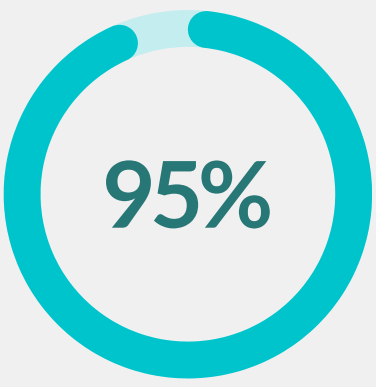
Reducing social isolation in older minority ethnic patients in Ealing



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

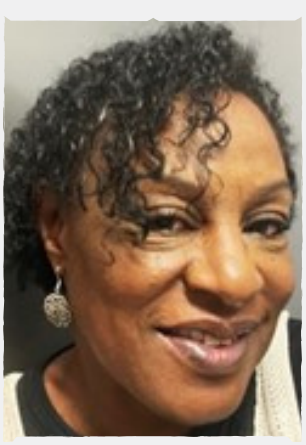
- Community Connectors project embedded into the core social prescribing offer across Ealing PCN
- Increased support offer for isolated black and minority ethnic over 65s in Ealing most impacted by Covid 19
- Improved needs assessment and triage for patients that are lonely and isolated, required in-person 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

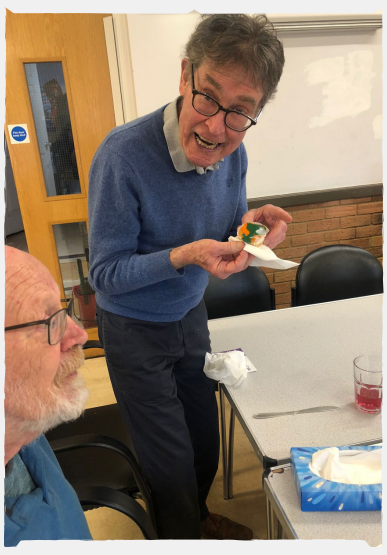


Further positive impacts

- *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.