Committee: Health and Wellbeing Board

Date: 28th November 2023

Agenda item: 2

Wards: All

Subject:

Lead officer: Amrinder Sehgal

Lead member: Mark Creelman

Forward Plan reference number:

Contact officer:

Recommendations:

A. *To note the contents of the report and to continue to champion Social Prescribing in Merton*

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

THE PURPOSE OF THIS REPORT IS TO UPDATE THE HEALTH AND WELLBEING BOARD ON PROGRESS AND DEVELOPMENT OF SOCIAL PRESCRIBING IN MERTON.

2 BACKGROUND

2.1 Introduction

Social Prescribing is based on the premise that a person's underly health concern is determined primarily by a range of social and economic factors. Therefore, such patients may not always benefit from medical or clinical intervention but rather a social prescription, which would involve accessing services provided by their local voluntary and charitable sector (VCS) or NHS/Local Authority. These interventions are commonly locally based and often provide patients with long term support as well as a sense of community, helping them develop a local support network outside of the local health and care provision.

Social Prescribing Link Workers are skilled in identifying and supporting these needs through motivational interviewing and behaviour change techniques. Link Workers support patients for approximately 2-6 sessions lasting 30-45mins each. Following this they signpost or refer them to VCS or statutory organisations which can support them whilst also remaining available should the patient need support with other parts of their lives.

The GP Forward View has highlighted that over 20% of a GP's caseload are patients who have an underlying psychosocial need and would be better supported with a non-medical intervention. Social Prescribing has become the vehicle for moving these patients out of General Practice and getting them the right support at the first attempt. It is a key strategic pillar and deliverable of the NHS Long Term Plan and the NHS Universal Personalised Care Strategy and has been further recognised as a key enabler of the Delivery Plan for recovering access to Primary Care. It has also

been acknowledged in the Joint Forward Plan as a key programme in supporting our local VCS, reducing health inequalities, improving community engagement and supporting people living with long-term conditions.

3 DETAILS

3.1 Current Model

Merton Connected are the current Social Prescribing Provider for Merton and have delivered the service since the pilot phase in 2016-17. Since 2019, SWL ICB in partnership with the Merton Primary Care Networks (PCNs) have commissioned Merton Connected to deliver Social Prescribing across all 6 PCNs to ensure a high quality and equitable service. The PCNs are satisfied by the service and have been supportive in expanding and enhancing the model. Merton Connected won the Highly Commended Programme 2020 at the National Association of Link Workers annual awards being nationally respected as one of the pioneers of mainstreaming Social Prescribing in Primary Care.

The service costs £229,993 per annum to commission, this includes;

- 9 Link Workers across 6 PCNs – 6 of these are funded through the Additional Roles Reimbursement Scheme, part of the Primary Care Network DES contract. The additional 3 Link Workers were part of the Pilot phase and SWL ICB has chosen to continue to fund these roles in order to further enhance the model.
- funding for provider overheads
- contribution to voluntary sector capacity building

3.2 Activity and Monitoring

The service is monitored through monthly activity reports and monthly contract meetings. In the last 12 months the service has received 3,745 referrals and delivered 7,530 appointments with an average capacity utilisation rate of 96% and an average DNA rate of 8%. The tables below segment this activity into demographic groups, focusing on the highest user groups by age, ethnicity and gender.

Table 1: Age ranges for those accessing Social Prescribing

Age Range	Percentage of Referrals
18 – 34	19%
35 – 44	16%
45 – 54	17%
55 – 64	17%
65+	31%

Table 2: Ethnicity breakdown for those accessing Social Prescribing

Ethnicity	Percentage of Referrals
White British	49%
Other White	9%
South Asian	7%
Black	11%
Other	6%
Not Disclosed	9%

Table 3: Gender breakdown for those accessing Social Prescribing

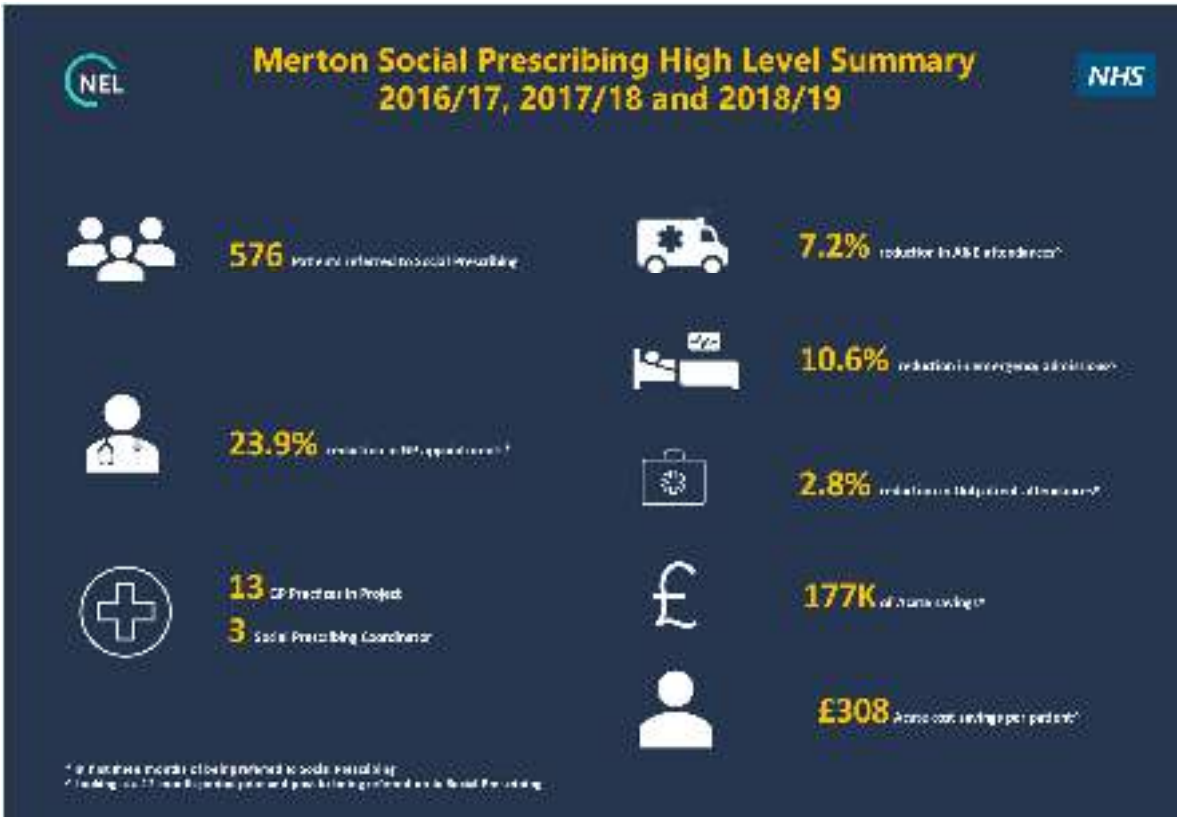
Gender	Percentage of Referrals
Male	33%
Female	67%

As can been seen from table 1, the service has been accessed across a variety of age ranges with similar levels of accessibility across the age bands covering 35 to 64. However, tables 2 and 3 show a significant trend towards access being favoured by particular ethnicities and genders. This data mirrors the information we have regarding access to Primary Care, which tells us men are less likely to the seek the support of their GPs until they are in crisis. This is a similar trend when looking at the ethnicity mix of those who have accessed the service within the last 12 months, whereby those from a White British background are more likely to be referred to the service than their global majority counterparts. There could be a number of reasons for this, which include;

- Language barriers
- Misunderstanding of the service
- Global Majority communities are known to access health care differently to other communities and this often means less frequently, which results in less opportunities for them to be referred into Social Prescribing

3.3 Evaluation and Quantitative Outcomes

An evaluation of the service by North East London Commissioning Support Unit, covering the period 2016 – 2019, cross referenced GP appointment data with secondary care healthcare usage data. This analysis proved that Social Prescribing as an intervention was impacting how patients were accessing and using local health and care services.



