Social Prescribing Year One

Central Bournemouth
Primary Care Network

A summary of the Social Prescribing Service
1st January 2020 to 31st December 2020

James Fisher Medical Centre • Moordown Medical Centre • Panton Practice • St Albans Medical Centre •

Central
Bournemouth
Network

Quarter One

Jan to Mid-March (pre-pandemic)

Launch of service

Referrals flowed at a good pace. Patients seen face to face in the community, at home or at a practice as well as receiving follow-up calls, visits and written communications. Additional signposting completed by phone for individuals looking for basic support information.

Service Specification

Personalised support included:

- Setting goals
- Signposting to activities and groups
- Accompanying to activities for first session
- Issuing foodbank vouchers
- Form filling assistance

Promotion of Service

Meetings with external agencies to introduce the role, nurture working relationships and map local service provision including:

- Public Health Dorset
- Community Action Network
- Community Centres
- Prama
- BCP Council
- Dorset Healthcare
- Dorset Mind
- LiveWell Dorset
- Active Dorset

Accompanied new Network Pharmacist in visiting all pharmacies across the PCN area to raise aware of these new roles and how to contact us.

Key Achievements

40 Patients seen face to face on at least one occasion in the community

18 Patients contacted and signposted by telephone

3 GP and 3 Nurse shadowing sessions

Meetings with 16 statutory and voluntary sector organisations

Introductions to all pharmacies in PCN

Social Prescriber embedded in MDT meetings

Creation of social prescribing template

Presentations made at two Network PLT sessions

Quarter Two

Mid-March to June

Supporting Shielding and Vulnerable Population

Lists of Clinically Extremely Vulnerable patients received from practices to conduct welfare calls. Other referrals for patients in moderate category, those needing to self isolate and people facing hardship due to furlough or experiencing pandemic anxiety. SystmOne enabled laptop and mobile phone allowed for rapid response from day one of lockdown. Our shielding population received calls from us often before being contacted by the National Shielding Service or Local Authority.

Change to Service

All face to face contact ceased and took place primarily over the phone with some written communication. Launch of BCP Together We Can and GoodSam provided volunteers for shopping, transport to essential medical appointments, prescription deliveries and befriending calls. GoodSam referrals initially only accepted from NHS or Gov email addresses with external sources facing a 3 day approval wait for each new referral. Social Prescriber being PCN direct employed avoided these delays.

Virtual Coffee Mornings

Early completion of initial welfare calls created the capacity to launch the virtual coffee mornings as a way of relieving loneliness and isolation for our population. Voluntary sector groups experienced enforced closure in lockdown, loss of volunteers and furlough of staff. The coffee mornings filled a gap in provision for people at home missing contact with the outside world. We have had social prescribers locally and nationally sit in on some of these sessions with a view to replicating the service in their own PCNs. Some participants have met up for socially distanced walks in line with guidelines. Feedback from some participants available later in this report.

Key Achievements

Registering for food parcels and delivery slots at shops

Arranging volunteers to collect shopping and prescriptions

Creation of twice weekly virtual coffee mornings

Weekly national social prescribing webinars run by NHSE

Linking with social prescribers nationally through NHS Future Collaboration Platform

Attendance at virtual MDT meetings

Implementation of weekly huddle for Self-Management Team

Introduction of NHSE SNOMED codes

Quarter Three

July to September

Reconnecting to Communities

Focus on encouraging the shielding population to take their initial first steps back into the community through walking and exercise outdoors, reconnecting with family or friends, how to create a support bubble and visiting shops again. General population also seeking more opportunities for in-person socialisation.

Challenges After Lockdown

Community venues remaining closed and ever-changing guidance made it difficult for activity groups to reopen meaning sessions to attend in person were few and far between. Confirmation from a number of groups that services would not resume until 2021. Some groups choosing to meet outside during nice weather but this was still not easy for anyone frail or with poor mobility.

