Southwark: using navigators to organise social prescriptions

Summary

A voluntary sector-led social prescribing scheme that works in partnership with the local council, GPs and communities through a single referral checklist. For people with multiple conditions there are navigators who link them with services and activities from a menu of options. These range from formal services like talking therapies and fire safety checks to community-based activities like singing and social clubs and much in between.

Main points

- Age UK Lewisham and Southwark appointed council-funded community navigators to coordinate social prescribing referrals
- GP-based navigators were then taken on when funding made available by CCG
- Easy-to-use checklist developed for health and care professionals to refer in – digital version produced that is compatible with the GP IT system
- Maximum of three visits per client introduced to keep waiting times down
- Navigators given time to find new groups and services to add to their menu of social prescriptions

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– JASMINE SPARROW, PROJECT MANAGER

Context

Southwark is a densely populated and diverse inner London borough situated on the south bank of the River Thames. It includes bustling areas such as Peckham and Camberwell and leafy districts like Dulwich.

The borough of Lambeth lies to the west and Lewisham to the east. It is home to around 315,000 people and is home to the largest Black African population in the country.

The borough is ranked 41st most deprived out of 326 local authority areas. Cardiovascular disease, cancer and respiratory illness are considered the main driver behind health inequalities in Southwark.

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> – DR PAYAM TORABI, GP AND SOUTHWARK CCG LEAD FOR CLINICAL EFFECTIVENESS

What was done?

A team of social prescribing navigators and a coordinator was created in 2013 in Southwark to work with the over 50s with multiple conditions. The navigators were employed by Age UK Lewisham and Southwark's SAIL (Safe and Independent Living) project under an agreement with the local council. SAIL accept referrals from GPs, hospitals and community services. It also accepts self-referrals. A year later Southwark CCG agreed to fund three GP-based navigators to work alongside the two community ones, shared between the local GP federations.

A referral checklist has been produced for local health and care professionals to fill in and refer people on. There is a paper version, although the checklist has also been incorporated into the Egton Medical Information Systems (EMIS) system used by GPs so they can complete it digitally.

It covers home safety, health and wellbeing, living conditions and income and finance, and links people in to a variety of support services in the borough. There is a menu of options, including formal services like talking therapies, fire safety checks and trading standards as well as a wide range of voluntary sector activities, such as singing, dancing and social clubs. The SAIL coordinator responds to each referral, linking the individual with all the needed services and saving them from having to chase up or make multiple calls themselves.

If someone needs support accessing social or support groups, the coordinator links in the navigators, who then meet with the individual to assess what services and groups they would be best supported to use.

The navigators can meet the individuals at the GP surgeries at their home or in community settings. Most of the time just one or two visits are needed to identify the support that is needed – although the navigators can attend groups with the individuals to get them settled if needed.

SAIL navigation and projects manager Jasmine Sparrow said: "We don't rely on lots of paperwork. We find that can get in the way. There are some screening questions that are done on the initial visits and then are followed up so we can record progress, but the key really is getting to know the individual and working out what will benefit them. "The GP navigators tend to see the more complex cases – people with at least three-long term conditions, while the community ones pick up the cases referred on from hospital as well as self-referrals and ones from other agencies."

What has been achieved?

The demand for services has grown almost every year. Between April 2018 and March 2019, SAIL received 2,200 referrals and navigators have worked with 765 clients.

The help given to Mr C is typical of the impact the service has. He is 74 and lives alone with no family nearby. He has multiple long-term conditions, including osteoporosis, arthritis and problems with his feet. He was referred to SAIL by social services. The navigator arranged for him to access talking therapies and got him a pendant alarm so he could alert services if he had a fall or needed help.

He was able to claim attendance allowance, a weekly benefit for people with frailty and disability, which he uses to pay for a cleaner, has joined a strength and balance class and regularly attends a local lunch club using the dial-a-ride service.

Another person who was helped was Mrs G. She had struggled for 15 years with little help and a chronic pain condition and had become depressed when she was referred in. The navigators worked with her to put her in touch with local groups and get her access to talking therapies. "They saw me as a human being – made me laugh. I have changed so much."

Dr Payam Torabi, a local GP and Southwark CCG lead for clinical effectiveness, said the social prescribing service is invaluable. "Having someone who is able to navigate and support our patients had been invaluable - the knock-on effects to their overall health and wellbeing has often been massive. Providing a holistic approach is at the heart of what primary care is about."

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– MRS G, PERSON WITH MULTIPLE LONG-TERM CONDITIONS

What lessons have been learned?

The pressure on services means it is always a challenge to keep waiting times down. The aim is to see people within six weeks of a referral.

Ms Sparrow says: "There are times when we get a backlog developing and we have to work really hard and do a bit of juggling. But we never turn people away.

"However, we have to be quite strict about the referrals we accept and the amount of work we do with them. We sometimes get people referred to us that actually need more intensive support from a specialist service – not just a social prescription.

"The temptation is to keep trying. It is hard to step back. But it is important for navigators to know when to refer on to other services."

What is happening now?

The GP-based navigators get the majority of their referrals from the practices they work in. However, they do accept referrals from neighbouring practices.

This is likely to grow in the coming years as the GP federation model takes hold. There are two federations in Southwark – SAIL has one navigator in one and two in another.

Time is also made to allow the navigators to explore new groups and activities to their menu of social prescriptions.

Ms Sparrow said: "Our navigators know the areas really well, but they are always on the look out for new community groups and activities they can refer on to. It is important they are given the time to develop this – we are seeing new things being added all the time."

As well as adding existing groups and activities to the menu of options, the service can also help volunteers establish new groups where there is a particular gap in the market.

The success in Southwark has also convinced Lewisham to set up a similar social prescribing system. SAIL now has five workers providing a similar service in the neighbouring borough.

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