



# Three Month Social Prescribing Impact Report from York CVS June 2020



## Introduction

A collaboration between York CVS and the newly formed Primary Care Network's in York began in January 2020. This collaboration was the first steps in ensuring that Social Prescribing was consistently available within Primary Care, as outlined in NHS Long Term Plan. This one year pilot has set out to explore how by working together with the voluntary sector we can improve wellbeing outcomes for patients registered with GP Practices in York. Our model of work reflects a holistic person centred approach to working with people, we have the time and opportunity to explore not what is the matter with people but what matters to them. The aim of Social Prescribing is to empower individuals to take more responsibility for their own health and wellbeing and to identify support networks within their community and to reduce the number of patients attending the GP's with non-medical conditions that may well have a social solution.

However, before this work was able to take off Covid-19 arrived. This report has been compiled to provide a snap shot of the work that has been carried out by the Social Prescribing teams during the three months March 2020 – June 2020, at the height of the Covid-19 Pandemic. When we went into lockdown York CVS offered a hotline number to all the PCN's that could go into their call menu. This number was staffed by the Social Prescribing Link Workers (SPLWs) and the team at York CVS and provided social and emotional and wellbeing support. We quickly became aware that a number of people were experiencing significant isolation and loneliness and began making weekly welfare calls, alongside a team of volunteers, to a number of patients across the City. We also made calls to lists of people who were coded as frail, shielding, Carers and patients living with a Dementia diagnosis.

In May York CVS was contacted by Andrew Lee at the CCG and asked to work alongside Nimbus Care Ltd. As part of the Covid-19 Monitoring Hub. This was set up to ensure that individuals who were symptomatic for Covid-19 were contacted on day 1, day 3 and then every day from day 7 to 14. This was identified as a need when it was recognised that on days 7 to 10 the symptoms of Covid-19 could worsen and it was necessary to ensure individuals had access to the medical support they needed.

**Moving forward:** SPLWs are part of both the general practice and community response to Covid-19, working to ease some of the pressure on primary care. They are currently carrying their own caseloads, as well as supporting shielded and other vulnerable groups. It is predicted that the pandemic will have an impact on health and wellbeing beyond the immediate crisis, and the hope is that SPLWs will be integral to primary care's effective response. Alongside this SPLWs are well placed to contribute to addressing health inequalities which have been highlighted during the pandemic.

