The Friends of The Chalfonts and Gerrards Cross Community Hospital

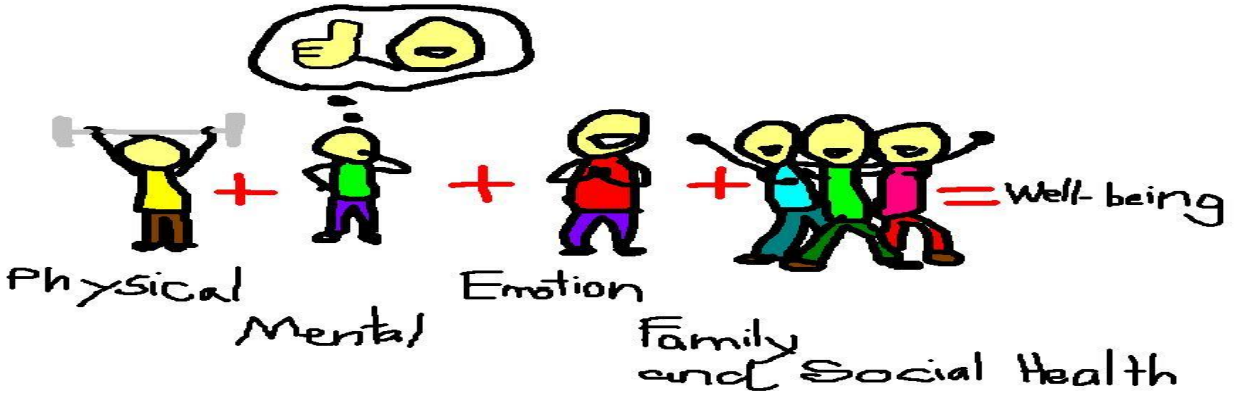
An Introduction to Community Health and Wellbeing, Hubs Integrated Neighbourhood Teams and Social Prescribing

This presentation provides a background to help us consider together with our Primary Care Networks, Buckinghamshire NHS Healthcare Trust, Buckinghamshire County Council and our Community Organisations how we might develop as a Community Hub for Health and Wellbeing

Introduction

- This presentation asks:
  - What does health and wellbeing mean for the communities we serve.
  - How can a community hub for wellbeing support community health
  - How can Integrated Neighbourhood Teams (INTs) and Social Prescribing be developed.
- It is hoped that this will provide a common starting point for some exchange of ideas and experience in developing a local approach to a Community Hub for Health and Wellbeing, INTs and Social Prescribing.
- This presentation provides links to many resources for training in specific areas, these include the recently formed Academy for Social Prescribing here
- The focus is on community action rather than clinical or social services which are determined by the NHS Trusts, CCG and Local Authorities.

What is Health and Wellbeing?



- Health is defined in the World Health Organisation constitution as:
  - A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity.
- There is no internationally agreed definition of wellbeing but:
  - *Physical, mental, emotional and community wellbeing gives every individual the **capability** to manage health conditions and risks, cope with normal stresses of life, find purpose and happiness, work productively and fruitfully, make a contribution to and draw support from family, community and their home and natural environment*.
- Take a moment to think how you would define health and wellbeing for yourself and the people you serve?

Capability Theory

- Developed by Amartya Sen, Martha Nussbaum and others from 1979
- Underlies UK Wellbeing Measures and WHO wellbeing policy
- Stresses freedom to pursue wellbeing as seen by individuals and groups
- E.g. provide resources – bikes
- Giving freedom - capability to travel
- To enable agency – taking part in community
- Support functioning – social community activity
- Enhancing utility – wellbeing
- And equity of outcomes
- Matched to individual needs and preferences

- Capability theory also applies to communities, it shows the need for local **Co-production** not top down one size fits all solutions : for the NHS guide to engaging individuals and communities in planning care services see here

Personalised Care Planning

- Capability theory underlines the need to engage patients in addressing their individual needs and preferences by:
  - **Personalised Care Planning** see here
- This means giving them the same choice and control over their mental and physical health and wellbeing that they have come to expect in every other aspect of their life.
- This is a renewed relationship between health and care professionals those they care for and their community
- It also requires integrated health and social care provision.

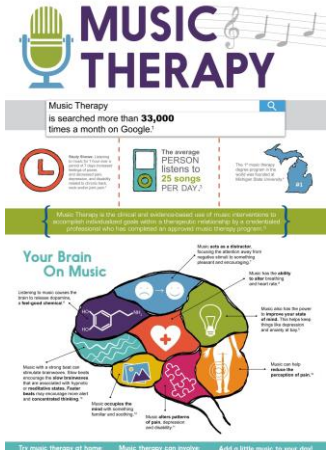
Integrated Health and Social Care for Wellbeing

- Integrated care creates social value, health and wellbeing see here
  - A whole person-centred care service from one team.
- This goes further than LA/NHS cooperation
  - It requires community engagement in co-production of: advice, social support self-care, activity and neighbourhood schemes
  - Thoughtful redesign of: housing, advice and support services, community spaces, transport, access to high street and shops and much more.
  - And recognition of arts and cultural elements of health and wellbeing
- It can also save time and money, better spent for the patient/client
- See Local Government Association resources here And NHS resources here

What Enables Health and Wellbeing?

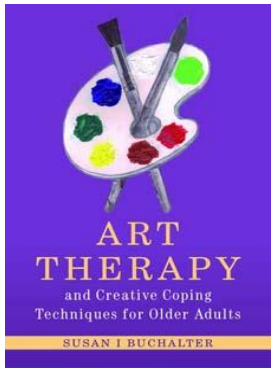
- Things that support health and wellbeing may include:
  - Family and social support, health and social services, community engagement, education, housing, environment, employment, physical and financial security, music, sport, art and culture.
- These are personal and social judgements about what we value
  - It is important to think through goals with individuals and communities to assess the wider health, wellbeing, social and cultural factors that are valued, see examples of reports by Croydon LA here and Liverpool CCG here
- Community is a mainstay of wellbeing: most often defined in terms of location.
  - But people are also members of communities of: faith, ethnicity, interest, political affiliation, hobbies and many other factors. A balanced approach to community development must recognise, different affiliations within a multi cultural community.

- Discussion what will improve health and wellbeing in our community?



Arts, Sports the Environment and Wellbeing

- The arts, sports, social and physical environment which bring people together as communities, are crucial to wellbeing.
- Engagement in these fields is important to the health of people who don't just need to return home but need to return to active life .
- Initiatives in these fields support health and wellbeing as an element of community social values, e.g.:
  - National Alliance for Arts, Health and Wellbeing here
  - Sport England Research on Psychological Health and Wellbeing here
  - NHS England Healthy New Towns Initiative here
  - Recent research on the health impact of the arts and culture by Daisy Fancourt at UCL shows a wide range of benefits here



Measuring Wellbeing At National and Local Levels

- The Office of National Statistics measure their interpretation of wellbeing using 4 questions from the Annual Population Survey (APS) - sample size 320,000.
- You can find the 2019 -2021 National result and by Local Authority Area here
  - This shows a sharp decline in wellbeing due to Covid
- Review the scores for your area of the country using this resource.

