NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Health and Care Overview and Scrutiny Committee
Monday 29 January 2024

Social Prescribing – Primary Care, Staffordshire and Stoke-on-Trent Integrated Care Board (ICB)

Recommendation(s)

I recommend that the Committee:

a. Consider the view of Primary Care Social Prescribing from the perspective of Primary Care Networks and the ICB.

b. Consider the view of developments planned for 2024-25

Report of the Staffordshire and Stoke-on-Trent ICB – Sarah Jeffery, Director of Primary Care

Summary

1. The report summarises the main requirements of the Primary Care Network (PCN) Directed Enhanced Service (DES) and how the ICB and the PCNs have supported the implementation of the specification.

2. The report highlights that there are variations amongst the PCNs in relation to the number of whole time equivalent (WTE) Social Prescribing Link Workers (SPLW) they employ/subcontract, activity numbers and patient cohorts targeted for proactive social prescribing,

3. The report indicates that much of the data relating to the impact the service has on patients relates to satisfaction surveys and case studies. There is work to be undertaken to ensure there is a system wide method to collate and analyse the impact. One PCN in the ICB is utilising software they purchased to achieve this aim.

4. The report provides an overview of wellbeing arrangements in place for SPLWs and also identifies that work needs to be completed on the supervision of these roles.

5. The report confirms that Additional Roles Reimbursement Scheme (ARRS) budgets are not expected to increase in 2024-25. The report highlights that the NHS Long Term Workforce Plan indicates that SPLWs to be in post across England by 2036/37 is 9,000 from the baseline of 3,000 in 2021/22.

6. The report concludes with areas to progress during 2024-25 with system partners, including:
    a. Information collation for data and impact
    b. Supervision models for ARRS roles
    c. Increasing awareness of health and wellbeing services available for all ARRS roles.

Social Prescribing – Primary Care, ICB

Background and DES Requirements

1. The ICB supports 25 Primary Care Networks (PCNs) in implementing the PCN Directed Enhanced Service (DES). 18 of these PCNs are in the Staffordshire area, although one PCN, About Better Care (ABC) is classed as a North Staffordshire PCN but does include some Stoke-on-Trent practices. The PCN DES states that PCNs must provide their Patients with access to a social prescribing service.

2. To comply with the DES, a PCN may either directly employ Social Prescribing Link Workers (SPLW) or sub-contract provision of the service to another provider.

3. The DES requires PCNs to review its targeted programme to proactively offer and improve access to social prescribing to an identified cohort with unmet needs. This offer must consider views of people with lived experience. The PCN need to undertake a proactive social prescribing service for their identified cohort and review and extend the offer of proactive social prescribing based on an assessment of the population needs and PCN capacity.

4. The DES suggests that PCNS may wish to:
   a. Work collaboratively with local partners to review experiences and outcomes, and to identify opportunities for improvements to service design and delivery for accessible and sustainable provision for the patient cohort(s);
   b. Use Population Health Management (PHM) data along with insights from the Health Inequalities Improvement Dashboard and from local partners, to identify additional or alternative patient cohort(s) to whom the service offer could be extended;
   c. Consider identifying cohorts that experience health inequalities as set out in the Core20PLUS framework, or High Frequency User groups, as outlined in additional guidance “Supporting High Frequency Users through Proactive Personalised Care”. This may include working with other roles such as health and wellbeing coaches and care coordinator Set targets for improved access and monitor performance against these; for example, reviewing referral targets and outcome measures;
   d. Use funding from the Additional Roles Reimbursement Scheme (ARRS) to increase service capacity where available; including, if possible, recruiting specialist SPLW with specific skills or knowledge for the patient cohort(s) identified.

Local Implementation of the Social Prescribing DES

1. The ICB held a series of social prescribing meetings for PCN Business Managers and social prescribers to support the implementation of the specification. The ICB produced a support document and associated planning templates to assist PCNs during implementing. The planning templates provided links to external sources of information to identify their proactive cohort and helpful resources.

2. All PCNs in Staffordshire have a SPLW, although one PCN did not have one for a few months. This PCN have recruited a replacement SPLW and they started in their role in January 2024. There is variation of whole-time equivalents (WTE) recruited between the Staffordshire PCNs from 1 WTE up to 6 WTE. The number of WTE per 10,000 patients varies from 0.2 WTE to 1.04 WTE with an average of 0.5 WTE across Staffordshire. Whilst the ICB can encourage the recruitment of SPLW roles it is

ultimately for the PCNs to determine how many are required to meet the needs of their patients, whilst remaining within their ARRS budget allocations.

3. PCNs chose their own patient cohorts to target with proactive social prescribing and examples of these are frequent attenders; learning disability; farming communities; chronic pain; mental health; prediabetes and carers.

4. The DES requires PCNs to record referrals using the clinical codes, specified in the DES requirement. In the 2022-23 PCN DES there was an Impact and Investment Fund (IIF) outcome indicator relating to the social prescribing specification regarding the percentage of patients referred to social prescribing service. The indicator was not achieved if below 0.8%, there was a lower threshold between 0.8% up to 1.2% and an upper threshold of 1.2%.

