NHS
South West London

Social Prescribing Merton

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Social Prescribing in Merton PCNs

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- In 2016 Merton Health and Wellbeing board commissioned a Pilot social prescribing programme
- In March 2019, following the announcement of the PCN DES Contract, SWL ICB saw an opportunity to further enhance the service and deliver a borough wide model.
- SWL ICB approach all Merton PCNs with the offer to commission an enhanced social prescribing model and manage the contract on their behalf.
- In October, SWL ICB in collaboration with Merton PCNs commissioned Merton Connected to deliver Merton's boroughwide social prescribing model.
- This includes the original 3 Link Workers from the first expansion

Social Prescribing – what is it?

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- Links patients to ‘ non-medical’ community basis of support (20 %)
- Many factors affect Health and wellbeing (one factor Social)
- Social need
  - Housing
  - Finance
  - Loneliness
  - Long term condition
- Presenting as
  - Depression underlying bereavement
  - Recurrent infections / respiratory flare ups -underlying poor housing

- Time with patient - Embedded in primary care

The Merton Model of Social Prescribing

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- The Social Prescribing contract for Merton is held by Merton Connected since 2017
- The Merton SP service is one of the most established and mature services in the UK
- The SP team consists of a total of 12 Link Workers, an equivalent of 9 fulltime Link Workers
- Each of the 6 Merton PCN receives support from 1.5 Link Workers
- The project is monitored through monthly contract monitor meetings with the ICB, quarterly quality assurance reports to the ICS
- The project has been clinically evaluated by Oxford University in 2022
- The Merton SP project won the award ‘ highly recommended programme of the year’, National Association of Link Workers’, 2020.

Primary Care Networks

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- There are 6 Primary Care Networks in Merton:
  - East Merton PCN
  - North Merton PCN
  - West Merton PCN
  - North West Merton PCN
  - South West PCN
  - Morden PCN

New referrals received

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Top reasons for referrals

1. Mental Health
2. Social Isolation and Loneliness
3. Financial Advice
4. Housing
5. Support for Cares

October 2022 – September 2023

3745 new referrals received

October 2021 – September 2022

3224 new referrals received

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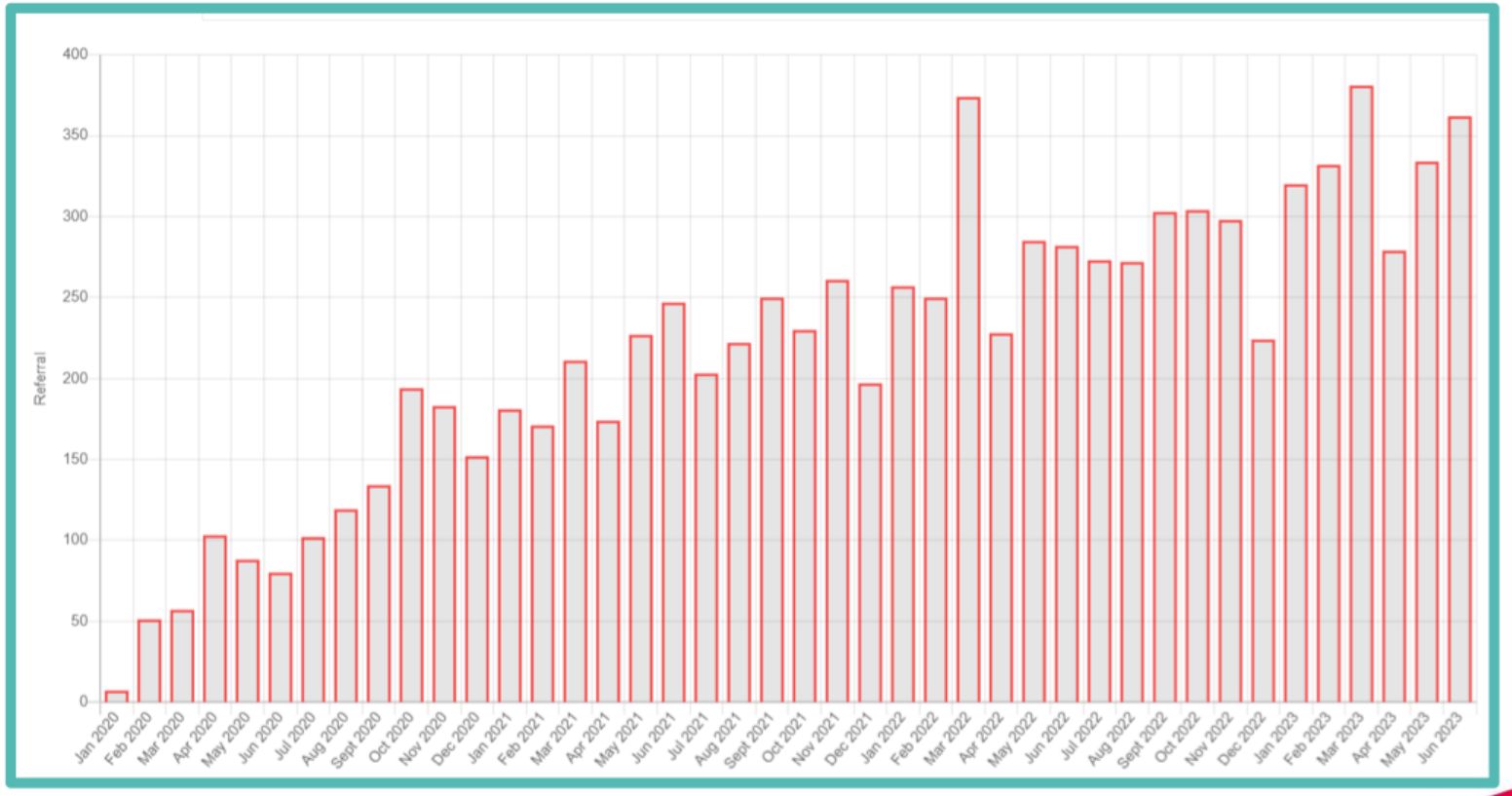
Overview Of All Referrals Since Beginning Of Licensee

The project has been using Elemental from the following date:
Merton Connected: 8th January 2020 (**3 Years, 5 Months**)

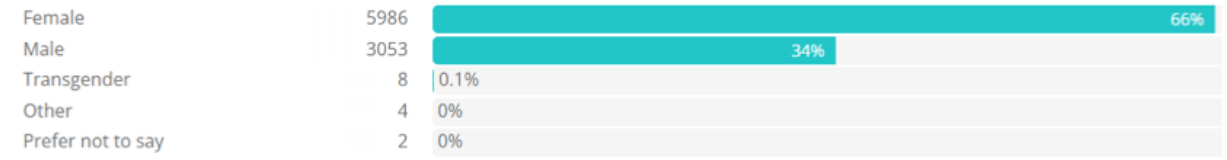
Throughout the course of the project, a total of **9,202** referrals have been made with the help of Elemental Software.

