Social Prescribing for long term conditions, a public health issue
...or.....Ways to Wellness

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Northumbria University and Chair, Ways to Wellness

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These are summary notes to accompany the presentation made by the above named speaker, as one of the knowledge exchange seminar series organised by the Fuse knowledge exchange group and is to be read in conjunction with the slide set, available on the Fuse website. Where SIB appears in the slides, it refers to Social Impact Bonds.

Professor Drinkwater introduced himself as the Chair of Ways to Wellness, and it was in the latter capacity that he delivered this seminar. Slide 2 depicts the dichotomy between the bio-medical model of health (very much about treatment) and the social model which concentrates on individuals and the communities they function in, with the philosophy that ensuring people’s general well-being will help secure their long term health and reduce their dependence on NHS, and, in particular, hospital services. Professor Drinkwater made the point that the hospitals and secondary care services in general required a lot of resources and that in the north east there has been prodigious investment in plant (referring to new buildings on Trust sites) and yet there is a clear indication that social circumstances determine health. Thus much more needs to be done at the individual and community end of the spectrum.

A definition of Social Prescribing is given in Slide 3 together with a link to a website providing more information, called, for short, “Thanks for the Petunias”. Slide 4 depicts a baseline mental health survey done by Newcastle New Deal for Communities. This identified a group of men aged 45-55 with the characteristics indicated. The response to identifying this cohort was to employ a health trainer who worked directly with this group of men and set up a fishing group. The positive health benefits of doing this are listed in Slide 5. Slide 6 depicts the monetary implications of setting up multiple communities for health, of which the fishing group was an example. Professor Drinkwater argued that these communities were not expensive and a good deal cheaper per person than, say, the medical alternative of prescribing a year’s worth of anti-depressants. Focus groups indicated that the typical person in these communities never attended a gym but as a result of being part of the process they did start attending a ‘gym’ but of a non-standard type (i.e.; not a commercial gym with expectations of wearing special clothing and a professionalised approach).

Slide 7 depicts a diagram, again drawn from “Thanks for the Petunias”. Within the diagram, the pink areas illustrate the medical care pathways, and the green, social prescribing. People at the self-care end of the diagram, just need a nudge to take steps to improve their health, whereas people at the other end of the diagram, due to their social circumstances, need a lot of input to obtain a similar outcome, and this is an illustration of the Marmot
principle of “proportionate universalism”. Ideally with the right support, people would move from needing high input to managing much more of their care by themselves, and at considerably lower cost to the health services. Slide 8 depicts a model of commissioning illustrating a similar theory to Slide 7. A key point to bear in mind is that generally people are responsible for their own health care because their contact with professionals is a very small part of their lives.

“Thanks for the Petunias” developed into NESTA, described in Slide 9. The main aim of NESTA is to design in conjunction with service users and that co-production is important “across the board”. Ultimately people need to feel that they can change their behaviour and that they are empowered to do so. Professor Drinkwater suggested to the audience that they peruse the NESTA website. There are savings to be made (see the final point on Slide 10) and the underlying issues are how is this approach embedded and scaled up? In his vision, Professor Drinkwater said that there would be, ideally, pooled place-based budgets which in the longer term would benefit all strategic agencies. The rationale should be about moving away from excessive medical dependency, addressing those he described as “under the bar” and identifying vulnerability so that social prescribing could be brought into play. He argued that it was not hard, as a GP, to identify vulnerability, it might, for example, be someone who lives alone, recently bereaved, and in receipt of four or more prescribed medicines. Clustering of these types of characteristics summed up a representative profile of a vulnerable person. It remained the case that the gap in healthy life expectancy between different social groups was much larger than the gap in life expectancy as such, and correspondingly the time spent coping with chronic ill health was much less for those in socially advantaged situations.

