

Black, Asian and Minority Ethnic Social Prescribing

Louise Hardwick, Head of Partnerships & Alliance Delivery, Ipswich & East Suffolk CCG

Shayra Begum, Service Manager, BSC Multicultural Services

NHS England and NHS Improvement

2 March 2022



Black, Asian and Minority Ethnic Social Prescribing

Commissioning a bespoke community connector service to address the needs of people from Multicultural backgrounds

Louise Hardwick, Head of Partnerships & Alliance Delivery, Ipswich & East Suffolk CCG

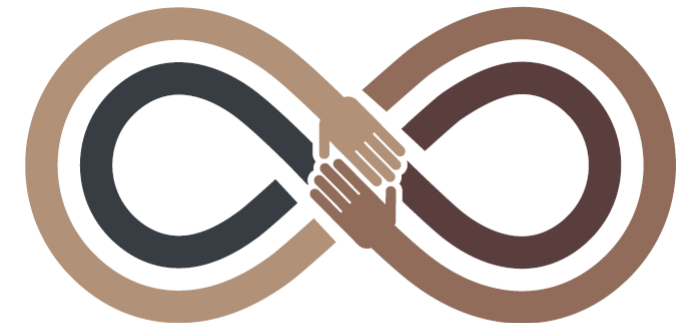
Shayra Begum, Service Manager, BSC Multicultural Services

Background

- Covid-19 disproportionately affected our BAME (Black, Asian and Minority Ethnic) communities, this is particularly pertinent for our residents living in the Ipswich area. Nationally death rates from COVID-19 were highest among people of Black and Asian ethnic groups.
- Following a public webinar with partners Ipswich and Suffolk Council for Racial Equality (ISCRE), Healthwatch Suffolk, CCG, Public sector leaders, and members of the multi-ethnic community it was identified that further support was needed for these residents not just in regards to Covid-19 but existing inequalities need to be addressed in order to close the gap. IESCCG identifies a moral responsibility to reduce inequalities.
- The disproportionate impact of COVID-19 on BAME groups presented an opportunity to create a bespoke sustainable change and mitigate further impact on our BAME communities. The change needed to be transformative and take a whole systems approach, taking action to address the structural and societal environments such as housing, education, neighbourhoods, workplaces and money management.
- Standard Social Prescribing services in Suffolk currently exist in localised schemes provided through commissioned VCSE organisations.



**CONNECT
for health**
Being Well Together



#WhatAreWeMissing

Scope

- Social Prescribing services in Suffolk currently exist in localised schemes across IESCCG. This bespoke service looks to specifically support members of our BAME communities to address their specific needs.
- Tailored holistic support by Community Connectors specific to the needs of the individual, taking into account cultural differences, identifying what is important to them, leading to improved health, wellbeing and resilience for the individual.
- The Community Connector post is the main component of the service and will be based in the local community within the East and West Ipswich INT area. Providers' bids were partly evaluated on how well the provider demonstrated that they could meet the needs of the BAME community.
- The contract is for two years, however the intention is that the service will operate for longer if the model is proven successful.
- BSC Multicultural Services were awarded the contract. BSC are a well-known local community organisation that have been provided support services to those from multiple ethnic backgrounds for over 20 years.



CONNECT
for health
Being Well Together

Are you worried
about your health
and finding
life difficult?



Your doctor isn't the only person who can help you feel better. You can improve your health & wellbeing through social prescription.

Social Prescribers can help you with a range of issues including:

- Social Isolation and loneliness
- Welfare benefits, housing issues and financial support
- Physical and emotional wellbeing
- Healthy lifestyle choices and much more

You can talk to your GP, social care and healthcare professionals for a referral or contact us directly using the contact information below.



BSC Multicultural Services
Supporting over 50 nationalities

Call: 01473 429740
Email: info@bscmulticulturalservices.org.uk
www.bscmulticulturalservices.org.uk



Multi-Cultural involvement and outreach

- Shayra Begum (service manager) and Paul Manhertz (community connector) from BSC Multicultural services who provide the service have been part of our One Team Connecting Communities leadership development programme
- Social prescriber is a key member of the core leadership team within the Ipswich Integrated Neighbourhood Team alongside GPs, social care, mental health, local councils
- Outreach service at the Unity Centre (social prescribing community hub in Whitton area of north-west Ipswich, pictured).



Success and Challenges

What has worked well?



- Personalised support provided for individuals in need
- Service gaps identified and addressed from Community Chest funding (e.g. Kurdish women's swimming group)
- Provider has promoted service well in communities with majority of participants being self-referred.
- Support provided for people who might otherwise not have sought help through the standard existing service
- Working with VCSE grass root multi cultural organisations

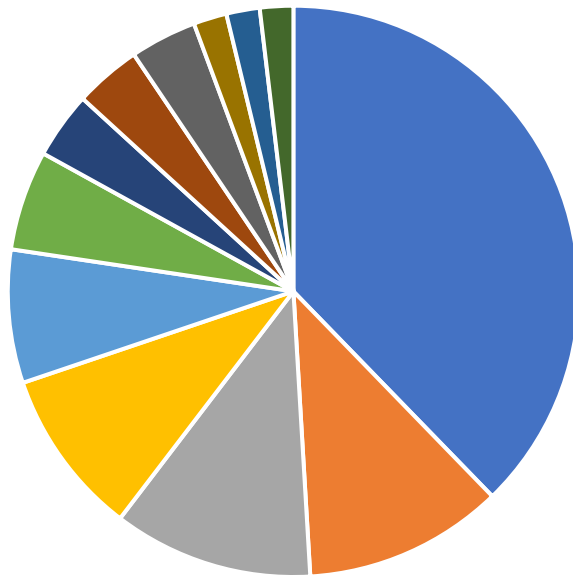
What have been the biggest challenges?



- Number of new referrals has dropped
- Communications/Marketing
- Engaging general practice
- Referrals have not come through statutory services or GPs
- Silo working with current SP model
- Covid working
- Workforce resources
- Information Governance

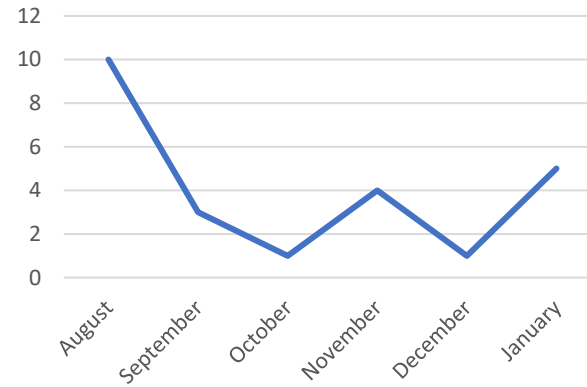
Statistics

Ethnicity of those supported by the programme

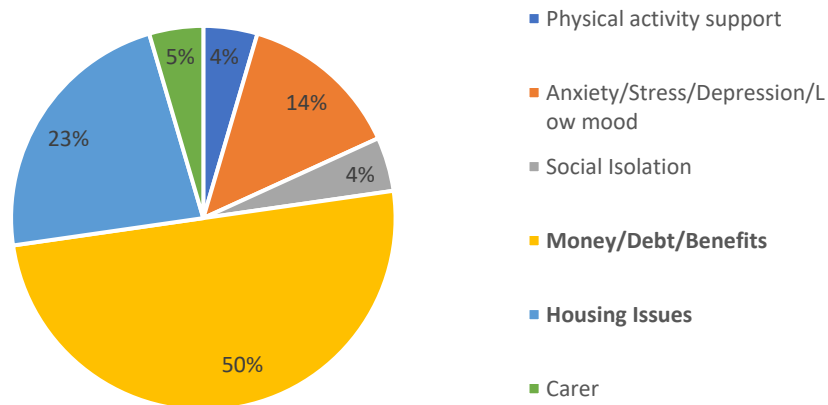


- Bangladeshi
- Portuguese
- Syrian
- Mixed heritage
- Bengali
- Sikh
- Comoros
- Iranian
- Turkish
- Jamaican
- Afghan
- not known

Total number of new referrals
Aug 21 – Jan 22

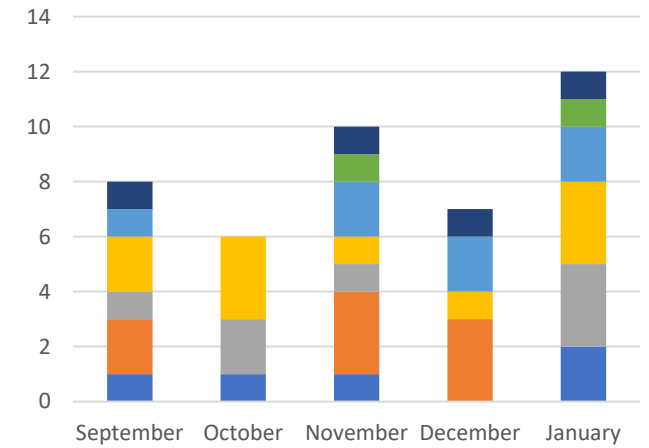


Reason for referral



- Physical activity support
- Anxiety/Stress/Depression/Low mood
- Social Isolation
- Money/Debt/Benefits
- Housing Issues
- Carer

Age of those supported since Sep 2021 to Jan 2022



- 18-29
- 30-39
- 40-49
- 50-59
- 60-69
- 70-79
- 80+

Support has been for all ages

Almost ¾ of referral so far have been for financial and housing reasons

Community 360





Together
We Thrive



My Social Prescription™

Spotlight on... Working within Hub Settings

Community360 is an independent charity formed in 1968

Community360 vision is of ***a less unequal society*** and we aim to inspire and enable social action to improve people's quality of life

- ✓ Volunteering
- ✓ Community Transport/ Shop Mobility
- ✓ ***Social Prescribing***
- ✓ ***Essex Family Support Service***
- ✓ Slipper Support

- ✓ Home from Hospital befriending
- ✓ Weight Management
- ✓ Winter Resilience
- ✓ Community360 Training
- ✓ ***Fundraising and Financial Group Support***

Community360 established the first social prescribing programme in Essex in 2014.

Since then, Community360 has expanded to:

- be based in primary and secondary care,
- develop dedicated roles, such as an End of Life Care social prescriber
- collaborated to develop new pathways to community support
- Sought to innovate and enhance the work undertaken in the area

Social Prescribers speak to approximately 5,000 people each year offering access to, and information about, local voluntary and community groups.

Self Referral/VCSE Referral

- Face to face
- Outreach
- Email/phone

PCN's

- Outreach
- GP Systems (i.e., EMIS)
- Population Health Management

Community Nursing/Urgent Community Response

- Home visits
- Email/phone
- Clinical Referrer

Essex Wellbeing Service

- PriorityMe referral platform
- Direct referrals from partners within network

EPUT (Primary and Secondary Mental Health)

- 24 hour inpatient referral pathway
- Drop in clinics for community patients
- Email/phone

ESNEFT (Colchester Hospital)

- Multi-disciplinary team meetings
- Email/phone
- Ward visits
- Pathway Light 24 hour response
- Welfare calls

One Colchester Hub

- Multi agency referrals
- Face to face

St Helena (End of Life Social Prescribing)

- Advanced care planning
- Outreach
- Clinical and non clinical referral

Discharge Hub - Our aim is to continue to improve outcomes for patients and their families, whilst supporting clinical and non-clinical staff on site at the Hospital.

From 1st April 2021, over the course of 10 months, C360's team have:

- **Accepted or facilitated 722 social prescription referrals to C360 and providers in other parts of Essex**
- **Reached out to 2293 patients as a welfare check upon return home**

The most common requests for support are to access information about local services, combat loneliness and isolation and help to living independently at home.

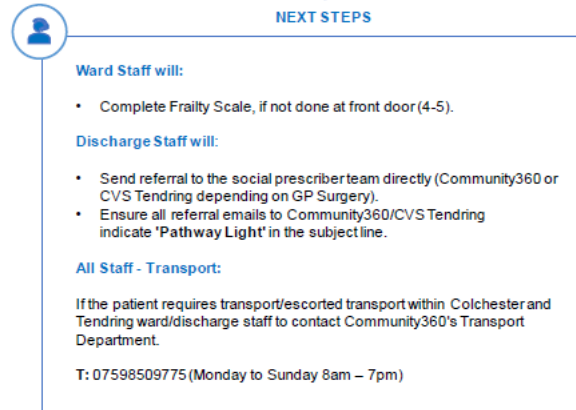
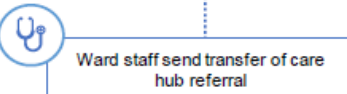
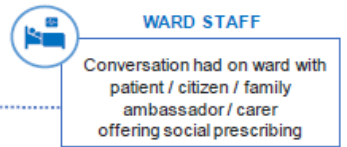
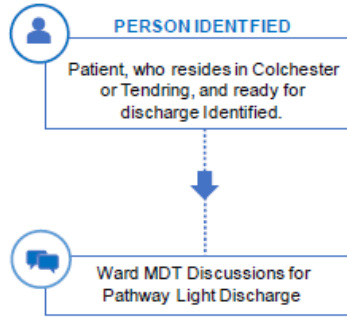
PATHWAY LIGHT

Pathway Light is intended to empower patients and their families (where possible) to be supported by a system approach of light touch encouragement which could cover signposting, enablement, volunteers and phone calls. Citizens can be better prepared and more confident to manage at home with joined up choices and greater independence.

0.5

Support Declined

Offer CVS materials to support patient/citizen/family member should support become needed in the future.

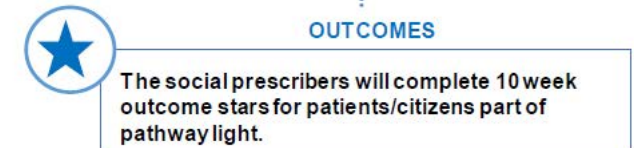
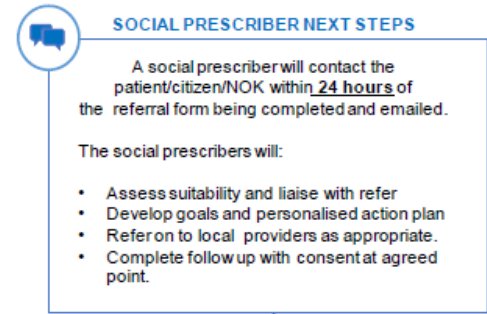


COLCHESTER GP SURGERY

Community360
E: C360_socialprescribing@nhs.net
T: 01206 505250
(Monday – Friday, 9am-5pm)

TENDRING GP SURGERY

CVS Tendring
E: neecq.tendringocialprescribing@nhs.net
T: 07514661345
(Monday – Friday, 9am – 4:30pm)



What Is Pathway Light – Ethos

- Empower citizens to be better prepared and more confident to manage at home
- Facilitate joined up working with VCS and families
- Improve independence
- Rapid VCS assessment - calls made within 24 hours of appointed discharge date – may take place before discharge if possible
- Respond to social needs influencing patient progress
- Integrate with wider VCSE offer, i.e. befriending, One Colchester/Tending Together
- Access to asset lists (mapping carried out in NEE)
- Sustained contact post discharge (10 week follow up)
- Outcomes and impact measurement for patients and families

Facilitating Funding for Individuals - Household Essentials and Discharge

Launched December 2021

- **Supported 151 households by 25 February 2022**
- Single referral route via C360 to multiple funds
- Grants of up to £500
- Anticipated - £10 - £300
- Some stipulations on spend – Social Prescribing and Essex Family Support Services teams assess and apply – i.e. limits on gas and electricity heating costs of no more than £200.
- Assigned to an adult aged over 18 but could support whole households

One Colchester Hub – is a based within the retail centre of Colchester town in a former shop location. Developed as a multi-agency space, it is used by voluntary groups, public sector and partnerships for a wide range of activities.

The team refer on to the opportunities held on site, including a regular, weekly timetable of events, one off clinics with specialists or events and celebrations. They can access support from partners to review complex cases through the Neighbourhood team structure.

- **C360 situates our social prescribing team in the Hub as a part of an emerging, centralised Neighbourhood team**
- **More than 600 visits are made to the Hub each month and this number is growing rapidly**



Case Studies

ESNEFT Hub

Home from Hospital Befriending
Assigned a C360 Home from Hospital befriender for weekly check ins.

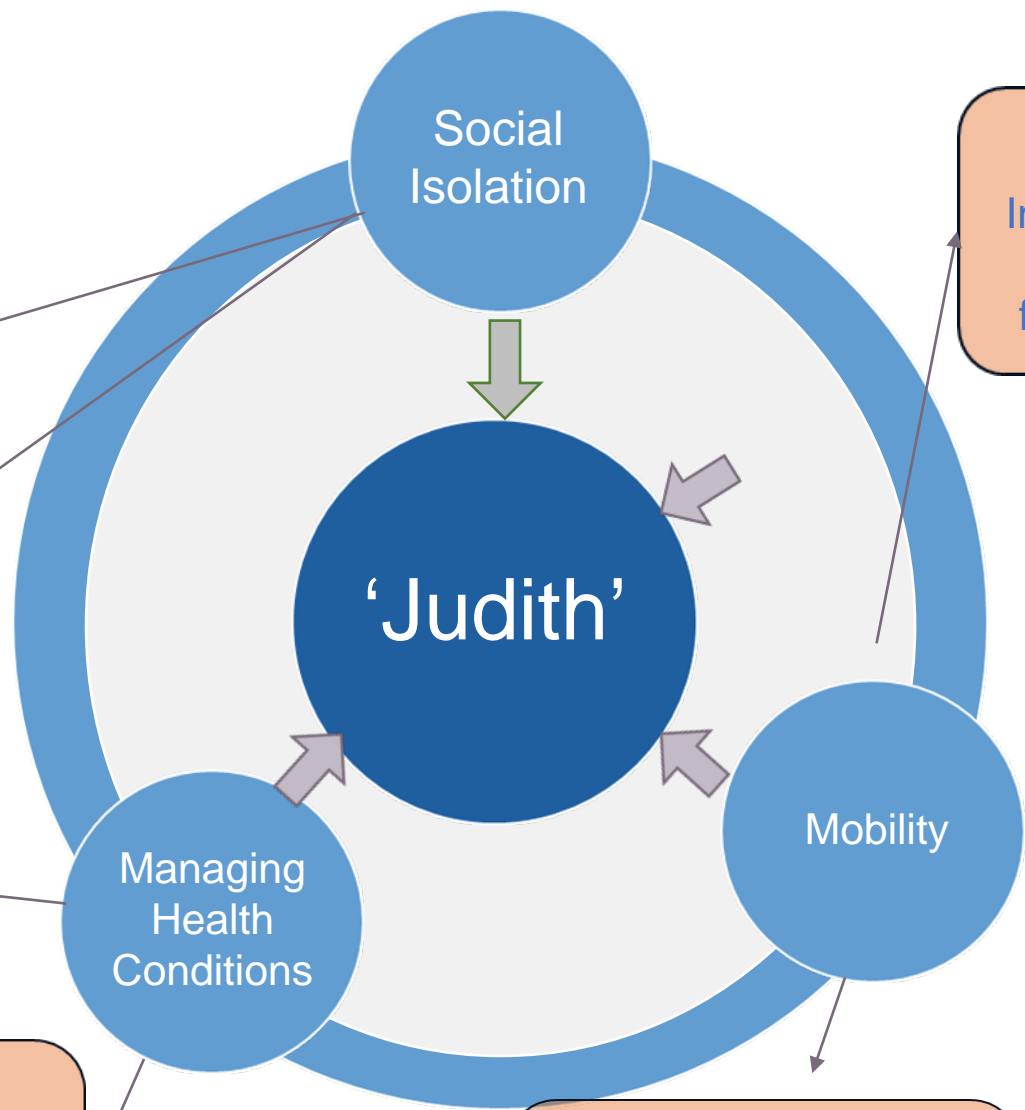
C360 Transport
Information sent about Community Transport to attend appointments and access community.

COPD- Breathe Easy
Information provided about the Breathe Easy support group for those with lung conditions.

Stroke Association
Information was provided about the Stroke Association and activities happening locally.

Slipper Support
A free pair of non slip slippers were provided.

Mobility Walker
Information sent about where to obtain 4 wheeled walker from in the Colchester area.



IMPACT
'Judith' was referred to C360 by the Stroke Unit at Colchester General Hospital. She was being well supported by family however wanted to know what other support was available. To combat social isolation 'Judith' consented a home from hospital befriender who will supporting her for up to 6 weeks. At risk of slips, trips and falls 'Judith' received a free pair of non slip slippers to support her at home. Information was also sent to her daughter in law about how to obtain a 4 wheel walker as well as how to access our Community Transport so 'Judith' can access appointments and the community. Additionally, support group information was shared so 'Judith' can get support following her stroke and with her COPD.



One Colchester Hub



Befriending
A referral was made for telephone befriending through Future in Minds, who specialise in Mental health support.

Support groups
"Roy" was signposted towards the Men's Mental Health group at the Community Hub, and began to attend sessions. "Roy" was also given the contact details for help lines, who he reached out to when he was feeling low and missing family

Food delivery
After a back injury, "Roy" became housebound for a few weeks, we arranged food deliveries from Colchester Food Bank

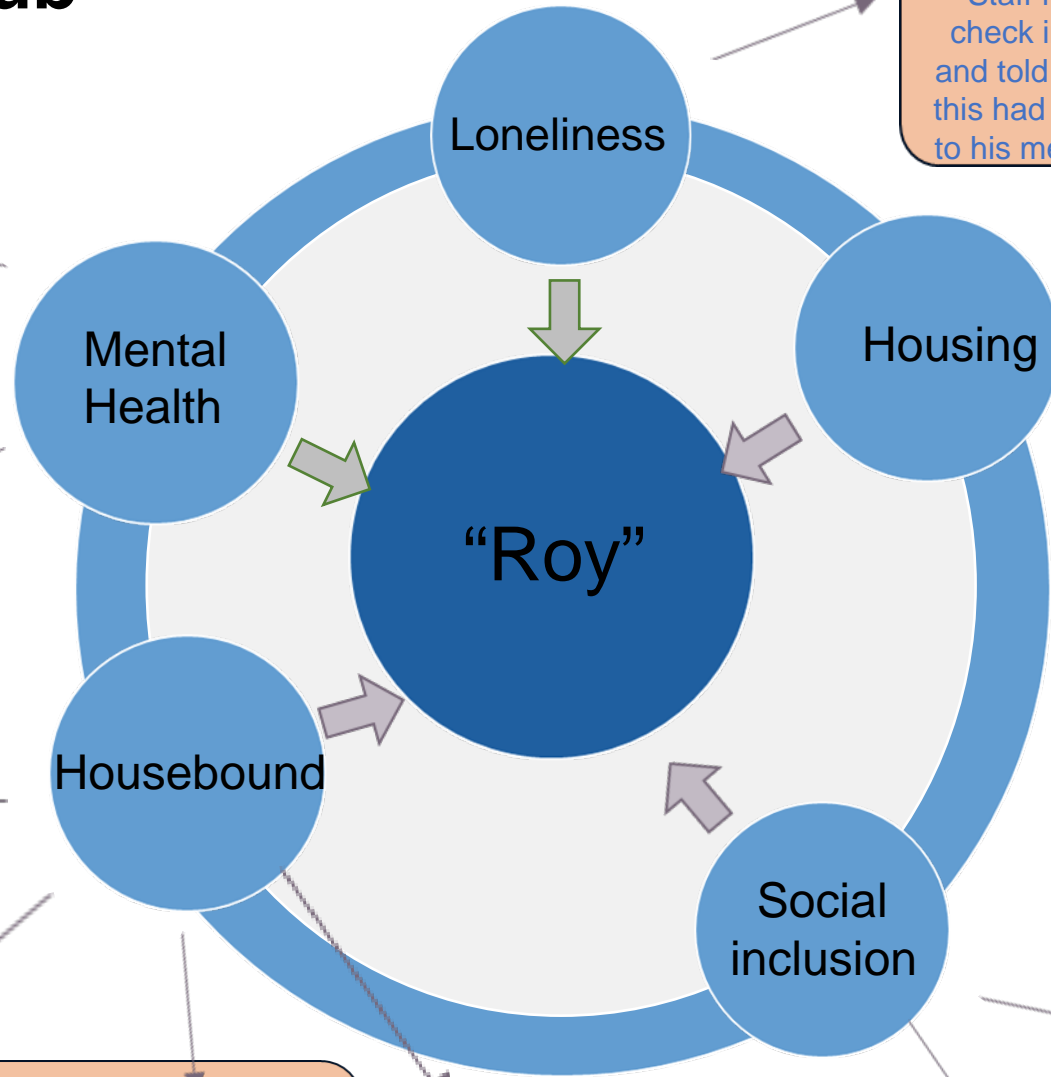
Book delivery
"Roy's" Care co-ordinator also mentioned that he enjoyed reading, and only had 3 books, so we hand delivered books to ensure that "Roy" remained stimulated whilst at home.

Community transport
"Roy" signed up for the Community Transport Scheme to ensure that he could remain mobile.

"Roy" has been using the Active at Home booklet

Community Hub
"Roy" regularly visited the Colchester One Community Hub for a coffee and a chat

Physical activity
When able, "Roy" intends to join the Finding Your Feet Walks.



Welfare calls
Staff regularly called "Roy" to check in, which he appreciated, and told his care co-ordinator that this had been making a difference to his mental health and positivity.

Bedding
After finding more suitable accommodation, "Roy" was given clean bedding from the hub.

IMPACT
"Roy" made a self-referral at the One Colchester Hub after being discharged from the Hospital accessing support for his mental health. He asked for support, social groups and volunteering opportunities to keep himself busy. Unfortunately he then sustained a back injury, and was unable to attend all of the groups, and continue with the activities that he enjoyed. The MSP team supported him throughout his recovery to ensure that he continued to have a positive attitude, until he could return to the Community One Hub for a cup of tea.

Outcomes include...

- Improved access to pathways
- Earlier intervention and prevention
- Innovative practice implemented at pace
- Flexible, adaptive approaches across teams and sectors
- Ability to scale up in response to demand or changing circumstances
- Joined up learning and development



For further information, please contact:

**Winsley's House
High Street
Colchester
Essex
CO1 1UG**

T: 01206 505250

E: c360.socialprescribing@nhs.net

Social Prescribing – The Essentials

Sian Brand

NHS England and NHS Improvement

2 March 2022





Social Prescribing – the essentials

January 2022

Siân Brand - Social Prescribing Facilitator



***‘There is
not a pill
for every
ill’***

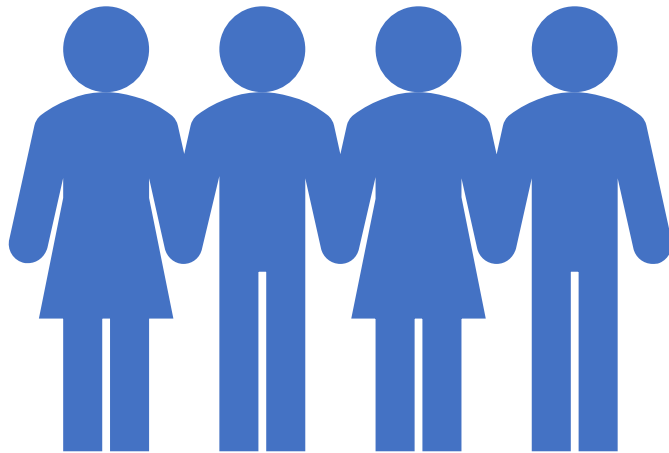
**Simon
Stevens**

Social Prescribing is...

...a process to help people make positive changes in their lives and within their communities by linking people to volunteers, activities, voluntary and community groups and public services that help them to:

- feel more involved in their community
- meet new people
- make some changes to improve their health and wellbeing

BUT IT'S PERSONAL





Why social Prescribing – for the system?

- A part of personalised care and support planning — Gives people more choice and control

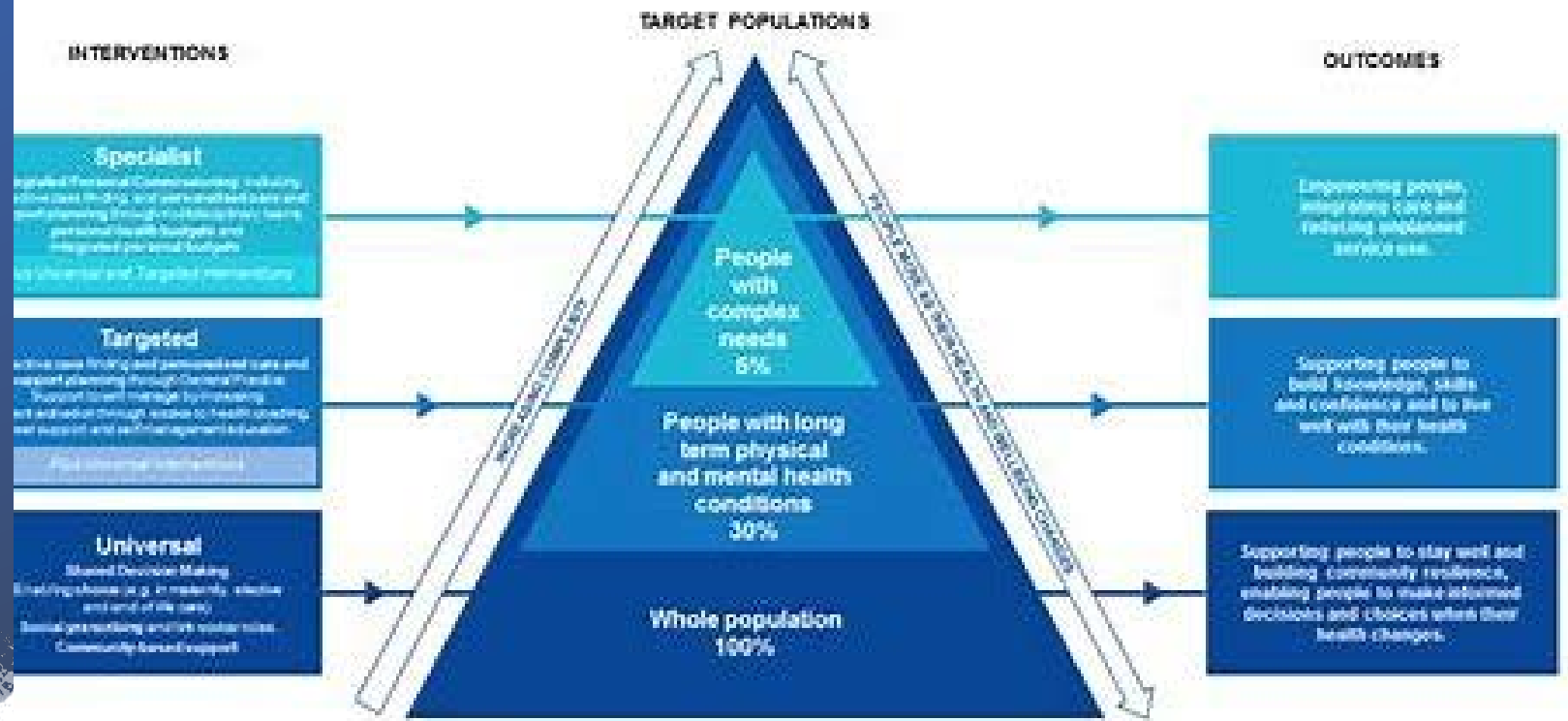
“No decision about me without me”

- Reduces health inequalities – long-term conditions, support with mental health, loneliness, complex needs.
- Reduces pressure & **assists in demand management** in General Practice, A&E social care & other services
- Supports self-care, self-management and prevention, personal & community resilience

Personalised Care for the whole population: the comprehensive model

Comprehensive Model for Personalised Care

All age, whole population approach to Personalised Care



Why social Prescribing – for me?

