Social Prescribing Co-Design Project

Feedback Loop 2

December 2020

BEACON STRATEGIES

Acknowledgement of Country

"I wish to acknowledge the Traditional Owners and Custodians of the land we are meeting on today.

"I pay my respects and honour to their Elders past, present and emerging and implicitly acknowledge their continuing connections to their ancestral lands."

BEACON STRATEGIES

What we'll be covering

- Overview of the project
- Project roadmap update
- Outputs from co-design sessions 3 and 4
- Next steps for the co-design process

Project background

1. **The Collaborative Pairs Program** (King's Fund, UK) is a healthcare development program that **brings together a consumer, patient or community leader to collaborate with a service provider, clinician or manager to develop new ways of working together and facilitate healthcare improvement**.

2. Between March - July 2020, COORDINARE sponsored Carrie Lumby (Lived Experience Advocate) and Dr. Belinda Thewes (Clinical Psychologist, The Health Psychology Clinic, Moruya) to develop a collaborative project, with the aim of developing a sustainable community-based approach to supporting people with chronic conditions to self-manage.

3. As part of this project, Carrie Lumby and Belinda Thewes (henceforth referred to as the Collaborative Pair) consulted with a range of key informants and subject matter experts to get advice, feedback, and direction in the design of a project proposal for a Social Prescribing Co-Design project to be delivered via a Collaborative Pairs process.

4. **COORDINARE has engaged Beacon Strategies in partnership with Carrie Lumby and Dr Belinda Thewes to undertake this co-design project and provide a report back to inform future service development and commissioning activities.**

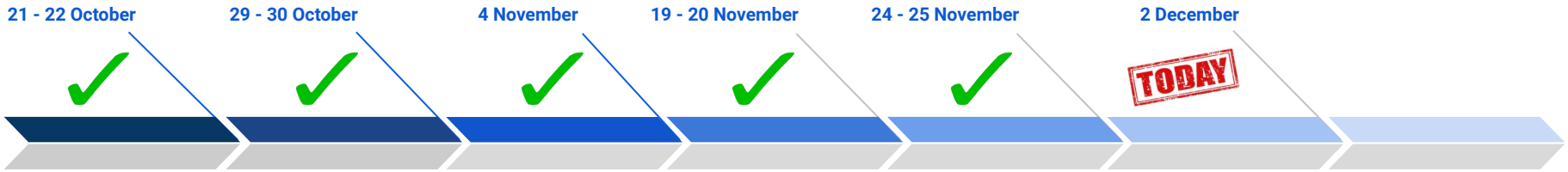
Project objectives

1. Undertake a **structured co-design process** that engages both health consumers and health professionals in a collaborative relationship and captures their perspectives relating to social prescribing

2. Design a **service model for social prescribing** linked to primary care that aims to build social connection and self-management capacity in people living with chronic conditions and can be further refined and piloted

3. Identify **implementation considerations and recommendations** for COORDINARE to csondier and inform the uptake of social prescribing within the region

Co-design process infographic



Local Pairs Sessions (Session 1)

5 pairs x 1.5 session over 2 days.

Collaborative Pairs facilitate focus conversations and Beacon collect data for via Mural.

Local Pairs Sessions (Session 2)

5 pairs x 1.5 session over 2 days.

Collaborative Pairs facilitate focus conversations and Beacon collect data for via Mural.

Feedback Loop 1

Recorded webinar followed by survey to co-design participants and all local community members who registered interest.

Pair Mentoring Sessions

5 pairs x 1 hr mentoring session over 2 days.

Discuss any issues/concerns to date and prepare for combined session.

Combined Co-Design Session (Sessions 3 + 4)

2 x 4-hour sessions

Collaborative Pairs facilitate focus conversations and Beacon to collect data for synthesis.

Feedback Loop 2

Recorded webinar followed by survey to co-design participants and all local community members who registered interest.

Final Webinar

Webinar to summarise outputs.

