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What is the impact of link workers or wellbeing coordinators on healthcare

(within an Integrated Care System in the UK)

Dr Felix Gradinger (MA, MSc, PHD)

Researcher-in-Residence (Integrated Care)

Plymouth Institute of Health and Care Research (PIHR) (Faculty of Health)

University of Plymouth, UK

Together for Devon

Health and care working in partnership with local communities in Plymouth, Torbay and the rest of the county

UNIVERSITY OF PLYMOUTH

NHS Torbay and South Devon NHS Foundation Trust

NIHR | Applied Research Collaboration South West Peninsula

Torbay Medical Research Fund

Acknowledgement of Research Partners:

- *Collaborators*: Sheena Asthana, Richard Byng, Rachel Purtell, Penelope Welbourne, Rod Sheaff, Gill Manthorpe, Susan Martin, Rachel Dennett, Debra Westlake, Alex Gude, Zoe Doran, Kerryn Husk, Chloe Myers, Mat Fox, Dawn Butler, Jo Williams, Lisa Smith, Felicity Thomas, Joanne Watson, Susanne Hughes, Tom El-Hoss, Katrina Wyatt, Paul Bywaters, Calum Webb.

- *Local Authorities*: Darin Halifax, John Bryant, Simon Porter, Stephen Honeywill, Julia Chisnell, Sue Ford, Simon Baker, Shaun Evans, Lincoln Sargeant, Nancy Meehan, Simon Chant, Alessia Rose, Sarah Pengelly

- *VCSE*: Helen Harman; Sue Wroe, Katie Chaplin, Jeannette Osmond, Jill Breyley, Emma Ellis, Miia Thomas, Marj Dawson, Emma Flint, Bob Alford, Diana Crump, Simon Sherbersky

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- *Members of the Public*: Julie Dingley, Barrie Behenna, John Barry Stevens, Linda Hughes, Kevin Dixon, Pam Prior

Researchers-in-Residence and Multidisciplinary Team co-presenting findings

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The impact of Covid-19 on the delivery of Social Prescribing in Devon, UK

Debra Westlake, Julian Elston, Felix Gradinger

(Researchers in Residence, Devon STP, Torbay and South Devon NHSFT)

Alex Gude, Kerryn Husk, Sheena Asthana (Community and Primary Care Research Group, Faculty of Hea
University of Plymouth)

Darin Halifax, Rebecca Harty, Devon Integrated Care System (ICS

Westlake, D., Elston, J., Gude, A., Gradinger, F., Husk, K., & Asthana, S. (2022). Impact of COVID-19 on social prescribing across an Integrated Care System: A Researcher in Residence study. *Health & Social Care in the Community*, 00, 1– 9. https://doi.org/10.1111/hsc.13802

Researcher in Residence methods

Service-level evaluation as part of embedded role within Devon Integrated Care System

Gradinger, F., Elston, J., Asthana, S., Martin, S., and Byng, R. (2019). Reflections on the Researcher-in-Residence model co-producing knowledge for action in an Integrated Care Organisation: a mixed methods case study using an impact survey and field notes. *Evidence & Policy* 15, 2, 197-215, available from: < https://doi.org/10.1332/174426419X15538508969850>)

Sources of qualitative data collected from 78 anonymised respondents working in Social Prescribing (variety of employing organisations and roles)	N=
Emails / comms from individuals	67
Reports / PowerPoint presentations (VCSE and PCN)	11
Meeting minutes - produced by others	7
Interviews conducted by RiR	9
Team's notes, observations and reflections from conversations and meetings	28
TOTAL	122

Categories of quantitative data	N=
Routinely collected data – SNOMED codes CCG	31 PCNs
Routinely collected data – other GP/SP records	Limited Case studies
VCSE reporting from own records	11 Reports

Service evaluation Survey data (Covid specific)	N=
Respondents to survey (front line n = 46, managers n = 6)	52

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Workforce Assets: funding and employment of SPs across Devon

Community

VCSE infrastructure: supporting, linking and coordinating with SP

PCN funded and contracted SPs (40%)

Primary Care Networks

PCN funded/VCSE contracted SPs (>60%)

PCN funded/ Trust contracted HWB coaches

NHS Trusts

Voluntary sector

Wellbeing Coordinators

Community builders

CONFERENCE

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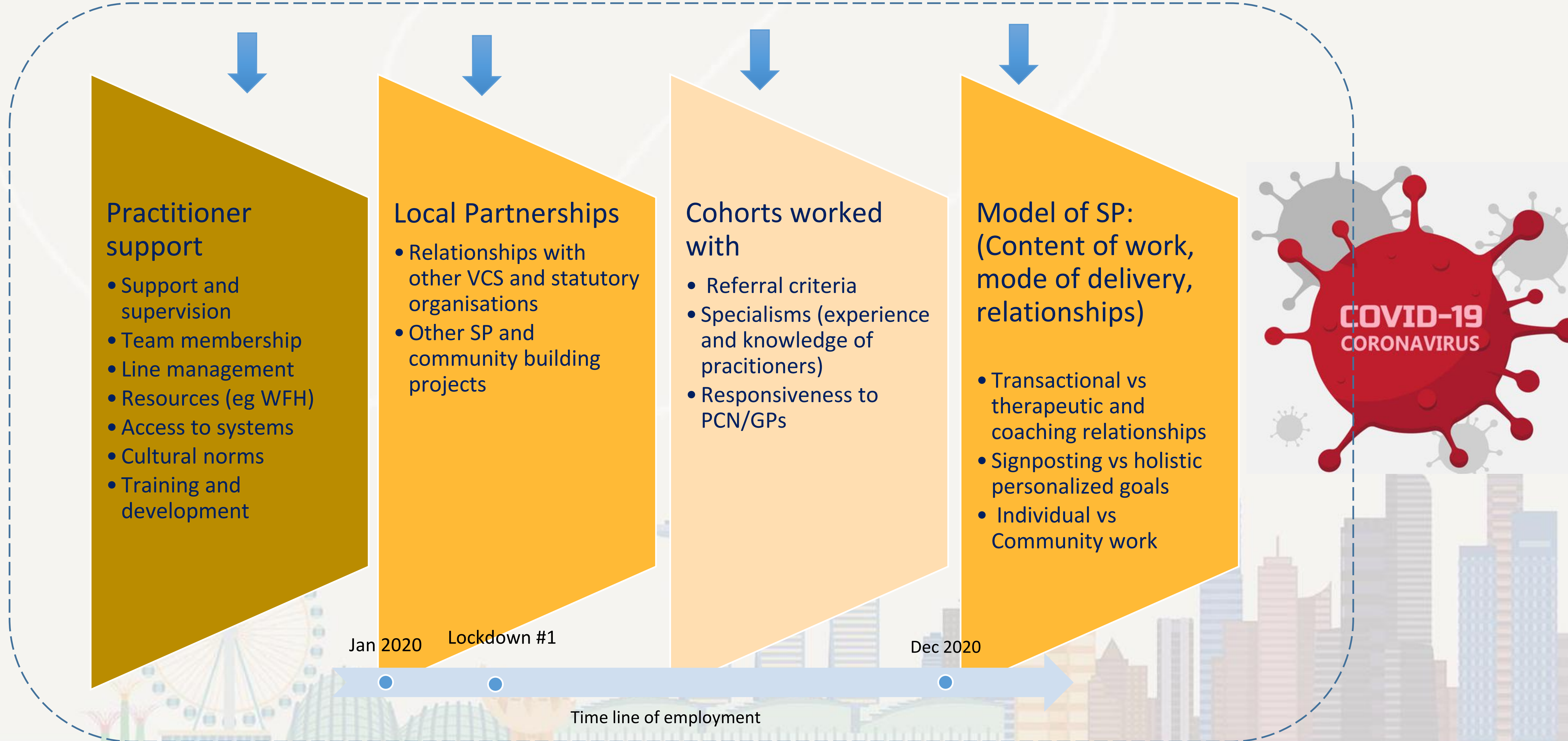

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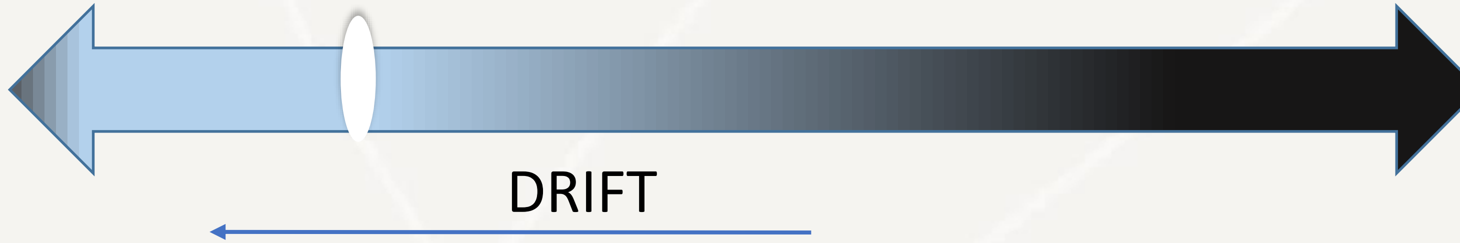
Continuum model of Social Prescribing engagement

Brief one off phone contacts (transactional relationships)
Waiting lists



Multiple contacts
Face to face
Quick response to referral
Relationship developed

- Transformative
- What Matters To You/person centred
- Intentional/listening

Vaccination support

Welfare checks

Food deliveries

Signposting eg debt support

Goal directed Coaching Motivational Interviewing (MI)

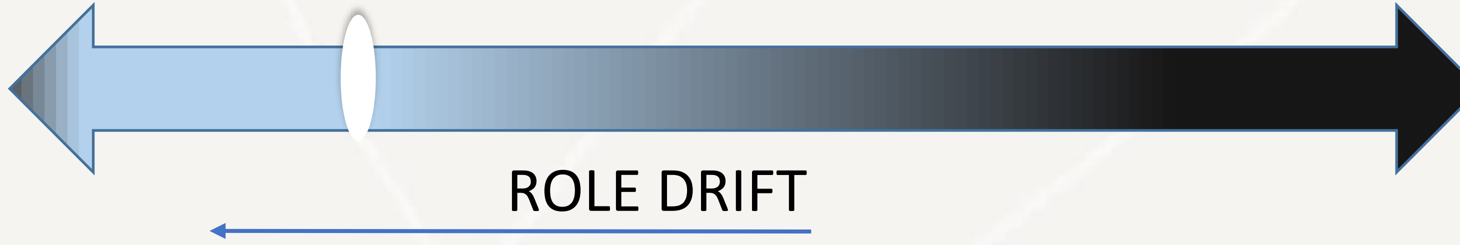
Responsive Person centred planning

Opportunistic SP connections and identification of need

Social Prescribing engagement – mental health cohorts

Gap filling

'Holding' people eg - lengthy phone contacts



Coordination and goal planning

Connecting/coordinating to community resources or statutory services

- Mental health work (eg managing Severe Mental Health)
- Befriending
- Counselling
- Social work eg debt support

- Goal directed Coaching MI
- Responsive Person centred planning
- Coordination/ case management with other services

Impact of the RiR role during Covid

National impact

- Timely findings fed to SP Institute (AHSN) and NHSE = increased funding for WF)
- Reciprocal learning with NHSE national around minimum dataset collaboration)

Local systems

- Feedback improvement cycles e.g. need for Communities of Practice
- Increase VSCE capacity to demonstrate value
- SP Exec co-production of recommendations post-COVID

"I relayed messages following your report on the issue of link workers not having sufficient resources – particularly telephones/laptops and often access to the surgery computer system […] **I think it is true to say that the extra £3,000 per link worker was partly a result of these discussions"**

Dr Michael Dixon,
National GP Lead for SP

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Wellbeing Coordination Programme

Julian Elston, Felix Gradinger

(Researchers in Residence, Torbay and South Devon NHSFT)

Richard Byng (Community and Primary Care Research Group, NIHR PenARC), Sheena Asthana (Plymouth Institute of Health and Care Research, Faculty of Health, University of Plymouth)

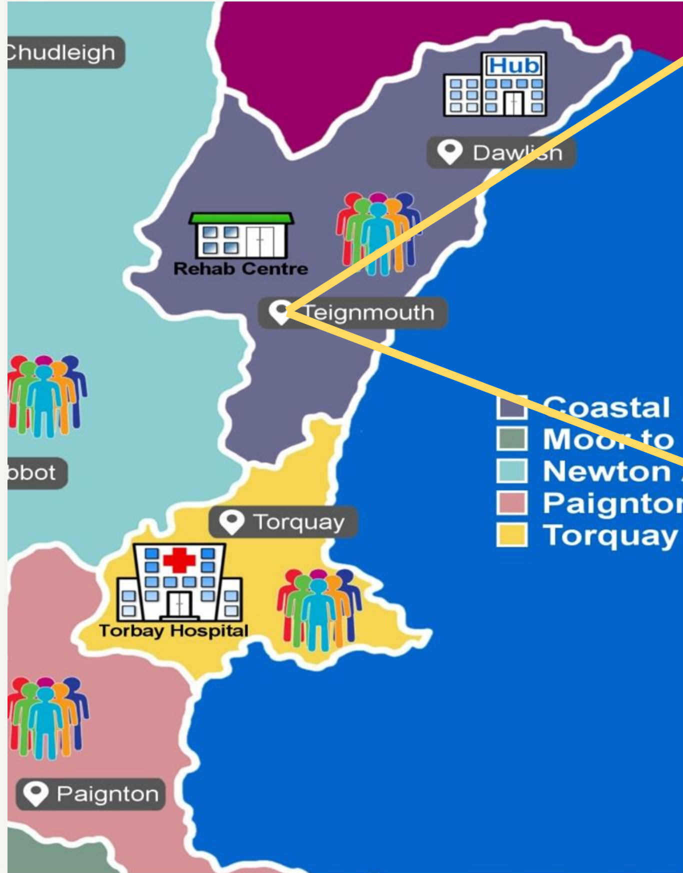
Elston, J., Gradinger, F., et al (2019). Does a social prescribing 'holistic' link-worker for older people with complex, multimorbidity improve well-being and frailty and reduce health and social care use and costs? *Primary Health Care Research & Development, 20*, E135. doi:10.1017/S1463423619000598

Asthana, S, Gradinger, F., Elston, J., Martin, S., Byng, R. (2020) https://www.ijic.org/articles/10.5334/ijic.5196/

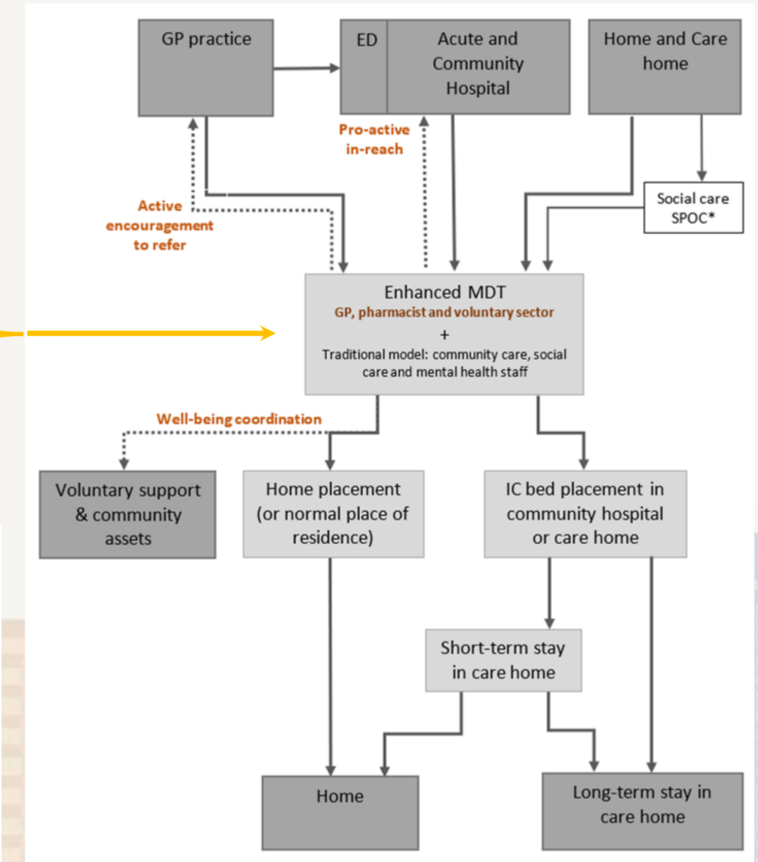
Gradinger, F., Elston J. et al (2020), Integrating the voluntary sector in personalised care: mixed methods study of the outcomes from wellbeing co-ordination for adults with complex needs, *Journal of Integrated Care*, Vol. 28 No. 4, pp. 405-418. https://doi.org/10.1108/JICA-02-2020-0010

Elston, J., Gradinger, et al (2022). Impact of 'Enhanced' Intermediate Care Integrating Acute, Primary and Community Care and the Voluntary Sector. *International Journal of Integrated Care*, 22(1), 14. DOI: http://doi.org/10.5334/ijic.5665

Enhanced Intermediate Care (EIC) and Well-being Coordinators (WBC) in Coastal locality



- Every morning from 9-10am
- Enhanced IC MDT attended by **GPs**, Nurses, Occupational Therapists, **Community Pharmacist**, Physios, **Social Workers** and a **Wellbeing Co-ordinator** from VIH
- Discuss new and existing the patients on the Intermediate Care Team caseload, and those approaching discharge in acute and community hospitals

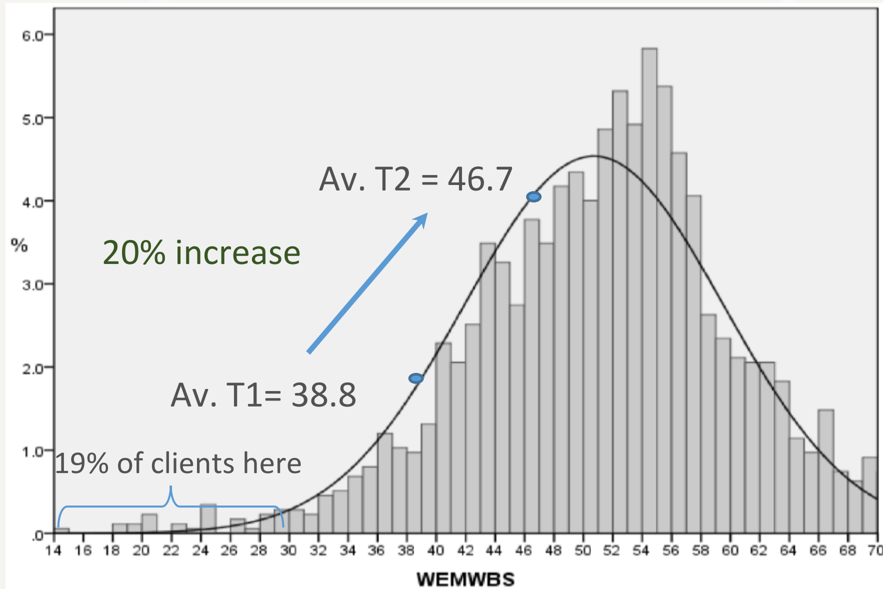


"Think Whole Person" - evaluation of the impact of Well-being Coordination on MH, activation and frailty (before and after study)

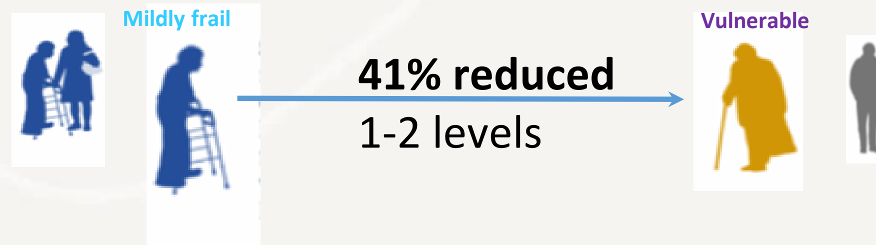
https://www.torbayandsouthdevon.nhs.uk/services/wellbeing-co-ordinators/

These were statistically significant improvements (n=86)

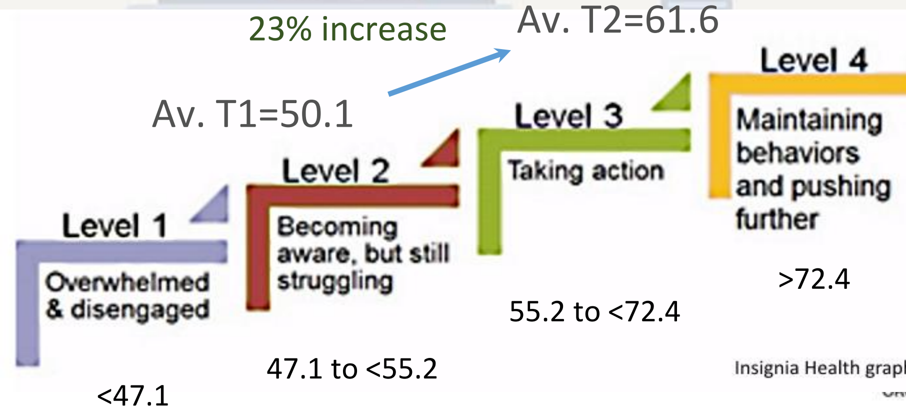
Warwick Edinburgh Mental Health and Well-being scale (WEMWBS)



Rockwood Clinical Frailty Scale



Patient Activation Measure (PAM)



Achievement of goals – 85%

- Analysis of health and social care activity data we more equivocal
- Qualitative analysis helped explain why/what was going on

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“Think System Benefits”

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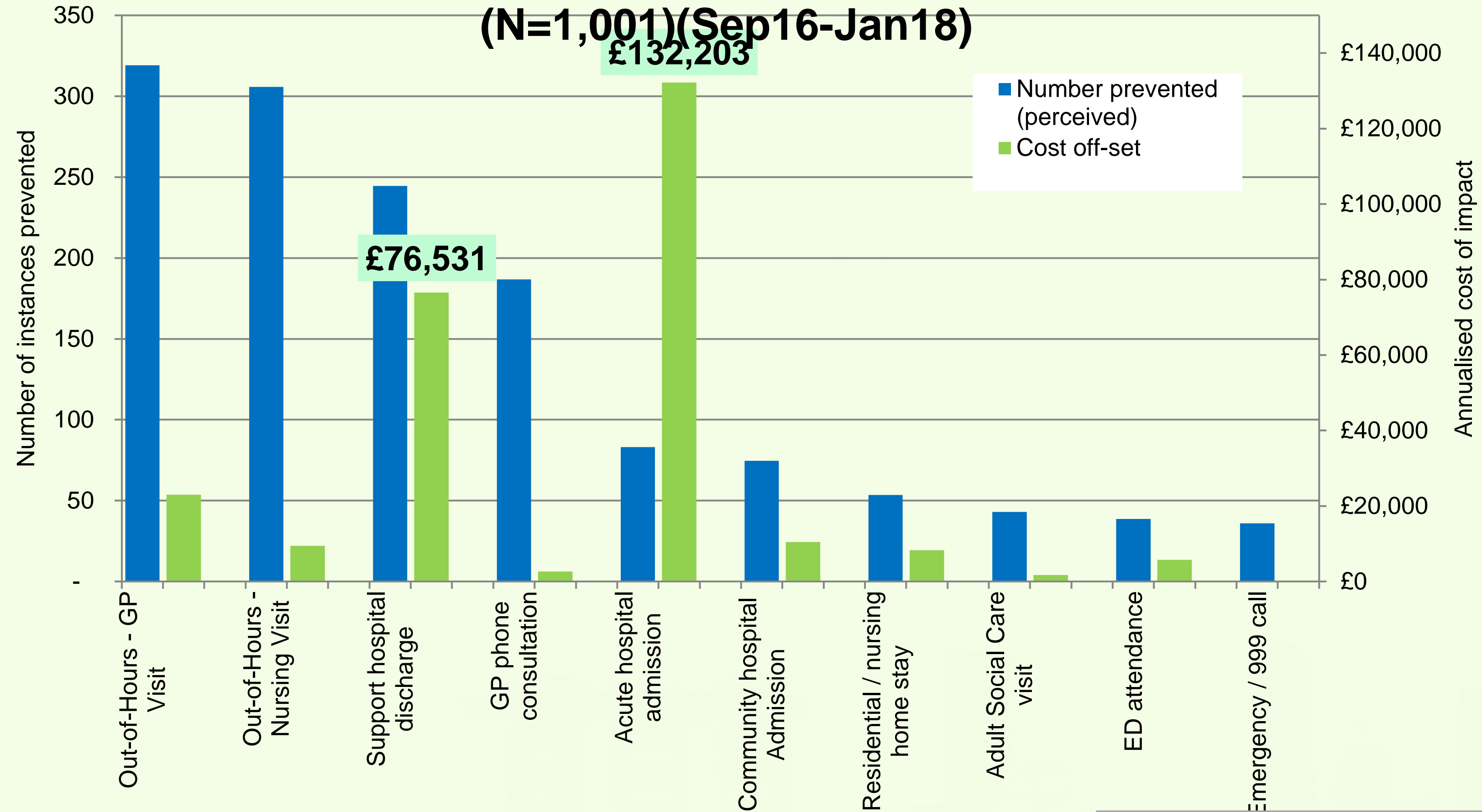
Coastal Locality Case Study



Annualised Av. IC cost of incidents prevented (n=1,940)	Annualised Av. IC cost per person (£130.90)	Annualised crude Av. Cost off-set (benefit)	Annualise cost per referral saved
£270,319	**-£87,349**	**£182,970**	**£193**

Annualised activity (≥ 70 years)

2.3% reduction in ED attendances

5.5% reduction in ED admissions

Elston, J .et al. (2019) *International Journal of Integrated Care*. 2019;19(4):584. DOI: http://doi.org/10.5334/ijic.s3584

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Recommendations

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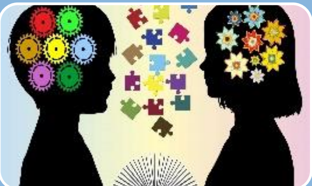
Listen, learn

Understand the different models of SP – contexts, barriers and facilitators

Integrate SP as a core programme in Devon ICS

Connect, collaborate

Connect workforce, community, primary care and VCSE: Community of Practice, trusted relationships

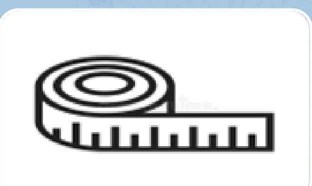


Define, communicate

What SP can and cannot do. Community building is part of SP. Communicate clearly to referrers, workforce, citizens.

Fund

Sustainable, strategic assets: pooled budgets, community infrastructure for SP; workforce development



Measure

Framework and apps for data collection and analysis: Who receives SP and why, outcomes