

Workshop 6 – Tackling loneliness: the role of health and social care

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All too often, primary care professionals can be the only human contact which chronically lonely patients have. Three out of four GPs say they see between 1 and 5 people a day who have come in mainly because they are lonely.

These interactions are therefore vital to help people to access the support they need and make the connections which will work for them. Having well established activities or groups in the local area to which people can be referred or signposted is clearly essential and the voluntary and community sector play a vital role in provision, whether or not their primary objective is health and social care focussed.

Educational and professional development resources for primary care staff are also important, helping identify earlier those people who are at risk of becoming lonely and better support them before they become chronically lonely.



This workshop looked at two approaches to supporting people in a medical setting, not using GP appointments but rather through supportive conversations, signposting and tackling problems.

Care Co-ordinator service

The Care Co-ordinator role was developed in order to give additional support and resources to those most at risk within a GPs patient list.

The average GP will see 41 patients a day, a practice such as Pickering Medical practice will see on average 200-300 a day. On average patient will be seen 4-6 times a year but for someone receiving end of life care that can be 16 times.

The importance of contact with the surgery is paramount but this needn't be just from Doctors but can be from a range of people working in a health care setting, including receptionists. By identifying a number of people identified by the Frailty Index and also their own RAG rating messages can be proactively given to help reduce anxiety and give practical signposting and communication in order to look towards social prescribing to take a preventative approach to people for whom this approach will be beneficial to their health condition.

Do you have to be poorly and to be seen by a GP in order to initiate contact?

No, because of its more holistic approach the contact from a Care Coordinator does not have to be initiated from a visit to the doctors but could be instigated by other agencies. The

Care-Coordinator role is to communicate regularly with other agencies and to support a patient using information from elsewhere such as social services, housing and care providers to make a difference

This is a proven approach but now the issue is how to make it sustainable. One way is to train all staff such as reception staff to be able to be a knowledgeable means to signpost and communicate key messages. Also what is needed is to make sure that all the approvals are in place to share information and to look at an easy but safe mechanism that this can be done.

Will it spread across North Yorkshire?

At present the trial is with three GP practices and the learning from this will inform future development but the benefits are definitely there.

Does it include younger people?

No at present because of funding it focusses on older people but that doesn't mean the same approach could not be developed to support younger people too.

Living Well Service

Living well are working closely with a medical practice in their area in order to provide the Living Well service to people who come into the surgery. After working with practice staff it was decided that the Living Well co-ordinator should spend a regular half day in the practice each week in order to reach those who are hard to reach but would benefit from Living Well support. The integration of the Living Well co-ordinator into the general team at the surgery has been paramount to the success of the project with surgery staff fully understanding what the Living Well team can do and comfortable about referring patients to see them. The Living Well team have dedicated time to persevere to build up confidence and trust with those visiting the doctors to look as some of the non-medical issues that can be dealt with in order for people to build up resilience.

What can be done supporting people on a more long term basis?

We need to continue to work closely with the NYCC Prevention contract to ensure that there is long term befriending support out there as well as a range of activities that can help people build up confidence, create social networks and feel better able access the right kind of support and information in a timely manner.

Group discussion

People asked, how do we work more closely together, is there an ongoing forum where we can have discussions

How to we gain traction in work to reduce social isolation

How can I get people to know about my group (bowling)

Discussed NY connect

How can we reduce competition for funding and volunteers

Generalist advocate roles are being cut, and can deliver services more cheaply than NYCC staff

Comment that NYCC can't solve everything, we need to work together more and NYCC needs to commission services from partners rather than delivering alone

We need to understand more who delivered what and how to access services

There appeared to be an appetite for people to work together and more closely and people were unsure of what forums are in place to take this forward.