

SOCIAL PRESCRIBING

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Social prescribing within primary care

Macmillan Primary Care Adviser, Sophia Nicola, on the role of social prescribing in supporting people affected by cancer within their local community.

Social prescribing programmes support people to access personal networks, and link them to practical and emotional support within their communities and the voluntary sector. Social prescribers work with people to identify needs that are having an impact on their quality of life.

They then agree action plans by arranging direct practical support or, more often, signposting or referring people to other professionals or services who are well placed to meet their needs. This takes into account the many different factors that contribute to a person's health, including emotional, practical and financial needs.

The aim of social prescribing models is to help people live as well as possible. There is a focus on supporting them to take control of, and improve their health, wellbeing and social welfare.

Individual needs vary, which means some people may only need limited contact with the social prescriber. However, for others, more regular contact and review might be necessary.

Social prescribing can also enable people to play an active role in identifying potential issues that are affecting their lives, and to work through solutions. It can support self-management and the development of coping skills for people with long-term conditions. This is an essential element of what social prescribing can achieve, working with the medical professionals involved in a person's care.

As well as the benefits to the individual, there is evidence from the University

of Westminster that supporting someone through social prescribing can reduce GP attendances by an average of 28% and accident and emergency attendances by an average of 24%. This demonstrates statistically significant drops in referrals to hospital.

What is Macmillan doing?

Macmillan recognises that social prescribing is an essential part of delivering integrated personalised care for people living with cancer. It is also an integral part of Macmillan's strategic ambition to make sure everyone with cancer has their needs assessed regularly and is helped to find their best way through.

Social prescribing involves a conversation between the person with cancer and a health or social care professional, the provision of information, an assessment of the person's needs and a care plan to help the person with cancer navigate the system and get the information and support they need.

The help available for each person will be different, depending on their needs, and the local support available to them. We are testing how this approach works across acute, primary, community and digital settings in 12 locations across the UK. This allows us to test and measure how the model works with different variables.



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Examples of best practice in primary care

This edition of Sharing Good Practice highlights some of the impacts that social prescribing services are having for people living with cancer across the UK. It specifically looks at examples within primary care. This is one of the more prominent models, although social prescribing can take place across many different health and social care settings. For example, you can read about cancer navigators working in acute settings on page 22 of this issue of *Mac Voice*.

Support is also available from Macmillan for social prescribers in delivering personalised care for people with cancer. For example, our Macmillan GP community may be able to provide training at local level, and we have more resources available online at macmillan.org.uk/gp (see page xi for more information). These include our top tips for social prescribing, which you can read below.

Top 10 tips for social prescribing

1. Social prescribing can be an essential way to support people with cancer in the community, from diagnosis and beyond.
2. Social prescribers should be considered vital members of primary and community care teams.
3. People with cancer describe feeling like they have ‘fallen off a cliff’ when they are discharged from regular follow up – social prescribing can help provide the further support they need.
4. Social prescribers can help people identify community groups, activities or support to alleviate the loneliness that almost a quarter of people with cancer experience.
5. Over 70% of people with cancer need emotional support – social prescribers can help identify these needs and signpost to appropriate support.
6. People with cancer are, on average, £570 a month worse off – social prescribers can ensure they are getting the financial support they are entitled to.
7. Over half of people with cancer don’t know where to get help with returning to work – a social prescriber could provide vital support.
8. Social prescribers can signpost people with cancer to local services offering appropriate advice on physical activity and support to stay active.
9. A close relationship with primary care teams and understanding links with secondary care can ensure any problems with the consequences of cancer and its treatment are identified early, with appropriate support offered.
10. Social prescribers can help primary care teams provide personalised care for people with cancer who also have one or more co-morbidities.

A dynamic approach to social prescribing

Macmillan Integrated Project and Programme Manager, Jo Dempsey, on a model of social prescribing that is exceeding expectations.

