeling close to other people' saw this metric change from 'none of the time or rarely' to 'all or some of the time'.

Over 70% of people also saw a positive increase in the following metrics. 'I've been feeling more relaxed' and 'I've been feeling more optimistic about the future'. This demonstrates the impact and importance of SP as we are seeing the established connections that people are beginning to form. For example, a wellbeing walking group attended by a group of patients have developed their own friendship group and regularly meet up, thus creating new connections and a support network.

95% of people found that Going Local were able to support them in some way towards the reasons they were referred. And 95% of people were either Satisfied or Very Satisfied with the service they received.

When asked where they would have gone for support if they had not been supported by their Social Prescriber - 63% of these people said their GP surgery. The ethos behind Social Prescribing is to ensure people come away with a greater knowledge of where else to turn in the community when their Social Prescribing comes to an end.

Over 60% of people say that they had 3+ visits with primary care in the 3 months preceding their engagement with their Social Prescriber. After engaging with the Going Local team 82% of those people saw a decreased use of primary care services.

The team has begun to measure the time spent with people that engage with the service. As we gather more of the data - recording the hours spent with people - we will cross reference this with the data collected on where people would have otherwise gone for support (e.g. to their GP). This concept is supported by the study referenced in the opening of this report, which shows that 20% of GP appointments are for non-clinical reasons. Ultimately, we intend to show the primary care time protected by having Social Prescribers supporting our communities in Adur & Worthing.

Headlines from our Equality and Diversity Survey

From a cross-reference of 250 cases that completed our E&D form we can say that:

- 88% of respondents identified as White British. 4.5% are from other white backgrounds, 3.5% from an Asian background, 2.5% from a Black background, and 1.5% preferred not to say.
- 4.5% of respondents identify as LGBTQ+ with 9% preferring not to state their sexual orientation.
- 28% of respondents have caring responsibilities.
- 66% of respondents consider themselves to have a physical or mental disability that has a substantial and long term effect on their ability to carry out day to day activities.
- 31% of respondents have accessibility needs (mobility or communication)
- 70.2% of respondents identify as female, 28.4% as male, 0.7% as transgender (1 in 200)

Compared to the data gathered in the previous year we have seen a higher % of people with a disability. With this in mind we aim to make sure we are accessible to our diverse communities.

Quotes from people we've supported this year

I felt listened to in a compassionate and pragmatic way. I was offered help and support, as well as referrals to other agencies and charities.

(My SP) gave me space and time to think things through for myself without jumping to suggestions. I appreciated having the space to do that as I haven't felt listened to before.

(My SP) was very good at listening to my needs and in a matter of a week she sent me all the info I needed. I'm generally happy and I feel she helped me, the rest is up to me.

(My SP) was very helpful and came up with very good suggestions to ways in which I could move forward. I have to admit I was feeling very low, demotivated and tired.

(My SP) was very patient and understanding and I did not feel pressurised. It was nice to know support was there when I needed it.

Going Local was vital for us during difficult times. They offered emotional and practical support to overcome the negative impacts and trauma caused by the domestic abuse. Their response for our problems was fast, balanced and effective. They gave me and our children hope, freedom and courage through difficult times. I am extremely thankful for their assistance.

Felt very supported. Felt that there was somebody else to discuss problems with and who came up with ideas we could use. I think that the Social Prescriber is able to reach out in all directions to various organisations. They can help the client " see the wood beyond the trees."

How else the service has supported people throughout 2022/23

Proactive Social Prescribing - In 2022/23, an additional requirement for primary care networks to provide a proactive social prescribing service was introduced as part of the contract. This means that primary care networks must work with a population experiencing health inequalities to proactively offer social prescribing interventions.

Proactive Social Prescribing

As part of the Proactive Social Prescribing project, we are targeting the cohort of Carers. Going Local recognise a need for Carers in our local community to have an opportunity to connect with other carers, focus on their wellbeing and have a safe space to share openly. Going Local and Carers Support (and Age UK in Adur) then discussed the idea of collaborating and running groups together. In Worthing these are held monthly at Worthing Town Hall and in Adur they are held monthly alternating between RVS Chesham House, Lancing and The Shoreham Centre. Our next stage with the groups is to gather feedback from the Carers attending about what is important to them and to develop the groups further informed by the feedback collected. We are also exploring specialist services collaborating with us to share information/support for the Carers with the possibility of hosting local groups to offer the Carers an opportunity to find out more about local services to improve their wellbeing and reduce feelings of isolation.

The Going Local team are planning to deliver another group (for 8-16 people) in partnership with the NHS Living Well Programme, aimed at supporting people with managing long term health conditions and chronic pain. This is due to start in October 2023 and will deliver these support groups as localised venues to ensure people across Adur & Worthing have access to this support.

The SPs are also developing areas they will each specialise in. This smart resourcing will ensure the team as a whole is more resilient by having a greater shared knowledge and expertise - while also enabling each SP to have an area of professional development in which they are passionate about. Some of these areas include; Neurodiversity, New Parents and Creative Arts.

Current Challenges the service is facing

Limited funding and resources: We are not currently able to reclaim the full amount of the incurred costs for some members of the team. The Better Care Fund (that currently funds the equivalent of 2.3 FTE across the team) will also be coming to an end in March 2024. There has also been an ongoing deficit in funding for management and administrative functions across the service, with additional pressures arising from inflationary rises.
We are exploring options with our PCNs to secure ongoing funding post March 2024 and will be working alongside the other SP services in West Sussex to address these shared issues around management and admin oversights.

Evidence base: While there is growing evidence supporting the effectiveness of Social Prescribing, further research is needed to demonstrate its long-term impact and cost-effectiveness. We are now tracking the time spent with people to demonstrate a cost

effectiveness, by showing how SP early intervention has diverted time away from Primary Care (where appropriate) and into more applicable local services relating to the individual needs. This intervention can also alleviate the risk that a person's needs may escalate and become an emergency situation at a later date, requiring the input from Secondary Care services.

Inequalities and accessibility: There are inequalities in health outcomes that exist in different communities, including those who may face additional barriers to accessing support, such as those with disabilities or those from low-income backgrounds. As a service we are gathering data around accessibility needs at the point of referral and will be using Census data to increase inclusion and provide equality of opportunity.

Capacity and workforce: Social Prescribing services require a skilled workforce to deliver effective support to patients. It can be a challenge for the team to reach a workable capacity to ensure a high quality of care. It is essential that the SP team engage with reflective practice, case review meetings and meet with community services - however the majority of time of a SP can be consumed by their complex caseloads.

The impact of the cost of living and current economic climate: The cost of living crisis can cause significant stress and anxiety, sleep problems, and a serious impact on someone's mental health. There can be limited options for support regarding certain situations around money or housing when people are referred into the team. The cost of living crisis has led to food insecurity and poor living conditions - which in turn lead to other health problems. This and the other concerns mentioned above can be all consuming for someone who is referred to the service and it could be a challenge for someone to see beyond the 'crisis issues'. The cost of living can also affect someone's ability to access services with transport and travel becoming a premium that some cannot afford.

National Social Prescribing updates

The **National Academy for Social Prescribing's** academic collaborative is compiling rapid evidence reviews and short briefings on priority themes. Those published so far include summaries of what the evidence tells us about the impact of social prescribing on measuring economic impact and health outcomes – you can access these here.

In **August 2021, a study** published in the British Medical Journal found that social prescribing can improve the health and well-being of people with long-term conditions. The study analysed data from 19 social prescribing programs in the UK and found that participants had reduced hospital admissions and improved mental health outcomes.

Tackling Loneliness Report March 2023: The Government has published this year's annual report assessing the current measures on tackling loneliness. The report references social prescribing and the role it can play in tackling isolation and supporting people to connect to their communities. Full report here.

Social Prescribing Map: The NASP has been commissioned to develop a map of social prescribing services. https://nasp.communitymaps.org.uk/welcome

The NHSE SP team has updated the **Case Study Database on The Platform.** This case study database covers a range of topics and can be used to access case studies that highlight good examples of SP and demonstrate progress and developments in SP across the country.

NHSE and the government have published a new **delivery plan for recovering access to primary care** which sets out actions to improve access to care, better support patients to manage their own health, and to modernise general practice.. The actions set out in the plan can give millions of patients more convenient access to primary care. The plan commits to supporting SPs as they continue to develop in their role connecting people to activities, groups and community-based services. The plan also reiterates that staff employed through the ARRS will be considered part of the core general practice cost base beyond 2023/24.

What's next?

Digital: We are aiming to improve our digital system to produce a higher quality of data and outcomes. We are looking to enhance the bespoke system we currently use, while also exploring the introduction of a specialist SP system - Social RX. A buying group across West Sussex is forming from the interested service areas.

Data: We are working on the Going Local Business Plan to show the value of continued funding post March 2024. As part of this we will calculate the unit cost of someone accessing the service to demonstrate the service value impact on Primary Care.

Integration: As part of the West Sussex SP operations group, we are working closely with the other SP projects - the current focus being the ongoing implementation of the **Social Prescribing Workforce Development Framework.**

Growth: The development of a Volunteer programme. This will provide additional support to residents of Adur & Worthing by helping those in need to access the services we connect them to - while also providing opportunities for people wanting to support their local community.

If you have any thoughts or queries relating to the report please contact the Social Prescribing Team Lead here: tom.visconti@adur-worthing.gov.uk

ADUR & WORTHING COUNCILS

GOING LOCAL
Happy is Healthy