Primary Care Network
NHS Confederation

Addressing the wider determinants of health – Exploring the impact of social prescribing on health

Thank you for joining us today, if you have any questions for the speakers, please put them into the Q&A box

CORE20 PLUS 5

NHS England

Social Determinants of Health

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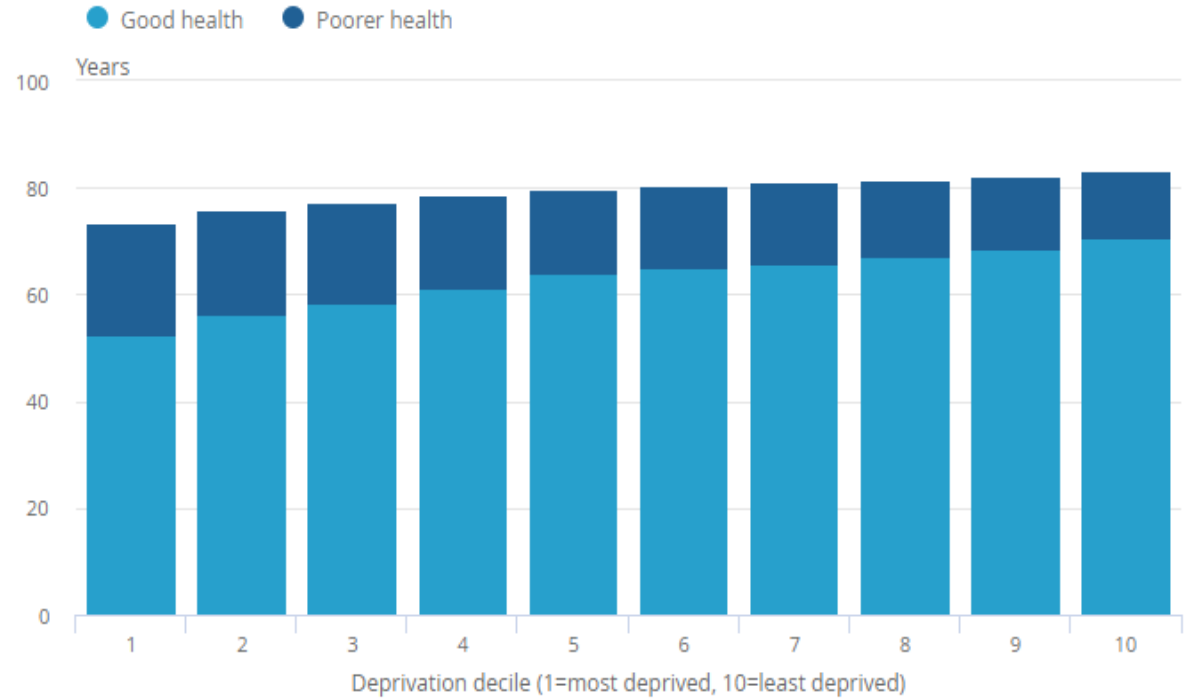
Healthcare Inequalities Improvement

V1.8: 31 Oct 2024

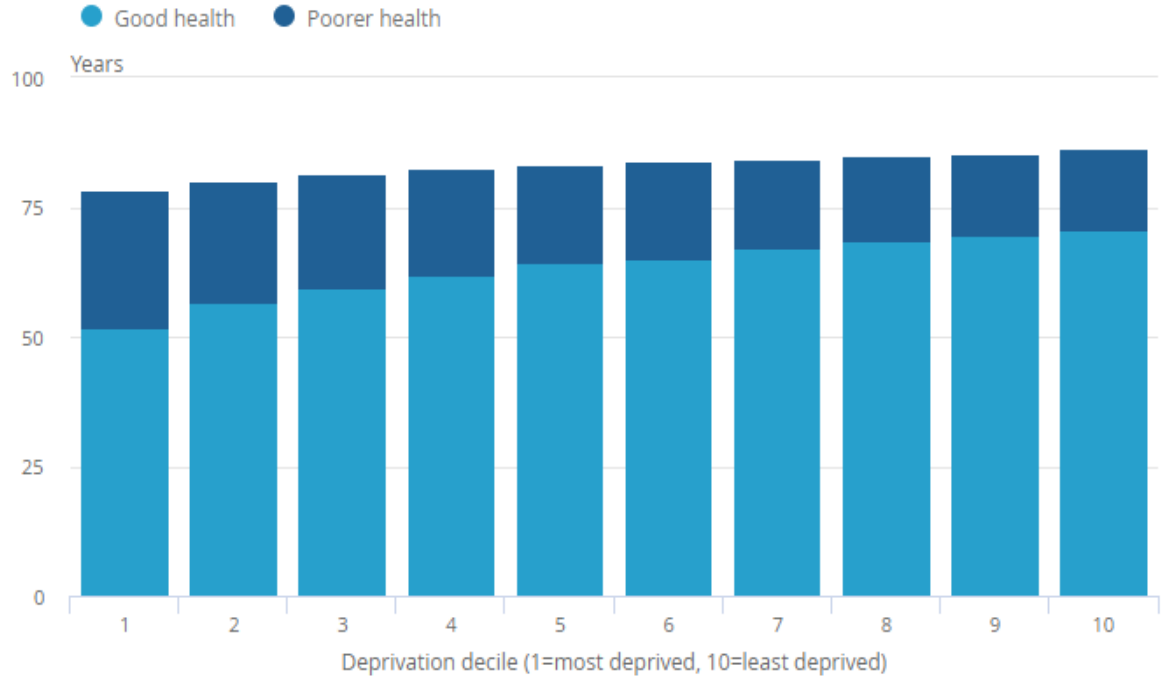
People living in deprived areas live a greater proportion of their shorter lives in poor health

