Walthamstow West Primary Care Network (WCPCN) Pre-Diabetes inWaltham Forest

100%

- 100% of participants /atendees **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.
- 36 participants attended a total of 3 groups out of 7 where 100% of attendees were successfully provided with additional support

> If I continue in my current day-to-day life and not really STOP and REFOCUS then I might end up becoming one of the Statistics.
>
> The time is to ACT NOW!
>
> PREVENTION IS BETTER THAN CURE

DPG Attendee

> I was impressed with how you managed to bring together such a diverse group and fulfil individual needs. That's been one of my highlights

Shuhala Abbas, Diabetes UK facilitator

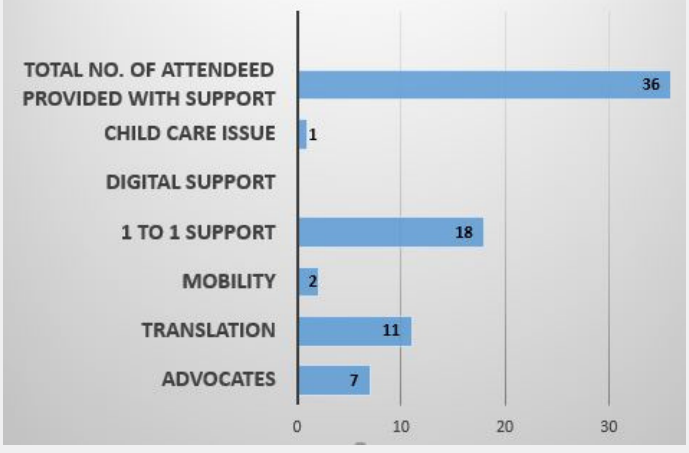
Key impacts

- GP's and other health professionals could better support their patients who previously had barriers to Diabetes prevention support
- Patients accessed Dietician and Physiotherapy, weight management support, mental health support as well as social prescribing support
- Most patients overall knowledge improved and all patients felt more comfortable accessing this services due to language support, some patients required multipe levels of support

> I recommend this group to everyone to prevent Diabetes. It's fantastic!

DPG Attendee

Types of support given to attendees of Diabetes Prevention Group



72% of **eligible patients** attended at least 1 in 2 face-to-face DPG sessions

All **Pre-diabetics** Felt more supported, motivated and knowledgable about making changes in their lifestyle to support Diabetes Prevention

100% **Service users who attended workshops** were given additional support at the DPG group

97% **Service users** were from a Black, South Asian and other ethnic backgrounds

The DPG was facilitated by Blossom CIC and supported by volunteer interpretors, Nutritionist, the Walthamstow West SP team and Diabetes UK facilitators

Diabates Prevention Group

- Group facilitators Blossom CIC felt that the DPG was successful due to direct involvement and support from Social Prescribers and access to eligible patients
- Diabetes UK facilitators were able to help support sessions and felt that the group was the 'first of it's kind' removing barriers for many hard to engage patients in the community most impacted by Diabetes

For more information on the Diabetes Prevention support, make an appointment with your Social Prescriber

**Data included is for 3 groups of 7 which are currently being delivered till April 2023*

Project Feel Good Now in City and Hackney

97%

Percentage of attendees who were from global majority background, 95% of who had never experienced self-care treatments and 80% who had never accessed social prescribing via their GP.

Average attendance per event was 12, and a third went on to access social prescribing services.

100% of attendees rated the events 5/5 and felt "immediate benefit" from the sessions

I'm a parent of a child with SEND and I never have time for myself or know about local activities so this has been great

As a social presscriber this session has made me think my employer values me

One person arrived with a walking aid and felt so good afterwards they did not have to use it to get home
Attendees reported increased feelings of self-esteem after the session and said "I feel cared about".
Attendees said they were "likely" or "very likely" to use the self care techniques shown in the workshop at home

88% OF SPLW felt stressed "most of the time" at work before the event

62% Of SPLW felt stressed most of the time one week after the event

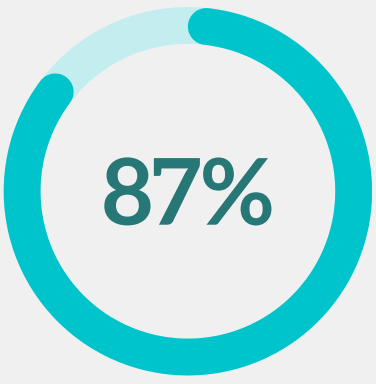
70% Of SPLW felt mierable or unhappy before the event