The above data from the pilot and early expansion phase shows the effectiveness of the programme, especially when deployed in key areas of deprivation such as Pollards Hill. A dashboard is being developed through the Health Insights platform, which will allow us to analyse this data in greater detail and should be launched early 2024-25.

There was a recent programme in Wales which focused on supporting a cohort of Primary Care frequent attenders using Social Prescribing as the only intervention. Over a period of 5 months, Social Prescribing was able to reduce the health care usuage of this cohort significantly and when extrapolated over 12 months, the savings equated to £78.20 per patient as a per unit per annum (Lynch and Jones, 2022).

For 2023-24, the cost of commissioning the service for SWL ICB was £229,993. Using the above rationale and assumed cost saving per patient, multiplied by the Merton referral numbers over the last 12 months (3,745x78.20), the cost savings of the programme in terms of activity avoided are estimated to be £292,859.00.

N.B. This is activity avoided rather than money saved, which could then allow access for other patients who may require the support/access/treatment more urgently.

3.4 Qualitative Outcomes

Additionally, the service also collects evaluation and outcome data using the Office of National Statistics Wellbeing Scale 4 (ONS 4). This tool measures improvements in Life Satisfaction, Happiness, Worthwhilness and reductions in Anxiety. The scores under these domains for patients who filled in the survey at least twice in the last 12 months are:

- 75% increase in Improvement in Life Satisfaction

- 72% Improvement in feeling Worthwhile
- 73% Improvement in Happiness
- 75% reported a Reduction in Anxiety levels

An average of 74% improvement across the wellbeing scale.

The above data highlights the impact the service is having on patient health and wellbeing, which has resulted in patients becoming more independent and relying less on the health and care services. Please see Appendix 1 and 2 for case studies, which highlight the impact Social Prescribing can have on someone who needs help but does not know who or where to turn to.

3.5 Other Social Prescribing Programmes in Merton

Social Prescribing has become a key support offer for the residents of Merton. The projects outlined below highlight some of the other work that is taking place across the borough.

- Merton Children and Young Persons Social Prescribing Service for children and families
- Macmillan Community Cancer Link Worker Service aimed at improving the holistic support available to those living with and beyond cancer in Merton
- Walk and Talk Green Social Prescribing initiative is designed to help residents access local walks to help with their mental health and feel more connected to their local community
- High Intensive User Social Prescribing Pilot aimed at those who are considered frequent attenders at St George's Foundation Trust.

3.6 Risks and Challenges

The increasing use and reliance of Primary Care on Social Prescribing has led to a significant increase in Link Worker caseload. As per NHS England guidelines, a Link Worker of a mature Social Prescribing service should see no more than 250 cases in a 12 month period. However, the Merton service has received 3745 referrals in the last 12 months, which is on average 416 cases per Link Worker. This has led to staff feeling stressed and has resulted in poor staff retention rates which has been exacerbated due to the lack of opportunities for career progression. This is a challenge all well established Social Prescribing services are facing as they become more embedded in Primary Care.

In 2019, the ICB took the decision to continue its original pilot investment of three link workers to ensure the Merton Social Prescribing model would continue to flourish and grow. Each PCN has invested in one Social Prescribing Link Worker, funded through the Additional Roles Reimbursement Schemes (ARRS). With Social Prescribing continuing to grow, PCNs need to consider further investment, utilising their ARRS funding to employ additional Link Workers to meet demand and ensure waiting lists are controlled. Currently some PCNs are seeing waiting lists of over 6 weeks for their Social Presecribing service with referrals numbers still increasing. If

this is not addressed, the impact of the service will be significantly reduced and General Practice will once again see a rise in patients who would be better supported elsewhere.

The Primary Care Network DES contract officially ends 31st March 2024. Currently there is no information regarding its extension or replacement. This is a significant risk for Social Prescribing as there is unlikely to be the resource available within the system to replace the salary reimbursement currently available through the ARRS. Without the continuation of this contract, Social Prescribing is likely to cease to exist in its current form within Primary Care.

The success and development of Social Prescribing is largely dependent on the local VCS and its ability to absorb the demand created by moving this cohort of patients out of Primary Care. Appropriate services need to be available within the VCS to refer patients on to, otherwise patients are facing the possibilty of having to access services out of borough or pay for private services which many cannot afford.

The intelligence collected by Link Workers on the local need and available resources has the potential to profoundly inform commissioning decisions and the provision of services that address inequalities and the wider determinants of health.
Trends that link workers are identifying include:

- An overall lack of housing stock
- Over 50% of referrals are related to mental health and the demand for these services appear to be outstripping supply
- There is a growing demand for benefits and debt advice with many clients presenting with problems for the first time and often requiring advocacy to access the appropriate support

3.7 Conclusion

The service has proven to positively impact the lives of patients on its caseload by measurably improving their sense of wellbeing and through identifying places within their local community they can go to for support. It has also helped to reduce inappropriate attendances in Primary and Secondary Care. It has proven to be value for money by producing potential savings that exceed the cost of funding and delivering the service. The service has developed a regional and national reputation for best practice and high quality outcomes, and is an important asset to the Merton health and care system.

The national direction of travel, to develop primary care networks into integrated neighbourhood teams, and the local ambition to invest in community assets within Place Based systems will require the involvement and engagement of the voluntary sector. Social Prescribing had provided the local VCS with a platform to showcase its strengths, diversity and adaptability with regards to supporting and contributing to the local heath and care system. This will be increasingly important as the system shifts from primary and community services into Integrated Neighbourhood and Place Based teams. This will ensure that the hyper local connection with communities can be maintained.

4 ALTERNATIVE OPTIONS

4.1. N/A

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. N/A

6 TIMETABLE

6.1. N/A

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. N/A

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. N/A

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. N/A

10 CRIME AND DISORDER IMPLICATIONS

10.1. N/A

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. N/A

12 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

12.1 Appendix 1

Patient Case Study from Wideway Medical Centre

L was referred to me by one of the GPs at Wide Way. She is a carer for her mother who has Alzheimer's disease. On our first appointment on the phone, L told me the difficulties she had been facing since her mother's condition deteriorated. Some nights, her mother would leave the house and wander around the neighbourhood which caused L a lot of concern for her safety. Stress had slowly built up for L as her caring role had become more challenging. She suffered from lack of sleep, feeling teary and depressed. She and her mother live alone with no other support.