Healthy life expectancy at birth, England, 2018-2020

Males



Females



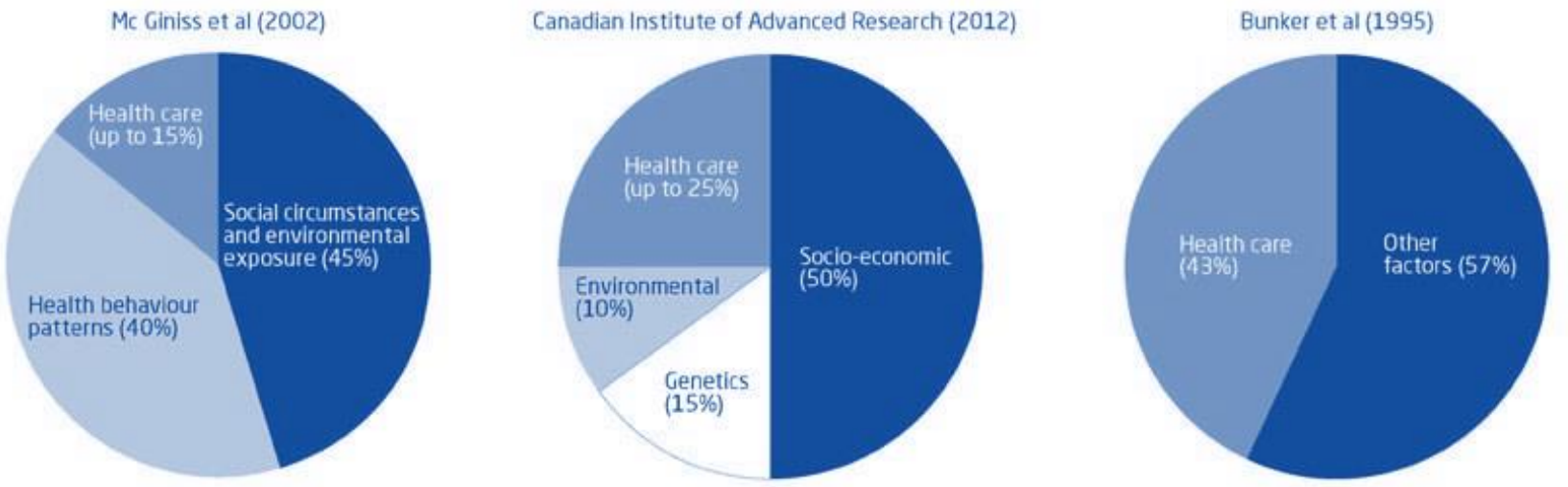
Both males and females in more deprived areas have a **shorter life expectancy overall**, but they also live a **greater proportion of those years in poor health.**

Healthy life expectancy of females in the most deprived decile is 18.8 years less than that of the least deprived decile. For males, the gap in healthy life expectancy between the most deprived and least deprived decile is 18.2 years.

Source: [Health state life expectancies by national deprivation deciles, England - Office for National Statistics (ons.gov.uk)]

As a healthcare provider, the NHS can influence between 15 and 43% of the variation in health outcomes

Though the fundamental social drivers of health inequalities lie outside the healthcare system, the NHS can make a central contribution to narrowing inequalities **by tackling disparities – in access to services, patient experience and healthcare outcomes as** a healthcare provider through service delivery.



Source: The King's Fund

The NHS has a wider role to play working with partners, such as the Office for Health Improvement and Disparities OHID at national level, and in Integrated Care Partnerships (ICPs) with partners such as local government and the Voluntary, Community and Social Enterprise VCSE sector at system and place level.

Health inequalities

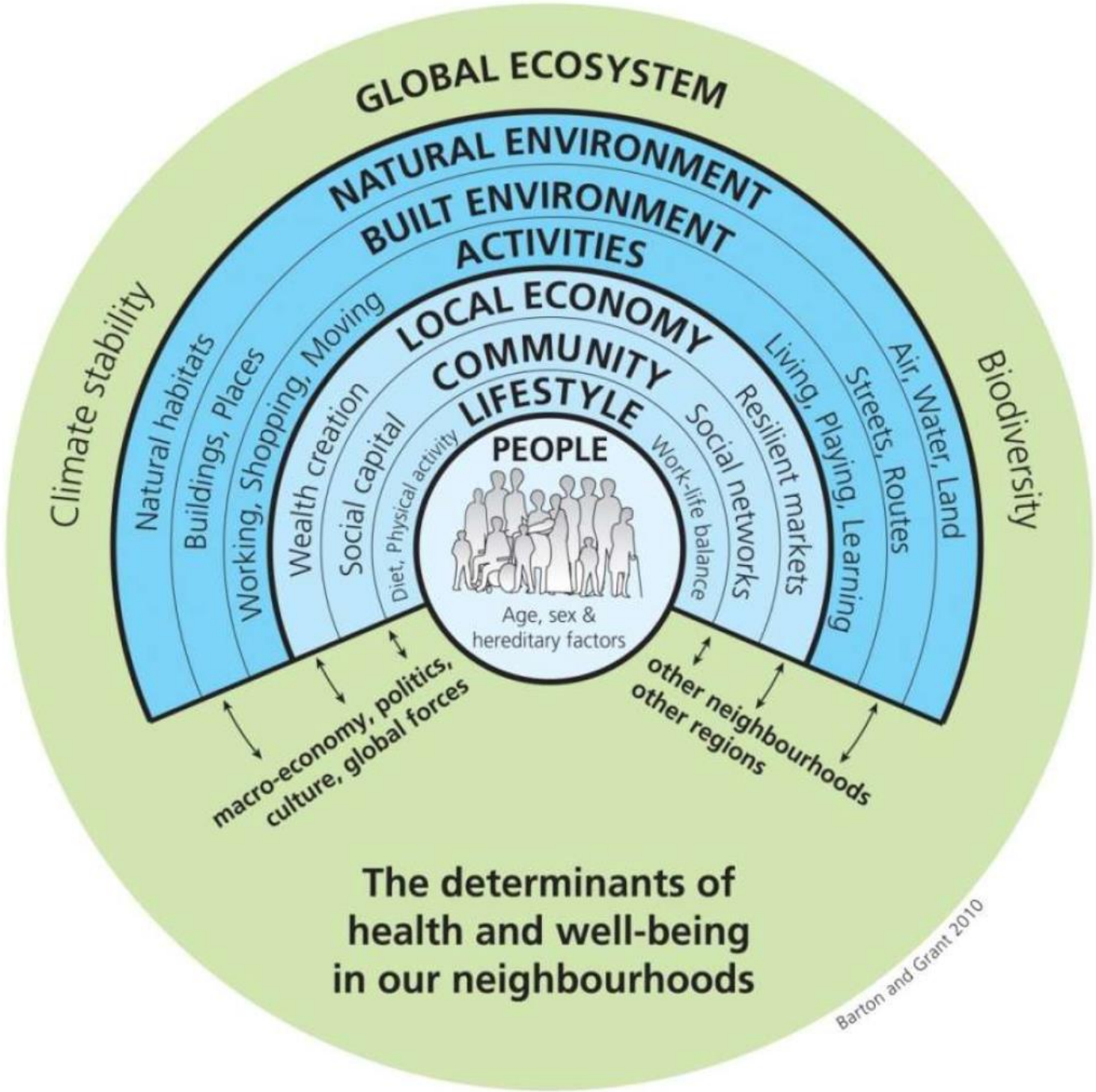
Health inequalities are unfair and avoidable differences in health across the population and between different groups within society.