What is Ways to Wellness? The key elements of this initiative are shown in Slide 12. Securing money to fund the project was not easy as statutory agencies can’t easily disinvest – hence seeking funding from the bodies included in Slide 12. Ways to Wellness will be a seven year project operating outside the commissioning cycle and in those seven years it would need to ‘prove’ a financial saving and then be handed over. In the meantime social investors have been approached to provide the funding. The current sources of funding (listed in the final bullet point on Slide 12) together are providing significant support. Slide 13 illustrates the model of operation of Ways to Wellness, where the latter acts as a broker between Clinical Commissioning Groups (CCGs) and social providers. In terms of sourcing social prescribing providers, Ways to Wellness has moved away from the concept of a lead provider.

Slide 14 is headed “Why an outcomes contract” and lists the reasons for this. Professor Drinkwater commented that the reasons reflect the modern world. One useful benefit is that the employment of health trainers is proving to be a source of job creation in its own right. Slide 15 shows the challenges – there are many issues listed and some of these revolve around how to market the Ways to Wellness approach. Slide 16 shows that there appear to be about 5,000 patients who could benefit, each year, from social prescribing. The link workers referred to in this slide could potentially become health trainers with the right training; however link workers are a good place to start because of their in-depth knowledge of the areas where they work. There will be a need for a common management system for future providers.
Slides 17-19 are about the selection of metrics to measure the effectiveness of Ways to Wellness. There is a human tendency to collect everything, so an attempt was made to reduce data collection to the essentials. The stress was on scaling up and not creating a research project. In defining the metrics (Slide 18) it might have been tempting to pick a single disease, but it was agreed that people were more important than a given disease and therefore a generic approach was taken. Slide 20 lists the proposed target groups, which are about looking for conditions characterised by poor health but with scope to improve. A key point is to act early to change patterns of behaviour that can otherwise become entrenched. 40% of people with long term conditions also have significant depression so working in this area is of clinical importance. In Newcastle West CCG there are high levels of prescribing of anti-depressants (above what might be expected for a deprived area) so any action that can reduce this will be critical for improvement in health. NEQOS (North East Quality Observatory System) was commissioned with some of the funding referred to in earlier slides, to help identify the 3 metrics set out in Slide 19, so, for example, bed days was chosen deliberately in preference to A&E attendances. The yearly intake of approximately 5,000 patients should enable statistical significance to be demonstrated through the data collection, and, there is the added benefit of using data that is already collected routinely.

GPs were divided in their enthusiasm for social prescribing, so, some, for example, saw their role strictly in medical prescribing terms and nothing more, which was why time was taken to work together on the criteria for the proposed target group described in Slide 20. One aim is to develop software which will prompt GPs to recognise people with long term conditions who could benefit from social prescribing on their usual visits for consultations in the surgery. Slide 21, on attribution, perverse incentives and “gaming” recognises that there will be changes in the environment that health professionals work in. It’s now understood that following up on, say, an exercise programme is no good just at ten weeks but needs to be much longer term to embed change, for example, at one year. Finding out if people are still active at one year will help determine which provider to work with in the longer term, based on results. It will be important not to create dependency, so effective discharge from the process will be critical.

With respect to the slide headed “Current Situation” (Slide 22) Professor Drinkwater commented on the high level of interest shown in non-executive director positions, well outstripping the number of positions available as indicative of the high levels of interest in Ways to Wellness. This slide also gives the weblink to the procurement prospectus. Slide 23 headed “Challenges” indicates the significant amount of money required for the project and reference was made to a £1.5m bid to the Big Lottery. It was explained that the providers would appoint the link workers. An ultimate goal would be that patients would actually ask for social prescribing, and, already some patient champions are creating case studies in their own right. The evaluation requirements of the Big Lottery fund are listed in Slide 24.

(For discussion, please see Page 4)
Discussion

Discussion took place on the following topics:

Q – Where are link workers based?
A – Professor Drinkwater referred to the Brazil model (1 GP, 2 nurses and 4 health community workers) which seemed like a good formula, but a concern of placing link workers in surgeries was that they would be “captured” by GPs. Link workers should be based in voluntary organisations but linked to surgeries and the neighbourhood. They must be out in the community.