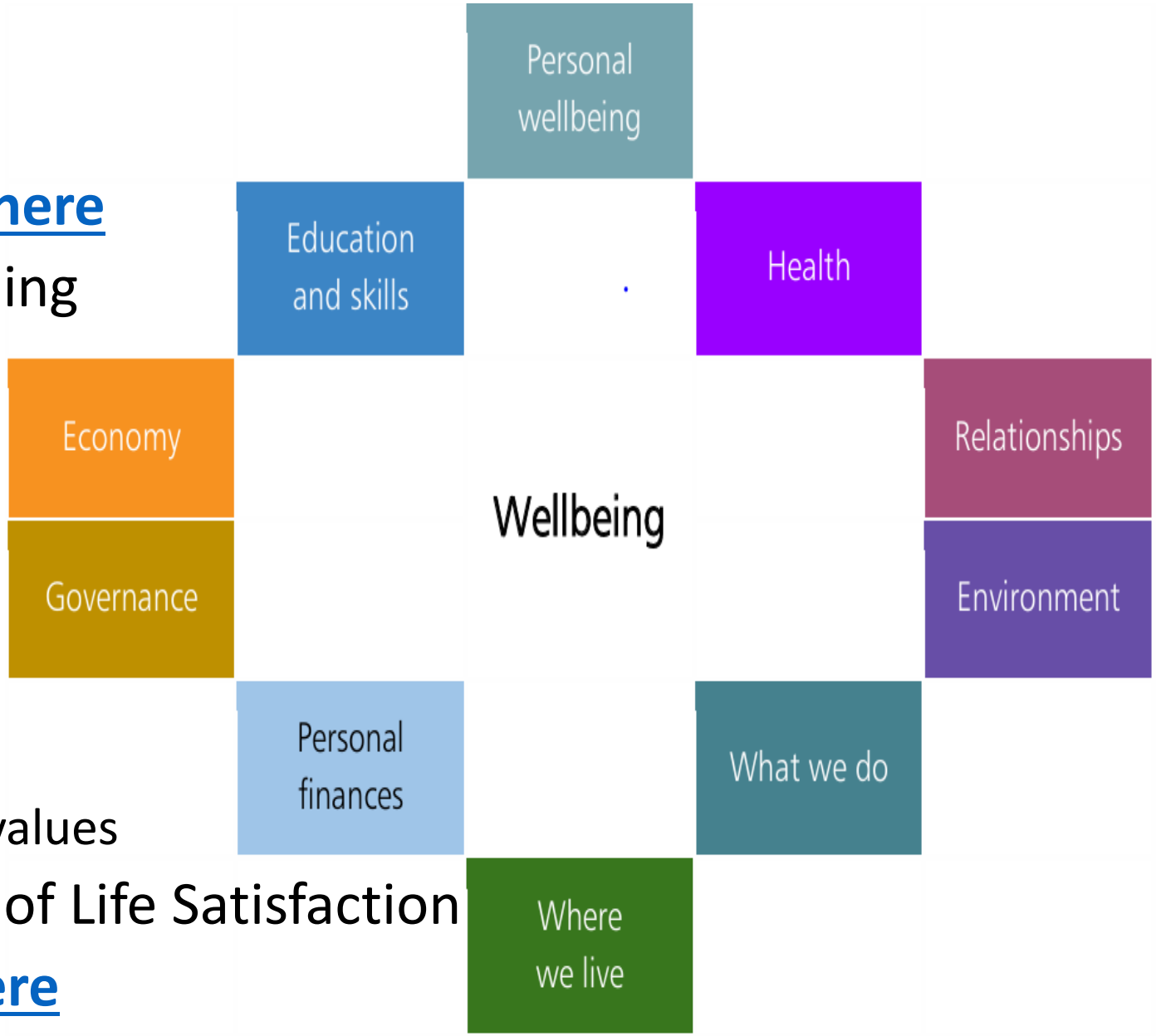
Personal well-being is assessed through 4 measures, often referred to as the ONS4:

Next I would like to ask you 4 questions about your feelings on aspects of your life. There are no right or wrong answers. For each of these questions I'd like you to give an answer on a scale of nought to 10, where nought is 'not at all' and 10 is 'completely'.

Measure	Question
Life Satisfaction	Overall, how satisfied are you with your life nowadays?
Worthwhile	Overall, to what extent do you feel that the things you do in your life are worthwhile?
Happiness	Overall, how happy did you feel yesterday?
Anxiety	On a scale where nought is 'not at all anxious' and 10 is 'completely anxious', overall, how anxious did you feel yesterday?

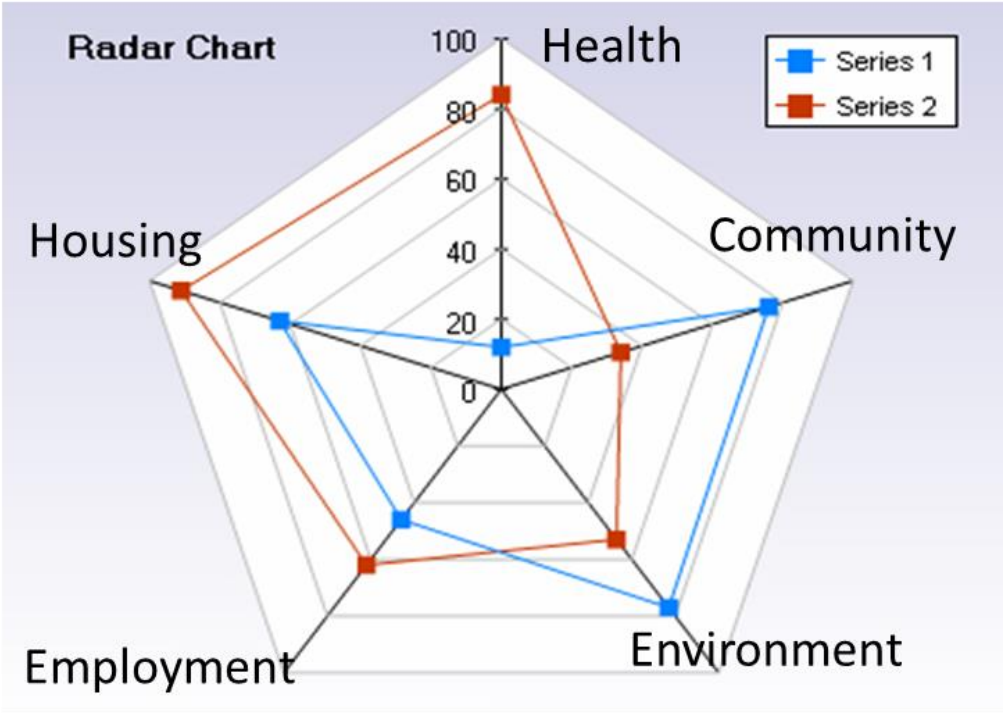
Measures of Wellbeing

- The UK Treasury Guidance of 2022 **here**
- Suggests 10 determinants of wellbeing
- Can be measured as WELLBYs
  - A Wellby is a wellbeing adjusted year
  - it equates to a one-point
  - change in life satisfaction
  - on a 0-10 scale, per person per year.
- The Treasury Guidance suggest
  - A Wellby has been valued at £13,000
  - In Social Cost/Benefit terms at 2019 values
- There are many different measures of Life Satisfaction
- See “What Works for Wellbeing” **here**