Knowsley in Merseyside is the second most deprived local authority in England¹, with cancer incidence of 692 per 100,000 population. This is significantly above the national average for England (610) and the regional average for the North West (637)². The borough only has one hospital and Macmillan Information Centre within its boundary.

Macmillan has invested in community-based projects in Cheshire and Merseyside to deliver the Recovery Package, including holistic needs assessments (HNA), care plans and health and wellbeing interventions. The aim was to find out if a local offer increased uptake of the Recovery Package and person-centred outcomes. Knowsley CCG won a bid to deliver a primary care model, which included 1.75 whole time equivalent (wte) navigators, a 0.6wte qualified nurse and a 0.6wte project manager. Nine GP practices were recruited for phase one of the pilot, which launched in February 2019, and by December 2019 this had increased to 12.

Our primary care model

The navigators offer:

- a meeting with all newly-diagnosed cancer patients, an HNA and care plan to support problem-solving and health and wellbeing interventions
- a meeting with people who have been referred onto a two-week pathway if their GP is concerned about their anxiety
- phone calls to patients to encourage uptake of cancer screening programmes (the navigators are trained as experts in the breast and bowel screening programmes).

The navigators are employed by, and embedded in, primary care. They undertook a three-month induction that included becoming experts in EMIS (primary care web system), understanding referral pathways, scoping local community assets to develop a service directory, placements, training days, online training and shadowing.

Social prescribing, sometimes referred to as community referral, is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services³. In Knowsley we wanted to exceed this definition with a truly holistic approach, meeting as many needs as identified by a person with cancer. We wanted to utilise primary care to enable faster access to services such as the practice pharmacist, community matron, community dietetics, charitable organisations and housing support.

The delivery

The trigger for a referral to the navigators is the receipt of a person with a new diagnosis of cancer to the general practice from a local trust. Once the diagnosis is received, the practice populates an EMIS referral template and emails the navigator to say a referral is on the system. The navigator then checks that the patient has been given their diagnosis and sends them an invitation letter to arrange an appointment to talk about their diagnosis and potential support. Two invitation letters are sent and a final 'we are here if you need us' discharge letter. To date, there has only been a 3.5% no response/opt out rate. Since the project started, 366 referrals have been received.



L-R: Tracy Sutton, Navigator, Janet Cummins, Cancer Educator and Gill Nolan, Navigator.

Once the patient has opted in, an appointment is arranged and the HNA is undertaken. Any issues generated from the HNA are compiled in a care plan and strategies to address concerns are agreed with the patient. We do not limit the patient to the top three issues. The navigators keep in contact with the patient until all the issues have been addressed.

They follow up with a phone call four weeks later and offer a second HNA at 12 weeks or the end of treatment. A copy of their care plan is added to a patient's record and can be used as the basis for a cancer care review.

Personalised care is part of the delivery of the NHS Long Term Plan⁴, and the Knowsley model is exceeding

expectations in the delivery of truly personalised care.

What have we found?

A significant proportion of people we have seen do not even have their most basic needs met, such as a bed to sleep in, cookers, washing machines, food and warmth⁵. We have seen people not attending investigations and treatments because they do not have the money to get to the hospital, or are isolated and living in detrimental conditions.

The navigators' dynamic approach, skill set, and knowledge of local assets has allowed them to help transform people's situations. Exceptional partnership working has meant that local bus service Mersey Travel have given people free bus passes, a local Tesco is offering vouchers to buy nightwear and toiletries, and several charitable trusts are fast-tracking the navigators' referrals for white goods and emergency provision.

Patient satisfaction is very high, with three patients already making a video to share their passion about the service. GPs are also enthusiastic, with one saying, 'I have never seen such positive impact on patient care in such a short time as provided by the cancer navigators.' This feedback, alongside the hard work undertaken by the navigators, has resulted in two primary care networks wishing to take on the navigators permanently at the end of their project time. This is great news for people affected by cancer in Knowsley.

You can read an example case study from the Knowsley social prescribing service on the next page.