View Results: [9,202 Referrals]



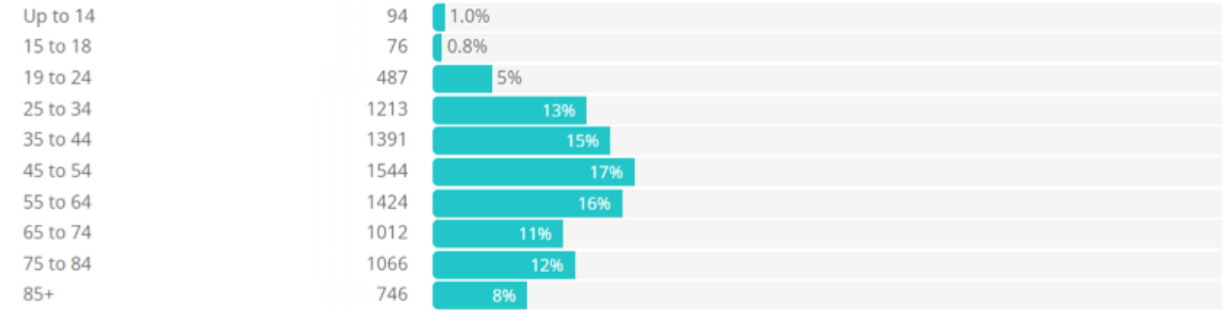
Cases Created Per Hub / Client Demographics (All Time)

Gender



Age

(on referral date)



- The most populated age range among **Merton** clients is the age range of ***45 to 54***, representing ***17%***.
- The age group of ***55 to 64*** is in 2nd place, making up ***16%*** of referrals.
- From the diagram below, we can see that the targeted group is younger adult / middle aged of society, vs. an younger / older skew.
- **9,053** Cases that were created were Female (***66%***), there was ***3,053*** Referrals for Male, representing (***34%***)

The total number of cases made is **9,053**.

View Results: [9,053 Cases]

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Health Impact Statistics (All Time)

Since the project's formation, we have tracked your clients using our Monitoring Tools – the **Merton Connected** licensee uses the **ONS** monitoring tool.

This measures client Satisfaction, Worthwhile, Happiness (**ONS 1,2,3**), and monitors their Anxiety (**ONS 4**) over time.

Merton:

- ONS 1: **66%** Increase
- ONS 2: **60.2%** Increase
- ONS 3: **62%** Increase
- ONS 4: **60.5%** Decrease

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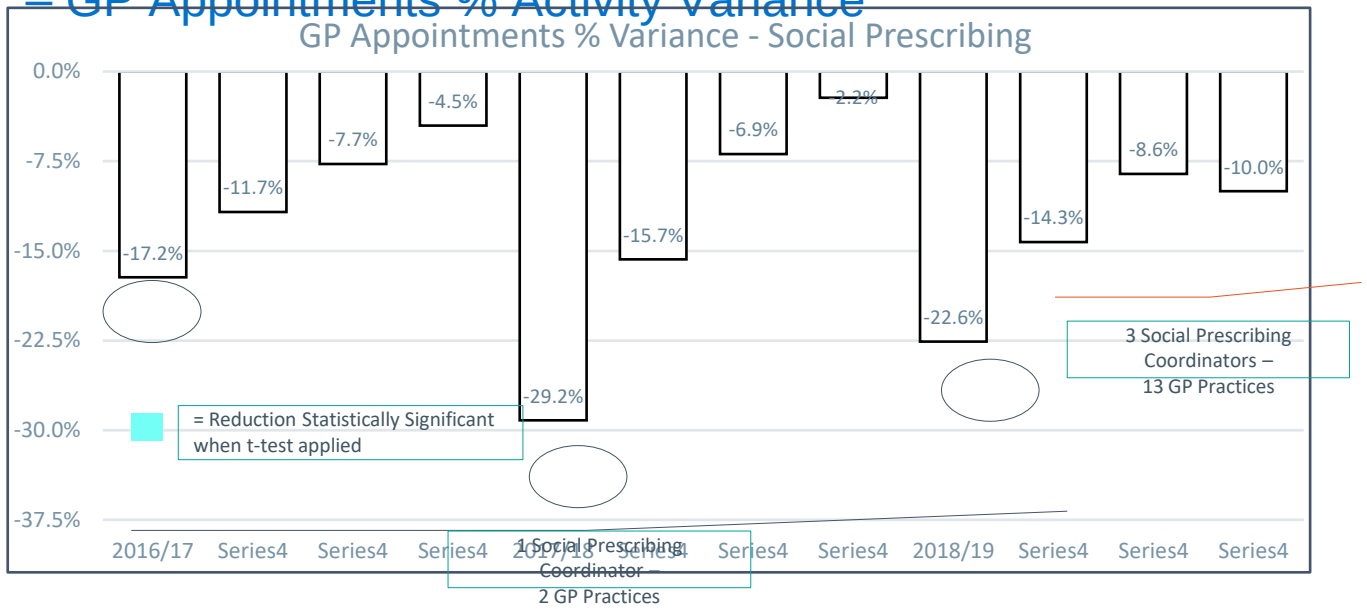
2016/17, 2017/18 and 2018/19 3,6,9 and 12 monthly Analysis – GP Appointments % Activity Variance



65 Patients seen **173 Patients seen** **338 Patients seen**

Comment

GP appointments analysis has been presented as an % activity variance by quarter over the years 2016/17, 2017/18 and 2018/19. These shows that the Highest % reductions in GP appointments are shown after 3 months (Q1) before reducing in Q2s,Q3 and Q4. In 2018/19 when the service was rolled out to 13 GP Practices although the % reductions between the quarters reduced there was still a 10% reduction in Q4 which was a lot higher that the 4.5% reduction in Q4 2016/17 and 2.2% reduction in Q4 2018/19.