Approaches to Community Health and Wellbeing

- A “Radar Chart” provides a way of comparing strategies for addressing a range of factors affecting health and wellbeing for a community
- This does not imply a trade off between different aspects of wellbeing but provides a visual metaphor
- What would our Radar Chart look like?
- A guide to measuring wellbeing agreed by the What Works Centre for Wellbeing can be found here

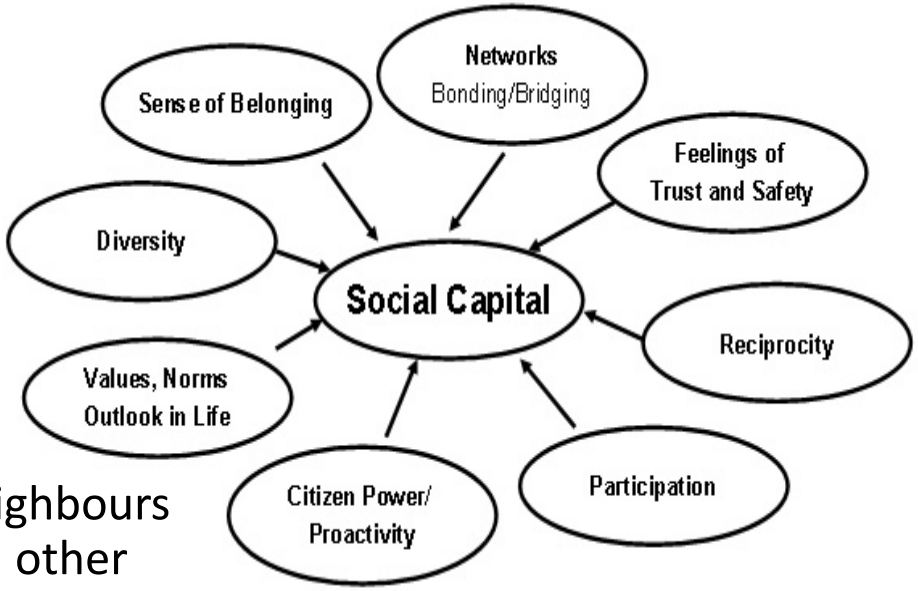


- What would you suggest are the key determinants of health and wellbeing for our community?

What is Social Capital: Does it support Health and Wellbeing?

- Social capital is the framework of values and norms that fosters trust and cooperation in personal relationships, social networks, and with civil organisations and leaders see here – it is part of what defines who we are.
- Social capital is essential to health, wellbeing and equity
  - Most care (70%) is provided by family and community resources
  - Most behaviour is determined by community norms (what people like us do)
  - Advice may change health behaviour but social support is what sustains it
  - Equity (respecting individuals needs) requires community trust and engagement
  - Low social capital results in greater loneliness, poor health and wellbeing
- For an example of a project to develop social capital (integration) for new migrant women see here for Age UK guidelines on loneliness see here.
- For the NHS Confederation initiative on social capital (value) see here

Measures of Social Capital



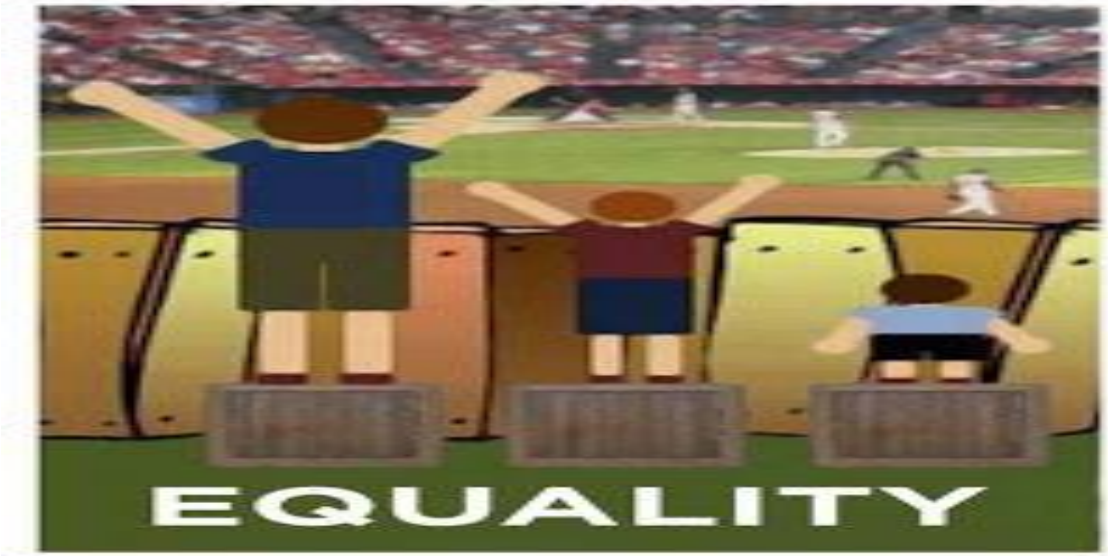
- Social capital was measured by ONS in 2019
- Based on 5 questions in APS asking degree to which people:
  - feel that people in their neighbourhood can be trusted
  - feel that people around where they live are willing to help their neighbours
  - feel that people in their neighbourhood do not get along with each other
  - feel like they belong to their neighbourhood
  - feel safe walking alone in their local area after dark

- The findings summarised here include
  - Most people felt positively about their neighbourhood. trusted others and felt a sense of belonging to their neighbourhood, people felt others were willing to help their neighbours and felt safe walking alone in their local area after dark. However social capital seems to be declining as trust in others decreases and trust in social media increases.
  - Those with higher levels of social capital tended to live in rural areas, have better environmental conditions, were retired, identified their ethnicity as “White” or “Asian” and were from higher income socio-economic groups.

  - Review trends shown by these measures and relate to your personal experience.

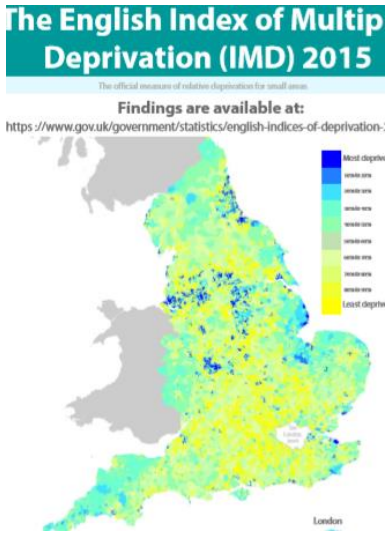
Why is Improving Equity in Health and Wellbeing Important?

