



**Canal &
River Trust**

Making life better by water

Understanding Social Prescribing

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Interreg

North Sea Region

European Regional Development Fund



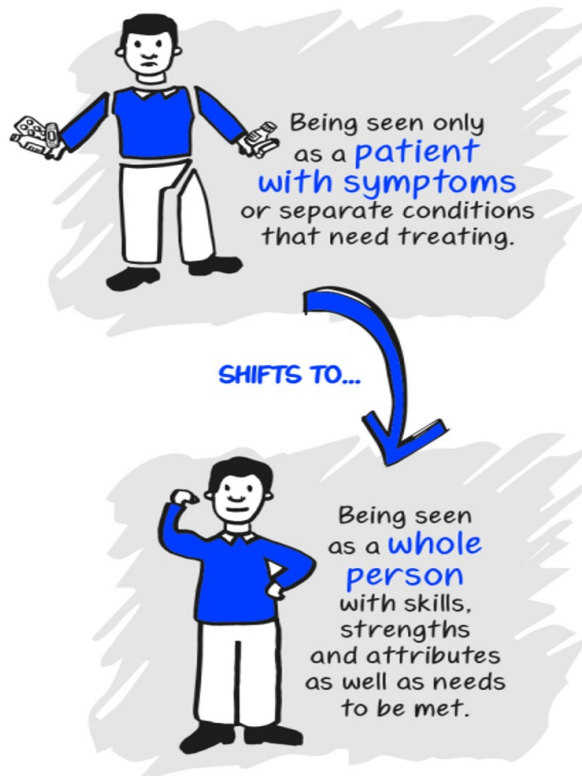
EUROPEAN UNION

Aim

- Explore social prescribing from a UK context
- Offer practical tools for delivering social prescribing in your context
- Very brief snapshot of a very complex issue from on the ground deliverers

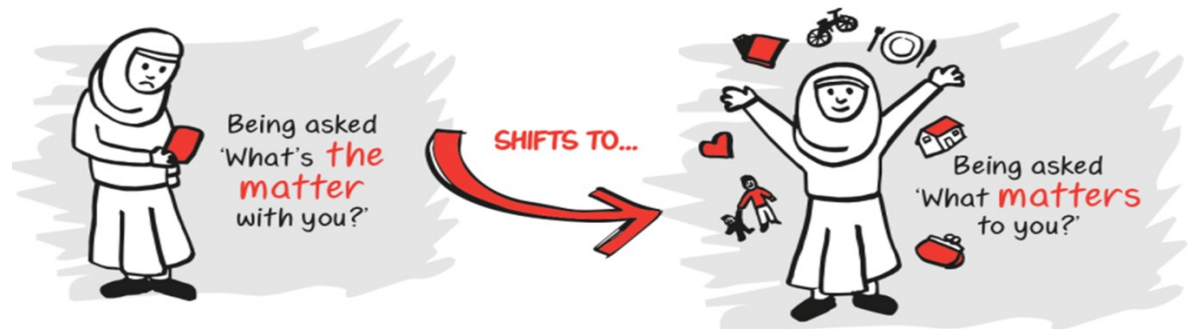


What is social prescribing?



‘shared responsibility for health’

Personalised Care: A shift in relationship between health and care professionals and people.



<https://youtu.be/O9azfXNcqD8>

What is social prescribing?

- Focus on wellness rather than illness
- Social rather than clinical
- The community have a say on what they want to happen rather than being told what will happen to them

Benefits of social prescribing

- enables organisations to refer people to services that offer support for social, emotional or practical needs, including feelings of loneliness, debt, employment or housing problems, or difficulties with their relationships.
- connects people to community groups and services, often through the support of a link worker.
- Develops connector schemes between local agencies (including doctor's surgeries) to produce a tailored plan to meet the person's wellbeing needs. Holistic, person centred, integrated care delivery
- local intelligence informing local focus and delivery
- activities include arts participation, volunteering, befriending and sport or exercise, as well as debt, housing or employment advice.

The UK context

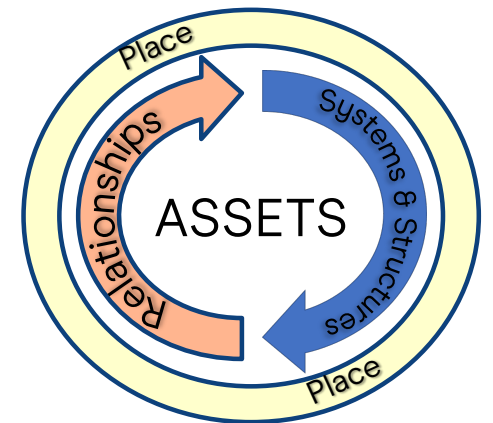
- Sits in National Health Service (NHS) Long Term Plan



- Improving population health
- Improving care outside of hospitals (primary and community services)
- ‘fully integrated community-based health care’ to meet the needs of a changing population
- NHS is a free to use public service

Some useful terms to know

- Primary Care Network (PCN) - General Practices (GPs) brought together to work at scale
- Local Care Partnerships (LCPs) -the model of joined-up team working to improve health and care delivery to local people
- Assets - skills, knowledge, capacity, resources, experiences (or enthusiasm) that individuals and communities have which can help to strengthen and improve things locally.



