10 High Impact Actions

NHS England

Innovations from around England that release time for GPs to do more of what only they can do.

bit.ly/gpcapacityforum

#GPforwardview

8 Social prescribing

The idea

- Signpost patients to care and support services which increase wellbeing and independence.
- Examples include leisure and social community activities, befriending, carer respite, dementia support, housing, debt management and benefits advice, one to one specialist advocacy and support, employment support and sensory impairment services.
- The service may be external to the practice, taking referrals, or there may be closer integration within the practice team, for example through team meetings or locating peer coaches or service navigators within the team.

Impact

- Reduced demand for GP & other appointments (eg Shropshire, 48% reduction in GP consultations, 33% reduction in A&E attendances and 58% reduction in unscheduled hospital admissions).
- Improved quality of life for patients and carers.
- Satisfaction and empowerment for volunteers (many of them former high users of GP practice).

Implementation tips

- Start by building a close working relationship with local voluntary sector groups, and involve them in shaping the work. and involve them in shaping the work.
- Maintain ongoing close relationships, for staff and volunteers to identify gaps and duplication in services, as there is usually room for improvement in collaboration in many directions.
- Aim to include plans for using savings (eg from reduced unscheduled care and admissions) to sustain the scheme.

Social prescribing models vary in the following key areas:

- **Population segment** - who is the service aimed at / it open to?
  - specified demographics / specified health needs or social situation / no formal criteria
- **Location** – where does the link worker work? Are they employed? By whom?
  - volunteer based in practice / employed by practice / based elsewhere but attached to practice / based elsewhere and 'referred to' by practice
- **Route of entry** – how do patients get into the service?
  - self-referral / referral by GP / referral by any clinician / any staff
- **Identification of patients** – how are eligible patients identified for referral?
  - ad hoc (eg during consultation) / proactive case-finding
- **Pre-consultation work** – does the worker obtain any additional information about the person?
- **Input from navigator** – what does the worker do for the patient?
  - information-giving (signposting +/- coached needs assessment process) / direct support (care coordination, health coaching, befriending, mentoring, advocacy)
- **Longevity of contact** – how long is contact maintained with the link worker?
- **Person specification** – what are the personal requirements for link workers?
- **Links with community groups** – how proactively do workers connect with providers?
- **Recruitment and training** – how are link workers recruited and trained?
  - led by practice / CCG / NHS Trust / voluntary sector
- **Funding for service** – how is the service funded?
  - resourced by voluntary sector / employed by practice or CCG +/- expenses / fee-for-service paid by practice or CCG / outcomes-based contract with practice or CCG NHS +/- non-NHS funding (eg social impact bond)

It is worth discussing all of these when designing your own service.

Questions for getting started:

- What links do you already have with local care and support services?
- What proportion of patients could benefit from additional non-medical care and support in the community?
- Is there already a local care navigation or signposting service to help connect patients with care and support?
- How could you ensure there is sufficient capacity to signpost and support additional service users?
- What sort of a service would be most beneficial? In particular, where do you want it to be on the spectrum from “someone based within the practice” to “external service to refer to”?
- Who could you connect with to learn more?
- How would a new or expanded service be sustained?

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