National Academy for Social Prescribing

Cheltenham Peripheral PCN

Interview with Susie Purslow – Lead Social Prescribing Link Worker

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Key lessons

- Knowledge of community development approaches and the social model of health helped develop a team proactive and responsive to local needs and assets.
- Social prescribing delivered as part of a multi-disciplinary team with a frailty nurse enables access for patients to holistic personalised care and support.
- Asset based approaches and good local relationships help realise the potential of people to help themselves and others.
- Recognition of the value of the VCFSE, collaboration and equal investment in social prescription benefits the community.

What is Cheltenham Peripheral PCN?

Cheltenham Peripheral Primary Care Network (PCN) is made up of five surgeries on the outskirts of Cheltenham covering a semi-rural area with some very isolated parts. We have a patient population of just under 54000.

What issues did you want to address?

Using our available data, we know that 25% of our patient population are over the age of 65. This is above the local average, with neighbouring PCNs sitting at 19% and 17% respectively. This is reflected in the data gathered from our social prescribing team who in the last 12 months, identified that 71% of those referred were over the age of 60. Even more interesting, 12% were for people over the age of 90. We believe that Frailty should not be an inevitable feature of growing old and that the right interventions in a timely manner can increase both health and wellbeing. By using our community development knowledge, and taking a multi-disciplinary team approach, we want to offer our older patients personalised care and support that harnessed the assets within the community.

How long have you been with the PCN?

I joined the PCN in March 2020 as an Additional Roles Reimbursement Scheme (ARRS) funded role. The PCN recognised and valued that I brought a wealth of experience working within communities both as a volunteer myself and in a variety of paid roles. I have completed a wide range of training, including Asset Based Community Development (ABCD) alongside the NHS Social Prescribing training, and have gained my level 3 Social Prescribing Qualification.

What did you do when you started the role?

I was given the opportunity to build the Social Prescribing team from scratch to a point today where we have social prescribing link workers, care coordinators and an ageing well nurse working together as part of a multi-disciplinary team approach. I have day to day management responsibilities for the team and sit on the PCN Board, working closely with the management team advocating for social prescribing.

What helped you develop the team?

My experience of the social model of health helped in building a proactive, collaborative approach embedded within the community to support patients ageing better. Having a good understanding of community development approaches has meant I value the time it takes to build and nurture relationships both with voluntary sector groups and individuals within the local community. I ensure this is embedded as part of the induction for all my team.

How does your team build local relationships?

Day-to-day we have time to build and maintain good relationships with “community connectors” from within the community who know about resources, activities and groups within the local area that could make up a social prescription. For example, we have good relationships with local parish councillors, foodbank coordinators and faith group leaders. This strategy is used because we know asset-based approaches and good local networks help realise the potential of people to help themselves and others. In Gloucestershire there are monthly meetings which bring together many voluntary sector organisations. By being part of these, my team can make strategic connections and ensure intelligence is shared.

How does your team know what the social prescription activities are really like?

My team take part in local social prescription activities themselves so they can authentically and authoritatively match social prescriptions with unmet social needs. Their attendance serves to ensure effective delivery of their role and raise awareness of social prescribing amongst the community. In recent weeks we have participated in seated exercise classes, a coffee morning for carers, attended a dementia tea party at the library, gone to a knit and natter group and visited a community event for people with sight loss.

Why is it important to engage with the community in this way?

This strategy provides a good overall vision of what is going on and helps to identify any gaps in provision. When a gap is identified, we then try and support filling those gaps by bringing together the right people and organisations and facilitating conversations. So, for example we have worked collaboratively with a local charity which runs a programme of arts projects with a specific focus on disability issues and social inclusion.

Together, we secured funding to offer a series of art-based classes. We recognised this creative activity was needed through talking to many socially isolated people who were interested in activities that were not condition focused but also offer social interactions. Not all people living with dementia for example want to go to a group that is labelled as dementia focused. By making a joint funding bid through the thriving communities grant we were able to utilise the charities expertise running courses with our local knowledge, and access to potential participants. We utilised our surgery waiting room screens as well as Facebook pages to help promote the groups. The courses have recently started and are proving very popular. A member of the team attends each session, so any additional needs that are identified can be met.

How does social prescribing work at your PCN?

Our Social Prescribing offer recognises that people are different, and what matters to them varies considerably. We offer face to face appointments at home, at the GP surgery or at community venues. We offer telephone calls and utilise texting if appropriate. Some of our patients like to walk and talk, so we arrange to meet them in a park. This bespoke offer enables us to build relationships with our patients that help to identify their own support needs.

