Barton Social Prescribing and Health Living Centre

With support from Barton Health New Town project and NHS England/Oxford City Council

REPORT FOR JAN- MAR 2017

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1.0 Summary of Progress:

Progress to date against agreed Terms and Conditions		
No.	**Terms**	**Evidence**
1	Deliver social prescribing pilot from Jan 1st to Mar 31st 2017 which will deliver increased reach into vulnerable groups, guiding patients towards BHNT associated activities	ACHIEVED: See graphs on p.2 and p.3 indicating number of referrals (40) and vulnerability of clients. Also see examples of vignettes of beneficiaries on p.5
2	Bury Knowle (BK) should work to ensure model used is replicable and share with OCC recommendations and sustainability of the project	ACHIEVED: budget and activities for replication prepared. Referral form –see appendix. Budget on request Recommendations made on p. 3
3	Subject to relevant data projection and patient confidentiality, will provide access to BHNT team and research partners with access to relevant info	ACHIEVED: Shared health data with respect to Barton population with researchers from Bury Knowle HC. Current report is also available to them.
4	Social prescribing model works with AMI and Getting Heard to develop a sustainable model linking pilot projects which work with volunteers to help vulnerable patients through prevention and self-care	PARTLY ACHIEVED: Links fostered via SP coordinator with Getting heard and a short report on p.6. The proposed link with AMI has not happened. Awaiting communication from AMI via Oxford City Council.
5	Bury Knowle to actively contribute to health champion training and development and be an umbrella organisation.	ACHIEVED: SP coordinator has contributed to health champion training and has offered itself as umbrella organisation
6.	Provide evidence that at least 80% of referred patients are from Barton	ACHIEVED: 36/40 patients from Barton –90% of referrals (see p.3)
7.	To work with OCCG and BHNT project to look at opportunities of new models of care with Barton HLC	ACHIEVED: MIND clinics ongoing at Barton HLC. Strong links to Go Active, Fluid motion, local church and community groups.
8.	BK to provide evaluation information on the on-going social prescribing and pilot for BHNT	Feedback given at monthly BNHNT meetings and will give final report in next meeting.

1.0 Social Prescribing Referrals between 1/1/17 and 31/3/17 including levels of vulnerability

During the period a total of 40 referral were made to our social prescriber with the majority 37/40 (>90%) from Barton.

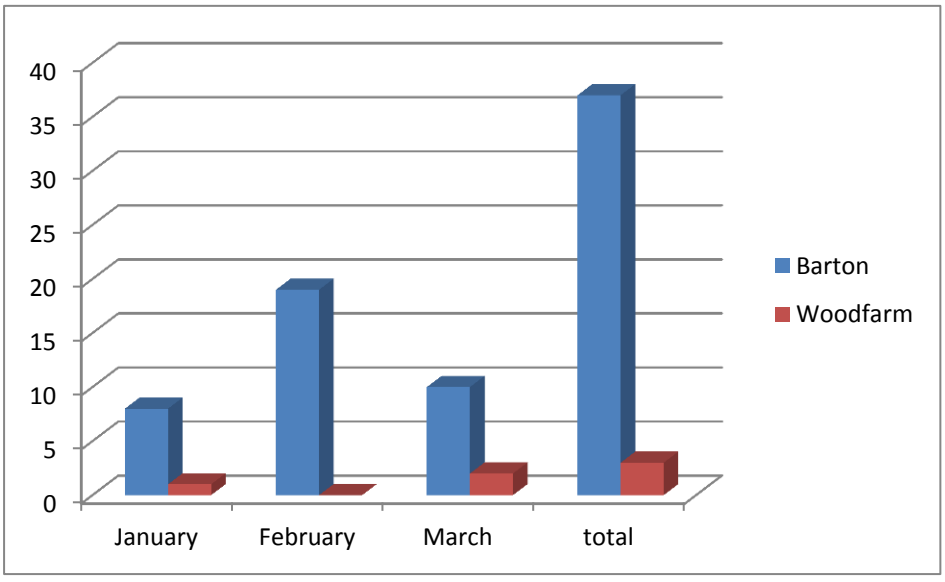
Of these, 29/40 (72.1%) were classified as vulnerable coming from one of the following groups:

- Methadone replacement /Alcohol dependence
- Patients on more than 5 medications indicating complex medical conditions
- Learning disability /Mental health register / Personality disorder /Dementia
- Thriving families patients or those with child and adult safeguarding issues
- Multiple occupancy households
- Those who are on proactive care plans
- Known carers
- The top 5% consulters at both sites