Focus changes from

“What’s the matter with me” to *“What matters to me”*

- Strengths rather than deficit
- Builds on existing assets
- Connects me to my communities
- Offers me a greater choice of opportunity & help that’s non-medical
- Meet new people and make new relationships including volunteering
- Build my self-responsibility, take control, engaging, empowering
- Improve my health and well being
- More enjoyable and/or rewarding

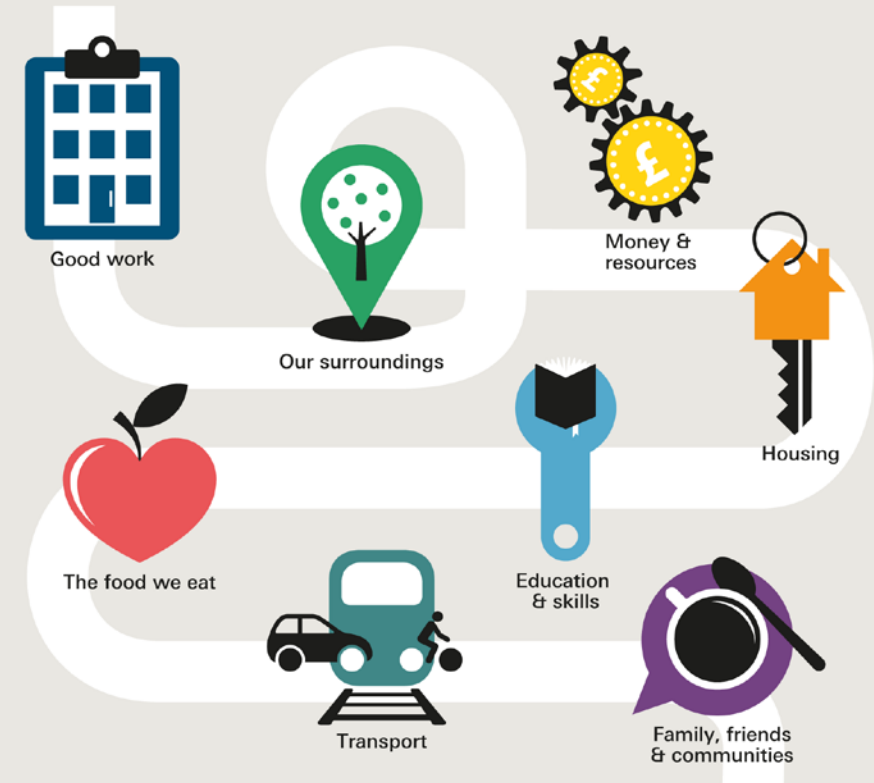
Social model of health

What makes us healthy?

AS LITTLE AS

10% of a population's health and wellbeing is linked to access to health care.

We need to look at the bigger picture:



But the picture isn't the same for everyone.

The healthy life expectancy gap between the most and least deprived areas in the UK is: **19** YEARS

What makes a good social prescribing model?



UNIVERSITY OF WESTMINSTER

Making sense of
Social Prescribing



This document is a work developed by the public sector and is available under an open license. For more information on the license, please visit <https://www.nhs.uk/our-licensing>.
© 2018 University of Westminster. All rights reserved. This document is a work developed by the public sector and is available under an open license.

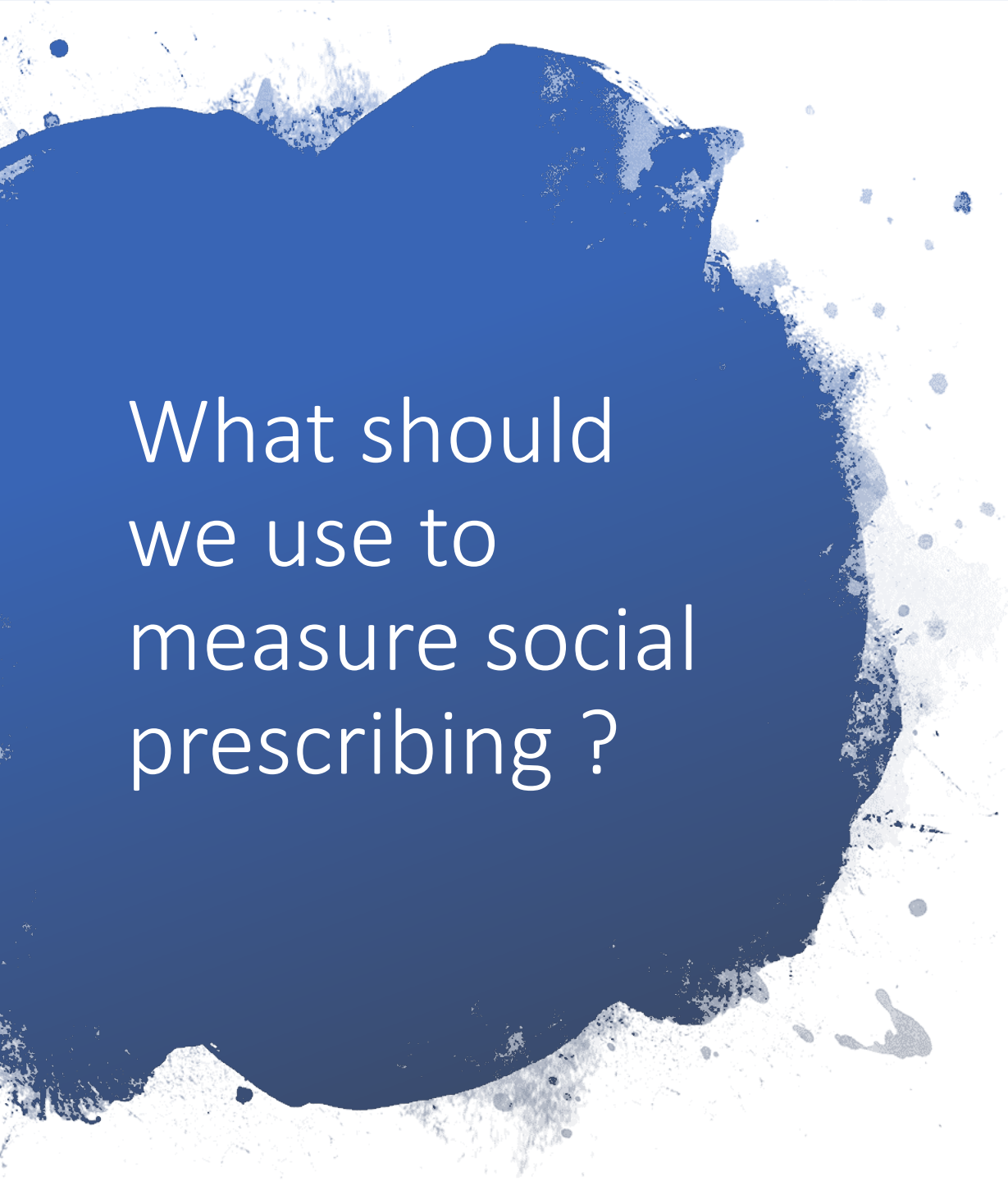


Social Prescribing Link Worker

- 6 to 12 sessions modelling – can be more or less depending on the person
- Conversation based – 50m/1hr slots – don't overload
- Home visits
- Health coaching approaches
- Well being plan – goals,
- Personalised care approach
- Not traditional PC consulting approach
- Community capacity building

Refer who?

- 25 – 40% of patients present with social issues
- DES states to be a member of the MDT - not the whole picture
- Discrete groups of patients – carers, parents, LTCs,
- Can be from any practice staff not just GPs
- Over time from any agency – police, social care, housing, DWP, self-refer
- Issues – self-esteem, loneliness, financial, employment, volunteering, lifestyle, activity, advocacy, lower level mental health,
- Earlier the prevention the better. Culture and behaviour change



What should we use to measure social prescribing ?

- Both qualitative & quantitative
- Case studies – nothing more powerful than the human voice
- SNOWMED
- ONS4
- PAM – as a patient activation measure foremost



Clinical supervision

- Mandated in DES for Link Workers
- Regular by a GP unless otherwise agreed with alternative appropriate arrangements – qualified
- Build relationships, understanding, knowledge & trust
- Share learning across the practice and PCN
- Will be working with some very vulnerable patients
- Link workers are generalists not specialists
- Link workers are not mental health specialists



Learning Coordinator

- NHSE regional role- 2 days per week for region
- STP wide peer support – monthly at the moment
- Support identification of training need and development of training delivery
- One to ones with new Link Workers
- Regular SP comms to Link Workers
- Covid – Lessons Learnt Survey & workshop
- Link to national SP team



Referral
Via a single point
of access



- Mental health needs
- Lonely and isolated
- Long term conditions
- Complex social needs

Link to

- voluntary sector
- community
- other statutory organisations
- wellbeing activities



- Low motivation
- One or more long term conditions
- Physical & mental health needs
- Low confidence

Link to

- confidence
- knowledge
- skills
- self-management
- behaviour change



- Needs information
- Uncoordinated care planning
- Frail/Elderly
- Multiple appointments

Link to

- community services
- secondary care
- mental health teams

New roles in Personalised Care



Health and wellbeing coach	Care coordinator	Social prescribing link worker
<ul style="list-style-type: none">• Focus on people with long term conditions or poor health or with risk factors for developing an LTC• Work with people in a coaching relationship and using a structured framework over a number of sessions to help them to work through a health related problem or problems.• Help people to find their own solutions and to build their knowledge, skills and confidence in living with their condition and dealing with challenges and ups and downs.• Work with people one to one or in small groups	<ul style="list-style-type: none">• Proactively identify and work with people to provide coordination and navigation of care and support across health and care services.• Manage a caseload of patients, acting as a central point of contact.• Bring together all the information about a person's identified care and support needs and explore options to meet these within a single personalised care and support plan.• Review patients' needs and help them access the services and support they require to understand and manage their own health and wellbeing, referring to social prescribing link workers, health and wellbeing coaches, and other professionals where appropriate.• Support people in preparing for, or follow-up, clinical conversations with primary care professionals (to enable them to be actively involved in managing their care/ be supported to make choices that are right for them).	<ul style="list-style-type: none">• Address the wider issues that affect people's health & wellbeing• Take a person-centred approach, to identify what matters to the person• Connect people to:<ul style="list-style-type: none">○ practical, social and emotional support within their community; and○ activities that promote wellbeing e.g. arts, sports, natural environment; and○ positive people, positive places and positive things• Identify and nurture community assets by working with partners such as VCSE, local authorities and health.• Tend to work with people experiencing loneliness, complex social needs, mental health needs or multiple LTCs.



Thank you

Sian Brand

Regional NHSE Social Prescribing

Regional Facilitator and Learning
Coordinator

sian.brand2@nhs.net

07724396670

Social prescribing and unpaid carers

Jodie Deards

Carer Experience Lead, NHSE/I East of England

Carers, why it should matter?

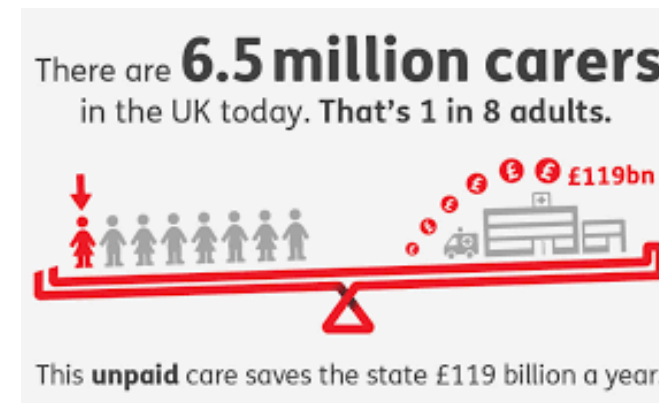
A **carer is anyone**, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid. (NHS England)

This includes carers

- in receipt of carers allowance
- Caring for someone in supported living / residential and / or nursing home
- People who fit these definitions but may not recognise themselves as being a carer

A **young carer** is someone under 18 who helps look after someone in their family, or a friend, who is ill, disabled, has a mental health condition or misuses drugs or alcohol (NHS England)

Young adult carers are young people aged 16-25 with unpaid caring responsibilities who are transitioning into adulthood.



Reframe the question:

Do you look after, or give any help or support to family members, friends, neighbours or others because of either:

- **long term physical or mental health/ disability, or**
- **Problems related to old age?**

What makes us healthy?

What makes us healthy?

Good health matters, to individuals and to society. But we don't all have the same opportunities to live healthy lives.

To understand why, we need to look at the bigger picture:

The infographic features eight icons arranged in a circular path, each representing a social determinant of health: a clipboard for 'Good work', a location pin with a tree for 'Our surroundings', a gear with a pound sign for 'Money & resources', a house with a key for 'Housing', a red apple for 'The food we eat', a bus and car for 'Transport', an open book for 'Education & skills', and a group of people for 'Family, friends & communities'.

The healthy life expectancy gap between the most and least deprived areas in England is over **18** YEARS

Find out more: [health.org.uk/what-makes-us-healthy](https://www.health.org.uk/what-makes-us-healthy)

The Health Foundation

© 2019 The Health Foundation.

As little as 10 % of a population's health and wellbeing is linked to access to health care.

90 % of a population's health and wellbeing is determined by the social circumstances they live in.

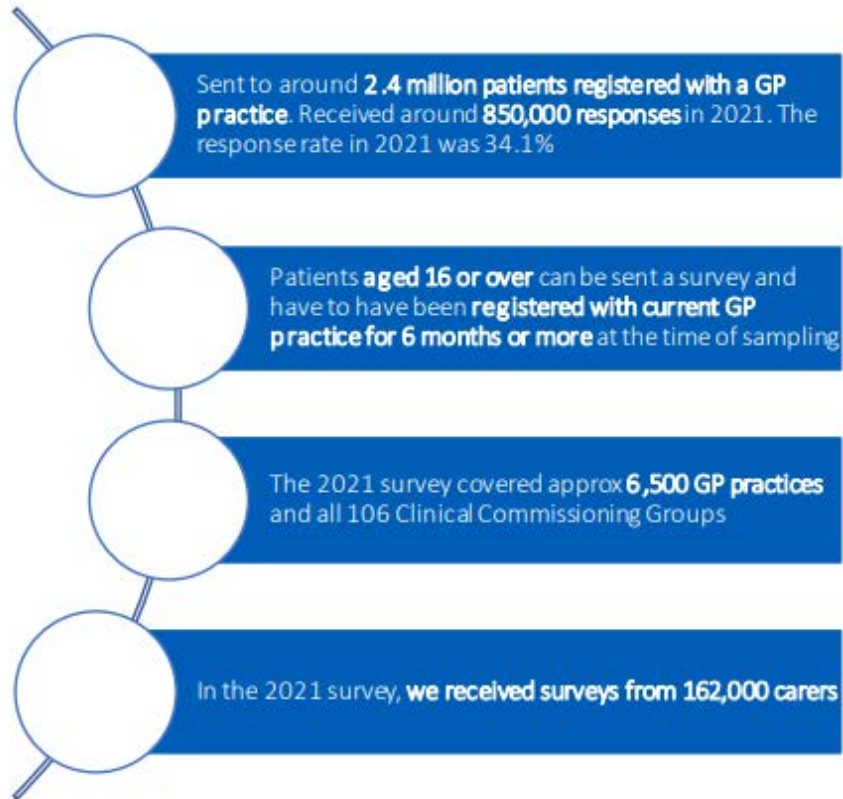
In March 2021, PHE determined that:

'caring is a social determinate of health'

[Caring as a social determinant of health: review of evidence - GOV.UK \(www.gov.uk\)](https://www.gov.uk)

“It's not your genetic code, it's your [post]code.”
Larry Cohen, *Building a thriving nation*³⁰

GP Patient Survey background



Q59 Do you look after, or give any help or support to family members, friends, neighbours or others because of either:

- long-term physical or mental ill health / disability, or
- problems related to old age?

Don't count anything you do as part of your paid employment.

- No
- Yes, 1 to 9 hours a week
- Yes, 10 to 19 hours a week
- Yes, 20 to 34 hours a week
- Yes, 35 to 49 hours a week
- Yes, 50 or more hours a week



'Non carers' are those who answered 'No' to Q59 and **'Carers'** are those who answered one of the following to Q59:

- 'Yes, 1-9 hours a week'
- 'Yes, 10-19 hours a week'
- 'Yes, 20-34 hours a week'
- 'Yes, 35-49 hours a week'
- 'Yes, 50+ hours a week'

Mental health need – Last appointment experience

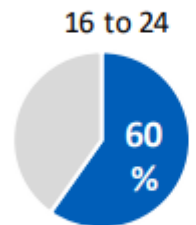


Half of carers (50%) had a mental health need at their last general practice appointment

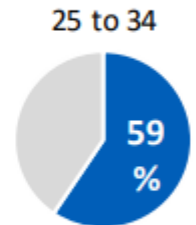


Compared with 47% of non carers

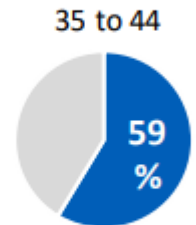
This rose to around three in five carers aged 16 to 44



Compared with 52% of non carers

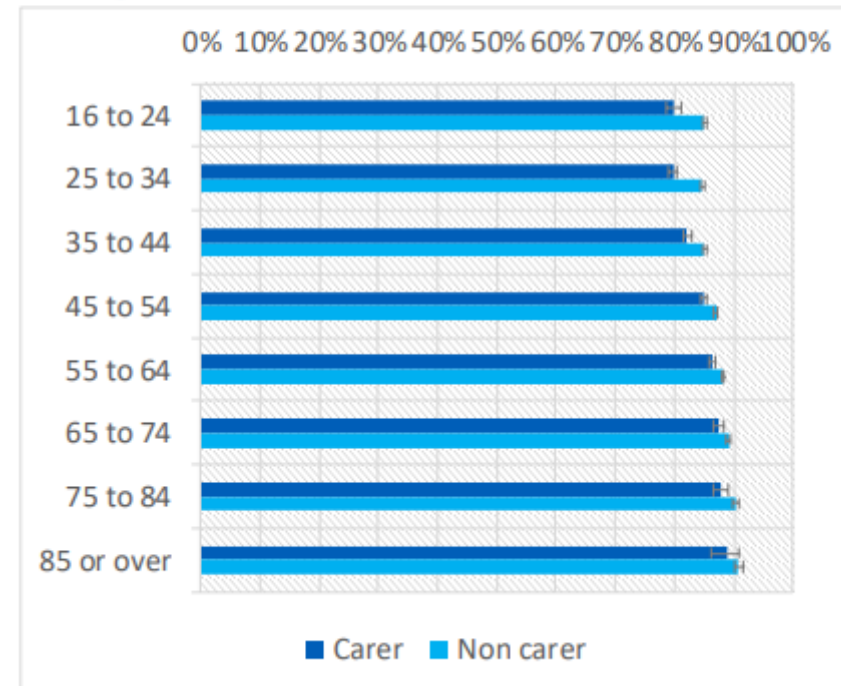


Compared with 52% of non carers



Compared with 52% of non carers

Carers aged 16 to 34 in particular were less likely to say their mental health needs were recognised or understood



Long-term conditions, disabilities and illnesses (1)

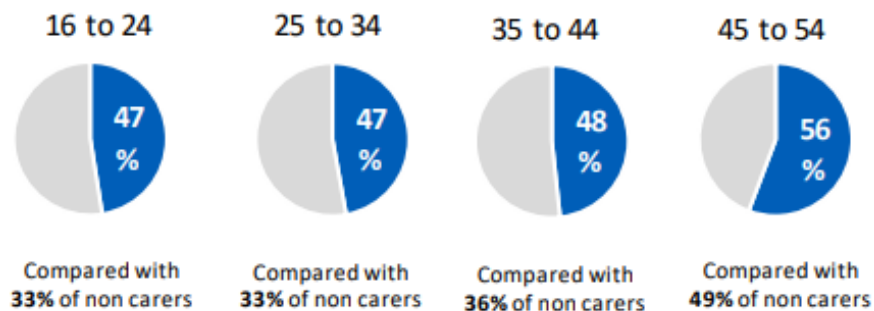


Three in five carers (60%) have at least one long-term condition, disability or illness

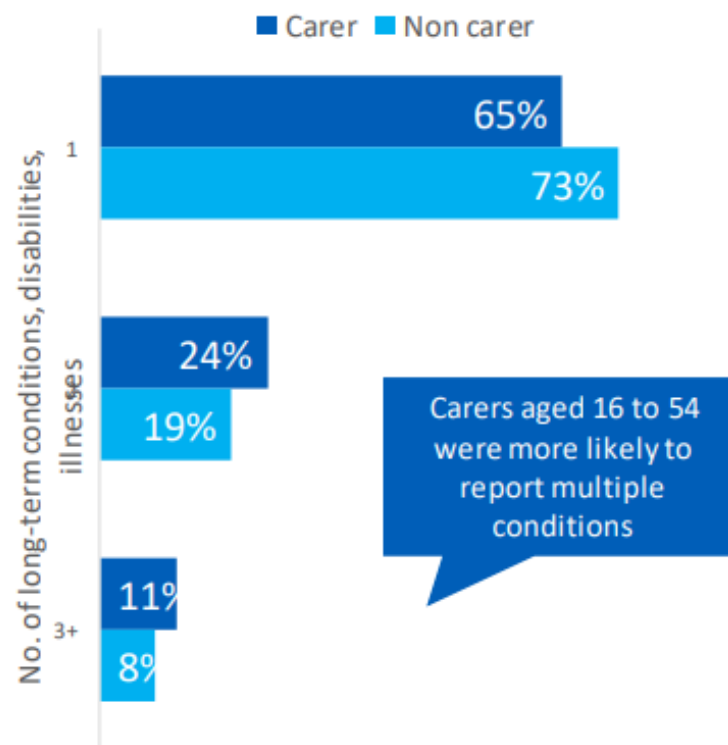
Compared with 50% of non carers



This is demonstrated across all ages less than 55



Of patients who had a long-term condition (aged 16 to 24)...

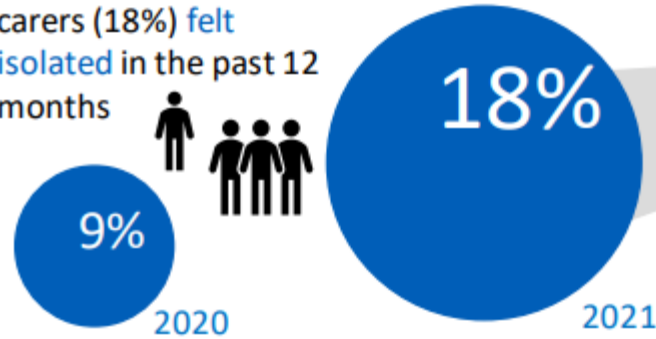


Carers aged 16 to 54 were more likely to report multiple conditions

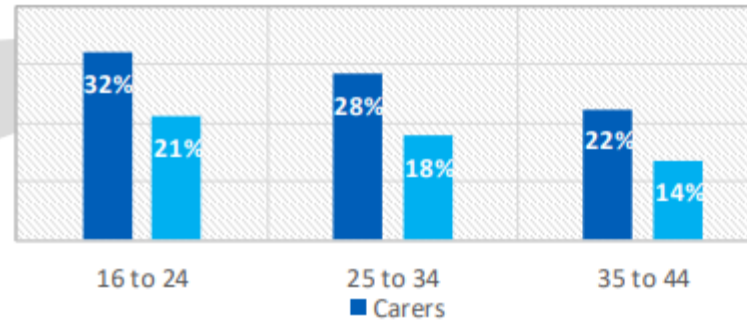
Feeling isolated from others and shielding



Around one in six carers (18%) felt isolated in the past 12 months



Carers aged 16 to 34 were most likely to feel isolated



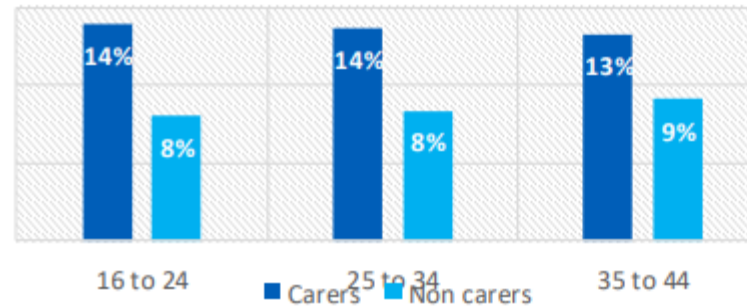
This magnitude of increase is seen for non carers too: 2020 (7%) and 2021 (14%)



18% of carers shielded for themselves over the past 12 months...

Compared with 16% of non carers

The difference between carers and non carers is greatest for younger patients



Social prescribing is the answer for carers



Level of risk (of carer breakdown)	Likely presenting factors	Percentage of carers
Level 1 – low risk Universal offer Carer is coping well and will receive ongoing info about groups/services	Able to promote own wellbeing Good support network Pro-actively seeks information	88%
Level 2 – moderate risk Preventative support using Carers Wheel Caring role is stable but carer at risk of social isolation and/or poor wellbeing and wants to make some pro-active changes Time limited support	Socially isolated Experiencing impact of caring on own wellbeing Not accessing other services	9%
Level 3 – high risk Intensive support Caring role at risk of breakdown or Safeguarding concern (open) Former carer at risk of breakdown	Exhausted/overwhelmed Highly stressed Neglecting self Recent change in health of cared for (e.g. hospital admission) leading to a more demanding caring role Open Safeguarding concern Recently bereaved showing signs of being overwhelmed with their loss	2%



Thank you

Jodie Deards

Carer Experience Lead, NHSE/I East of England

jodie.deards1@nhs.net

england.nhsthinkcarer@nhs.net

Do I look like I care? #NHSThinkCarer

Welcome to: **NHS**

Commitment to Carers Programme

Bi-Monthly Lunch & Learn Webinar

Wednesday 19th January, 2022, 13:30pm – 14:30pm

NHS England and NHS Improvement

Collaborate

Collaboration is the backbone to future NHS. The more we connect, share and learn, the more our community benefits.

Connect

We make it simple to tap into the skills, all genes, expertise and those who are passionate about the same things as you are.

Share

Share your work and views easily. Contribute to the biggest interactive source of health and social care knowledge.

Learn

Benefit from knowledge, people and learning you won't find on Google.

Analysis of GP Survey 2021



- Covid-19-specific research: 72% of carers had no breaks since first lockdown; 74% exhausted as a result of caring (Carers UK survey)
- *Carers Health and experiences of primary care: (n = 850,000 responding to GP survey): 1 in 5 (18%) have unpaid caring responsibilities*
- 60% of carers had long-term health condition/disability (50% non-carers)
- 70% of LGB carers had long-term condition (60% straight carers)
- 86% of white carers thought professionals understood their mental health needs - only 78% of black and 76% of Asian carers did
- 36% of LGB carers have a mental health condition (13% straight carers)
- [Caring as a social determinant of health: review of evidence - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/reviews/caring-as-a-social-determinant-of-health)

Carers and Social Prescribing

Carole Whittle – Health and Wellbeing Manager

*Making
Carers Count*

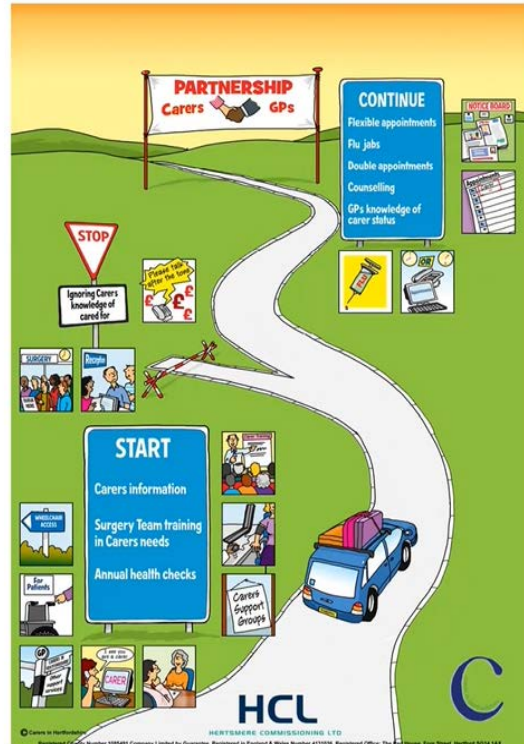
charity registration number 1085491

Carers and Social prescribing

- Build the relationship
- Coproduce the solution
- Create the menu
- Discover the difference.

Building trust and confidence

2009 – Co-produce the vision, Carers and GP's



2021

Carers Champions in:

- GP surgeries
- Hospitals
- Community Trusts

Link workers and Social Prescribers trained in Carer Awareness and hosted by Carers in Hertfordshire.

Coproduce the solution

Individual Work



Collective voice



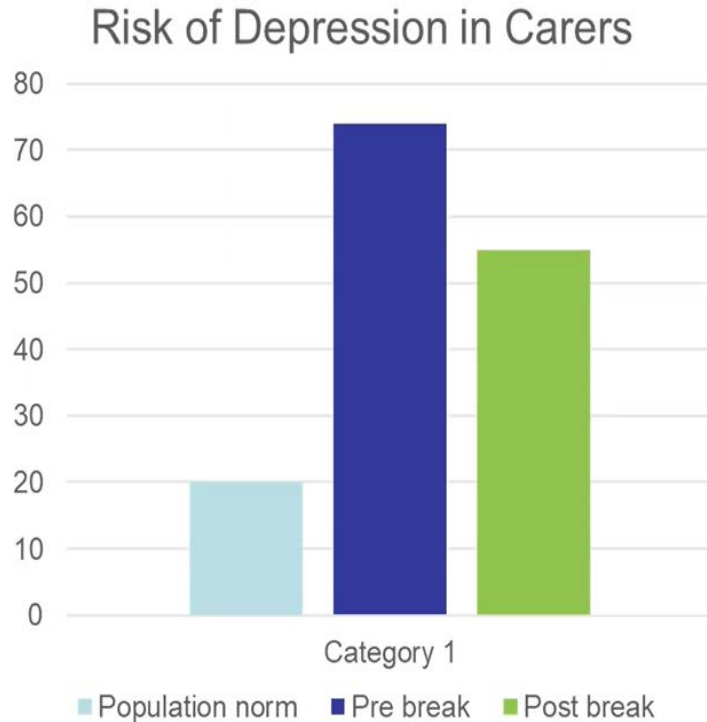
Creating the menu

Tailored to the individual need:

- Information and Advice
- Care in the Home
- Training
- Peer support
- A way to have their voice heard
- A break from caring
- Specialist Dementia Nursing support

Impact from Make a Difference for carers

Data from SF12v2



Case Study

Took break away from home.

- "this has saved my life".
- For the first time in 27 years carer felt supported enough to leave son and go on holiday.
- Carer is considering volunteering for Carers in Hertfordshire.

External Evaluation of Mentoring Pilot

The Mentoring Unit, University of Hertfordshire:

it is evident from the qualitative feedback that the recipients found the mentoring useful in a number of ways. These included tangible benefits such as accessing additional support or respite care but many also referred to the benefit of having someone who was not family to confide in.

Carers as part of the solution

- “The skills and knowledge I have learnt have been life-changing and I can take these skills with me everywhere I go.”
Young adult carer who was a young carer volunteer
- “We hadn’t heard of Carers in Herts until quite recently, and I can honestly say we wouldn’t be surviving lockdown without them. The support we have received has been completely overwhelming, we can’t thank you enough. We have spoken to so many volunteers who have all reassured us that we are doing a good job, and the services we have been provided with is unbelievable.”

Carer supported by volunteers during COVID

What carers say about peer support

Extraordinarily helpful to talk to someone in a similar position knowing they "got" what I was feeling.

It made me truly appreciate I was not alone and helped me identify ways I could help myself.

I was at a low point. My mentor was really good, she saved my life and gave me good advice about relationships. ♦

Health and carers working together

"I feel so much happier just talking to you, I am very glad that I have spoken to you. It's the first time I have called your number, I am very pleased about calling you, I feel so much less stressed about things. I know things will settle down, they are looking at my wife's meds and hopefully things will get better once they review her meds again. Just being able to talk about things has helped."



Get in touch

Carers in Hertfordshire,

The Red House,
119 Fore Street,
Hertford,
SG14 1AX

Tel: 01992 58 69 69

Email: contact@carersinherts.org.uk

Website: www.carersinherts.org.uk

www.facebook.com/carersinherts



@carersinherts



Family Carers' Prescription

Andy McGowan

Head of engagement

Ruth Young

Carer helpline team manager



About us

Caring Together is a charity that provides information, runs services in our local communities and campaigns, so that carers have choices.

