

# Social Prescribing for Health and Wellbeing in Haringey

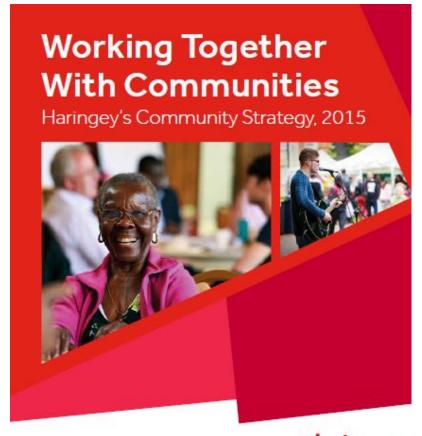
Health and Wellbeing Board 23<sup>rd</sup> February 2016

## National policy drivers behind social prescribing



- Marmot Review (2010) 'Fair Society, Healthy Lives' prioritised the social determinants of health, via correlation between health inequalities and social and economic inequalities;
- Focus on prevention and health promotion as a form of 'managing' rather than treating poor health;
- Encouraging asset-based approaches to improving health and wellbeing, utilising a community's individual, organisational, cultural and physical resources;
- Co-production (service users and professionals jointly design and deliver public services) and citizen participation and volunteering in public sector.

Local policy and strategy drivers



haringey.gov.uk



Building a Stronger Haringey Together

#### **CORPORATE PLAN**

2015-18





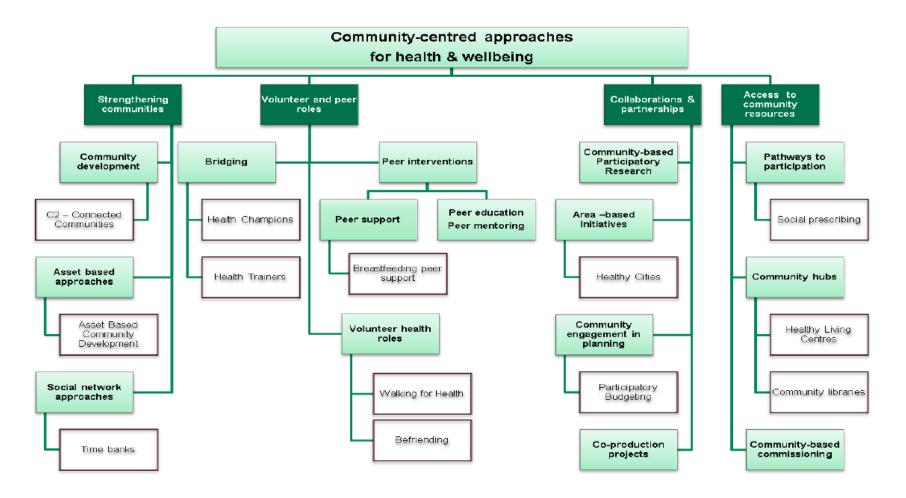


Haringey Health and Wellbeing Board

Haringey's Health and wellbeing strategy 2015-2018

All children, young people and adults live healthy, fulfilling and long lives

# The family of community-centred approaches linked to health and wellbeing



# Social Prescribing (or 'community referrals')



- Linking patients with non-medical support in the community, usually via primary care but there are different models (e.g. community hubs, community navigators)
- Activities include: arts, creativity, physical activity, learning new skills, volunteering, advice on benefits, housing, debts, legal advice, parenting support, etc.



### Models of social prescribing [1]



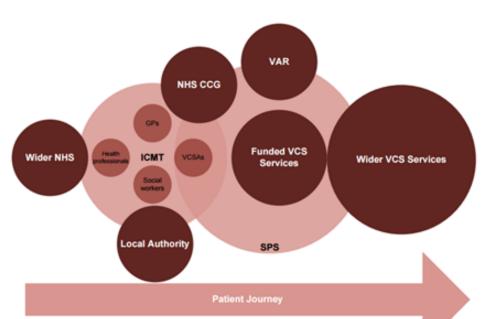


### Models of social prescribing [2]



### Examples







#### Social prescribing through link worker

Patient presents in primary care with nonmedical / psycho-social symptoms

Primary care staff refer patient to link worker based in primary care practice or charity Link worker interviews patient to determine suitable scheme available from directory Patient
attends
scheme and
reassessment
after fixed
number of
sessions (free
or subsidised)

Reassessment is fed back to link worker, patient is signposted to similar activities (often incurring cost)

> Patient (aged 55 years or over) presents in primary care with mental health issues

#### Social prescribing as part of IAPT provision

GP refers patient to IAPT for Step 1 of stepped service (up to 6 sessions of psychological therapy) Counsellor at IAPT refers patient to suitable scheme as adjunct to or while waiting for Step 1 of IAPT

Patient
recovers or if
condition
worsens
moves to Step
2 with further
scheme as
adjunct to
IAPT

Assessment of benefits of scheme for patient is fed back to IAPT, IAPT report on patient is fed back to GP

#### **Outcomes**



- Increased levels of social interaction
- Improved overall wellbeing by improving access to opportunities
- Building confidence, resilience and coping skills
- Reduced levels of service use
- Increased patient satisfaction



#### Does it work?

- Some evidence of effectiveness for people with mental health problems and those with long-term conditions;
- Evaluation programmes not yet sufficiently robust (need for controlled comparisons, not just before & after)



#### Local initiatives and drivers

Neighbourhood connects

JS Medical Practice pilot

Time Bank

Welfare hubs

**IAG** 

Integrated wellness

Locality coordinators

Bounds Green Medical Practice and PPG

Primary Care Strategy NCL Estate devolution

Healthwatch workshop

Cultural & Creative Industries Strategy