I referred L's mother to Adult Social Care for a needs assessment to see if she is entitled to any care packages from the council. I then referred L to Merton Carers Support to request a carer assessment and information on respite. I also referred her to the Dementia Hub in Mitcham to get some advice and support on caring for someone who has the condition.

L's mother was then assessed by the Adult Social Care team, and she was given an hour a week care package. Merton Carers Support arranged respite for L and Dementia Hub got in touch with her to offer support.

I spoke to L after she had her first respite. She reported to me that she was feeling a lot better and that it makes looking after her mother easier and less stressful. I had six sessions with L and her ONS score improved on our 4th session.

L gave the following feedback to Merton Connected regarding her experience of Social Prescribing and the support she received from her Link Worker.

'You were great in that you listened and did your best to get the council to hurry up and take action. It was a long journey for both of us and you were so supportive, thank you so much.'

12.2 Appendix 2

Case Study Patient Perspective
Grand Drive Surgery – Merton South-West

The below case study is for a patient from Grand Drive Surgery. She was referred to Social Prescribing by her GP in January 2020 for anxiety, emotional stress, and social isolation. She suffers with several long health term conditions that were affecting her well-being. She had been shielding throughout the pandemic and lives alone at home.

Ms. C was diagnosed with HIV, MS, Rheumatoid Arthritis, and several auto-immune complaints linked to her long-term conditions. She was diagnosed with PTSD following some traumatic events in her past life. She is a middle-aged white woman born and brought up in the UK.

The following transcript is from a telephone interview conducted with the patient recently.

When/Why did you see a social prescriber?

'I've been suffering with ill health for over 20 years and from around Christmas 2020 and beyond I felt depressed. My GP suggested I talk to a Social Prescriber – a new addition to the GP Surgery. I agreed although I wasn't quite sure what the 'social prescriber' could do for me.

I was referred for a telephone appointment in January 2021. The social prescriber made appointments over the telephone, and she called me every week until beginning of February. I must have had half a dozen calls with her. It was good to have weekly contact and knowing someone was interested in supporting me and my needs.

What challenges have you faced?

'After having a happy and fulfilled working and social life, I have been suffering with several long-term physical conditions, including MS.

I also have PTSD and now suffering with depression. Life is one long challenge, and I am not an easy person to be around. I live alone but have many friends who I am in regular contact with over the telephone.

I have been particularly anxious due to getting the Covid vaccine and it has been particularly stressful as I was promised the 2nd dose after a few weeks then it was put back to 12 weeks I had to again fight my case to have the booster jab.

I am also trying to survive on benefits which isn't easy when it comes to paying the bills.

How have you benefitted from social prescribing?

‘My experience is that the Link Worker has been a fantastic new addition to the surgery. My Link Worker is professional, empathetic and at the same time chatty and friendly.

My real issue was getting counselling; I wasn’t interested in groups but 1:1 therapy. I had been on the waiting list with Merton Uplift for about 9 months for the right kind of counselling.

My Link Worker urged them on my behalf and wrote to them to highlight my need for counselling to come through and ‘hey presto’ in a few weeks I had an assessment. Now I am so happy to have the (free) counselling, too. I ‘gel’ with the therapist and she challenges me. I am a strong character and that’s what I needed.

She has pointed me in the right direction for online well -being activities, which I wasn’t really interested in to be honest, but it is good to know they are there. She has emailed me information on how to access support for paying my bills in the winter months and how I can get help this way. Also, we had some good chats about what’s going on with Covid and the vaccination programme.

What words would sum up social prescribing for you?

‘First of all, I don’t think it is the right name for the job she does. I think she should be called a Gateway Worker. I think that would explain it better to me as it’s opening up avenues to places, I hadn’t thought about, such as online art classes, which I might sign up for when I’m in the mood.

I think people get confused as to what social prescribers are for. Or they think they are counsellors. I think they can be a font of all knowledge and a good source of advice and information especially for the local area. She gave me lots of ideas as I am living alone and pretty isolated. My Link Worker gave me some ideas about doing online art activities and zoom classes with the Merton MS society. Also, she gave me information as I am on a low income and finding it difficult to pay my bills.’

Tell us a bit about yourself. Is there anything interesting you would like us to know.

‘I think there’d be too much to tell you here, as I have had a full and varied life with so many adventures. Maybe I can start writing my biography…..’

After waiting nearly a year for counselling, Mrs C. is really pleased that her therapy sessions are going well. She is building up a good relationship with her therapist and is feeling more positive at the moment.

Recently she has not felt very well and has been in a lot of pain, but she makes regular appointments with her GP for her medical needs. She understands that she can be referred to a social prescriber at any time in the future should she need further help or support.

13 BACKGROUND PAPERS

Lynch M, Jones CR. Social prescribing for frequent attenders in primary care: An economic analysis. Front Public Health. 2022 Oct 14;10:902199. doi: 10.3389/fpubh.2022.902199. PMID: 36311628; PMCID: PMC9615419.

NHS
South West London

Merton Health and Wellbeing Board Social Prescribing Update

28th November 2023

Amrinder Sehgal – Merton Social Prescribing Lead (SWL ICB)
Ben Halschka – Merton Social Prescribing Manager (Merton Connected)
Dr Mohan Sekeram – SWL Social Prescribing Clinical Lead (SWL ICB)

Social Prescribing – What is it?

NHS South West London

- According to GP Forward View, 20% of GP caseload is non-medical in need, which can include:
  - Housing
  - Finance
  - Loneliness
  - Mental Health
- Social Prescribing links patients to 'non-medical' community-based support available within the local Voluntary Sector
- Link Workers spend between 30-45 minutes with a patient to understand their concerns and then refer them onwards to appropriate services.

How Social Prescribing Started in Merton

NHS South West London

- In 2016 the Merton Health and Wellbeing Board championed the East Merton Social Prescribing Pilot

- In March 2019, following the announcement of the PCN DES Contract, Merton CCG saw an opportunity to further enhance the service and deliver a borough wide model.

- Merton CCG approached all Merton PCNs with the offer to commission an enhanced social prescribing model and manage the contract on their behalf.

- In October 2019, Merton CCG in collaboration with Merton PCNs commissioned Merton Connected to deliver Merton's boroughwide social prescribing model.

- This includes the original 3 Link Workers from the first expansion

The Merton Model of Social Prescribing

NHS South West London

- The Social Prescribing contract for Merton has been held by Merton Connected since 2016
- The Merton service is one of the most established and mature services in the UK
- The team consists of a total of 12 Link Workers, the equivalent of 9 whole time equivalent
- Each of the 6 Merton PCN receives support from 1.5 Link Workers
- The project is monitored through monthly contract monitor meetings with the ICB, quarterly quality assurance reports to the ICS
- The project has been clinically evaluated by Oxford University in 2022
- The Service won the award ‘highly recommended Programme of the year’ - National Association of Link Workers 2020.