Methodology- Session 3 and 4

- Structured facilitated codesign group sessions
- 5 people with lived experience of chronic conditions (people with conditions and 1 carer)
- 5 health professional working with people with chronic conditions
- From diverse locations within SE NSW PHN region

Outline - Sessions 3 and 4

Session 3

- Findings from Feedback Loop #1
- Priority needs
- Identifying the potential range of non-clinical supports
- Outcomes and how to measure success of social prescribing model
- How to name and describe a local social prescribing service to users

Session 4

'Blue sky thinking' session to design an ideal local service model within hard boundaries:

- Model for meaningful service improvement
- Must be workable in local community/region
- Must involve general practice
- Outcome is the service model, not the service

World Cafe method used to explore key features of the service model, including:

- Clients/Eligibility criteria
- Service user experience
- Referral Process/Connection to Service
- Location of service
- Staffing
- Cost/Resourcing

Feedback from collaborative pairs
Session 3

Priority needs for consumers and health professionals to be addressed by a local social prescribing service model

Consumers priority needs:

- Access to information for what's out there from a trusted, reliable source
- Connection, belonging and interaction with others
- Not to be discriminated against, stigmatised or seen reductively
- Support that is easy to access
- Carers/natural supporters to be involved with the person
- Individualised care to meet diverse needs
- A one-stop-shop

Do the slides presented accurately reflect your experience and insights? If not, please share your thoughts.

Health professionals priority needs:

- Clear and simple referral pathway
- Knowing what is out there (e.g. centralised hub for information)
- Education for health professionals to enable them to understand the benefits
- Mechanisms for properly funding any social prescribing model
- Process for prioritising goals and interests of individual consumers
- Recognition of the need for a 'support person' to guide consumers along the journey and supports to participate
- Recognition of the value of social prescribing (from practitioners to funders)

Range of supports and types of non-clinical supports you would like to see implemented?

Ideas for types of non-clinical support:

- Yoga
- Cold water swimming
- Ceramics
- Beauty/glamour activities such as manicures, facials, etc
- Volunteering
- Woodworking
- Purely social activities that have secondary benefits
- In-home visits for exercise
- Lock picking

Key qualities of non-clinical supports that should be factored into prospective service/s:

- Engaging consumers mind in things
- Fun, delight, joy
- Engaging like-minded people
- Safely pushing people out of their comfort zone
- To get people to find and engage in things, a mindset change needs to come first
- Give people time and recognition to deserve these services
- Challenge people's perceptions of themselves (eg. "I'm not sporty", "I'm not creative")

Do the slides presented accurately reflect your experience and insights? If not, please share your thoughts.

Considering your experiences, what value do you feel social prescribing provides?

Consumers

- Self-motivation
- Provide the grounds to better tailor services or create new ones
- For aged care sector and NDIS to adopt these ideas
- Identification of what services are missing
- Switch ‘type’ of treatment to less medications for same impact
- Consumers getting what they feel they need
- Consumer needs are put first
- Reducing dependence on medications

Health professionals

- Ability to tap into the wisdom of a health consumer
- Understanding what someone wants to be different
- Working out value-based goals
- To hear what the person is saying
- Improved community-level impact
- Positivity and optimism for the future
- ‘Person-centred care’
- Long term health outcomes and management of conditions
- Capacity to know what to do
- As health improves, mood improves

Do the slides presented accurately reflect your experience and insights? If not, please share your thoughts.

Considering your experiences, when done well, what outcomes do you feel social prescribing should achieve?

Outcomes identified by consumers

- Extent to which a person's needs have been identified
- Extent to which a person's identified needs have been met
- Improved consumer self-motivation
- Uptake of less medicalised services for same impact and cost
- Consumer satisfaction (I'm getting what I need)
- Increased integration of social prescribing models within existing service delivery environment (e.g. aged care sector and NDIS
- Identification of what services are missing

Outcomes identified by health professionals

- Consumer engagement
- Consumer satisfaction
- Connection with relevant supports
- Autonomy and empowerment
- Positivity and optimism for the future
- Improved management of health conditions
- Improved health and wellbeing
- Increased capacity of health professionals to understand the broader needs of consumers
- Delivery of person-centered care
- Improved whole-of-community awareness and capacity
- Reduced system level costs

Do the slides presented accurately reflect your experience and insights? If not, please share your thoughts.