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Signpostings (Whole Project)

SIGNPOSTINGS

Results: 8,475 Signpostings

WIMBLEDON GUILD	696	8%
ONE YOU MERTON	359	4.2%
AGE UK MERTON	313	3.7%
Citizens Advice Lambeth and Merton (C	257	3.0%
Merton Uplift	239	2.8%
MERTON UPLIFT - WELLBEING WORKSH	222	2.6%
South West London Law Centre	217	2.6%
SUNSHINE RECOVERY CAFE	214	2.5%
MERTON UPLIFT - IAPT	186	2.2%
Carers Support Merton	185	2.2%
South West London Law Centre - Financ	182	2.1%
Merton Benefits Service	179	2.1%
Wimbledon Guild Talking therapies	166	2.0%
Merton Council Needs Assessment	148	1.7%
MERTON MENCAP	141	1.7%
Dementia Hub Merton	122	1.4%
Walk and Talk movement - Wimbledon	117	1.4%
Age UK Merton	112	1.3%
Sustainable Merton - Merton's Commun	101	1.2%
Wimbledon Guild Welfare Grant	95	1.1%
Merton Carers Support	85	1.0%
DONS Local Action Group	76	0.9%
Merton Housing	75	0.9%
Homestart Merton	70	0.8%
Off the Record - Merton	69	0.8%
MCIL (Merton Centre for Independent Li	66	0.8%
Hestia - Recovery Cafe for Mental Health	54	0.6%
Age Uk Merton	54	0.6%
Studio Upstairs	49	0.6%
Wimbledon Food Bank	49	0.6%

Walk and Talk movement - Morden Hall	49	0.6%
TURN2US	45	0.5%
WIMBLEDON FOODBANK	44	0.5%
St Raphaels - The Wellbeing centre	44	0.5%
RAYNES PARK BEREAVEMENT	42	0.5%
IMAGINE INDEPENDENCE	41	0.5%
Occupational Therapy Merton (OTSS Me	41	0.5%
Better Gyms - Morden Leisure Centre	39	0.5%
FAITH IN ACTION	38	0.4%
Walk and Talk movement - Canons Hous	37	0.4%
The Trussell Trust - Food Bank	35	0.4%
Merton Connected - Volunteering	35	0.4%
Home Instead Wimbledon and Kingston	34	0.4%
Central London Community Healthcare	34	0.4%
Grants - WaterSure and WaterHelp	33	0.4%
WDP Merton	33	0.4%
VICTIM SUPPORT	31	0.4%
Ethnic Minority Centre	31	0.4%
Merton Libraries services - Wimbledon	30	0.4%
Inner Strength Network	30	0.4%
The Caravan Drop-In Counselling Service	29	0.3%
Recovery College	29	0.3%
MACMILLAN	29	0.3%
Merton Family Services Directory - Famil	29	0.3%
MERTON WALKS FOR LIFE	28	0.3%
CRUSE BEREAVEMENT	28	0.3%
CHS Healthcare	27	0.3%
IESOHEALTH	27	0.3%
Connect Health - Nelson, Cricket Green,	27	0.3%
MAGGIES CENTRES	26	0.3%
JIGSAW 4U	26	0.3%

These are the most heavily assigned signposting's within the **Merton** project:

- **Wimbledon Guild** (**696**)
- **One You Merton** (**359**)
- **Age UK Merton** (**313**)
- **Citizens Advice Lambeth And Merton (Cab)** (**257**)
- **Merton Uplift** (**239**)
- **Merton Uplift - Wellbeing Workshops** (222)
- **Southwest London Law Centre** (**217**)
- **Sunshine Recovery Café** (**214**)
- **Merton Uplift – IAPT** (**186**)
- **Carers Support Merton** (**185**)

Social Prescribing evidence (nationally recognised)

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- Initial pilot 2018 - funded by public health Merton
  - https://healthydialogues.co.uk/wp-content/uploads/2019/04/East-Merton-Social-Prescribing-Evaluation-Report-2018.pdf
- **Powerful** video by Health London Partnership
  - https://www.healthydialogues.co.uk/wp-content/uploads/2019/04/Merton-SP-evaluation-report-August-2021-V2.3.pdf
- A study of the upscaling of the Social Prescribing Service in Merton (2021)
  - whttps://www.healthydialogues.co.uk/wp-content/uploads/2019/04/Merton-SP-evaluation-report-August-2021-V2.3.pdf
- Finalists HSJ Award for pilot 2018
- https://fabnhsstuff.net/fab-stuff/social-prescribing-in-merton

Further information

Response of social prescribing during Covid

https://www.england.nhs.uk/personalisedcare/social-prescribing/case-studies/a-gp-perspective-on-social-prescribing-and-the-response-to-covid-19/

Enhanced Social Prescribing

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- Children and young person's Social Prescribing Pilot in East Merton and Morden PCN.

- PCN Proactive Social Prescribing programmes to increase access and uptake of Social Prescribing. Each PCN has identified a specific cohort to work with which are currently underrepresented in the current Social Prescribing referrals.

- MacMillan Cancer Link Worker programme which operates across Merton, Wandsworth and Croydon. The programme aims to improve the awareness of, access to, and uptake of services available to those living with and beyond cancer, whilst ensuring that holistic support is offered locally at key points in the cancer pathway.