It is our mission that people know where to go for help before, during and after their caring role and get the practical support that matters.



6,000

Every minute four people in the UK take on a caring role. That's 6,000 people every day.

3 in 5

of us will become a carer at some point in our lives.



Family Carers' Prescription (FCP)

- ✿ Gives carers of all ages, including young carers and parent carers, access to a worker at Caring Together who will discuss the support options available and support the carer to access them.
- ✿ The worker supports the carer to design a short break that works for the carer and they also provide support for this break to happen.
- ✿ The carer decides what gives them a break – it may be assistance going out with the person they care for, someone being with the person they care for whilst they do something or it could be something else (e.g. purchasing something).

Family Carers' Prescription

- ✿ Commissioned by the Cambridgeshire and Peterborough Clinical Commissioning Group
- ✿ Carers access the 'prescription' through their local health professional, including GPs, or directly via our carer helpline identifying carers who would benefit, who will then liaise with the GP on their behalf.
- ✿ Focus is on providing flexible, person-centered support to:
 - Carers at risk of reaching crisis point (including caring at end of life)
 - Carers with their own health issues
 - Carers who have got their own health appointments they need to attend

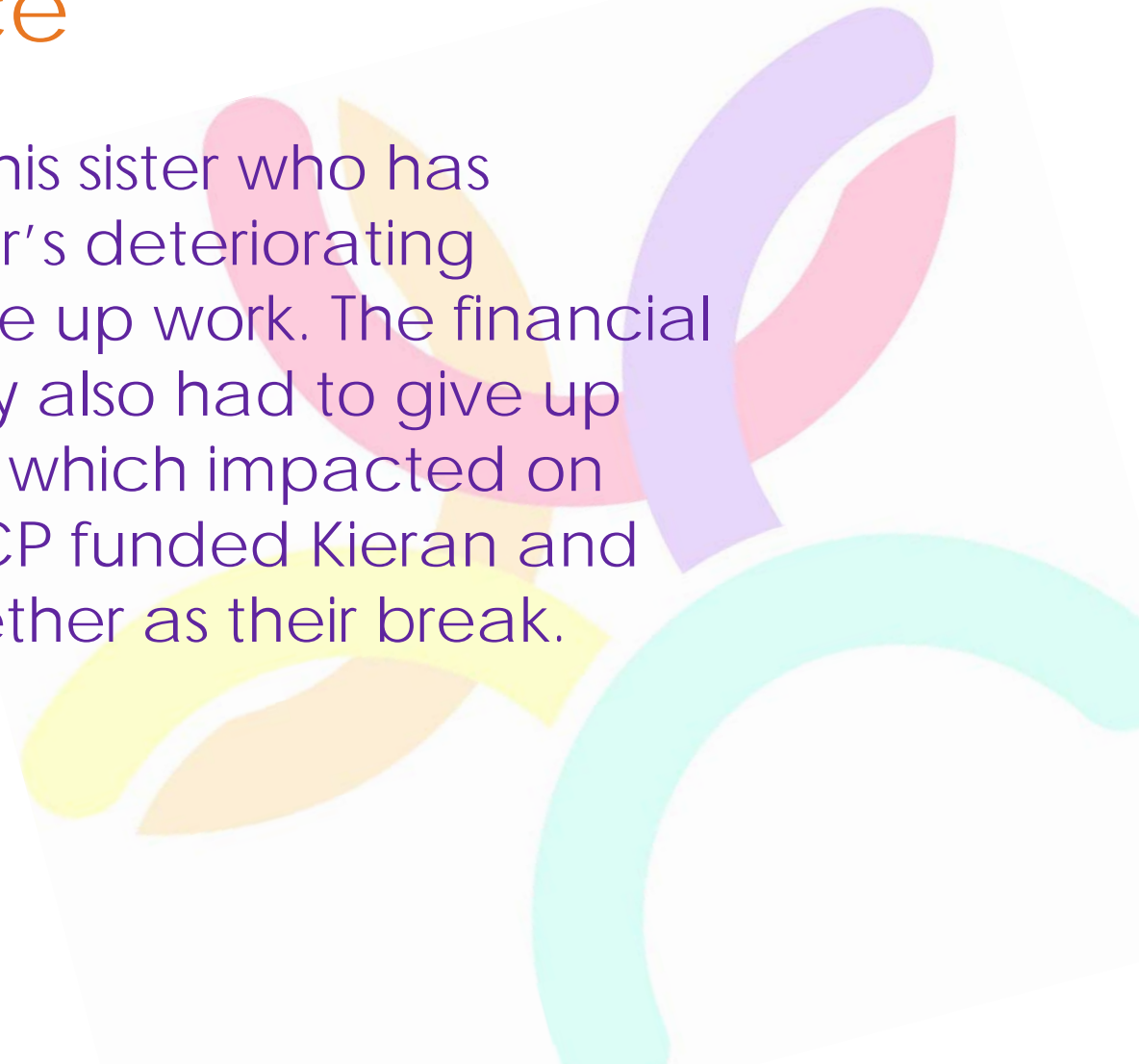
Examples in practice

Bob cares for his wife who has dementia. He called our carer helpline as he was feeling exhausted and overwhelmed with his caring role. His wife is having support through Continuing Healthcare 4 times a day but in between Bob is with his wife alone. He said she was verbally aggressive toward him and he was becoming totally exhausted with dealing with that and all the organisations that he had to be in contact with. He had not had a break for over a year and just wanted to be able to take some time out.

We were able to quickly arrange a care worker to go and support Bob's wife so Bob could have some time out. He had 3 full days of support spread over 3 weeks so he could go out and get some time to himself.

Examples in practice

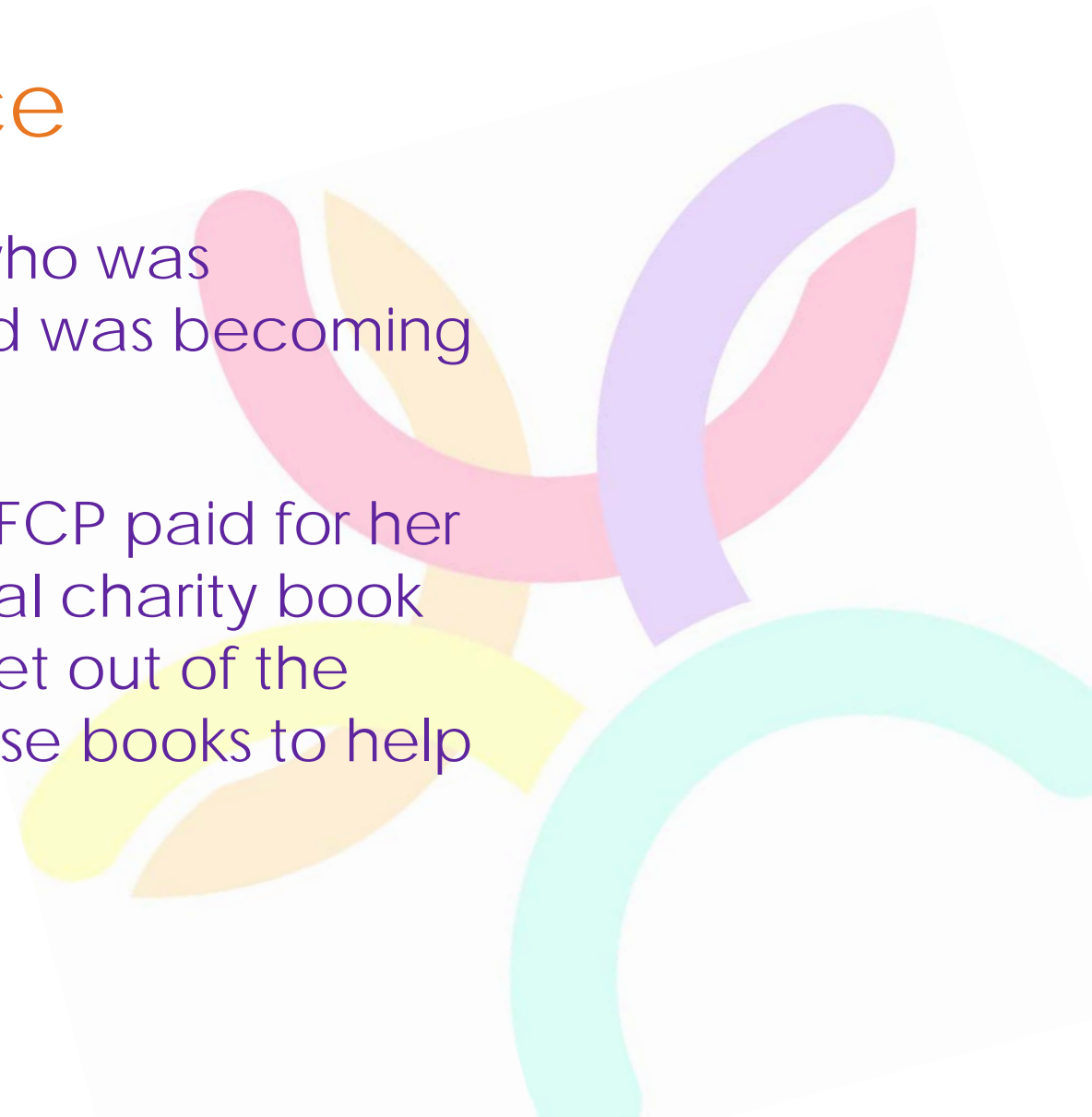
Kieran is 6 and helps care for his sister who has cerebral palsy. Due to his sister's deteriorating condition, his mum had to give up work. The financial impact of this meant that they also had to give up the weekly swimming sessions which impacted on Kieran's mental health. The FCP funded Kieran and his mum to go swimming together as their break.



Examples in practice

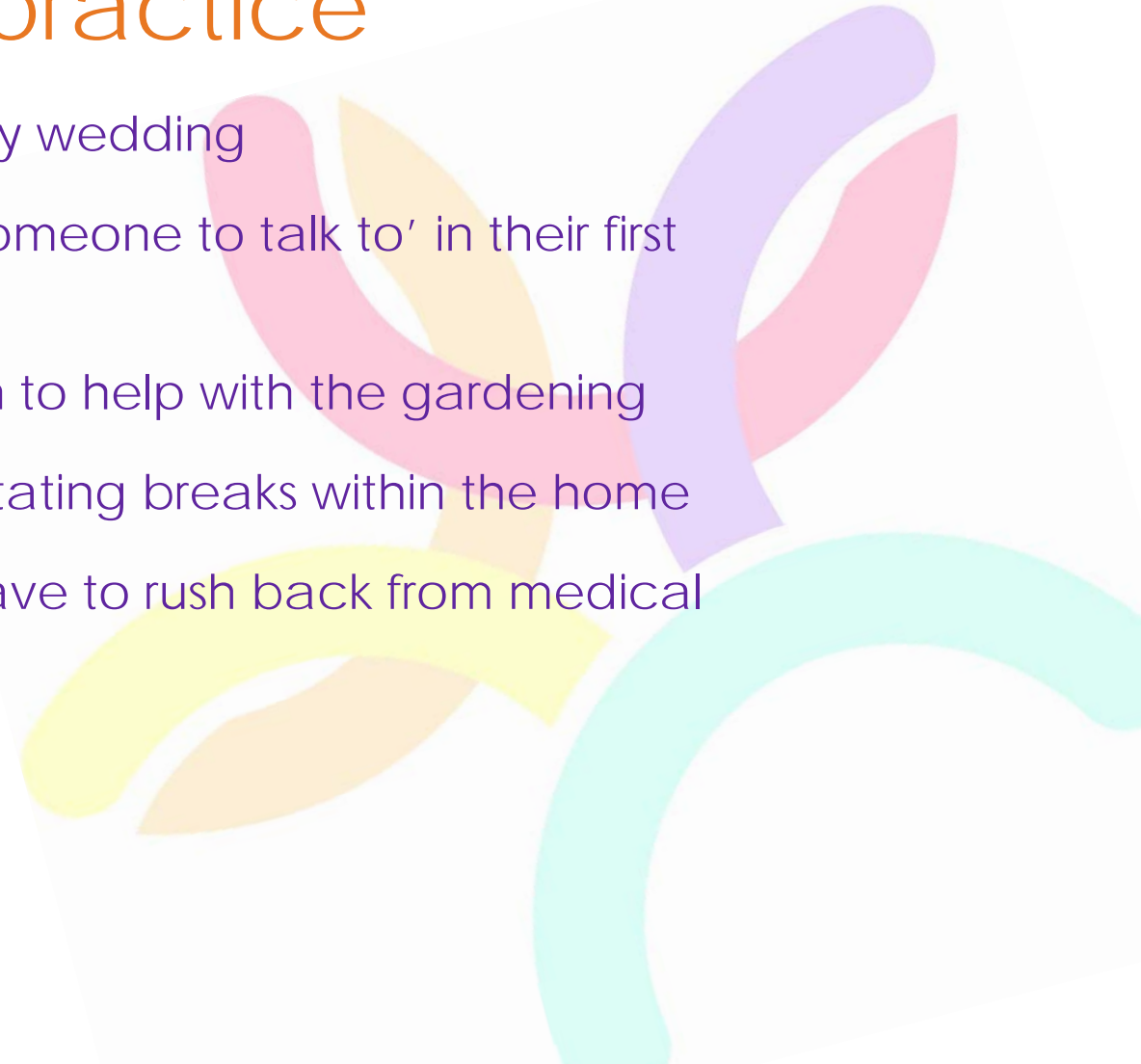
Molly is a young adult carer who was struggling with her anxiety and was becoming very isolated at home.

She loved reading and so an FCP paid for her to purchase books from a local charity book shop – this supported her to get out of the house more as well as purchase books to help her to try and relax at home.



Other examples in practice

- ✿ Enabling a carer to attend a family wedding
- ✿ Helping a parent carer to have 'someone to talk to' in their first language
- ✿ Helping a carer to get someone in to help with the gardening
- ✿ For some carers, can involve facilitating breaks within the home
- ✿ Supporting carers so they don't have to rush back from medical appointments/treatment



What difference does it make?

- ✿ 89% of carers said they were less stressed or anxious
- ✿ 88% said they now can cope better with their caring role
- ✿ More than 95% would recommend the service to a friend or relative
- ✿ A study in 2019 showed that over a year, the estimated saving through avoided hospital and residential admissions was £1.7 million (NB - These figures do not even take account of the additional potential savings associated with the prevented admission of the person they care for)

Thank you

L D H House
Parsons Green
St Ives
PE27 4AA

caringtogether.org



A Network Partner of
**CARERS
TRUST**



Health Creation and the VCFSE Sector

Tim Anfilogoff – Head of Community Resilience Herts CCG

Kristy Thakur – VPAC Programme Lead & Head of Community & People Well-being

NHS England and NHS Improvement

2 March 2022



Health Creation and the VCFSE Sector

Tim Anfilogoff

**Head of Community Resilience
Herts CCGs**

**NHSE Regional Associate, Social
Prescribing, East of England**

Mobile: 07900 161673

Kristy Thakur

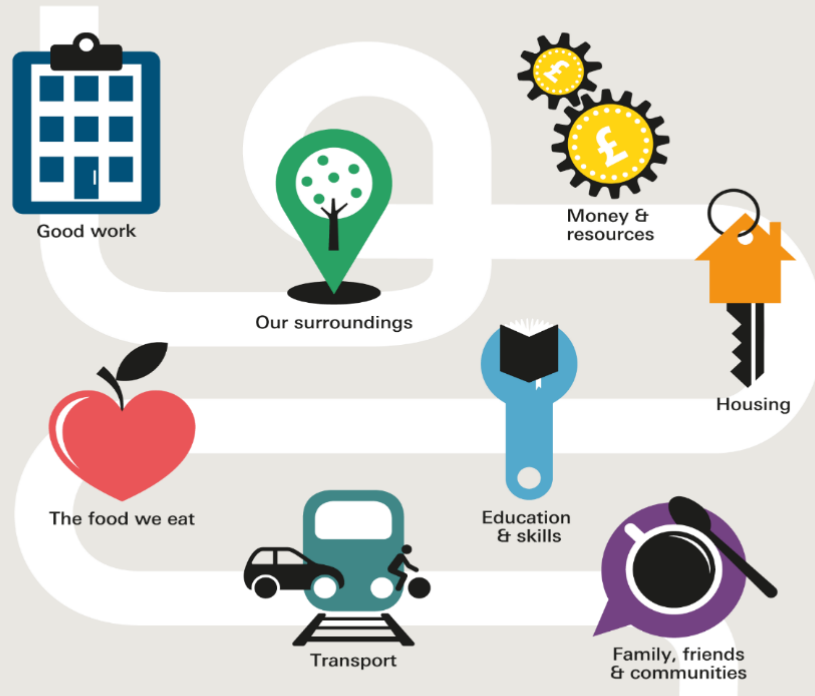
**VPAC Programme Lead &
Head of Community & People
Wellbeing
Adult Care Services
Hertfordshire County Council**

Covid = Syndemic

What makes us healthy?

AS LITTLE AS
10% of a population's health and wellbeing
is linked to access to health care.

We need to look at the bigger picture:



But the picture isn't the same for everyone.

The healthy life expectancy gap between the
most and least deprived areas in the UK is: **19** YEARS

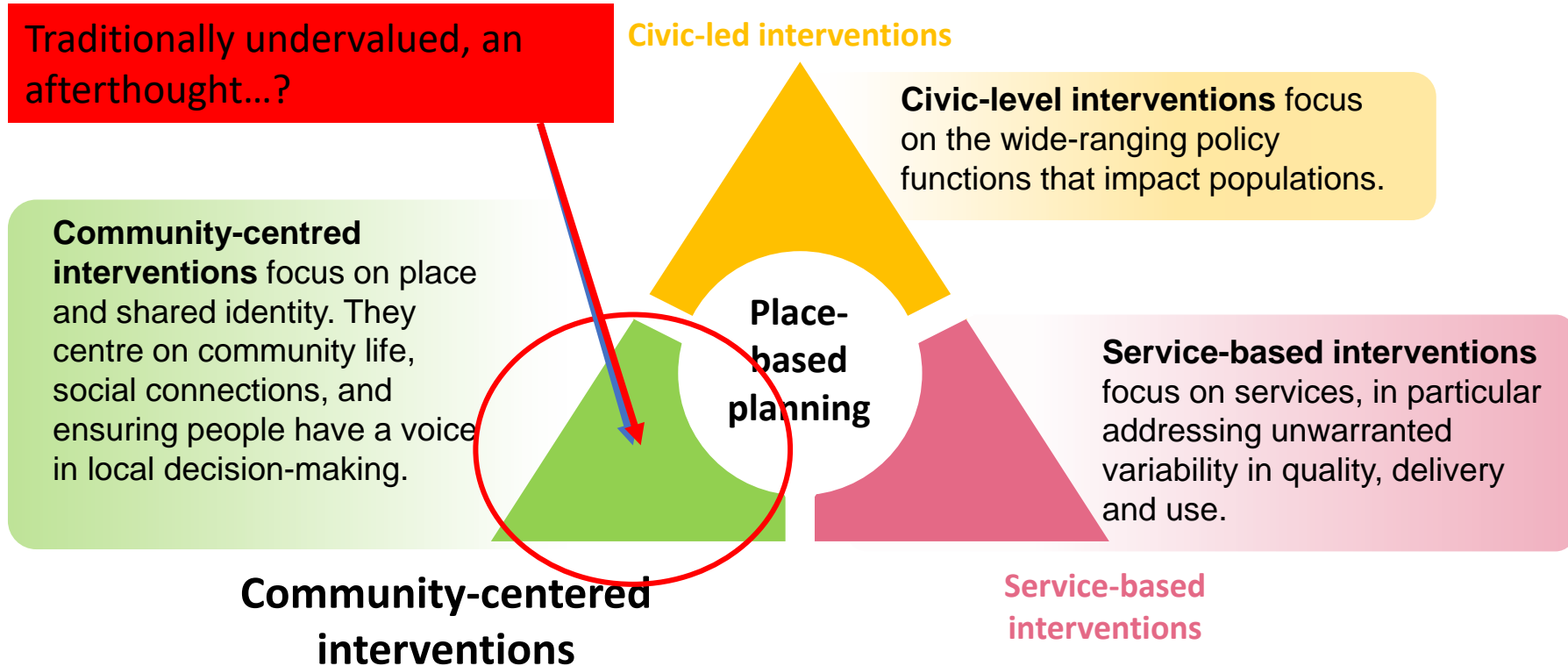
- Aggravating existing health inequalities
- Particularly BAME, digital exclusion, domestic abuse, isolation of caring, mental health...
- Impacting most on those with deprivation induced LTCs

Key Challenges for Recovery

- 10 years of austerity and worsening health inequalities
- Exhaustion of staff (statutory and voluntary)
- Economic consequences
- Social and MH consequences



Population Intervention Triangle (PIT)



- PIT shows the main components of place-based interventions: **civic, community** and **service**
- Each have potential to independently make a quantifiable change at population level
- Joint working across interfaces between civic, service and community sectors can help the whole be more than the sum of its parts.

What are health inequalities?

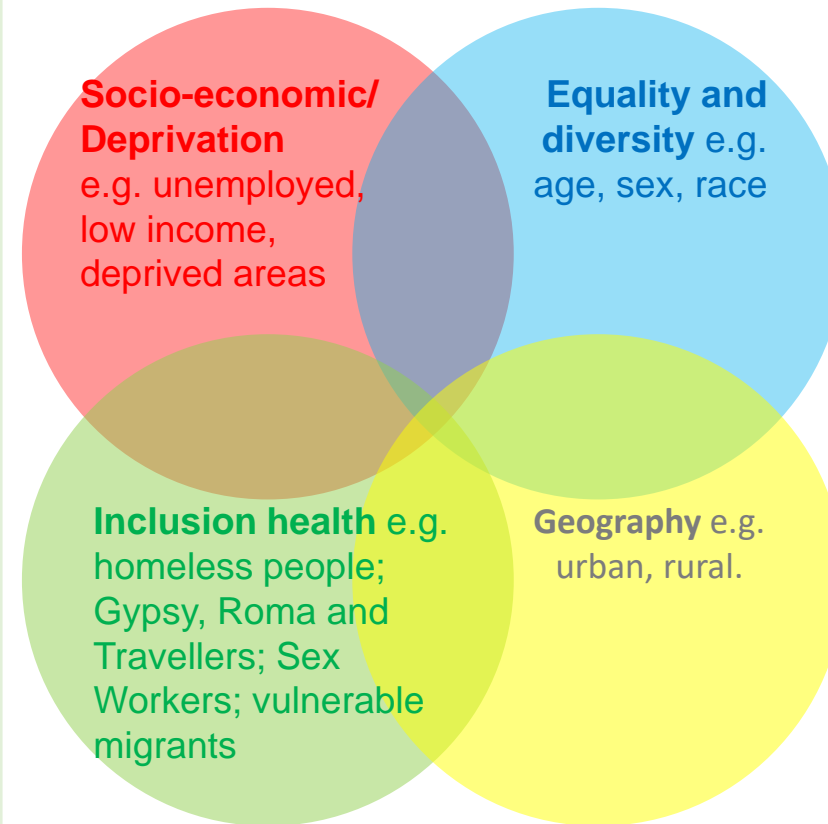
Unfair and avoidable differences in health across the population, and between different groups within society.

Arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.

Have been documented between population groups across at least four dimensions, as illustrated to the right.

Action on health inequalities requires improving the lives of those with the worst health outcomes, fastest.

Dimensions of health inequalities





Supported by

**NHS CHARITIES
TOGETHER**

NHS Charities bid (HWE) Nov 2020

PROPOSAL	Year 1	Year 2	Bid
1. Covid Recovery BAME workers (1 for E, 1 for W)	£100k	£100k	£200k
2. Practical support to BAME and other carers	£20k	£20k	£ 40k
3. Staying Connected (digital inclusion worker)	£50k	£50k	£100k
4. Enhancing work of Herts charities to address fuel poverty, cold homes, isolation	£7.5k per DC	£7.5k per DC	£150k
5. SP for YP in crisis at Watford and Lister Hospitals to connect YP to help in the community	£45k	Link to HCNS review	£45k
6. Digital inclusion and BAME engagement work (West Essex)	£89k	£89k	£178k
TOTAL			£713k

1. BAME Covid Recovery Workers

- Started 12 April
- Integrating with Social Prescribing and Advocacy 'system'
- Supporting capacity building in BAME VCFSE
- Invited to participate in Central Watford Pilot
- naomi.duncan@cdaherts.org.uk
rushna.miah@cdaherts.org.uk
(West Herts)
- mercy.bwomono@cdaherts.org.uk
(East Herts)



2. BAME Carers Breaks

- New BAME Breaks Coordinator being recruited (i/vs 21 June)
- Building on Carers' Urgent Breaks on prescription in West Herts
- Massive increase in carers identifying to primary care (3,250 in first quarter 2021)



3. Digital Inclusion

- Cindy Withey started 1 February 2021
- Corporate Social Prescribing to source equipment
- Socially prescribing where real impact on wellbeing
- Not just kit: volunteers to help with skills and support/data poverty etc...
- cindy@communityactiondacorum.org.uk



There are four main areas of this project

- (a) access to equipment
- (b) access to connectivity
- (c) fear of using equipment
- (d) skills in using the equipment

4. Winter

- £75k NHSCT monies distributed
- Mainly on digital and loneliness and additional volunteers
- Levered further £35k (DWP monies (food and fuel), MH monies, Dacorum BC monies)
- Will repeat winter 21-22



5. Young People's Mental Health Social Prescribing

- 3 day per week workers, 1 in WGH, 1 in Lister – both appointed end May
- Based with Watford FCT in West, Youth Connexions in East
- Will link those in crisis to support when they get home/prevent admission



6. Digital inclusion Mental Health and BAME engagement work (West Essex)

- Recruitment undertaken
- Digital Platform started
- Identification of those in need undertaken
- Partnerships established with Mind WE and BAME organisation/s
- Steering Group established

Contact: Clive Emmett

ceo@cvsu.org.uk



Relationships/Social Capital are key

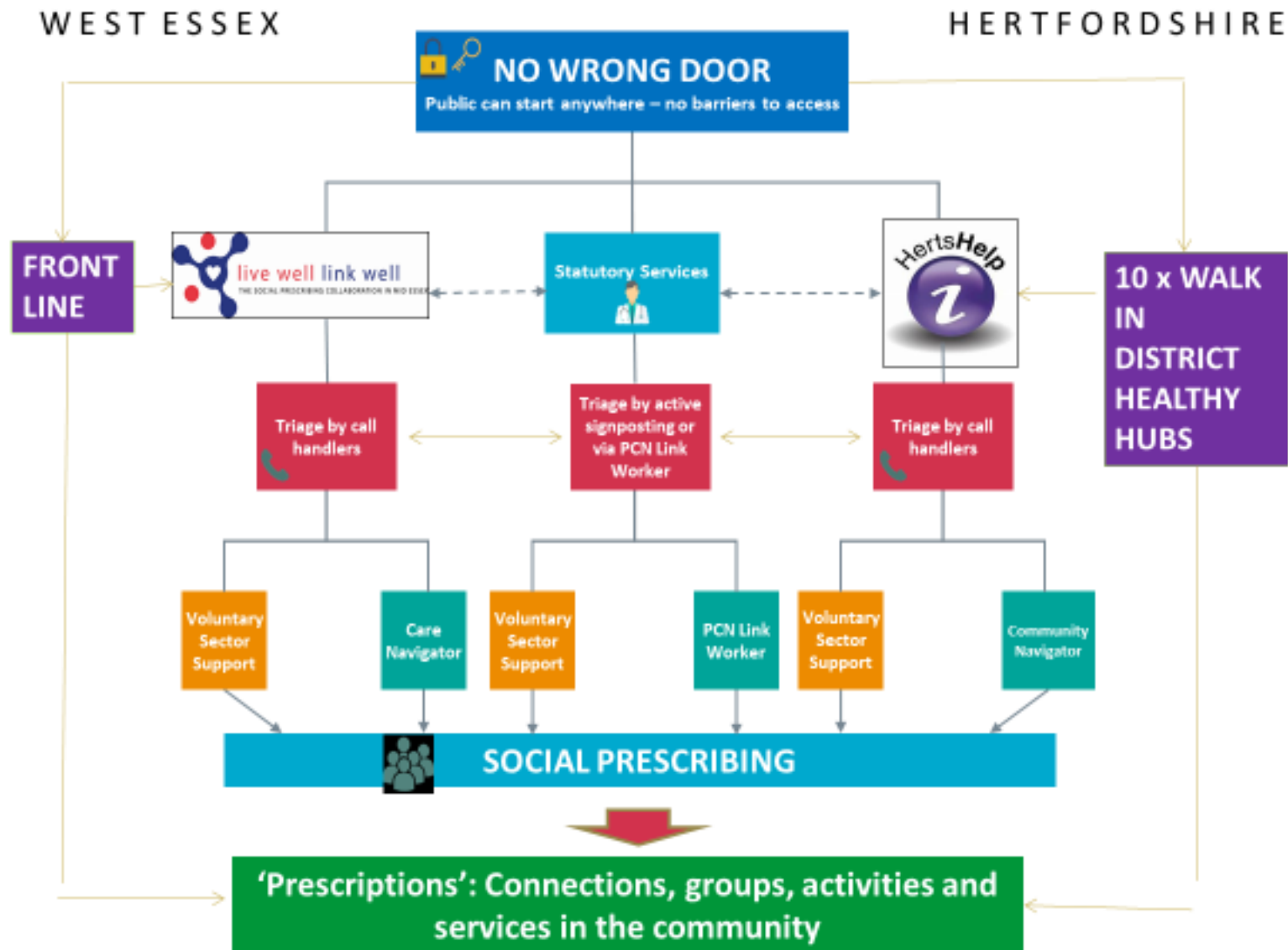
- More responsive and integrated (within and between sectors)
- Built new services very quickly:
 - 2-week discharge wraparound
 - Pathway 0 welcome home calls
 - Outreach to quarantined travellers, refugees etc
 - **Community Help Herts** countywide support with food, medicine, befriending all linked to Herts Help
- In West Essex, District Councils and CVS's worked together to form District based Hubs to support those in need



Framework for Building on Collaboration

1. ***No Wrong Door*** approach – access for all, especially those who need it most
2. Supporting unpaid, family carers
3. Volunteering
4. All joined up through integrated commissioning of the VCFSE focused on ‘health creation’

1.
N
O
W
R
O
N
G
D
O
O
R



It only works as a system if you understand it and treat it as a system...just doing so adds value



CommunityHelp
Hertfordshire

*A partnership of voluntary sector infrastructure
organisations funded by Hertfordshire's public sector*

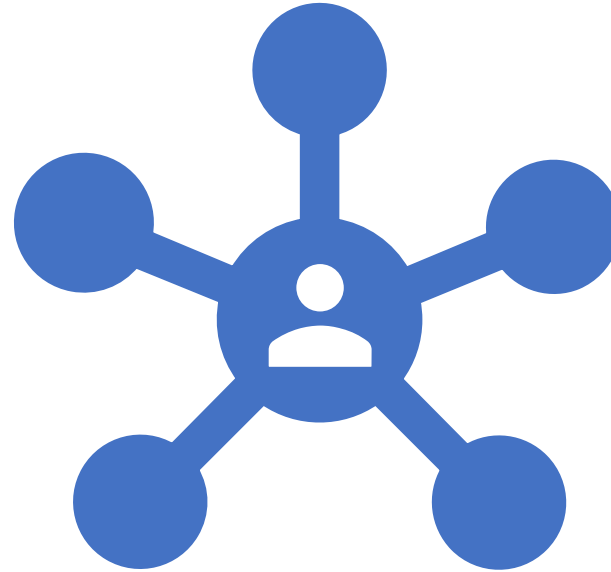
COVID-19 Information Champions

To ensure Hertfordshire residents receive regular information updates which are clear and consistent about COVID-19 from Public Health. The project will:

- Utilise the strong local networks established with the community by the voluntary sector
- Identify and train CICs and peer educators to share key messaging with friends, families and local communities
- Embed information and behaviours in our communities



Shared Plan for Social Prescribing



Tim Anfilogoff, Head of Community Resilience with both CCGs (and NHSE Regional Associate Social Prescribing) is available to support any PCN in developing its plan tim.anfilogoff@nhs.net

2. Family Carers

- 10% of population before Covid
- Worse health than peers (GP survey)
- Caring is a social determinant [Caring as a social determinant of health \(publishing.service.gov.uk\)](#) – health inequalities issue
- New Herts Strategy developing with HCC
- Carers self-identify when see value (vax)
- Much more support (including mutual support) delivered online
- Many had no break for a year: anxious,

CARERS PATHWAY



- Getting older volunteers re-engaged (wellbeing implications)
- Holding on to new volunteers (11,000 during crisis in Herts)
- Developing 'post-crisis' roles including in primary care
- Back to work support through volunteering (key social prescription)
- Waiting list management, keeping in touch, outreach etc
- Impact of NHSR?