- Reducing inequity in health and wellbeing is a target for LAs and NHS. But progress has been slow, health and lifestyle support groups and services are taken up most actively by higher income groups, and lower income groups are more likely to smoke, eat junk food and take drugs, alcohol consumption increases with income but people with low incomes are more likely to die of alcohol related causes.
- With the result that people living in the poorest neighbourhoods will on average die 7 years earlier than people living in the richest neighbourhoods.
- See the 2010 White Paper Equity and Excellence: Liberating the NHS here



Measuring Impact on Equity

- Equity impact can be measured as % of patient/clients from most disadvantaged local areas (LSOAs)* as shown by the Index of Multiple Deprivation (IMD) see here
- IMD measures a combination of:
  - Income Deprivation
  - Employment Deprivation
  - Education, Skills and Training Deprivation
  - Health Deprivation and Disability
  - Crime
  - Barriers to Housing and Services
  - Living Environment Deprivation



- The IMD is useful for urban areas but is less useful in rural areas, an index of rural deprivation is also available see here. But objections have been raised because such measures seem to assume that communities are deficient in some ways. It is stressed that each community has its own values which should be recognised by coproduction of wellbeing see the report "Hard to Reach or Easy to Ignore" here.
- The needs and aspirations of other disadvantaged groups such as: isolated individuals, some ethnic minorities, travellers, people with disabilities and LGBTQ people may be more relevant to addressing equity in our communities than measures based on locality.

*Lower Super Output Areas (small areas with populations of 1,000 – 1,500 people)

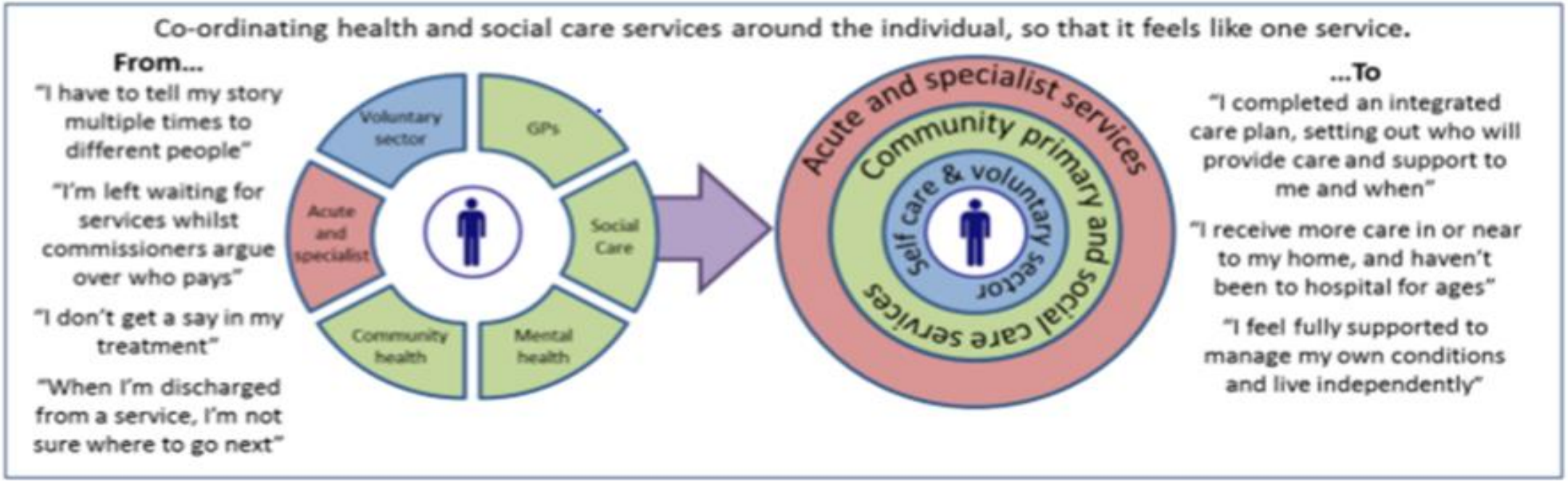
Developing a Community Health and Wellbeing Hub

Your community Your care
Developing Buckinghamshire together

- The NHS Long Term Plan see here was developed through a process of consultation and learning from local "Vanguard Projects".
- These included the Buckinghamshire, Oxfordshire and West Berkshire (BOB) strategy for Integrated Care, which envisages Community Hubs for Health and Wellbeing providing personal care closer to home for 125-150,000 people and local integrated health and social care teams serving 30-50,000 people here.
- The Marlow and Thame Hubs show how "hospital at home" and "day hospital" provision can be delivered including: Community Assessment and Treatment Services, Rapid Response Intermediate Care and Community, Mental Health and Social Care Coordination see the evaluation report here.
- In areas serving 30-50,00 people integrated teams offer health and social care support with Primary Care Networks providing INTs and Social Prescribing see here.
- Early consultation on these plans encouraged the Friends of Chalfonts and Gerrards Cross Community Hospital to consider how community action could support a Community Hub, INTs and Social Prescribing for our communities
  - Our hospital is at the centre of the border of South Bucks and Chiltern (pop 160,000)
  - Local Primary Care Networks (Chalfonts serves 31,000, South Bucks serves 50,000 patients)

A Community Hub for Health and Wellbeing

- Providing "Hospital at Home" and "Day Hospital" services closer to people's home
  - Serving populations of 125-150,000 people (e.g. South Bucks and Chiltern Districts)
- Community Wellbeing Hub for physical and mental health and community support
- Integrated Neighbourhood Teams: and Social Prescribing
  - Serving communities of 30-50,000 people (e. g. catchment of our local PCNs)
- See The Integration and Better Care Fund Policy Framework 2017 to 2019 here



Potential for Community Action

- The Joint Strategic Needs Assessment (JSNA) is produced by Local Authorities and Clinical Commissioning Groups working through a joint Health and Wellbeing Board to assess current and future health, care and wellbeing needs of the local community. It is also a starting point for considering the need for community action for health and wellbeing.
- For Buckinghamshire the JSNA analysis for each area can be found here
- A “Life Course” approach - thinking through needs and resources at each stage of life is helped by the NHS Choices web site here showing the location of current support groups and services.
- For the catchment area of our community hospital and Primary Care Networks serving Gerrards Cross and the Chalfonts and South Bucks an analysis showed key gaps in current community support groups here
- To illustrate the cost effectiveness of community action a further review of evidence showed the likely beneficial impacts on demand and costs here

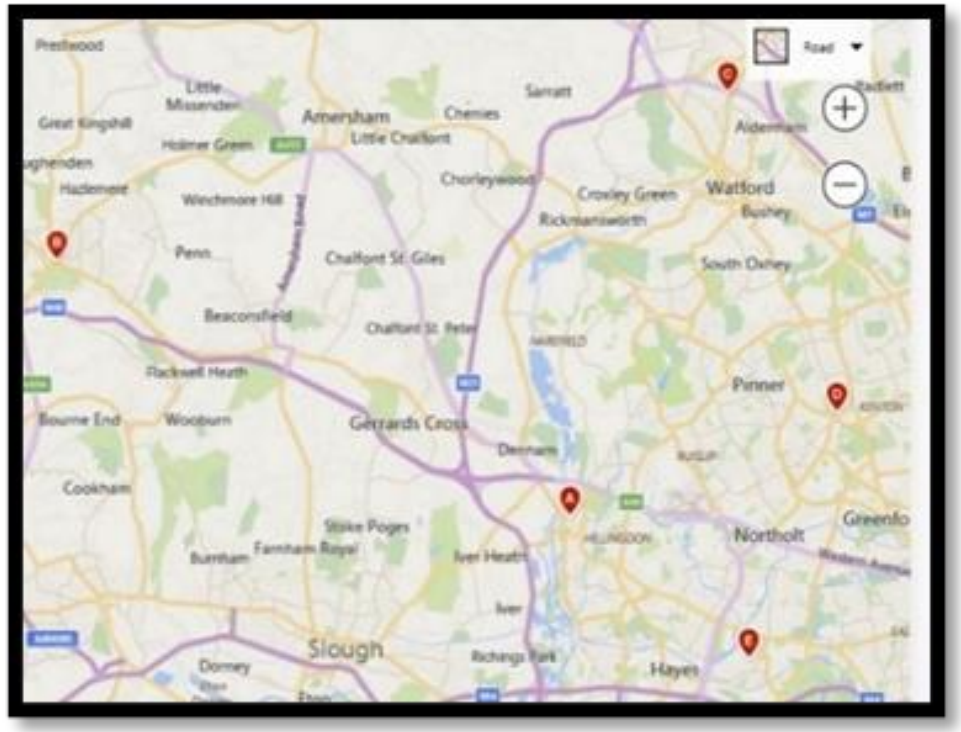
Buckinghamshire Community Wellbeing Hubs