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Knowsley: an example case study

Jean* is 64 years old and has recently been diagnosed with lung cancer. She lives with her husband and has been struggling emotionally since her diagnosis, which is impacting on her daily life. When Macmillan Cancer Navigator Gill visited to complete an HNA with Jean, many concerns were raised. These were all addressed to improve quality of life for Jean and her husband.

Jean's care plan is outlined below. She will receive a phone call in four weeks to check how she is, and a second HNA will be offered in 12 weeks. Jean can also contact Gill at any time for support.

Emotional concerns

- Gill has contacted the clinical psychologist who is happy to meet with Jean and provide emotional support to her and her husband. The secretary will contact Jean to arrange an appointment.
- Complementary therapies can help with relaxation. The Macmillan Information Centre has suggested that Jean phones them within the next few days to book in for therapies such as Indian head massage, back massage or reiki, which are free of charge.

Practical concerns

- Gill has applied for a grant for £400 for Jean to purchase a new bed and will update her as soon as she hears whether it has been approved.
- Gill has applied to Macmillan for a cash grant for £300 to enable Jean to replace her broken fridge/freezer.
- Gill has contacted the benefits adviser at the Macmillan Information Centre

and requested she contact Jean directly to arrange to review of the benefits she is entitled to.

- Gill has requested occupational therapy contact Jean to review the need for adaptations around her home, such as grab rails, a shower chair and an additional bannister rail.

Physical symptoms

- Gill has arranged for the practice pharmacist to contact Jean to review her current medications and agree blister packs.
- Gill has added an alert onto Jean's GP record for our reception staff to be aware that she is on active treatment and to prioritise her appointments should she request one.

Family concerns

- Gill has sent a referral to the local carer centre for Jean's husband to receive support and assessment.

*Jean is not a real person, but her story reflects an average HNA/ care plan for the service. This is to avoid identifying anyone who has accessed the service.

Coordinating support in Cardiff

Macmillan Cancer Wellbeing Coordinators, Jane Breeze and Antonia Luscombe-Whyte, on a pilot project to provide holistic, non-clinical support for people affected by cancer.

Macmillan has funded two new cancer wellbeing coordinator roles for three years, in partnership with Cardiff and Vale University Health Board and the Macmillan Primary Care Cancer Framework.

After patients finish acute care and treatment, it can feel like they are ‘falling off a cliff’ when going back to primary and community care. The pilot Macmillan Cancer Wellbeing Coordinator (MCWC) service aims to reduce that feeling by offering holistic, non-clinical support for local people affected by cancer.

The role for social prescribing is increasingly recognised, yet until now there have been no cancer-specific social prescribing services in the Cardiff area. As this is a new approach for the areas, with input from both primary and secondary care, a steering group was established to provide strategic direction and provide assurances around governance. The group responds to operational learning and shares good practice. It includes stakeholder representation from primary care, Macmillan, the Macmillan Primary Care Cancer Framework and the local health board’s Macmillan lead cancer nurse.

The service employs two Macmillan cancer wellbeing coordinators, who both work three days a week in very different parts of Cardiff. Jane Breeze is based in North Cardiff and covers GP practices in Radyr and Whitchurch, and Antonia Luscombe-Whyte is based west of Cardiff and covers some of the practices based in Ely. As this is a small pilot, patients must be registered with specific surgeries to be eligible for this service.

Cardiff is the most ethnically diverse local authority in Wales, with 19.7% of the city’s population coming from a non-white background, and over 100 languages spoken in the city⁶.

The service aims to meet the diverse needs of the local population to ensure that no one is placed at a disadvantage. The two areas chosen for the pilot are quite different in prosperity and ethnicity. The Ely area has a high number of former and current council houses and Housing Association properties, and is supported by a wide range of community initiatives. Radyr and Whitchurch are slightly more affluent and have fewer community-run groups, but libraries and hubs are expanding the range of community support available.