Primary Care Networks

NHS South West London

- There are 6 Primary Care Networks in Merton:
  - East Merton PCN
  - North Merton PCN
  - West Merton PCN
  - North West Merton PCN
  - South West PCN
  - Morden PCN

Activity Analysis

Top reasons for referrals in the last 12 months

1. Mental Health
2. Social Isolation and Loneliness
3. Financial Advice
4. Housing
5. Support for Cares

Referral Numbers

October 2022 – September 2023

3745 new referrals received

October 2021 – September 2022

3224 new referrals received

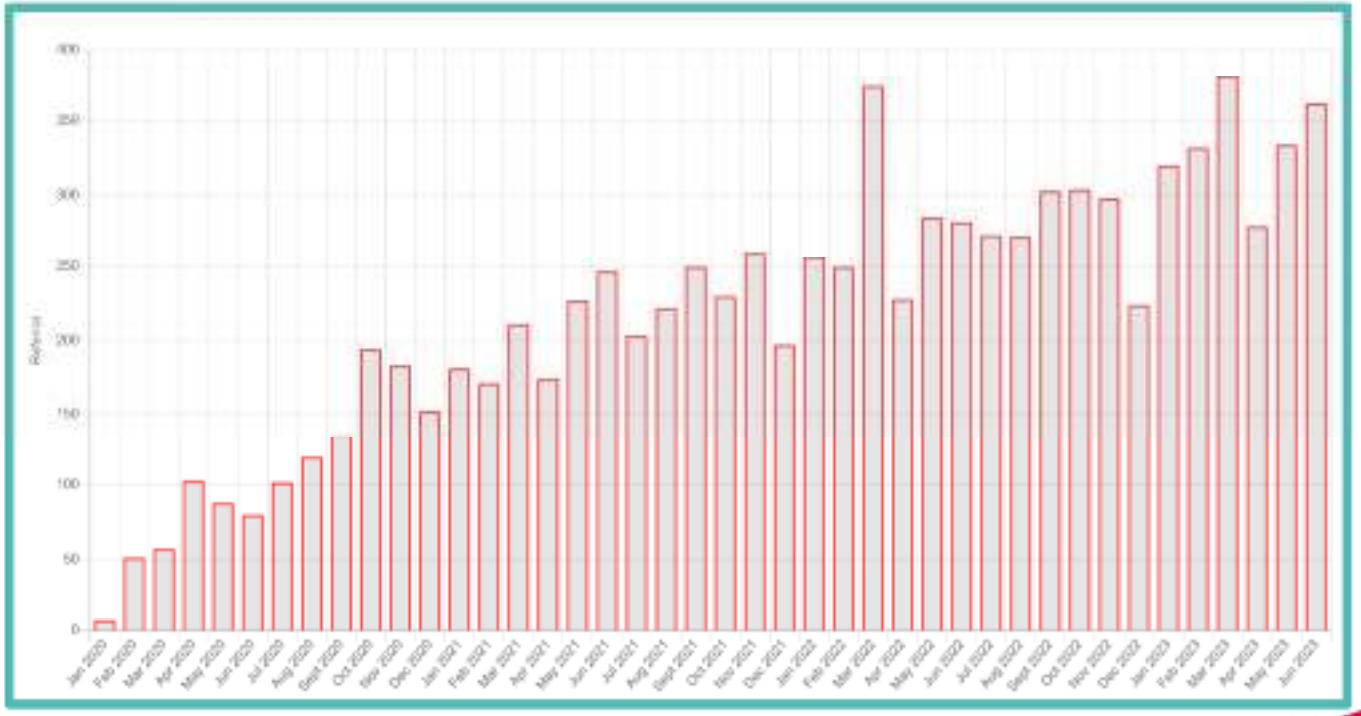
access
freedom to do more

Overview Of All Referrals Since Beginning Of Licensee

The project has been using Elemental from the following date:
Merton Connected: 8th January 2020 (**3 Years, 5 Months**)

Throughout the course of the project, a total of **9,202** referrals have been made with the help of Elemental Software.

View Results: [9,202 Referrals]



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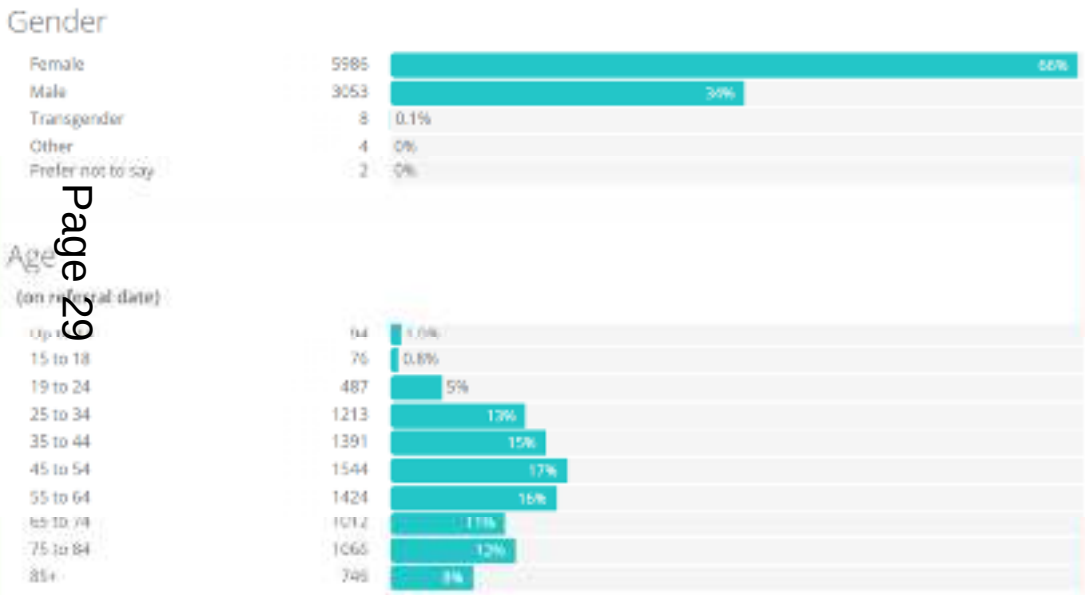
Cases Created Per Hub / Client Demographics (All Time)



- The most populated age range among **Merton** clients is the age range of ***45 to 54***, representing ***17%***.
- The age group of ***55 to 64*** is in 2nd place, making up ***16%*** of referrals.
- From the diagram below, we can see that the targeted group is younger adult / middle aged of society, vs. an younger / older skew.
- **9,053** Cases that were created were Female (***66%***), there was ***3,053*** Referrals for Male, representing (***34%***)

The total number of cases made is **9,053**.

View Results: [9,053 Cases]

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Health Impact Statistics (All Time)

Since the project's formation, we have tracked your clients using our Monitoring Tools – the **Merton Connected** licensee uses the **ONS** monitoring tool.

This measures client Satisfaction, Worthwhile, Happiness (**ONS 1,2,3**), and monitors their Anxiety (**ONS 4**) over time.

