Step Five: Making it Happen

The Surgery

Social prescribing for non-statutory services creates huge opportunities to help convert plans into reality. For most people starting to develop a health and social plan based on ‘what is important to me’ is a daunting task even if they are supported. But it is likely that most will rapidly loose interest if it is felt that the plan is meaningless. Equally while the plan should be aspirational, it also has be grounded in reality with detail on how to make it happen and who will support the person. It is therefore essential that once there is an agreement, there is a genuine attempt by both statutory and non-statutory services to enable the person to put the plan into action.
In some cases people will not need help and will be able to take control of their own plan. In other cases people will need support from a range of statutory and non-statutory services funded to provide support. These will range from community nursing to community navigators often from the voluntary sector.

The essence of making it happen is to put the person in control but that does not mean everything done for them by hard pressed NHS staff. A key element of making it happen is to reduce – not increase – the dependency cycle, recognising the benefits of an asset based approach to care. Surgeries, working with other surgeries within the neighbourhood, to contribute to the identification of a range of alternative services that would need to be available locally and funded by local CCG, LAs or local health and social care boards will help support this approach.

Without this local intelligence, supported by surgeries who are best placed to know what their local registered population needs and can act as advocates, encouraging local funders to commission these services locally people won’t be supported to achieve their own goals.

The Local System
In the devolved nations, we already see Health and Social Care Boards while in England, CCG are committed to an element of pooled budgets with local authorities called the Better Care Fund. Whichever part of the UK GP surgeries are based, we feel it is important for surgeries to engage with the local system on behalf of their registered list. Increasingly across the UK practices are grouping into neighbourhoods with population 30-60,000 in which community, social and voluntary services are working together.

Equally the local system has to have a responsibility to listen to what GP surgeries are saying and also to ensure arrangements are in place with non-statutory services to enable CCSP.

We envisage that over time local systems will develop a directory of services that will be available to the local population with access to these being encouraged as part of social prescribing as an alternative to pharmaceutical prescribing or referral to an NHS service.

We do not believe that primary care should be the only route to these services but they will facilitate access using social prescribing in support of CCSP.
Personal Health Budgets (PHB) are being promoted in some areas as part of the process and it is inevitable that there will be some demand for a PHB. This should be seen where possible as a means to enable CCSP and not an end in itself.

There remains the vexed question of how do we respond if a person includes a service in there plan which does not have an evidence base. There is no right or wrong answer here except to say that the evidence base for many of the services provided by the NHS is weak in the context of multimorbidity and local discussions are required.