A wide range of support

The cancer wellbeing coordinators use the holistic needs assessment (HNA) form as a starting point to support people with a range of non-medical topics, and to signpost them to relevant resources. These include health and wellbeing programmes, support groups and advice lines, and services for the elderly or people who are bereaved. These options will depend on whether the person is more comfortable with online or face-to-face support.

The coordinators can also refer people to specialists for practical support, such as welfare advice and money management. They can also discuss social opportunities such as singing groups or art groups, emotional support or volunteering opportunities.

At the start of the project, the coordinators scoped out local services and met with a range of providers. This also raises awareness to other service providers about the MCWC service, which hopefully will encourage reciprocal referrals. They are building up a broad base of local resources, so that in addition to Macmillan information and other local Macmillan services, they have local contacts for Tenovus, Maggie's Centres, Breast Cancer Care and other local groups.

Patients can be referred by their GP or they can self-refer by completing a short form at the reception of the participating surgeries, and from local libraries, pharmacies and community centres. The coordinators can also see family members and carers of people who have been diagnosed with or who are living with cancer, to provide support to them.

The role includes helping people to navigate the NHS if they have got lost in the system and hopefully reduce any sense of abandonment by supporting people once active cancer treatment has finished. The coordinators have attended training on advanced care planning. They may get involved in cancer care reviews to support people with non-clinical needs, and hopefully help to reduce pressure on GPs.

Progress and evaluation

In the early stages of the project the coordinators saw around 20 to 30 patients each. Since promoting the service, they are seeing many more new patients. They have signposted to support groups, helplines and websites, as well as emotional support, over several appointments. Appointments can be up to one hour and the scheme allows each patient up to six appointments, although most people require far less.

Each patient intervention is recorded on a database. This captures every phone call, text and face-to-face contact, information about each patient and the outcomes of each meeting in terms of signposting, referrals, and the type of information shared. The spreadsheet is used to produce quarterly statistics for the steering group.

In most face-to-face meetings, the patient has completed an HNA in advance, and a care plan is prepared at the end of the appointment. An overview of the discussion is recorded on the patient's electronic record at each GP surgery, together with a copy of the HNA and care plan.

The coordinators are currently discussing using the Macmillan feedback form as a standard way of obtaining feedback. However, it is important to ensure that these forms still protect patient anonymity when they are returned to the surgery. They are also receiving training on 'patient stories' so that more general feedback can be obtained from a random selection of patients, with each coordinator interviewing people from the other's catchment area.

As the project develops it will be interesting to see what impact the role of the Macmillan cancer wellbeing coordinators has on people dealing with the effects of cancer and how this impacts their lives.

The project also aims to evaluate any reduction in the number of appointments that people at the pilot scheme surgeries have subsequently made with their GP or nurse, to see what impact this has had on workload. The project is on-going until March 2022.



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Maximising community-based support

Macmillan Primary Care Navigator, Claire Simpson, on delivering a pilot holistic support and information service for people with cancer in the community.

The NHS long-term plan for cancer states that 'by 2021 where appropriate, every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.'⁴

Since September 2019, we have developed and launched a community navigation service to support people with cancer living in Wandsworth in South West London, with initial testing in Battersea. Our focus is to identify the physical, practical, emotional and social needs of people with cancer in a proactive way.

We aim to address these through health coaching interventions, and signposting or referral to national and community-based services. A key part of our project is to empower the patient and maximise the potential of both digital and community-based support.

On average, a GP currently has a caseload of eight or nine new cancer diagnoses per year, while also looking after up to around 30 people living with and beyond cancer⁷. With the success of earlier diagnosis, alongside innovative treatment options, cancer survival is the highest it has ever been⁴.

As such, there are increasing numbers of people in the community who require associated follow-up care and support. Macmillan predicts that between 2015 and 2030, the number of people in Wandsworth living up to 21 years after a cancer diagnosis could increase by over 60%.