100% **SSPLW reported feeling ongoing positive wellbeing effects 1 week later**

This series of commuity events with a focus on promoting social prescribing to underrepresented communities and also studying the effect of wellbeing events on social prescriber stress has unmeasured benefits in cash terms, but has potential for not only improving access to social prescribing by meeting people in their neighbourhoods but also improving the wellbeing of SPLW themselves

Learn more here: @feelgoodnowcic - IG

Barking & Dagenham Innovators Project 2022 - 2023



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.

Social Prescribing areas of referrals Housing / Money & Debt / Mental Health / Family Support / Adult Learning & Employment / Substance Misuse / Domestic Abuse / Healthy Lifestyles / Social Isolation and Loneliness

> The nappies and milk given to me for my 8 week old baby was so needed - I felt listened to and was given support quickly
>
> single mum, asylum seeker

> Thank you so much for listening and supporting with food and mental health services. I am now volunteering to support others
>
> newly diagnosed mental health patient

- 399 patients attended Pop Up Clinics saving £15,960 from GP appointments
- 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 main area of concern for patients closely followed by Money & Debt, Family Support and Healthy Lifestyles

£15,960 Saved from GP appointments not being needed (approx cost £40 per GP appointment)

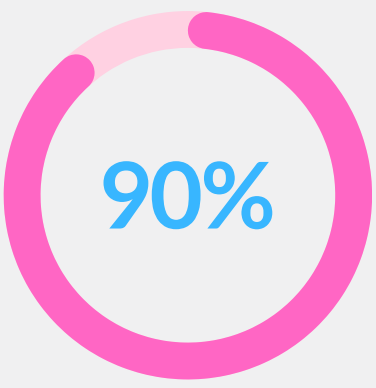
399 Patients attended pop up clinics across 5 PCN areas

53% Patients seen in clinics needed Housing support

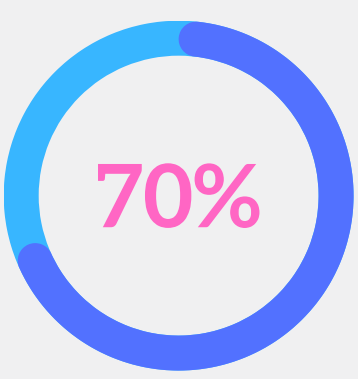
Link Workers, Care Coordinators and partners on National Social Prescribing Day 2023

socialprescribing@lbbd.gov.uk

SOCIAL PRESCRIBING SUPPORT VOLUNNTEERS IN CAMDEN



One of the challenges Social Prescribers face is 'burn out' and feeling overwhelmed by the demand of the role.
Focusing volunteer roles into direct support to social prescribers made a significant impact in the last 6 months; 90% of retention as opposed to the 53% experienced in the last 3 years.



Target set was recruiting 10 volunteers within the 6 months period. 7 was successfully recruited.

2 actively supporting social prescribers
1 trained - not yet started the role
4 in training

Volunteer progression:
The volunteers received full training required for the Social Prescriber role and provided with experience that could lead to employment within the social prescribing field.

TIME FREED UP TO SPEND WITH COMPLEX CASE CLIENTS

CLIENT SATISFACTION :
Stress taken out of being able to attend hospital and GP appointments

Being able to exercise / gentle walking with the help of the volunteer

Being able to call on someone when in need of completing forms;.

Receiving regular welfare calls.

Being connected to social activities.

Learn more here:

Men's Engagement in Social Prescribing in Tower Hamlets

In Tower Hamlets, referrals to Social Prescribers have increased year on year and are on course receive over 9000 referrals this financial year.