Merton:

- ONS 1: **66%** Increase
- ONS 2: **60.2%** Increase
- ONS 3: **62%** Increase
- ONS 4: **60.5%** Decrease

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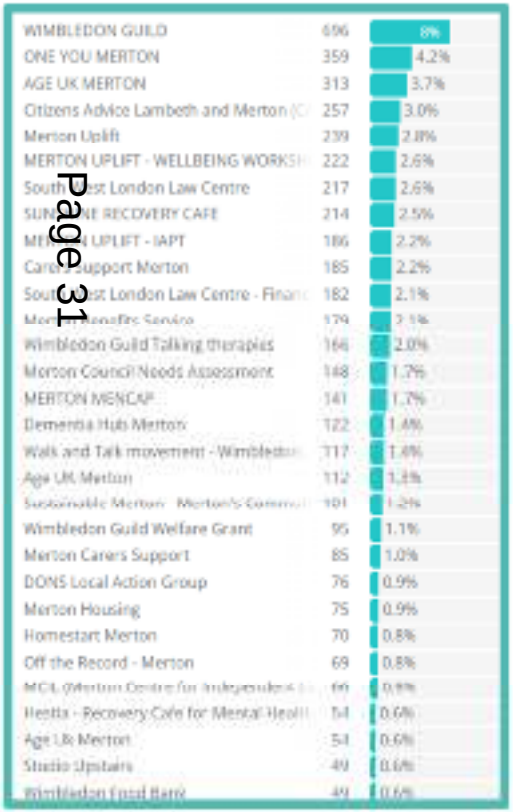
Signpostings (Whole Project)

SIGNPOSTINGS

Results: 8,475 Signpostings



These are the most heavily assigned signposting's within the **Merton** project:

- **Wimbledon Guild (696)**
- **One You Merton (359)**
- **Age UK Merton (313)**
- **Citizens Advice Lambeth And Merton (Cab) (257)**
- **Merton Uplift (239)**
- **Merton Uplift - Wellbeing Workshops** (222)
- **Southwest London Law Centre (217)**
- **Sunshine Recovery Café (214)**
- **Merton Uplift – IAPT (186)**
- **Carers Support Merton (185)**

Enhanced Social Prescribing

NHS
South West London

- Children and young person's Social Prescribing Pilot in East Merton and Morden PCN.

- PCN Proactive Social Prescribing programmes to increase access and uptake of Social Prescribing. Each PCN has identified a specific cohort to work with which are currently underrepresented in the current Social Prescribing referrals.

- MacMillan Cancer Link Worker programme which operates across Merton, Wandsworth and Croydon. The programme aims to improve the awareness of, access to, and uptake of services available to those living with and beyond cancer, whilst ensuring that holistic support is offered locally at key points in the cancer pathway.

Social Prescribing beyond Primary Care

NHS South West London

- High Intensity User Project
- 7 Green Social Prescribing projects
- Social Prescribing patients' Support Group
- Pain Clinic Pilot with Epsom and St Heliers NHS Trust

Social Prescribing - Overview

Back to Content Page

You have selected a cohort of **2,184** patients who attended a Social Prescribing appointment