Within a climate of public spending cuts, increased patient expectation and the demands of supporting people with long-term conditions in an aging population, general practice has faced many challenges. However, these are increasingly being met with innovative solutions.

In addition to the pivotal roles played by GPs, practice nurses and clinical nurse specialists in supporting people with cancer, a huge range of support can be successfully provided by specialist non-clinical staff. This can be through place-based approaches, hospital-based Macmillan support workers, and the recent national roll-out of locally-commissioned community social prescribers. Our service is provided by a non-clinical primary care navigator.

Our approach

Our service is being developed and delivered by a full-time navigator and a part-time clinical lead, who are both supported by a steering group. We are piloting the project at one practice (Lavender Hill Group Practice) within the Battersea Primary Care Network, with the long-term aim of rolling out across Wandsworth's nine primary care networks.

The navigator is experienced in addressing a wide range of needs, and the service does not discriminate between prognosis, diagnosis or stage of treatment. The service reaches out to those with a new cancer diagnosis and accepts self-referrals or referrals from GPs and nurses at any point in the cancer pathway.

We are trialling an 'opt-out' service for those with a new diagnosis, in line with offering equity of service provision. We expect that evaluation will highlight when community support is most beneficial.

Patients are offered an electronic holistic needs assessment before an initial hour-long face-to-face appointment at the practice. Concerns are then prioritised and a care plan is created in collaboration with the patient.

In addition to listening, the service supports people to access further physical, emotional, practical, financial and spiritual support, as well as support for carers. This includes providing free, written information and signposting or referring people to services such as psychological support, complementary therapies, benefits advice and support groups.

Both GPs and patients will hopefully benefit from a tangible referral pathway, as there is not always time to address someone's complex needs during the typical 10-minute GP appointment⁸. As the navigator is embedded in the practice workforce, escalation and communication to the patient's GP is supported with a shared clinical system and regular attendance at clinical meetings.

Integrating the project within the wider practice is key to service delivery, as there are a range of ways that patients express need. This might be a seemingly random comment on a call to a receptionist, to the proactive self-identification of need to the GP.

Learning and engagement activity

Stakeholder engagement continues to be an important part of this pilot, learning from other local and regional initiatives funded by Macmillan. Engagement with other London cancer support roles and

services such as cancer leads, clinical nurse specialists and information and support centres has been an important part of understanding existing patient pathways.

Within Wandsworth and nationally, numerous services to help support patients both during and beyond treatment have been identified. The aim is to establish a directory of services to support future navigators and people with cancer who wish to self-manage.

The success of the stakeholder engagement is greatly attributed to the relationships between Macmillan professionals, particularly through the pivotal role of Dr Owen Carter, Macmillan GP and Lead Cancer GP within Wandsworth Clinical Commissioning Group.

Next steps include recruiting a project manager to help deliver a sustainable service across Wandsworth. We hope this can be achieved through the addition of further navigators and continued evaluation against intended outcomes.

Many thanks to the Knowsley CCG Primary Care Navigator Pilot for sharing their learning, and we look forward to more shared learning from Macmillan Right by You pilot sites across the country. To find out more, please contact us at macmillan.batterseanavigator@nhs.net

To find out more about Right By You and Macmillan's strategy, go to <https://learnzone.org.uk/strategy>



Further information

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Resources

Resources from Macmillan

- **Social prescribing for cancer patients: A guide for primary care networks**
- **Primary care resource pack**
- **Primary care 10 top tips for social prescribing**

These resources are all available at: macmillan.org.uk/gp

NHS England (2019). Social prescribing and community-based support: Summary guide

A guide intended for people and organisations leading local implementation of social prescribing. Enables an increased understanding of what good social prescribing looks like, and covers commissioning and collaborative working. Available at: england.nhs.uk/publication/social-prescribing-and-community-based-support-summary-guide

The King's Fund (2017) What is social prescribing?

An overview of what social prescribing is and the emerging evidence to support it. Available at: kingsfund.org.uk/publications/social-prescribing

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