Social prescribing

How do we know it is reaching those who need it most?

Authors

Clare Mahoney
Helen Duckworth
Liverpool Clinical Commissioning Group

Debbie Nolan
Citizen's Advice South Liverpool

Overview

In order to inform new models of primary care, we set out to deepen our understanding of the relationship between illness and social and economic hardship in the context of Liverpool health services.

The problem

Good clinical care accounts for 20% of what makes us healthy, compared to 40% for social and economic factors. We wanted to know what health services should do to reach vulnerable patients and help remove barriers to health and wellbeing.

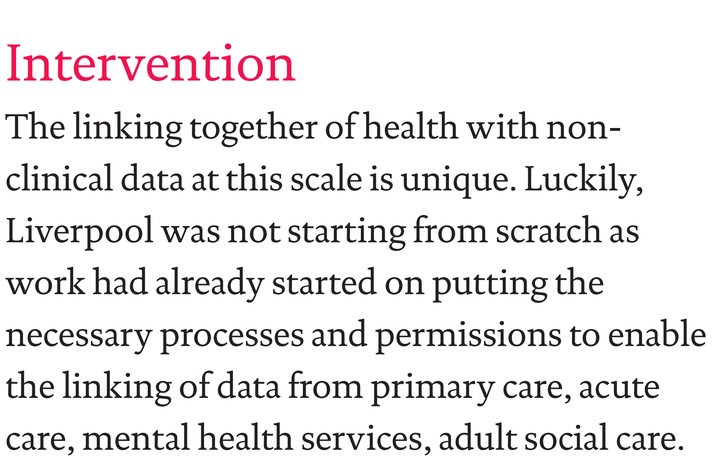
Could we find a way to link person-level data from our clinical and social prescribing case-management systems? And if we did, what could it tell us?

Intervention

The linking together of health with non-clinical data at this scale is unique. Luckily, Liverpool was not starting from scratch as work had already started on putting the necessary processes and permissions to enable the linking of data from primary care, acute care, mental health services, adult social care. The steps we took to include data from the social prescribing service were made easier as a consequence.

We linked person-level data from our Citizen's Advice social prescribing service, covering April 2015 – Sept 2018.

Figure 1.



The preliminary analysis focused on:

- What is the demographic, socio-economic and health profile of the clients that have utilised the social prescribing service?
- What are the health and social care service utilisation patterns?

Results

Our study finds that financial and social hardship is so intrinsically connected to poor mental health, that when used as a criterion to identify patients who would benefit from advice and support, the majority are also found to have multiple physical health conditions.

Figure 2. Number of different long-term conditions per client

We knew that social prescribing was reaching some of the poorest people in the City. We also learnt that they were living alone (47%), female (55%), and between 40 – 65 years old.

> 'These are the patients that keep coming back to surgery, and every experienced GP knows who they are…the woman who asks for sleeping tablets - because worrying about her debts keeps her awake at night, the carers who can't cope with the financial stresses that caring places upon them, the young mothers who are making choices about whether to eat a meal or heat their homes, they are the patients who we cannot treat with medicine'.
>
> — Liverpool GP

> 'Can it be spread to other services?'
>
> — Lead Nurse, Respiratory Community Services

Lessons learned

Social prescribing can help stratify for proactive care by highlighting financial and social risk factors.

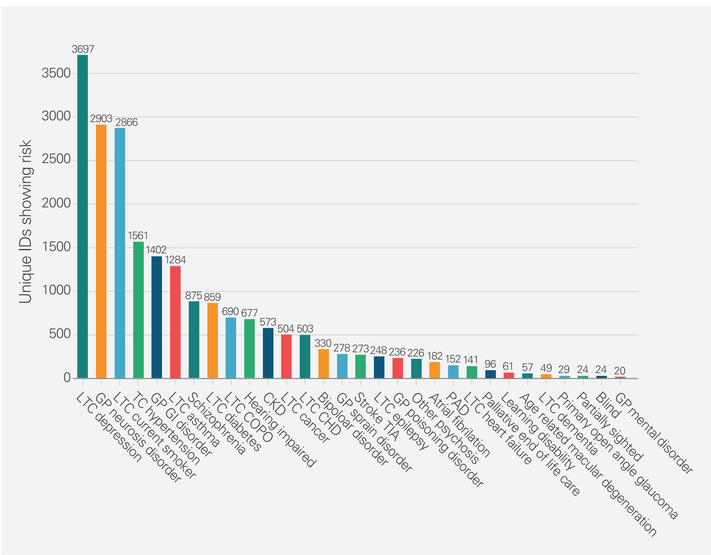
Collaboration pays off. The benefits of having Citizen's Advice as a partner have been immense. Culturally the voluntary sector is more inclined towards flexibility and creative problem-solving, and we needed both on many occasions.

Don't wait to the end to start dissemination. Citizen's Advice helped us establish a national and a local profile for the project.

Next steps

- Dig into the data and do further analysis, particularly for patterns of service utilisation.
- Use the findings to influence our growing social prescribing model.
- Develop an algorithm that measures health and well-being outcomes, using a range of markers from the linked data-sets.

Figure 3. Long-term conditions in the study cohort compared to the general population



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