Proactive SP in Merton – additional projects

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- High Intensity User Support
- Support for patients with Learning Disabilities
- 7 Green Social Prescribing projects
- Children and Young People's SP
- SP support for patients diagnosed with cancer
- A SP patients' Support Group
- Delivering the National Qualification of Level 3 certificate in Social Prescribing
- Support for patients of a Pain Clinic in Sutton, Secondary Care

Social Prescribing - Overview

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You have selected a cohort of **2,184** patients who attended a Social Prescribing appointment

Period between **April 2018** and **September 2021**

Total Patients referred
2,364

Total Patients attended
2,184

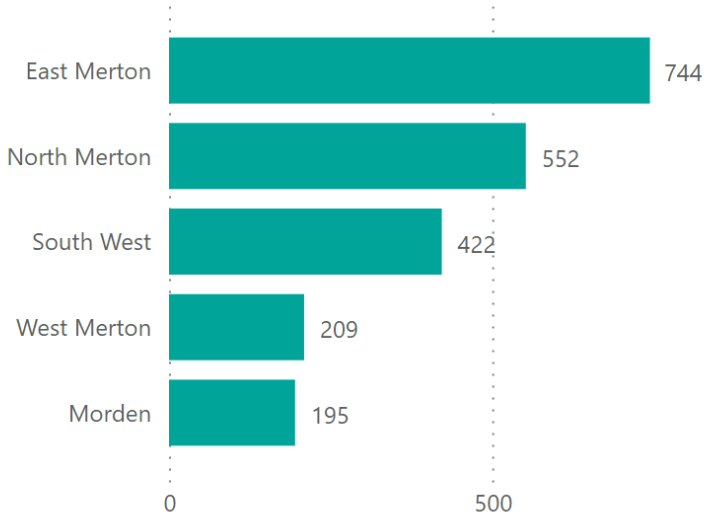
Total appointments made
8,513

Number of attendances
7,051

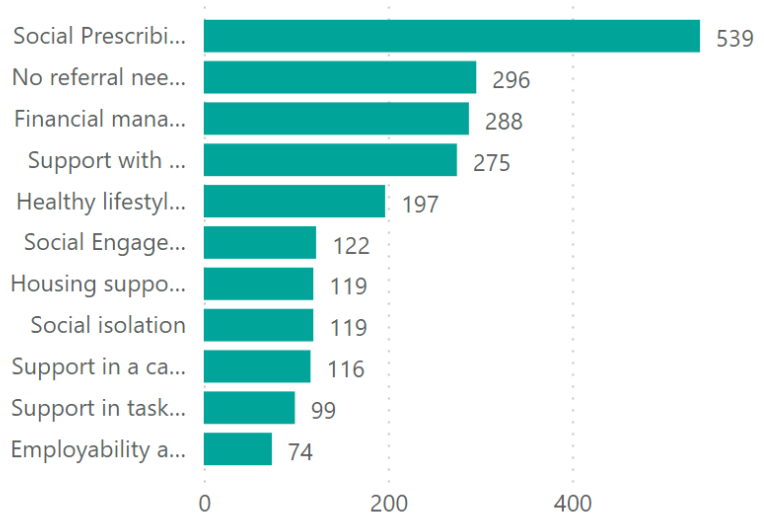
Average attendances per patient
3.2

% DNAs and Cancellations
17%

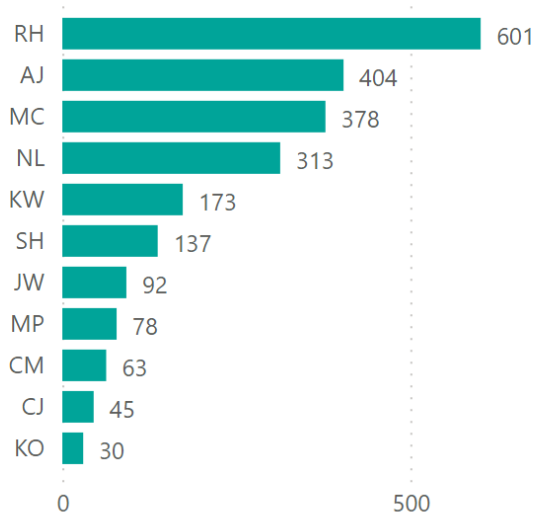
Patient locality



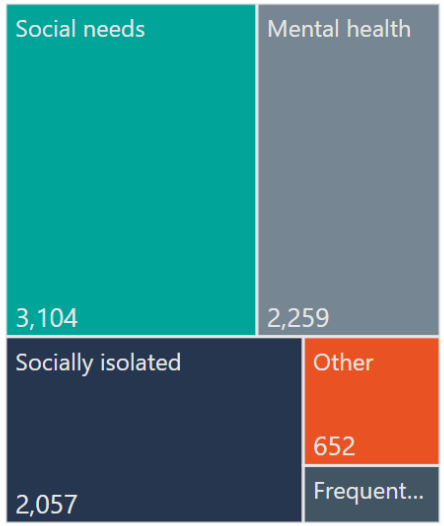
Top 10 frequently attended services



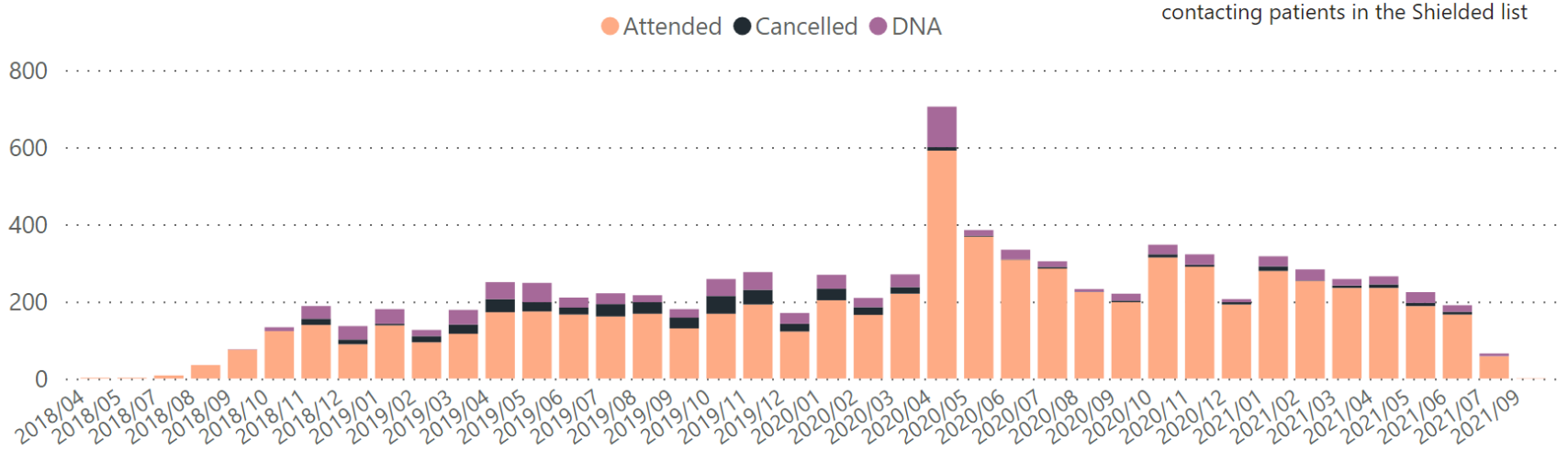
Leadworker caseload



Top 5 reasons for referrals



Appointment outcome



* April 2020 - increased activity after contacting patients in the Shielded list

Social Prescribing - Demographics

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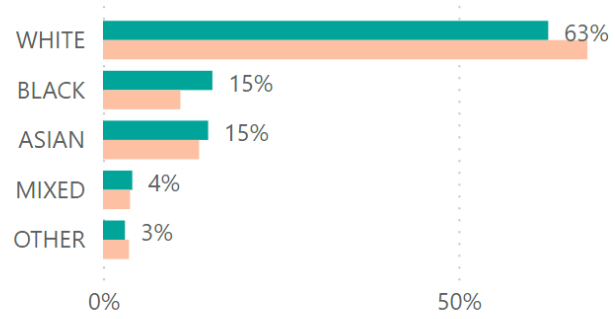
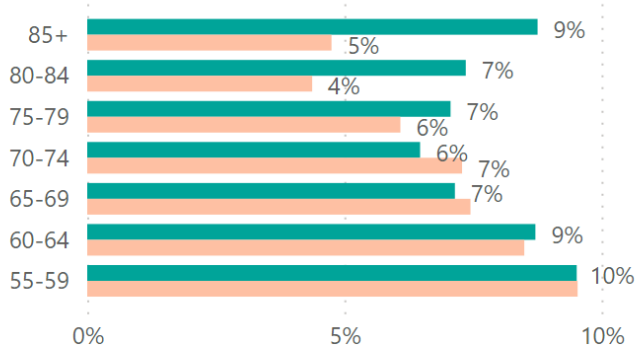
Click on ↓↓ to go to the next level in the hierarchy