Department for Health
Policy and Funding Level-entire population

Integrated Care System (ICSs)
Bringing together NHS providers, commissioners and local authorities-populations of 1-3 million

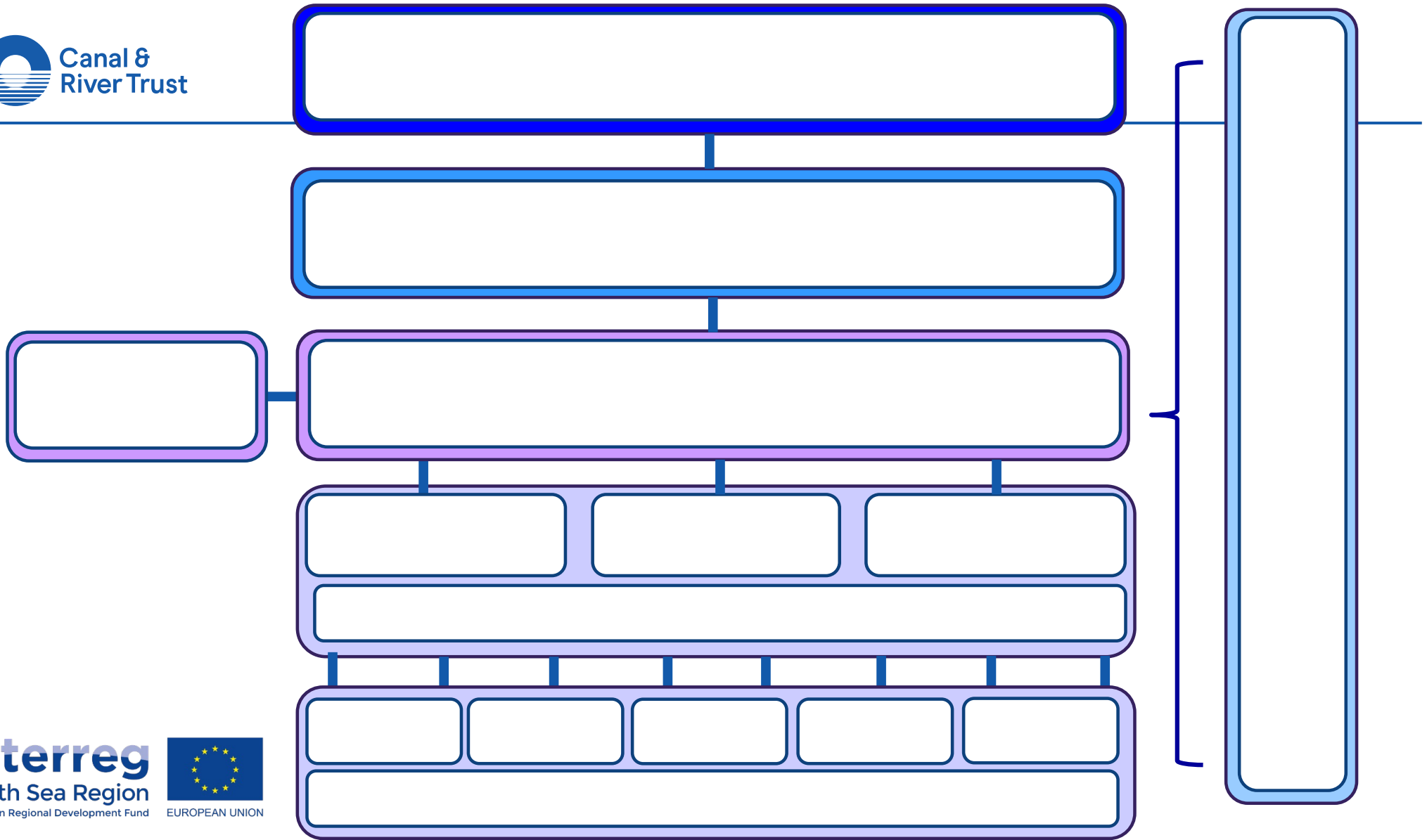
**NHS Foundation
Trusts**
Deliver the services
locally

Clinical Commissioning Group (CCGs)
Groups of hospitals & services that cover a geographical area-
decide which services & treatments are available in hospitals

**Primary Care
Networks** **Primary Care
Networks** **Primary Care
Networks**
GPs working together with community services to focus on
patients-populations of 30,000-50,000

**Local Care
Partnership** **Local Care
Partnership** **Local Care
Partnership** **Local Care
Partnership** **Local Care
Partnership**
Joined-up team of health, community, link workers and assets
working to improve health and care delivery for local people

NHS England
Umbrella body overseeing healthcare. Ensures the CCGs are effective.