4. New Joint Strategic Commissioning Board (Herts): Health Creation & the Voluntary, Community, Faith and Social Enterprise Sector (VCFSE)

- Key Stakeholders Commissioning VCFSE sharing vision
- ICS, HCC, DCs, VCFSE, Police and Crime Commissioner, PH, MH and CYP commissioners etc – with independent VCFSE Chair
- Meetings with stakeholders to agree principles
- First meeting September 2021
- Focusing on recovery, integration and promoting wellbeing
- West Essex building on work of ***Health Inequalities Committee***

Reviewing Overall Spend to Identify

- Greater integration and synergy (build on Covid legacy)
- What works
- Strengths and gaps – partic in relation to health inequalities and ‘recovery’
- Impact on the framework ‘themes’
- How the sector helps with Population Health Management (eg Central Watford pilot, developing CYP SP offer in some parts of Herts etc)

Top Tips for PCNs from Health Creation Alliance

1. Don't wait until the Tackling Neighbourhood Inequalities DES kicks-in, start now.
2. Involve your local communities and local partners in shaping your PCN.
3. Make sure your PCN governance arrangements include people from diverse communities.
4. Share the process of developing your actions for tackling health inequalities with local partners.
5. Support member practices to work with communities as equal partners in pursuit of improved population health.

Family Carers' Prescription

Andy McGown – Head of Engagement

Ruth Young – Carer Helpline Team manager

NHS England and NHS Improvement

2 March 2022





Family Carers' Prescription

Andy McGowan

Head of engagement

Ruth Young

Carer helpline team manager



About us

Caring Together is a charity that provides information, runs services in our local communities and campaigns, so that carers have choices.

It is our mission that people know where to go for help before, during and after their caring role and get the practical support that matters.



3 in 5

of us will become a carer at some point in our lives.

6,000

Every minute four people in the UK take on a caring role. That's 6,000 people every day.



Family Carers' Prescription (FCP)

- ✿ Gives carers of all ages, including young carers and parent carers, access to a worker at Caring Together who will discuss the support options available and support the carer to access them.
- ✿ The worker supports the carer to design a short break that works for the carer and they also provide support for this break to happen.
- ✿ The carer decides what gives them a break – it may be assistance going out with the person they care for, someone being with the person they care for whilst they do something or it could be something else (e.g. purchasing something).

Family Carers' Prescription

- ✿ Commissioned by the Cambridgeshire and Peterborough Clinical Commissioning Group
- ✿ Carers access the 'prescription' through their local health professional, including GPs, or directly via our carer helpline identifying carers who would benefit, who will then liaise with the GP on their behalf.
- ✿ Focus is on providing flexible, person-centered support to:
 - Carers at risk of reaching crisis point (including caring at end of life)
 - Carers with their own health issues
 - Carers who have got their own health appointments they need to attend

Examples in practice

Bob cares for his wife who has dementia. He called our carer helpline as he was feeling exhausted and overwhelmed with his caring role. His wife is having support through Continuing Healthcare 4 times a day but in between Bob is with his wife alone. He said she was verbally aggressive toward him and he was becoming totally exhausted with dealing with that and all the organisations that he had to be in contact with. He had not had a break for over a year and just wanted to be able to take some time out.

We were able to quickly arrange a care worker to go and support Bob's wife so Bob could have some time out. He had 3 full days of support spread over 3 weeks so he could go out and get some time to himself.

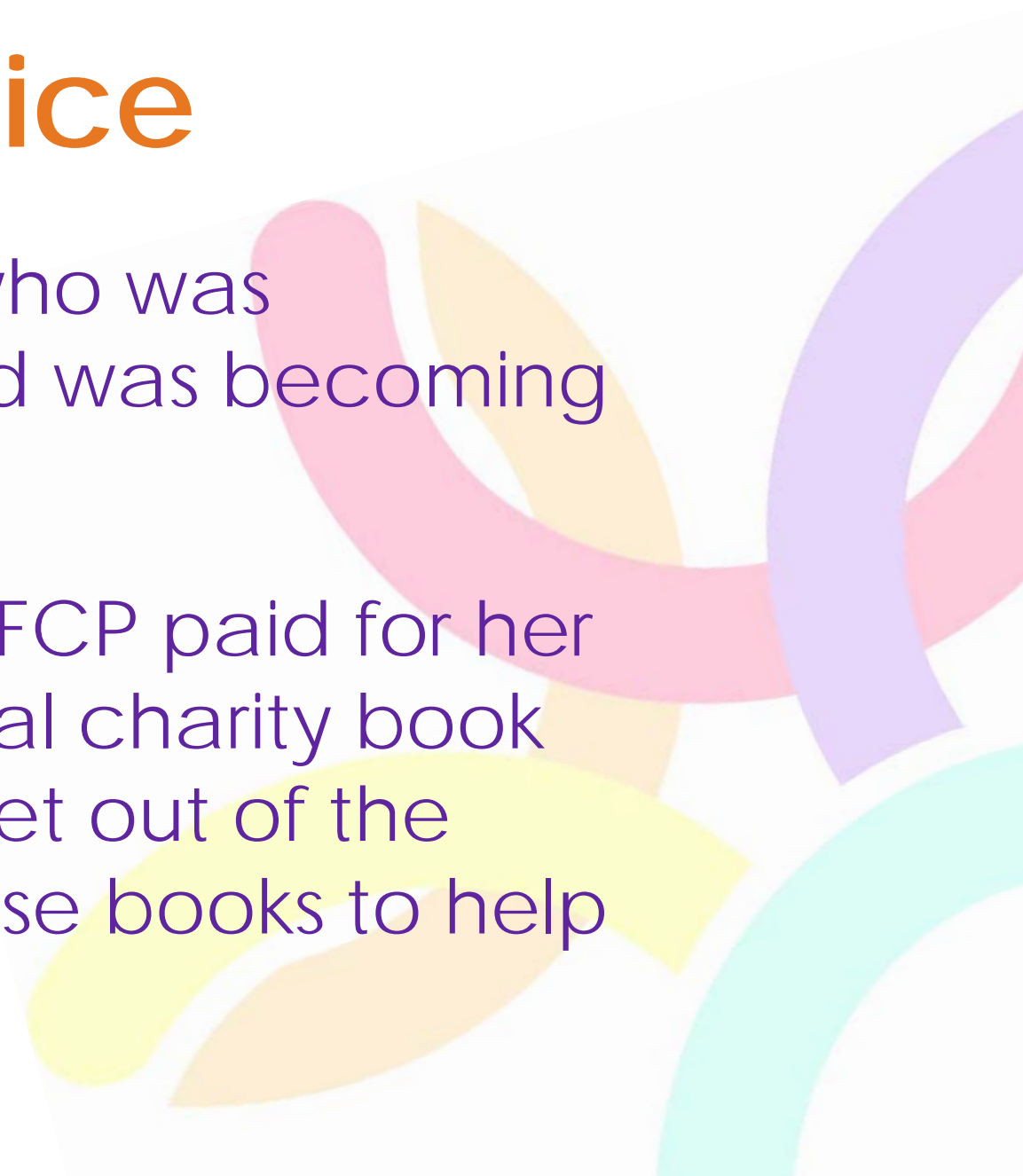
Examples in practice

Kieran is 6 and helps care for his sister who has cerebral palsy. Due to his sister's deteriorating condition, his mum had to give up work. The financial impact of this meant that they also had to give up the weekly swimming sessions which impacted on Kieran's mental health. The FCP funded Kieran and his mum to go swimming together as their break.

Examples in practice

Molly is a young adult carer who was struggling with her anxiety and was becoming very isolated at home.

She loved reading and so an FCP paid for her to purchase books from a local charity book shop – this supported her to get out of the house more as well as purchase books to help her to try and relax at home.



Other examples in practice

- ✿ Enabling a carer to attend a family wedding
- ✿ Helping a parent carer to have 'someone to talk to' in their first language
- ✿ Helping a carer to get someone in to help with the gardening
- ✿ For some carers, can involve facilitating breaks within the home
- ✿ Supporting carers so they don't have to rush back from medical appointments/treatment

What difference does it make?

- ✿ 89% of carers said they were less stressed or anxious
- ✿ 88% said they now can cope better with their caring role
- ✿ More than 95% would recommend the service to a friend or relative
- ✿ A study in 2019 showed that over a year, the estimated saving through avoided hospital and residential admissions was £1.7 million (NB - These figures do not even take account of the additional potential savings associated with the prevented admission of the person they care for)

Thank you

L D H House
Parsons Green
St Ives
PE27 4AA



caringtogether.org



A Network Partner of
**CARERS
TRUST**



Hospital & Community Navigation Service



Hospital & Community Navigation Service

Overview HCNS Referrals Q1-Q3	
Total SP Referrals from PCN's	3858
Total Hospital Referrals	3066
Total SP Referrals from Other Sources	7814
Total	14737

Top 5 Issues Supported West Herts	
Social Isolation	24%
Mental Health	12%
Carers Support	11%
Debt, Finance and/or Benefits	10%
Housing	8%

Top 5 Issues Supported East Herts	
Social Isolation	24%
Mental Health	12%
Debt, Finance and/or Benefits	12%
Support at Home	11%
Housing	6%

Top 10 Client Groups Supported	
Older Person	27%
Long term illness/condition	18%
Mental health	16%
Carers	7%
Physical Disabilities	6%
Mental Health - Dementia	5%
No disability	5%
Mental Health - Older Peoples'	3%
Learning disabilities/difficulty	2%
Substance misuse	2%

Top 10 Onward Referrals
Crisis Intervention Service
Age UK Hertfordshire
Reach Out
Carers in Herts
CAB Hertfordshire
Adult social Care
MIND
Communities 1st
Samaritans
HILS (Meals)

Enhanced 2 week Wrap Around service
Hoarding/Decluttering
Bed Moves
Keysafes
Meals



Hospital & Community Navigation Service Projects

Pathway 0 over 22000 patients Contacted	
Social Prescribing Support Needed	9%
Statutory	3%
Non Statutory	6%
Statutory Support	
Adult Social Care Assessment	
OT Assessment	
GP/District Nurse	
Non Statutory Support	
Help at Home	
Mobility Aids	
Social Isolation/Keeping Active	

Waiting Lists	
No Support Required	56%
Social Prescribing Support Needed	14%
Has Already had NHS surgery	12%
Has already had private surgery	7%
Currently in Hospital	2%
No Answer 3rd Attempt	9%
Social Prescribing Support Needed	
Equipment & Adaptations	
Carer support	
Benefits	
Social Isolation	
Help to lose weight	

Supporting Afghan Families in Bridging Hotels

Veteran Project

Population Health Management Project

Sensory Community Link worker

Covid Calls 6600 patients contacted	
GP Vulnerable Lists	
Housing Vulnerable Lists	
Carers Lists	
SMI Lists	

NHS England and NHS Improvement



Veterans Community Project

In partnership with
Hertfordshire Heroes

Herts Help – Hospital and Community
Navigation Service

NHS England and NHS Improvement



Project work – Hospital and Community Navigation Service

- HCNS have recently been awarded funding from the Control outbreak management fund to support improving Covid information and vaccine uptake by Veterans.
- As part of this work, Hospital and Community Navigation Service will be providing the outreach side of the project.
 - ▶ The main aims are to identify more ex-armed forces members (veterans), and to provide them with better care and support in the community. As well as promote the need for Covid vaccinations.
 - ▶ Veterans can be less likely to ask for support and help, usually they reach out at point of crisis. They are also very unlikely to tell you they are a veteran/ex-armed forces unless YOU ASK!
 - ▶ This is due to lack of awareness from both professionals and veterans, as to what support is available which is tailored to veterans needs, veterans families and their carers (where applicable).
 - ▶ What we are aiming to do during this work, is identify ex-forces members within our community, and ensure that veterans and GPs know what support is out there.
 - ▶ Part of the project is to get as many GP practices as possible 'Veterans Accredited'. GP practices will be 'Veteran friendly' meaning they are open to support veterans and know the best services for them. Aiming for 1 surgery per PCN.

Project work

- Social Prescriber (Ashlee Manning Veterans Lead) has been a guest speaker on a Personalised Care Institute podcast, all about Veterans and Social Prescribing - <https://omny.fm/shows/personalised-care-podcast/veterans-care-and-social-prescribing>
- The aim of this podcast is to show how well social prescribing works, and how it can be perfect for veterans.
- Produced case studies which have been shown at a Integrated Care Partnership meeting in June, this is with board members from the NHS and Herts County Council.
- These case studies are to show the NHS and Hertfordshire County Council, how our work can support the community and how social prescribing works alongside primary care.
- HCNS also has contact/links with the Royal British Legion Hertfordshire/Bedfordshire branch, Hertfordshire Heroes and local NHS boards.

Project work continued

Referral form with Royal British Legion now created

Linked with South West Armed Forces board – Sharing best practise

Supported by Public Health England regarding Covid tests/PPE/Leaflets free of charge for veterans

Finding new Armed Forces support services. Making better connections with existing services

Working with Hertfordshire Heroes who will also support with social media communications

Have made contact with team who can get client's service history

Provided talks about project at MDT, Partnership meetings and NHS England

Sitting on Hertfordshire Armed Forces Covenant Board

HCNS plan going forward

- HCNS to help identify and support veterans both in the community and NHS system.
- Provide person centred care by having 'What matters to me' conversations with veterans. Helping to navigate various support options to find a service that fits their needs and goals.
- Identifying veteran tailored services within Hertfordshire, creating links and referral pathways.
- Veterans support can range through anything social related. Issues include housing, debt/benefits/specialist grants, employment, mental health services etc
- Outreach/drop in sessions – HCNS will be holding drop in sessions throughout Hertfordshire, partnered with relevant local services. The aim is to reach out to veterans, helping them to come forward and find out what support is available. This in turn will give us a chance to identify any unmet need in the community.
- The first drop in session is being planned now, it will be held at a library with the Job Centre (DWP) Armed Forces lead and Walking With The Wounded in attendance.
- HCNS will be providing sessions with GP surgeries and local NHS trusts to encourage Veteran 'Friendly' Accreditation and awareness of support for veterans.
- Promote vaccination uptake amongst veterans and identify and health inequalities.

ARMED FORCES SINGLE POINT OF CONTACT (SPOC) PILOT SITE

- This project is a major piece of NHSE work currently at the scoping stage following analysis by NHSE and MOD on the challenges Armed Forces members, families, carers and veterans face when posted to a new area, particularly from outside England, or on leaving the services.
- Hertfordshire and West Essex ICS have been chosen as 1 of 3 nationally to lead on this pilot.
- There will be 1 clinical SPOC working across Herts/West Essex to improve information sharing between MOD and NHS. Ensuring continuation of medical care from MOD to NHS, and to patient's moving between ICS areas (including medical waiting lists).
- The other role will be a SPOC to provide service mapping of all Armed Forces support services across the area. Supporting all members of the Armed Forces community including serving members/families/veterans/carers.
- This means continuation of the funding for the current Hertfordshire HCNS care coordinator role (Ashlee Manning) located in Herts Help hub. With hope to employ a Veterans Community Navigator to continue this work.

Thank you!





Health Creation through the Voluntary, Community, Faith and Social Enterprise (**VCFS**) Sector

Tim Anfilogoff

Head of Community Resilience, Herts CCGs

(NHSE Regional Associate for Social Prescribing, EoE and Co-Chair National Academy for Social Prescribing Thriving Communities Programme EoE)

Kristy Thakur

VPAC Programme Lead &
Head of Community & People Wellbeing
Adult Care Services
Hertfordshire County Council

NHS England and NHS Improvement



Contents

1. Scope of paper/slides
2. What do we mean by VCFSE?
3. State of Sector (Nationally)
4. State of Sector (Herts)
5. Learning from Covid re Social Determinants etc
6. What do we mean by Health Creation?
(Addressing social determinants vs weight management as an example)
7. What has the VCFSE ever done for us?
8. Benefits of joined up commissioning (NHSCCT example)
9. Where do we go from here, strategically?
10. Voice of the Sector (and Embedding in ICS)

Appendix: VPAC Key Stats slides

1. Scope of Paper:

- Focusing, in these slides, mainly on Hertfordshire
- West Essex and HCC engaged so far as follows:
 - In ICS Social Prescribing Sub Group (since 2017)
 - Carers HSJ Award bid (2018) – we won!
 - In Captain Tom bid, October 2020 - £713k
 - ICS Partnership Board Report, June 2021 re Health Creation/VCFSE
 - EOI for Embedding the CVS, September 2021
 - Observers at Herts NHS Carers Group, October 2021 – discussion with ECC and WECCG this month re aligning strategic carers work and self assessment re NHSE Carers' Maturity Matrix

2. What do we mean by the VCFSE?

Key features of a Voluntary Organisation (NCVO):

- 1. Formality:** formalised and institutionalised to some extent, with recognisable structure, and constitution or formal set rules
- 2. Independence:** They are separate from the state and private sector
- 3. Non-profit distributing:** Do not distribute profits to owners or directors but reinvest in organisation/for benefit of community
- 4. Self-governance:** They are truly independent in determining their own course
- 5. Voluntarism:** through having, for example, a trustee board, volunteers, and donations
- 6. Public benefit:** They have social objectives and work to benefit the community

Social Enterprise? CICs?

Question: are we right to assume the ICS wish to include in its commissioning strategy?

7. Social Enterprise – “a business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or community, not driven by the need to maximise profit for shareholders and owners”. [A guide to legal forms for social enterprise \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/424222/a-guide-to-legal-forms-for-social-enterprise.pdf)

8. Community Interest Companies (CICs): CIC’s are required by law to have provisions in their articles of association to enshrine their social purpose, specifically an ‘asset lock’, which restricts the transfer of assets out of the CIC, ultimately to ensure that they continue to be used for the benefit of the community; and a cap on the maximum dividend and interest payments it can make.

3. State of Sector Nationally (NCVO Almanac)

- 2018/19 down to 163,000 voluntary organisations (VO's) in UK, (167,000 in 17/18)
- Steady increase in 2000s, followed by notable drop - financial crisis
- Then stable till Covid-related fall; further fall likely in coming years
- Most VO's (80%) small – income < £100,000 a year, handful of staff
- Grass Roots Sector's overall income and spending (4% and 5%) - generally very local and spread quite evenly around country
- There are 59 'super-major' VO's (£100m+ a year) 736 "major' VO's (£1m+ a year) with 80% of sector's income and spending. Mainly national or international. *[Herts has a small number of £1m+ players...]*
- Over 950,000 people worked in sector as of September 2020 – a 3% increase on 2019 (32,000+ additional jobs). But how sustainable is that?

4. State of Sector (Herts)

HCF Report, May 2020 (n=222)

- 30% doing more; 30% doing less; 13% the same
- 27% ceased delivery completely
- Huge changes - mainly to adapt services to digital and remote
- 60% same no of volunteers as pre-lockdown; 30% fewer; 10% more
- Many volunteers over 70 now self-isolating
- Difficulties training volunteers due to social distancing
- 56% had capacity to work with more volunteers; 44% did not
- ***Prediction then: If extensive social distancing, 40% not sustainable for six months (ie by November 2020). For others, negative financial impact will hit 2021...***

HCF Survey Autumn 2021 (n=97)

IMPACT OF HCF GRANTS

- 56% of VO's - funding from HCF in past year was essential; 22% helpful, 2% not essential
- 73% - enabled to support mental health and wellbeing, 66% loneliness and social isolation and 18% to support victims of domestic abuse - recognised nationally as emerging needs
- Monies used mainly just to keep functioning, to convert to remote or safe physical services
- 70% - expect demand to increase further, 9% thought it would decrease and 21% stay the same.
- Respondents identified three main priorities for 'recovery' from a menu: 1) health and wellbeing 2) social isolation and 3) physical health
- 17 VO's identified additional priorities (not on menu): inc development delays in babies and toddlers born during lockdown, suicide prevention, discrimination against special needs adults and children, an increase in the number of women as the non-resident parent, and neuro disability

Financial Position, Herts Sector, Autumn 2021

- 43% financial position had remained same; 31% deteriorated and 26% improved
- Currently, 68% could remain viable for more than 12 months, 26% between 6 and 12 months and 7% said less than 6 months
- Challenges next 6 to 12 months: 66% reduced income; 33% reserves decreasing; 3% considering making staff redundant, 22% relying on volunteers to reduce costs; 5% considering closure
- 14% expect income to increase, 8% expect increase in reserves; 35% plan to extend team
- Many juggling day-to-day delivery of services with trying to achieve long-term sustainability
- Some swamped by growing demand - Covid and lockdown impacting on beneficiaries
- Some said changing delivery profile requires them to restructure.
- Some not delivered services since start of lockdowns; unsure when, how, if can relaunch
- Some lack venues to provide services in safe and stable manner. Many community venues still closed, competition for space high
- Others highlighted financial burden of empty buildings

Volunteering, Herts Sector, Autumn 2021

- Number of volunteers increased overall during the pandemic, but some VO's lost some or all volunteers – change of service/need to isolate
- 77% plan to recruit more; 23% plan to keep same number. None plan to reduce
- Some need to replace volunteers who've moved on; others need to recruit new volunteers to cope with increased demand or to help address gaps in staffing

NCVO Almanac (national picture):

- In 2020/21, 16.3m people volunteered 'formally' ie through a VO = substantial **decrease** from year before (20.1m people). Mainly due to closure of indoor activities during lockdowns and older (= majority) volunteer-base shielding
- Drastic increase in people volunteering *informally* – providing support to people not relatives or friends. Over half UK adults volunteered at least once in last year. Mutual aid groups in first lockdown significant
- NB people in most deprived areas half as likely to volunteer 'formally' (smaller differences in 'informal' volunteering) – and less likely to be trustees
- Data about ethnicity of volunteers is variable/mixed; disabled people equally likely to be regular volunteers; less likely to be occasional volunteers

How to build sector's resilience

90% fed back re support that would help build resilience (from menu)

- **69%** - fundraising support and training (esp small groups) in partic strategic thinking re long-term objectives, capital development projects, move to digital fundraising platforms, bid writing and attracting legacies
- **51%** - partnerships/collaborations key both during Covid and going forward
- **43%** - marketing advice (partic social media), engaging press, writing case studies and literature
- **33%** training (staff and volunteers): income generation, volunteer and staff recruitment, event management, health & safety, first aid, digital skills, safeguarding, management development, equality, diversity and inclusion, dementia awareness, personal safety, wellbeing...etc
- **16%** - training for Boards (trustee responsibilities, team building, effectiveness/recruitment/retention
- **33%** - wellbeing support (staff and vols) - risk of burnout, partic where demand growing or remote working impacting - support re confidence to deliver F-2-F again. MH First Aid training, wellbeing toolkits, more time to available to support volunteers, team building, access to a wellbeing budget
- **26%** legal or HR advice - difficult to find charity friendly services and struggled to cover costs
- **23%** strategic support: business planning, understanding local needs, finding venues for delivery

State of Sector (Herts) as at Oct 2021

- Boosts from HVCCG and HCC, DC (some) and HCF small grants processes – short term benefits during crisis
- Crisis/one-off funding available also through HCF/ VPACC/ HMG/ Captain Tom
- Burnout and exhaustion
- Recruitment issues???? Impact of uncertainty and furlough etc??
- New awareness in statutory sector of VCFSE contributions from welfare, food-, drug- deliveries to emotional support and vaccination infrastructure...
- 10,000 volunteers on stream (community sector) since Covid; 6,000 active – beginning to see drop off?

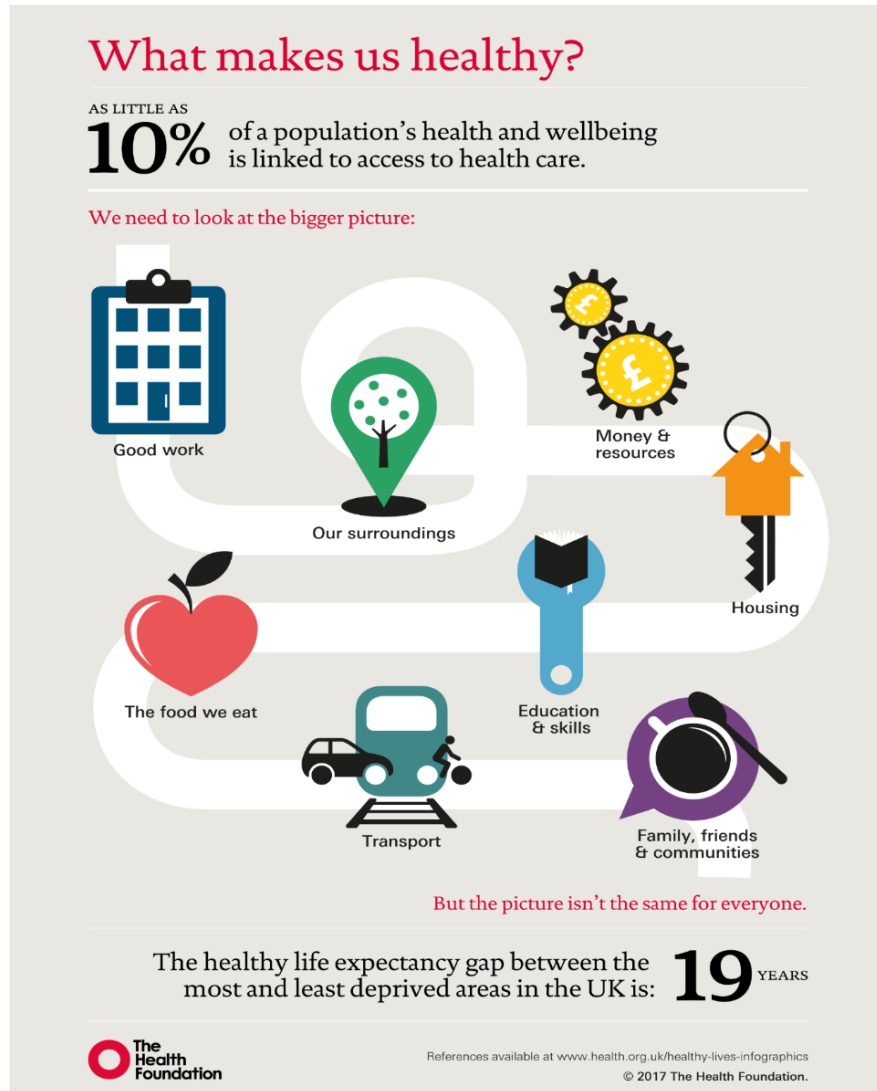
Summary of Herts' Sector's contribution

- VCFSE (where able to function) reacted fast, flexibly and with innovation, often at own risk and without waiting to be told
- Worked quickly in new partnerships with HCC/DCs and NHS and more than rose to the occasion
- Often had better understanding of needs and opportunities on the ground
- Not just 'formal' sector – lots of informal, mutual aid groups as well as the 10,000 formal volunteers (Herts) and others through NHSR
- General consensus: need to build on this productive partnership working going forwards

5. Learning from Covid re Social Determinants

Covid = Syndemic

- Aggravating existing health inequalities
- 25% higher death rate in Greater Manchester
- Particular issues around BAME communities, poverty, digital exclusion, domestic abuse, isolation of caring, mental health...
- Impacting most on those with deprivation-induced LTCs - **who often don't trust statutory services**
- Health is NOT created (mainly) by NHS



HCF Hertfordshire Matters Report 2020

- Herts still has lower than average proportion of households in poverty
- Since 2016 report all districts have shown an **increase in relative deprivation**
- **45 neighbourhoods** now among 30% most deprived in the country
- **Debt** levels, for both mortgage and personal debt, above national average in majority of districts
- **Deprivation** more likely in urban areas, while rural areas face poor quality housing, difficulty in accessing vital services like GPs and hospitals and fuel poverty

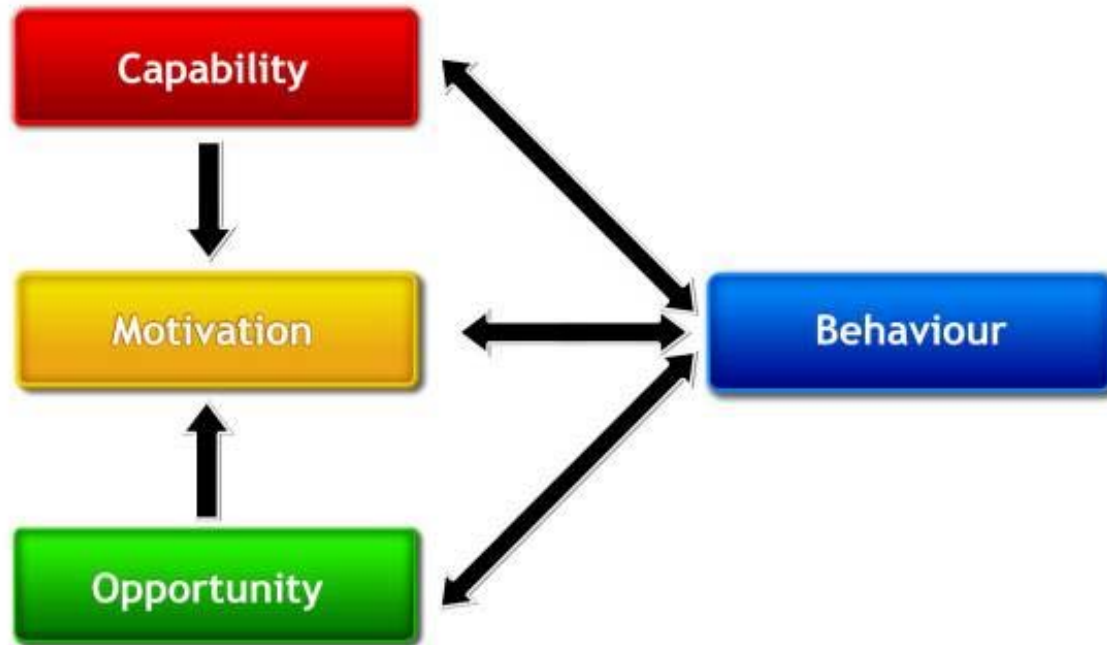
6. What do we mean by health creation?

'Health Creation is the process through which individuals and communities gain a sense of purpose, hope, mastery and control over their own lives and immediate environment; when this happens their health and wellbeing is enhanced.'



The Health
Creation
Alliance

Traditional model: Behaviour Change Wheel - Individual



Susan Michie et al, 2011

Is *this* what public services do?

'If you want to get somebody to do something, make it easy. If you want to get people to eat healthier foods, then put healthier foods in the cafeteria, and make them easier to find, and make them taste better. So in every meeting I say, "Make it easy."



Richard Thaler, Economics, Nobel Laureate 2017



University of Hull
Hull York Medical School

Empowering vs blaming patients

- Survey of 3,000 people with type 2 diabetes
- Loneliness, stigma, embarrassment, blame, guilt
- Feel they're seen as burden on NHS

'If you have type 2 people think it is your fault, that you haven't looked after yourself properly.'

'At Christmas or going out for a friend's birthday it isn't easy to cope with not being able to eat the same food, the same birthday cake as everyone else. So instead – you just don't go out.'