Period between **April 2018** and **September 2021**

Total Patients referred
2,364

Total Patients attended
2,184

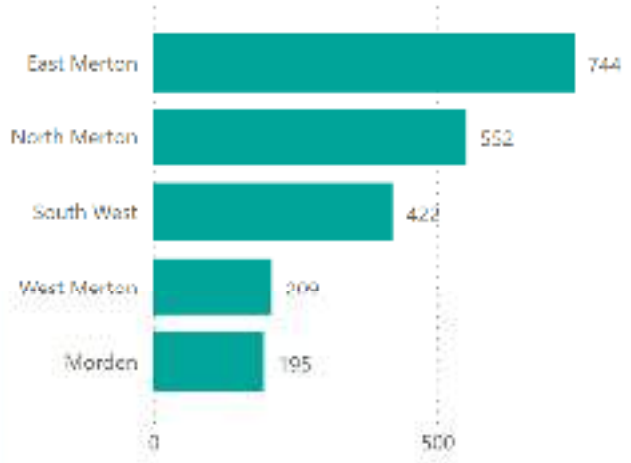
Total appointments made
8,513

Number of attendances
7,051

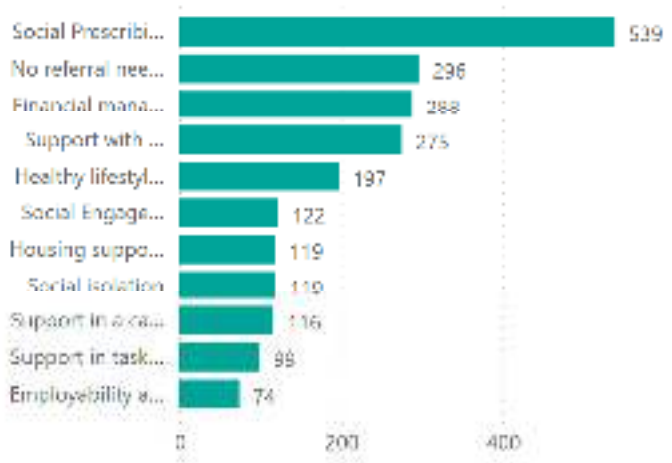
Average attendances per patient
3.2

% DNAs and Cancellations
17%

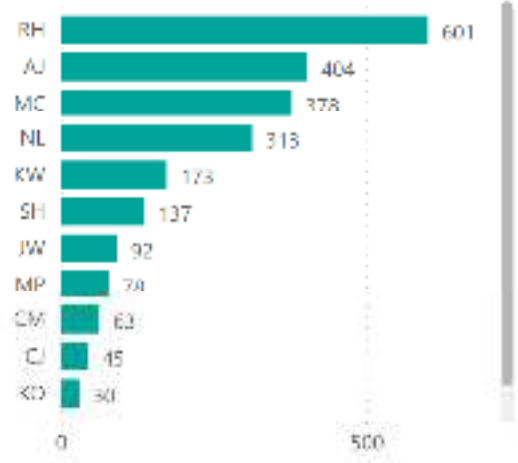
Patient locality



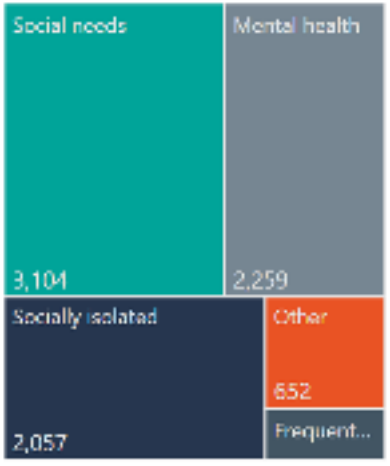
Top 10 frequently attended services



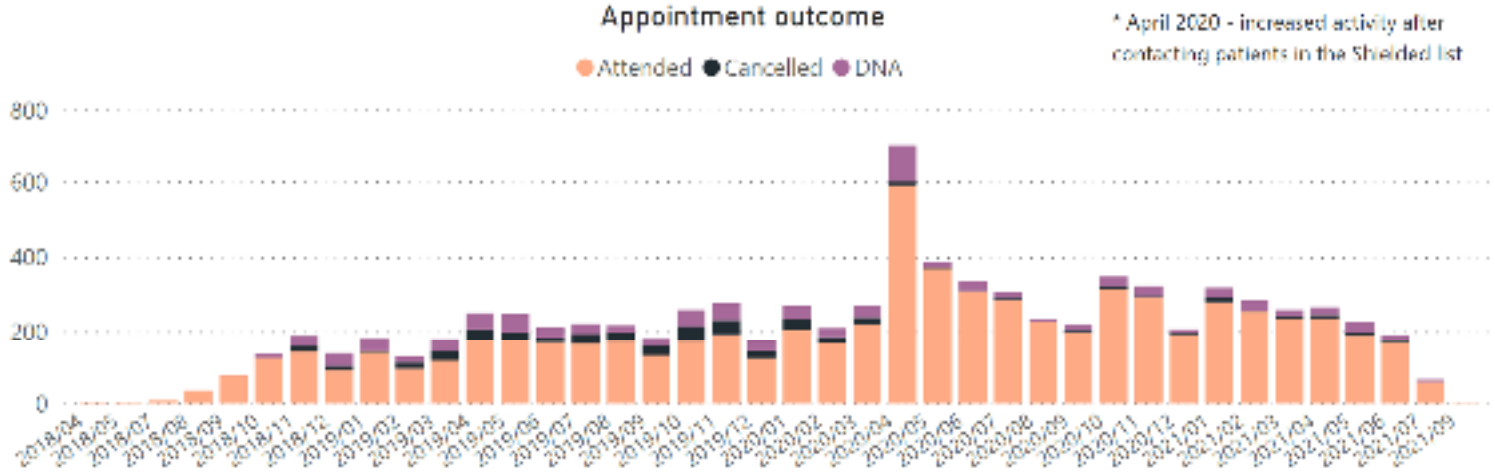
Leadworker caseload



Top 5 reasons for referrals



Appointment outcome



* April 2020 - increased activity after contacting patients in the Shielded list

Social Prescribing - Demographics

You have selected a cohort of **2,184** patients who attended a Social Prescribing appointment

Total Patients referred
2,364

Total Patients attended
2,184

Total appointments made
8513

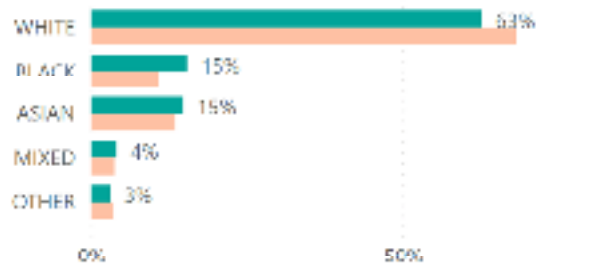
Number of attendances
7,051

Average attendances per patient
3.2

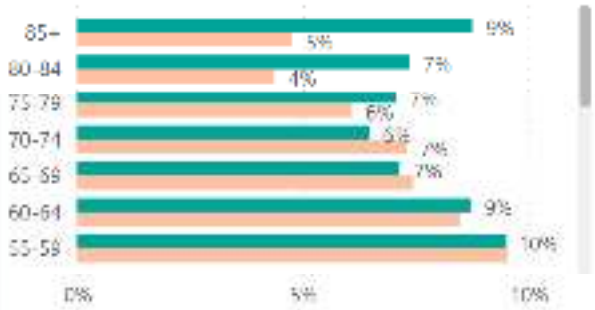
% DNAs and Cancellations
17%

Click on ↓↓ to go to the next level in the hierarchy

Ethnicity



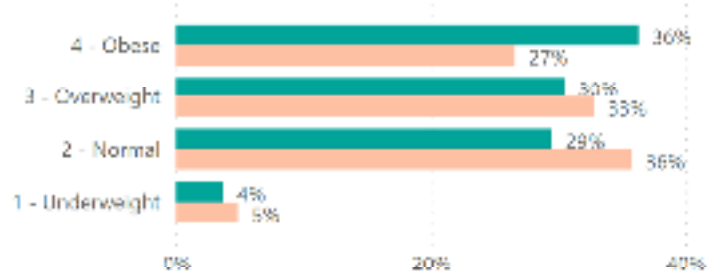
Age



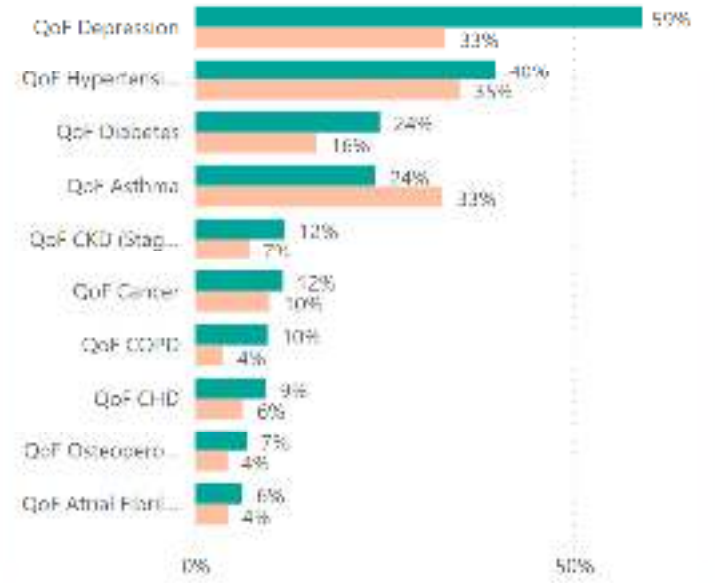
Gender

Social Prescribing SWL Population

BMI



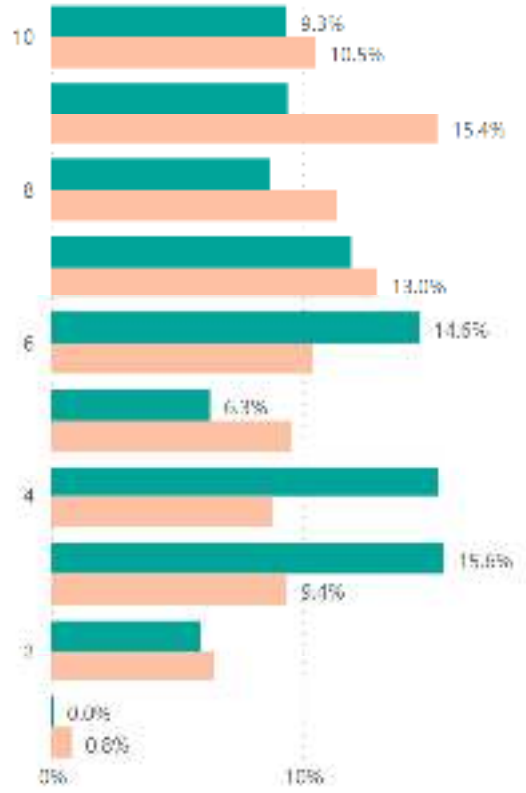
Top 10 QOF long term conditions



Refer to *[Report Notes]* *Deprivation* for definitions

IMD Deprivation | Crime
Education | Employment | Environment
Health | Housing | Income

IMD Deprivation (decile 1 = most depriv...



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Report Notes

Reporting on Merton patients at the time of writing - December 2021. It is anticipated the Social Prescribing programme will eventually roll out to other boroughs in South West London.

Records with data items recorded as either null, blank or invalid have been omitted from reporting together with patients that have recently passed away.

Pathway summary and pathway patient level pertain to activity over the last 24 months.

