

# my Best Life



# Why Social Prescribing?

*“People’ s health is determined primarily by a range of social, economic and environmental factors, social prescribing seeks to address people’ s needs in a holistic way” - Kings Fund*

- None medical interventions
- Strength based conversations
- Link worker/navigator/advisor
- Community solutions = long term sustainability

# A different way...

*"I would have prescribed anti-depressants and referral to Mental Health services"*

Barnsley North GP

*"Patients are seeing clinicians for social aspects, this increases the demand on the practice team. Because of MBL the clinicians have more time to deal with more complex health needs."*

MG, Barnsley ANP



# Strength Based Approach

All our advisors receive Motivational Interviewing and Strength Based Conversation training.

The power of 'strengths based' conversations

- What are you good at?
- What do you enjoy doing?
- What do you want your life to be like?



# Social Prescribing Services

- 1) My Best Life
- 2) My Best Life – High Intensity User Group
- 3) My Best Life – Secondary Care

# The Team

Service	Advisor	Area	Email address	Phone Number
My Best Life	Abby Younger	Penistone	a.younger@syha.co.uk	07740373267
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My Best Life	Alaina Briggs	North East	a.briggs@syha.co.uk	07579962320
My Best Life	Amber Goddard	Dearne	a.goddard@syha.co.uk	07773085802
My Best Life	Kay Dire	South	k.dire@syha.co.uk	07854403827
My Best Life	Lisa Baugh	Central	l.baugh@syha.co.uk	07966373247
My Best Life	Gracie Butler	Volunteer Coordinator	g.butler@syha.co.uk	07966303903
My Best Life	Natalie Crampton	Team Leader	n.crampton@syha.co.uk	07970399427
Secondary Care	Kate Walsh	Team Leader	k.walsh@syha.co.uk	07875407233
Secondary Care	Janice Starkey	Borough wide	j.starkey@syha.co.uk	07471992461
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My Best Life Referrals: [mybest.life@syha.cjism.net](mailto:mybest.life@syha.cjism.net)

Secondary Care Referrals: [mybestlife.secondarycare@syha.cjism.net](mailto:mybestlife.secondarycare@syha.cjism.net)

# My Best Life - Key Features

## WHAT?

- ✓ Connecting & empowering people in their community
- ✓ Building peoples resilience and improving their health and wellbeing
- ✓ Reducing pressure in the Health & social care system, including High Intensity Users (HIU)

## HOW?

- ✓ Borough wide
- ✓ Accessible & Integrated in primary care – MBL Champions
- ✓ Increased confidence & motivation of individuals
- ✓ Reduction in GP appointments



# My Best Life - Key Features

- ✓ GPs and other health professionals are able to link patients with non-medical needs to their local MBL advisor
- ✓ Strengths based conversation in the customer' s home
- ✓ Work with customers for up to 12 weeks
- ✓ Develop an action plan built around the Five Ways to Wellbeing
- ✓ Advisors source, and provide support that' s individually tailored to the customers health and wellbeing needs
- ✓ Connect to local non-medical sources of support
- ✓ Volunteering opportunities



# My Best Life - Referral Criteria

- Frequent attendance at GP practices or other Primary Health Care services
- Low level mental health
- One or more managed health condition(s)
- Socially isolated or lonely



# What can we help with...

- Access support for making connections
- Access housing solutions
- Looking after emotional wellbeing
- Managing money and support with welfare issues
- Manage symptoms and promote healthy lifestyles
- Access work and volunteering opportunities
- Support to stay living at home



# My Best Life

## Customer Data - Year 1 and 2

- 2289 referrals to MBL
- 4.5 hours average time spent with customers
- 1716 onward referrals to 167 partner organisations
- 38% referrals for customers who' s mental wellbeing is affected by social situation
- 2 days until first contact
- All Barnsley GP' s refer into the service
- 8 GP appointments on average in the 3 months prior to referral



# My Best Life

## Customer Data - Year 1 and 2

- 35% of customers are registered disabled
- 172 customers are carers or hidden carers
- 56% of referrals over 60
- 64% referrals are female
- 48.5% of customers are retired
- 27.5% long term sick
- 4.5% job seeker
- 4% not seeking work
- 5% of customers in full or part time employment

# Who refers into MBL?

GP  
Neighbourhood Nursing  
OT  
Physio  
IAPT  
Practice nurse  
Long term condition nurse  
Social Prescribing Champion  
Pharmacist  
Community Mental Health Teams  
Other primary care health teams



# MBL – Outcomes Data

- Resilience monitoring utilising WEMWEBS and 5WTW
- Increase in self assessed wellbeing\*
- 17% increase in feeling optimistic
- 14% increase in feeling relaxed
- 18% increase in keeping learning
- 29%\*\* reduction in GP appointments