Question: how does a focus on individual behaviour change fit with the need for a societal/systemic culture change? Whose is the 'blame' really?

Is the focus right?

[Campaign launched to help public get healthy this summer - GOV.UK](https://www.gov.uk)
(www.gov.uk)



1. Childhood obesity policy based on behaviour change research
2. Analysis of 153 research papers found most interventions aim to teach children to improve diet and/do more physical activity
3. Main approach for 30 years and rates of childhood obesity **increased**
4. Generally accepted a collection of interventions is required to change the **environments that children grow up in**
5. Need systems approach to address environments we live and work in, social circles, media and marketing messages, and government policies etc
6. **Lifestyle factors** (such as diet, physical activity) account for one in six (**16%**) of the causes of obesity but **58%** of interventions; **social and community factors** (family, friends, neighbours) account for one in seven (**14%**) causes and one in 27 (**4%**) interventions

Nobles J, and others. [A secondary analysis of the childhood obesity prevention Cochrane Review through a wider determinants of health lens: implications for research funders, researchers, policymakers and practitioners.](#)

A systems approach to addressing obesity



- Obesity is complex caused by many different factors
- Systems mapping gives a comprehensive representation of all of the factors relevant for individuals and populations
- This can help a discussion with a community the drivers of the problem and how they interact with each other
- There needs to be a **systems approach** to tackling obesity, understanding the **locus of control**, national government, local authority (inc. Public Health, Schools, social care etc, ICSs, PCNs, CVS, Voluntary, Community and Social Enterprise sector, **community groups etc**)

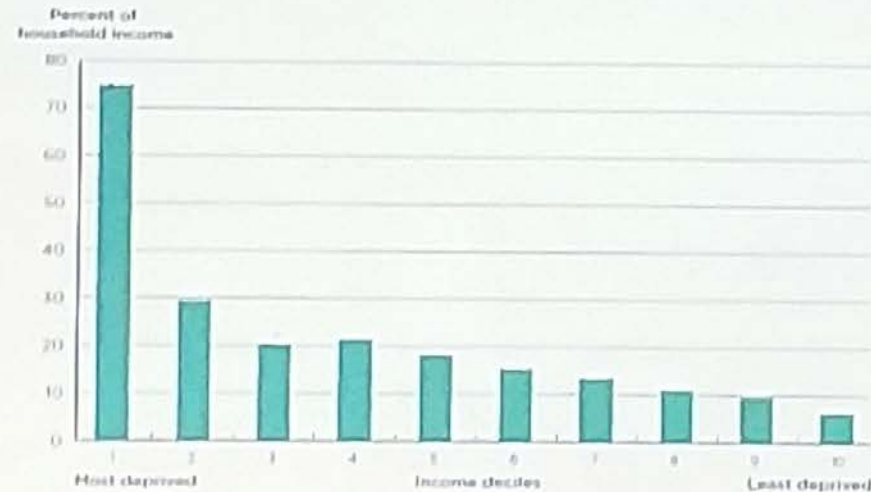
© NHS England and NHS Improvement



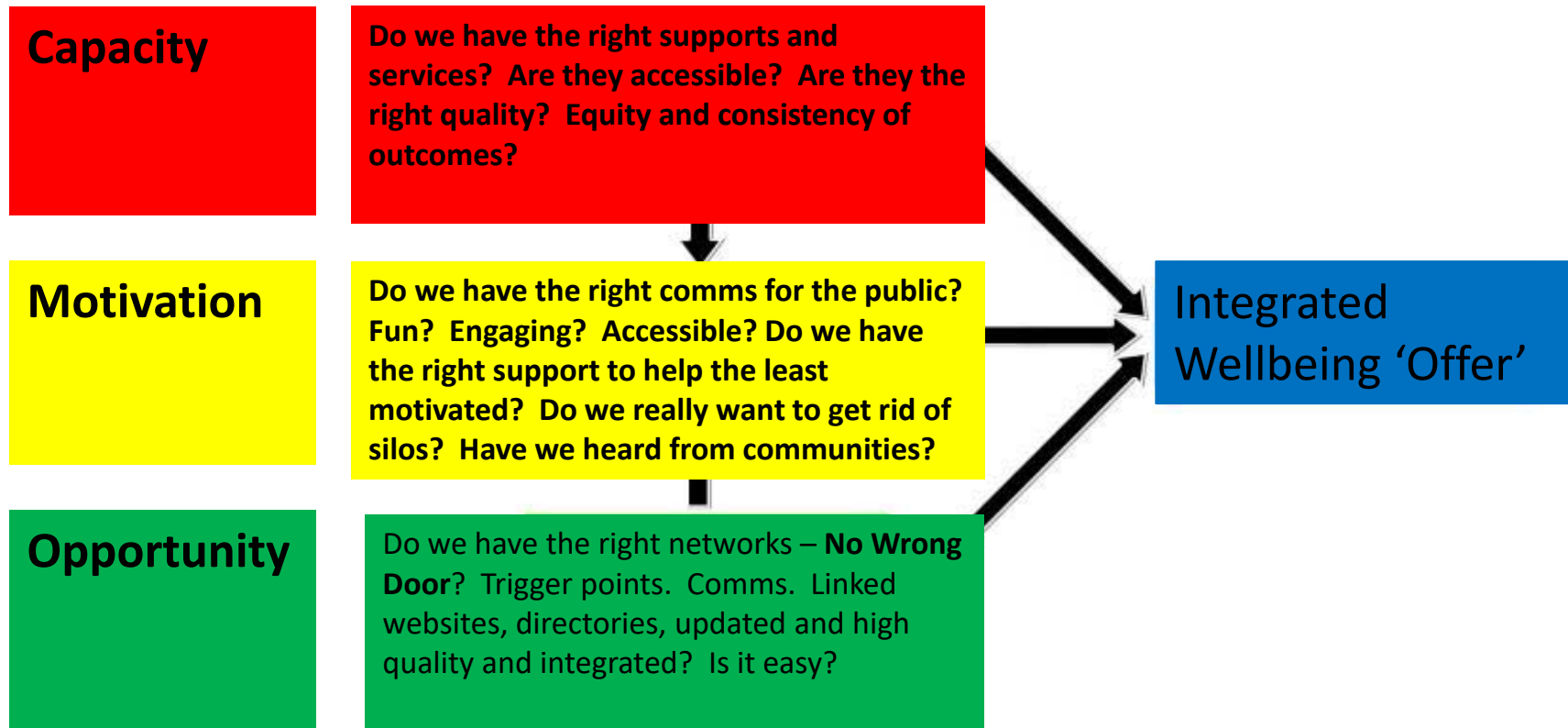
Is this about behaviour change?



The most deprived decile households would spend 75% of their disposable income to meet the NHS Eatwell Guide



Behaviour Change – The System's Responsibility to Change and Integrate



Role of Social Prescribing: Obesity Case Study

X cared for mother who'd recently died after decades of ill health. X had lived with her, never married and he had no circle of friends.

X had prostate cancer, (well managed) but needed knee surgery and was in pain. Too overweight to undergo surgery - asked by GP to lose weight. He'd tried *Weight Watchers* in past without success.

Navigator persuaded X to take up free 12 week course with Slimming World and referred him to supported activity scheme to try gentle local exercise. X found he enjoyed bowls and started to make new friends. Initially taking taxis to slimming world, he started walking there with a new friend.

The weight kept reducing. He finished with Slimming World but after 6 months still played bowls and enjoyed long walks. His knee stopped hurting so much - by the time of review, he was healthy weight for surgery **but no longer needed it**. Activity had strengthened his knee and the pain was gone. His cancer had also gone into remission.

X had tried these things before. The support of the navigator and new friends changed his motivation. It wasn't just about diet but a holistic package of support which transformed his life.

Realising the Full Value of Integrated Care

- ‘In most places, attempts to achieve better population health and wellbeing fall short because efforts **tend not to focus on the root causes – the determinants of health and the reduction of health disparities.**’
- ‘There is growing evidence to demonstrate that empowering local communities is essential for citizens’ wellbeing and for the care system to function effectively.’

[The International Foundation for Integrated Care
\(integratedcarefoundation.org\)](http://integratedcarefoundation.org)

ICS Design Framework, June 2021

*'...Integrated Care Systems (ICSs) will play a critical role in aligning action between partners to achieve their shared purpose: to improve outcomes and tackle inequalities, to enhance productivity and make best use of resources and to strengthen local communities. Throughout the pandemic our people told us time and time again that **collaboration allowed faster decisions and better outcomes**. Co-operation created resilience. Teamwork across organisations, sectors and professions enabled us to manage the pressures facing the NHS and our partners.'*

7. What has the VCFSE ever done for us?

(first peak)

but see also VPAC slides – full set as appendix

Over 5000 volunteers deployed

40,000 volunteer activities

227,000 hot meals delivered

110,000 food parcels delivered to individuals

11,000 food parcels to organisations

2,300 pharmacy deliveries

HertsHelp hours extended, calls increased from 35,000-140,000

8. Benefits of joined up commissioning - NHSCT as example: (Part 1)

- £712k of NHST monies for this ICS (over two years)
 - 1. BAME Covid Recovery Workers**
Mercy.bwomono@cdaherts.org.uk (for East)
Naomi.duncan@cdaherts.org.uk &
Rushna.miah@cdaherts.org.uk (job share West)
 - 2. BAME carers' breaks work**
carole.whittle@carersinherts.org.uk (Kava Johnson starts w/c 4 Oct)
 - 3. Digital Inclusion (Staying Connected) –**
Tesco, HCC and other sponsorship
cindy@communityactiondacorum.org.uk



HSCT Example (Part 2)



4. **Winter projects:** 28 funded by small grants (Herts-wide) process in partnership with Districts and HCC in Winter 20/21 – 12,000 users; about to repeat for 21/22

5 a) **Lister Hospital Adolescent Social Prescriber** Hannah.Mahoney-Smith@hertfordshire.gov.uk based with Youth Connexions **(East Herts)**

5 b) **Watford Football Club Trust Adolescent Social Prescriber (West Herts)** Stephen.Ware@watfordfc.com

6. **Digital Inclusion (Mental Health and BAME Engagement (West Essex)** ali.firth@westessexcan.org leading and recruiting MH post in September



10. Where do we go from here, strategically?

- New Joint Strategic Commissioning Board: Health Creation and VCFSE
- Met for first time 28 September
- HCC (adults, children, mental health etc), NHS, PH, DCs (Alan Gough for West, Sian Chambers for East), PCO, Herts Community Foundation, VCFSE observers
- Focus for looking at all commissioning (agreed at ICS level):
 - **Integrated access to community support** ('No Wrong Door')
 - **Support for unpaid/family carers**
 - **Volunteering**
 - **The robustness of joint strategic commissioning of and engagement with the sector**

Main Next Steps:

- **January 2022 meeting of JSCB will:**
- Summarise overall level of statutory sector spend on wellbeing related VCFSE projects (c£30m?) in advance of January meeting of JCSB to improve analysis, integration, evidence of outcomes generally
- Start to Design **Annual Workplan**
 - Work with PH et al to understand VCFSE contribution in relation to health inequalities and social determinants – with links to PHM agenda, tackling neighbourhood inequalities, anti-poverty work etc
 - Design process for identifying an ideal % of spend on Health Creation in the VCFSE and a strategy for working towards it (including CSR)
 - Design process (equalities impact assessment) for ensuring appropriate investment in VO's addressing outcomes for those facing health inequalities

Themes to look at in all commissioning:

- **No Wrong Door**

- Build on successful network around *HertsHelp* (inc Healthy Hubs and SP)
- Review Hospital and Community Navigator Service (HCC and CCG funded, but also employing bulk of ARRS funded PCN LWs) building on quality, integration and 'big data' re referrals and outcomes (12,000+ cases in HCNS alone) – key to addressing inequality of access
- April 2022 new whole systems comms focusing on post-Covid wellbeing through VCFSE (with escalation to formal and clinical services only if needed)

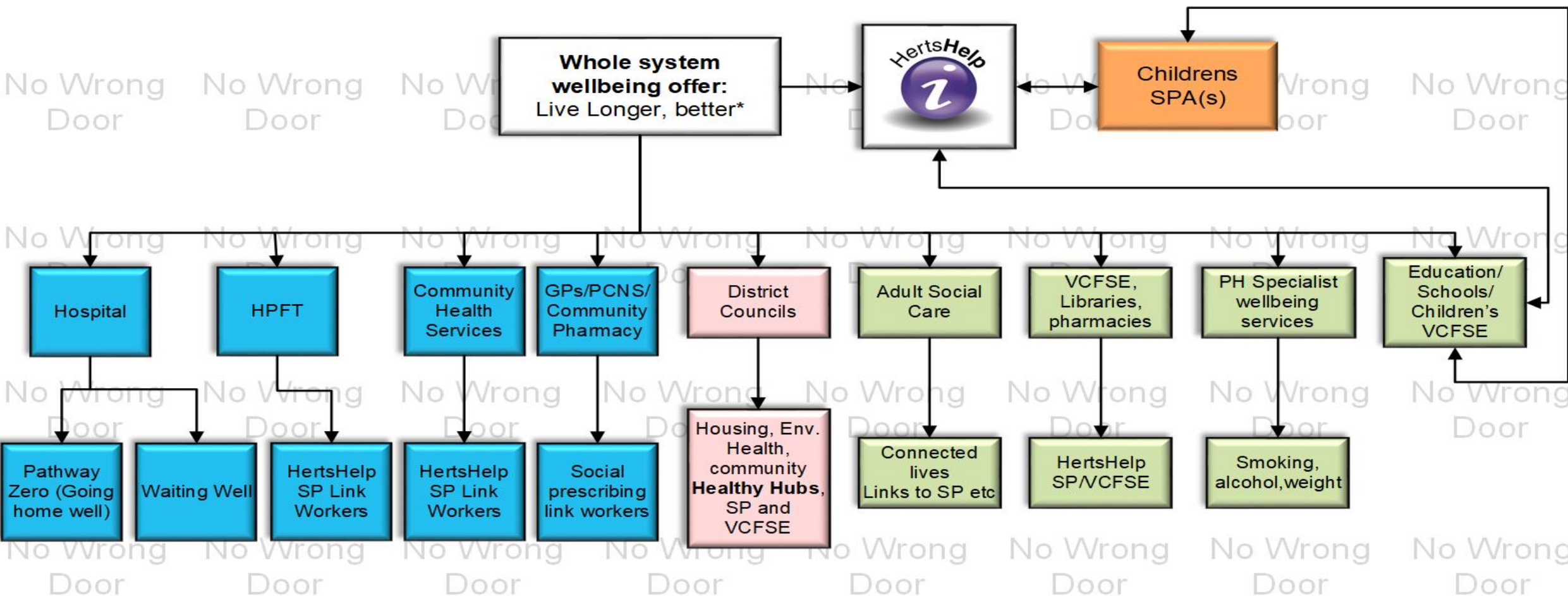
- **Family Carers** – new Herts Carers Strategy by January 2022 and engagement with West Essex and ECC on synergies with ECC-led carers' strategy – need to address significant additional health challenges of Covid - seriously impacted by UC cut

- **Volunteering** – look to use to reduce pressure on NHS and increase 'kindness' eg 'waiting well', 'pathway zero discharges' identify and refer social needs to HertsHelp/HCSN etc, build on digital inclusion and other new equalities projects...

No Wrong Door – To Living Better

- Plans to create ‘a whole system wellbeing offer’ ie make it as easy as possible for people to seek non-stigmatising, local help with *HertsHelp* as key tool to ensure the many doors are networked together (see next slide)
- Ensuring all statutory organisations know **one thing** about the VCFSE at least: that ***HertsHelp*** is the gateway to 12,000 different groups and services and the social prescribers that can help people access them
- So if you present at your library, your pharmacist, your GP, your district council with an issue that’s not for them – ***HertsHelp*** is the place they should direct you to (unless they already have relevant knowledge)
- Working with hospital trusts and VCFSE on wellbeing support: Pathway Zero pilot, waiting well pilot, two week VCFSE wraparound at discharge – providing wellbeing input across the pathways...not just via primary care

Connecting to stay well: *“there is always someone who can help”*



* borrowed from Herts Sports Partnership as a placeholder

Health Creation Comms (very draft)

We all want to live in friendly, connected communities.

We also know that thriving communities is the way to make the general health of the population better. That is why a range of local organisations – NHS, local government and charities- are working together to make sure people know:

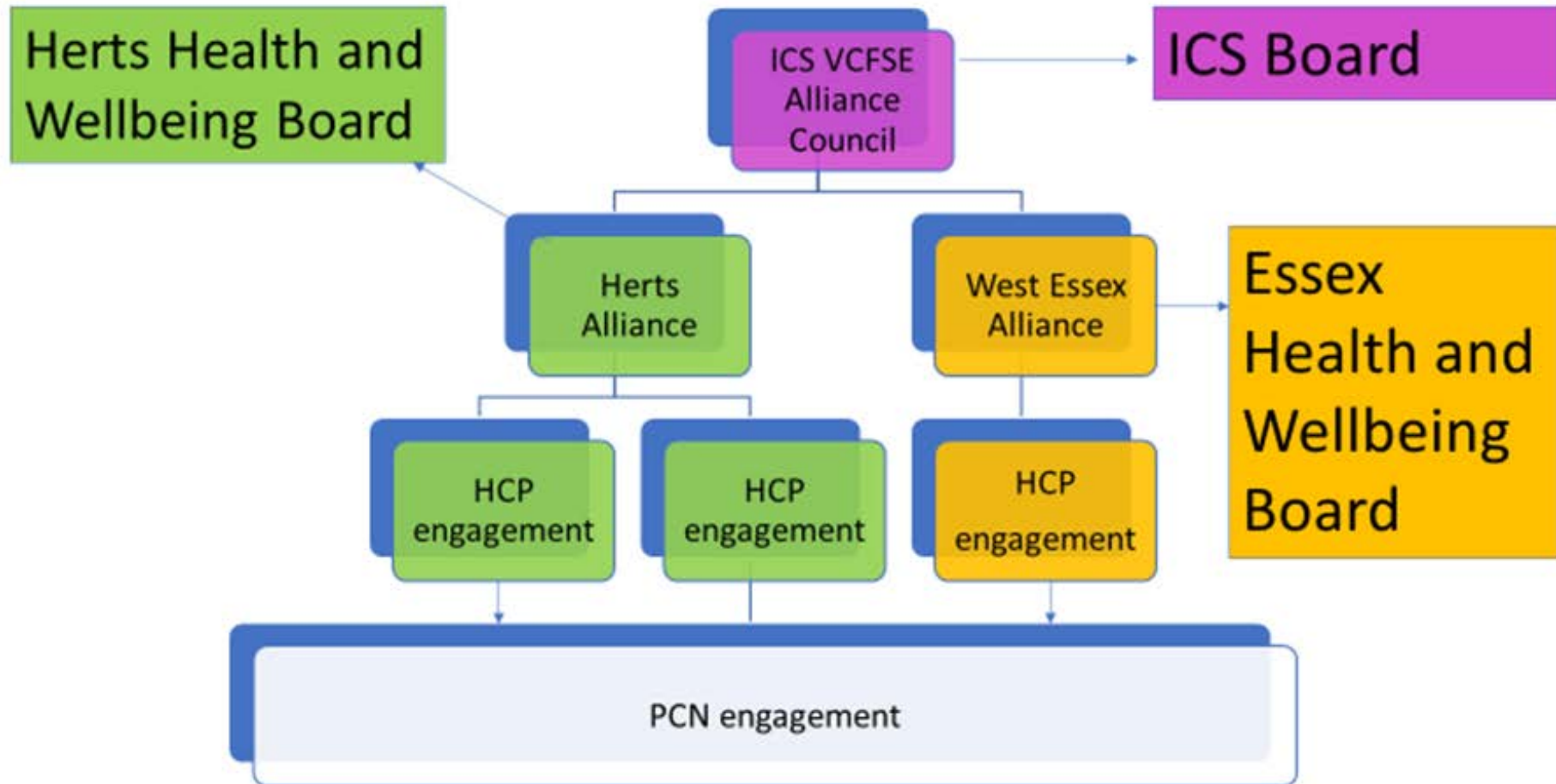
- **There is always someone who can help - whoever you are, wherever you live**
- **It is always possible to make new friends** if you'd like to.
- **Everyone who wants to improve their health and wellbeing can find help to do so**
- **Everyone can get help to make sure they get what they are entitled to**
- **No one should be left out**
- **No one should have to care alone**
- **Everyone who wants to help make a difference, can**



Trying to make seeking help 'normal' and volunteering too.

Friendly generic messages acting as a front window for a system that isn't full of silo-ed obstacles but is working to make life as easy as possible for the people who need help. Social Prescribing and BAME workers etc key for those who do not trust the system...

10. Voice of the Sector: Embedding in ICS



Immediate Next Steps

- £25k NHSE funding acquired for Embedding VCFSE in ICS
- Interview for project manager, 26 October
- First engagement webinar 16 November
- Particular focus on reaching groups (by interview etc not just meetings) focused on health inequalities/inequalities to ensure their voice fully heard
- Steering Group of CVS's (1 per HCP) chaired by Herts Community Foundation with secretariat from NHS and HCC
- First webinar engaging sector in co-design of Alliance planned for 16 November
- New Alliance to be in place by end March 2022
- HCC committed to resourcing the Herts Alliance going forward (building on Herts Community Leaders' Forum developments to date)
- First meeting with Simone Surgenor re governance, 21 October, and NAVCA consultant Simone Hensby 22 October who will support the Alliance development

Final Thoughts:

- Are we all clear about what the wellbeing offer is? Or are we still all using different language (prevention, health inequalities, population health management, community development...etc)
- Are we still too clinical in our response to socially created ill health?
- What is the right role for the VCFSE in health creation?
- Is there a notional right proportion of statutory pot that should go to the sector? How would we work that out?
- What is the role of anchor organisations in support in kind etc?
- What is the role of private sector CSR (strong role, eg, in the Digital Inclusion work VCFSE is doing)?
- Crowdfunding and micro-commissioning?

We are always happy to talk further

tim.anfilogoff@nhs.net

kristy.thakur@hertfordshire.gov.uk

Appendix on VPAC outcomes attached

Physical activity and health
conditions; benefits outweigh
the risks



Connecting with health and wellbeing

“ Strengthening the connections between sport, physical activity, health and wellbeing, so more people can feel the benefits of, and advocate for, an active life.”

Unlock health for all

Being active can maintain or improve health, wellbeing or quality of life

An equal chance to get benefits of an active life

Investing more to support those least active can play a role in reducing health inequalities

Context for the Consensus Statement on Risk



- Public Health and Clinical guidelines are clear that physical activity has a key role to play in the management of long term conditions
- The International Society for Physical Activity and Health (ISPAH) identify integrating physical activity into healthcare as one of the eight best investments to combat inactivity. But there are systemic challenges to making this a reality.
- People with long term conditions being twice as likely to be inactive then those who do not have health conditions.
- These barriers include almost 50% of GPs, in a recent survey of 830 GPs in England, indicating that a barrier to effectively advising patients about physical activity were concerns by the patient about perceived risks of taking up PA (46%), including aggravating symptoms.
- Current pre participation screening protocols within the sport and physical activity sector & requirements for medical clearance

The response



The Faculty of Sport and Exercise Medicine, Sport England, Office Health Improvement and Disparities (formerly Public Health England) and the Royal College of General Practitioner's have collaborated to enable the development of clear statements, through expert consensus, about the medical risks of physical activity for all adults, irrespective of age, living with one or more long term conditions for healthcare professionals to use to support their clinical practice.

Methodology



Preparation

Rapid
Evidence
Review

Steering
Group

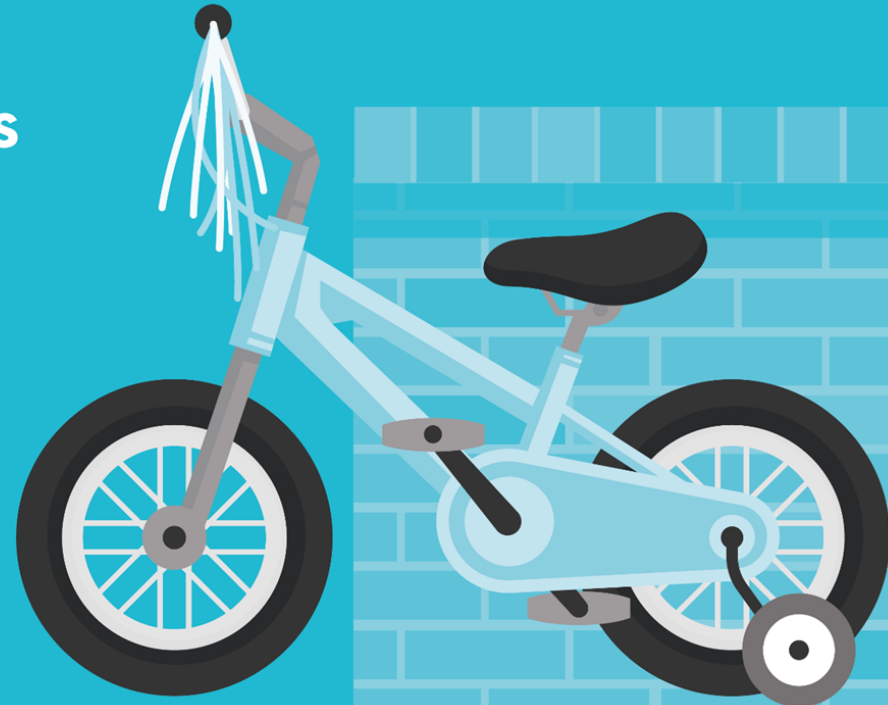
Delphi
Process

Headline statements



1. The benefits outweigh the risks

Physical activity is safe, even for people living with symptoms from multiple medical conditions.



Headline statements



2. The risk of adverse events is very low but that's not how people feel

Well informed conversations with healthcare professionals can reassure people who are fearful of their condition worsening, and further reduce this risk.



Headline statements



3. It's not as easy as just telling someone to move more

Be aware of the concerns of individuals and their carers to help build confidence



Headline statements



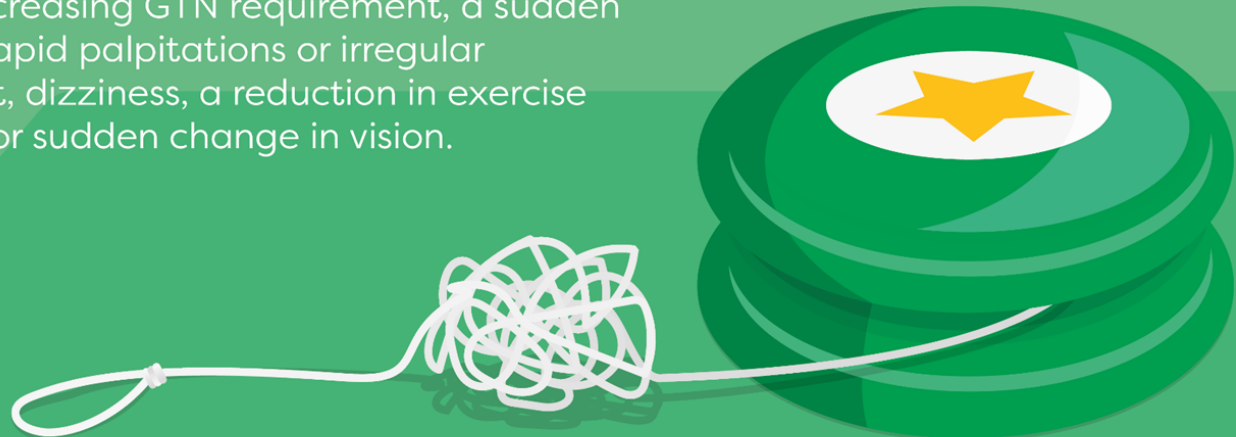
4. Everyone has their own starting point, begin there and build up gradually

Headline statements



5. Stop and seek medical review if...

You notice a dramatic increase in breathlessness, new or worsening chest pain and/or increasing GTN requirement, a sudden onset of rapid palpitations or irregular heartbeat, dizziness, a reduction in exercise capacity or sudden change in vision.



Symptom Statements

- MSK Pain
- Fatigue
- Shortness of breath
- Cardiac Chest Pain
- Falls and Frailty
- Dysglycemia
- Palpitations
- Cognitive impairment

The list of conditions covered by this consensus statement is not exhaustive. For instance, Chronic fatigue syndrome/ME and Long COVID were excluded from this study as evidence regarding the risks of physical activity in these conditions is evolving. Existing guidance should be followed for these conditions.

MSK Pain

- A temporary increase in pain is normal and does not represent tissue damage.
- It will stop once their body adapts.

Fatigue

- A temporary increase in fatigue is normal.
- Physical activity is good for fatigue, sleep and wellbeing.

Shortness of breath

- Physical activity will make people feel more breathless.
- Breathlessness can be frightening.
- Advise people to start at a low level and build gradually.

Cardiac chest pain

- The long-term benefits far outweigh the temporary slight increased risk of adverse events in those with ischemic heart disease.

Falls & frailty

- First, inactive people have much to gain from building strength and balance.
- Even small improvements reduce the risk of falling and improve confidence.
- Activities should be tailored to the individual's functional and cognitive capacity.

Dysglycemia

- There is a risk of short-term dysglycemia.
- Hypoglycemia is the most common adverse event in diabetics treated with insulin or insulin secretagogues, and can occur if not managed appropriately.
- The overall risk of severe hypoglycemia is not increased.
- High intensity physical activity can make blood glucose levels rise, so people with diabetes will need strategies to deal with this.

Palpitations

- Increased awareness of your heart beat during physical activity can be frightening.
- Physical activity is contraindicated in people with symptomatic and unexplained cardiac tachy- or brady-arrhythmia and appropriate medical management is needed.
- People with controlled atrial fibrillation benefit from regular physical activity.

Cognitive impairment

- Strategies to maintain motivation, engagement and safety are important and people will often benefit from support from others.
- Consider functional level, stage of disease, communication ability, perceived environment, risk of falling and other medical conditions.

Logos: The University of Edinburgh, SPORT ENGLAND, and the University of Glasgow.

Endorsements to date



Key messages within our communications



The consensus statements are based on a rapid review evidence and have been developed through an academically rigorous consensus process by Healthcare Professionals, for Healthcare Professionals.

The key message is that the risk of adverse events when getting active is low, and that physical activity is safe, even for people living with symptoms of multiple health conditions. Regular physical activity, in combination with standard medical care, has an important role to play in the treatment and prevention of many conditions. Well informed, person centred conversations with healthcare professionals can reassure people and further reduce this risk.

Key messages continued



It provides the foundation and evidence for future collaboration across health, sport and physical activity partners, including insurers to explore and review the need for medical clearance and determine what appropriate pre participation screening protocols should look like to ensure safety and better meet the needs of people with long term conditions and providers and further remove systemic barriers to getting active experienced by people with long term conditions.

Using the statements to activate wider system change



Faculty of Sport
and Exercise
Medicine UK



Royal College of
General Practitioners



Office for Health
Improvement
& Disparities



The article sets out that this work fits within a broader programme of work led by Sport England, the Office for Health Improvement & Disparities, the Royal College of GPs and wider partners to improve the physical activity experience for people living with LTCs.

With the following statements being made

- Sport England will, in collaboration with others, explore how the consensus statements can support the removal of systemic physical activity barriers for people living with LTC's. This includes encouraging discussions with a range of partners, including the physical activity and leisure sector insurers, and supporting a review of pre participation protocols used by health, physical activity and sport partners, including the need for medical clearance.
- In addition, FSEM, Sport England and the Richmond Group of Charities, alongside others, will work together to consider how we use the statements to challenge patient's perceptions about risk and physical activity including evolving them into public-facing resources that empower people's decision making and connect to wider support such as the We Are Undefeatable campaign.