The role of the “social prescriber”

Building community connections

- Work at a local level=direct link to individuals most affected by loneliness and isolation
- Good local intelligence about the services available for signposting e.g. housing benefits, outdoor provision such as Canal and River Trust
- Access to local data to inform targeted support

Devise a patient pathway

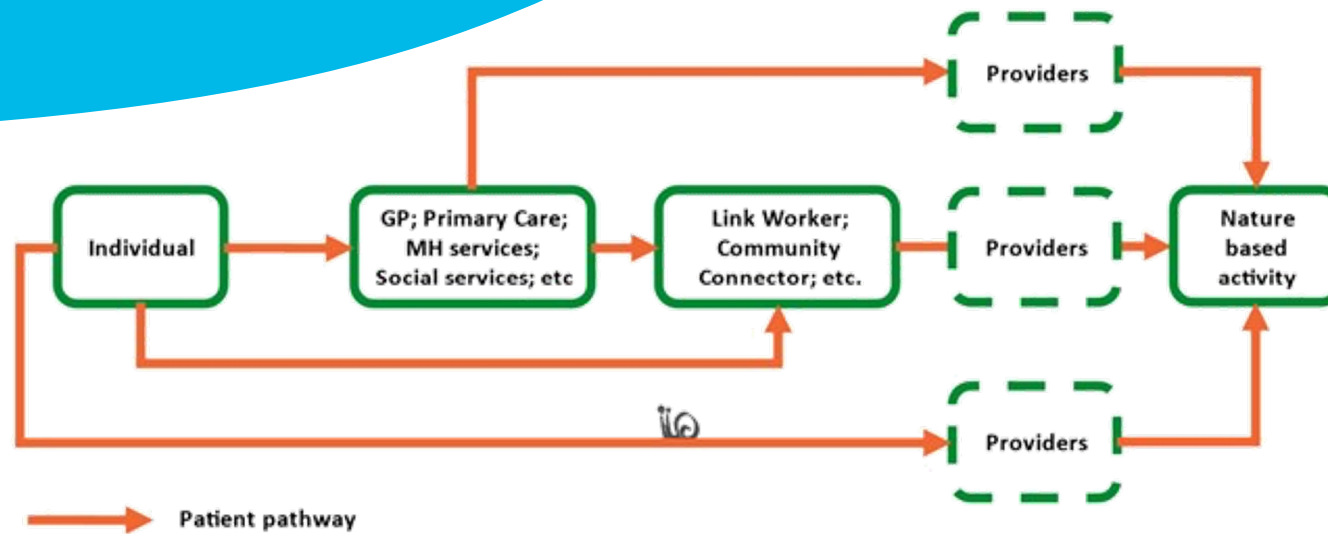


Figure 3 the patient pathway through the social prescribing process

Devise a patient pathway

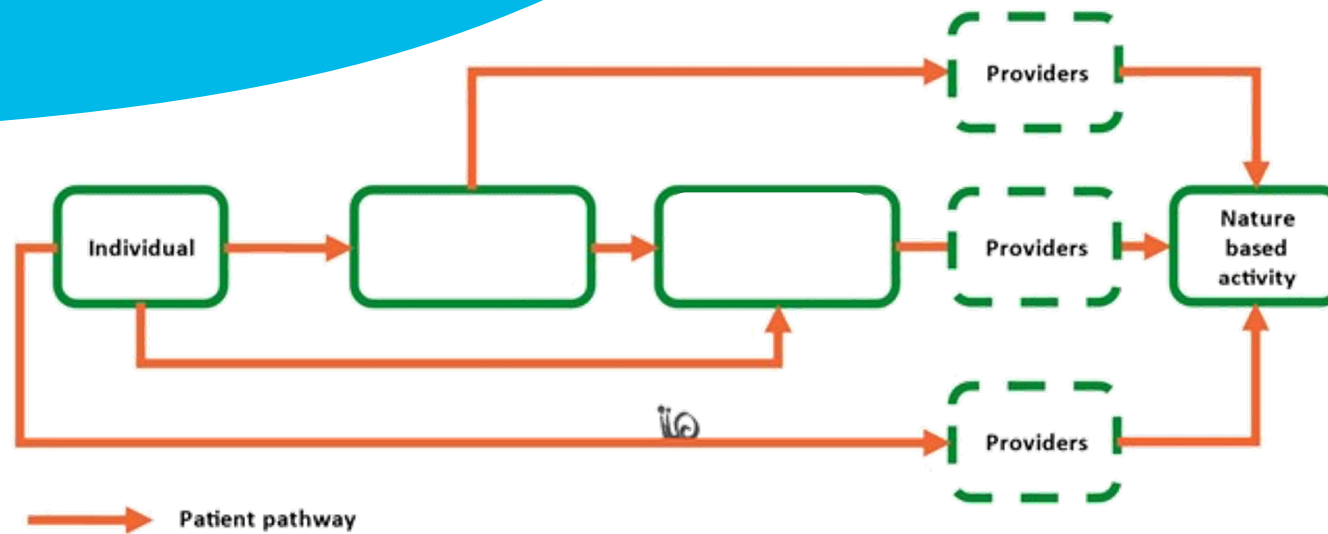


Figure 3 the patient pathway through the social prescribing process

Tips

- Work with the community groups to identify key needs and barriers
- Knowledge share with healthcare professionals and other organisations and services on training and the benefits of Social Prescribing
- The nature of Social Prescribing and those who access the service requires flexibility and consistency



Tips

- Consider what the bridging role between the health care providers and the asset providers will look like:
 - Where will it fit in your current health care system structure?
 - Where/how will funding be devolved/commissioned?
 - Will the role be a community connector? Inclusion coordinator? Link worker? Asset mapper?
 - What data/intelligence will drive their provision?

Devising an IT system to support social prescribing that links health care providers to services/community assets