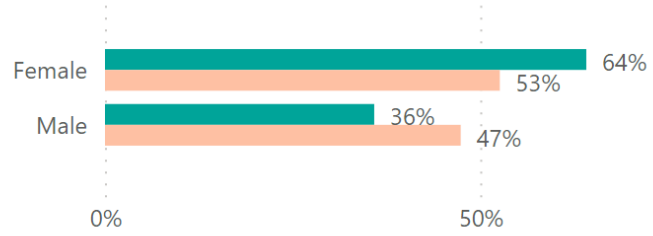
Ethnicity



Age

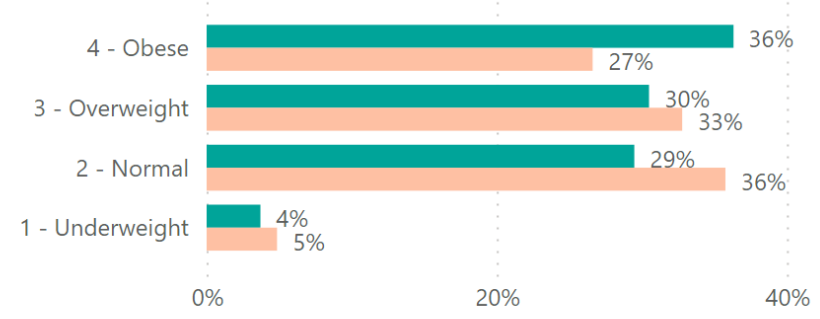


Gender

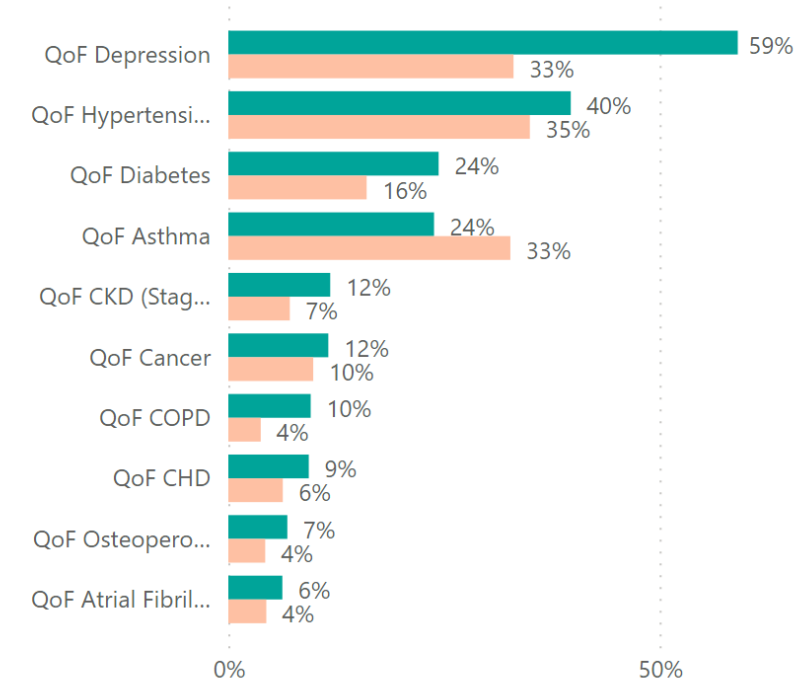


Social Prescribing SWL Population

BMI



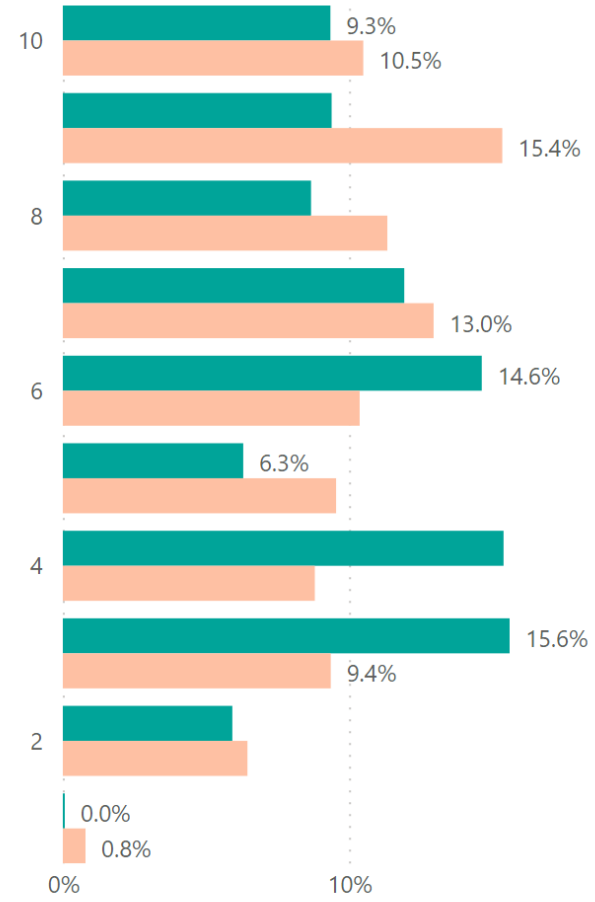
Top 10 QOF long term conditions



Refer to *[Report Notes] - Deprivation* for definitions

IMD Deprivation | Crime | Education | Employment | Environment | Health | Housing | Income

IMD Deprivation (decile 1 = most depriv...



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Report Notes

Reporting on Merton patients at the time of writing - December 2021. It is anticipated the Social Prescribing programme will eventually roll out to other boroughs in South West London.

Records with data items recorded as either null, blank or invalid have been omitted from reporting together with patients that have recently passed away.