The trend in the proportion of referrals for males has remained fairly consistent as referrals have increased, with the share of referrals for males hovering around 40% in comparison to 60% female in the last 3 years (2020 - 23)

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

Observed impacts, reflected in both survey & consultations:

- Men largely had little awareness of social prescribing as a whole
- The largest barrier to men taking care of their wellbeing was work or feeling too busy
- Keeping healthy, whether through physical activity, healthy eating or advice were the top interests for men

52% Survey respondents felt loneliness currently has a negative impact on their health / wellbeing

79% Survey respondents would choose to do physical activities if offered by social prescribing

70% Survey respondents chose work as the reason they might not be able to do things they enjoy

68% Survey respondents did not know how to access social prescribing

This project was led by Tower Hamlets GP Cares Group, St Margaret's House, Social Action for Health and Voicebox.

We consulted 6 diverse men's groups based in Tower Hamlets and ran an online survey with 54 respondents to explore how we can better engage men in social prescribing activities. We also consulted 4 male social prescribers to ask for their thoughts on male participation.

Our learnings showed there is a need for men-only activities, and for wider awareness on how men can access these activities.

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*

Reducing social isolation in older minority ethnic patients in Ealing

Overall, 95% of patients referred to a Community Connector were satisfied with the service.

The 20 patients who were referred between October 2022 and February 2023 saw the Community Connector for 3 sessions on average.

Patients on low incomes and impacted most by cost of living were able to access free in-person support to help with basic needs.

I am excited at the benefits the Community Connector's role can offer to assist the more reluctant groups to get out and access services

Carolyn Blackford - Community Connector (pictured below)

Funding from the Social Innovation Fund, has enabled AGE UK Ealing to evaluate its Community Connectors programme together with A2Dominion. The results show how an integrated health, housing and care approach can provide real value for money for commissioners, reduce loneliness and isolation and increase the wellbeing of elderly black and minority ethnic communities.

Reginald Parkinson Chief Executive Age UK Ealing

Key impacts

- Community Connectors project embedded into the core social prescribing offer across Ealing PCN
- Increased support offer for isolated black and minority ethnic over 65s in Ealing most impacted by Covid 19
- Improved needs assessment and triage for patients that are lonely and isolated, required in-person support to manage the basics and improve their mental health and wellbeing
- Improved integration of health, housing and care through partnership between EPCN, A2Dominion and Age UK
- Funding secured from EPCN for additional social prescriber with mental health specialism

24% **Average increase in ONS score**
In 19 out of 20 patients

68% **Patient referrals to the project** addressed loneliness & isolation, managing long-term health or day2day needs

80% **Patients ethnicity**
Registered as from Irish, mixed or Asian and multiple ethnic groups

11% **Patient referrals to social prescribers** accessed additional community connector support

Further positive impacts

- *Improved referrals and casework management through the use of 'Joy' by voluntary sector partners and GP practices.*
- *Bids in the pipeline to continue community connectors in West Ealing.*
- *Cost-effective model which improves wellbeing for black and minority ethnic over 65s that can be replicated and scaled up.*
- *Social value generated: £160,179 on overall budget of £10,000 (for every £1 spent, £16.02 achieved in additional social impact)**

**HACT measures: Ability to obtain advice locally; Regular attendance at voluntary or local organisation; Good/improved overall health.*

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.

The CC visited Mr and Mrs H at home and arranged for them to register with ECT transport. This would enable Mr H to get to appointments and go out on his own to attend a local group at the church nearby. Speaking with Mr H, the CC could understand the reason for him being frustrated with his declining mobility. She made further suggestions of other groups that he could try, including an Age UK day centre.

In February the CC arranged a trial date for Mr H at AGE UK, with transport there and back. Mr H is now regularly attending the day centre, enjoying the activities and talking to other users there. He says he feels "very looked after" and Mrs H is happy that he has settled in well with the group where he contributes with his wealth of knowledge and travel experiences.

In March, Mr H was successfully discharged from community connectors.

Conclusion

Mr H is happy attending the day centre. He manages well, even without his walking stick most of the time. He feels he copes better when he is not anxious as he says he is well supported. His wife is grateful to us now that she doesn't worry so much when she is away from the home, and he has regained his independence somewhat without depending on her to take him out.