Year 2 – Quarter 4 Distance Travelled Report

\* 405 customers with comparable/distance travelled data

\*\* Self reported via follow up monitoring data



# MBL – Outcomes Data

- 98% of customers rate our service as excellent or good
- 90% of customers agree or strongly agree that they are more aware of services and support in their local community
- 73% of customers agree or strongly agree that they feel better supported to manage their health needs
- 63% of customers agree or strongly agree that they are more confident in managing their own health conditions



# MBL – High Intensity Group

## Year 1 and 2 Data

The My Best Life Team are able to hold a High Intensity Case Load. This comprises of customers who receive 5+ hours of one to one support due to multiple needs.

- 236 Customers
- 70% customers referred due to poor mental wellbeing affected by social circumstances
- Average of 13.5 hours spent with customers
- 24% reduction in GP appointments



# Partnership Working – Onward Referrals

The below shows some of our onward referrals for March 2019:

- DWP – Benefits
- Barnsley CVS
- Berneslai Homes
- BMBC – Welfare Rights
- Adult Skills and Community Learning
- Age UK
- Barnsley Advocacy Service
- DIAL
- Making Space
- Recovery College
- Royal Voluntary Service

# Partnership Working

Onward referral Split –

- 60% Community/Voluntary sector
  - 39% Statutory Services
  - 1% Private sector
- 
- We hold steering meetings to discuss partnership working, onward referrals and areas for improvement/development. This group is attended by CVS partners
  - Senior managers meet bi monthly with BCVS to discuss any impacts on the wider sector
  - We work with the ICS lobbying/influencing around supporting the CVS across our region



# Secondary Care - Key Features

## WHAT?

- ✓ Referrals from Secondary Care
- ✓ Connecting & empowering people in their community
- ✓ Building peoples resilience and improving their health and wellbeing
- ✓ Reducing pressure on the Health & social care system

## HOW?

- ✓ Borough wide
- ✓ Increased confidence & motivation of individuals
- ✓ Reduction in presentation to Secondary Care
- ✓ Smaller case load, and intensive support



# Secondary Care - Referral Criteria

- Frequent attendance of Secondary Care services
- At risk of Hospital admission
- Medically fit for discharge but social issues preventing this
- Long term physical or mental health condition(s)
- Poor mental wellbeing affected by social circumstance



# Who refers into SC?

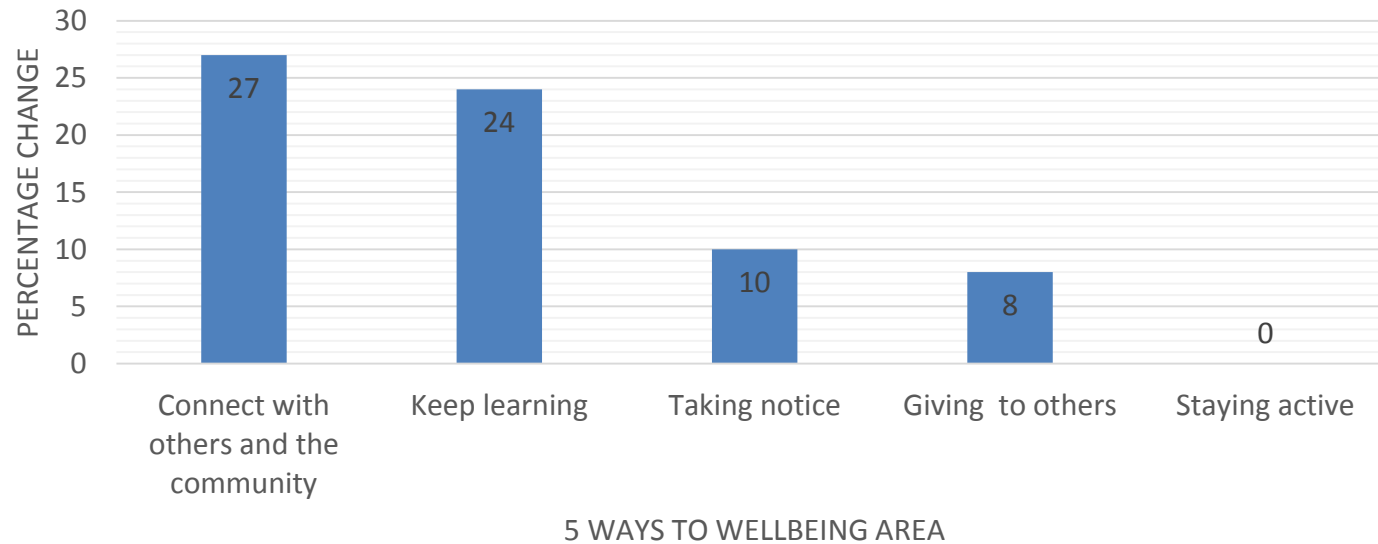
- HIU and CQUIN Groups
- Community nurse
- IAPT
- GP
- Neighbourhood Nurse
- Emergency Department
- Discharge Teams
- Yorkshire Ambulance Service

