Project snapshot

Camden Care Navigation and Social Prescribing Service (SPIP13) - Katalin Swann & Donna Turnbull (SP service manager, Community Development Manager)

AIM: to tackle recruitment and retention through the development of a voluntary role to support SPLWs with admin & transactions around referrals.

Target goals/outcomes:

1. **Recruitment of 10 volunteers** to test and learn approach with assisting social prescribers and taking on transactions.
2. **Training and skills development** on the job to develop pool of future SPLWs
3. **Retention** of social prescribers.

Highlights:

- Good promotion of initiative
- Successful recruitment of volunteers
- Team working well together

Impact so far:

✓ By having volunteers in the service supporting Social Prescribing Link workers, there was **90% retention of the team** as opposed to the 53% experienced in the last 3 years.

✓ 7 out of the target 10 **volunteers successfully recruited** in the last 6 months

Benefits voiced by the team:

➢ Time freed up to spend with more complex cases

Benefits voiced by clients:

➢ Stress taken out of attending GP and hospital appointments

➢ Being able to excersize and being connected

➢ Receiving regular welfare calls and having someone to call when needing to complete forms

Project snapshot

Men's project (Tower Hamlets) (SPIP16) - Sahdia Warriach, Ceri Durham (SP manager, CEO – social action)

AIM: To engage men of all ages in Tower Hamlets and find out from them directly how we can increase their engagement in social prescribing

Target goals/outcomes:

1. To **work with local men to co-create project ideas** that they would actually like to see and link this with social prescribing
2. To **deliver 4 planning/training sessions with the team:** St Margaret's House, TH GP Care Group, Social Action for Health and Voicebox Theatre
3. To **deliver 8 sessions with local men** to find out the above

Highlights:

- Good communication across all partners on the project
- Good structure for delivery of the projects was agreed

Findings:

- 68% of respondents **did not know how to access social prescribing**
- 52% felt **loneliness currently has a negative impact** on their health / wellbeing
- 70% chose **work as the reason they might not be able to do things they enjoy**
- 79 % would **choose to do physical activities** if offered by social prescribing

To see full survey results, and slides summarising male social prescriber's reflections and the results from our consultations with men's groups, please use the link: *shorturl.at/mAVX9*

Word cloud representing responses of 5 men's groups to the question: 'What social prescribing activities would you like to engage in?'

Project snapshot

The Confederation, Hillingdon CIC (SPIP28) - Samar Battikh, Rianna Breen

(Associate Transformation Manager , SPLW lead)

AIM: To improve the quality of care given to clients with mild to moderate mental health needs/challenged behaviours by SPLWs, focusing on 'what matters to me' safety for them and patient and connecting people to community groups

Target goals/outcomes:

1. **Recruitment and upskilling of 6 SPwSI**
2. Set up **training schedule** for candidates working with NWL Training Hub
3. **Theoretical and practical training and skill development of Social prescribers** for Mild- Moderate MH and challenging behaviours

Highlights:

- Enthusiasm of SPLWs to be involved
- Good team working of everyone involved

Findings from the pre-programme SPLW confidence survey results set the baseline to analyse growth and improvements

- 58% **do not feel confident building holistic relationships with patients of this cohort** and support them for their self advocacy.
- 57% do not feel they have the **skills to deal with a challenging behaviour** when it is directed at them.
- 42% feel they c**annot easily analyse/ identify a challenging behaviour** in a patient.
- 43% d**o not feel confident in discussing uncomfortable/ sensitive information** with patients & carers.

They have:

- Developed a **Specialist training programme for the SPwSI in Mental Health and Challenging Behaviours with MHFA**
- **Standardised reports and streamlined referrals** for all SPLWs in Hillingdon, making use of JOY
- Reviewed documentation, patient pathways, including escalation procedure, risk assessments and Lone Working Policies.
- Secured m**entoring support with Adult Mental Health practitioners** for SPLWs.