Pathway summary and pathway patient level pertain to activity over the last 24 months.

Link worker's full name have been omitted and replaced with their initials for confidentiality purposes.

Targets used for monitoring patients with **Diabetes**:

- HbA1C 58 mmol/mol or below
- Cholesterol below 5 mmol/l
- Blood Pressure 140/80 and below

Targets used for monitoring patients with **Mental Health**:

- Smoking
- Body Mass Index (BMI)
- Alcohol
- Blood Pressure 140/80 and below

Social Prescribing - Impact on patients with diabetes

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Total Patients referred
549

Total Patients attended
517

Total appointments made
1,944

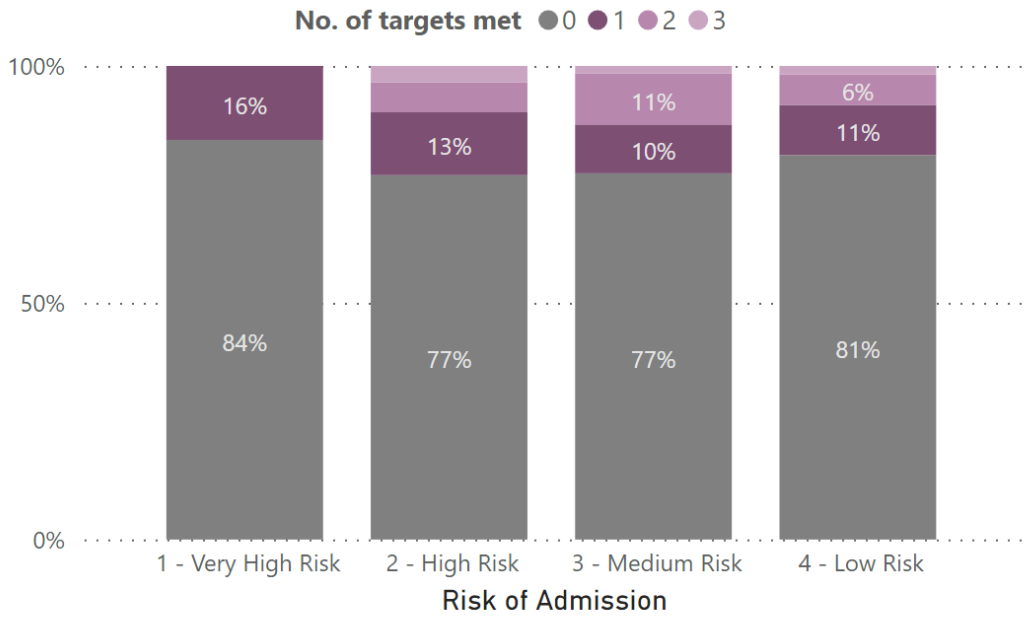
Number of attendances
1,660

Average attendances per patient
3.2

% DNAs and Cancellations
14%

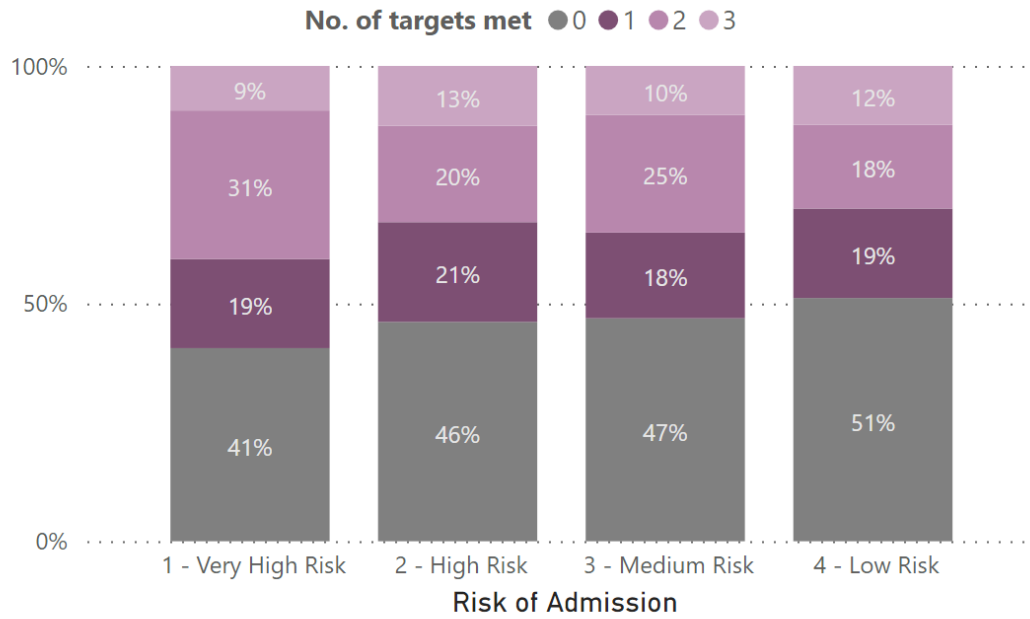
Targets met within 12 months **prior** to first contact