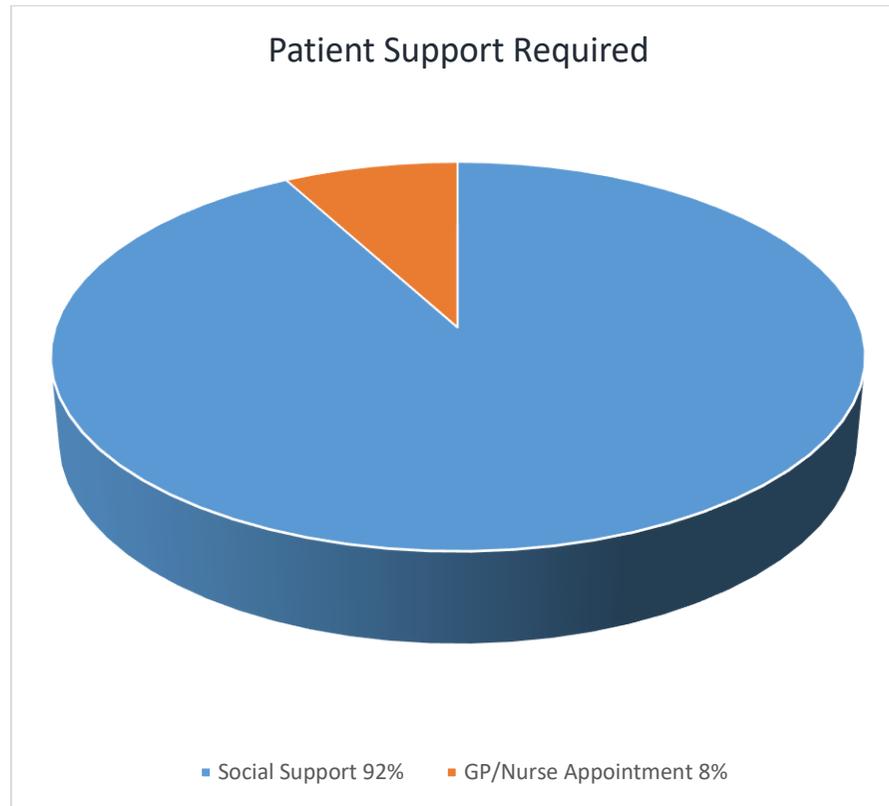
# What We Did



1,759 people supported



Saving  
Primary Care  
of £56,525



## IMPACT

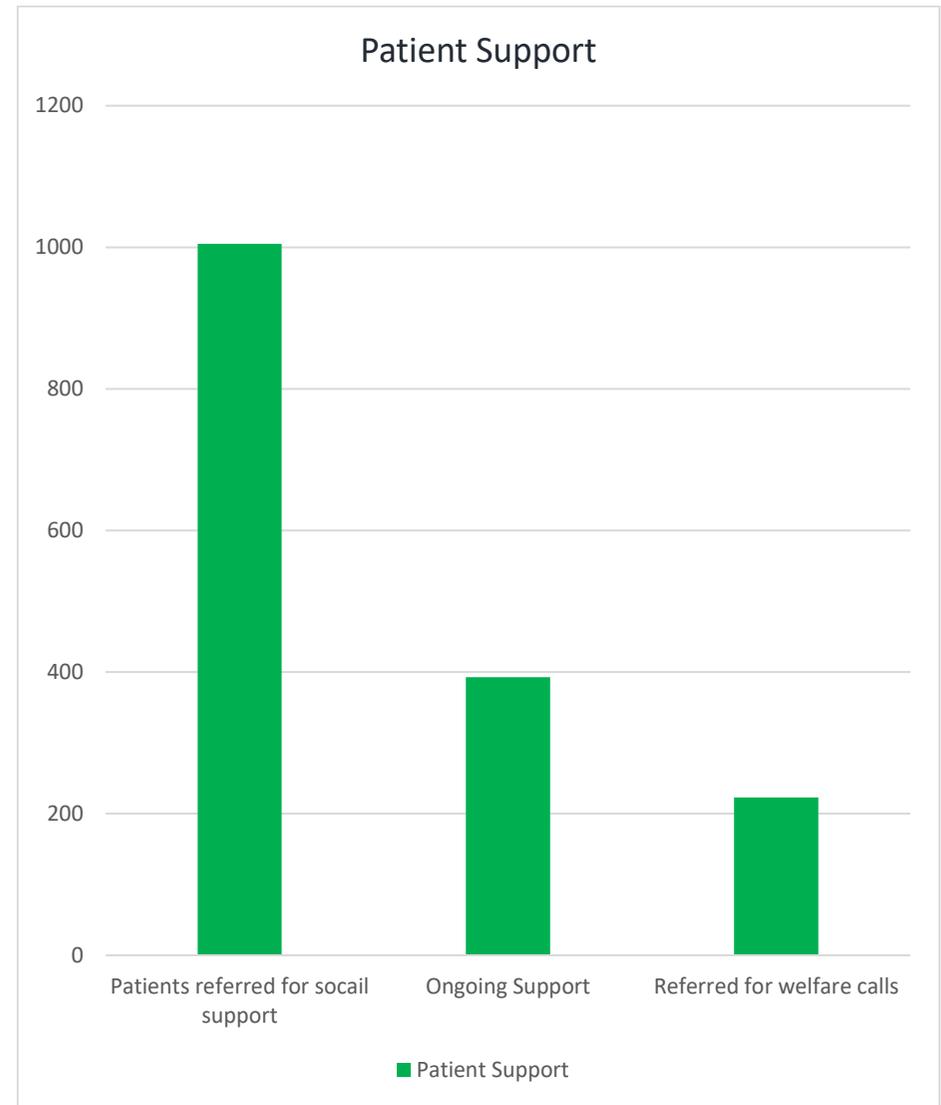
- Over the last 3 months we have supported 1,759 people
- Of the number of patients that were referred to the Social Prescribing team or contacted the Social Prescribing number only 8% required an appointment with a GP or Practice Nurse
- This equates to saving Primary Care £56,525\*