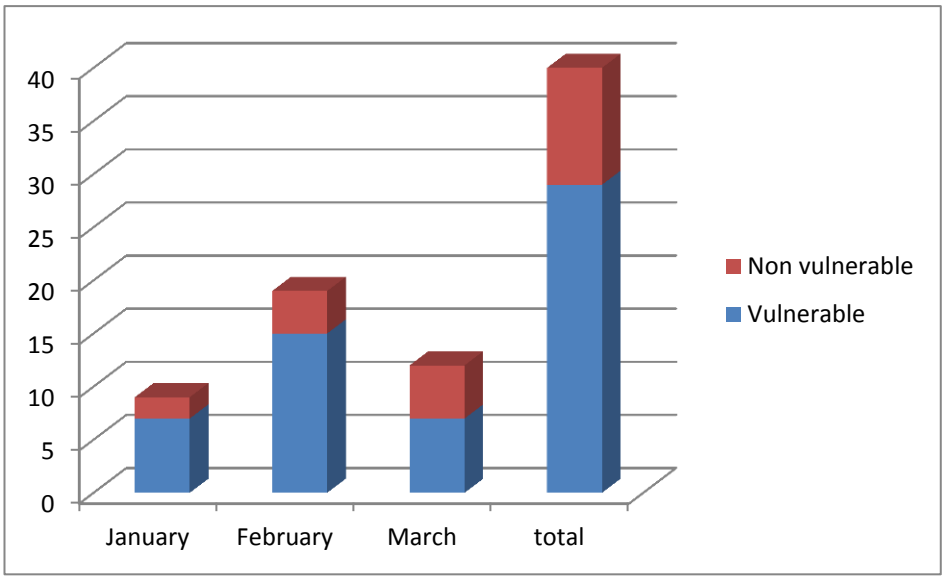
Graph 1 below indicates the number of referrals from both Barton and Woodfarm catchment populations on a monthly basis and illustrate that the majority of those referred (90%) are from Barton.

In graph 2, monthly referrals are categorised into vulnerable and non-vulnerable groups. Again, the SP work is shown to target mainly vulnerable groups. The remainder of those referred, though from non-vulnerable groups, are mainly seeking assistance for mental health problems including debilitating anxiety and depression and while not in the longer term vulnerable populations, they are vulnerable for that period of time while unwell.

Graph 1: Showing SP Monthly Referrals and Total - Barton Woodfarm



Graph 2: Vulnerable vs. Non-Vulnerable Patients



2.0 Recommendations including sustainability of project

Previous work in Barton and Woodfarm has demonstrated that those referred to social prescribing have shown reduced utilisation of GP and acute secondary care for the 6 months after using the service compared to the 6 months prior to being referred. This creates a strong argument for OCCG and NHS England to support the future of social prescribing in Barton and Woodfarm as well as expanding its use to more widely in all social deprived areas. Indeed, social prescribing has been identified as one of 10 high impact activities that can reduce the burden and pressures on GP as part of the GP forward View 5 year plan.

Currently, a funding gap has occurred in the SP work which BK have stepped into fill for the next quarter with the hope of some retrospective financial support to meet our costs. We are doing this to ensure the project survives while a new year of funding for both OCCG and NHS England commences. It is the hope that a proposed Local Incentive Scheme by the OCCG will act as a vehicle for supporting future work but current indications are that the funding remaining for this scheme across the whole of Oxfordshire is wholly inadequate to fund even a very localised piece of work in one or two deprived wards.

By reducing spending at secondary care through A&E attendances and admissions, the savings should be moved from secondary care into primary care.

The ***main recommendations*** regarding the long term sustainability of the work are:

1. ***Funding horizon***: Provide for a more realistic horizon of funding at least 2 years but preferably 3 years to allow time for the role to develop and provide some job

security for the social prescribing coordinator and backfill /support staff. Benefits to secondary and primary care will accrue and savings made can be used to offset costs in the future.

2. ***Utilising Care Navigators***: Oxfed are currently funded to employ practice care navigators (PCN). Whilst helpful in potentially reducing GP work and referrals for elderly vulnerable adults, they currently cover a narrow range of patient needs (elderly vulnerable and at risk of admission) which does not address the vast needs of a younger population with many health issues as seen in many deprived wards. Practice care navigator costs per patient helped is not clear at present but is likely to be a high cost intervention. We would propose expansion of the range of the PCN role is likely to make them more efficient, busier and fulfilled in their roles.
3. ***Room availability***: Limited physical space at GP surgeries is a real threat to new models of GP care, jointly working with social services and other agencies. While co-location of clinics within the health centre provides more of one stop shop, our surgery (and many others) require more room for our expanding patient population. Thus the immediate and pressing priority on existing room space is for clinical services expansion. The lack of space jeopardises future co-location of non-clinical well-being services – e.g. MIND, Go Active. It would be important that support to room rental is provided for these activities either directly or via the budgets of the organisation themselves. Future GP surgery design should be facilitate this important intervention.
4. ***More outreach*** to communities is needed and this can happen with strong linkages via health champions as well as via groups such as Getting Heard and AMI. These organisations are still in their infancy and need further support. The time to coordinate and oversee support to volunteers needs to be considered in the role of the social prescribing coordinator by expansion of hours and our associated costs
5. ***Expansion:*** This is valuable work and many surgeries in deprived areas with high GP and A&E attendances would benefit from it. These should be the first to be targeted in any planned expansion. While Barton is benefitting, other deprived areas of our catchment could also benefit more such as Woodfarm and the Northway part of Marston. Even within the remainder of our population, targeting vulnerable groups would be of value to the surgery and to secondary care.