Examples in practice



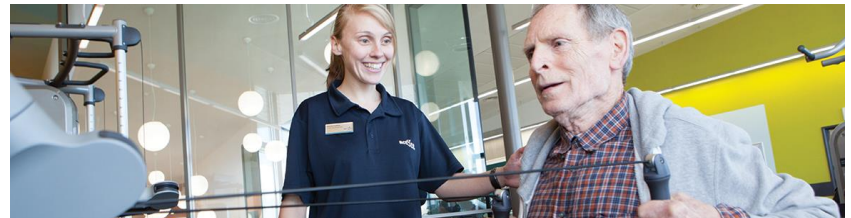
Total Wellbeing supports people living in Luton who want to improve their physical and emotional health.

Examples in practice



I was referred to Total Well Being after to complaining about Knee pain that was caused by my Arthritis. My BMI was high and I was also on medication for high blood pressure. Tau spoke to me about some physical activity session, some of which, I never knew existed. We came up with a plan of action. We even spoke about me diet and what foods I should cut down on in order to lose some weight and take the pressure off my knees.

Since my appointment I have been regularly attending the gym and I really enjoy it. I have been able to lose a stone and a half. I really grateful for the support that I have received thus far. It has really changed my life. I have been given permission from my doctor to decrease my meds.



Impact of intervention

I started on social prescription programme in October 2020 after being referred by my GP, as I was feeling very low due to feeling socially isolated and my ongoing health issues. I was enjoying sessions so much that I encouraged my husband to attend the Total Wellbeing cardiac rehab program, which he has now started as well. I am also now a part of a health walk group as well as doing hydra health, water based activity has given me the confidence and boost to take care of my physical health, as well it has shown me how group activities can enhance my social and emotional wellbeing. I am really pleased that my GP referred me as I would not have known the wonderful services that were available to me, had I not met her and been supported by the Total Wellbeing team.

“ Thank you so much Yakini and the team at Inspire for being so lovely and helping me to see the benefits of taking care of myself.”

Impact of intervention

This client was waiting for a hip operation and her GP referred for social prescription support. A referral was done for BIG gym and fitness. She has lost weight and feels more confident. "Thank you Sarah, I would have never known about this place, more people should know as it's a great place and not what you think it will be like'. By going to the gym she has lost weight and improved her health. This has been important in preparing her for hip surgery which has been successful. She has now had her hip operation and is attending hydra health as part of her recovery.



Useful websites



<https://movingmedicine.ac.uk/>

<https://www.sportengland.org/>

<https://weareundefeatable.co.uk/>



Key Links



Any Questions?

What has been their greatest challenge during COVID?

What is proving to be the biggest asset going forward?

What methods are people using to get help and support if they want to find out what is available to them?

Key Links



Thank you for your time

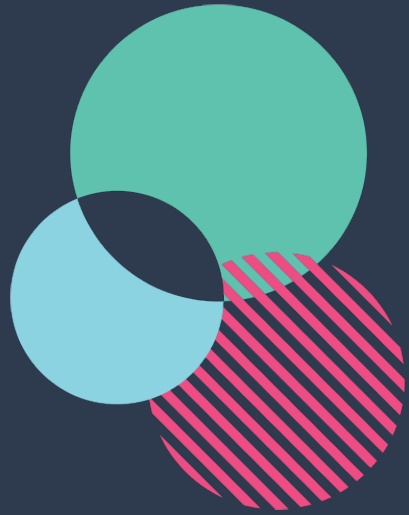
Thriving Communities - National Academy for Social Prescribing

Tom Watkins – Regional Lead for the East of England

NHS England and NHS Improvement

2 March 2022





National
Academy
for Social
Prescribing

Introducing

Thriving Communities

Tom Watkins – Regional Lead for the East of England

About Thriving Communities

Champions the work of local community, faith groups, voluntary organisations and social enterprises supporting communities most impacted by COVID19. Working alongside social prescribing link workers we build and promote sustainable services for those in need.

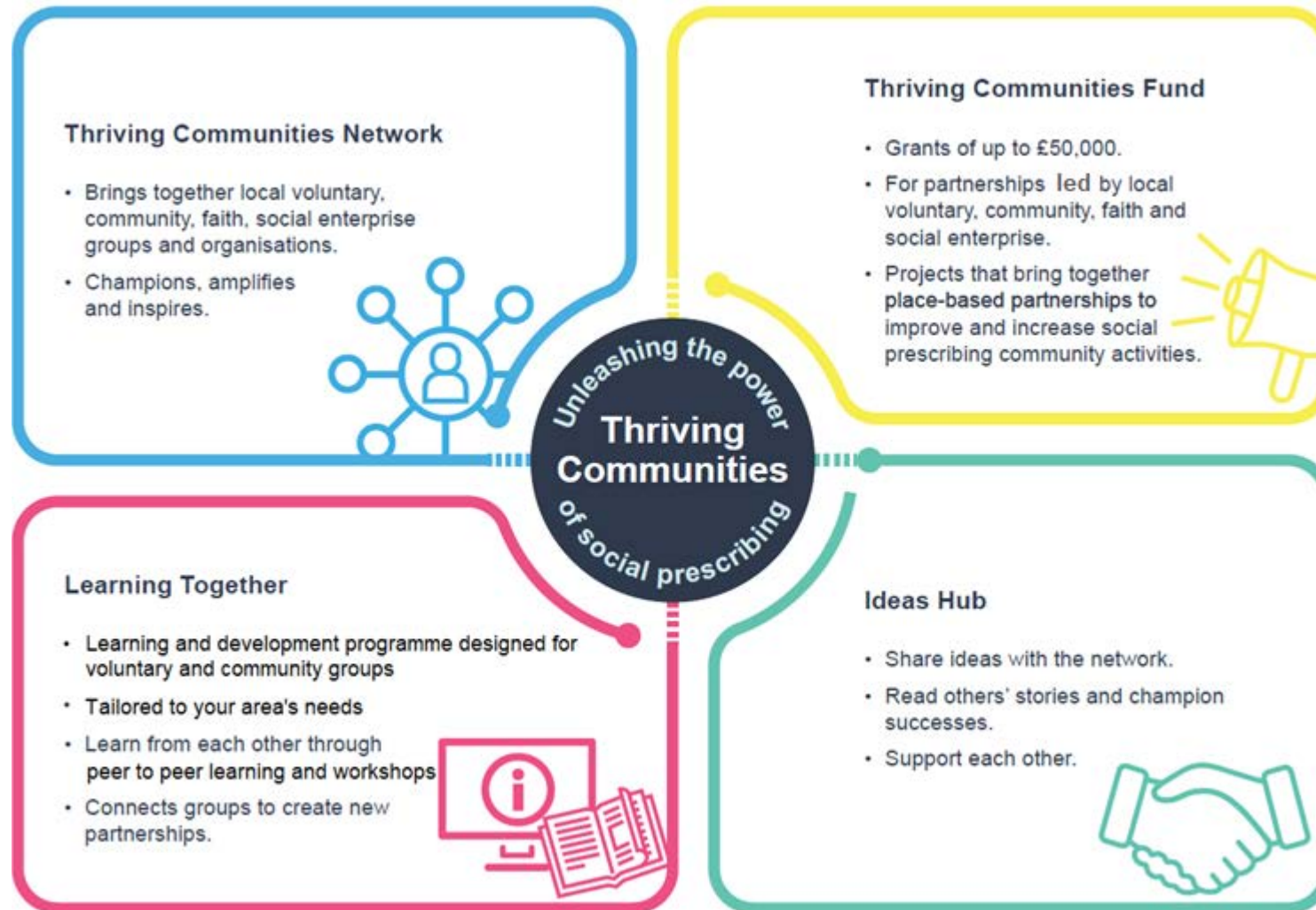
The programme is designed to help **share learning, gain new ideas, facilitate funding and develop partnerships across the region.**

It is supported by our team of regional and national voluntary sector partners: Sport England, Money and Pensions Service, Natural England, Historic England, Arts Council England, NAVCA, Independent Age, NHS England & NHS Improvement.

Thriving Communities Comprises 2 Core Elements:

1. 'Learning Together' Regional Development & Support Programme
2. Thriving Communities Regional & National Networks

Thriving Communities



Thriving Communities Fund

- Grants of £25-£50k were issued in early 2021 for **partnership work**, led by VCFSE organisations, totalling £1.4 million
- Aim to increase community activities and support for people impacted by COVID19, accessible for link workers to refer to.
- Partnerships to connect people to arts, nature, physical activity, financial wellbeing, health and care – the things that keep people well and leading a fulfilling life!
- Arts Council England administered the fund: **Round 1 ended 8 January 2021 - Round 2 TBC...**

‘Learning Together’

Open Regional support for the whole system:

- Flexible and responsive programme of regional learning and development opportunities
- Aimed at voluntary, community, faith and social enterprise groups and any organisations supporting their communities’ needs post-pandemic.
- Maximise and enhance the support you offer your communities.
- Online workshops, Regional Webinars and virtual peer-to-peer learning sessions organised regionally
- Opportunities to network with others participating in Learning Together locally and throughout the region.

Thriving Communities Networks

- Free to join, open to all
- **National Ideas Hub** - share your work: films, stories, blogs...
- Join **Monthly National Webinars** - delivered by community leaders
- Receive **Free Resources** for social prescribing development, funding, community ideas & MORE!

Workshop Questions

- Biggest challenge during Covid
- Biggest asset or strength going forward
- Where do you go if you want to network/know more about what's available to support your organisation or community?



National
Academy
for Social
Prescribing

Talk to us...

SocialPrescribingAcademy.org.uk/

[ThrivingCommunities](#)

[@NASPTweets](#)

[#ThrivingCommunities](#)

Tom.Watkins@communities1st.org.uk



MDT Role of the Social Prescribing Link Worker



Ground rules

Take part to the best of your ability – fully engage in this session

Respect others' opinions

Don't be afraid to challenge others (respectfully)

One conversation at once (if unmuted)

Keep personal issues out of the session

Maintain confidentiality within the group

Be here now ... no surfing the internet!

Your questions

Type in the chat box and we will pause and answer at points throughout the session.

...

To: **All panelists and attendees** ▾

|type message here...



Your role in implementing this learning

Activity – What are the challenges in the care home and general practice settings?

As you listen to the presentation, consider the challenges of implementing this learning in the care home or general practice setting. Type your ideas in the chat box. Think about possible solutions to these challenges, who would be responsible for the implementation of these solutions and what your role would be, including who you would need to communicate with.

Challenges	Solutions	Responsible people	My role

MDT: The role of the social prescribing link worker

Your role in implementing this learning

Activity – What are the challenges in the care home and general practice settings?

As you listen to the presentation, consider the challenges of implementing this learning in the care home or general practice setting. Type your ideas in the chat box. Think about possible solutions to these challenges, who would be responsible for the implementation of these solutions and what your role would be, including who you would need to communicate with.

Challenges	Solutions	Responsible people	My role

Introductions

Jessica Hardwick

Hospital and Community Senior Navigator
Watford & 3 Rivers

Tim Anfilogoff

Head of Community Resilience
Herts CCGs

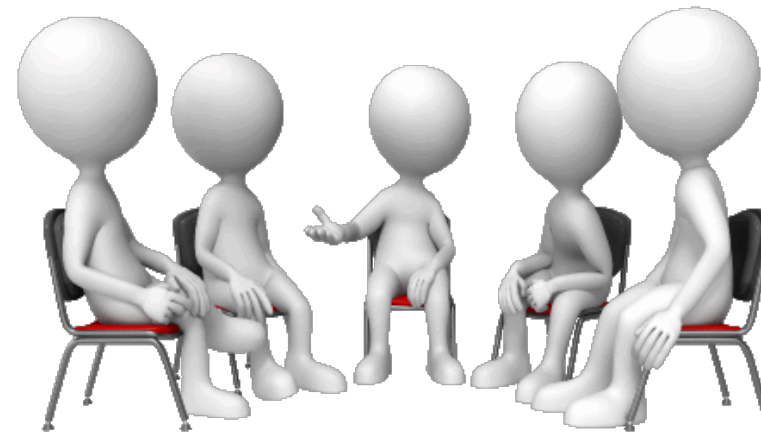
Social Prescriber name

Sarah Sales

Social Prescribing Link Worker

North Watford PCN

Herts Help Hospital & Community Navigation
Service



What we're going to cover...

- The role of social prescribing link worker and how it has evolved.
- How involvement provides overall outcomes for patients
- How social prescribing link workers assess people
- What 'treatments' are prescribed
- How are people followed up -what are the different responsibilities of the MDT?
- How would SPLWs liaise with the rest of the MDT -specifically in the clinical systems etc.
- Case studies of prescribing for individuals with pharmacy involvement -ie case studies
- Future developments

Warm up



kahoot.it

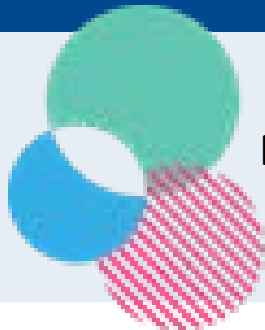


Supported by

NHS CHARITIES
TOGETHER



Tim Anfilogoff
Head of Community Resilience
Herts CCGs



National Academy for Social
Prescribing (Thriving
Communities)

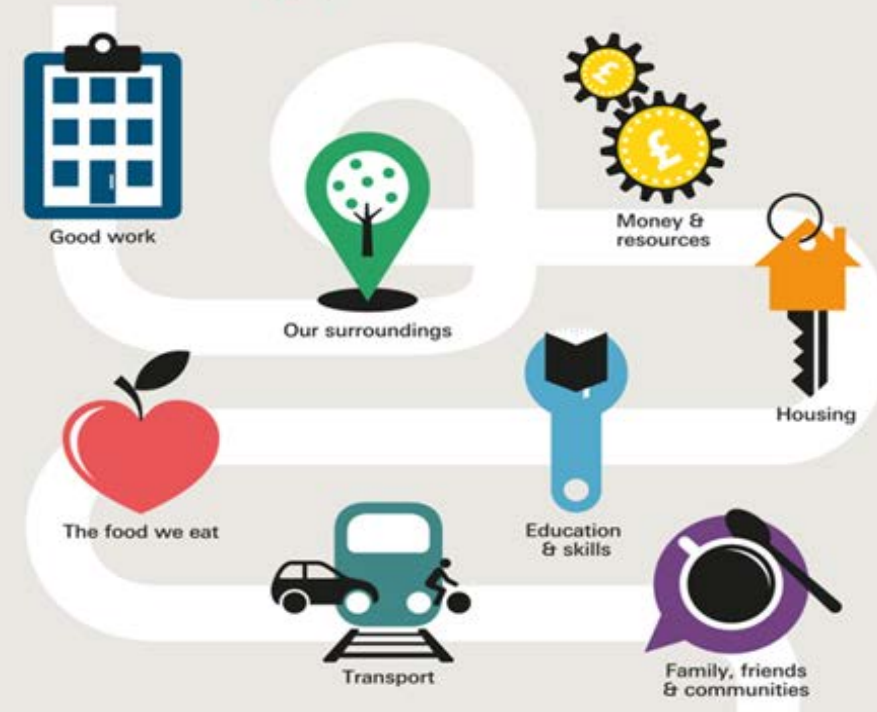


**Social Determinants
impact our health more
than the NHS!**

What makes us healthy?

AS LITTLE AS
10% of a population's health and wellbeing
is linked to access to health care.

We need to look at the bigger picture:



But the picture isn't the same for everyone.

The healthy life expectancy gap between the
most and least deprived areas in the UK is: **19** YEARS

Where do people actually go? (Pre-Covid)

- **GPs** – 20+ % GP face-to-face time - non-medical issues
- 8-10 min consultations (shortest in developed world?)
- 50% of appointments LTCs
- ‘Consultation length linked to doctor's ability to empower people’



<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4311338/>

Where do people actually go? (Pre-Covid) cont.

- 15% GP time on 'welfare' issues
<https://www.lowcommission.org.uk>
- *'the lights are always on in A&E'* (eg lonely people more likely to use)
- Can miss 20% of what matters to patients if don't start by asking that question...



<http://journals.sagepub.com/doi/abs/10.1177/1534735414555809>

Is *this* what public services do?

'If you want to get somebody to do something, make it easy. If you want to get people to eat healthier foods, then put healthier foods in the cafeteria, and make them easier to find, and make them taste better.

So, in every meeting I say, "Make it easy."



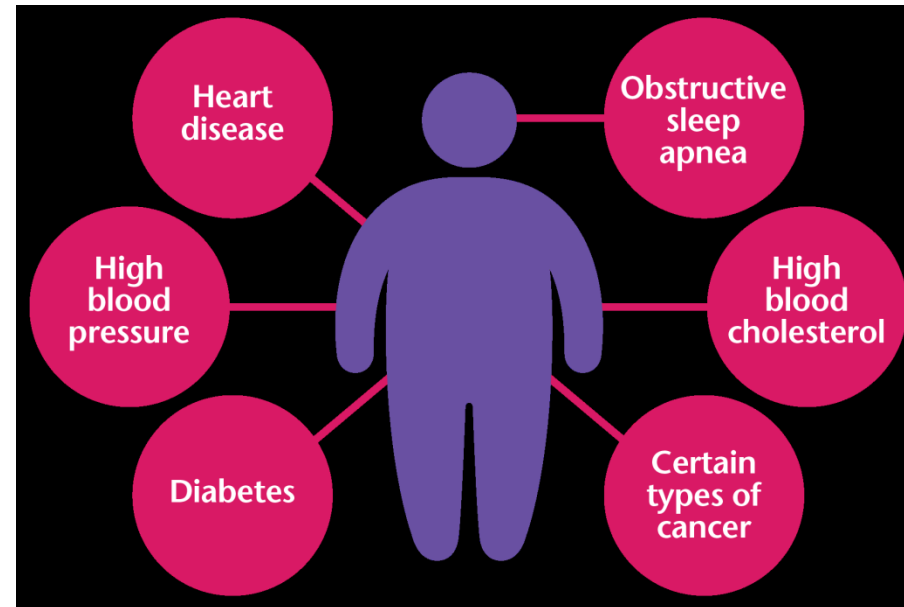
*Richard Thaler,
Economics, Nobel Laureate 2017*

Obesogenic Culture?

Martin McShane, NHSE, 2015:

“These figures are a stark warning and reveal the increasing cost of diabetes to the NHS.

“We’ve said it before and we’ll say it again, it’s time to get serious about lifestyle change. Prevention is better than treatment for individual health as well as the health of the NHS.”



Empowering vs blaming people



University of Hull
York Medical School

- Survey of 3,000 people with type 2 diabetes
- Loneliness, stigma, embarrassment, blame, guilt
- Feel they're seen as burden on NHS

'If you have type 2 people think it is your fault, that you haven't looked after yourself properly.'

'At Christmas or going out for a friend's birthday it isn't easy to cope with not being able to eat the same food, the same birthday cake as everyone else. So instead – you just don't go out.'

The role of the social prescribing link worker

What is the definition of social prescribing?

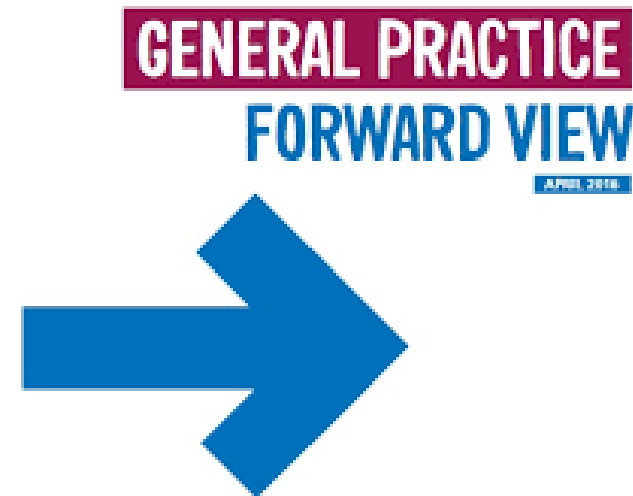
Currently there is no universal definition, but an easy bite-sized definition is:

‘Enabling health care professionals to refer patient to a link worker, to co design a non-clinical social prescription to improve their health and wellbeing’¹

1. Social Prescribing Network Conference Report 2016

National agenda

Social prescribing is listed as one of the ten in the NHS England high impact actions General Practice Forward View



Background

- People with multiple long-term conditions account for an estimated 50% of all GP appointments.
- Shift is needed from asking:

'What's the matter with you?'



'What matters to you?'

- Otherwise known as *'Personalised care'*.
- The social prescribing link worker role has emerged over the past few years.
- Link workers are employed in non-clinical roles.

What matters to you?

An important element of social prescribing support is for the person and their link worker to **co-produce** a simple plan or a summary personalised care and support plan, which outlines:

- what matters to the person – their priorities, interests, values and motivations.
- community groups and services the person will be connected to.
- what the person can expect of community support and services.
- what the person can do for themselves, in order to keep well and active.
- what assets people already have that they can draw on – family, friends, hobbies, skills and passions.

Who do we support?

Social prescribing supports a wide range of people, including (but not exclusively) people who:

- are lonely or isolated
- have long-term conditions
- use the NHS the most
- have mental health needs
- struggle to engage with services
- have wider social issues e.g. debt, housing problems, employability issues, relationship problems
- are carers.

What do we do?

- Social prescribing link workers help to reduce health inequalities by supporting people to unpick complex issues affecting their wellbeing.
- They connect people to community groups and help the person to develop skills, friendships and resilience.
- What is the average number of contacts made over three months? (Type in the chat box)

A link worker may be situated within a GP surgery, in the local community, or a mix of these, depending on how the social prescribing scheme has been developed.

Referral process

- A patient is referred to a link worker by a healthcare professional (usually their GP) or a community-based practitioner.
- Referral process varies:
 - Can be via clinical systems (if social prescribers have access)
 - Paper referrals
 - Self referral.
- Consent by referrer to make a referral is required.
- The social prescriber will also seek consent to feedback to referrer.

Who are the most vulnerable?

- Older people.
- People with mental health issues.
- People on the autistic spectrum.
- People with learning disabilities.
- People with undiagnosed dementia (or other cognitive impairments).
- Isolated people with no support network.
- People living in poverty.
- Family carers, especially hidden ones.
- There are vulnerable people in all communities, not just the obvious ones such as areas of deprivation.

People who tend to fall through the gaps are....

- People who don't visit their GP (or other referrer)
- People who don't meet the criteria
- People who don't know social prescribing exists
- People living rurally
- People who don't acknowledge they have a problem
- People who don't like to ask for help or may be embarrassed
- Hidden carers
- Working people
- Busy parents

Identifying a 'treatment'

- Patient and the link worker co-design a non-clinical social prescription that best suits their needs.
- Link workers are professionals who inform, set a goal and offer health coaching.
- Commonly, the patient is referred-out to the voluntary and community sector whose services can include practical information, advice and guidance, income support, social support, community activity, physical activities, befriending and enabling services.

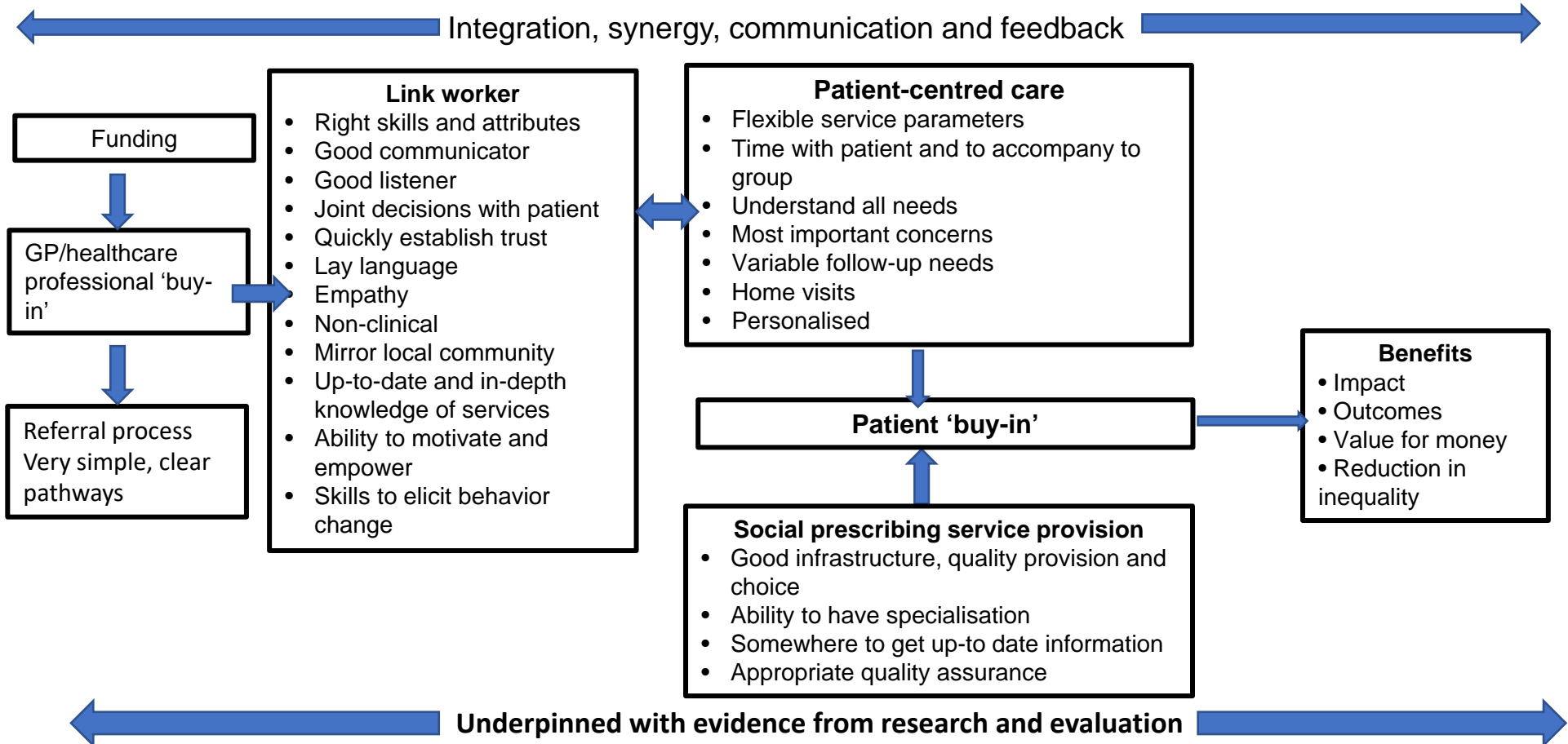
Treatment and practical support

- Debt management CAB MAU
- Benefit checker (and application)
- Grant applications (Home adaptations, white goods)
- Links with Housing providers and associations for temp Housing and transfers
- MIND
- Age UK (befriending and help in the home)
- Carers support services
- Art classes online
- WFC – exercise and Fitness sessions
- Reach out Services
- Emergency food parcels
- Local church Groups
- HCC for pendant alarms and falls alarms
- volunteer transport services,
- Healthy Hubs for stop smoking and losing weight etc
- Hoarding and declutter services
- +Volunteering Schemes
- Services will depend on different localities

How we work with clients

- Depending on the client's needs, consultations are conducted either:
 - telephone
 - face-to-face appointments
 - Zoom
- In the initial consultation social prescribers use Motivational interviewing techniques to facilitate clients to articulate their top two concerns and their feelings of general wellbeing.
- Referrals are then made to various organisations to support needs

Key ingredients of social prescribing model



Benefits for patients

Increase in self-esteem and confidence, sense of control and empowerment

Improvements in psychological or mental wellbeing, and positive mood

Reduction in symptoms of anxiety and/or depression, and negative mood · Improvements in physical health and a healthier lifestyle

Increases in sociability, communication skills and making connections

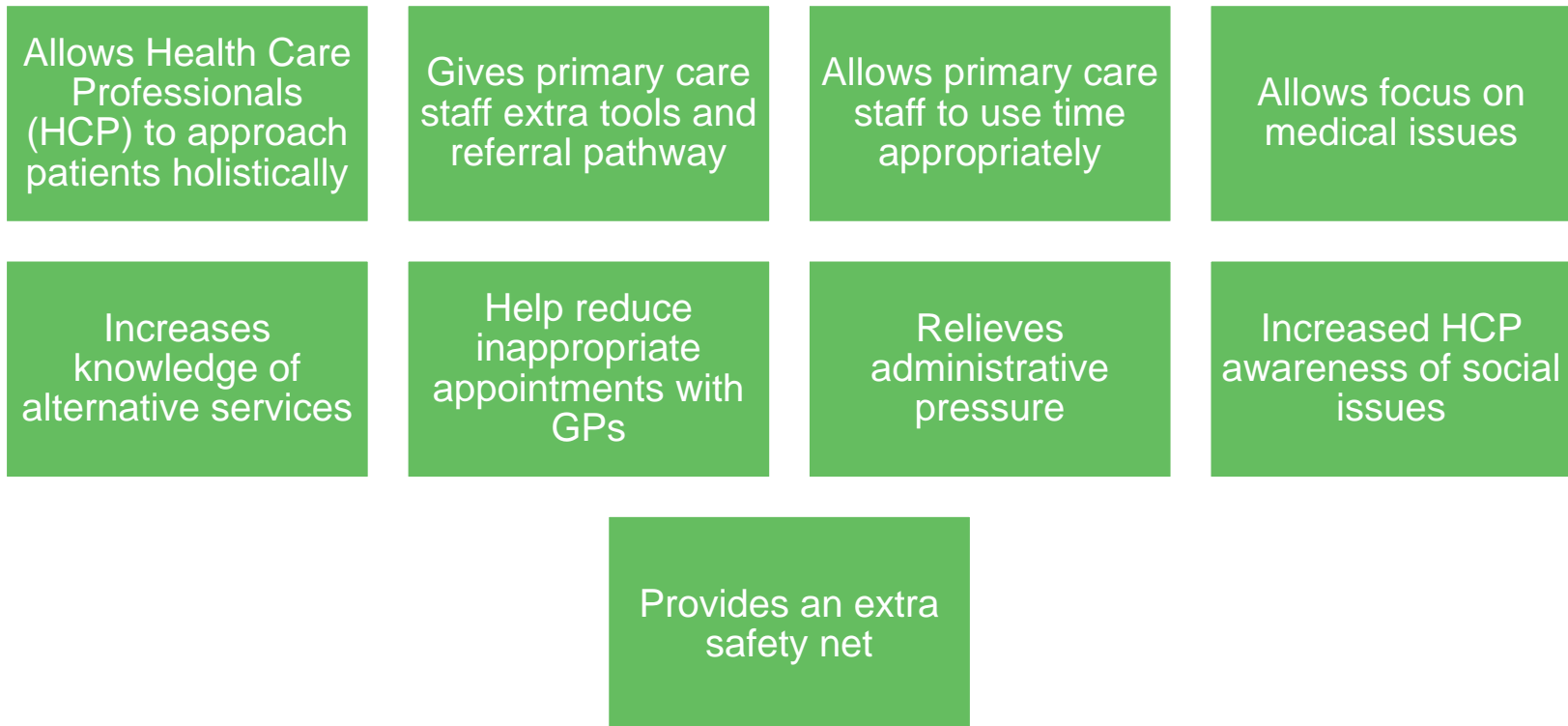
Reduction in social isolation and loneliness, support for hard-to-reach people

Improvements in motivation and meaning in life, providing hope and optimism about the future

Acquisition of learning, new interests and skills, including artistic skills

Reduction in number of visits to a GP, referring health professional and primary or secondary care services

Benefits for general practice



What are the barriers?

- The main barriers to people accessing services appear to be:
 - Lack of knowledge about social prescribing.
 - Not linking with a 'referrer'.
 - Lack of knowledge and/or acceptance that help is needed.
 - Not wanting to engage.
 - Not wanting to 'bother' their GP.
 - Lack of time (being in full-time employment).
 - Lack of local appropriate services- both in type of service and availability.
 - Fear.

Barriers to success.....

How can we prevent people falling through the gaps?



Overcoming barriers -suggestions

- People need to know it exists - professionals as well as the general public.
- Increased media presence (including social media).
- Successful outcomes from the work should be celebrated publicly.
- Communities may need to be encouraged and supported to set up more groups or activities to support the growing needs (particularly for those in full time employment).
- Continue building links and alliances with existing networks.
- A thorough knowledge is needed about everything that is available, not just the more well-known services esp. in more rural areas
- Some people may need more support than others when first joining a new group or activity. A 'buddying' scheme could work really well, where the service user is paired with someone who travels with them, walks in with them and stays until they feel comfortable to do this alone.
- Increased self referrals.