Risk Score Band	0	1	2	3	**Total**
1 - Very High Risk	84%	16%			**100%**
2 - High Risk	77%	13%	6%	3%	**100%**
3 - Medium Risk	77%	10%	11%	2%	**100%**
4 - Low Risk	81%	11%	6%	2%	**100%**



Targets met within 12 months **after** first contact

Risk Score Band	0	1	2	3	**Total**
1 - Very High Risk	41%	19%	31%	9%	**100%**
2 - High Risk	46%	21%	20%	13%	**100%**
3 - Medium Risk	47%	18%	25%	10%	**100%**
4 - Low Risk	51%	19%	18%	12%	**100%**



Social Prescribing - Impact on patients with Mental Health

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Total Patients referred
252

Total Patients attended
226

Total appointments made
814

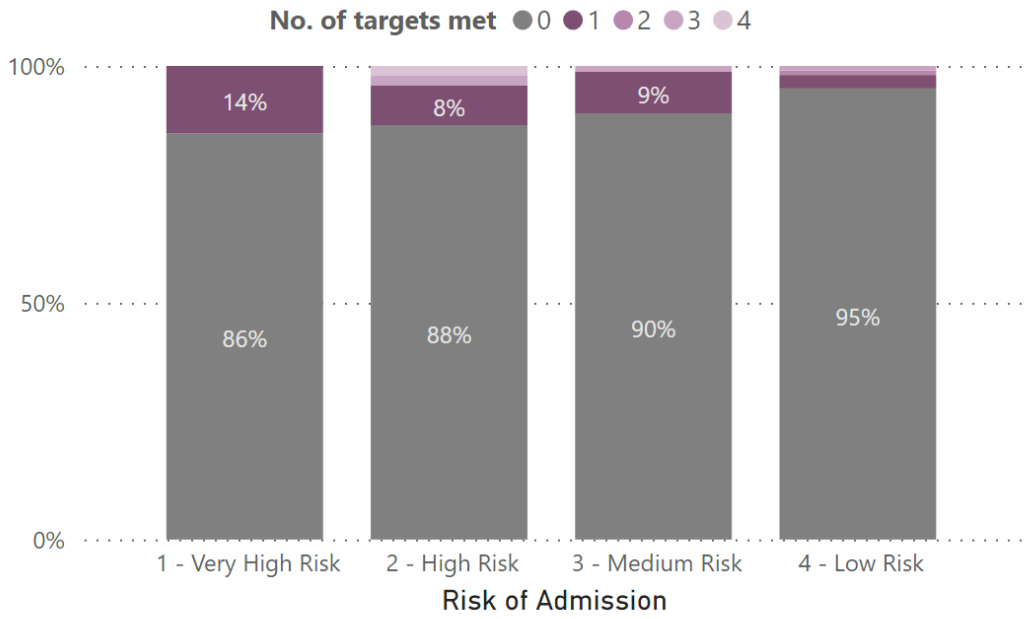
Number of attendances
670

Average attendances per patient
3.0

% DNAs and Cancellations
17%

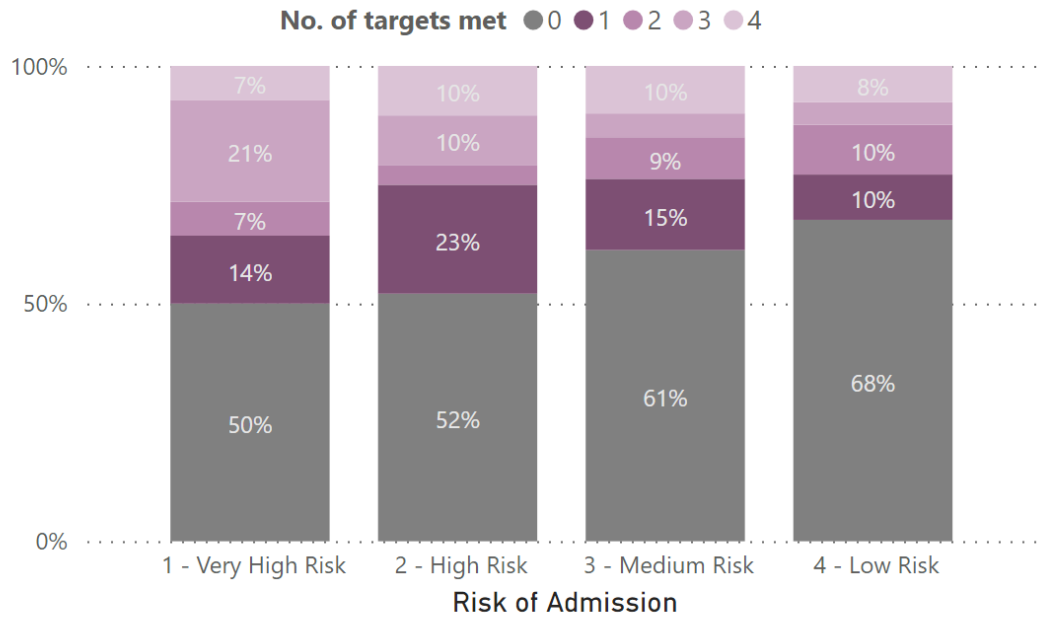
Targets met within 12 months **prior** to first contact