Project snapshot

West and Central Camden Primary Care Network , Denise Marsh, Richard Mendall (Social Prescriber, GP)

AIM: Increase the percentage of people from an Asian, Black, Somali and Arab ethnicity receiving social Prescribing referrals and ensure they have high rates of satisfaction from the service

Target goals/outcomes:

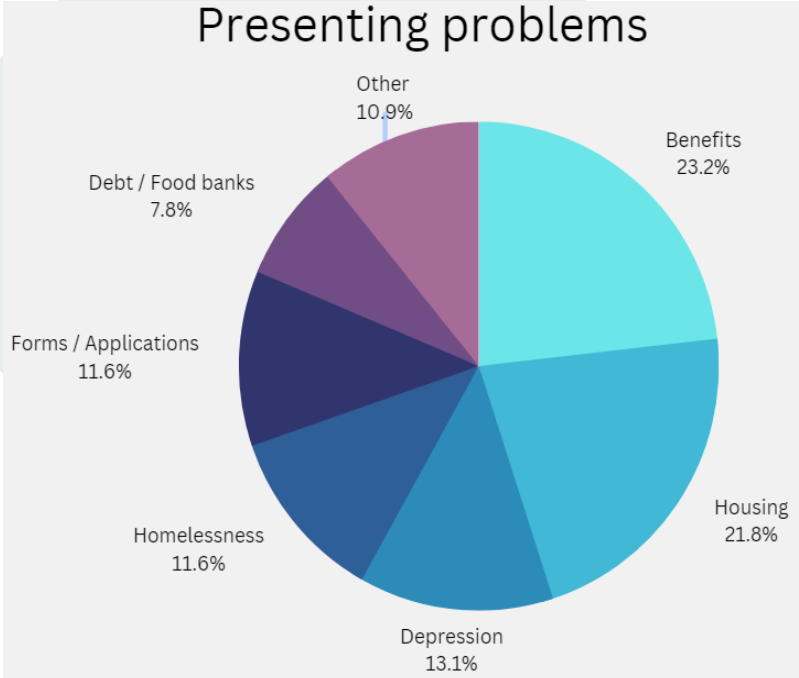
1. Recruit a **Social Prescriber to work with BAME patients**, who speaks different languages.
2. **Promote social prescribing within the community** to attract BAME patients
3. **Record types of problem** the BAME Patients are seen about

Highlights:

- Ethnic minority Social Prescriber recruited who has experience of community initiatives and has been a Councillor.

Impacts:

- ✓ 100% of patients referred to the service who responded, would recommend it .
- ✓ Out of all the patients seen from Dec-Mid March (176) the proportion from Ethnic Minority Backgrounds increased from 56% to 65%. Of the patients seen:
  - 25.6% South Asian
  - 13% Somali
  - 7.4% Arabic
  - 15.3% Afrocarribean
- ✓ Awareness of social prescribing in the BAME communities increased, there was evidence that demand for the service also increased as word of mouth spreads
- ✓ There were also good satisfaction rates from the service



Project snapshot

A2Dominion Community Link Worker - Social Prescribing in Ealing - Caroline O'Leary (Social Prescribing Link Worker

AIM: Tackling loneliness and isolation in older (65+) people from predominantly black and minority ethnic backgrounds in Ealing through Social Prescribing.

Target goals/outcomes:

1. Employ two part-time Community Connectors to take on a caseload of approx. 20 clients
2. Lonely/isolated clients accompanied to medical/social appointments and given SP support
3. Increased attendance at appointments; SPs' time focused on complex cases

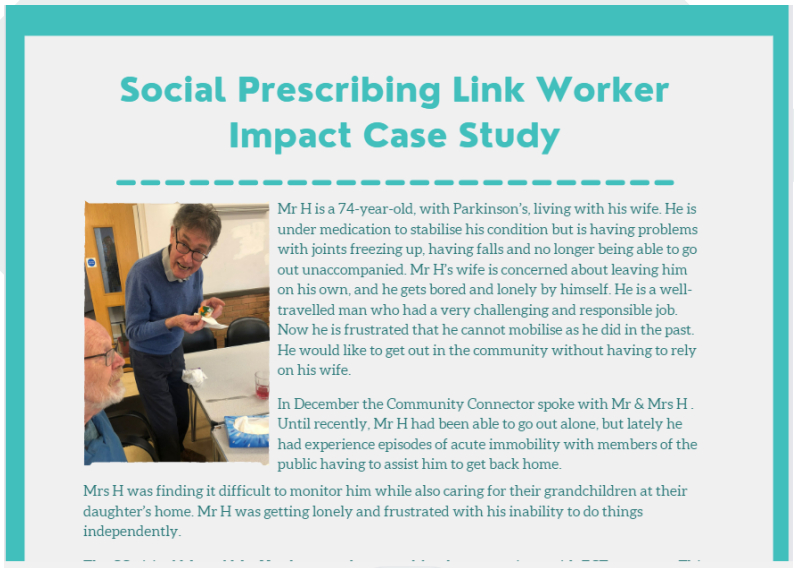
Highlights:

- Steering Group partnership between Age UK and A2Dominion
- Newsletter, "SP News", promoting service and wider SP activities, circulated to Ealing PCN and clients.