What would you name the social prescribing service and how would you describe it?

Consumers

Names:

- Opening connections
- Let's get social
- Life scripts
- Prescription for fun
- Your call to connect

Health professionals

Considerations:

- Avoid sounding like another clinical service
- Try to give it some meaning through words that capture the purpose and principles of it
- Community, connection, belonging, gathering - these give the meaning to it
- People find it confused if names are similar to existing programs
- What's wrong with 'social prescribing' as the name?
- 'Link' is an often used word

Do the slides presented accurately reflect your experience and insights? If not, please share your thoughts.

Feedback from collaborative pairs
Session 4

Service user experience: How would you like the service users to feel when utilising social prescribing? What would improve the current experience?

- Need to be listened to
- Different needs and views need to be respected, tailored and individualised treatment for each person
- Streamlined ease of access
- Non-assuming service and staff (no preconceived ideas)
- A meaningful experience in both process and outcome
- Not a box-ticking exercise, where staff are “there to connect”
- Consumer feels as though health professionals take an interest in them as a person
- Consumers are informed of the process nd what is happening
- Consumers feel staff have empathy, they listen and see what matters to that person’s life
- Consumers feel as though they’ve had “the human touch” and “there is someone looking out for them”

“Not just a cookie cutter approach”

“It’s all about the relationship”

“Meaningful is such a great word because it has to come from the heart”

“It would be so nice for it to not feel like another medical appointment”.

“The first conversation is really important – being clear and transparent so that people know what’s available”.

“I want to feel like I’m equal to the person making the referral”

Does the slide presented accurately reflect your insights regarding how consumers should feel when utilising a social prescribing model? If not, please share your thoughts here.

Clients/eligibility criteria: Who should social prescribing be for? What do you think the eligibility criteria for accessing should be?

- Eligibility should not be focused on diagnosis but on individual need
- Important for it not to be siloed into disease types
- A non-stigmatised and inclusive approach
- Recognition that resourcing and targeting need to be considered, but there was disagreement on the balance between inclusivity and resourcing
- Important to not make assumptions based on what meets the eye
- Someone who's need has been identified in collaboration with health care professional/s
- Want and need measured equally

"**No closed door** approach"

"It should be for **anyone** who wants to use it "

"It is important this is not a medical space"

"Someone who is young, fit and healthy but needing this might be at risk of developing a chronic condition later on."

"There is a tricky balance between people not wanting to do this and being encouraged to participate because it is going to be helpful."

"There is a benefit in getting older and younger people together"

Does the slide presented accurately reflect which consumers you feel should be able to access the social prescribing service? Do the eligibility criteria reflect your views? If not, please share your thoughts here.

Referral process/connection: Who should be able to refer consumers? How should consumers access social prescribing? What are some of the ways consumers can find out about it?

Who should be able to refer?

- Primary care e.g. General Practice, practice nurse and admin staff
- Community and social services e.g. NGOs
- Disability services, including NDIS
- Mental health and alcohol and other drug services
- Allied health providers e.g. physiotherapists and psychologists
- Human services e.g. Centrelink, Medicare
- Family, friends and carers
- Self-referral possible

How should consumers find out about social prescribing?

- Target whole of population
- Segmented communication campaigns (e.g. by age and/or other demographics)
- Print media
- Broad advertising
- At commonly access community facilities e.g. libraries, art galleries, tourism information centres
- Aged care homes

How should consumers access social prescribing?

- If wanting a single activity, a health professional could refer directly
- Where needs are more complex an additional 'coordination' /support navigation layer is needed.
- Diverse range of organisations register as a 'provider'

Does the slide presented accurately reflect who should be able to refer consumers into the social prescribing model and how consumers should become aware of the service? If not, please share your thoughts.

Location: Where should the service be geographically located? Where should someone go to access the services provided (eg. physical or virtual)?

