Social Prescribing Pilot Programme

West ICP

27 May 2015

"Social prescribing…… creates a formal means of enabling primary care services to refer patients with social, emotional or practical needs to a variety of holistic, local non-clinical services" (Brandling and House, 2007)

Aim of the programme

- **To take an early intervention approach to the Frail Elderly population aged >65.**
- **Older people who may be experiencing personal difficulties, for example, social isolation, bereavement, a family crisis or chronic loneliness can be referred by their GP to the Social Prescribing Co-ordinator.**
- **The Social Prescribing Co-ordinator will be the one point of contact for onward referral to the most appropriate community and voluntary services in the locality.**

Intended benefits

- **Improved quality of life.**
- **Help to overcome social isolation among older people living independently.**
- **Reduce dependency on health and social care.**
- **Improve communication and partnership working between GPs, Community and Voluntary Sector and frail elderly patient.**

Numbers	Age	Gender	Reasons for referral
Aberfoyle Medical Practice: 8	65 -84	Male:3 Female:5	Social isolation , loneliness, social exclusion, long term conditions(including Parkinson's, arthritis, COPD) health & fitness , mental health and emotional wellbeing and leisure and recreation
Eglinton Medical Practice: 5	65 - 79	Female: 5 Male: 0	

Social Prescribing Pilot Programme

- **Procurement process has concluded with Bogside & Brandywell Health Forum (BBHF) the successful applicant.**
- **The pilot will run from 1 March 2015 until 31 March 2016.**
- **The pilot will include two GP practice areas, one rural- Eglinton Medical Practice and one urban, Aberfoyle Surgery.**

Feed Back

- *“It’s somewhere to send patients that I don’t have the skills to deal with, things like bereavement, loneliness, social exclusion all those social problems that as a GP, I don’t want to be prescribing anti depressants for” (GP talking about the Social Prescribing Service)*

Social Prescribing Pathway Case study

Refer

- Mrs A is a 79 year old woman who was referred to the SP Programme for exercise due to having decreased mobility and because of low mood.

Visit

- The Coordinator arranged a visit , to undertake an initial assessment and discuss local services that would suit her needs. Mrs. A decided that she would like to undertake an exercise programme at a local community centre.

Support

- The Coordinator contacted the service provider to organise an induction for Mrs. A and then supported her to access this service , accompanying on her initial visit.

Review

- The coordinator has remained in contact with Mrs A and the service provider to review progress. Both have commented that the programme has benefited Mrs A's health and well being and she intends to continue to access this service. Mrs A's initial assessment will be followed up with a review after 12 weeks.