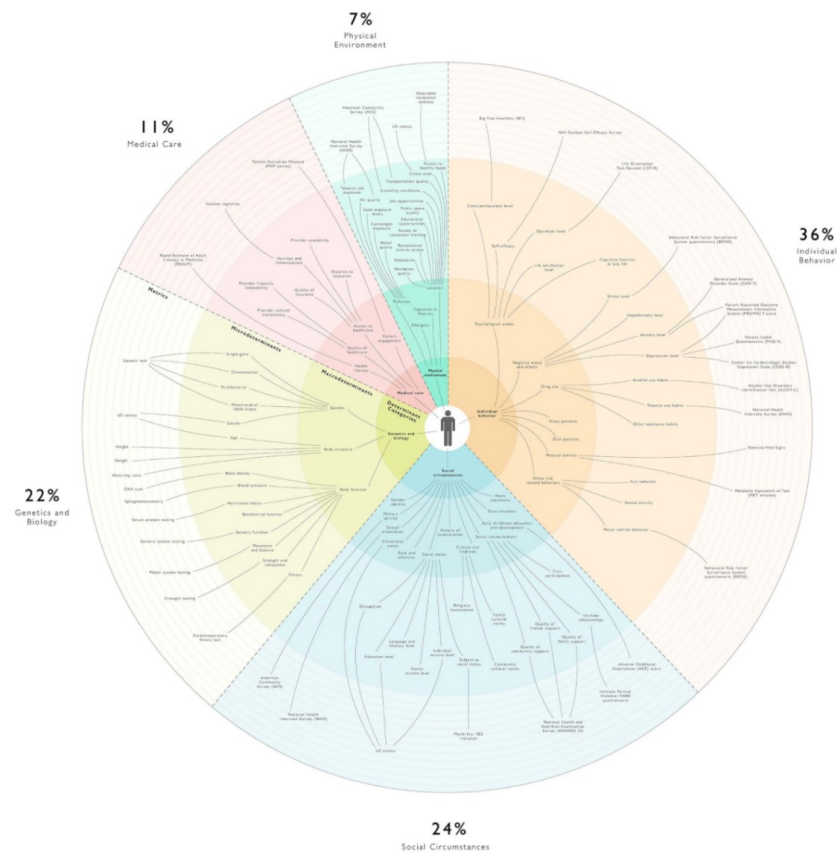
I2I From Isolation to Inclusion



Stijn Coolbrandt
Managing Director Health Endeavour
Founder Zipster



**Limited attention for the
psychosocial needs of people**



determinantsofhealth.org

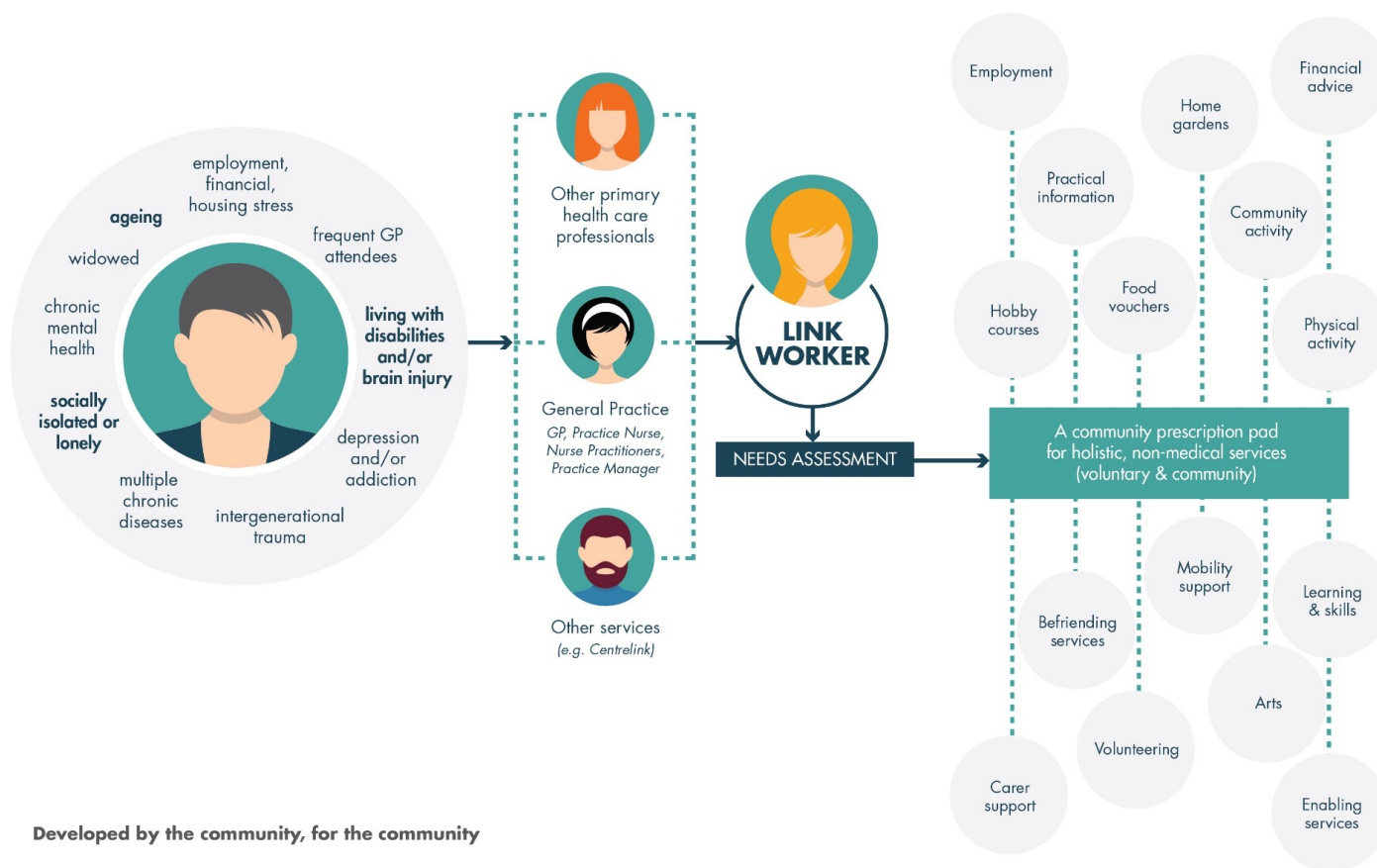
SOCIAL DETERMINANTS OF HEALTH



What if we support healthcare professionals to better detect psychosocial needs and refer patients to the most appropriate local services?

DETECT AND REFER





Social Prescribing @ NHS: <https://www.england.nhs.uk/personalisedcare/social-prescribing/>

ENTER SOCIAL PRESCRIBING



The concept of Link Workers does not formally exist

A number healthcare professionals already do a variation of social prescribing however

Social Prescribing has some hurdles for healthcare professionals

- It's not always easy to identify the needs of the patient
- It's not always obvious to which local service you can refer for what
- There's limited time
- When you refer someone you often don't know what happens afterwards

SOCIAL PRESCRIBING HURDLES





SOCIAL PRESCRIBING PLATFORM

A digital referral platform that helps healthcare providers refer
patients to local welfare actors

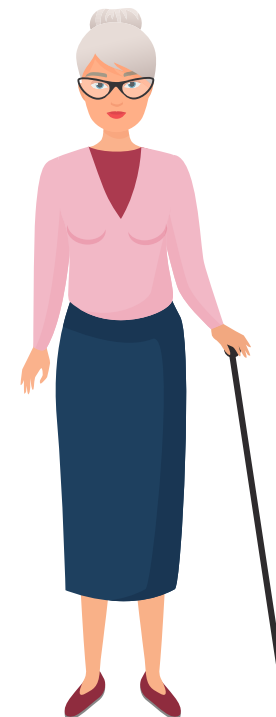
ENTER ZIPSTER 

ANNA

Age
73

Social Status
Single

Social Needs
Loneliness
Need for administrative support



HOW DOES IT WORK?