Impacts:

- ✓ 95% of patients (out of 20) referred to a Community Connector were **satisfied with the service**.
- ✓ Patients on low incomes, impacted most by cost of living were able to access free in-person support to help with basic needs.
- ✓ On average there was a **24% increase in in ONS scores,** in 19 out of 20 patients.
- ✓ 68% of patient **referrals to the project addressed loneliness & isolation, managing long-term health or day2day needs**
- ✓ 80% of patients ethnicity Registered as from Irish, mixed or Asian and multiple ethnic groups

Please see the patient case study here.



Social Prescribing Link Worker
Impact Case Study

Mr H is a 74-year-old, with Parkinson's, living with his wife. He is under medication to stabilise his condition but is having problems with joints freezing up, having falls and no longer being able to go out unaccompanied. Mr H's wife is concerned about leaving him on his own, and he gets bored and lonely by himself. He is a well-travelled man who had a very challenging and responsible job. Now he is frustrated that he cannot mobilise as he did in the past. He would like to get out in the community without having to rely on his wife.

In December the Community Connector spoke with Mr & Mrs H . Until recently, Mr H had been able to go out alone, but lately he had experience episodes of acute immobility with members of the public having to assist him to get back home.

Mrs H was finding it difficult to monitor him while also caring for their grandchildren at their daughter's home. Mr H was getting lonely and frustrated with his inability to do things independently.

Transformation Partners in Health and Care

Project snapshot

WCPCN Wellbeing Partnership (Waltham Forest) - **Sue Kofi** (Social Prescribing Link Worker

NHS

AIM: Tackle the challenge of inadequate services for patients with mental health issues through designing more specialised social prescribing support for these patients

Target goals/outcomes:

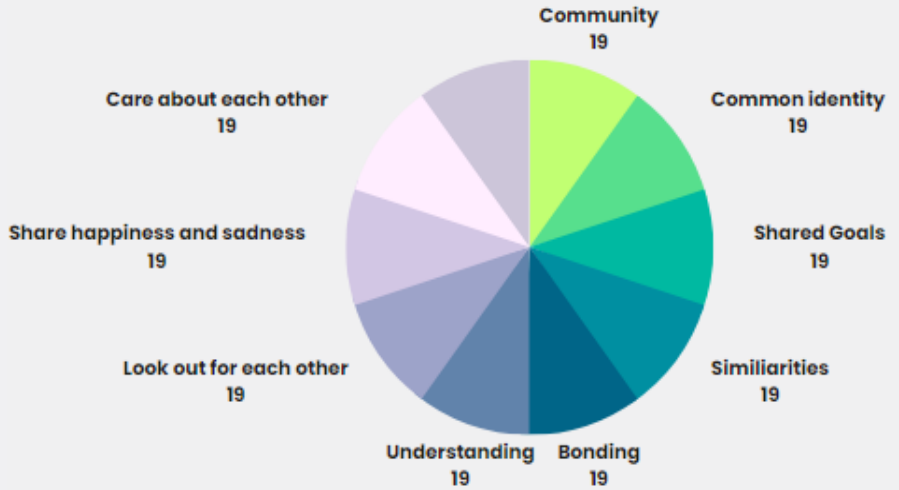
- To engage with up to 25 patients from across the PCN in wellbeing cafes, 12 sessions delivered by mid Feb
- To ensure patients are aware of other support networks within the Borough

Highlights:

- The Team work!
- Really nice mix of participants who are all engaging and supporting of each other

Impacts:

✓ After 10 weeks in the Wellbeing Cafe, all 19 participants experienced a 100% improvement in these areas and the 5 areas of wellbeing (Give, Connect, Be Active, Take Notice, Keep Learning)



19 Participants

68% of Participants identified as Female

32% of participants identified as male

84% of participants identified within minority ethnic groups

Project snapshot

HBD Women's Health Network (SPIP40) – Ruth Vidal-Tunkar, Cheryl Alfred

(SPLW, PCN Project Support Assistant)

AIM: To proactively support cohorts to access SP, specifically patients with material/social issues & wellbeing/mental issues, enabling SP services to be more holistic.