Health inequalities arise because of the conditions in which we are born, grow, live, work and age.

Health *inequity*

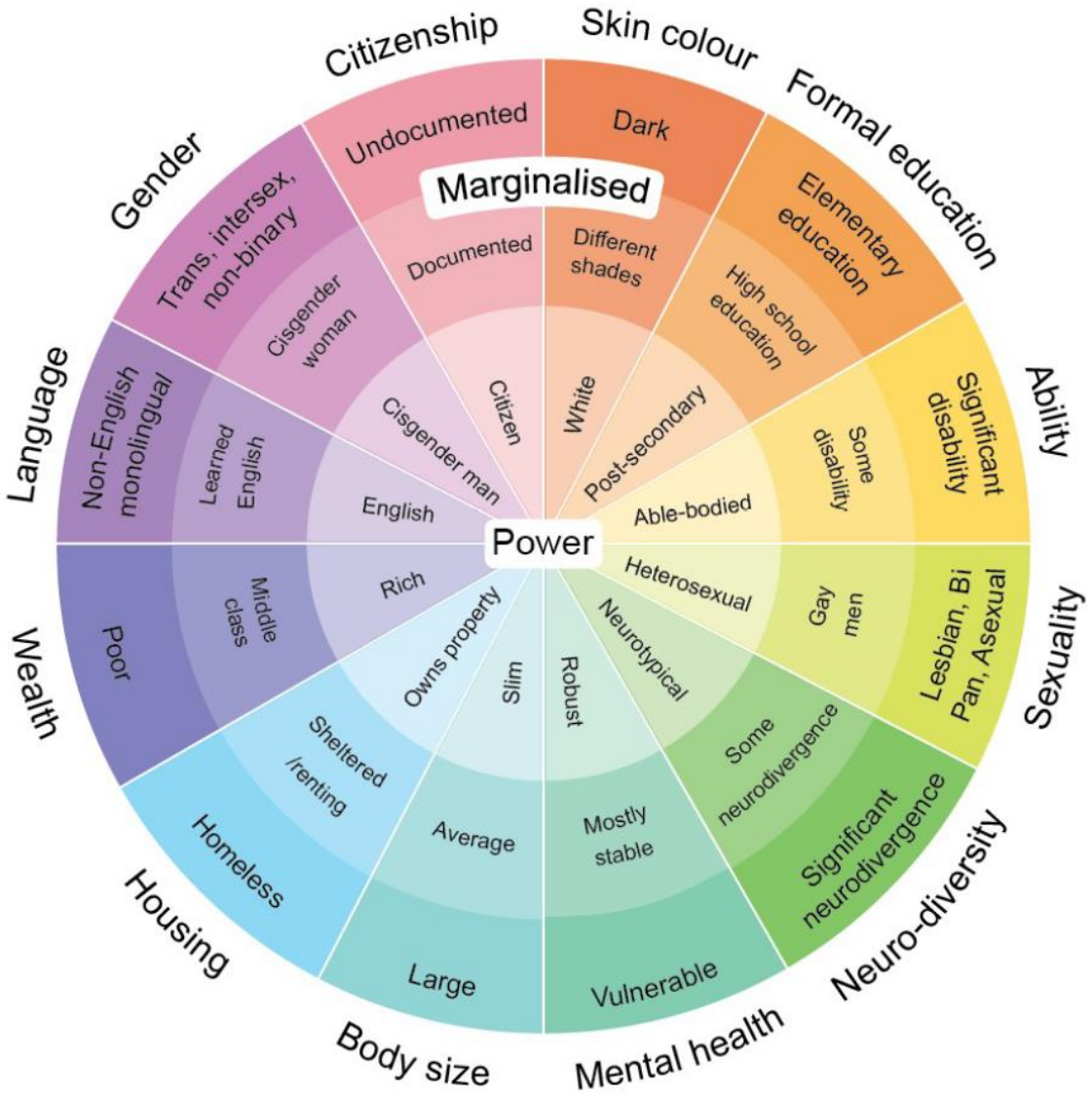
Refers to those inequalities in health that are deemed to be unfair or stemming from some form of injustice.

