HEALTH AND SPORT COMMITTEE

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

SUBMISSION FROM ARGYLL & BUTE HEALTH AND SOCIAL CARE PARTNERSHIP (NHS HIGHLAND)

1. Is social prescribing a suitable and appropriate alternative to traditional medicine orientated prescribing?

The existing pressure on health and social care services is well documented and evident to all in the population.

With an aging population, and more sophisticated screening techniques, individuals are being diagnosed with conditions at an earlier age, and living for longer due to advances in scientific research, technology and healthcare systems.

This means that new approaches to health and social care need to adopt a leaner (more effective) approach to meet the health and social care demands of the current and future population.

Whilst traditional medicine orientated prescribing is obviously essential in many cases, there are a significant percentage of health and social care needs which could be addressed through social prescribing, rather than prescribing pharmaceuticals. These are issues such as anxiety, depression, hypertension, diabetes type 2, heart disease, falls, etc.

Focusing on prevention of these conditions through addressing the underlying socio-economic issues, which often lie at the root of health and social care problems, can prevent, or at least delay, the onset of many health and social care issues. Examples of the socio-economic issues which can be addressed through social prescribing are: loneliness, relationship breakdown, bereavement, housing, fuel poverty, lack of physical exercise, debt advice, stress management, nutritional advice, etc.

In some cases, a social prescribing approach can provide the individual with an accessible alternative to a pharmaceutical prescription for an immediate problem, but also address underlying contributory problems at the same time as easing pressure and dependency upon statutory health and social care services. For example: a social prescription for an allotment gardening group can address issues around loneliness, depression, physical activity and improved knowledge and accessibility to nutritional foods, as well as the financial benefits of ‘growing your own’.

Whilst social prescribing is not a silver bullet, it can ease the pressure on traditional health and social care services, through prevention and non-pharmaceutical interventions at an early stage, resulting in reduced waiting times to see a GP, fewer
unplanned admissions, and the prevention of long term conditions often associated with an aging population, and reduce dependency on pharmaceutical prescriptions. Ultimately, it should mean that more advanced cases can have faster access to the health and social care professionals and services they need.

2. Can social prescribing for sport and physical activity lead to *sustained* participation in sporting activities?

The evidence around whether social prescribing for sport and physical activity can lead to *sustained* participation in sporting activities is limited. Human behaviour is such that the majority of people who set out to exercise will ‘drop out’ after a short time and struggle to sustain any new habit such as taking up exercise. It often takes several cycles of starting and stopping a new physical activity before it becomes a sustained habit. Such is the nature of behaviour change, often the most difficult part of health and social care prevention work. This is where the work of a link worker, in being able to follow up on participants to encourage them to rejoin an activity, should they want to - say 6 months later - would be invaluable.

The benefits of social prescribing are that it helps to introduce people to sport and physical activity which they may otherwise never consider accessible to them. Even if a small percentage stick with their new activity, the long term savings (health benefits gained, improved quality of life and economic cost saved) far outweigh the initial cost of providing the physical activity.

In Argyll and Bute, specifically, the geographical dispersion of the population raises additional problems which affect the sustainability of attending classes etc. Individuals are likely to have to travel a considerable distance to access activity groups/clubs, and are often reliant on private car travel, due to the minimal transport infrastructure available. This adds to the time and expense involved in attending such an activity, which can contribute to a barrier in attending over the long-term.

3. Who should decide whether social prescribing is the best, most appropriate prescription for a patient?

GPs and other qualified health professionals and suitably qualified link workers, should be able to offer a social prescription with an explanation of why they advise such a route to be taken over that of a traditional prescription, or potentially alongside a traditional prescription.

However, as health and social care provision should be delivered in a person-centred approach, the individual should be able to make the choice as to whether they take the route of a social prescription. In order to do this, the patient needs to be able to make an *informed* decision, ie, know the context and reasoning behind *why* they are being offered/recommended a social prescription, and the alternatives
available to them, as well as the health risks they may be exposing themselves to if they choose not to act on the social prescription, rather than the social prescription simply being issued.

The ability to self refer, for those individuals who do not require the support of a link worker or GP referral, is a beneficial option in that it skips the need for an appointment with a GP solely to refer, meaning unnecessary GP appointments can be freed up.