Target goals/outcomes:

1. Create a more holistic and unified approach to proactively support cohorts of patients to access a range of social prescribing and health interventions
2. Address the barriers to offering a more transformative Social Prescribing service within primary care

Highlights:

- Positive feedback from attendees, GPs and a pharmacist who's supported two sessions
- Enabling effective cross sector partnership working
- Space to build relationships with other patients, peer support encouraged

Impact:

- Held **12 Women's Health Network sessions** since October & seven more scheduled before end of June
- Invited people known to the service, those on waiting lists & specific cohorts
- **84% of attendees** reported that their first contact with Link Workers was at one of the sessions
- Led to a **reduction from 6 to 3 weeks in waiting list times** at busiest practice since October 2022 through engaging those on the waiting list via these sessions
- **Patient reach increased by 50%** (225 patients) over the last 6 month period
- Built capacity through group working, collaborating with community partners and encouraging peer support which lessens the dependency on link worker support
- Spearheaded collaboration and co-design with **clinical colleagues and community organisations**
- **Secured additional funding** to continue sessions from **April to end of June 2023**.

Project snapshot

Project Feel Good Now (SPIP10) – Miranda Cook

(Feel Good Now CIC Director & SPLW)

AIM: To host holistic wellness events and promotions in multiple PCNs, bringing together statutory, health and VCSE organisations to evolve the SP offer in City and Hackney.

Target goals/outcomes:

1. To promote social prescribing in City and Hackney to people not currently served by SP, including young people, asylum seekers, homeless populations and others
2. To reduce health inequalities by offering people tools for self care

Highlights:

- Huge potential for not only improving access to social prescribing through proactive outreach to neighbourhoods but also improving the wellbeing of SPLW themselves

Impact:

Held seven wellbeing events concentrated on three postcodes in Hackney, and invitations sent through community groups:

- **Average attendance** per event was **12 people**
- **97%** of attendees were from **underrepresented communities & global majority heritage**
- **95%** had **never experienced self-care treatment**, which was provided at the events
- **80%** had **never accessed SP through their GP** but **one third went on to make an appointment with the SPLW**
- **100% rated the event 5/5** and felt ‘immediate benefits’ including **increased feelings of self esteem**
- Attendees said they were **"likely" or "very likely"** to use the **self care techniques** shown in the workshop at home

Also held an **event for SPLWs**, and collected data before, immediately after and one week after the event:

- **88% felt stressed ‘most of the time’** before the event but **reduced to 62% one week after**
- **70% felt miserable or unhappy at work** before the event yet **100% reported feeling ongoing positive wellbeing effects** one week after

Project snapshot

My Community Social Prescribing Evaluation Project (SPIP33) – Alexandra Norman, Ollie Shotton

(My Community Services Manager, My Community Social Prescribing Lead)

AIM: To design a process to evaluate services with SPLWs at the core in order to support recruitment & retention and demonstrate impact.

Target goals/outcomes:

1. Design an evaluation process that can be completed annually
2. Upskill SPLWs to support with the delivery of reporting and workshops

Impact:

Collected quantitative data using a survey sent to three stakeholder groups (PCN staff, Link workers and clients):

- 61% average survey response to survey (56%: SPLWs, 60%: clients, 67%: PCN staff)
- 100% of service users would recommend the service
- 83% of service users would like to attend the evaluation workshop to explore further & help shape service design
- 89% of SPLWs believe social prescribing has a positive impact, and 67% of SPLWs agree client lives are improved by engaging in SP
- Key theme from SPLWs and clients is around community hubs- a space for more activities to take place and client peer support

Highlights:

- Team are meeting weekly with the International Futures Forum to explore using Three Horizons Framework to help design current evaluation & shape workshops for clients and link workers
- Coproduction with service users and staff to improve the service for the community it serves

Project snapshot

Health Innovators Pilot project: Hounslow Asylum Seekers and Refugees (SPIP31) – Khadijah Arije , Cheryl Chin

(Social Prescribing Team Leads)

AIM: To engage unregistered populations in Hounslow, specifically migrant, asylum seekers and refugees using an outreach SPLW.