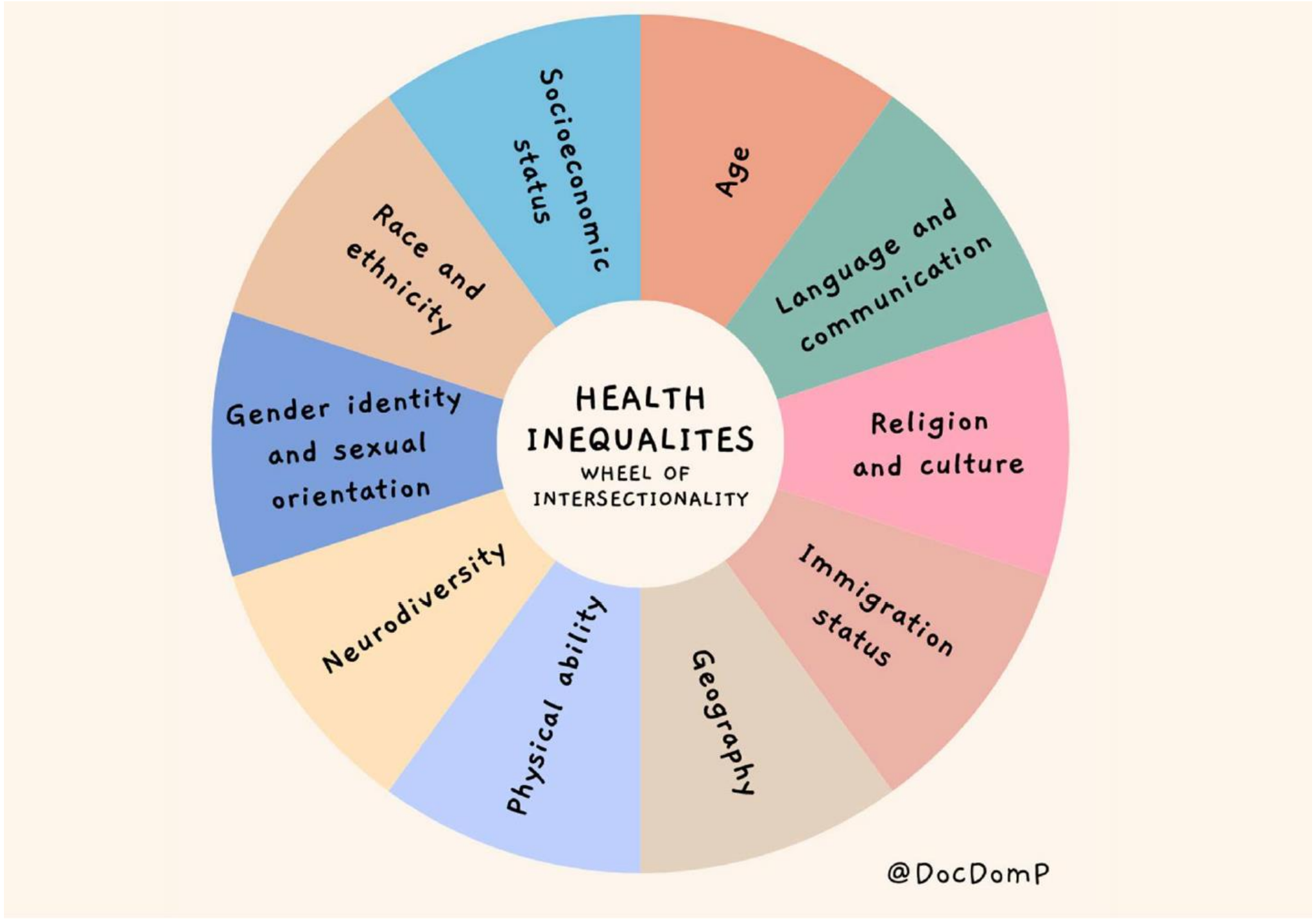
Those that are **avoidable**, **unnecessary, or controllable.**


GLOBAL ECOSYSTEM
NATURAL ENVIRONMENT
BUILT ENVIRONMENT
ACTIVITIES
LOCAL ECONOMY
COMMUNITY
LIFESTYLE
PEOPLE
Age, sex & hereditary factors
Natural habitats
Buildings, Places
Working, Shopping, Moving
Wealth creation
Social capital
Diet, Physical activity
Work-life balance
Social networks
Resilient markets
Living, Playing, Learning
Streets, Routes
Air, Water, Land
Climate stability
Biodiversity
macro-economy, politics, culture, global forces
other neighbourhoods other regions
The determinants of health and well-being in our neighbourhoods
Barton and Grant 2010

INTERSECTIONALITY

NHS England




HEALTH INEQUALITES
WHEEL OF INTERSECTIONALITY
Socioeconomic status
Age
Language and communication
Religion and culture
Immigration status
Geography
Physical ability
Neurodiversity
Gender identity and sexual orientation
Race and ethnicity
@DocDomP

The NHS can contribute towards action on the social determinants of health

The conditions in which we are born, grow, live, work and age impact our health and wellbeing. These are called the social (or wider) determinants of health (SDoH) and include factors such as employment and work conditions; education; food; quality of housing and the surrounding built and natural environment; transport and connectivity; feeling safe and secure; and our relationships with family, friends, and wider community networks.

The NHS sees the downstream effects of the social determinants, for example:

- Social isolation and loneliness are associated with a 30% increased risk of heart disease and stroke
- Children living in cold homes are more than twice as likely to suffer from respiratory problems than children living in warm homes.

Source: What-makes-us-healthy-quick-guide.pdf

Health Literacy

It is the duty of health information producers to be 'health-literacy' friendly in all they do. It is a crucial element of tackling health inequality and misinformation. This was demonstrated by the COVID-19 pandemic. Health information must be accessible to all.'