- Buckinghamshire Health and Social Care Academy supports the development of Community Wellbeing Hubs across the county
- BHSCA is partnered by NHS England, Buckinghamshire Healthcare Trust, Berkshire University, Buckinghamshire New University, Buckinghamshire County Council, Fed Bucks and Buckinghamshire College Group.
- It creates places for physical and mental health and social care professionals, Voluntary, Community and Social Enterprise (VCSE) providers to collaborate and co-locate services to improve health and wellbeing and share lessons learnt .
- BHSCA has co-designed and delivered Community Wellbeing hubs in Aylesbury and High Wycombe to benefit the learner and local citizens.
- It has recently been acclaimed as the 'Health Creating Community Space of the Year' by The Health Creation Alliance.
- BHSCA will now open a Community Wellbeing Hub at our hospital in partnership with BHT, BCC, local primary healthcare providers and the Friends

The Community Hub as a focal point for Coordination and Communication

- NHS primary care has undergone major changes in recent years
- We must now use the NHS App, expect a range of health professionals to call us for phone consultations, and use local pharmacies for minor illness.
- We could also look after our own health and wellbeing better with the help of the many community groups and voluntary organisations available
- If only we had better knowledge of local services and community support
- And they knew and understood our needs and were better coordinated
- We hope our Community Wellbeing Hub can help address these issues
- As a meeting point for health and care staff and community providers

We are varied communities of villages and small towns



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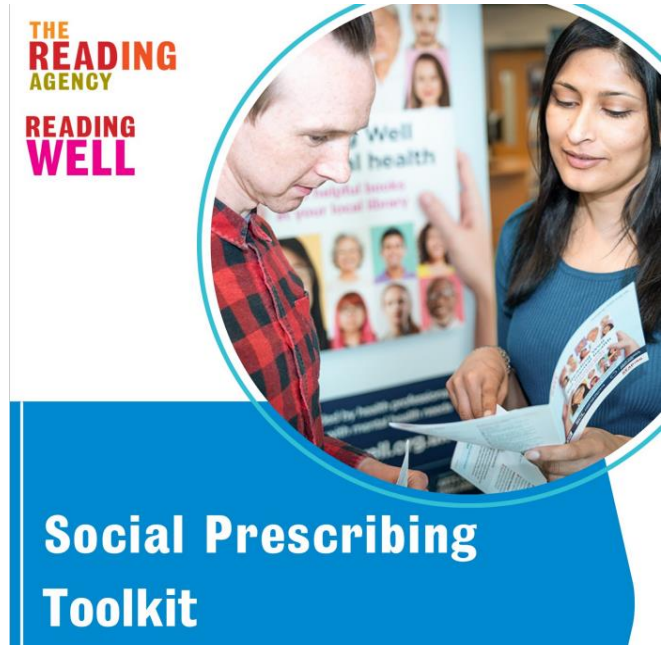
- The role of a Community Hub is not confined to one space
- It must serve communities defined by common interests as well as location.
- It must partner with groups based in different locations or in their homes
- The Hub can bring teamwork and cooperation to serve all
- And will work with existing community facilities and local groups
- Of which there are a great many across the Chalfonts and South Bucks

Navigating the Health Web and IT: A Digital Health and Wellbeing Centre

- National and County plans for integrated care also stress the growing need to enable people to use digital services
  - To monitor and manage health and care including personal alarms, fall sensors, devices for people prone to wandering and health monitors that can communicate with GP and other health services, see the Bucks CC website here
  - To use mobile phone “apps” see the NHS Health Apps Library here
  - To find websites and resources relevant to particular conditions, see for example the MIND A-Z of resources for Mental Health here and our list of resources on this page
  - In future “hospital at home” services will use monitoring and communication devices to support patients, it is vital to help people use such IT see here
- Our Community Wellbeing Hub could help provide a human face to technology by guiding people in the use of digital services or helping them find support.
- In our community it would be helpful to provide an eHealth centre, with computers and equipment for patients and perhaps staff (see RCN page here)

The Community Hub as a focus for Working with Community Groups, Libraries and local businesses



- There are some 200 local organisations and groups many of which have already shown interest in befriending.
- During the Covid Pandemic volunteers at libraries in Gerrards Cross, Chalfont St Peter, Chalfont St Giles and Farnham have helped provide tests and information. They could also be encouraged to use the toolkit available here at to join a local network for community health and wellbeing. They could also provide access to ehealth resources.
- The Hub could also engage local businesses for example providing better information on the services provided by pharmacies and promoting healthy eating aisles in supermarkets and lower sugar options in coffee shops.

Introducing INTs and Social Prescribing

- Social Prescribing and INTs may be called upon to perform many different roles
  - Dealing with multi-morbidity, mental confusion, older patients and sometimes youth health, working with communities and social care services
- Experience suggests it is essential to agree priorities
- Possible steps in Chalfonts and Gerrards Cross based on University of Westminster guide “Making Sense of Social Prescribing” here

1. Establish leadership – steering group and operational lead
2. Engage local organisations - to share an understanding of SP
3. Agree objectives and priorities - roles, processes and location
4. Set up evaluation - describe, measure and value costs and outcomes
5. Recruit and train the team – and first link worker (s) – learn from others
6. Year 1 tasks – community contacts/self referral /signposts/priority cases
7. Develop community befriending – review and improve your SP system

Integrated Neighbourhood Team Support for People who are Frail

- Frailty refers to a person's mental and physical resilience, or their ability to bounce back and recover from events like illness and injury for example from chronic diseases or falls see here. It may be due to complex physical or mental health issues.
- Around 7-10% of people aged over 65 live with frailty. This rises to between 25% and a 50% for those aged over 85 see here.
- Frail patients use GP and hospital services at 5 times the average rate and account for more than 1/3rd of GP appointments. But Frailty can also lead to social isolation avoiding contact with services or community groups.
- Such patients may be said to find it difficult to "cope" with their condition and service providers may also find it difficult to cope, that is to meet their needs.
- A Frailty Support INT Team as proposed by the Chalfonts and South Bucks PCNs can be of great value in addressing their health and care needs to ensure they receive integrated care and community support reflecting their whole person needs.