3.0 **Social prescribing vignettes Jan- Mar 2017**

The following accounts attempt to fill in the human face behind the statistics presented in the previous pages and give an idea of how social prescribing works and can impact the lives of our patients.

Patient number 1: was referred for depression, low mood, isolation, and exercise. We have met up a couple of times and have been focussing on self-esteem and confidence. Referral has been made to MIND to attend some confidence and Well-being course which started in March.

The depression and low mood has been triggered from a recent loss of relative, and therefore we have referred this patient to a bereavement group in the local Church which is run by age UK.

She has also been referred to *Fluid Motion*, an aquatic exercise class run by an osteopath and physiotherapist to improve pain scores for those with chronic conditions and to dance home visits to help improve her weekly exercise.

To support with the mood have also referred the patient to a local community art and craft groups that have been held in Woodfarm and Barton church. We are trying to build the patient's circle of support with widening her friendship groups, as she feels she has been let down by a few friends recently.

As a result, she has recently reported been out with a friend, and has attended the dance group. She is beginning to enjoy life more and is starting to get back some form of a new social life. She feels very proud with herself for having addressed some of these recent challenges.

Patient number 2: had been referred for housing support. Due to health problem and joint pain, he has recently been struggling to manage the large flight of stairs in his current accommodation.

He was referred to the Housing department of Oxford City Council (OCC), who made contact with him and assessed the situation along with allocating a team from OCC to look at sheltered accommodation.

The patient had the opportunity to bid on 11 properties, and has already been successful. He has been offered much more suitable housing in another area.

He was very happy that he has now been offered a ground floor flat, with a small garden and is due to move this month.

Patient number 3: was referred for depression, housing and benefits advice. Patient had recently moved back into the area, and currently sofa surfing with an old friend. Recently mood has been very low, due to breakup with long term partner. Friend's house had very limited amenities in the house, therefore not eating properly, with support from friends and the neighbourhood have managed to get a cooker into the flat. Patient has been referred to weekly food bank from the

Barton neighbourhood centre to help reduce weekly food costs and collects food parcels from surgery 2/3 times a week.

Financial problems with ex-partner remain as they have a joint account, and the ex-partner is withdrawing money from the account, leaving patient with no money. With regards to supporting patient with his benefits, this patient was referred to Barton advice centre to help claim the right benefits.

Patient has long term mental health issues, and now back in Oxford has been referred back to the relevant services. Patient attended MIND to help with emotional needs.

Patient number 4: was referred for housing, and isolation, currently having to take 3 flights of stairs to access his accommodation. Due long term severe COPD, and mobility problems, this is now becoming impossible.

Referred to OCC as currently his tenancy is for a two bedroom property, but happy to down size into a one bedroom bottom flat, happy to consider sheltered housing.

OCC have been out to meet the Patient and they are in the process of sorting out suitable housing and a possible move.

4.0 Examples of Referrals made to 'Getting Heard'

One of the projects that Bury Knowle social prescribing project has been working together with since September 2016 is the Getting Heard 'Buddy' project. The aim of the project is to help support socially isolated patients to attend their primary care appointments.

A referral process is completed by the Social prescribing co-ordinator. The patient gives permission to Getting Heard to access their information and they support patients over 65 to get to their GP or nurse appointments. During the period, we identified 5 suitable patients for referral. Examples of those assisted are outlined below:

Patient 1: This was an elderly lady who had recently lost her confidence as she had a nasty fall, and broke her wrist, and then became housebound, through anxiety. This patients 'Buddy' met with her twice a week, and attended her appointments with her. Eventually the patient has gained back some confidence, and started to manage to attend the appointments on her own.

Patient 2: This patient has chronic lung disease, often misses appointments and at times finds it hard to collect medication from the Pharmacy. With the support from his buddy, he found it useful to be reminded of his appointments, and his buddy did attend a few with him. Also the Buddying was used to make sure he ordered his medication, and when due to ill health during the winter was unable to collect medication personally from the pharmacy would collect his medication for him.

Appendix: Example of Referral Form for Social Prescribing

Social Prescribing Referral Form –Barton/Woodfarm Healthy Living Centres

Patient Details

Name of patient: PURPLE, Father (Mr)

Address: 16 Elm Road, Headington, Oxford, OX3 7YF

NHS number: Date of Birth: 22-Feb-1944

Telephone number: Home: Mobile:

Email address:

Ethnicity:

Referrer Details

Name of referring doctor/nurse/HCA: COLLINS, Andrew (Dr.)

Date of referral: 5 October 2016

HLC: Barton ☒ Woodfarm ☐

Referral Details (Please tick one or more boxes)

1	Depression/anxiety/low self esteem	☒	**9**	Simple foot care problems	☐
2	Weight management	☐	**10**	Literacy /Language difficulties	☐
3	Loneliness/isolation	☐	**11**	Parenting challenges	☐
4	Benefits advice	☒	**12**	Seeking volunteering/work opportunities	☐
5	Money/Debt advice	☒	**13**	In need of help around the house/garden	☐
6	Housing problems	☒	**14**	Basic IT training	☐
7	Exercise	☐			

8 Other (including 'not sure'):

Additional information if required: