

Ageless Thanet Social Prescribing Pilot



What is Social Prescribing?

Recognising that people's health is affected by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health.

It is sometimes referred to as community/care navigating or community referral and is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services.

Social prescribing schemes can involve a variety of activities which are typically provided by voluntary and community sector organisations. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports.

Social prescribing is designed to support people with a wide range of social, emotional or practical needs, and many schemes are focused on improving mental health and physical wellbeing. Those who could benefit from social prescribing schemes include people with mild or long-term mental health problems, vulnerable groups, people who are socially isolated, and those who frequently attend either primary or secondary health care.

Almost without exception, people want to improve their situation, particularly those with complex needs. These changes can seem impossible to navigate or achieve without sustained support and the motivation needed to make a positive change. Without support, negative consequences can build up, such as depression, anxiety and social isolation.

This will often lead to people booking appointments with GPs when really they need support with housing, finances or becoming more connected within their community, rather than medical intervention.

In a survey conducted in 2013 by The Campaign to End Loneliness, over three quarters of GPs reported seeing one to five lonely people a day and one in ten said that they saw between six and ten lonely people a day.

Having the opportunity to refer a patient to a Social Prescriber (sometimes referred to as Navigator or Link Worker), takes the pressure off GPs by freeing up more of their time to focus on medical issues.



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In 2018 Ageless Thanet were awarded funding from The National Lottery Community Fund to pilot a Social Prescribing project in Thanet, to help reduce social isolation and loneliness, and to improve the mental and physical health of residents over the age of 50.

What did we do?

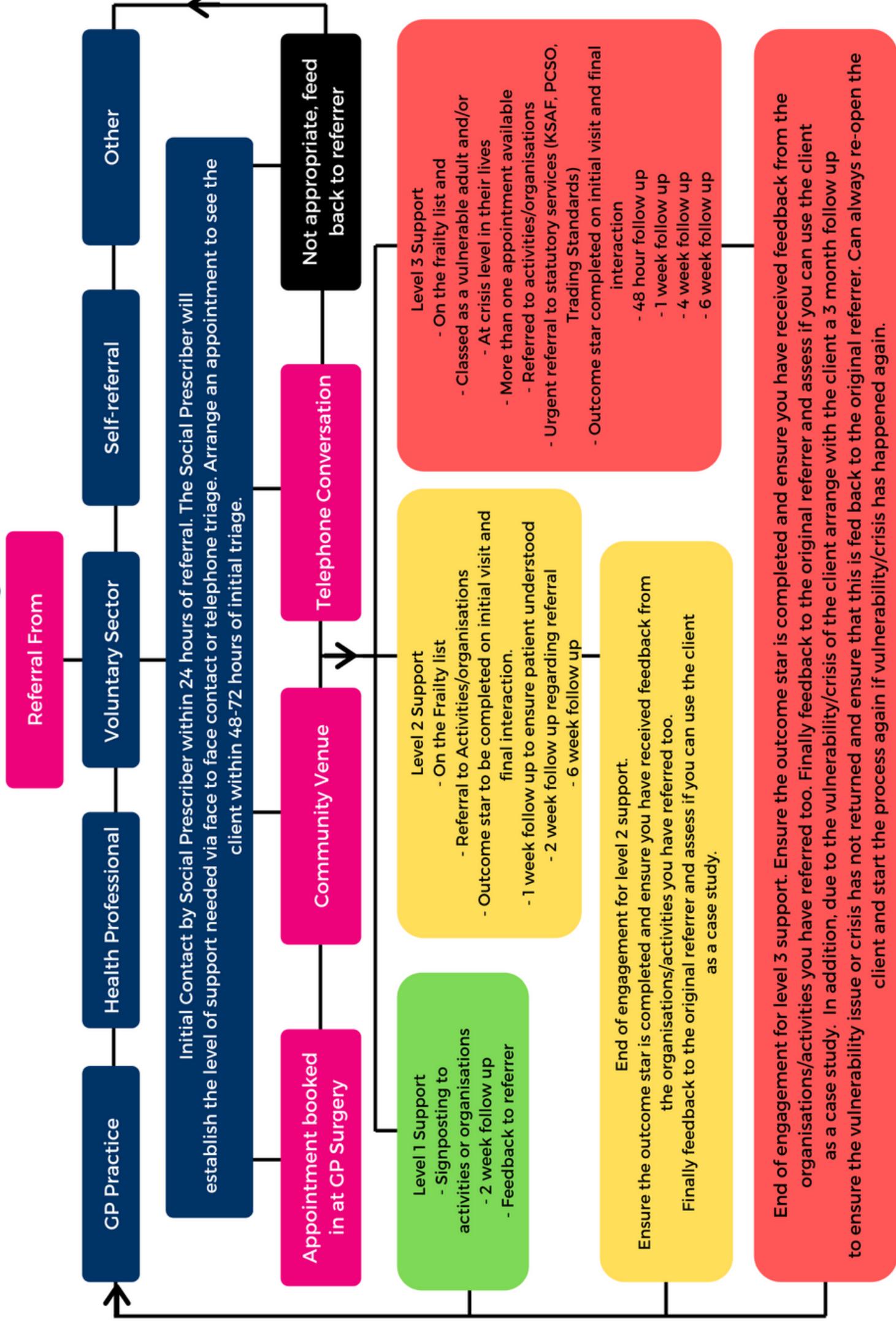
We already had a good relationship with some of the GP Surgeries in Thanet, thanks to hard work earlier in the project, as well as running regular drop-in sessions in practices. It was decided that we would work with four GP Surgeries: Bethesda Medical Centre in Cliftonville, Birchington Medical Centre, Mocketts Wood Surgery in Broadstairs, and Westgate Surgery.

It was necessary to build a database of services and organisations that people could be referred to for the pilot to be a success. This was relatively easy to do, as we had linked in with lots of these providers through other aspects of the project.

Clinics were held in each of the surgeries, where Receptionists and Doctors could book appointments for people who needed support with non-medical issues. There was also the option for the doctors to send patients to see the Social Prescriber there and then, providing they weren't seeing another patient at the time.

The Social Prescriber would refer the patient to the relevant organisation/s and then follow up with them three weeks later and then another three weeks after that.

Social Prescribing Model



What have we learnt?

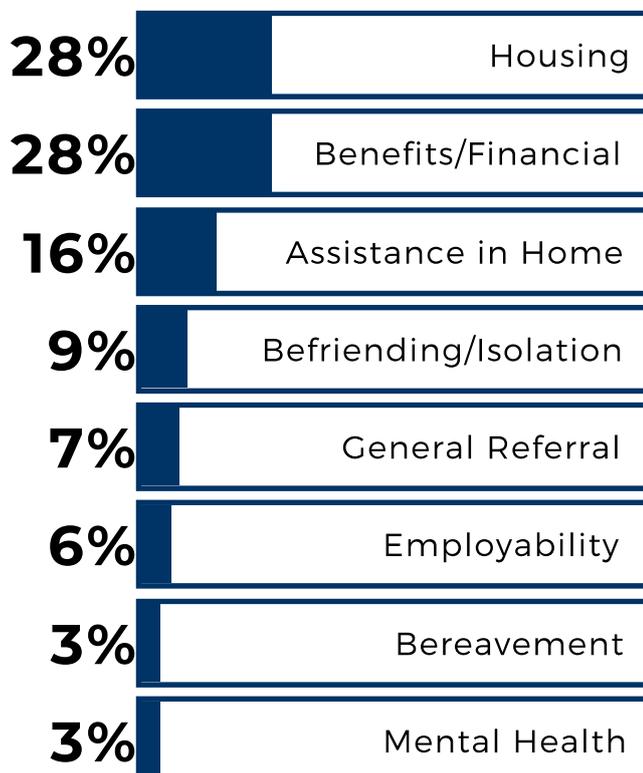
For this approach to work, we have learnt that it needs to be centered around the person. The person has to be completely on board with the change you're trying to make for it to have a long-term positive impact. If they are not fully committed to the service or group you are referring them to, the chances are that it will have a positive short-term effect, but they will slip back into old habits quite quickly.

However, if the person is involved in the process and feel that they have been given a choice about which organisations they are referred to, they are much more likely to take up the service. It comes down to people being treated like individuals and not as a problem to be solved.

A key piece of learning is the value of home visits. All of our appointments were conducted at GP Surgeries or community venues, so we were not able to get the full picture as to what is going on in their lives. Conducting a home visit would have allowed us to see other issues that were having a negative impact on quality of life such as hoarding, little-to-no food, and other poor living conditions that a person may not share at a meeting in a community venue or GP Surgery.

In the relatively short period of 8 months that we piloted this Social Prescribing service we saw 69 clients in total. Whilst this is a relatively small data set, there are some interesting trends worth exploring.

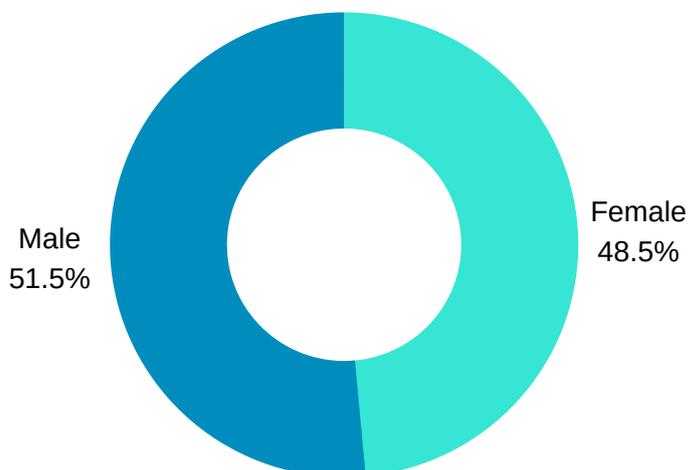
Reasons for referral



The two biggest reasons for a person being referred into the service were housing and benefits or financial support.

While our primary aim was to reduce social isolation and loneliness, the majority of people were not referred to us for that reason (9% referred for befriending or isolation). This suggests that people often had bigger issues to solve that took precedent over any feelings of loneliness/isolation. We therefore feel that the success of interventions to reduce loneliness or isolation is dependent on other underlying issues such as housing or financial need being resolved

There was a fairly even split between the number of men and women seen through this service. This in itself is quite unusual from the other Ageless Thanet project areas, where we have seen a lot more women engage than men.



Impact

We conducted a short baseline and follow-up survey to understand if the intervention had a positive impact on the client. For this survey we used the Warwick-Edinburgh Mental Wellbeing Scale, as this is widely used and academically validated. The scale is made up of 14 questions, and is scored from 1 'none of the time' to 5 'all of the time', with higher scores indicating greater levels of wellbeing. The highest possible score is 70 and the lowest is 14.



According to the results from the Health Survey for England (2011), the average person scores 51.6 on the scale. With the average initial score being 32, this suggests that we were reaching our intended audience. While the average follow up score still puts our clients below the population norm, for what was a relatively short intervention, we are pleased to see that there has been a fairly significant improvement in their mental health and wellbeing.

We are delighted that the value of this pilot has been recognised by Kent County Council, and Social Enterprise Kent is now leading a partnership working with Age UK, Carers' Support, and Red Zebra Community Solutions on the Social Prescribing and Community Navigation service in East Kent.

Find out more...



If you would like to find out more about the other aspects to the Ageless Thanet project, please get in touch -

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Social Enterprise Kent, the lead organisation of the Ageless Thanet project, is a Community Interest Company (CIC), registered with, and regulated by, the CIC Regulator. We have been in operation for over 30 years, with the overarching vision of "Improving Lives, Supporting Communities".

Our key aims:

To provide support for people, particularly in areas of deprivation or for those most disadvantaged, to gain skills and employment

To support the creation, organisation and management of social enterprises and small enterprises; and to develop a way of making this sustainable

To support in the regeneration of deprived areas in Kent, by creating jobs and skills

If you would like to find out more about SEK, we would love to hear from you -

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