We work at the pace and number of appointments each person needs. Some patients are supported over a few appointments, some over more than six months due to complex situations. There are also unique patients who require support when their mental health is unstable and may take the form of a few appointments in one year and then a few more the following year. We have the flexibility to provide this ad hoc support as a form of supported self-management without which they would deteriorate and need clinical support.

What do you do when you receive a referral?

We always explain that we are ringing from the surgery when we first make contact and that we support patients with any non-medical needs. We hold gentle conversations to find out what their situation is and what support if any they may benefit from. Most importantly, we give them time to really focus on what matters to them and use Health Coaching techniques to support this. We ask how they are, and a range of simple, useful questions such as if they have family, how they manage practical things like changing bed sheets – if it's increasingly challenging or manageable, if they cook for themselves and do the shopping?

We use scenario-based questioning like - on a cold, icy morning with slippery pavements have you got somebody that could get you a pint of milk? These types of questions provide a realistic impression of their situation and help us to identify any unmet needs they may have.

What type of life circumstances you do support through Social Prescribing in your PCN?

Patients may be eligible for benefits such as Attendance Allowance, so we check if they know about it and go through the criteria with them. Whilst we don't fill forms in for people, if they need help, we'll take them or a nominated family member through the types of things they may want to highlight or connect them with local agencies who do have trained staff to support with this. When people are aware of the type of information needed before they start completing the form, they are more successful with the application as a result. Similarly, if a patient is starting to need formal care, we can talk them through how a care needs assessment or financial assessment with social care works. We have a local directory we can give to the patient or family member and are aware of local CQC registered care providers, and what current availability is like. This ensures they have the information they need to make informed choices.

We have people who are over 90 years old, still fit, and active, exercising regularly, maintaining a range of hobbies and interests and very much active within their communities. And then we have others who are very frail and needing a lot of support. Many people have caring responsibilities for elderly relatives, but don’t themselves live locally, and this is another great example where social prescribers can utilise their local knowledge and Voluntary, Community, Faith and Social Enterprise (VCFSE) sector connections to provide information which enables people to make informed choices for themselves. We regularly work with older people who have suffered a bereavement. When you reach the age of 90, and you've potentially been married for 65 years, it can be hard to restructure your life without that person. Equally, when a partner or loved one has gone into a care home, but you have remained at home you can find yourselves having to restructure your life on your own.

How do you provide support on ageing well?

As our experience and expertise as a team has grown, we wanted to explore taking a proactive approach alongside our routine referral pathways. Our Ageing Well Project uses population health management techniques to take a proactive approach towards all patients over the age of 85 years, identifying any unmet medical or social needs,

increasing awareness of support available and offering a stepped approach with targeted interventions to enable an improvement in how our population ages.

We find the patients by using the data and running reports on SystmOne. From this we prioritise anyone without a ReSPECT Form who has had a fall in the last 12 months. ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment. It's a process that creates a personalised recommendation for clinical care in emergency situations, where an older patient is not able to make decisions or express their wishes. It enables conversations with professionals and loved ones ahead of an emergency.

The Project process starts with 12 questions. We ask patients to record how they would describe their health, ask if they have lost weight so that clothing is loose, do they find yourselves forgetting to take medications, have they got a carer in place? We list things like housework, shopping, managing money and ask - do any of these affect your ability to stay well and independent? By asking these questions it gives us, not only a medical overview, but more importantly, an overall picture of somebody's life. When we get the questionnaire responses back, we then hold a multi-disciplinary team meeting (MDT) which consists of social prescribers, care coordinators and our frailty nurse. We also invite colleagues from the Complex Care at Home team who sit within the Integrated Community Team.

Who deals with the medical concerns?

If there are concerns from a medical perspective and they don't have a ReSPECT Form in place, then our frailty nurse will go out and meet the patients in their own home. She will give our patients time and identify any concerns they may have. As a qualified nurse, she can carry out memory assessments, start conversations about advanced care planning and resuscitation and refer to community teams for Occupational Therapy (OT) assessments, or physio as appropriate. She can review medication, take blood pressure readings and if appropriate have conversations on the patient’s behalf around deprescribing with the pharmacy team. Additionally, a care coordinator will carry out a follow up call two or three weeks after the frailty nurse visit. This is to check the patient has understood everything that the nurse has gone through and see if there is any further concerns or questions. Sometimes patients think of queries after the nurse assessment, so this provides an opportunity for those to be discussed.

What about unmet social needs?

If the questionnaire responses highlight other needs such as support needed with day-to-day living, this triggers a social prescribing referral. A 1:1 appointment within the patient’s home is arranged which typically lasts an hour.