# Secondary Care – Customer Data

- 34 referrals
- 79% referrals are female
- 18 GP appointments on average in the 3 months prior to support
- 1.67 Average number of onward referrals
- 18.45 hours average Advisor time spent with customers

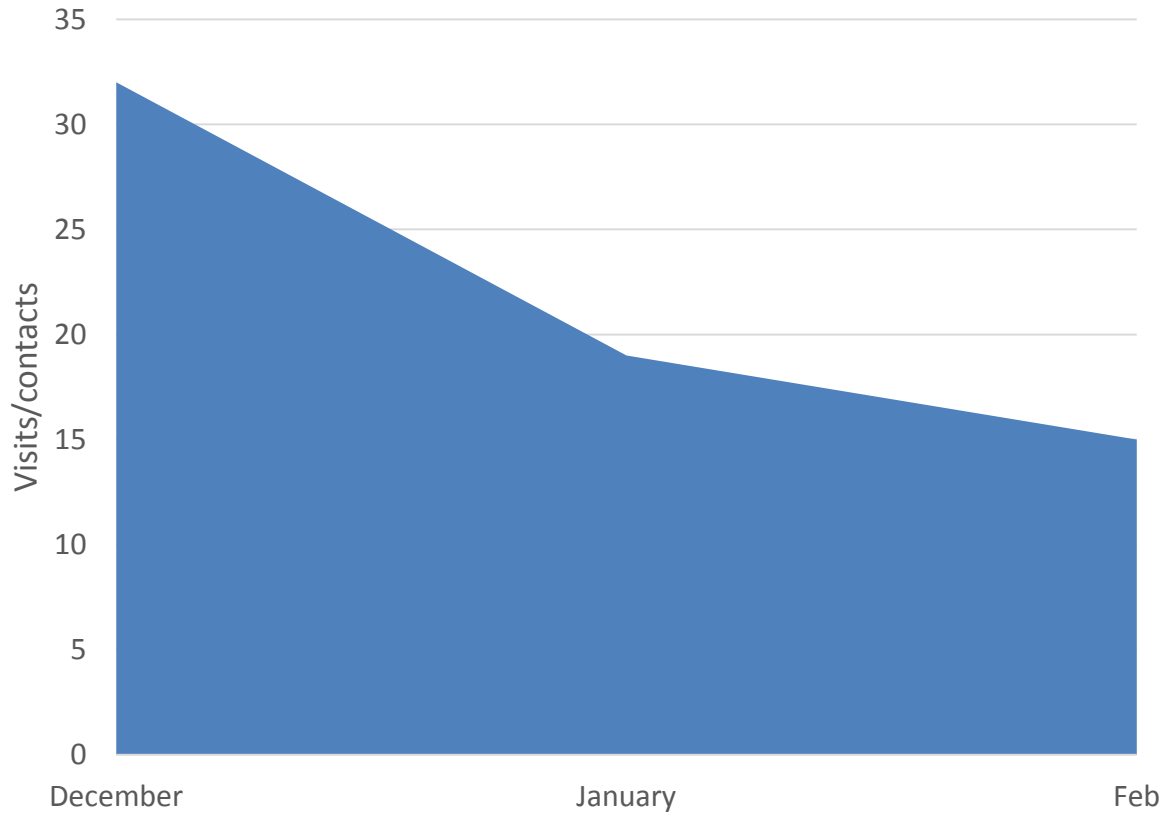
# Secondary Care – Customer Data

## 5 Ways to Wellbeing: %age change over time



# Secondary Care -

## ED Reductions





# SC – Outcomes Data

- 62.5% of customers agree or strongly agree that they are more aware of services and support in their local community
- 37.5% of customers agree or strongly agree that they feel better supported to manage their own health needs
- 37.5% of customers agree or strongly agree that they are more confident in managing their own health conditions



# The People behind the 2289:



# Good to know...

- Acknowledgement receipts sent for all referrals received
- Feedback sent to referrers at the end of support
- Partnership working with health and social care, and voluntary and community groups recorded
- One to one guidance and support provided by advisors
- Our teams attend MDT' s, Neighbourhood Nursing meetings, LA meetings and other relevant events
- Data and case studies shared monthly with BCCG. We are happy to share so please let us know



Any  
Questions?