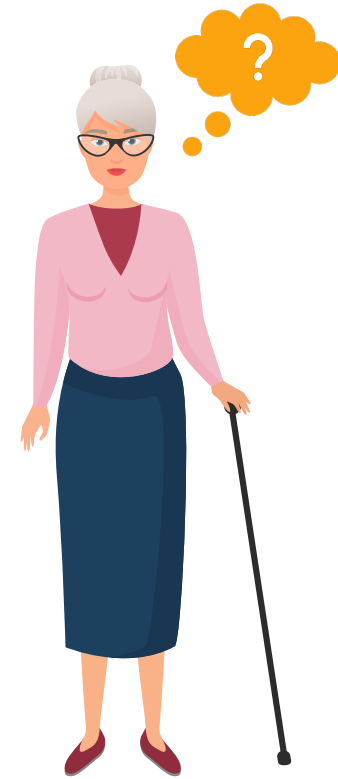


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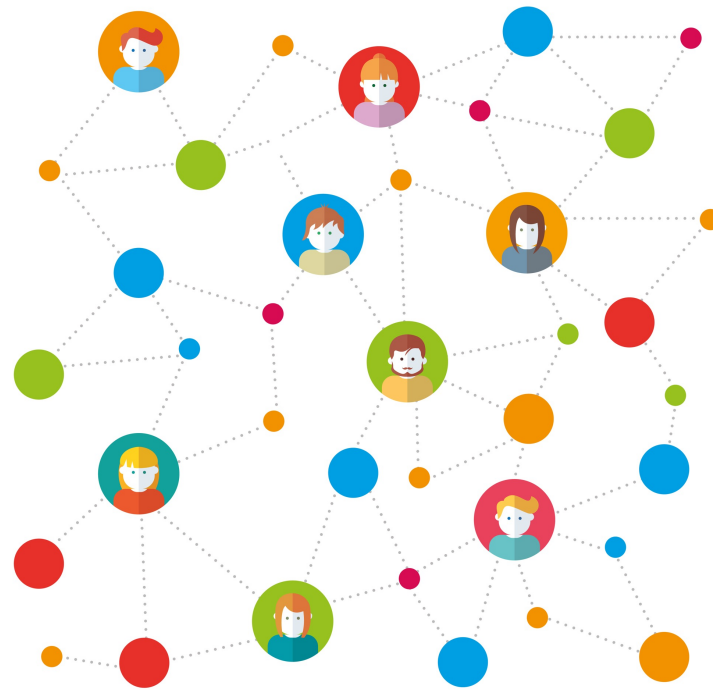
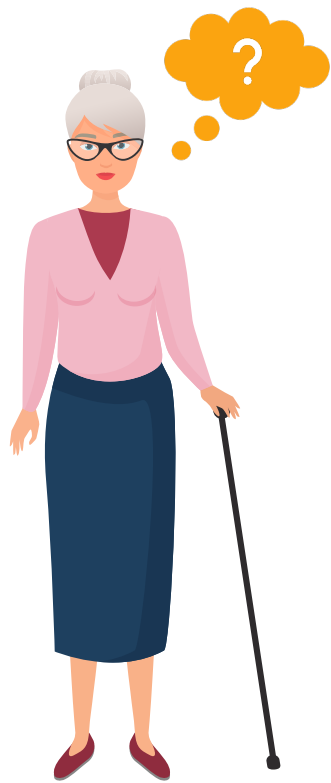


GP MARY

- Wants to improve the wellbeing of Anna
- Doesn't always know to which organization she can refer for what
- Has limited time to do a referral
- Often doesn't get feedback about the referral



HOW DOES IT WORK? ➤

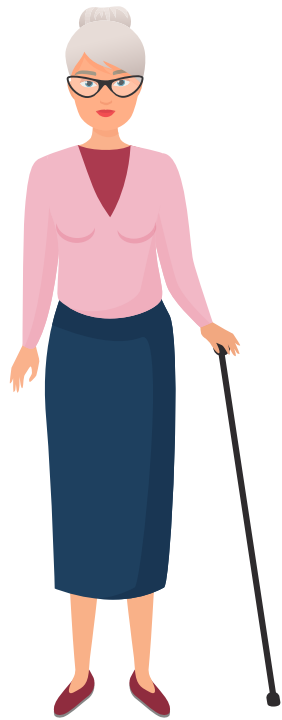


 zipster



HOW DOES IT WORK?





SOCIAL SCREENING

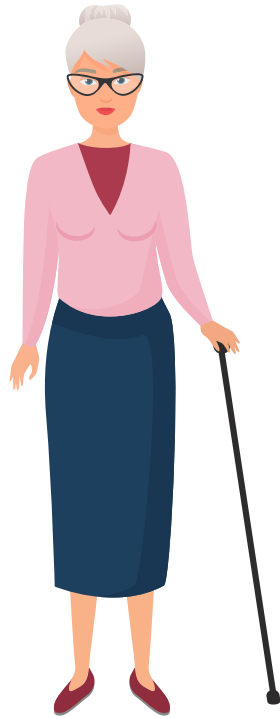
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HOW DOES IT WORK?