Link worker's full name have been omitted and replaced with their initials for confidentiality purposes.

Targets used for monitoring patients with **Diabetes**:

- HbA1C 58 mmol/mol or below
- Cholesterol below 5 mmol/l
- Blood Pressure 140/80 and below

Targets used for monitoring patients with **Mental Health**:

- Smoking
- Body Mass Index (BMI)
- Alcohol
- Blood Pressure 140/80 and below

Social Prescribing - Impact on patients with diabetes

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Total Patients referred

549

Total Patients attended

517

Total appointments made

944

Number of attendances

1,660

Average attendances per patient

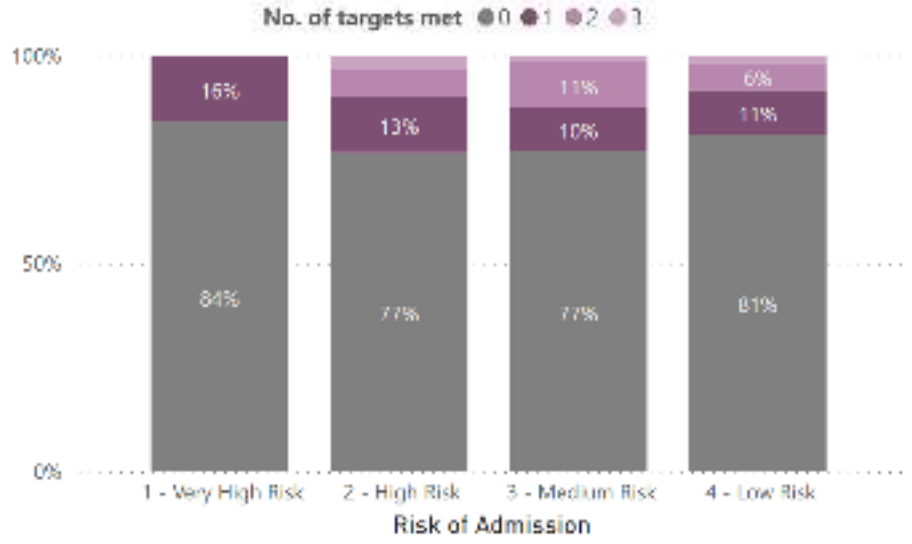
3.2

% DNAs and Cancellations

14%

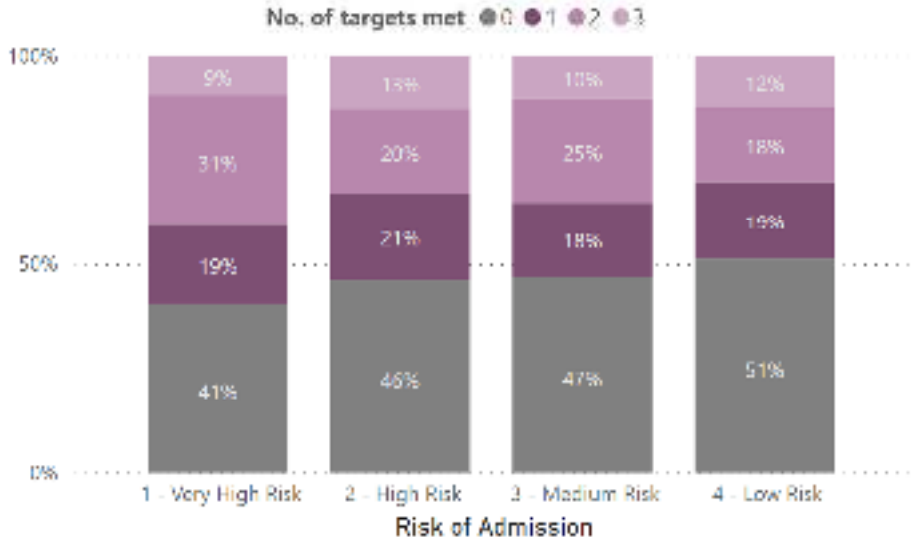
Targets met within 12 months **prior** to first contact

Risk Score Band	0	1	2	3	Total
1 - Very High Risk	84%	16%			**100%**
2 - High Risk	77%	13%	6%	3%	**100%**
3 - Medium Risk	77%	10%	11%	2%	**100%**
4 - Low Risk	81%	11%	6%	2%	**100%**



Targets met within 12 months **after** first contact

Risk Score Band	0	1	2	3	Total
1 - Very High Risk	41%	19%	31%	9%	**100%**
2 - High Risk	46%	21%	20%	13%	**100%**
3 - Medium Risk	47%	18%	25%	10%	**100%**
4 - Low Risk	51%	19%	18%	12%	**100%**



Social Prescribing - Impact on patients with Mental Health

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Total Patients referred

252

Total Patients attended

226

Total appointments made

814

Number of attendances

670

Average attendances per patient

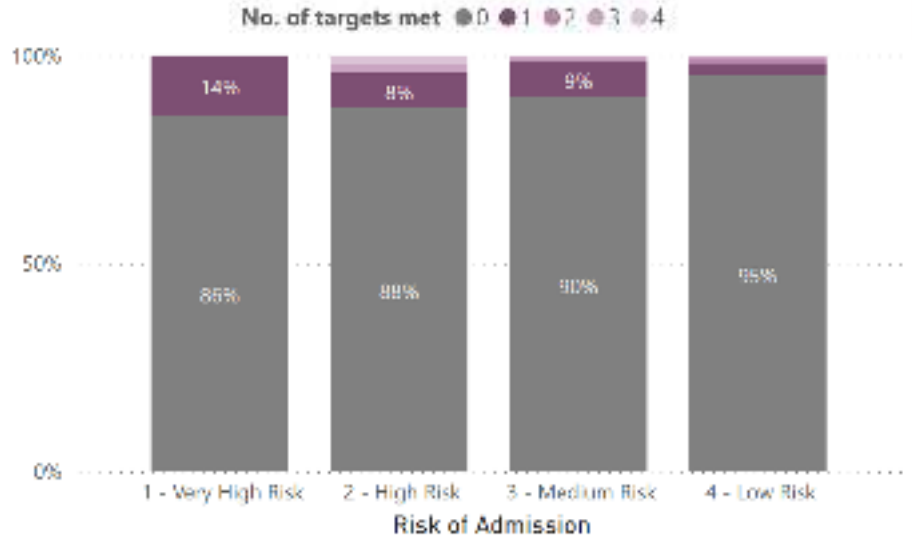
3.0

% DNAs and Cancellations

17%

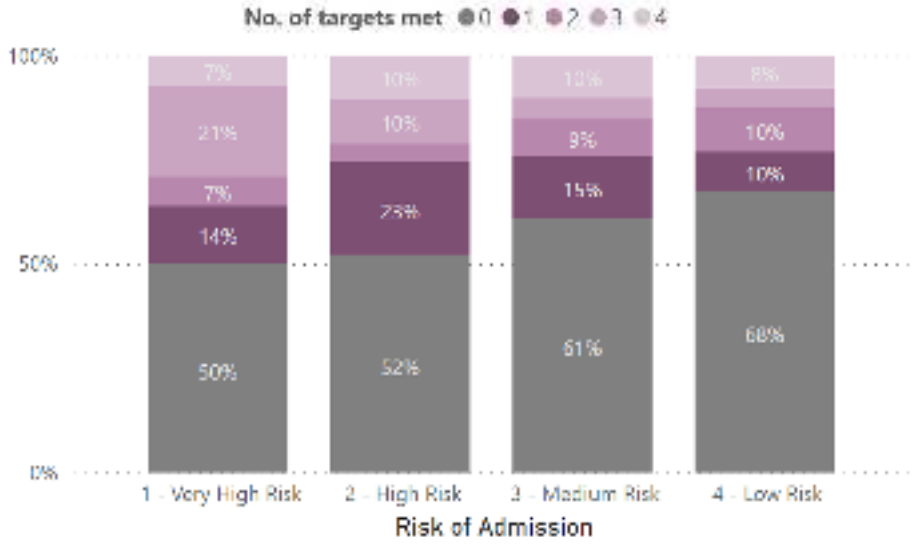
Targets met within 12 months **prior** to first contact