4. What are the barriers to social prescribing? How can these be overcome?

Several barriers currently exist to social prescribing:

➢ Not all GPs support the concept of social prescribing, due to time constraints, and lack of strong evidence demonstrating the long term effectiveness of social prescribing. In addition the level of experience and understanding of what social prescribing is varies greatly amongst GPs.
   - Additional engagement work on raising awareness of social prescribing and promoting the benefits can go some way to help overcome this.
   - An ability to demonstrate an effective way of measuring the impact of social prescribing, and promotion of this evidence, would help overcome this.

An engagement exercise was conducted with all GPs in Argyll and Bute Health and Social Care Partnership this year and only 11 responded. Although no conclusions could be drawn from such a small number there was a very mixed view with some degree of scepticism.

➢ Due to the current economic climate, an ever decreasing pool of funding is available to third sector services. The limited funding available is often committed on a short-term basis, meaning that services within the community are restricted to planning to the short-term, and unsustainable due to the lack of long-term funding. The difficulties around monitoring the effectiveness and impact of these services only compound this issue, as these services often find it difficult to quantify their effectiveness when reporting back to donors.
   - Commitment to longer term, performance based funding would help ease this problem.
   - An effective tool (such as Elemental) would facilitate the monitoring and evaluation of any funding invested, with the ability to customise reporting on specific KPIs, etc.

➢ Of existing services, it is difficult to predict the level of service provision required to meet the demands of social prescribing. Thus, it is difficult to
identify whether individual services have the **capacity** to meet the demand which may come from social prescribing.

- A tool such as Elemental below, would enable the HSCP to track the numbers of people referred to a particular service, ‘drop out’ rates and long term attendance of individuals to a particular service, and see any waiting lists building up for particular services. This would in turn help these organisations demonstrate their worth, and any waiting lists demonstrating demand, in funding applications, etc. The flip side of this is that the Elemental tool enables the HSCP to easily identify those services underutilised, or those which may not be serving a need within a locality and thus help highlight where funding should be directed within Argyll and Bute. Time dedicated to each client is also tracked within Elemental, which would help with prediction of costing of future services, etc.

- Given the way that short-term funding is awarded, it can mean that a service has to cease operating due to cash flow issues or lack of long term funding to attract and secure suitably qualified staff for the long term. Organisations and community groups providing highly sought after services can fold due to lack of funding, before they have a chance to establish themselves well enough to demonstrate their value to potential funders and the community.
  - Longer term performance based funding would help towards alleviating this issue, especially with regard to securing qualified staff to provide quality services.

- Again the geography of Argyll and Bute raises its own particular issues around service provision. For example many service provision roles cover a large part, if not the full geography, of Argyll and Bute, involving long journey times in a day’s work, or an individual having to wait for the day an outreach service comes to their locality, etc. For example the Citizens Advice Bureau is a highly valued service which holds regular outreach clinics across different localities in Argyll & Bute.
  - Increased adoption of existing technology e.g. 1:1 video sessions for advice would ease this for some services, but not all. For those who own a mobile phone or tablet, video calls/sessions could be scheduled for a time convenient to the individual to ensure they can place themselves in a location where they feel comfortable and safe talking about any private issues. For those who don’t own a mobile phone or tablet, some additional investment will be required to improving the number of access points to such technology/VCs, strategically placed within community ‘hubs’ for both service providers and service users to access. It should be noted that limited broadband access is a real
issue for a considerable area of Argyll & Bute, with some areas still having no broadband access whatsoever.

- **Note:** Care must be taken here that the hidden benefits of a physical visit are not lost as sometimes the full context of an individual’s situation only becomes apparent during a physical visit or appointment, which would be lost over a ‘video call’ due to only seeing their ‘head and shoulders’, for example, not seeing how they carry themselves when walking towards you, their living conditions, or other secondary symptoms out of camera view, etc.

- As mentioned above, a limited public transport service and the geographical dispersion of services available in relation to where the population lives in Argyll and Bute will have a direct impact on the feasibility of uptake and sustainability of social prescribing in Argyll and Bute. For example, a group may be set up in Dunoon, which is totally unrealistic for individuals resident in Mull, Lochgilphead, or Campbeltown to attend. But even those residing closer to Dunoon, but in outlying areas of Cowal, can struggle to access these services due to poor transport links and long journey times even if they have access to a private car, especially in the winter months with hazardous driving conditions.
  - Additional investment/subsidisation of reliable local transport links would help alleviate this problem in Argyll & Bute to some extent, but extended travel times will always be an issue for both service provider and service user in Argyll & Bute.