Case study

Jackie Cook



www.bigstock.com · 253646461

Jackie is 75 years old and lives alone

She is frail and has recently fallen in her home so her son has taken her reluctantly to the GP.

GP treated for minor bumps and Jackie said she was well but her son had concerns she lived alone.

Jackie explained her son was the only support she had, she had no other family and no friends or companions and she was isolated.

Referral to social prescribing link worker was made with Jackie's consent.

Case study cont.

First Telephone consultation :

Jackie explained that she is okay, initially, however when conversation opened up regarding what matters to her, she explained that she sometimes forgot simple things.

Action:

Link Worker to call GP and discuss

Follow up call (5 days later)

Jackie more chatty, explained she struggles with bathing, social prescribing link worker asked if she had hand rails in bathroom, she said she had not as she could not afford to have them installed.

Action:

Suggested Occupational Therapy assessment be made to look at adaptations she may need in the home.

Case study cont.

Subsequent follow up call

- Jackie's son had been furloughed and was able to give mum more time was able to become a carer. Over the phone I helped her son apply for Attendance Allowance as was unable to visit. Jackie qualified for the higher rate. This money can be used to access help.
- To help with loneliness, referral made to befriending scheme.

What else can be done to support Jackie and her son?

Resources

- **Making sense of social prescribing (2017)**
Polley, M.J., Fleming, J., Anfilogoff, T. and Carpenter, A. London University of Westminster
<https://westminsterresearch.westminster.ac.uk/item/q1v77/making-sense-of-social-prescribing#:~:text=Making%20Sense%20of%20Social%20Prescribing%20%20%20Title,%20%20https%3A%2F%2Fwww.westminster.ac.%20%207%20more%20rows%20>
- **Social prescribing and community based support: Summary guide (2019) NHSE**
<https://www.england.nhs.uk/publication/social-prescribing-and-community-based-support-summary-guide/>
- **The Social Prescribing Network**
<https://www.socialprescribingnetwork.com/>
- **The National Academy for Social Prescribing**
<https://socialprescribingacademy.org.uk/>

Feedback is a gift...

Please complete the online CPPE evaluation form.







<https://cppesurveys.onlinesurveys.ac.uk/online-cqc-seminar-and-other-webinars-survey-2>



www.cppe.ac.uk
info@cppe.ac.uk
0161 778 4000

Follow us on Twitter, Facebook, LinkedIn and YouTube:

-  www.twitter.com/cppeengland
-  www.facebook.com/cppeengland
-  www.linkedin.com/company/centre-for-pharmacy-postgraduate-education
-  www.youtube.com/user/YouCPPETube

Social Prescribing during Pregnancy, Birth & Beyond

Celia Suppiah – CEO parents 1st UK

NHS England and NHS Improvement

2 March 2022





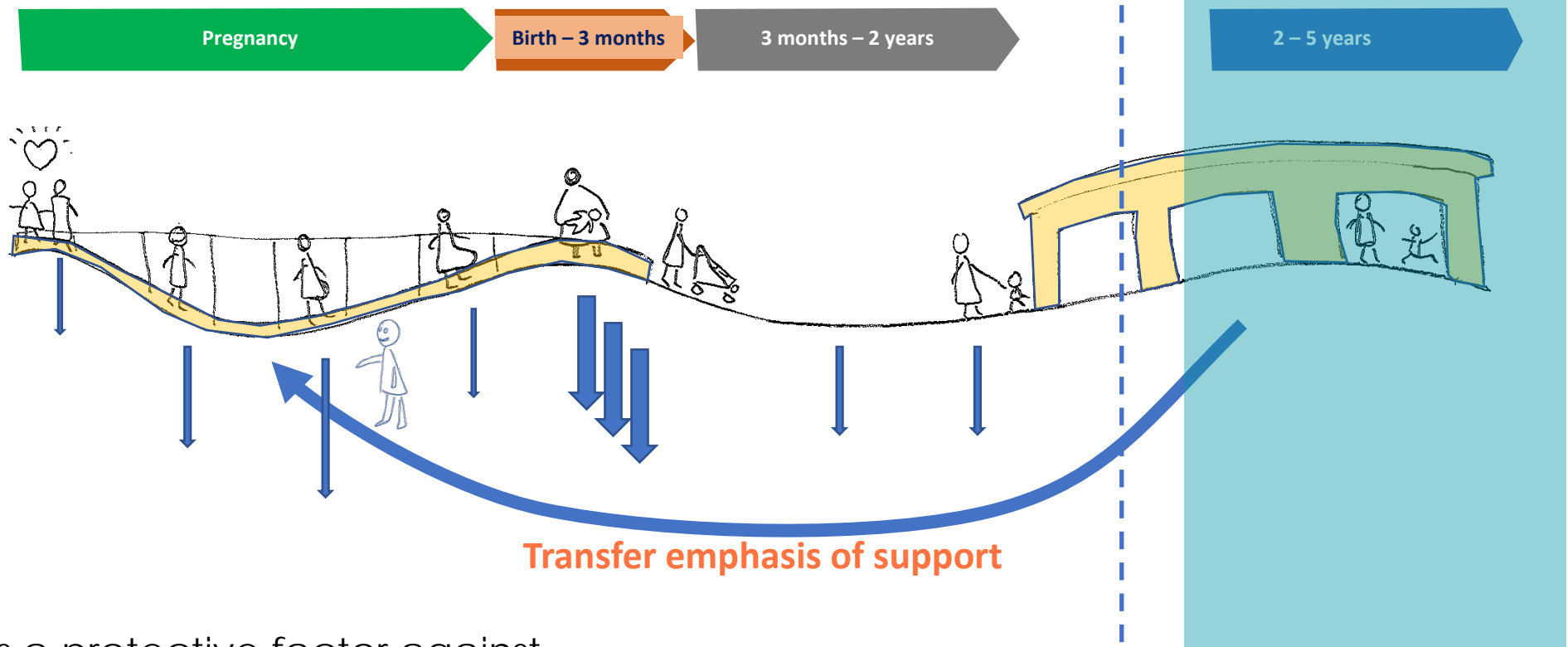
Social Prescribing during Pregnancy, Birth & Beyond

Celia Suppiah
CEO Parents 1st UK

England and NHS Improvement

www.parents1st.org.uk | www.essex.parents1st.org.uk

The Transition to Parenthood is a Window of Opportunity



Social support is a protective factor against antenatal and postnatal anxiety and depression

(Robertson et al 2004, Leigh & Milgrom 2008, Lee et al 2007, Littleton et al 2007)

Parents 1st Model

Establishing trusting and purposeful peer support relationships starting in pregnancy

Sits alongside local professionals

- Midwives
- Perinatal mental health
- Health Visitors
- Social Care
- Children's Centres
- Other VCS



Nurturing resilience
to give babies the
best start in life

New Ideas and Setting Goals



What makes it successful?

- Structured
- Strengths-based
- Community outreach
- Life experience
- Personal qualities & skills
- Boundaries & ground rules
- Quality standards & robust training
- Skilled supervision

How it works



150 referrals a year in South Essex



- Pregnant women: mental health issues; socially isolated; previous traumatic birth; poor physical health; domestic violence
- Easy referral process (on line, phone)

Coordinator / Link Worker

- Single point of contact
- Manages all referrals
- Visits each expectant mother / father / partner at home
- Empathy and listening skills
- A “Wheel of Circumstance” helps understand each woman’s unique situation

Mutually agreed next steps

- Signposting (groups, antenatal classes, exercise sessions)
- NHS England and NHS Improvement
Matched with a peer supporter for one-to-one peer support:
home – hospital – community – online

Continuum of personalised support throughout pregnancy, birth and beyond

- **Assisting** parents-to-be to connect with others in their community
- **Listening, encouraging** and offering useful **information**
- **Building confidence:** preparing for birth and being a parent
- **Assisting communication** with professionals



Includes physical and emotional support during labour and birth



Pregnancy, Birth & Beyond
Helping organisations
to continuously
improve volunteer
programmes for babies,
parents, families and
communities.



bespo
ng ba
w

Pregnancy

Getting out and meeting others

Keeping healthy during my pregnancy

Healthy eating

Preparing for labour and birth

Preparing to look after my baby

Preparing to breastfeed

Bonding with my developing baby

Feelings and emotions

Personal relationships

Money worries

Housing

Helping me to access services

Menu of ideas & plan of things to work on

After the birth

Getting out and meeting others

Looking after my health

Healthy eating

Looking after my baby

Breastfeeding

Bonding with my baby

Feelings and emotions

Personal relationships

Money worries

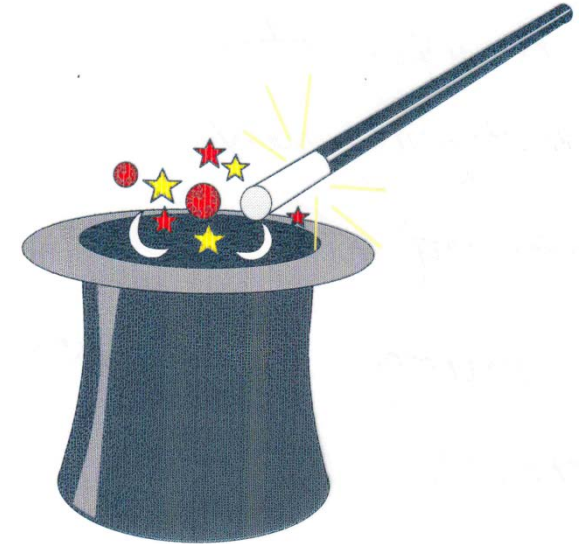
Housing

Helping me to access services



Information Resources Start a Conversation...

- Shared during home visits
- Trigger discussion
- Pictures and videos overcome literacy issues
- Reminders after the visit



Important health, wellbeing and parenting topics

Shared in an informal and friendly way

Virtual support groups for pregnant women led by peer support workers



**FREE Virtual information sessions for mums
Sharing and preparing together**

Book your place today -
call us on 01268 525758 or email info@parents1st.org.uk

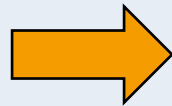
Virtual Groups for Expectant Dads



FREE online workshops for dads!
Book your place today -
call us on 01268 525758 or email info@parents1st.org.uk



- Obesity
- Mental health issues
- Social isolation



Online and Wickford

Fit4Mums Exercise Group Sessions

Increased:

- Health & wellbeing
- Exercise in pregnancy
- Social connections

Improved preparation for
labour and birth

Parent Impact Data

The programme works across multiple areas

The visual tool ('The Wheel of 'Circumstance')

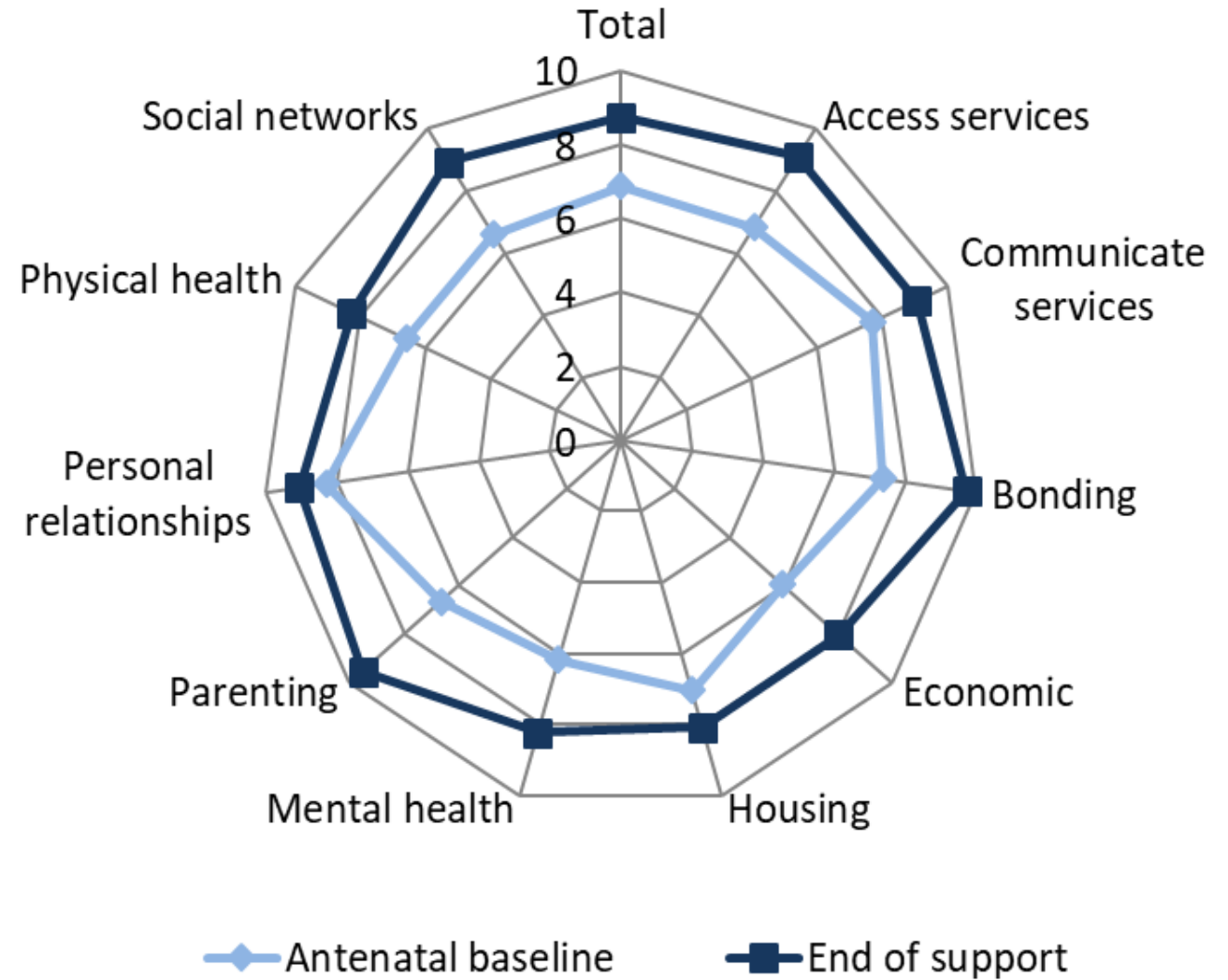
The fundamental finding from the review of the evaluation framework with Parents 1st is the very broad range of areas of a parent's life that the approach can support, and how these can add up, in different ways, to the achievement of the overall objective.

Different parents will experience that benefit differently.

Wheel of circumstance



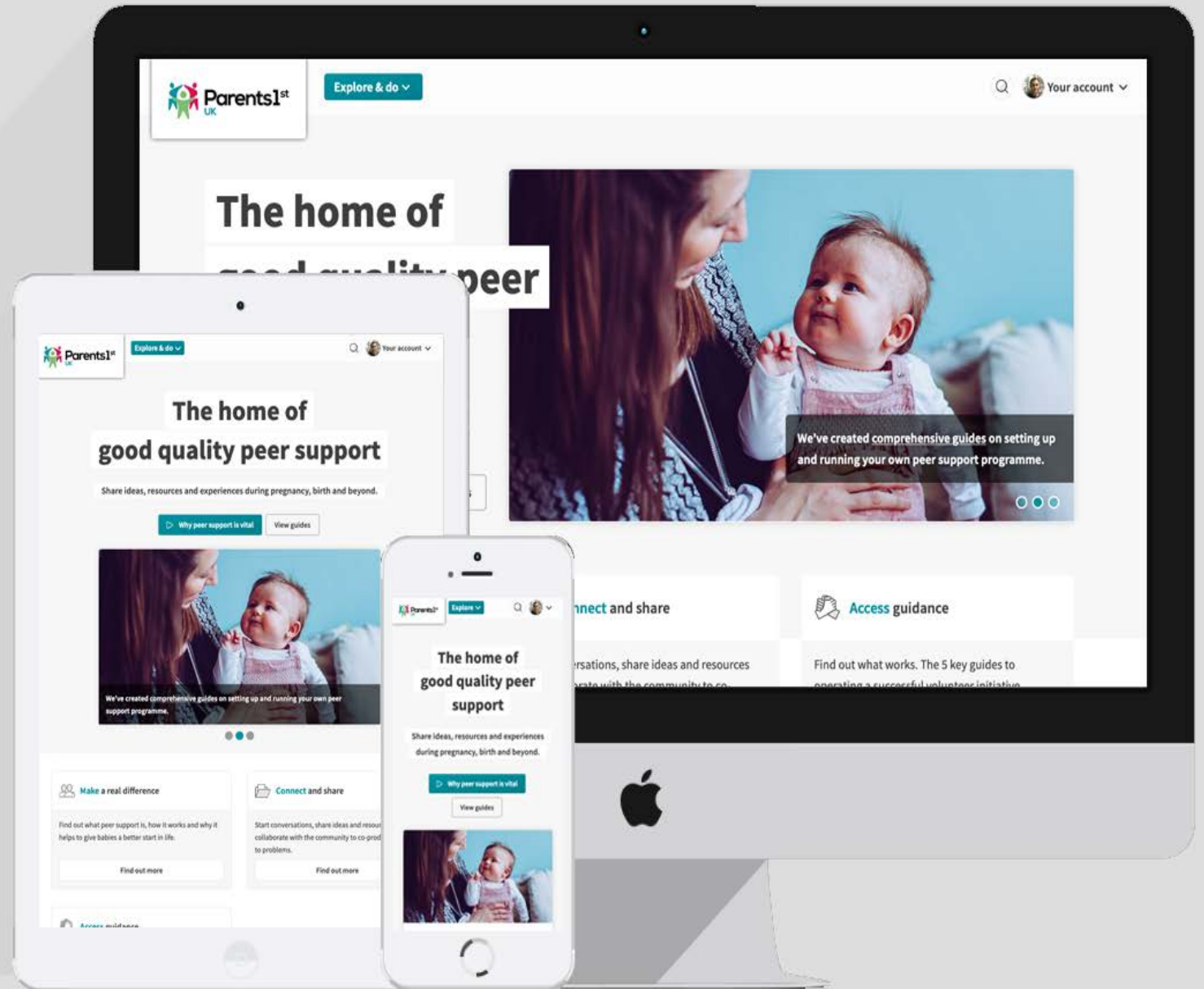
The majority of pregnant women see highly significant statistical change when comparing their overall average scores at antenatal baseline with scores 3 months post birth (92% demonstrate a rise in scores)



Specific Areas of Large Change

- **Feeling better prepared for labour and birth** (85%)
- **Health & wellbeing in pregnancy** (82%)
- **Parenting** – Feeling better prepared to look after the baby (81%)
- **Bonding** – Feeling a closer bond with the baby (70%)
- **Mental health** - Feeling emotionally well (69%)
- **Social networks** - Feeling there are people to turn to in the community (69%)

A central, free, dedicated space to connect, share, celebrate, learn, & gain free guidance and resources



www.parents1st.org.uk



A Tried and Tested Model of Perinatal Social Prescribing

contact@parents1st.org.uk

Tel: 07718 494228

Follow @parents1st
England and NHS Improvement



www.parents1st.org.uk

www.essex.parents1st.org.uk

Re-engage

Paula Nelson – National Engagement Officer

NHS England and NHS Improvement

2 March 2022



Introduction slide

Paula Nelson – National
Engagement Officer

Reengage

Bringing generations together

CPPP
Reengage



Who are we?



- A national charity dedicated to tackling loneliness and social isolation amongst the over 75s.
- Supported by around 14,000 volunteers nationwide

Bringing generations together

What do we do?

Monthly social groups:

- Often in the form of tea parties, 6-8 older guests plus volunteers
- Small and friendly, held in volunteers' homes or community venues
- Transport, food and drink provided free of charge to our older guests
- Pre-pandemic we had around 80 groups meeting across the East of England. Gradually re-opening



Bringing generations together

What do we do?

Call Companions

- Telephone befriending service launched in 2020 in response to the pandemic
- Older people are matched thoughtfully with a volunteer who will call them on a weekly basis
- Launching 'Rainbow call companions' in March – volunteers from the LGBT+ community matched with older people who identify from that community



Community Christmas

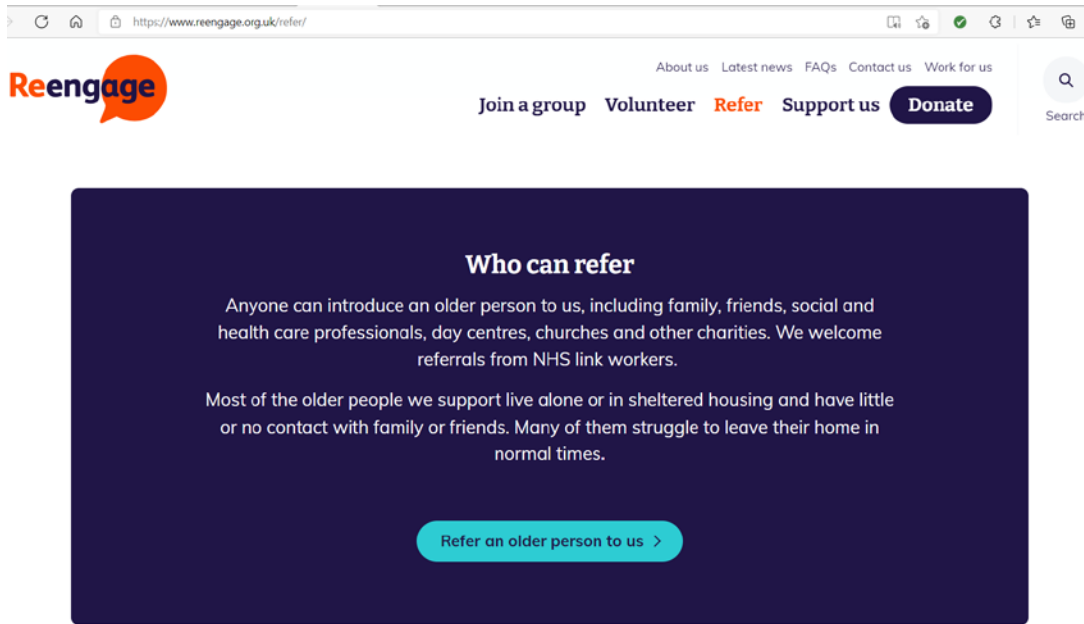
- Free online directory of events across the country open to older people who would otherwise be alone at Christmas
- Older people can enjoy some fun and companionship when they most need it.
- Helps to introduce people to other Re-engage services



Referrals

Easy referral through our website for call companions and tea parties

www.reengage.org.uk/refer/



The screenshot shows the Reengage website's referral page. At the top, there is a navigation menu with links for 'About us', 'Latest news', 'FAQs', 'Contact us', and 'Work for us'. Below this is a search bar and a 'Search' button. The main content area is dark blue and features the Reengage logo on the left. The central text is white and reads: 'Who can refer', 'Anyone can introduce an older person to us, including family, friends, social and health care professionals, day centres, churches and other charities. We welcome referrals from NHS link workers.', and 'Most of the older people we support live alone or in sheltered housing and have little or no contact with family or friends. Many of them struggle to leave their home in normal times.' At the bottom of this section is a light blue button that says 'Refer an older person to us >'. The browser's address bar at the top shows the URL 'https://www.reengage.org.uk/refer/'.

Email me on paula.nelson@reengage.org.uk if you are wanting information on CC or TP referrals



Bringing generations together



Any questions?

paula.nelson@reengage.org.uk

Bringing generations together

Evidence for Social Prescribing



The evidence for social prescribing

DOES SP WORK AND HOW?

Social Determinants of Health

- NHS cannot address alone
- Local Authorities cannot address alone
- Prevention of poor outcomes means helping those who find it hardest to self-care/use services because of (not exclusive):
 - Poverty
 - Isolation
 - Chaotic behaviour
 - Low educational attainment
 - Lack of trust
 - Lack of sense of autonomy, purpose and hope

Where do people actually go?

- **GPs** – 20+ % GP face-to-face time - non-medical issues
- 8-10 min consultations (shortest in developed world?)
- 50% of appointments LTCs
- ‘Consultation length linked to doctor's ability to empower people’



Where do people go? (2)



- 15% GP time on ‘welfare’ issues
<https://www.lowcommission.org.uk>
- *‘the lights are always on in A&E’* (eg lonely people more likely to use)
- Can miss 20% of what matters to patients if don’t start by asking that question...

1. David (heart disease patient)

- SW made referral
- Link Worker visited David at home discovered:
 - Hoarding and property unsafe
 - Stockpiling food, much of it rotting
 - Bedroom & bathroom unusable
 - No heating or hot water
 - Significant unmanaged debt
 - Lonely
 - Unable to use his garden - overgrown and cluttered
 - Not healthy environment to recover from heart surgery



2. Fred

Fred: Doctor, it's my leg.

Doctor: Mmm, I need you to raise it when you go to bed at night.

Fred: Doctor, I don't, *have* a bed...



3. George



- Brain injured
- Mother (carer) visiting GP every week (help!)
- Mental health services can't/won't deal
- George is homeless/'sofa-surfing' and in and out of prison (injunction against him)

4. Jean

- Psychiatrist discharged her to local talking therapy service
- They couldn't make contact. Jean has stopped answering phone or letters...



5. Daisy

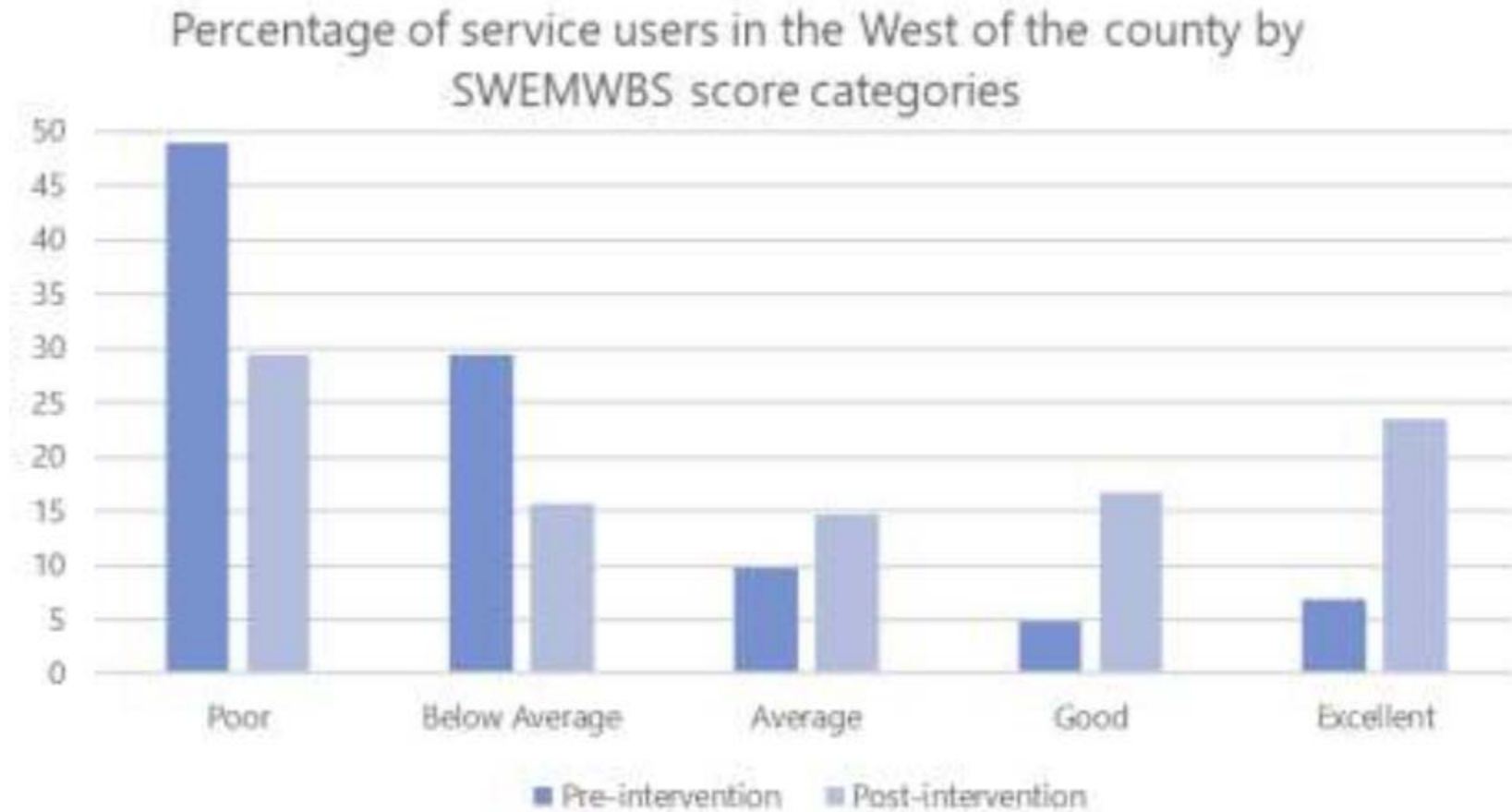


- Community Safety referred Daisy
- Serious hoarding (rotting food upsetting neighbours etc) by Daisy, African lady ideally needing help from LW of African heritage...
- Daisy refused police entry (enforcement order) so door forced
- Daisy told LW (despite African heritage) to go away initially but let her help her identify sentimentally significant objects that could be saved

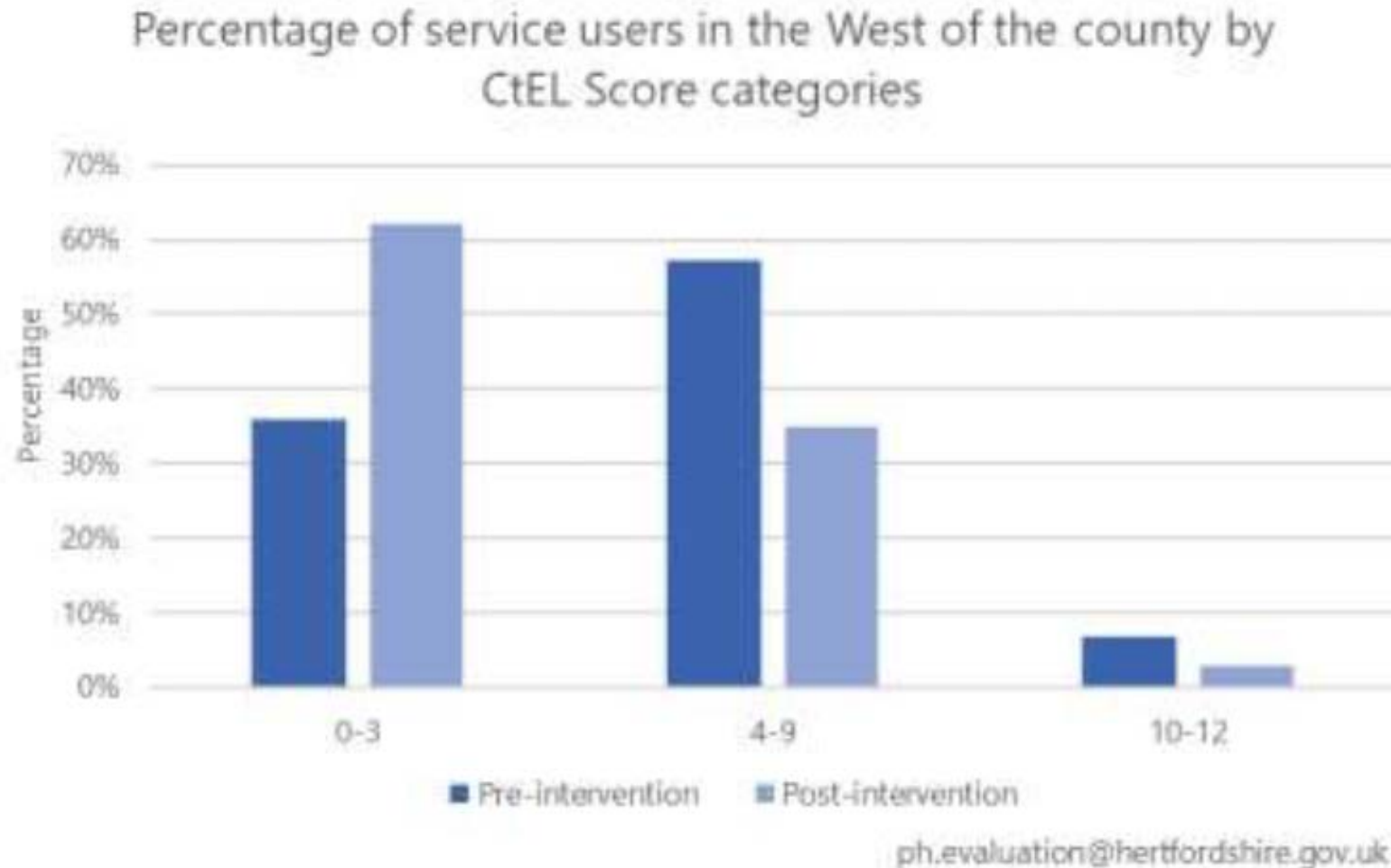
Some Numbers - Herts

- Last year, the Hospital and Community Navigator Service supported **9,691** clients in Herts (now employing an additional 13 Link Workers)
- There was an **11% increase** in mental wellbeing (Short Warwick-Edinburgh: 529 cases) and **18%** decrease in loneliness (Campaign to End Loneliness tool: 445 cases)
- High Intensity User pilot (three specialist navigators): **44%** reduction (conservative) in A&E use post referral (currently suspended)

HCNS Outcomes: Warwick-Edinburgh Short Scale



HCNS Outcomes: Campaign to End Loneliness Tool



[Higher number means lonelier]

PH study of pre-Covid SP Casework:

Jo McKenzie (HCC PH)

Key Messages

(Based on 23 case studies from 2018 and 2019)

www.hertshealthevidence.org/documents/thematic/hcns-casestudyanalysis2019.pdf

- Clients' issues intertwined (biological, social, psychological)
- Often rooted in social problems (eg finance and housing)
- **One** issue unaddressed led to **multiple** issues
- Solutions showed importance of addressing basic living needs **before** trying to connect with groups
- Clients saw increase in mental wellbeing (reduced stress, anxiety, depression) ability to stay independent/increase social connectedness
- 'System' saw more appropriate use of medical services prevention of escalation and costs for NHS and local authorities

A Realist Evaluation of staying well in your community: Identifying SP intervention profiles for type and impact

Preliminary findings: the link worker/patient relationship appears to be a key mechanism in the outcome of the intervention. The trust, engagement, and sense of belonging may give the patients confidence, motivation, and knowledge to manage their own well-being

Authors: Susan Beese (susan.beese@southwales.ac.uk) Carolyn Wallace, Gina Dolan, Mark Llewellyn, Anne Morris University of South Wales, Interlink RCT

<https://www.thelancet.com/journals/lancet/article/PIIS0140-67362032000-6/fulltext>

Hospital and Community Navigator Service (HCNS) Headline Data

April 19 – March 20 – 12 months

- 9,362 referrals
- 13,528 issues
- 1798 issues were from hospitals
- 54% of referrals were for residents over 75 years old
- **High Intensity User navigators:** 40% reduction in use of A&E

Apr 20 – Nov 20 – 8 months

- 8,050 referrals
- 10,033 issues
- 923 issues were from hospitals
- 43% of referrals were for residents over 75 years old
- **Link workers completed over 7,000 calls from PCN lists**

HCNS – most frequent issues

April 19 – March 20

Top 5 issues

- Debt/Benefits
- Paperwork support
- Housing
- Social Isolation
- Cleaning support

Apr 20 – Nov 20 – 8 months

Top 5 issues

- Help with shopping
- Help to collect medication
- Help with food
- Debt/Benefits
- Paperwork support

SP and Value (national data)

QUANTITY

- **28% reduction** in demand for GP services
 - **24% fall** in A&E attendance following referral
- <https://westminsterresearch.westminster.ac.uk/download/e18716e6c96cc93153baa8e757f8feb602fe99539fa281433535f89af85fb550/297582/review-of-evidence-assessing-impact-of-social-prescribing.pdf>
- **IMPACT** (Independent evaluation by Sheffield Hallam University)
 - In-patient spells reduced by **11%** and **17%** drop A&E attendance for all patients
 - For U80's, receiving long term support from VCSE groups, **51%** drop in-patient stays, **35% fall** in A&E attendances.