Lead Contacts for those with Frailty

- Frailty often results from a combination of factors and may require a team approach to address a range of health and social issues and needs
- An essential starting point is always a constructive conversation with the patient and family or carers to listen to their needs as they see them.
- A lead contact is required who can can develop a relationship with the client/ patient and who also has a good understanding of the roles and resources of other Integrated Neighbourhood Team members. In complex cases this may be a care coordinator but in most cases, it will be member of the team with close contact
- A Lead Contact is not necessarily the senior member of the team, it is the person with the closest relationship with the patient/client.
- The leader of the Frailty team working with the client/patient and making decisions about the use of time and resources may be a GP or Geriatrician

Social Prescribing for Health and Social Care

- The success of the NHS means that more patients/clients are older, many with complex mix of physical and mental health and social care needs.
- This and the financial and staffing difficulties of health and care services puts an increasing strain on LA/NHS staff and the people they care for.
- Social Prescribing is part of a transformation towards whole person care
  - Developing partnership with community groups to co-produce health see here
  - Communication to raise awareness of health issues and resources e.g. see here
  - Helping patient discharged from hospital and/or with complex needs see here
  - Supporting patient choice, e.g. for Personal Care Budgets see here
  - In the longer term operating within an Accountable Care Budget see here

Towards Social Prescribing

- Social Prescribing helps people find the community support needed to manage mental, physical and social health.
- It can take many forms including:
  - Self referral - online or with leaflets maybe prompted by Making Every Contact Count
  - Maybe just recommending books from the Library see the Reading Well scheme here
  - Simple signposting by a member of the team or community support group see here
  - Referral to a Link Worker from a GP, Discharge Interview, AHP or Nurse Appointment
  - Link Worker holds an open conversation to understand their needs and preferences
  - The client (not patient) may be introduced to a group by a community befriender
  - In some cases the client may need support by a Link Worker or a social case worker
  - In other cases (e.g. bereavement) they may need help to find their motive (joy in life)
  - Sometimes support from health trainers may be appropriate
- See “Driving forward social prescribing: A framework for Allied Health Professionals” here

Hints for Social Prescribing

- From the University of Westminster International Conference on Social Prescribing:
  - The team need a shared understanding of the people to be helped and process for SP
  - Evaluation is part of the process, following up signposts, service use and outcomes see here
  - A written Social Prescription form helps reassure and engage the client
  - In year 1 referral to Link Workers was from GPs only but this might be extended in future
  - It is important to involve and consult local organisations and support groups
  - The list of support groups and their capacity will change and must be managed
  - Such groups need support and resources from Local Authorities and others
  - A non clinical setting (e.g. a community café) is a better site for Social Prescribing
  - A Social Prescriber can also be proactive in developing community support groups see here
  - Training is required for the team as well as the individual Link Workers see here
  - Open questioning, listening skills and empathy are essential for Link Workers see here
  - It helps to share experience particularly in helping people with mental and physical problems sometimes compounded by low motivation see here

Teamwork for INTs and Social Prescribing

- INTs and Social Prescribing require a culture change focussed on self-care and healthy behaviour.
- It requires team work with NHS, LAs and volunteers:
  - GPs who may refer people to INTs, Link Workers or Community support groups
  - Lead contacts or link workers who may meet the client 3-6 times
  - Signposting from Making Every Contact Count to Social Prescribing
  - A Care Coordinator may help people link with Befrienders in Community Groups
  - Signposting by Hospital Discharge Teams, Nurses and Allied Health Professionals
  - The Social Care Reablement Team, see here may also play an important role
  - And in some cases Health Trainer Service support may be appropriate
- The team includes physical and mental health and social care professionals, community groups and organisations at village, county and national levels. It is vital to coordinate their roles as a team.

Active Signposting for INTs and Social Prescribing

- Active signposting is much more than simply providing:
  - A reading list, leaflet, web site, address, email or other details
- Depending on the client's needs it will involve,
  - Helping the client choose the support they need
  - Contacting the provider and setting up a meeting or appointment
  - Arranging for a support service or "befriender" to accompany the client
  - Following up to check on the clients response to the service or support group
- This approach needs to be understood and shared by the PCN team
  - Including GPs, Community Nurses, Receptionists and other staff
  - The Integrated Health and Social Care Team and Hospital Discharge teams
  - The Community Groups working with the PCN
- Training for primary care groups can be found here and funding for this type of training from NHS England is referenced here

Sharing Knowledge and Understanding in INTs and Social Prescribing

- JOY is an online Social Prescribing system to connect health and care providers with local service and Community Support Groups see here
- It can also be used by local INTs to refer patient/clients to other professionals and refer or signpost them to Community Support Groups
- It requires information about each local service provider and relevant community groups and can share information about patient client needs
- It is essential service providers should not only share the roles of team members, they also need to know and understand one another
- And while some can be “signposted” to Community Support in many cases a more personal understanding and introduction is needed
- Use of JOY by our INTs and Social Prescribers also needs Team Work

Listening Skills for INTs and Social Prescribing

- The art of INT working and Social Prescribing requires skills in questioning and active listening, a constructive conversation with clear purpose to help clients find their answers:
  - It should build rapport, trust and understanding in a confidential exchange
  - And must establish the appropriate level, timing and rhythm of the exchange
  - Open questions allow the client to explore their issues at their own pace
  - The Link Worker can then help the client find their life plan with practical options
- While some clients will require limited signposting and support
- Others will require more time to reflect and gain confidence
- Social Prescribing is neither Social Work nor Psychotherapy
  - But lessons can be learnt from these professions see videos here and here
  - Better still talk to Social Prescribers to share experience see the video here
  - And run your own Samaritan's course on listening skills here

Common Issues: 1 Weight/Diet/Activity

- Being overweight is the most obvious and common health issue
  - It affects nearly 2/3^{rds} of adults and causes over £6 bn NHS cost and £27bn social costs
  - Open questioning shows people are often embarrassed by their weight
  - Being overweight can make it harder to take up diet and exercise regimes
  - Which are often promoted by images of slim young people
- Signposting should show that diet and activity groups are for people like us
- Obesity is a complex personal issue and certainly not a simple process of just signing up to a diet or fitness class

- A Link Worker may need to help clients find their own path to healthier weight
- And the self-assurance needed to set out on their path.
  - The NHS Weight Loss Plan can be found here local groups that help people find activities that suit them and local commercial weight loss groups are listed in the local directory

2 Addiction – Alcohol/Drugs/Tobacco

- Addiction can take many forms and has many causes
  - It is said that addiction enters when self-love is lost.
  - Loss of identity (a sense of self) can give way to an addiction identity
  - It can result in people turning to many things including – opioids, food, gambling…
- The essential first step is for the client to recognise their problem
  - More direct prompting may be needed (after entering dialogue by open questioning)
  - Local NHS Alcohol Support resources here
  - Local Drug Addiction Services from the FRANK web site here
  - Local NHS Smokefree services here
- Advice may help change behaviour in the short term, but
  - Group support helps develop self esteem and maintain behaviour in the longer term
- A link worker can help connect clients to such services and groups, but also
  - To help clients sense of self-worth see the NHS Moodzone-raising self-esteem here