5. PCNs 2022-23 end of year performance against this indicator varied from 0.61% to 4.63% with a Staffordshire average of 1.42%. Four PCNs did not achieve the indicator, five reached the lower threshold and nine exceeded the 1.2% upper threshold.

6. The social prescribing IIF indicator was removed in the 2023-24 PCN DES, however, the ICB continue to collect the information on referral performance. The forecast year-end position, based on activity data from April-November 2023, predicts a Staffordshire average of 1.52%. These forecasts also show an improvement in activity across the PCNs and a reduction in the variation. Comparing against the old IIF targets, three PCNs would not meet the target, two PCNs would meet the lower threshold and the remaining thirteen PCNs would exceed the upper threshold.

7. It is important to note that not all work undertaken by SPLW results in activity that can be recorded by one of the clinical codes, specified in the DES requirements. Their work also involves making new community connections, finding new organisations, organising community awareness sessions, actioning patient referrals and solving any new issues and these activities cannot be recorded via clinical coding.

8. PCNs collect quantitative data relating to numbers and sources of referrals, patient demographic data and social prescriptions brokered.
PCNs currently collect patient experience questionnaires to inform improvements to their SPLW service. These questionnaires provide the PCNs will some quantitative data on the impact of the service. Much of the evidence the PCNs use for impact is described in individual case studies. There are several case studies in appendix 1, highlighting the impact of the work of SPLW on individual patients or particular cohorts of patients.

9. NHSE guidance advises that PCNs use impact measurement tools depending on local needs and suggests the use of the Short Warwick Edinburgh Mental Wellbeing Scale (ONS4). The guidance does not require social prescribing services to stop using existing impact measurement tools, but to consider adding the ONS4 to allow national comparison (NHSE, 2003a). The ONS4 tool measures a score across the four areas of the patient's life satisfaction, feeling worthwhile, happiness and anxiety.

10. Currently the PCNs and ICBs do not routinely collect quantitative metrics relating to the impact of the SPLW service. The ICB would like to look at how outcomes and impacts can be captured and demonstrated for this service, particularly any appropriate patient reporting outcome metrics before and after interventions. These could include the monitoring of patients' quality of life and wellbeing before and after

interventions from the SPLW. During 2023-24 the ICB are piloting the use of outcome metrics, including Health Related Quality of Life Measure (EQ5D / EQ5D5L) with the frailty services, and the learning from this pilot could be transferred to recording patient outcomes for the SPLW service. The ICB will look at the implementation of the ONS4 measurement tool across the SPLW and solutions to collate data from all PCNs.

11. Mercian PCN have employed social prescribers prior to the inception of the PCN DES and ARRS roles, and have developed their service following the introduction of these roles within the DES. The PCN currently fund, from their own PCN monies, a software application that collects information relating to metrics before and after SPLW interventions. This includes measuring the percentage change of the four ONS4 ratings of patients, changes in numbers of GP appointments taken up pre and post referral, impact of the interventions on the patient's problems as well as service activity statistics. Mercian have used this software to demonstrate that their SPLW saved 4,205 GP appointments during 2022-23 across their PCN, equating to £151,380 (based on £36 per appointment).

12. All staff within SSOT ICB, including those within General Practice, PCN and ARRS roles have access to the Staff Psychological Wellbeing Hub. The psychological wellbeing hub is a safe and confidential space for staff to discuss their feelings and additional support they may need. The service is provided by a team of qualified mental health professionals that offer help, support and advice to staff who feel they would benefit from some additional support for their psychological wellbeing. The service provides the ICB with the total numbers of staff referred, however this is not broken down into individual role types to ascertain whether SPLW are accessing this service.

13. The PCN DES highlights that PCNs must identify a first point of contact for general advice and support and (if different) a GP to provide, at least monthly, supervision for SPLW. The ICB's ARRS Task and Finish Group have identified that a piece of work is needed on the supervision models for all ARRS roles, so a review of the arrangements for SPLW will be included within this project.

Social Prescribing Service Development

1. The PCN DES for 2024-25 has not been released, however, confirmation has been received that there will be no huge increases in ARRS budgets, and they will remain relatively the same. PCNs are able to plan their ARRS staff against their ARRS budget allocations for the next financial year, however, some may be waiting to review any changes or additions to the roles that can be reimbursed through the ARRS budget. There are a handful of PCNs that have not yet spent their full ARRS allocation and the ICB will work with these PCN to identify whether further SPLW support would be beneficial to their patient population.

2. The NHS England Long Term Workforce Plan (NHSE, 2003b), released in June 2023, indicates that the target number of SPLWs to be in post across England by 2036/37 is 9,000 from the baseline of 3,000 in 2021/22. SSOT system's contribution to the 2036/37 target will be roughly 150 SPLWs. If this increase is solely to be made in primary care through ARRS roles, this will see a 300% increase in the number of SPLWs in the next 12-13 years from the current 49.5 WTE SPLWs, ICB wide. As ARRS budgets are not increasing next year, there will be little scope to make much progress against this target until 2025.