– **Sophie Randall, Director, Patient Information Forum (PIF)**

Around half of the population struggles to understand information that can help them manage their own health and care. Understanding health information (health literacy) is essential for taking medications correctly, knowing which health services to use, and managing long-term conditions. The most disadvantaged groups in society are most likely to have limited health literacy. Efforts to improve health literacy could therefore reduce health inequalities.

Questions?

Innovation Hub: Background

Improvement Academy

Bradford District and Craven Health and Care Partnership Innovation Hub

ACTasONE

The Health Foundation

Background

- ‘The Spread Challenge’ report, highlighted the challenges facing the NHS in improving the uptake of new ideas and practices
- There should be more opportunities for real-world testing of innovations and improvements in health care before trying to spread them

Funding

- The Health Foundation offered funding for four Innovation Hubs
- To support effective adoption of innovation in healthcare
- Bradford District and Craven Integrated Care Partnership was one of the four selected

Bradford District and Craven

- The aim:

  'make it easier for Bradford District and Craven to implement innovations that help people to live happy and healthy at home'

- To do this, the Hub will:
  - champion the benefits of innovation adoption and how to do it well;
  - connect information and resources including signposting to key partners and developing learning networks;
  - ensure resources are targeted where they can have the greatest impact

Selection Process

- Multiple opportunities were identified to support innovation in heathcare
- The opportunities were evaluated through:
  - 3 workshops
  - 20+ stakeholders

Where the project began .....

The Ridge: LONG-TERM skew of GP appointments

2% ⇨ 14%

- **2% of the list (584 patients) take**
- **14% of GP appointments last year (and the 2 years before)**
- **Pre-booked this year also?**
- **Will be 14% of next years GP appointments without changes**

EST 1892 LSBU

Social Prescribing: Summary February/ March 2025

To make a referral to our service please retrieve a patient and type in the search features box -> PCN All in one Template

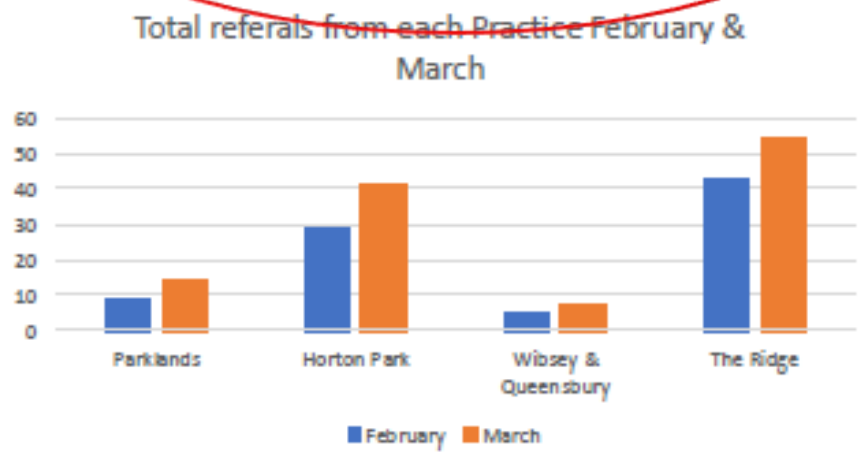
Social Prescribing

Referrals Review

- We have received 202 referrals within February & March, we have seen a slight increase from Wibsey & Queensbury as we now have a weekly presence within the surgery which we were not able to so previously.
- Reasons for referrals continue to be varied, however they are becoming more complex in nature.

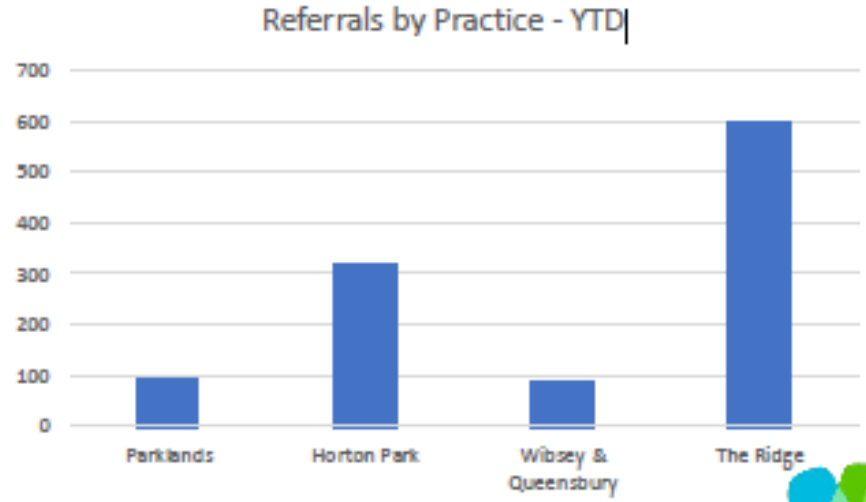
Total referrals YTD – 1099 (349 over the full annual target)

- **Welfare rights/debt/ housing issues**
- **Financial issues related to cost-of-living crisis/food parcels**
- **Social isolation and loneliness**
- **Mental Health – anxiety, depression and low mood**
- **Drugs & Alcohol together with housing issues**
- **People with dementia/cancer**



Discharges Summary

- We have signposted/referred on or discharged 142 patients in December & January to other professional, statutory or community organizations.