Telephone Friendship Group/Yours Sincerely

Joined a strategic resilience task force made up of representatives from a number of local charities and statutory agencies which led to the creation of the Telephone Friendship Group spearheaded by Prama and the Yours Sincerely multi-generational pen pal project headed up by A Good Life. We were able to link this group to a contact at the Arts University which led to the creation of logos for both groups being done on a pro-bono basis by students working on their portfolios.

Expansion of Social Prescribing Team

Sarah Gallagher joined the PCN as our second Social Prescriber in mid-August. Coming straight from a role as a Crisis Advocacy worker, Sarah was an ideal candidate. With knowledge and links to existing services locally, she has been able to provide support to our patient population from day one.

Key Achievements

Joining BCP Access to Food Forum

Linking with new and re-emerging groups in the community

Leading on creation of Dorset-wide Facebook group for all Social Prescribers - over 40 members currently

Creation of Central Bournemouth PCN Facebook page

Additional Social Prescriber appointed

Linking Telephone Friendship Group and Yours Sincerely to Arts Uni Bournemouth for creation of logos

Quarter Four

October to December

Winter Pressures

Challenges of social isolation continued. Activities for individuals to attend were low and difficult to access. Worsening weather meant cancellations for some groups that were meeting outdoors. Anxiety about festive period and not being able to see family.

Second Lockdown

Majority of community groups that had been able to reopen in a covid-safe way were put back on hiatus or moved online. Shielding measures re-introduced for CEV patients. Reopening of registration for supermarket priority slots for anyone who missed the first round.

Festive Coffee Mornings

With the cancellation of all community based festive luncheons in our geographical area, we had a number of patients facing Christmas on their own. We created two special virtual coffee mornings to take place on Christmas Day and New Years Day. We were able to partner with Crumbs, a local catering charity, to provide attendees with a mince pie or cupcake to enjoy during the session on 25th Dec.

Food Poverty

Working with the Access to Food Forum to map service provision for our population facing food poverty due to self-isolation, loss of income or furlough including Crumbs Christmas Dinner delivery service and CityGate Christmas Hamper scheme for families.

Covid 19 Vaccination Effort

With short notice of the vaccine arriving, the whole Self Management Team were drafted in to make calls to over 1,000 patients aged 80+ and book their vaccination appointments.

Key Achievements

Introducing the PCN to Dorset Mind model for Active Monitoring and the subsequent commissioning of this role to launch in 2021

Festive virtual coffee mornings on 25th and 31st December

Became registered members of National Association of Link Workers

Distribution of excess food to vulnerable patients via Access to Food Forum

Linking with Dorset Police to promote the role and awareness of Social Prescribers

Supporting vaccine roll out by contacting our aged 80+ population to book appointments

Statistics and Figures

Panton	Moordown	St Albans	James Fisher

Number of Patients Referred for Social Prescribing

176	77	83	108

Number of Patients Declined Referral for Social Prescribing

1	3	2	2

Number of Social Prescribing Clients on Shielding Register

77	33	46	73

Percentage of Patient Population Referred

1.1	0.8	0.7	0.6

The social prescribing service received 444 referrals, 226 of which were also on the shielding register. The 444 referrals equates to 3.2% of the registered patients across the PCN. Of these referrals, 8 patients declined the service which means over 98% of all referrals made were successful in receiving support.

Reflective Thoughts on Year One

Covid changed the role of a social prescriber dramatically. Instead of helping people reconnect to communities through activities and socialisation, we have been supporting them with food supplies, welfare calls and staying positive. Lack of community activities has been the biggest challenge. We have tried our best to keep people connected through virtual coffee mornings and friendship lines but understandably these don't have the same attraction as an in-person chat over a cup of tea.