3. The ICB will work with partners to progress the following areas in 2024-25

a. Information collation for data and impact
b. Supervision models for ARRS roles
c. Increasing awareness of health and wellbeing services available for all ARRS roles.

List of Background Documents/Appendices:

References

NHS England (2023a) Social prescribing: Reference guide and technical annex for primary care networks NHS England » Social prescribing: Reference guide and technical annex for primary care networks

NHS England (2023b) NHS Long Term Workforce Plan, NHS Long Term Workforce Plan (england.nhs.uk)

Appendices

Appendix 1 – Case Studies

Contact Details

Lead Officer: Sarah Jeffery (Director of Primary Care) and Jackie Bryan (Primary Care Programme Lead)

Report Author: Jackie Bryan
Job Title: Primary Care Programme Lead
Telephone No.: 07784360431
E-Mail Address: Jackie.Bryan@staffstoke.icb.nhs.uk

Appendix 1 – Case Studies

Leek and Biddulph PCN

Leek and Biddulph PCN have implemented a proactive social prescribing project for the farming community within their PCN. It all started when the social prescribers attended a livestock market in their area, to hold a drop-in session. They attended to promote, to the farming community, the services that social prescribers can offer and to engage with as many people as they could.

The first three people that came up and spoke to the social prescribers identified that they had all experienced a friend, a neighbour, family member or someone from the farming community that had taken their own lives, within the past two months. Many other people that spoke to them throughout the day spoke about these recent suicides and the social prescribers listened to the lived experiences of this community to find out possible causes.

Many identified that there were less opportunities to socialise and gather than there used to be as pubs had either closed or transformed from local pubs to gastro pubs and hunts had ceased. The farming community identified that many of them live on their own with no family nearby and their main chance to socialise was attending the livestock market. The farming community identified that the farming community do not tend to talk about their mental health.

The social prescribers worked with the market manager to organise regular attendance at the market for health checks and mental health support provided by Everyone Health Staffordshire. The market manager identified some common issues the farmers experience that weren't in the expertise of the social prescribers, so they organised for the Farming Community Network to attend to support farmers with issues such as, animal healthcare, rural payments, and animal passports. The market manager also secured a prime spot, right outside the entrance to the main office for the Everyone Health trailer, to enable them to offer health checks and simple tests, like blood pressure monitoring.

As the trailer is at the cattle market on a regular basis and is in a convenient location, more farmers are confident in approaching to gain support on issues that are affecting their mental health. The service has expanded to include referrals to a free counselling service from the Rural Agricultural benevolent institution (RABI), which is a service offered by people who understand and have lived within the farming community. The next stage of the service is to move into a dedicated room, identified by the market manager.

The PCN continue to identify gaps in provision to expand their social prescribing offer. Recent, newly formed groups include bereavement support and a specialist support group for people whose loved one has gone into care.

Cannock North PCN

Cannock North PCN have focussed on proactively offering social prescribing for frequent attenders at the practices. One of these patients used to visit their practice 1-2 times a week. The patient suffered with their mental health for over 5 years and spent their time, at home, watching TV.

At the initial consultation, the Social prescriber outlined strategies to transform his life such as: practicing mindfulness, engaging in green spaces, improving physical activity, using positive affirmations, and combating his loneliness and isolation by human connections by attending a

group. The patient opted to be introduced to a Volunteer Buddy and following this, the patient agreed to join the Volunteer Buddy at an allotment group he attended. Since then, the patient has been referred to Inspiring Healthy Lifestyles for 50% off Cannock Leisure Centre membership, to incorporate going to the gym into their lifestyle. The patient has since been attending walking, bowling, canoeing, and cycling activities.

The impact the social prescriber service has had on this patient is that they are in the process of being accepted for a volunteer role themselves and are thinking about getting their HGV licence. The social prescriber in the process of contacting Employment Disability Officer at the Job Centre for employment support. This patient was presenting for four appointments a month between January 2023 and September 2023 and following their consultation with the social prescriber, they have had no further GP appointments, other than 1 telephone consultation to discuss some test results.

The social prescriber has provided personalised continuity of care to this patient, holding 12 social prescribing consultations, of which four were one hour face to face appointments and 32 text/email messages to date. This continuity has allowed the social prescriber to signpost the patient to services as and when the patients' needs develop and change.

Cannock North PCN

Cannock North PCN helped a palliative cancer patient to enable them to celebrate Christmas with their family. They were living with a friend as they couldn't afford to live on their own. They have three children and was unable to buy any presents for them or provide any food for them. The social prescriber sorted out a food hamper for them and submitted an application for supermarket vouchers.

The patient had already been signposted to a drop-in centre at a local church and the patient engaged with some of the activities provided there by a Volunteer. The social prescriber, with the patients' permission spoke to the church about their Christmas predicament and the church gave the patient a donation of £150 to support them to fund some Christmas spending. The patient was very appreciative of the support received and was able to enjoy what would probably be their last Christmas.