Q – A questioner suggested that on the basis of the figures presented there would be almost nothing for a provider’s fee – where would the funding come from for this aspect?
A – This needs working through, although in some cases there will be overlapping activities, which could be streamlined or pre-existing activities that could be tapped into. [The questioner responded by debating how bed days as a metric were attributed, whether there could be any kind of control group and what the payback to investors would be.] It was noted that payback could be the subject of a separate lecture. In addition a comment was made that the whole care team in primary care was included and that identifying and following up on the estimated 5,000 patients was not just a GP responsibility.

Q – Who is investing in the scheme? Can link workers have sufficient knowledge to span all the possible topics that might come up in their work?
A – Examples of investors included Big Society capital and social impact bond investors in general, who were easily found with an internet search. This triggered a series of suggestions about whether companies not perceived as having strong public health priorities such as Greggs and Nestle could invest. Professor Drinkwater explained that as far as possible Ways to Wellness sought ethical investors. In terms of the link workers the key thing was that knowledge of communities outstripped technical knowledge. Link workers were provided with some training in motivational interviewing and some information about long term conditions as the core of their preparation. There was an awareness that GPs would tend to refer on their most problematic patients (i.e. who they found disruptive) and that there was a need for specialist back-up. On the whole though, GPs tended to over-protect their patients, in Professor Drinkwater’s opinion.

AR/CD final as at 11\textsuperscript{th} March 2014
Ways to Wellness

Professor Chris Drinkwater
Chair, Ways to Wellness
Re-balancing the bio-medical & the social: Looking in both directions

Choosing Health White Paper 2004
What is Social Prescribing

A means of addressing the social, psychological and emotional needs of patients.

- Physical activity
- Healthy eating/cooking
- Arts for health
- Befriending
- Welfare rights/benefits
- Volunteering opportunities
Newcastle NDC baseline mental health survey (2001 & 2005)

Men aged 45-55

- Living alone - 49%
- Economically inactive - 58%
- GHQ above threshold - 63%
- Associated high levels of smoking, alcohol consumption and obesity.

Newcastle New Deal for Communities 2000 – 2010
Social Prescribing - Outcomes

- Supportive social network
- Increased self-esteem
- More physically active
- Better nutrition
- Decreased alcohol/smoking
- Better diabetic control
Communities for Health
Building supportive social networks for vulnerable older people and people with LTCs

• Referral pathway from GPs established
• Consortium of providers
• Over **426** people referred
• Costs range from £244 per person for the higher level of support and £70 per person for the low level/preventative work
• Over 200 previously sedentary individuals now taking part in regular physical activity

LA “Communities for Health” funding - 2008
Condition specific care pathways
COPD, Diabetes, Obesity, Mental Illness, Older People, Learning disability

Initial assessment/stabilisation

Annual care planning

Menu of activities related to needs/dependency

Self care
- Own programme

Minimal support
- Direct access to services with initial induction and regular review

Moderate support

High support
- Link worker personalised programme and intensive review

Medical

Social

£££ £ £
Commissioning for Long Term Conditions: The learning

Traditional Biomedical care
- Complex / specialist / inpatients
- QOF / Surveillance / medication

Added value
Year of Care
Co-production

Supporting self management
In the health service
- 1:1 consultation
- Care planning
- Joint decision making
- Structured patient education

Supporting self management
In community
- Living with long term condition
- Life style issues
- Community support / social capital
- Public health / well being

From Year of Care Programme at www.diabetes.nhs.uk/year_of_care
NESTA – People Powered Health (PPH)

- Co-production models.
- Equally important for LTCs, public health and social care.
- Acknowledges importance of social networks in normalisation
- Activation of people to make the best decisions for them.
- Enhances self-efficacy

http://www.nesta.org.uk/project/people-powered-health
NESTA PPH Outputs

• Changing the nature of the consultation.
• Peer to peer support models
• Local integrated networks
• Commissioning: embedding innovation in practice.
• Business Case for PPH – estimated savings of £4.4 billion per year if universally adopted.
Commissioning social prescribing

Pooled place-based budget

Health & Wellbeing Board

Rationale
- Integrated approach
- “No health without mental health”
- Need to address vulnerability before it becomes expensive dependency.
- Better outcomes for long term conditions
- Local social capital
- Addressing gap in healthy life expectancy
What is Ways to Wellness?