Risk Score Band	0	1	2	3	4	Total
1 - Very High Risk	86%	14%				**100%**
2 - High Risk	88%	8%		2%	2%	**100%**
3 - Medium Risk	90%	9%		1%		**100%**
4 - Low Risk	95%	3%	1%	1%		**100%**



Targets met within 12 months **after** first contact

Risk Score Band	0	1	2	3	4	Total
1 - Very High Risk	50%	14%	7%	21%	7%	**100%**
2 - High Risk	52%	23%	4%	10%	10%	**100%**
3 - Medium Risk	61%	15%	9%	5%	10%	**100%**
4 - Low Risk	68%	10%	10%	5%	8%	**100%**



Social Prescribing - Impact on patients with Asthma and/or COPD

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Total Patients referred
676

Total Patients attended
628

Total appointments made
2,580

Number of attendances
2,152

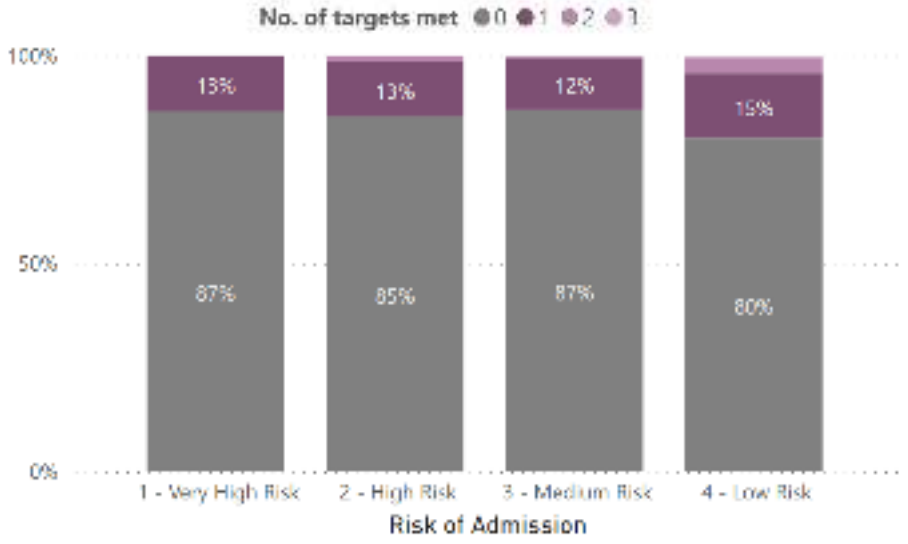
Average attendances per patient
3.4

% DNAs and Cancellations
17%

Note there were **zero** patients that met all 4 targets pre or post 12 months from their first Social Prescribing contact date. To discuss, may need to revisit logic or replace with other measures.

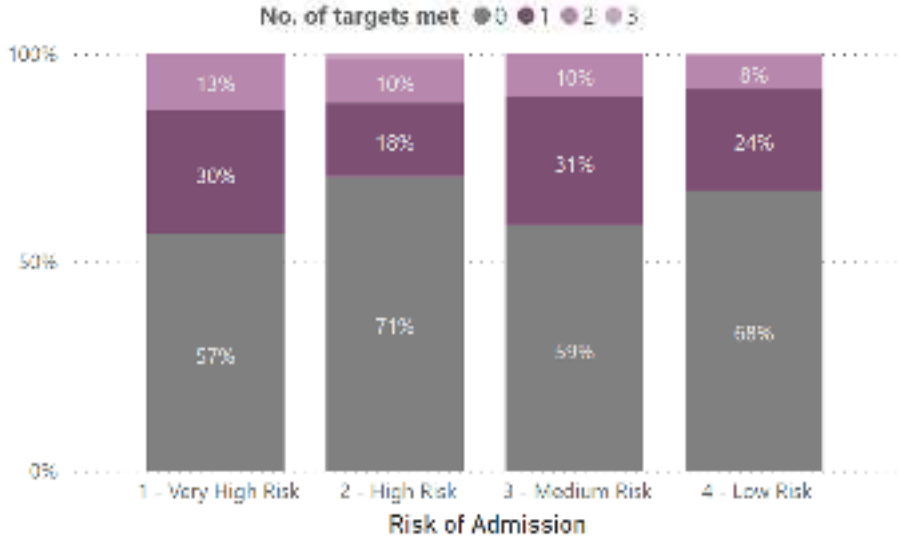
Targets met within 12 months **prior** to first contact

Risk Score Band	0	1	2	3	Total
1 - Very High Risk	87%	13%			100%
2 - High Risk	85%	13%	1%		100%
3 - Medium Risk	87%	12%	1%		100%
4 - Low Risk	80%	15%	4%	1%	100%



Targets met within 12 months **after** first contact

Risk Score Band	0	1	2	3	Total
1 - Very High Risk	57%	30%	13%		100%
2 - High Risk	71%	18%	10%	1%	100%
3 - Medium Risk	59%	31%	10%		100%
4 - Low Risk	68%	24%	8%	1%	100%



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The Future of Social Prescribing

- Social Prescribing in Adult Social Services
- Developing a Community Chest initiative
- Condition Specific Social Prescribing Programmes
- Self-referrals (improving access)

Further information

Response of social prescribing during Covid

https://www.england.nhs.uk/personalisedcare/social-prescribing/case-studies/a-gp-perspective-on-social-prescribing-and-the-response-to-covid-19/

Social Prescribing evidence (nationally recognised)

NHS South West London

- Initial pilot 2018 - funded by public health Merton
  - https://healthydialogues.co.uk/wp-content/uploads/2019/04/East-Merton-Social-Prescribing-Evaluation-Report-2018.pdf
- **Powerful** video by Health London Partnership
  - https://www.healthydialogues.co.uk/wp-content/uploads/2019/04/Merton-SP-evaluation-report-August-2021-V2.3.pdf
- A study of the upscaling of the Social Prescribing Service in Merton (2021)
  - whttps://www.healthydialogues.co.uk/wp-content/uploads/2019/04/Merton-SP-evaluation-report-August-2021-V2.3.pdf
- Finalists HSJ Award for pilot 2018
- https://fabnhsstuff.net/fab-stuff/social-prescribing-in-merton

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Any Questions

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