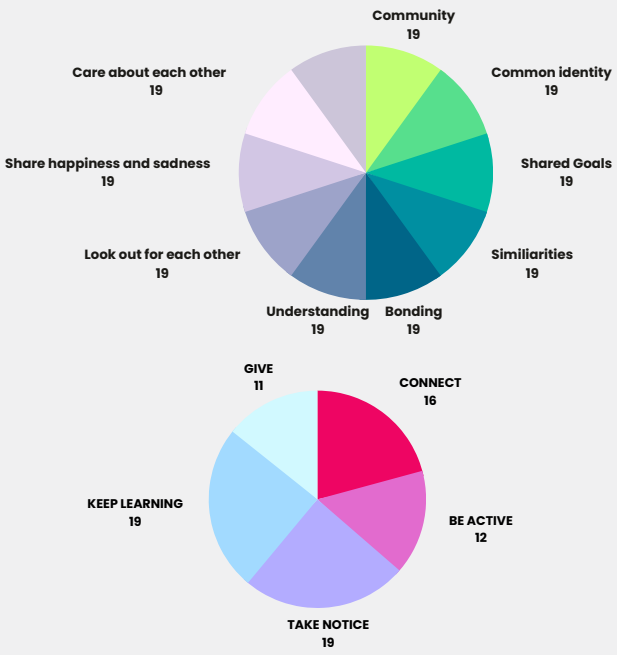
WCPCN WELLBEING PARTNERSHIP in Waltham Forest

Impact of the Wellbeing Cafe:

- Enhanced sense of community
- Tailored resources and support
- Improved mental health
- Increased happiness
- Life-changing experiences
- Holistic approach to wellbeing
- Served as a successful model

Why it needs to continue ? :

- Continuity and sustainability
- Ongoing support for mental health
- Foster community resilience
- Seek funding and partnerships
- Strengthen community bonds
- Promote a supportive and inclusive society



After 10 weeks in the Wellbeing Cafe, all 19 participants experienced a 100% improvement in these areas.

- Community
- Common identity
- Shared goals
- Similarities
- Bonding
- Understanding
- Looking out for each other
- Sharing happiness & sadness
- Caring for each other
- Supporting with poverty, health, care, cost of living

Participants improved an all aspects of their wellbeing:

- **Connect**: Social events, support groups
- **Be active**: Exercise classes, workshops
- **Take notice:** Mindfulness, meditation
- **Keep learning:** Seminars, personal growth
- **Give: Volunteering**, community service

> **The emphasis on community and social support is what sets the Wellbeing Cafe apart. It provides a space where individuals can come together and support each other, which is essential for building resilience and improving mental health outcomes.**
>
> Sajid Patel Social Prescribing Link Worker South Leytonstone Primary Care Network

> **I truly believe that this Cafe will benefit many people who are struggling at the moment, providing a lifeline for vulnerable individuals. I was one of those people.**
>
> Participant

> **Having something to look forward to can also give us a sense of much needed hope or optimism about the future. The trip was like that and made me feel happy.**
>
> Participant

Participants in the Wellbeing Cafe reported significant positive impacts on their mental health and wellbeing, including:

- Social support
- Connectedness
- Resilience
- Reduced anxiety
- Increased self-esteem
- Confidence
- Mental health awareness
- Reduced stigma
- Motivation
- Purpose

Participants also felt:

- Less loneliness
- Higher self-esteem
- Knowledge growth
- Stigma reduction
- Awareness promotion
- Motivation boost
- Goal pursuit
- Community strength

19
Participants

68%
of Participants identified as Female

32%
of participants identified as male

84%
of participants identified within minority ethnic groups

100%

Of participants told us they had improved mental wellbeing from the start point

100%

Of participants reported improvements in their life satisfaction

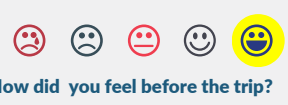
WHAT A DAY TRIP CAN ACHIEVE

GREENWICH AND THE CHRISTMAS LIGHTS - MONDAY 19TH DECEMBER 2022

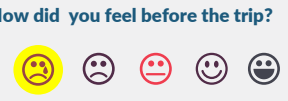
Feelings before

Feelings after

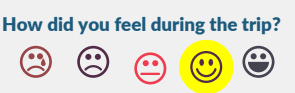
How satisfied have you been with the trip?



How did you feel before the trip?



How did you feel during the trip?



How do you feel now?