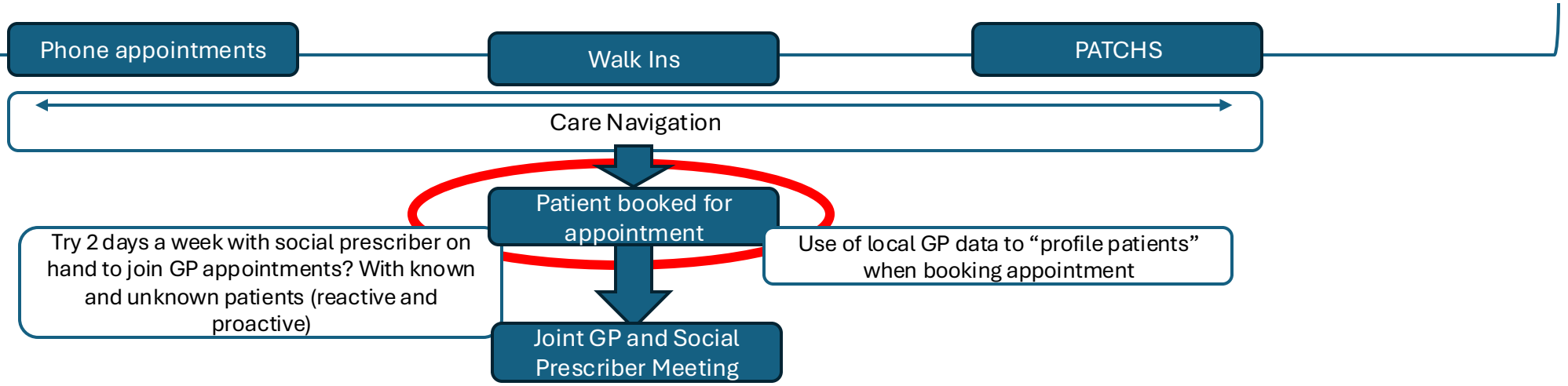
Royds

The Five Parks Primary Care Network

NB: month to month figures for discharges should not be compared to referrals due to the lag for individual cases – further analysis is being sought on discharge rates

Proposed Intervention: Joint GP and social prescriber appointments

Integrating medical and social care to provide more holistic and patient-centered care. This approach involves GPs and social prescribers working together in a coordinated manner during patient appointments, particularly for patients with complex social needs that affect their health and well-being