Loneliness



Need for administrative support

PSYCHOSOCIAL NEEDS DETECTION

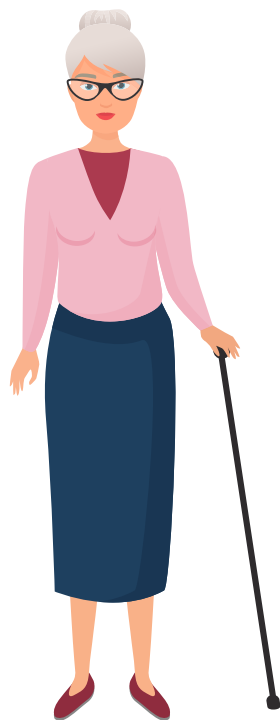
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HOW DOES IT WORK?





SUGGESTION LOCAL SERVICES

3

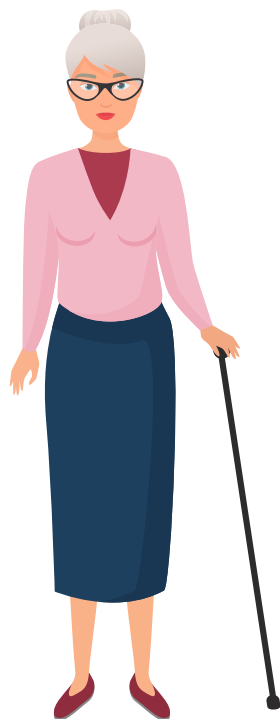


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HOW DOES IT WORK?



Taking into account residence, age, ...



SUGGESTION LOCAL SERVICES

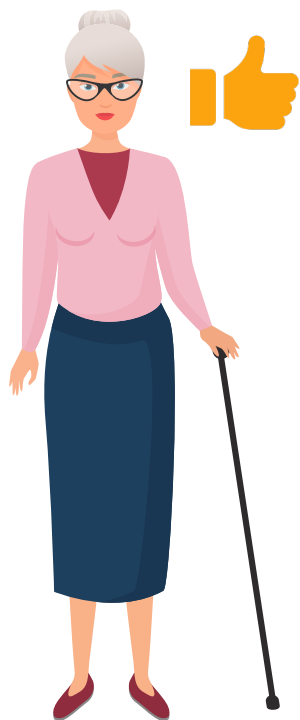
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HOW DOES IT WORK?



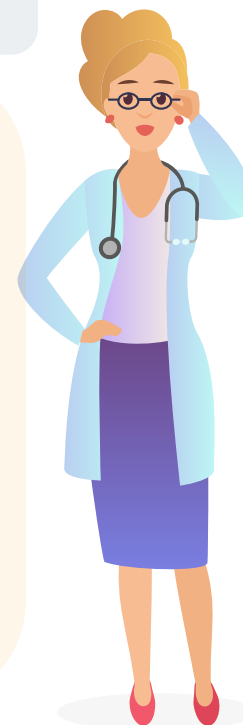


With approval of the patient



REFERRAL

4



1

HOW DOES IT WORK?



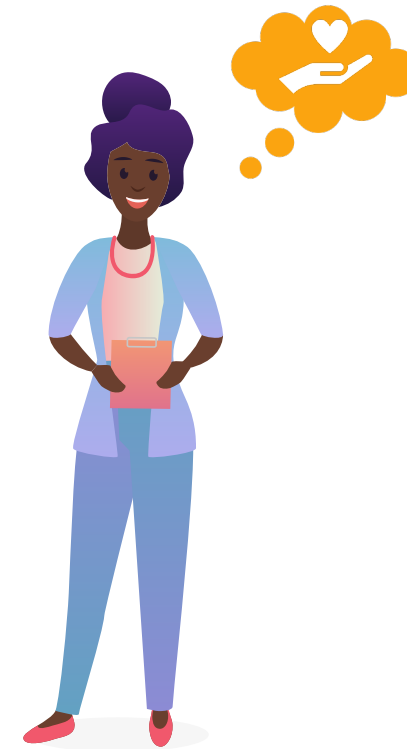
DORA



Dora works for the **CAW**

Helps people with diverse social needs ranging from loneliness, housing needs, mental wellbeing, administrative support, insufficient income, ...

Dora can consult the referrals via Zipster



HOW DOES IT WORK?