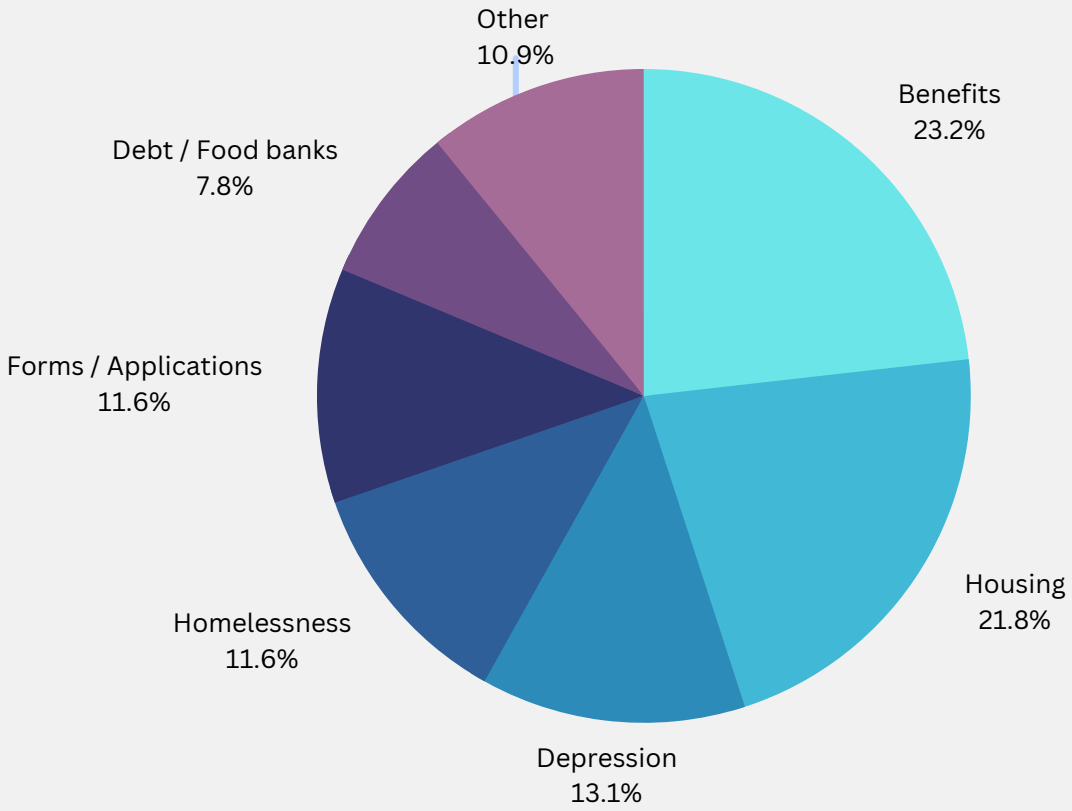
SPLW TARGETING ETHNIC MINORITIES IN CAMDEN

100% of patients referred to the service who responded, would recommend it .
176 patients were seen at Brondesbury Medical Centre between December and mid March 2023

"The Link officer was superb and very reassuring. It is a service where people in hardship and confusion can find some light and hope."
"An excellent service where I felt safe sharing my issues."
"More than excellent"

% of all patients seen who were from Ethnic MInority Backgrounds increased from 56% to 65%. Of the patients seen:
25.6% South Asian
13% Somali
7.4% Arabic
15.3% Afrocaribean

Presenting problems



KEY IMPACTS

- increase in Ethnic Minority usage of the Service
- Enhanced knowledge amongst Ethnic Minority patients about Social Prescribing
- high satisfaction rates
- many success stories - housing, benefits, grants
- valuable resource for clinicians to help tackle social problems
- Demand for service increasing as word of mouth spreads

Social Prescribers with Special Interest in Mental Health & Challenging Behaviours in Hillingdon

The Confederation

Patient Journey
Each PCN works differently across Hillingdon. As a result, the referral process presents its own unique challenges. We identified that people with a Mental Health condition and challenging behaviours are not receiving the standards of care and support that we expect for them. Our aim is to standardise the process of referrals whilst creating new career pathways for SPLWs.

Preventing People from Avoidable Harm
Within the context of creating these enhanced roles, we wanted the SPLWs to better assess the risks to peoples health and safety and to themselves during care in order to make sure they have the right qualifications, competence and skills to do so.