- Need for flexibility, options and **choice**
- A service that can cover the whole region, despite location
- Mixed opinions about co-location with GP services
- Co-location with another service is a popular opinion, especially in regional and rural areas, due to transport issues
- Need options for online and face-to-face
- Options for home visit as “some people can’t get out”
- Geographical locations - broad agreement that bushfire impacted areas should be #1 priority
- Broad agreement that a mobile social prescriber would be beneficial - cost effective

“I envisage them in a Kombi van”

“If you’re already going to see your GP then it’s easy for the GP to write you a social prescription”

“A “neutral space where the general public will go and where stigma is taken away - not going to another disability or medical service”

“It comes down to giving people a choice”

“I like the model of a one-stop-shop”

Does the slide presented accurately reflect where you feel the social prescribing service should be located, taking into consideration both the mode of delivery and physical location? If not, please share your thoughts here.

Staffing: Who should be responsible for direct delivery of social prescribing service? What skills are needed?

Who

- Peer volunteers or peer workers very important
- General practice staff, potentially practice support staff best suited - more time, good communicators
- Social workers, psychologists, welfare workers, community workers, nurses, Grand Pacific Health staff
- Include both public and private sector representation

Skills

- Peer workers need training in chronic disease space
- Awareness of risks
- Training needs to address:
  - Intent and purpose behind social prescribing
  - Evidence base
  - Local needs, services and barriers/issues
- Motivational interviewing and coaching skills

"You need a panel of people with a a whole range of different skills"

"It's an absolute no brainer that peer workers are involved"

"Needs to involve people from both the public and private sector"

"It might be helpful to train an organisation rather than an individual"

"There are a lot of people out there already doing this who just don't have the awareness"

"Not just the how to do it but the why and what kind of impact it can have on people's lives"

Does the slide presented accurately reflect the staffing model you feel should be in place for the delivery of the social prescribing model? If not, please share your thoughts.

Cost/resourcing: How should social prescribing be funded? Should users contribute towards costs of accessing non-clinical support?

Costs

- So many different things could be the 'prescription' and model needs to take into account the cost
- Important that cost doesn't become a barrier to using the service
- Initial costs (assessing and linking) vs. ongoing costs to consumer (using the prescription) to consider
- Needs to understand a person's capacity to pay for the service
- Recognition of there is value in co-contribution if people can afford it
- General Practice is already well-funded, could it be funded through what is already available through GPs?
- Consider costs to the user/consumer ($/time) and costs to the services (education, implementation, changes to practices way of working, etc)
- Consider existing funding opportunities
- Attention needs to be given to business model and economics

Resourcing

- Mix of health professional and peer workers
- Separation between the meta-function of coordinating, and the activities themselves
- Resourcing for a position to implement model - work with practices to gather information about what is available
- Enabling things through partnerships - philanthropic, donors, etc

Does the slide presented accurately reflect the cost and resource model you feel should be implemented with the social prescribing service? If not, please share your thoughts.

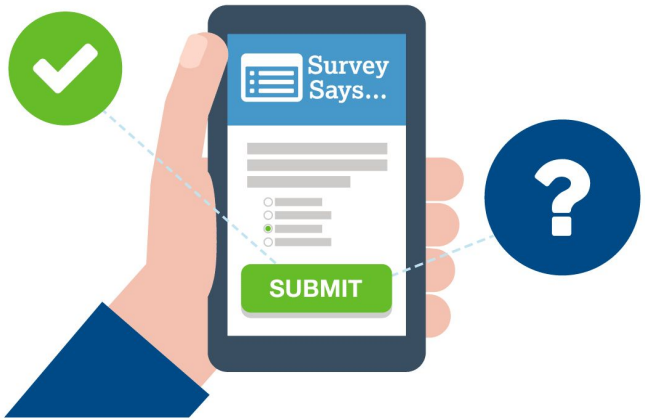
Next steps: Survey

When?

*Feedback loop 2 will be open until **Thursday 17th of December.***

Aims

- To determine the degree to which people who have and have not been involved in the process so far agree with and endorse the current findings
- For those who *haven't* been involved so far:
  - Any further information they would like to provide
  - Identifying gaps
  - Identifying other important points we need to know



Please click on the link below to complete the online survey:

https://www.surveymonkey.com/r/feedback-loop-2

Thank you.

Please reach out if you have any questions or comments.

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