Target goals/outcomes:

1. Improve **health, nutrition and social capital** for residents of two hotels in Hounslow, many of whom are asylum seekers and refugees
2. Understanding from residents what matters most to them and engaging them in available community support and activities

Highlights:

- Social Prescribing Link Workers enabling direct links into the community
- Holistic approach supporting health lifestyles, providing advice/information and signposting to further support available

Impact:

Held initial tea & talk sessions with residents:

- Common themes of resident needs were: English language lessons, food & nutrition, warm clothing, and physical activities (access to gyms & outdoors)
- 8% of service users were invites to tea & talk sessions

Held activities to meet needs highlighted in tea & talks including walks & language lessons, and exploring food support for future sessions:

- 82% of SPLWs involved in the project attended prep training activities
- 100% of service users improved according to mood charts after the activities
- 50% of service users attended the activities

Project snapshot

Walthamstow West Primary Care Network Pre-Diabetes Project (SPIP7) – Farah Ahmed, Shahid Mahood

(Social Prescriber, Chief Executive Officer at Blossom)

AIM: To tackle health inequalities and improve access to appropriate Pre-diabetic support for those facing barriers in access.

Target goals/outcomes:

1. To set up a diabetes Prevention Group in a community setting with language and culturally adapted support in collaboration with Blossom CIC and NHS Diabetes Prevention Group Xyla
2. 10% of patients targeted in Walthamstow West PCN to engage in the Diabetes Prevention support

Highlights:

- Cross sector partnership between PCN, VCSE organisation and NHS Diabetes Prevention Programme
- Diabetes UK facilitators supported sessions & felt that the group was the 'first of its kind' removing barriers for patients in the community most impacted by Diabetes

Impact:

Blossom CIC ran Diabetes prevention groups for eligible patients from five surgeries, partnered with Walthamstow West PCN, and supported by Diabetes UK facilitators, volunteer translator's and advocacy workers as well as The NHS Diabetes prevention program Xyla:

- 100% of pre-diabetic patients contacted by Social Prescribers in PCN Walthamstow West agreed to attend the face-to-face Pilot Diabetes Prevention Group (DPG) so far
- 72% of eligible patients attended at least one in two DPG sessions and 97% of service users were from a Black, South Asian and other ethnic backgrounds
- 36 participants attended a total of 3/7 groups & 100% of attendees were successfully provided with additional support
- Patients accessed a Dietician & Physiotherapy, weight management, mental health & SP support
- GP’s & other health professionals could better support their patients with Diabetes prevention support
- Most patients’ knowledge improved and all patients felt more comfortable accessing services due to language support etc.

Project snapshot

Barking & Dagenham Innovators Project (SPIP12) – Lucy Walsh, Emma Gillan

(Care Coordinator East One, Relationship Manager and Link Worker East One)

AIM: to improve access to SP services for those in the community who aren't able to access via the GP referral pathway.

Target goals/outcomes:

1. Increase number of social prescribing referrals for vulnerable patient groups
2. Create alternative and easier referral pathway, in a relaxed and welcoming environment
3. Reduce number of Non medical GP appointments

Impact:

Running pop up clinics in community venues across five PCN areas:

- Each PCN ran individual events and one joint event in aid of SP Day
- Third sector organisations invited to share services and enable sign ups
- **399 patients attended** which was estimated to save **£15,960 in reduced GP appointments**
- **87% of patients** seen in the **20 pop up clinics** received Social Prescribing support either through full referral or signposting with Link Workers and Care Coordinators
- **19,000 patients invited** from different cohorts on different days including **Mental Health, Carer, over 75's, LD patients, frequent attenders, families with children under 5**
- **Housing** was the main area of concern for patients (**53%** needed housing support) closely followed by Money & Debt, Family Support and Healthy Lifestyles

Highlights:

- Proactively targeting 'at risk' cohorts of patients
- Providing safe space to meet in a community setting, allowing for more time to sit with patients, understand needs and support immediate referrals
- Developed stronger relationships between third sector services in local area and SPLWs