Personalised Care Planning
We've recognised we need to strengthen our care planning, especially for patients with mental health and challenging behaviours, to fully reflect their physical, mental, emotional and social needs. With increasing demand for SPLW services, which includes complex patients, there is also a need for a new set of social and emotional enhanced competencies.

Testimonials

"I have a total of 35 patients on my caseload, 15 of which have... MH symptoms."

"It's sometimes difficult to gauge whether some patients are stable enough to support with any social needs."

Key impacts: Quantitative & Qualitative

- Reviewed documentation and patient pathways, including escalation procedure, risk assessments and Lone Working Policies, which has strenghtened the support for SPLW & patients.
- Introduced new standards and good organisational practice.
- Conducted pre-programme confidence survey results set the baseline to analyse growth and improvements.
- Secured mentoring support with Adult Mental Health practitioners improving mental and physical health and care for this cohort
- Standardising reports for SPLWs and streamline their referrals- introduction of JOY- integration of new system for all Primary Care Networks of Hillingdon
- Bespoke Training Programme for SPLWs

Confidence Scale Results: Baseline

58%

Do not feel confident building holistic relationships with patients of this cohort and support them for their self advocacy.

57%

Do feel they have the skills to deal with a challenging behaviour when it is directed at them.

43%

Do not feel confident in discussing uncomfortable/ sensitive information with patients & carers

42%

Feel they cannot easily analyse/ identify a challenging behaviour in a patient.

SPLW Specialist Training

MHFA England

The Training Hub have been working hard to develop a Specialist training programme for the SPwSI in Mental Health and Challenging Behaviours.

This training builds upon the Mental Health First Aider course.

Breakaway training : Course Summary

- **Legal frameworks**
- **Understand the causes and build up of an attack**
- **Actions to avoid being restrained or attacked**
- **Safely disengage from being held**
- **Safely disengage another person from being held**
- **Avoid and defend kicks and punches**
- **Post incident actions**
- **Record keeping and de-briefing**

SPLW Accreditation

- Review portfolio of SPLW patients with Mental Health and challenging behaviours to panel.
- Complete specialist training programme to build SPLW confidence and knowledge.
- Gain feedback from Mental Health Practitioner mentor who has offered support and guidance throughout the process and beyond.
- SPLW to respond to panel scenario questions as part of their experiential learning.

Updates to our project will be on our website: Home (theconfederationhillingdon.org.uk)
or contact hillconfed.transformationteam@nhs.net for more information.

Health Innovators Pilot project: Hounslow Asylum Seekers and Refugees

- Reach out to residents of the hotels and discover what matters most
- Aim to engage residents of the hotel through initial TEA & TALK sessions and to explore what matters to them most within our social prescribing remit
- Social prescribers as links to the community
- Supporting healthy lifestyle
- Sign-posting - Advice/Information

Would like access to a gym or other physical activities

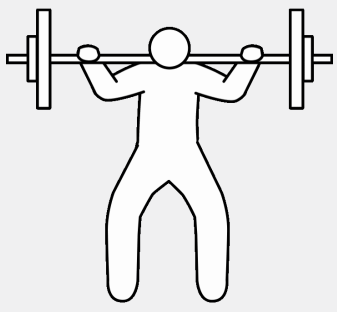
Asylum seeker resident, 35yrs F

Would like more access to food. Wife pregnant

Asylum seeker, 45yrs M

Common themes of resident needs:

- english language lessons
- food
- warm clothing
- physical activities e.g. access to gyms, outdoors



8% **Service users in hotels**
Invited to the tea&talk attended

82% **Social Prescribing Link Workers in project attended prep training and activities**

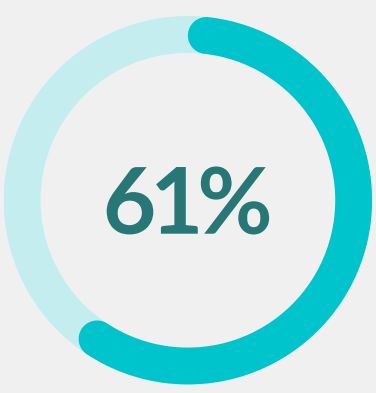
100% **Service users mood charts**
Improved after the activities

50% **Service users attendance to activities**
Full attendance for languages, walks weather dependant

Hounslow PCNs Social Prescribers

Learn more here:

Social Prescribing Evaluation Project in Lambeth



Average survey response completed across all three stakeholders (social prescribing Link Workers (SPLWs), clients and PCNs).
Exact survey breakdowns are as follows:

SPLWs: 56% surveys completed
Clients: 60% surveys completed
PCNs: 67% surveys completed

> It was very helpful and it was nice to have a human on the other side to give a human perspective. Prior to being connected to the service it felt like a tick box exercise.