This will focus on what matters to the patient, and a social prescription will be drawn up. With every appointment, a direct phone number is left with them in case additional support is required at any point in the future. This also helps reduce the number of non-medical calls going into the GP centre.

Why do you deliver your social prescribing offer for older people in this way?

This Ageing Well project embraces a different way of working - reaching out and talking to patients before they need us. Instead of calls where somebody has just come out of hospital or just started having falls when they need help then and there, it's much easier if we can have conversations, provide support and information, and put together social prescriptions before they actually need it. These proactive conversations cover a variety of topics. We talk about the importance of booking routine flu appointments or attending COVID appointments. We ask if they are still visiting the dentist. We encourage the importance of keeping moving, from specialised exercise classes to daily walks to using the Coronation Street advert break to get up out of your chair, walk to the kitchen, walk back and sit back down again. We talk about the importance of maintaining contact with others and the effects of social isolation.

We try to put into practice the NHS guidance for how to live well and get that message out to as many of our older patients as we can. When a support need has been identified, we'll look at what's available in the local community for them. This is made possible through our excellent links with both the community leaders and the VCFSE.

What if a patient lacks confidence in taking up a social prescription?

The care coordinators play a part too regarding social prescription activities. Some patients need confidence to attend an activity and without a care coordinator meeting them at the venue, to get them “over the threshold”, they would not turn up. Sometimes knowing where to park, and where the entrance is can make all the difference. I've had members of my team meet people off a bus to walk them from the bus stop to the venue for that first time. I've even had a member of staff accompanying a woman to a clothing store as she didn't have any suitable clothes to wear to go to an exercise class. This facilitative support is part of being a social prescriber because breaking down barriers is important to ensure people can access the groups and activities they may benefit from.

Our challenges and how we overcame them

Starting a project from scratch was the first challenge we faced. We needed to recruit staff for the project, which took time both in the recruitment process and in their inductions. We reached out to other PCNs locally, and other Ageing Well initiatives so we could learn from their experiences.
We needed to ensure we were reaching the right patients. This took time to finesse, and we worked with our surgery colleagues including practice managers and data experts at the Integrated Care Board to make this both simple and effective. We reached out to other PCNs locally, and other Ageing Well initiatives so we could learn from their experiences regarding patients too.
We had to build the reports on SystmOne and check to ensure the right data was being pulled. We also factored in time to rerun these regularly as we recognise more patients will turn 85 each month.
Finally, we gave time to colleagues both within the PCN, our surgeries and the wider community nursing teams to ensure they understood our objectives and knew that our work was an additional offer of support. We would be adding value, as we captured up-to-date information about patients, addressed any unmet social needs and made referrals as necessary to specialist teams if needs were identified.

Results

One of the positive results for the PCN with this Ageing Well project is proactively finding patients who have not necessarily had much engagement with their GPs over recent years. We can have conversations with them about future care planning and offer them support with any lifestyle changes they are having to make before they have hit crisis point. Most patients have been so grateful that someone has checked that they are okay, and they appreciate the offer of support. Although the project is still very much in its infancy, the early data is showing that 9/10 people who responded to the questionnaire had an unmet need. 4/10 had a full frailty assessment with our Nurse, 3/10 met with a Social Prescriber, 1/10 needed support from a care coordinator and 1/10 had an onward referral to the Complex care at home team part of the Integrated care team.

Anecdotally, GPs could visibly tell the team was making an impact because there were fewer appointments for older people needing referrals to community services. Patients' feedback conveyed how valued they felt that someone had reached out and checked in with them. There has also been an increase in the number of completed respect forms, that the GP can easily access if needed.

Thanks for the very thorough assessment of this chap, he was very complimentary about your care. I have called him today to further assess the blood pressure issue you highlighted.

GP Partner

We are very grateful for the help and support my father has had; it was so nice to know that support is there if we require it. We will definitely be using the Social Prescribing service again in future should we need to.

Son of patient

The Ageing Well project is a wonderful initiative and is long overdue for vulnerable older people.

Daughter of patient

What’s next?

Future plans would see an increase in the size of the team. Our Frailty nurse currently works 22.5 hrs a week and we have already identified a need to increase this capacity. Increasing the size of our team will enable us to offer the Ageing Well service to a wider range of patients. We know that we have a high Percentage of our population who are over 65 in the locality and would to love to engage earlier with individuals to enable them to live well for longer.
We have ambitions to host an “Ageing Well” community event, where we can bring together a number of VCFSE organisations to create a one stop shop event, which would showcase what the local community has to offer our older population.

We will continue to identify gaps within local provision and hope soon to increase the seated exercise options within the area by facilitating conversations between the right agencies. We would also like to start conversations to explore seated and supported exercise options for those who are housebound.