3 The Client who feels lost

- Bereavement, depression or loneliness can lead to
  - A feeling of aimlessness, loss of joy in life, being lost….
- The issue is not just what they should do but why do anything
- This is a difficult conversation, the client needs help to find
  - Perhaps their purpose or faith and how they can connect to others
- This may lead a Link Worker to suggest:
  - Bereavement counselling or other forms of group support see here
  - And help to find volunteering opportunities, adult education, their cause
- See NHS resources for bereavement here, depression here and loneliness in older people here also see Bucks Adult Learning here

4 Mind/Body/Spirit – Health

- Link Workers need to listen to the language of their client
  - Some focus on physical issues, others on the mind, some may refer to spiritual health
- This can provide clues for guidance towards different forms of support
  - Healthy mind and body disciplines such as Yoga, Pilates or Tai Chi may be useful
  - Exploration of anxiety and stress and perhaps mindfulness may help some
  - While a faith community can be an important resource for others.
- See NHS Mindfulness here NHS Yoga and Pilates Videos here NHS Guide to Chaplaincy Care here and a guide to spiritual care for all staff from NHS Scotland here and resources for Mind and Spirit from Credible Minds here
  - It is not suggested that Link Workers should act in a chaplaincy role or lead clients in any of these directions but should follow the needs of their clients.
  - And while Chalfonts and Gerrards Cross religious groups play a very important role in our communities their support and groups are not dependant on participants beliefs.

5 Mental Wellbeing, Frailty and Social Prescribing

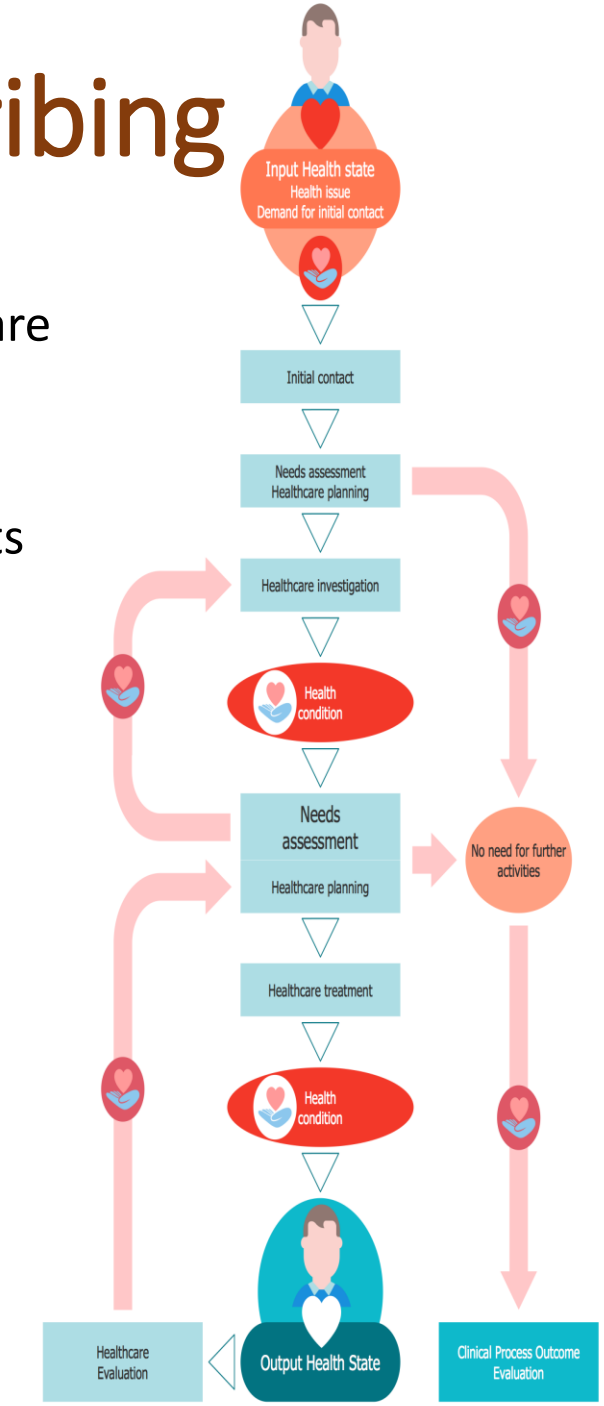
- Many clients may need help to address their mental wellbeing issues
- The Warwick-Edinburgh Mental Well-being Scale - WEMWBS can help clients express their feelings. Originally developed to assess population mental wellbeing but the Scottish Association for Mental Health shows how this can be used as a self assessment tool see here
- There is also a short form SWEMWBS using 7 questions. Note that use of these measures is free but you need to register to use them
- Other resources for people with mental wellbeing issues include the NHS Mood self assessment tool here and resources on the Bucks Live Well Stay Well site here and the Every Mind Matters resources here

Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks.

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time	SCORING EXAMPLE
1. I've been feeling optimistic about the future	1	2	3	(4)	5	=4
2. I've been feeling useful	1	2	(3)	4	5	=3
3. I've been feeling relaxed	1	(2)	3	4	5	=2
4. I've been feeling interested in other people	1	2	(3)	4	5	=3
5. I've had energy to spare	1	2	(3)	4	5	=3
6. I've been dealing with problems well	1	2	3	(4)	5	=4
7. I've been thinking clearly	1	2	(3)	4	5	=3
8. I've been feeling good about myself	1	(2)	3	4	5	=2
9. I've been feeling close to other people	1	2	(3)	4	5	=3
10. I've been feeling confident	1	(2)	3	4	5	=2
11. I've been able to make up my own mind about things	1	(2)	3	4	5	=2
12. I've been feeling loved	1	2	3	4	(5)	=5
13. I've been interested in new things	1	2	3	4	(5)	=5
14. I've been feeling cheerful	1	2	(3)	4	5	=3
SCORING EXAMPLE	=0	=8	=18	=8	=10	SCORE =44

Continuity of Care INTs and Social Prescribing

- Continuity of Care is a basic strength of UK Primary Care, requiring
  - A continuing relationship with a GP service which manages patient health and care
  - Maintenance of long term, unified patient records accessible to patients
  - Relationships amongst providers of health and care services to ensure
  - Smooth transition and good communication between providers and with patients
- Continuity of Care (CC) faces challenges due to
  - Complex needs and services for ageing population and more patient choice
  - Failure to bridge gaps between health - social care services - VCSE
  - Changes in GP contracts, greater movement of GPs and more part time work
- A Lead Contact/ Care coordinator or Link Worker may play a role in:
  - Maintaining relationships with relevant health and care providers and VCSE
  - Helping patients make decisions on health and care and lifestyle choices
  - Enhancing patient records to reflect health and social care needs and choices
- These role must be agreed within the PCN see here



Community Engagement for INTs and Social Prescribing

- Social Prescribing and INTs require co-production with communities
  - It is important to understand social geography – how communities define themselves
  - Groups who define themselves by: place, faith, interests, needs, activities
  - Based on mutual trust, listening to and supporting local leaders see here
  - To find specialist services for people with long term conditions see NHS Services A-Z here
- Team Leaders needs skills in Asset Based Community Development (ABCD)
  - Recognizing and working with local resources: creating a community support network
  - Leaders, active citizens, natural environment, halls and local issues and passions
  - For PH England example see here and for training and other resources see here
  - Community Impact Bucks show this approach in North Bucks see here