Risk Score Band	0	1	2	3	4	**Total**
1 - Very High Risk	86%	14%				**100%**
2 - High Risk	88%	8%		2%	2%	**100%**
3 - Medium Risk	90%	9%		1%		**100%**
4 - Low Risk	95%	3%	1%	1%		**100%**



Targets met within 12 months **after** first contact

Risk Score Band	0	1	2	3	4	**Total**
1 - Very High Risk	50%	14%	7%	21%	7%	**100%**
2 - High Risk	52%	23%	4%	10%	10%	**100%**
3 - Medium Risk	61%	15%	9%	5%	10%	**100%**
4 - Low Risk	68%	10%	10%	5%	8%	**100%**



Social Prescribing - Impact on patients with Asthma and/or COPD

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Total Patients referred
676

Total Patients attended
628

Total appointments made
2,580

Number of attendances
2,152

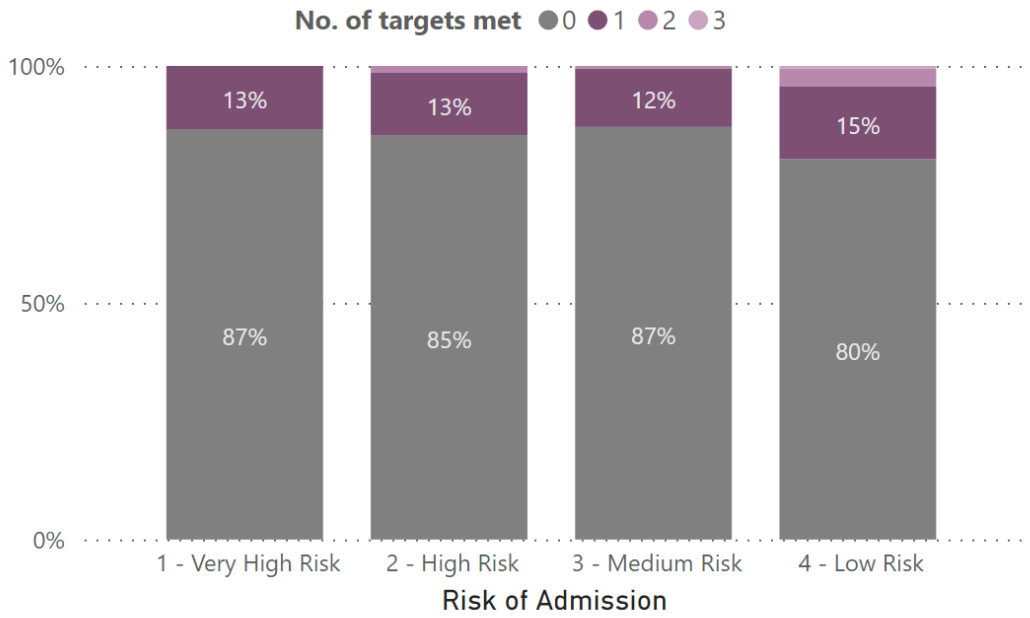
Average attendances per patient
3.4

% DNAs and Cancellations
17%

Note there were **zero** patients that met all 4 targets pre or post 12 months from their first Social Prescribing contact date. To discuss, may need to revisit logic or replace with other measures.

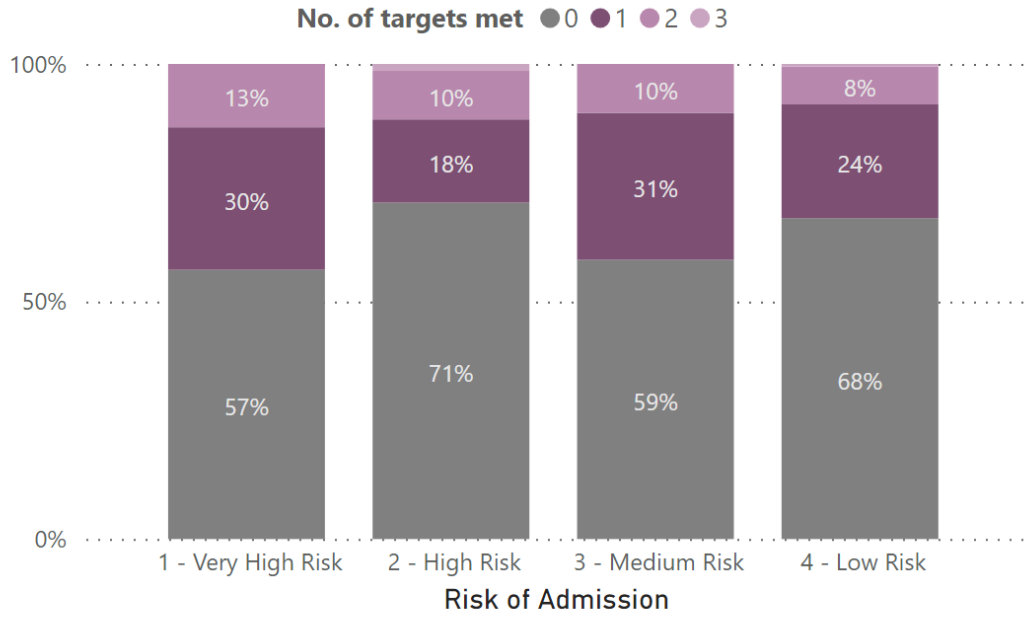
Targets met within 12 months **prior** to first contact

Risk Score Band	0	1	2	3	Total
1 - Very High Risk	87%	13%			**100%**
2 - High Risk	85%	13%	1%		**100%**
3 - Medium Risk	87%	12%	1%		**100%**
4 - Low Risk	80%	15%	4%	1%	**100%**



Targets met within 12 months **after** first contact

Risk Score Band	0	1	2	3	Total
1 - Very High Risk	57%	30%	13%		**100%**
2 - High Risk	71%	18%	10%	1%	**100%**
3 - Medium Risk	59%	31%	10%		**100%**
4 - Low Risk	68%	24%	8%	1%	**100%**



Possible future opportunities - require funding and capacity

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- Self referrals
- Front door pilot work with Social Care?
- Community chest development ?
- Pro active projects - target long term condition
- Community integration