- 1,005 PATIENTS REFERRED FOR SOCIAL SUPPORT
- 393 PATIENTS CONTINUE TO RECEIVE SUPPORT FROM THE LINK WORKER TEAM OR WELFARE CALLS
- 223 PATIENTS WERE REFERRED TO THE WELFARE CALL VOLUNTEERS
- 876 WELFARE CALLS MADE
- THIS EQUATES TO SAVING PRIMARY CARE £30,660

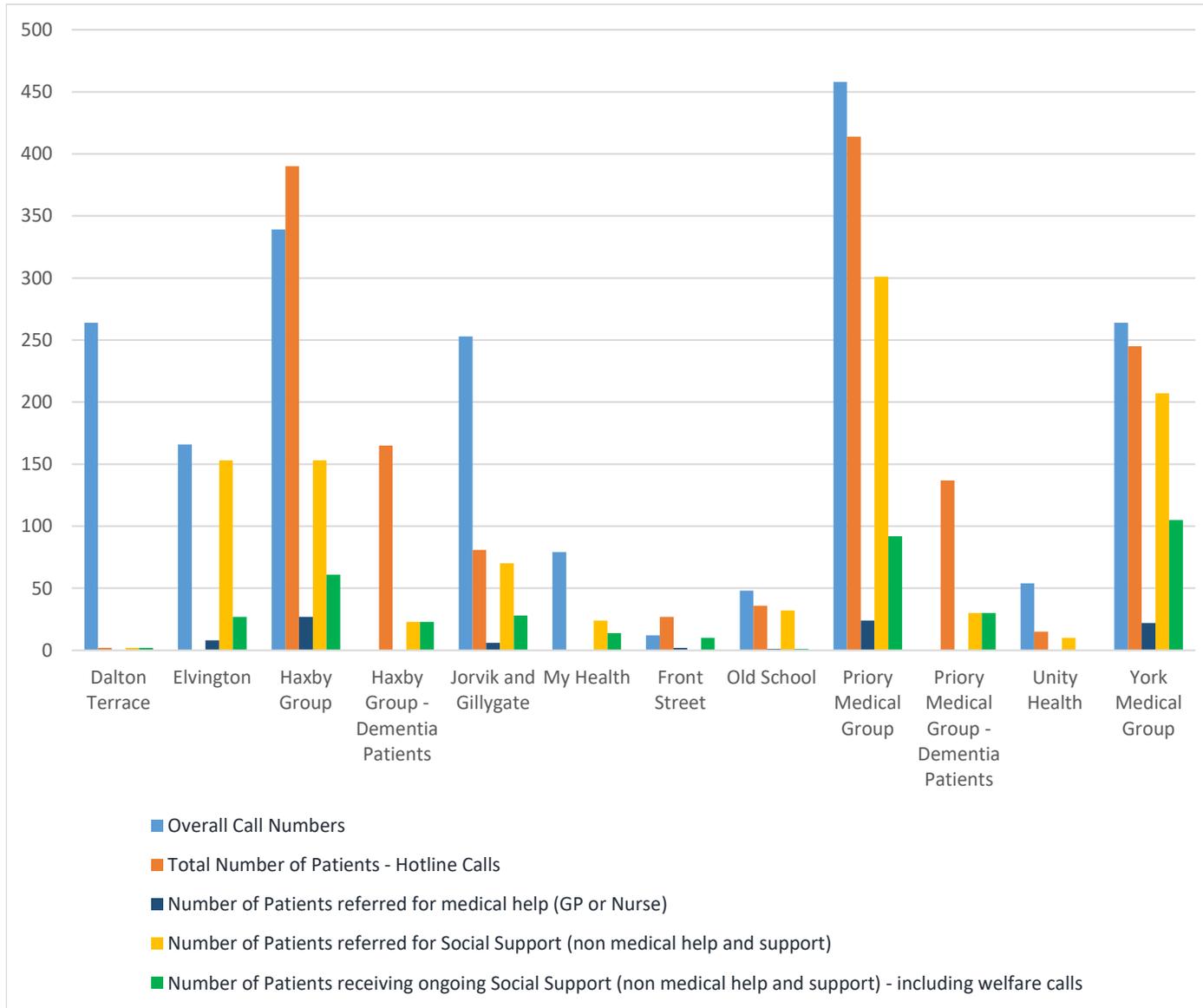