Social prescribers nationally were under enormous emotional strain, particularly during the first lockdown, dealing with anxious and frightened people. Our roles give us the luxury of time with patients helping them identify goals, support needs and plans to address health inequalities. In the midst of a pandemic though, this often meant being sounding boards for people having their worst days and dealing with waves of anxiety and grief. In July the National Association of Link Workers published a report with findings that 1 in 3 social prescribers were considering resigning due to feeling unvalued. It is testimony to our PCN that we have full support from our Network Manager, are embedded in the practices with the correct equipment and systems access, meet weekly as part of the wider Self-Management Team and during this year invested in a second social prescriber as well as a new role of mental health coach for young people and the implementation of Active Monitoring launching early 2021.

On a positive note, the pandemic has helped cut through red tap and facilitated conversations between organisations. The task force that led to the creation of the Telephone Friendship Group and Yours Sincerely was able to move at an incredible pace. The rapid launch of Together We Can as a combined effort by BCP Council and Community Action Network provided the help and resources to our patient population at a critical time. The Access to Food Forum was able to set up the BCP Food Map quickly and effectively providing crucial details of agencies and organisations able to offer food to local residents experiencing food poverty.

Virtual Coffee Morning Feedback

It is lovely to meet up with people from outside your usual social group and we have all formed a bond. We are a very diverse group but are looking forward to meeting up together when we are able. It has been nice to see a couple of participants have already managed to do so, socially distanced of course.

These are a life line and mostly because they are "Normal". It is a little bit of normality that is missing from all of our lives at the moment and these one hour chats, twice a week have been keeping me sane in an insane world. Normal people, normal chat, normal issues, normal desires ..... I never want them to end – EVER

The sessions are a bit of light in my dark life. Without them I could go several days without seeing or speaking to another person.

We have been able to talk through our worries and receive help and advice. We also have a laugh and discuss much lighter matters. The hosting team are excellent in introducing new topics for discussion when there is a lull in conversation. I have thoroughly enjoyed the sessions, have learned some new things and made new friends. Thanks to all who have been instrumental in this and I look forward to continuing. Thanks also to the team who are giving up their time on Christmas day to be there for those who are spending their day alone.

Research from the Campaign to End Loneliness shows lonely people:

Have 26% higher mortality rate

Are 50% more likely to access emergency services

Are 40% more likely to have 12+ GP appts a year

Case Study

51 year old female. Lives alone. One family member living in local area but they have a complex relationship. History of anxiety and mental health needs. Referred by GP to social prescribing service due to support needed during shielding period.

Talking through shielding guidelines and what this meant for her.

Registered for Extremely Vulnerable Support Service to get priority shopping slots and food parcels.

Supported to register with online pharmacy for delivery of medication.

Suggestions for home-exercise options.

Signposting to Connections and NHS One You for mental health support.

Referred to Together We Can for interim shopping volunteer.

Help planning quiet dog walking routes.

Regular check-in calls during shielding.

Support to plan conversation with manager around returning to work.

Patient always had access to food and essential supplies.

Maintained exercise and physical activity.

Manged her anxiety and mental health at home.

Felt supported by her GP practice without needing input from clinician.

Successfully returned to work after shielding.

Plans for 2021

Spring-Summer 2021 should see social groups and activities reopening on a larger scale. We are dependent upon vaccines, failing infection numbers and Government guidance but we remain hopeful for a return to more traditional Social Prescribing.

Encouraging our virtual coffee morning group to become involved with the Health Champions and helping to resume the previous activities such as the knitting club and walking group. Expanding on these activities to create more practice-based interactive sessions.

Utilising the new role of Mental Health Coach for Young People and the Active Monitoring Service to bring in an additional cohort of social prescribing referrals. Once a patient has been through the Coaching or Monitoring process, they can be supported to find activities and opportunities to continue their wellbeing journey.

Remapping community provision and resources post-pandemic to discover re-emerging and new groups, activities and services. Helping to capacity build the voluntary sector by ensuring appropriate referrals are made to these organisations.

Continue to support the PCN with the vaccine roll out by making appointments by phone, marshalling clinics and anything else required. There is currently no bigger health inequality than the one being faced by our elderly and clinically vulnerable population who have spent 10 months indoors.