Personalised care in the community

Herts Valleys CCG worked with the Better Care Fund to establish a community navigator service. This was a social prescribing programme providing personalised and community-centred care in west Hertfordshire.

Why?

GPs are unable to fix people's health problems with the medical model when they are caused by psychosocial factors. There is demand for broader conversations outside the surgery to take place that can address the non-clinical factors impacting people's wellbeing.

How is it rethinking medicine?

The service enables clinicians to better support patients with concerns linked to the wider social determinants of health that would previously have been beyond their remit. It also establishes clinicians within a much wider network where a variety of community workers collaborate to get patients access to the right services for them.

How does it work?

First, the individual has a conversation with a link worker about the psychosocial factors impacting their wellness. Together they agree a plan and the link worker supports the person to connect to different services and opportunities. The link worker makes sure these connections are successful and supports the person to maintain them.

How was it set up?

Herts Valleys CCG employed link workers to have personalised conversations with service users and direct them to suitable services. Referrals to the community navigator service may come from clinicians or others working in the community, like social workers and job centre staff. The CCG used HertsHelp, a network of organisations in Hertfordshire, as a directory and triaging service. Although HertsHelp was commissioned in 2010, it was not well used by GPs until the community navigator service was established.

rethinking medicine

What has it achieved?

Since the introduction of the community navigator service

- Herts Valleys received over 2000 referrals in 2016/17 alone
- GPs make 12 times more referrals into HertsHelp than other areas
- 50% of CCGs are now commissioning some kind of social prescribing and every STP is required to have a social prescribing plan
- NHS England has committed to recruiting 1000 link workers across the country.

What can we learn?

Important aspects of the project include

- relieving pressures on GPs by enabling non-traditional professionals working in the community - ie social workers - to make meaningful referrals
- providing a qualitative record of patient data and a space for people to tell their stories (including the stories of those that Social Prescribing champion Dr Essam has personally seen benefit)
- connecting patients to a much broader network of support that is personalised, community-centred and beyond the usual scope of medical practice.

Further reading

https://www.england.nhs.uk/personalisedcare/upc/comprehensive-model/case-studies/social-prescribing-represents-the-most-effective-wide-reaching-and-life-changing-of-all-initiatives-to-date-a-gps-perspective/

https://www.longtermplan.nhs.uk/case-studies/social-prescribing/

https://www.england.nhs.uk/blog/primary-care-networks-making-connections-through-social-prescribing/

https://ockham.healthcare/marie-anne-essam-social-prescribing-and-link-workers/

https://www.scie.org.uk/future-of-care/asset-based-places/blogs/asset-based-social-prescribing

https://www.hertfordshire.gov.uk/media-library/documents/adult-social-services/better-care-fund-high-level-plan.pdf

https://www.kingsfund.org.uk/sites/default/files/media/Tim_Anfilogoff.pdf