• Uses a social impact investment solution – no risk to CCG and moves away from restrictions of annual commissioning cycles

• Minimum 7 year project

• “Phase 3 of social prescribing in Newcastle West”

• Hosted by VONNE - secured £130k development funding from SEIF and £7.5k from ACEVO + further £150k from Lottery Commissioning for Better Outcomes Fund
Social Investment Contracting and Referral Model
Why an outcomes contract

• Commissioner cannot afford to pay for outputs without evidence that they translate into outcomes.
• SIBs provide a rigorous model of thinking this through.
• NHS needs to save money and increase productivity.
• Investors are looking for confidence that they will get a return on their investment.
• Balancing financial with social return on investment.
Challenges

• New and innovative project
• “...how savings are materialised and crystallised so WtW funded from savings ...not an additional cost pressure for CCG?”
• Additional support needed for legals, sense checking, establishing performance benchmarks
• Clarifying Target Group
• Managing expectations
Service overview

• Social prescribing for approx 5,000 patients per year
• GPs refer patients with LTCs to WtW who match patients to activities
• Link Workers motivate and action plan with individuals
• Progress tracked through Management Information System with regular feedback to GP.
Principles behind metrics choice

• There should only be a few contract measures – keep it simple
• Have a spread that includes patient reported improvements and actual health service use levels
• Has to be practicable – there is a cost to very measure and some are more expensive than others
• This is not a research project, it is an exercise that tests the effectiveness of scaling up social prescribing
Defining the Metrics - Background

1. Need to maximise the impact of WtW in terms of scale, target group and financial return – generic rather than disease specific approach

2. Within this group need to focus on those most likely to generate future NHS costs – poor health with scope to improve.

3. Based on existing evidence conditions most likely to generate a return at scale are – musculo-skeletal disease, COPD/asthma, and LTC with co-morbid depression.

4. Need for measures that can be used consistently over time, are associated with financial costs and are easy to collect
# The 3 metrics

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<th>Outcomes Star</th>
<th>Anti-depressant Use</th>
<th>Beddays</th>
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<tbody>
<tr>
<td>Relevance to wtw goals</td>
<td>High</td>
<td>High</td>
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<td>Ability to reflect short / medium / long term changes</td>
<td>Short &amp; Medium</td>
<td>Medium</td>
<td>Long term</td>
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<td>Occur frequently enough to demonstrate statistical change</td>
<td>100%</td>
<td>Up to 40%</td>
<td>Infrequent events but large numbers</td>
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<tr>
<td>Costs / challenges of data collection</td>
<td>Already Routine</td>
<td>Already Routine</td>
<td>Already Routine</td>
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Proposed Target Group
Picked to maximise cost-effectiveness

Conditions
• Arthritis/chronic MSK pain
• COPD and angina
• LTCs with depression

Inclusion criteria
• Poor English literacy
• Social isolation
• Obese and/or inactive

Judged by GP to have
• Poor understanding of their condition
• Poor concordance with Px
• Willingness/ability to change
• Poor health but scope to improve – not end stage
• Frequent attender
Attribution, perverse incentives and ‘gaming’

• Attribution of effects to external factors – regular review

• Failure to sustain behaviour change post intervention – incentives for providers who succeed in demonstrating long term change

• Cherry picking of easy patients – case mix review

• Hanging onto stable case load – effective discharge policies
Current situation

• Company limited by shares established
• 7 year Contract Heads of Terms agreed with CCG
• Non-Exec Directors being appointed (21 applications)
• Investors being approached and bid to Big Lottery Commissioning for Better Outcomes being prepared
Challenges

• Raising £3 million of investment
• Procuring and managing providers using a shared management information system.
• Consistency in training and delivery from Link Workers.
• Marketing - ensuring referral push from GPs and stimulating a pull from patients
• Overall evaluation
Big Lottery Evaluation Requirements

• Regular performance reports
• Process evaluation
• Impact assessment
• Cost benefit analysis
• Final Report
Thank you for listening

Any Questions?

Further information at
http://www.vonne.org.uk/policy/waystowellness/