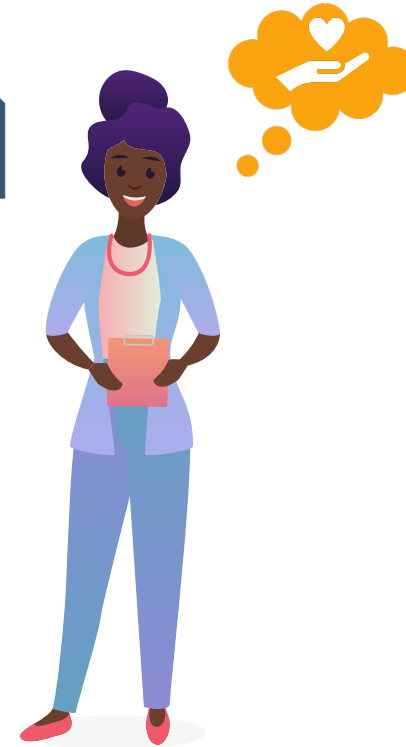
REFERRAL VIA ZIPSTER

From
GP Mary

Who
Anna

Social Needs
Loneliness
Need for administrative support

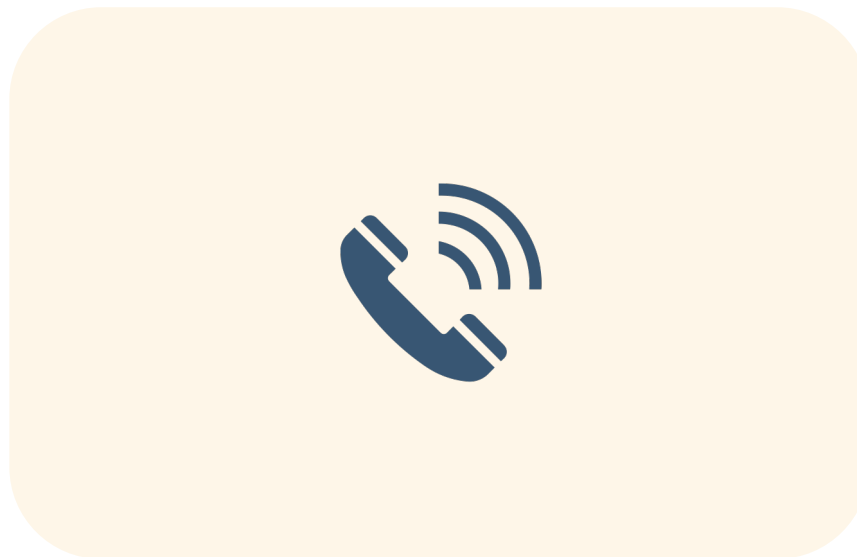
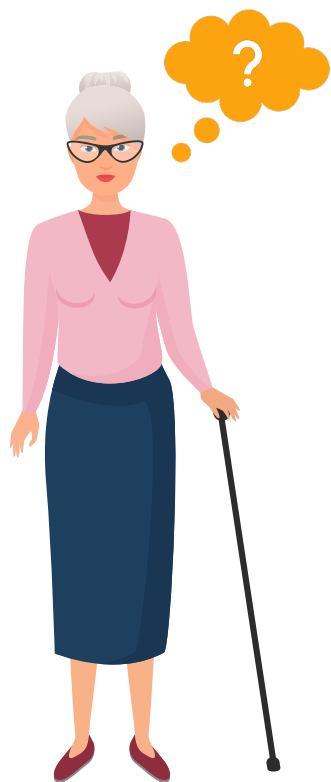
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HOW DOES IT WORK?





HOW DOES IT WORK?





FEEDBACK VIA ZIPSTER

We will support Anna!

FOLLOW-UP

5



CAW
versterkt welzijn

HOW DOES IT WORK?

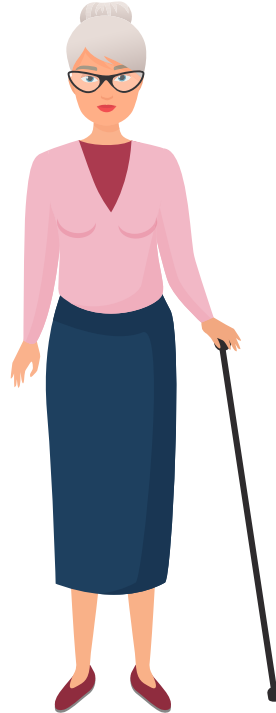


GP MARY



Can detect needs and refer patients

ANNA



Gets timely the most appropriate support

DORA



Can support people that might have not reached out for help otherwise

HOW DOES IT WORK?



A **digital tool** such as Zipster **can make it easier** to do **Social Prescribing**, even when there is no one to take up a Link Worker's role.

KEY TAKEAWAY



- <https://youtu.be/O9azfXNcqD8>
- <https://forumcentral.org.uk/glossary/>
- <https://www.socialprescribingnetwork.com/>

<https://www.communityfirstyorkshire.org.uk/resources/toolkits/social-prescribing-toolkit/>