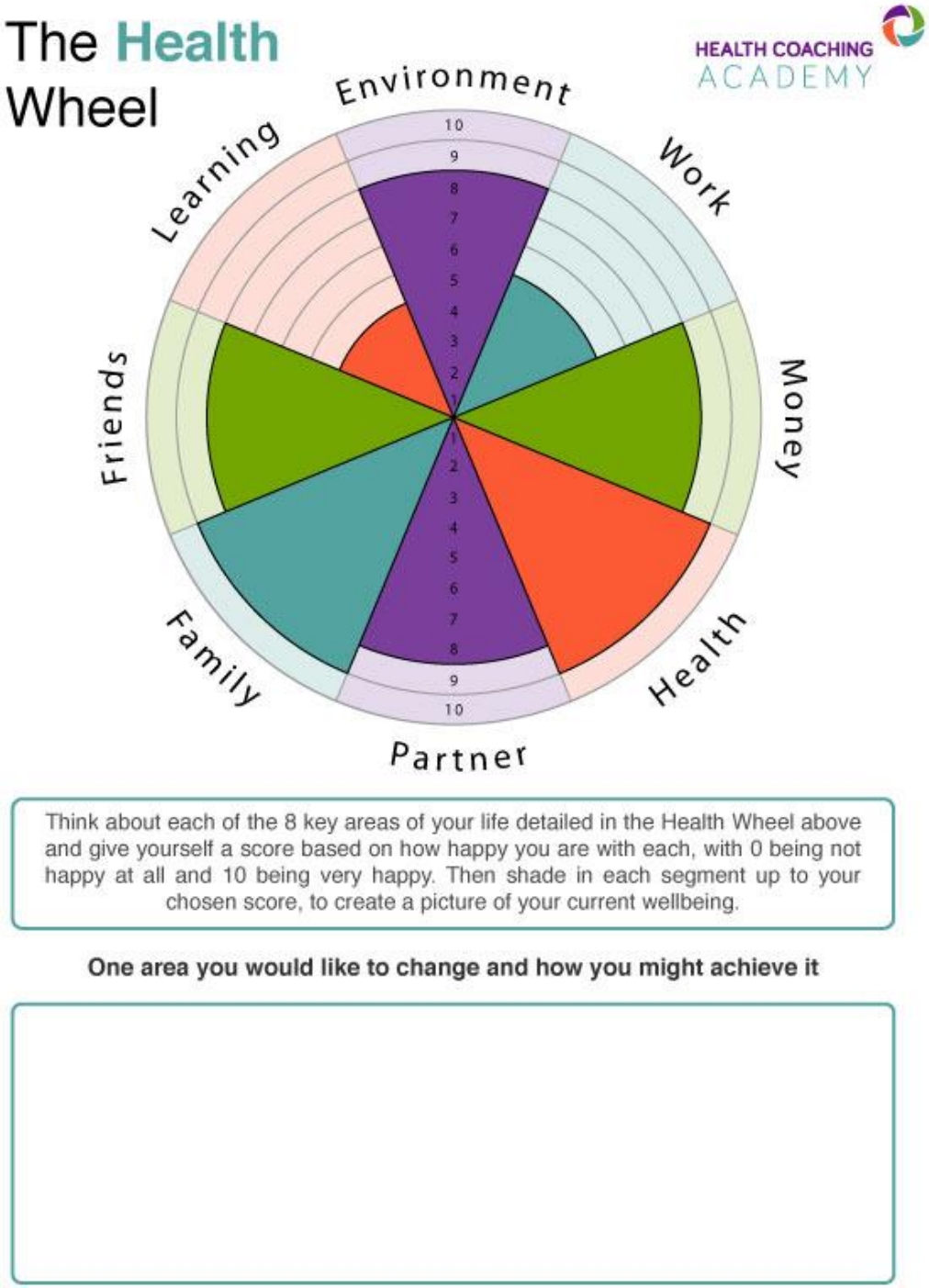


Purpose and Objectives	Possible intervention components	Possible Implementation strategies	Example outcomes?	Challenges and considerations	Monitoring and evaluation
Holistic Patient Care: Main goal is to address medical and social, emotional, and practical needs of patients **Enhanced Care Coordination:** Collaborate in real-time during appointments to ensure that patients receive comprehensive care tailored to their individual needs. **Reduce GP Workload:** Alleviate some of the pressures on GPs through smarter working and enabling social prescribers to take earlier intervention on non-medical aspects of patient care	**Integrated Appointments:** Allows for immediate discussion of medical and social needs, with both professionals contributing to the care plan. **Personalized Care Plans:** Together, GP and Social Prescriber create a personalised care plan that covers all aspects of the patient's well-being. **Referral and Support Services:** Social prescriber can directly refer and hand hold patients to local services and community resources during the appointment **Follow-Up and Monitoring:** Social prescribers handle follow-up on the social aspects of care, maintaining regular contact with patients to monitor progress and adjust support as needed	**Training and role clarity:** GPs and social prescribers are provided with joint training sessions to understand each other's roles, ensuring effective collaboration during appointments. **Practice-Level Integration:** Requiring coordination between practice managers, GPs, and social prescribers to integrate scheduling and workflow. **Patient Selection:** Prioritise patients with complex needs or those who frequently attend GP appointments for issues that have significant social components (loneliness and isolation)	**Improved Patient Outcomes:** Addressing both medical and social determinants of health in a single appointment **Increased Patient Satisfaction:** Higher satisfaction levels when patients feel their social needs are acknowledged and addressed alongside their medical care. **Reduction in GP Appointments:** By addressing underlying social issues this intervention can reduce the frequency of GP appointments **Enhanced Use of Community Resources:** Patients more likely to take up local support services when referred directly by a social prescriber during an appointment	**Logistical Coordination:** Scheduling joint appointments requires careful capacity planning **Patient Awareness:** Ensuring patients understand the role of social prescribers and the benefits of joint appointments is crucial. **Resource Allocation:** Capacity of existing social prescriber time and how many appointments they can support. Is additional investment possible? **Data Sharing and Confidentiality:** Clear protocols for sharing patient information between GPs and social prescribers while maintaining patient confidentiality.	**Patient Feedback:** Collecting feedback from patients who have participated in joint appointments to evaluate the intervention's effectiveness and identify areas for improvement. **Outcome Measures:** Monitor a range of outcomes, including reductions in GP appointments, improvements in patient-reported outcomes, and increased referrals to community services. **Continuous Improvement:** Regular review meetings between GPs and social prescribers to help refine the process, addressing any challenges and ensuring the intervention continues to meet patient needs effectively

Health Wheel

The health wheel (as shown) is a reflective tool provided to patients prior to their appointment with both the GP and the social prescriber. Its purpose is to help identify which areas of their life may be contributing to their current health and wellbeing. Patients are asked to rate various aspects on a scale of 1 to 10, with 1 indicating “really dissatisfied" and 10 representing "completely satisfied.“

This process not only supports the clinical team in gaining a more holistic understanding of the patient's situation but also encourages the patient to consider how different areas of their life may be influencing their overall health. At a later stage, patients are invited to complete a second health wheel with their social prescriber to reflect on any changes in their circumstances and to evaluate progress or areas where further support may be needed.



Patient 1

Summary of situation before the appointment:

- 48-year-old female suffers with headaches, migraines and depression.
- Had 12 GP appts in 3 months prior to the appointment
- Never seen Social Prescriber before
- Before the Joint Appointment patient felt that “her care from the Practice was pretty good but she just felt that everything to do with her health was at a standstill”

Summary of situation after the appointment:

- Had 8 GP appts in 3 months following the appointment
- Social Prescribers have contacted the patient 11 times, she has not engaged to a high level, often not answering the phone and not attending recommended activities, she reports that is mostly because of ill health.
- After the Joint Appointment, patient felt “positive straight after she left the room but unfortunately, she hasn’t felt able to make any adjustments due to how poor her health has been since then. She felt the insight from Dr A Khan was helpful and said that the Social Prescriber had been lovely during the catch-up calls.

Patient 2

Summary of situation before the appointment:

- 52 year old male suffers with abdominal problems and mental health.
- Had 12 GP appts in 3 months prior to the appointment
- Never seen Social Prescriber before
- Before the Joint Appointment patient felt that “the care he got from the Practice before the appointment was good”

Summary of situation after the appointment:

- Had 5 GP appts in 3 months following the appointment
- Social Prescribers have contacted the patient 4 times, he has since gone back to work, made new friends at his workplace and is now part of a 5 a side football team.
- After the Joint Appointment, patient felt he had more “insight into his care by recognising that he needed to get out more and the social prescribers were very helpful”

Patient 3

Summary of situation before the appointment:

- 38 year old female suffers with fibromyalgia, endometriosis and mental health issues
- Had 6 GP appts in 3 months prior to the appointment
- Never seen Social Prescriber before
- Before the Joint Appointment patient felt that “the care she received before was just getting blamed on her ongoing conditions”

Summary of situation after the appointment:

- Had 6 GP appts in 3 months following the appointment
- Social Prescribers have contacted the patient 7 times, originally a home visit was agreed but patient cancelled due to being unwell and patient hasn’t engaged with them since by not answering the phone on multiple occasions.
- After the Joint Appointment, patient felt “positive initially but struggled to make adaptations due to ongoing health issues but said she finds the social prescribers friendly and helpful”

Reflections at this point .....

What have we learned so far?

Looking back on these patients, we have observed that many of them haven't engaged with the Social Prescribers in the ways we had hoped for, not answering their calls, not attending activities and still coming frequently to the GP.

We learned that:

- The cohort of patients we invited had lots going on health wise and there was very little they thought the social prescribers could do for them
- The way the patients were invited in took them slightly "off guard" and was almost seen as a "cold call"
- There wasn't any continuity of care from the Drs during the subsequent GP appointments.