Community Action for INTs and Social Prescribing

- Practical steps that can be supported by Social Prescribing and INTs include:
  - Working with community groups to develop befriending services
  - Providing an eHealth centre to show people how to use online resources
  - Extend Making Every Contact Count - culture change to increase health awareness
    - E.g. Library Volunteers – Reading Well Scheme - Services for Older People –NHS Healthchecks
  - Engage local businesses in health and wellbeing
    - E.g. Healthy Eating Aisles, Dementia Friendly (no black mats, safe spaces), Healthy Workplace
  - Work with other healthcare providers
    - E.g. Healthy Living Pharmacies, Healthy Living Opticians and Local Care Homes
  - Collaboration with Town or Parish Councils to maintain and grow Community Groups
    - E.g. Engaging with our local Town and Parish Councils through the Community Board
- Resources to support such steps include
  - NHS guide to resources on befriending here and MECC here my evaluation for NHS England here, NHS Healthcheck here, Healthy Eating Guide here the Alzheimer's Society guide to dementia friendly communities here , Stay Well Pharmacy campaign here Healthy Living Opticians are at an earlier stage see here, NHS Guide to Enhancing Health in Care Homes here Community Impact Bucks here, Healthy Town Guide here

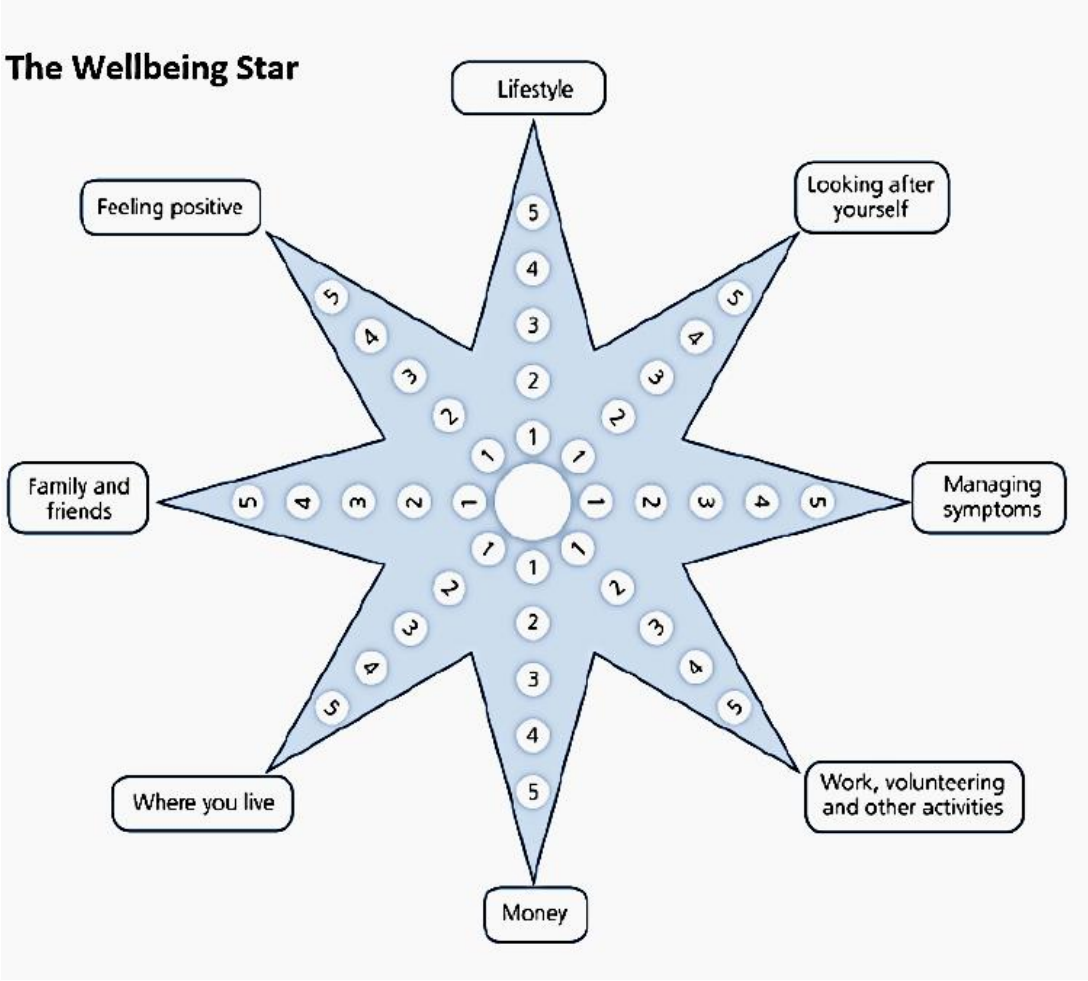
Evaluating Personalised Care

- Community Wellbeing and personalised care is seen by NHS England as essential for health
- Evaluation is needed at 3 levels:
  - Quality of Service: clients, health and care providers and local organisations response – does it help them?
  - NHS costs: what does it cost and how much is saved in terms of reduced GP and A&E demand/attendance
  - Social Impact: what costs and other impacts are borne by all stakeholders and what is the value of benefits to society in terms of health and wellbeing
- "A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications" by Polley et al (2017) here showed reductions in NHS demand and costs and positive Social Return on Investment. Other studies show positive client and community response.
- For more guidance on socio economic evaluation for health and wellbeing see my course here.

- See NHS England standard Model of Social Prescribing here

Evaluating Impact on Clients The Wellbeing Star

- In East Merton see here this Outcome Star was used to evaluate impact on 8 factors from 1 not thinking about it to 5 as good as it can be (see Mackeith 2011 here)
- The factors considered were:
  - Lifestyle
  - Looking after yourself
  - Managing symptoms
  - Work, volunteering and other activities
  - Money
  - Where you live
  - Family and friends
  - Feeling positive



- This draws on a Capability Theory approach introduced earlier

A Word of Caution

- Professor Daniel Frings*, has been conducting a national study of Social Prescribing. He reminded us that while SP has been very successful:
  - It is important to have a realistic understanding of what one Link Worker can achieve
  - The Link Worker need the support of a team of Colleagues and Community Volunteers
  - Inappropriate referrals (people who are not ready for help) can clog the system
  - And it is essential to take into account the impact on community groups
- Our local PCN has worked with Prevention Matters see here who reminded us** of the importance of teamwork and Chiltern District Council see here who support Community Groups through Community Impact Bucks see here

  * At the League of Friends AGM 5th Nov 2019

  ** At the League of Friends SP Meeting with Local Groups 17th Oct 2019

My conclusions
What do you think?

- Community Wellbeing, Social Prescribing and INTs are not “Silver Bullets” but
- They are important steps in the transformation of health and social care services
- Towards community and personal engagement in manging health and wellbeing
- This requires teamwork by health and care staff focussed on whole person care
- It requires better skills in listening to patient/clients and improved communication
- Coupled with use of technology to support patients and carers
- This can engage and empower individuals and communities and reduce NHS costs.