876 welfare calls made

Savings to Primary Care of £30,660

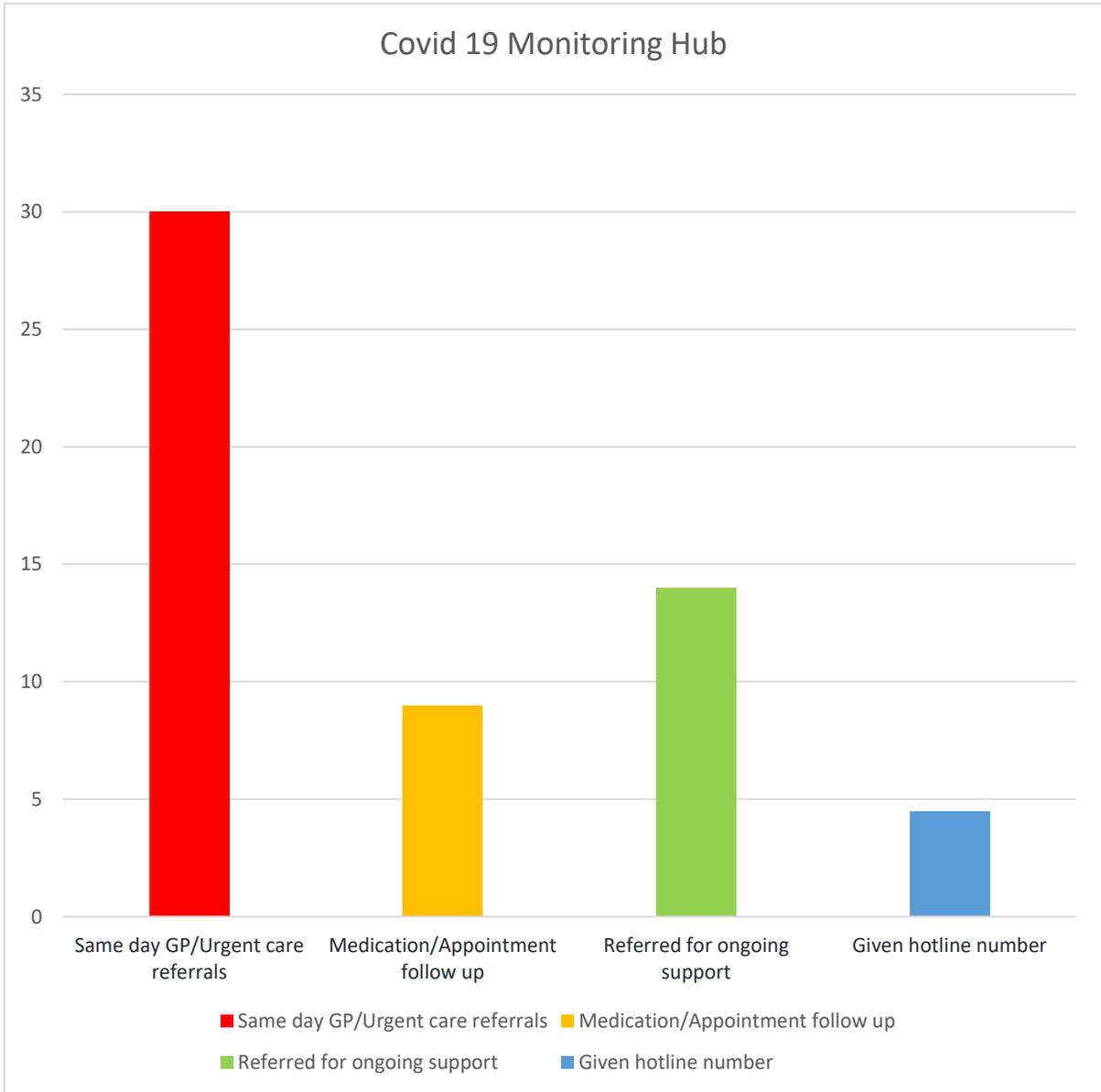


The data below shows the impact the Social Prescribing team had within specific practices, the data provided includes all calls received, referrals received and proactive calls made to vulnerable and shielding patients.