QUALITY

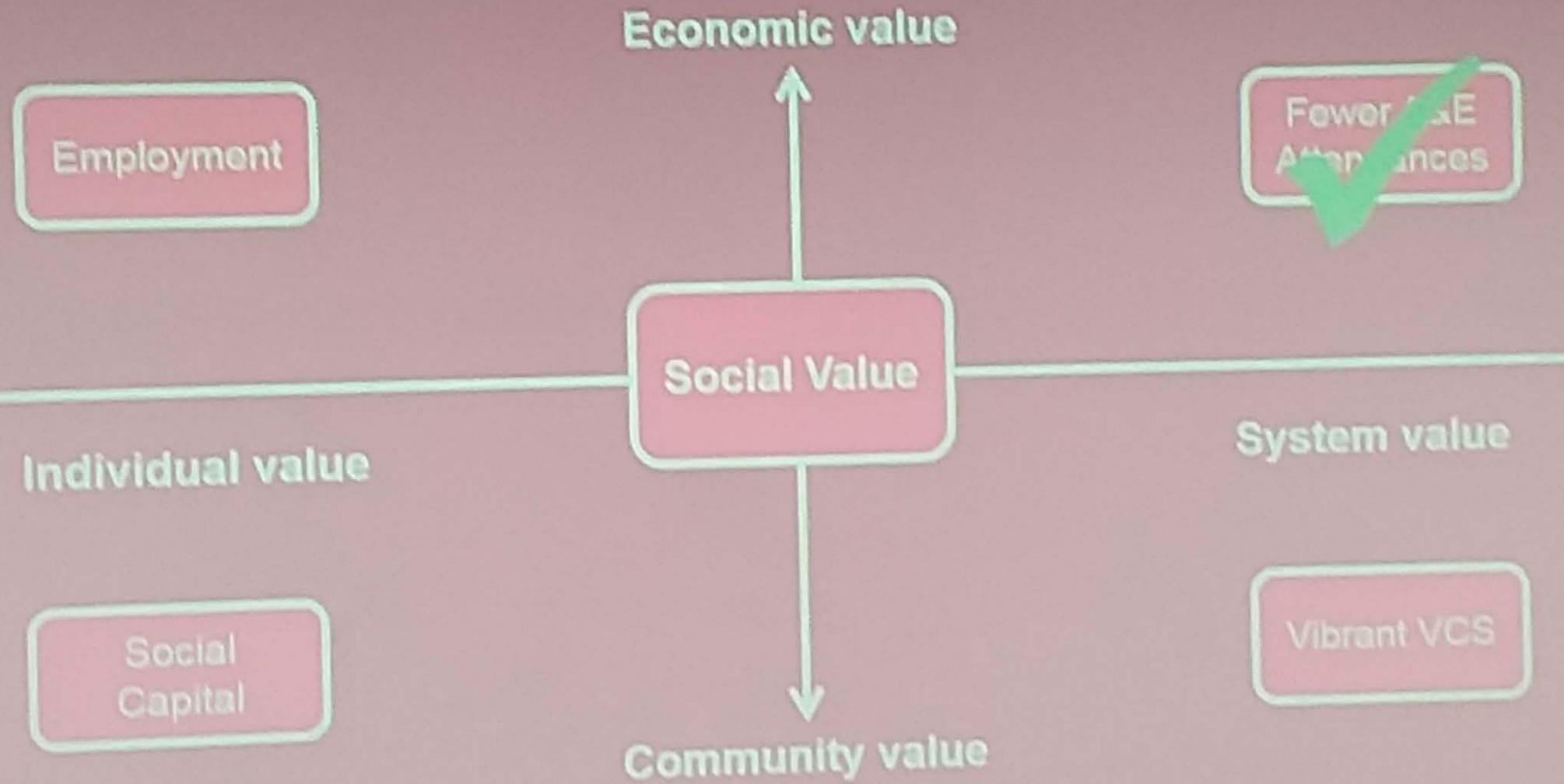
'I feel like I have a reason to get up in the morning...'

'I can see light at the end of the tunnel...'

'I feel like part of the community...'

SP

A value mismatch - the full value of SP is not valued...



Professor Chris Dayson, International SP Conference, July 2019

www.socialprescribingnetwork.com/resources

From Professor Chris Dayson: Reflections on evidence base

- Evidence base better than we think! Consistent and universally positive messages: wellbeing and reduction of reliance on services
- SP gives time (link worker role is vital) **(relationships = vital)**
- SP gives hope to people for whom hope had been lost
- SP provides pathways to existing voluntary and community assets
- SP builds (new) and strengthens (existing) assets
- SP enables cross-sector multi-disciplinary working - bridging professional boundaries and implied hierarchies **(relationships = vital)**

NB 1 Only 50-60% of medical care is delivered in line with level 1 evidence

NB 2 Approximately 50% of patients do not take medications as prescribed

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3068890/>

Outcomes (under development)

- Volunteering
- Back into work
- Waist reduction, reduced risk of diabetes (**but** Snomed...)
- Better informed
- More activated patient (**but** PAM to be trialled for some)
- Happier? (ONS4 recommended by NHSE)

SP and 'Patient Activation'

- Predicts health outcomes better than ethnicity or age
- More activated more likely to attend, adopt positive behaviours (eg, diet and exercise) etc
- Less activated less likely to engage with treatment or understand advice
- Less-activated cost 8% more in baseline year, 21% more in subsequent year
- Least active tend to increase scores the most – effective interventions can engage even the most disengaged



Feedback from one client during Covid

'...When...needed to isolate, I wasn't feeling well with the COPD making me really breathless. My car wasn't working so I had to get two buses down to Sainsbury's to get my medication and to buy 12 weeks supply, only to find the place crammed with people and astonishingly empty shelves. I couldn't buy that much because of the weight of carrying the shopping back to the bus stops and my home. I went to four supermarkets over those few days between the announcement and the Sunday we had to isolate. So I really was exhausted, and though I've never done online shopping I tried to do it but made several mistakes and then couldn't do it.

Please, please, pass on my thanks to EVERYONE concerned. Its very important that you all know how their hard work and generosity is appreciated...'

RCGP Report: General Practice in the Post-Covid World

*'The social prescribing link worker role has really come into its own in the pandemic response. Social prescribers have often been at the heart of local support for vulnerable patients, connecting up shielded patients with NHS volunteers and signposting to other sources of social, practical and financial support. **This is a practical demonstration of the role that primary care can play in building community resilience and tackling health inequalities.'***

Bromley by Bow Centre

Rob Trimble, CEO:

*“The most profound insight from our experience over the last 35 years is that more medicine is far less effective at driving better health than having **more friends, a sense of purpose in your life and the feeling that you belong in a strong community**”*

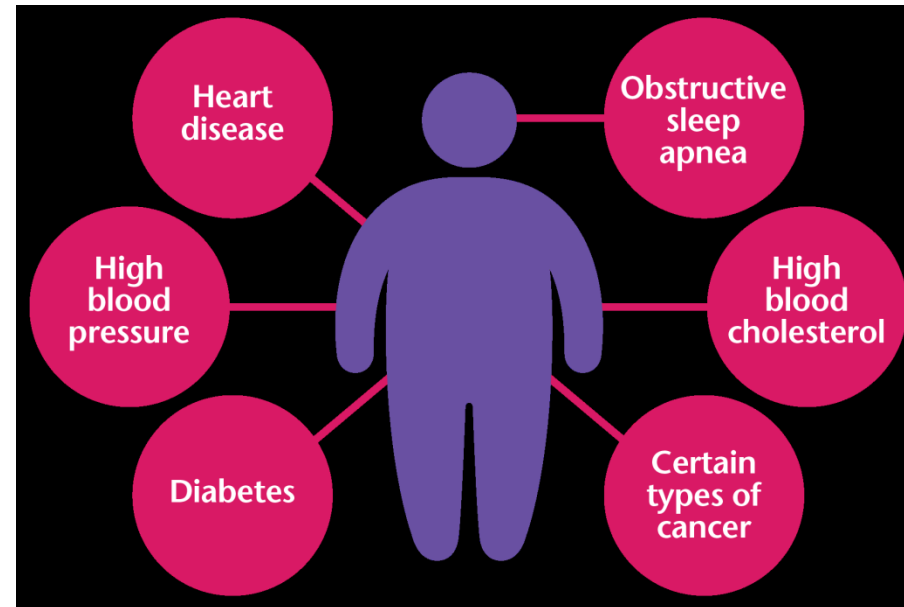


Obesogenic Culture?

Martin McShane, NHSE, 2015:

“These figures are a stark warning and reveal the increasing cost of diabetes to the NHS.

“We’ve said it before and we’ll say it again, it’s time to get serious about lifestyle change. Prevention is better than treatment for individual health as well as the health of the NHS.”





Empowering vs blaming patients

- Survey of 3,000 people with type 2 diabetes
- Loneliness, stigma, embarrassment, blame, guilt
- Feel they're seen as burden on NHS

'If you have type 2 people think it is your fault, that you haven't looked after yourself properly.'

'At Christmas or going out for a friend's birthday it isn't easy to cope with not being able to eat the same food, the same birthday cake as everyone else. So instead – you just don't go out.'

Is *this* what public services do?

'If you want to get somebody to do something, make it easy. If you want to get people to eat healthier foods, then put healthier foods in the cafeteria, and make them easier to find, and make them taste better. So in every meeting I say, "Make it easy."



*Richard Thaler, Economics,
Nobel Laureate 2017*

David – what happened?

- LW **took** him to CAB for benefits advice and *Step Change* to get debt restructured
- *Care 4 Freedom*, hoarding service – worked on psychological dependence on old stuff
- *Herts Healthy Homes* visit sorted emergency heater & finance re fuel poverty
- Linked to “Meal at Easter” (local CVS) and church coffee group for social life
- Greenaiders cleared his garden
- Community Hardship fund for repairs to heating and hot water system
- Heart operation now supported by improved living conditions for positive rehabilitation



Fred – what happened?



- Debt relief order
- Supported through benefits tribunal
- Backdated benefits of £7k
- Able to buy furniture
- Plugged back in to the community
- Better clinical outcomes

George – what happened?

Prevented (in GP's view):

- Admission because of rough sleeping
- Prison stays because of behaviour
- GP workload (carer continually asking for support)
- Anxiety and depression of carer
- Burden on mental health services (a lot of process in frequently declining referral)
- *'Sorry can't really quantify, but genuinely all sorts of positive stuff has/will come out of it, and mostly has filled a gap in this chap's care that no other element of the service (health/prison/police/social/mental health services) were able to do.'* **George's GP**



Jean – what happened?

Community Navigator persisted in making contact, gained her trust and worked on the what mattered to Jean.

‘Once threat of eviction removed...I felt a weight had lifted and I could now concentrate on me and on tackling the depression... I still feel that I have something to give and ultimately I want to get back into work and I would like to look at volunteering as a way of doing this...’



Jean could now make use of talking therapy

5. Daisy – what happened?

- Daisy calmed by culturally sensitive intervention - but got very distressed when condemned fridge forcibly removed (gift from deceased brother)



- Daisy removed by police for clearance process
- Daisy amazed when LW rang her next day
- LW built relationship and sourced identical fridge from charity
- Took Daisy shopping for African food (she refused standard food parcel)
- LW liaised with Housing Assoc and visited monthly x 6 to ensure Daisy not hoarding and was seeing relatives and friends
- Agreed Daisy didn't need visits but could always contact LW.



42 Ascend Community Learners during Covid made remotely made this:

They said they will never forget the time when they were in isolation lockdown but came together as a team to share their experiences. They did not feel on their own, they picked each other up and kept each other going, all experiencing highs and lows at different times. On our isolation journey we created these wonderful unique and personal artworks...documenting this unprecedented time [with] our **Self-Isolation Blanket.**”

Comments welcome

- This is a draft of a set of slides designed to form the evidence base/logic-model for the CCGs' (Herts) overarching approach to harnessing social prescribing to address health inequalities
- It is based on national and local evidence and experience but is not meant to be exhaustive
- The **National Academy for Social Prescribing** has a national brief to develop evaluation further
- Comments to tim.anfilogoff@nhs.net or 07900 161673

Social Prescribing & Health Inclusion

Stephen Windmill – Central Watford PCN Social Prescribing Link Worker

NHS England and NHS Improvement

2 March 2022





Social Prescribing and Health Inclusion at Meadowell Clinic, Watford Health Centre

Stephen Windmill

PCN Social Prescribing Link Worker, Central Watford PCN

stephen.windmill@nhs.net

NHS England and NHS Improvement



MEADOWELL CLINIC

(Part of Watford Health Centre)

- **PRE-COVID SERVICES INCLUDED:**
- Drop-in GP appointments
- Substance Nurse (by appointment)
- Psychotherapy (by appointment)
- Social Prescriber Link Worker drop-in clinics, 2x sessions per week, every week
- Mental Health Link Worker drop-in support, 1x session per week, every week
- Complex Needs Service (Turning Point) drop-in support, 1x session per week, every week
- Dentistry services, drop –in, 1 day per week, every week
- Chaplaincy listening service (1x weekly)

CONTINUING SERVICES DURING COVID INCLUDED:

- Telephone GP consultations with follow up Covid-secure face to face appointments as required
- Substance Support Worker, telephone and Covid-secure face to face (by appointment)
- Remote Psychotherapy (by appointment)
- Remote Social Prescriber Link Worker support on demand
- Social Prescriber Link Worker Covid-secure face to face support as required

POST-COVID SERVICES INCLUDE:

- Telephone GP consultations and face to face appointments as required
- Substance Support Worker, telephone and face to face appointments
- Psychotherapy telephone and face to face appointments
- Social Prescriber Link Worker face to face appointments and telephone support as required
- Nurse face to face appointments
- Development of sex worker monthly health clinics, to include a social prescribing element

Meadowell Clinic Social Prescriber service includes:
direct 'hands-on' support, onward referrals and signposting.
Summary of the main key patient issues:

- Benefits
- Housing
- Liaison with housing providers
- Liaison with local authority
- Move-on from temporary housing
- Mental health (community-based support services and HPFT services)
- Emotional support and reassurance
- Managing finances and debts
- ASB
- Immigration/EU Settled Status issues
- Employment/ training/ education support

WATFORD BOROUGH COUNCIL HOMELESSNESS SUPPORT:

- March 2020 onwards: 'Everyone In' accommodation provided in town centre hotels
- July 2020 onwards: Medium Need accommodation created in Watford YMCA: a floor of the building was repurposed to provide 22x rooms, with on-site support workers available
- Further Medium Need accommodation to be created in Watford YMCA to provide an additional approx. 22x rooms, with on-site support workers available, following additional funding obtained from central government
- 11x studio accommodation units to be created at Watford YMCA, following additional funding obtained from central government
- Funding obtained from central government for Housing First projects, with support for 10x service users per cohort
- Homelessness Taskforce MDT meetings to discuss specific cases and to coordinate support for individuals, hosted by Watford Borough Council. Currently meeting remotely, fortnightly
- Watford Borough Council Single Pathway for Rough Sleepers, established in late 2021

OTHER KEY LOCAL HOMELESSNESS SUPPORT SERVICES:

- **New Hope:**
- Provision of The Haven day centre in central Watford, providing hot breakfasts, clothing, washing facilities, housing support, information and advice
- Provision of night shelter facilities and move-on properties and community homes. Tenancy support service
- Street outreach support service
- **CGL Spectrum:** Drug and alcohol services, including scripts, peer support and other support
- **YMCA:** Temporary accommodation and support services at temporary accommodation, host of Housing First support workers
- **Emerging Futures:** Accommodation and floating support
- **MIND:** Community support: mental health and floating support (including housing support)
- **Herts Young Homeless:** Homelessness and mental health support for under 24 year olds
- **GROW:** Accommodation and support services

POST-COVID FUTURE: SOCIAL IMPACTS ON HOMELESSNESS, HEALTH INCLUSION AND MENTAL HEALTH

- Rent arrears / Section 8 evictions
- Cost of living crisis
- Debt/finances and utilities arrears
- Increase in Section 21 evictions
- Benefits issues/restrictions/cuts
- More punitive benefits environment
- Increase in mental health issues
- Increase in substance issues
- Scarcity of MH support services
- Scarcity of social care support
- Lack of social/affordable housing
- Lack of access to affordable private sector housing (level of Local Housing Allowance and refusal of PRS landlords to let to benefits claimants)

Feedback from the addiction psychotherapist at Meadowell Clinic:

“Every patient I see has shared wonderful stories about the Social Prescriber, about how hard he works and how much time, effort and care he lavishes on each patient. Please know that through his efforts countless possible suicides have been prevented as he makes sure patients have enough money for food and rent.

The Social Prescriber is an unsung hero who quietly and professionally does his job very well and has moved us all deeply at Meadowell for his heart warming and dedicated service to the homeless people of Watford.”

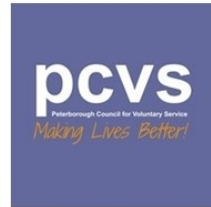
Thriving Communities – Wonder Women

NHS England and NHS Improvement

2 March 2022



Thriving Communities



Wonder Women

With thanks to partners:



Metal



PECT
CREATING SUSTAINABLE PLACES

Supported by the Thriving Communities Fund, made possible thanks to



ARTS COUNCIL
ENGLAND



Historic England



Money &
Pensions
Service



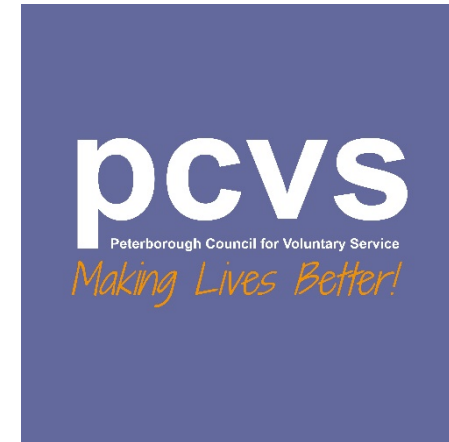
NHS CHARITIES
TOGETHER



SPORT
ENGLAND

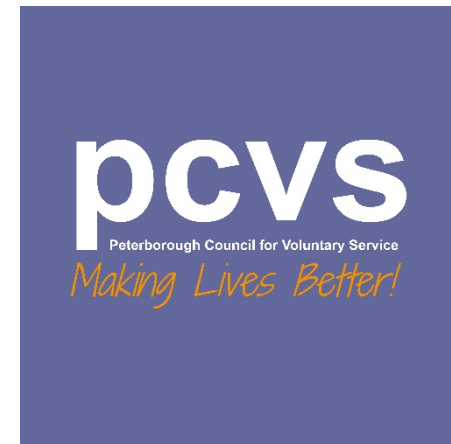


Addressing Health Inequalities through social prescribing



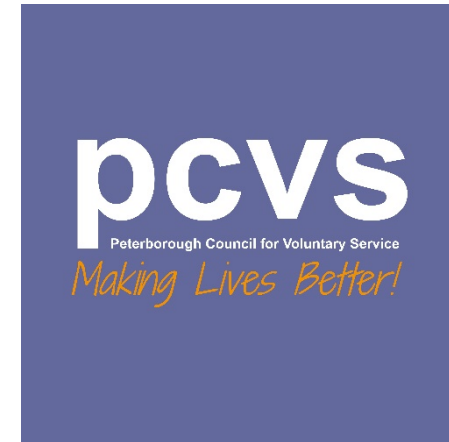
- Pre Covid, PCVS set up Forums in response to local gaps and needs
- Women's Forum
- Focus on DA then positive activities for women – confidence and self esteem
- Overall ambition re: Women's Centre

Thriving Communities



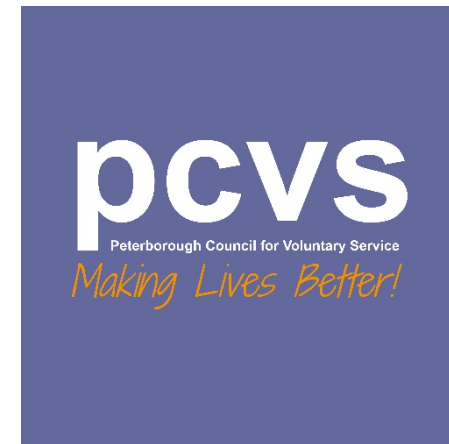
- Women's mental health wellbeing
- Confidence and self esteem
- Driven by what women want
- Focuses on 3 areas – Central, New England and Paston – identified by women attending
- Arts, Environment and Sports activities

Delivery



- Created safe spaces for women
- Appropriate venues chosen
- Identified needs for different communities and faiths

Snow's thoughts



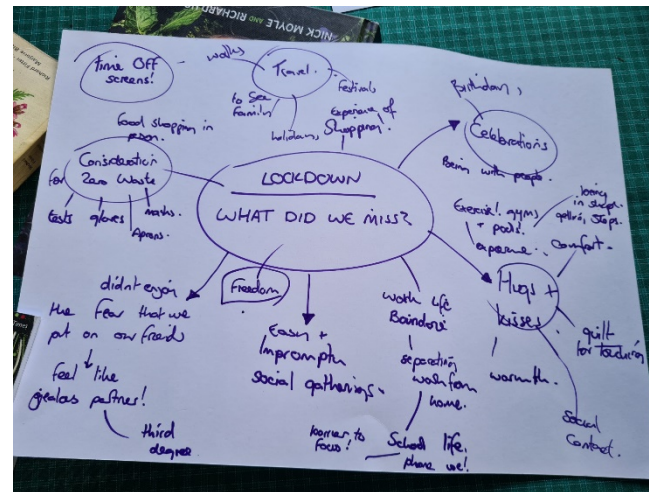
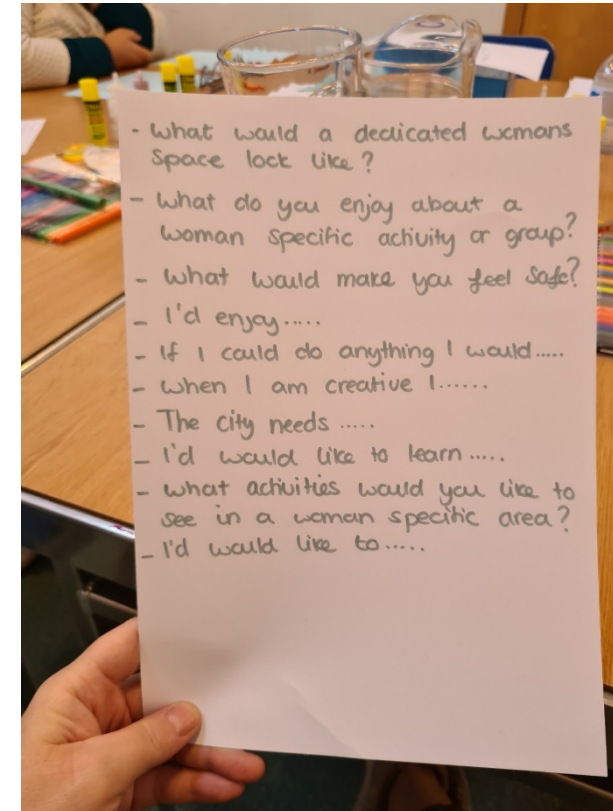
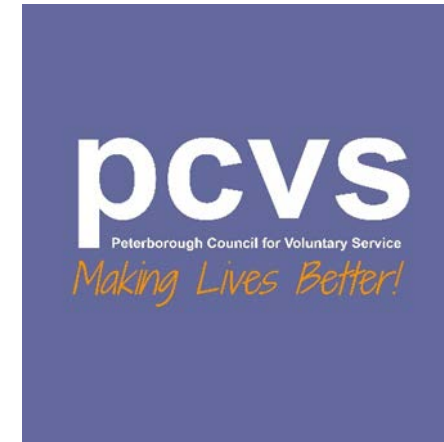
- A volunteer seeking to help each person, asking for help, joining the PCVS team to be able to do more.
- Listening and focusing on the feelings and wishes of the ladies attending the sessions.
- Adapting to the wishes of the ladies.
- Building the long lasting relationships with them.
- Helping in other ways of their day-to-day life.

The Workshops: DIFFERENCES COMING TOGETHER

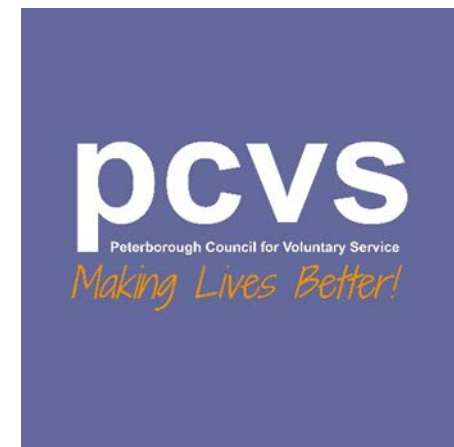
pcvs
Peterborough Council for Voluntary Service
Making Lives Better!



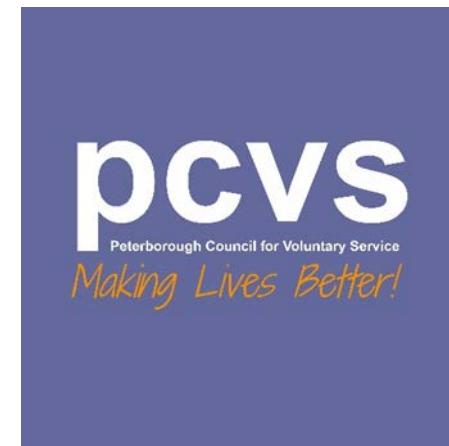
The Workshops: EXPRESSING OUR THOUGHTS AND WISHES



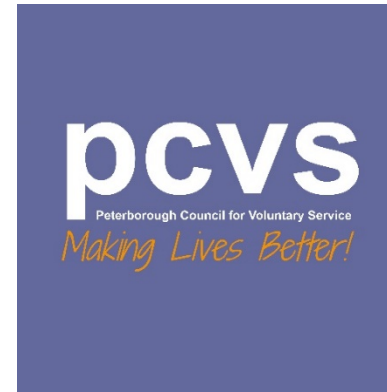
The Workshops: LEARNING NEW THINGS



The Workshops: COMMUNICATING AND MAKING FRIENDS

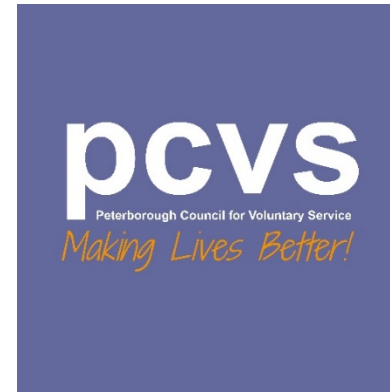


Thriving Communities



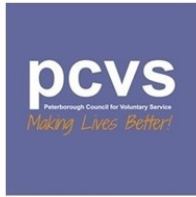
- Essential to have this funding to deliver activities tackling health inequalities
- Accessibility – activity costs
- Sustainability of community services
- Voluntary sector isn't free
- A little funding goes a long way
- Activities will stop as ongoing funding not identified

What next?



- Seek funding to run further women's activities/
Women's Centre
- Keep connection through Women's Forum
- Keep speaking out about SP and voluntary sector linkages –
build on what we have
- Women's activities from diverse groups

- **Christina Alexander – Communities Manager, PCVS**
christina.alexander@pcvs.co.uk
- **Snow Maliavskaja – Project Coordinator**
snow.maliavskaja@pcvs.co.uk



Wonder Women

With thanks to partners:



Supported by the Thriving Communities Fund, made possible thanks to



Historic England



Money & Pensions Service



NHS CHARITIES TOGETHER



SPORT ENGLAND