

An outcomes contract for social prescribing for long term conditions

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Pathways between medical and social models of health

LEAR OF CAR



https://www.diabetes.org.uk/upload/Professionals/Year%20of%20Care/thanks-for-the-petunias.pdf

Developing the programme

- Steering group hosted within Voluntary Organisations Network North East (VONNE).
- Strong project team finance, operational and voluntary sector experience (SEIF & BLF).
- Developing the service specification & procuring providers.
- Negotiating with the CCG and agreeing outcome metrics.
- Setting up the governance framework.
- Sourcing funds BLF, Cabinet Office, Bridges Fund Management.

Key Elements

- Prime contractor 7 year contract with CCG, sub-contracts with 4 providers
- Simple outcomes
- Dedicated management information system
- Focus on funding link workers rather than activities
- Information governance (HSCIC Level 2 AQP)
- Further evaluation built in



Baseline Population & Referral Criteria

- Registered with a GP practice in Newcastle West (18 practices, 112,000 population, 14,229 on LTC QOF Register)
- Long-term condition (LTC):
 - COPD, Asthma, Diabetes (Type 1 or 2), Coronary Heart Disease, Heart Failure, Epilepsy, Osteoporosis
- 40 to 74 years of age
- Further prioritised referral criteria:
 - social isolation
 - poor understanding of condition, frequent attender at GP or hospital, poor adherence to prescription
 - anxiety or depression (in addition to one of the above LTCs)
 - poor health but with scope to improve with lifestyle change
 - poor English literacy
 - obese or inactive











Outcomes

Show data on Star

1. Well-being StarTM

Average improvement over 1.5 results in an outcome- based payment (30%)

2. Secondary care costs

Savings in scheduled & unscheduled admissions, out-patient and A&E costs compared against a matched cohort results in an agreed payment (70%)







Access specialist services and support

Healthy eating and cooking



Service Metrics – Referred in Month Service to Date





- Referred in Month in Year 1: 1,142 = 97% of target
- Referred in Month in Year 2:
 1,508 = 79% of target

- Referred in Month in Year 3:
 386 = 71% of target
- To Date Referred in Month:
 3,036 = 83% of target

607 shortfall in referred in month service to date

Service Metrics - Referrals by GP Practice Service to Date







Above Target

Below Target

Target to 30 June 2017

Starts 'Successful New Referrals'

Highlights from further data analysis: first 1347 patients

- Men 46.6% (1st Star 28.6) Women 53.2% (27.4)
- Age 40-59 45% (1st Star 26.5)
- Age 60-74 55% (1st Star 30.4)
- 40.6% with 2 or more LTCs, numbers increase with age.
- Link workers spend an average of 8.4 hours with each patient, which represents an average of 23 contacts per patient





"I feel like finally there is a light at the end of the tunnel and I want to say thank you for calling me and listening, I really appreciate it." "I do believe that knowing the Ways to Wellness team is like winning a lottery ticket in life."

"I now have a totally different outlook." "I feel really proud of myself that I'm getting out and about more." "This service has resolved a lot of issues that worried me."

> "It has helped to focus my mind and gave me belief that things can change."

Institute of Health&Society



http://bmjopen.bmj.com/cgi/content/full/bmjopen-2016-015203?ijkey=GgHZG0gd300M44i&keytype=ref

"I feel better already talking to you. It helps motivate me."

Ways to Wellness



Thank you to all our providers and funders







NHS Newcastle Gateshead Clinical Commissioning Group







Health Education North East



Thank you for listening Questions?

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