- Supported a number of vulnerable individuals identified by their GP to successfully amend prescriptions and arrange delivery or collection of medicines.
- Provided support for people with learning difficulties to understand the importance of staying home and how to access support.
- Put plans in place for individuals living with Dementia to receive a daily welfare call.
- Supported individuals in crisis to access same day appointments with their GP and/or made referrals to Adult Social Care and the crisis team.
- Arranged patient transport for individuals who otherwise would not have been able to attend their appointments.
- Arranged for emergency food parcels to be delivered to those most in need, when this has been the only option. When there has been no other option we have delivered it ourselves!
- We have worked closely with staff in the surgeries to ensure that those individuals who need medical support have received it.

7<sup>th</sup> May 2020 - 30<sup>th</sup> June 2020



350 PATIENTS RECEIVED MONITORING CALLS

- 30 PATIENTS REQUIRED SAME DAY GP/URGENT CARE REFERRALS
- 9 PATIENTS REQUIRED MEDICATION/APPOINTMENT FOLLOW UP
- 14 PATIENTS WERE REFERRED TO RECEIVE ONGOING SUPPORT FROM THE LINK WORKER TEAM OR WELFARE CALLS
- 13 PATIENTS WERE GIVEN THE HOTLINE NUMBER FOR SUPPORT



350 patients called

6  
\*Where the cost of each GP appointment is £35 (this does not take into account repeat appointments)

## The Impact (stories)

We supported an Elderly lady who was living with her daughter and grandchildren. Her Daughter was hospitalised with Covid-19 which meant there was limited income coming into the house and this was impacting their ability to shop for food and other essentials. The lady was extremely distressed and unsure of her options for support. The Social Prescribing Link Worker initially ensured prescriptions and food were being delivered, then liaised with Adult Social Care, alerting them to the current situation. Adult Social Care are now monitoring the situation and carers are going in to the home. We will continue to make welfare calls to this lady and work alongside Adult Social Care.

An existing GP referral for a very isolated lady has meant that she has benefitted from our continued support over the phone instead of face to face appointments. She lives with her cat and, other than a member of our team, wasn't speaking to anyone else. Through rapid changes to the service we've been able to arrange for a volunteer to call her once a week for a social call. She said speaking to another human over the phone makes such a difference. A social prescriber talked to her about practical ways to manage her mental health at home. We searched online for community based alternatives and she has now started watching the National Theatre at Home plays online each week. Crucially, this also enables her to chat with others who are online. We also explored ways to stay physically active at home and manage anxiety with online yoga. A referral to York Mind's adapted 1-1 emotional wellbeing support over the phone means she's getting more practical tips to manage her anxiety and mood. At the moment she's still picking up her prescriptions, but her anxiety meant she was very worried about what happened if she or her cat became unwell – now that a volunteer is checking in each week and she knows Move the Masses can bring out prescriptions and there are options for 'click and collect' food delivery her anxiety has lessened as she knows help is out there if she needs it.

### IN SUMMARY

-THIS PIECE OF WORK IS A 12 MONTH PILOT; PART OF A BIGGER 5 YEAR CONTRACT IN -LINE WITH THE NHS LONG TERM PLAN.

-THIS IS THE FIRST ATTEMPT (SINCE STARTING THE PILOT IN FEBRUARY) TO QUANTIFY THE SOCIAL AND ECONOMIC VALUE OF SOCIAL PRESCRIBING IN PRIMARY CARE.

-THIS REPORT IS EVIDENCE OF THE YORK CVS RESPONSE TO COVID – 19. OUR NEXT STEP IS TO ENSURE THAT OUR SOCIAL PRESCRIBING OFFER IS FULLY ALIGNED WITH THE PLANS OF EACH PCN, MEETING THEIR NEEDS FOR THE FUTURE.

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***We appreciate and value your feedback please contact [christinemarmion@yorckcvs.org.uk](mailto:christinemarmion@yorckcvs.org.uk) with any thoughts or feedback. Thank you.***

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