5. **How can we monitor and evaluate the effectiveness of social prescribing?**

Monitoring and evaluation of the impact and effectiveness of social prescribing is notoriously difficult, especially in demonstrating the longer term benefits to be gained to the individual, the community as a whole, and the demand on HSCP services (reduced waiting times, unplanned admissions, mental health, etc.).

**Numerous issues contribute to this:**

- Difficulty in tracking who actually follows through on their social prescription, to attend the service to which they were referred. Ultimately, it is up to the individual whether they choose to take up the social prescription.
- Difficulty in measuring success/failure due to the high drop-out rates normally associated with social prescriptions (e.g. an individual may attend the first session of an exercise/counselling session, but then choose to stop attending).
- The main problem in monitoring and evaluating the impact and effectiveness of social prescribing is the current ‘disconnect’ between in the patient pathway between the NHS and the referral pathway to the link worker/service, and
what happens to that individual after meeting with the link worker. An e-mail/e-prescription form referral system should enable a patient’s CHI number to be attached to any social prescription (data protection issues need to be considered here), enabling the full pathway of an individual to be followed.

➢ If the CHI can be used as a referral ID then a fuller picture of the impact of social prescribing on an individual would have the potential to be measured, as the CHI can be used to link back to things like number of unplanned admissions, number of future GP appointments, any reduction in prescription medicines, etc. prior to and post their social prescription. In such a case, link workers etc. would only see the patient CHI number as an identifier on the social prescription, and would NOT have any access to medical records, etc.

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Attachments:

Appendix A: A scoping of social prescribing and link working in Argyll & Bute – Summary of survey results from GPs and TSI

Appendix B: A summary of the capabilities of the Elemental software tool

Appendix C: Sample costs
Appendix A:

A scoping of social prescribing and link working in Argyll & Bute – Summary of survey results from GPs and TSI

As part of a scoping exercise on link working and social prescribing in Argyll & Bute, we conducted a survey of GP practices and Third Sector organisations across Argyll & Bute, in May 2019, on their views and vision of link working and social prescribing. We received 11 responses from GPs, and 56 valid responses from the Third Sector.

A summary of the responses is listed below.

Main points of GP Survey on Link Working:

- 11 responses received covering Cowal, ‘Islay & Jura’, and ‘Mull, Iona, Coll, Colonsay & Tiree’.
- No responses received covering Bute, Mid Argyll, Kintyre, ‘Oban & Lorn’ or ‘Helensburgh & Lomond’.
- 45% of respondents covered areas sitting outside of a town or village setting, ie. ‘other rural’.
- 90% of respondents were contracted GPs;
- A third have experience of working in Social Prescribing, and of mixed experience.
- Understanding of concept of ‘social prescribing’ and ‘link working’ varies greatly (from none at all, through to a strong understanding).
- 45% believe link working will improve outcomes for their patients.
- 73% recognised a particular group would benefit from access to link working, and a wide variety of known services listed.
- 56% felt there was a need for a distinct link worker role, while the other 44% felt existing staff could take it on as part of their existing role.
- Views were split on the best link worker option which would be most effective in their area, of the 10 GPs who expressed a view on this:
  - 3 supported link working being commissioned from the Third Sector;
  - 3 supported the GP Practice Team doing the link working;
  - 2 supported an NHS employed link worker;
  - 1 supported a link worker being employed by the GP Practice; and
  - 1 GP expressed their wish “to have nothing to do with it [link working] and would not support it.” And “emphatically believes this is not an NHS role.”
- 3 of the 11 GPs expressed their willingness to be involved in any focus group which may be created to further develop effective social prescribing practice and an appropriate link worker model for their area.
Main points of Third Sector Survey Monkey on Link Working:

- 56 valid responses were received spread quite evenly across all areas of Argyll & Bute, across a wide variety of service provision.
- 50% hold experience in working with Social Prescribing programmes.
- Understanding of the concept of ‘social prescribing’ varies from 1 (‘not at all’) right through to 10, with 62% of respondents stating their knowledge at level 8, 9, or 10 (i.e. confident to advanced).
- 64% (36) receive referrals from Health & Social Care (HSC) Staff, with the great majority receiving 1 or 2 referrals from HSCP per month, but 3 others receiving 15, 20 or even 30 per month.
- 63% (35) receive referrals from out-with the HSCP, from a wide selection of sources (see ‘Q9’ additional detail attached from some).
- 57% (32) of the Third Sector responses expressed their preference for a link worker to be based within the GP Practice. 23% (13) expressed a preference for any link worker to be based elsewhere (see Q12 responses attached), and the remaining did not give any indication of which their preference.
- 29 respondents (roughly half) gave additional feedback as to how link working could be most effective in their locality (see Q13 responses attached).
- Of the 56 valid Third Sector respondents, 28 (50%) expressed their willingness to be involved in any focus group which may be created to further develop effective social prescribing practice and an appropriate link worker model for their area, 24 of which gave their contact details.
Appendix B:

A summary of the capabilities of the Elemental Social Prescribing Software

Elemental Social Prescribing software has been specifically designed to manage and evaluate social prescribing. It has already been successfully adopted in several areas across the UK, and addresses the majority of issues around monitoring and evaluation of social prescribing.

Without the adoption of a system such as Elemental, it is unlikely that social prescribing and link working will be effectively implemented or evaluated.

Whilst an annual licence for the HSCP in Argyll & Bute would be approximately £20,000, the level of benefits and efficiencies to be gained would make the difference between the success and failure of social prescribing in Argyll & Bute, as outlined in the list of benefits below.

✓ Facilitate more people to access and engage in social prescribing services;
✓ Streamline administrative duties and increase staff capacity;
✓ Demonstrate the impact of community based programmes and services;
✓ Provide customised analytics, reports and evaluations for funders, and annual reports, etc.
✓ Ability to tie in reports to organisational KPIs, national priorities and targets, etc.
✓ Create and develop cross-sector connections, bridging the gap between health, social care, housing and the community.
✓ Monitor and measure social prescription progress and outcomes by patient, by service, by GP or an age group or other common demographic, etc. (e.g. ‘over 65 males who attended the Men’s Shed in Oban’, etc.);
✓ Can pull out which services are being accessed by reason for referral, e.g. which services are being chosen for mental health/financial support, etc.);
✓ Track time spent with clients including writing up of case notes;
✓ Link worker receives notification of referrals received, who they can then triage;
✓ Flexibility to use existing measures e.g. Warwick Edinburgh Mental Wellbeing Scale, frailty scores, visceral fat, etc. or create your own additional measures to be incorporated;
✓ Self referral to Link Worker (bypassing GP or health professional) available via an access button which can be placed on organisational websites, etc.;
✓ Client can access their own progress report and charts & calendar of activities;
✓ Schedule follow-up visits;
✓ Can see attendance to classes, and identify those with high drop out rates (what’s going on? How can we support the service/users?);
✓ ‘Superusers’ can see full dashboard over all clients, GP surgeries, etc.
✓ The App can be used offline or where there is no signal, meaning you can upload to the system on your return to your base;
✓ Can limit access to ‘confidential cases’ to only certain workers;
✓ A ‘patient agrees consent’ statement & checkbox for sharing of information with services they are referred to;
✓ Manage referrals to see which referrals have been picked up by whom, their health scores, etc.;
✓ Licence cost determined by number of individuals accessing the service as a user, not number of professionals accessing the software to refer, or services provided.

Please visit www.elementalsoftware.co for more detail.
Appendix C:
Sample costs

➢ Sample cost per head for provision of a 5hr gardening session (Source: Branching Out, Argyll & Bute): £43.

➢ Average cost per head of delivering 6 week ‘X-Pert for Diabetes’ programme: £180

Cost per attendance (NHS Highland):

➢ Acute Services, Average cost per inpatient stay: £2,914

➢ Acute Services, Average cost per day case: £1,076

➢ Acute Services, Average cost per day patient: £303

➢ Consultant, outpatient (average across all specialties): £191

➢ General Psychiatry, outpatient: £184

➢ Acute Services, outpatient: £145

➢ Accident & Emergency, outpatient: £142

➢ Physiotherapy, outpatient: £85

➢ Occupational Therapy: £50