And how have we adapted in April?

It became evident that we should change our approach to gain a greater buy-in from the patients so:

- We have changed the way we invite patients in, rather than using a search built on frequent attenders, age and condition, we have a small test group of practice clinicians involved in the project, asking them to flag up patients that they come across during routine consultations whom they would like to spend longer with in another appointment and involve the Social Prescriber too.

Impressions since the April adaptation .....

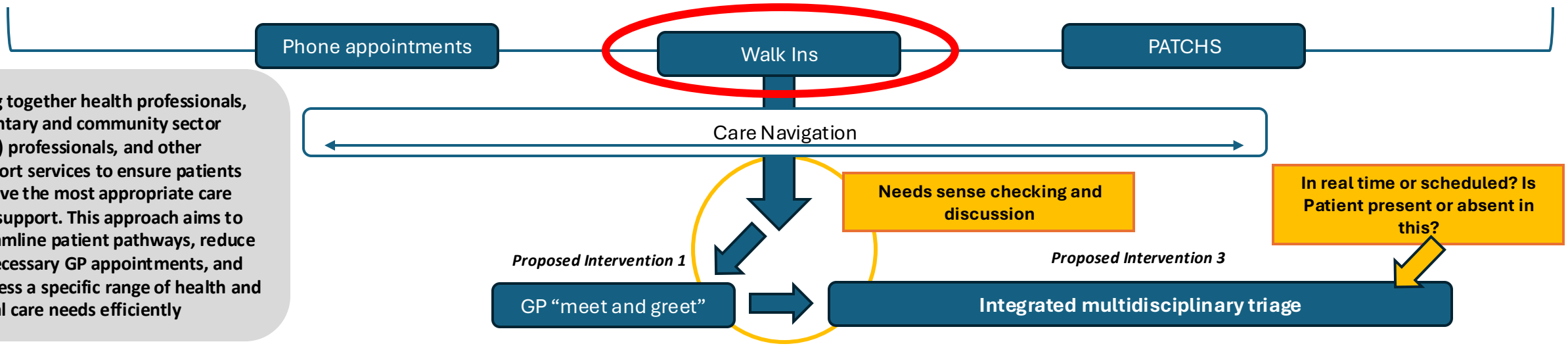
- Rebecca Kelly (ANP involved) held her first joint appointment with a patient she had identified herself, and felt it was a positive experience, and she was able to give the patient a more contextual insight to what role the Social Prescriber plays, and the patient has been engaging with the Social Prescriber very well since
- Dr Muhammed Sultan (Salaried GP) held a joint appointment with a patient he had identified himself. Patient came out feeling very positive and has already been adjusting her lifestyle by going on walks.
- Dr Katrina Butterworth (salaried GP) held a joint appointment with a patient she had identified herself, and the patient is engaging well with the Social Prescribers and has accepted some support for herself as she is a carer for her husband.

These changes were implemented and actioned only in April, but the results are encouraging, and the outcomes appear to be more positive.

This will continue to be monitored by the Care Co-Ordinator

Proposed Intervention: Integrated multidisciplinary service triage

Bring together health professionals, voluntary and community sector (VCS) professionals, and other support services to ensure patients receive the most appropriate care and support. This approach aims to streamline patient pathways, reduce unnecessary GP appointments, and address a specific range of health and social care needs efficiently



Purpose and Objectives	Possible intervention components	Possible Implementation strategies	Example outcomes?	Challenges and considerations	Monitoring and evaluation
Integrated Care Delivery: To provide a holistic approach to patient care by integrating medical and non-medical services, ensuring that patients' health and social needs are met in a coordinated manner **Efficient Use of Resources:** To reduce the burden on GPs and other healthcare providers, directing patients to the most appropriate service or professional from the outset. **Improved Patient Outcomes:** To enhance patient outcomes through timely and appropriate referrals to both healthcare services and community support resources.	**Multi-Disciplinary Triage Team:** Form an appropriate team to collaborative reviews and triages patient cases. **Centralised Triage Process:** Possibility of this being part of the meet and greet process potentially and done in real time? **Use of Technology:** Shared electronic health records and decision support systems could help to ensure that patients are directed to the right services efficiently. •**Patient Involvement:** Patients to be involved in the triage process, ensuring that their preferences and needs are considered when determining the best course of action.	**Team Formation and Training:** Forming a well-coordinated team with clear roles and responsibilities. Training to help team members understand each other's expertise and how to work together effectively. **Establishing Referral Pathways:** Clear and efficient referral pathways are developed between the GP practice and various VCS organizations involving formal agreements or partnerships **Setting up co-located services:** Based on evidence of need and patient flows, co-located services can be set up and connected to this model offering seamless and same day access to vital social and non-medical support services	**Reduced GP Workload** Reduce number of patients who need to see a GP, freeing up GP time for more complex cases. **Enhanced Patient Satisfaction:** Patients benefit from quicker access to the services they need, whether those are medical, social, or community-based, leading to higher satisfaction levels **Improved Health and Well-being:** Addressing both the medical and social determinants of health in a coordinated manner lead to better overall health and well-being outcomes for patients **Stronger Community Links:** Fosters stronger connections between GP practices and local VCS organizations, leading to more robust support for patients	**Coordination and Communication:** Regular meetings and the use of shared digital platforms are essential to keep everyone aligned **Sustainability:** The model might require ongoing funding and support, particularly for the involvement of VCS professionals. **Patient Understanding:** Patients need to understand the role of the triage team and trust the process, which may require education and clear communication about how their care will be manage	**Data Collection:** Collect data on patient outcomes, referral patterns, and the impact on GP workloads **Patient and Staff Feedback:** Surveys, focus groups, and interview methods might need to be used for gathering feedback **Continuous Quality Improvement:** Model should to be part of a continuous quality improvement process, with regular reviews and updates based on evaluation findings