Social Prescribing client

> Service was amazing, particularly as she is not getting much support from mental health services. It was great to speak to someone connected to surgery to feel heard.

Social Prescribing client

Key observations

- Reviewing survey questions to make more succinct and shorter increased engagement from all stakeholders,
- Lost member of project team which sadly set the project back and has postponed in-person workshops. Tough decision to postpone but felt it was best for the wider team and to ease pressure,
- Surveys are good for providing quantitative data to analyse but need the workshops for discussion and planning,
- Key theme from SPLWs and clients is around community hubs- a space for more activities to take place and client peer support.

100% Service users would recommend the service

83% Service users completing the survey would like to attend the evaluation workshop

67% SPLWs agree client lives improved by engaging in social prescribing

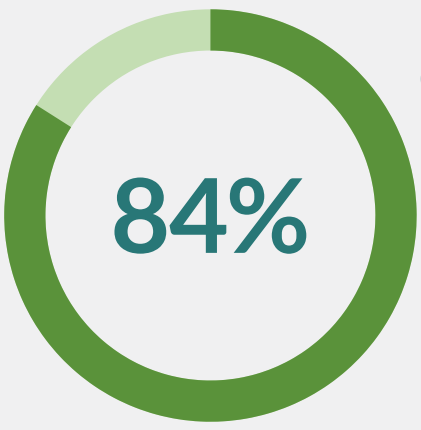
89% SPLWs believe social prescribing has a positive impact

Through working on report template and subsequent networking the project team were able to link in with International Futures Forum.

Introduced to The Three Horizons framework:

At its simplest we can see it as describing three patterns of activity and how their interactions play out over time. The framework maps a shift from the established patterns of the first horizon to the emergence of new patterns in the third, via the transition activity of the second.

HBD Women's Health Network in Lambeth



Addressing health inequalities by proactively engaging patients to encourage supportive community connections and raise awareness of how to better manage their health

84% of attendees reported that their first contact with Link Workers was at a Women's Health Network session

(snapshot of one session)

A patient commented that attending the WHN session is the best thing she'd done since covid and that she no longer needed her anti-depressants.

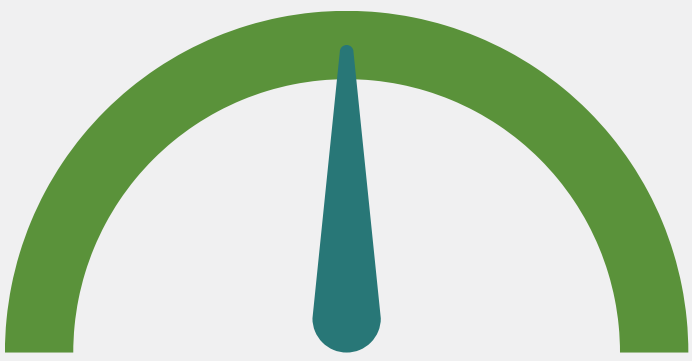
GP from a participating practice

Really valuable thing you guys have put together here, each woman mentions it in each discussion.

Clinical colleague - Pharmacist who has supported 2 sessions

By bridging the gap between Link Workers & community based support we have:

- Reduced waiting times for Link Worker 1st contact for patients at the busiest practices.
- Patients are being signposted and offered support more quickly.
- Raised patient awareness about the support and well-being options available to them.
- 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.



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

50% We have increased our patient reach by 50% (225 patients) over the last 6 month period

Women's Health Network

Supported by Hills, Brook & Dale PCN

What do attendees enjoy about the sessions?

Finding out about the variety of services offered

Taking time out from home for myself

The sessions are thrilling, everyone is enthusiastic and always very practical

Having people to talk to face to face

Meeting new people

12 sessions delivered since October 2022 - 7 more scheduled before the end of June 2023