The Friends of The Chalfonts and Gerrards Cross Community Hospital

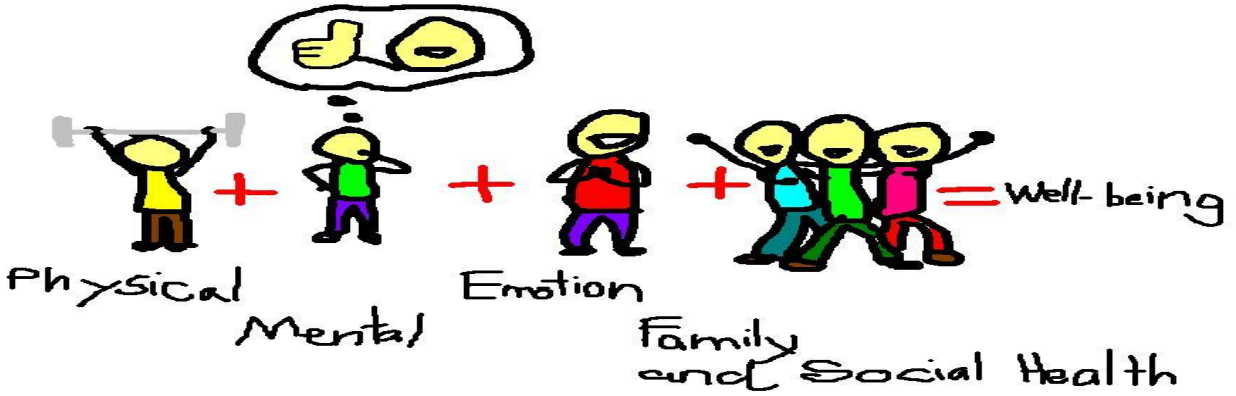
An Introduction to Community Health and Wellbeing and Social Prescribing

This presentation provides a background to help us consider together with our Primary Care Network, Buckinghamshire NHS Healthcare Trust, and the South Bucks and Chiltern District Councils how we might develop Social Prescribing and as a Local Hub for Health and Wellbeing

Introduction

- This presentation asks:
  - What does health and wellbeing mean for the communities and people we serve.
  - How can community action support a community hub for health and wellbeing
  - How can Social Prescribing be developed for our communities.
- 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 Social Care 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 Trust and 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
- By recognising individual needs through –
  - **Personalised Care Planning** see here

- 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

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
- Communities are 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.

- What will improve health and wellbeing in your community?

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.

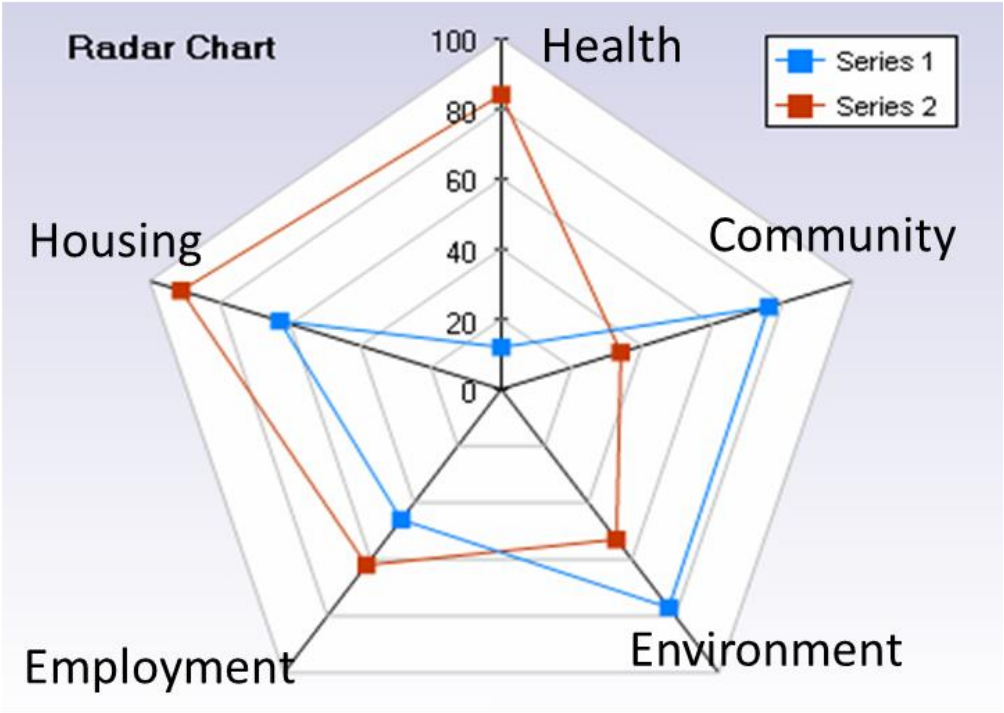
Personal well-being is assessed through 4 measures, often referred to as the ONS4:

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?

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

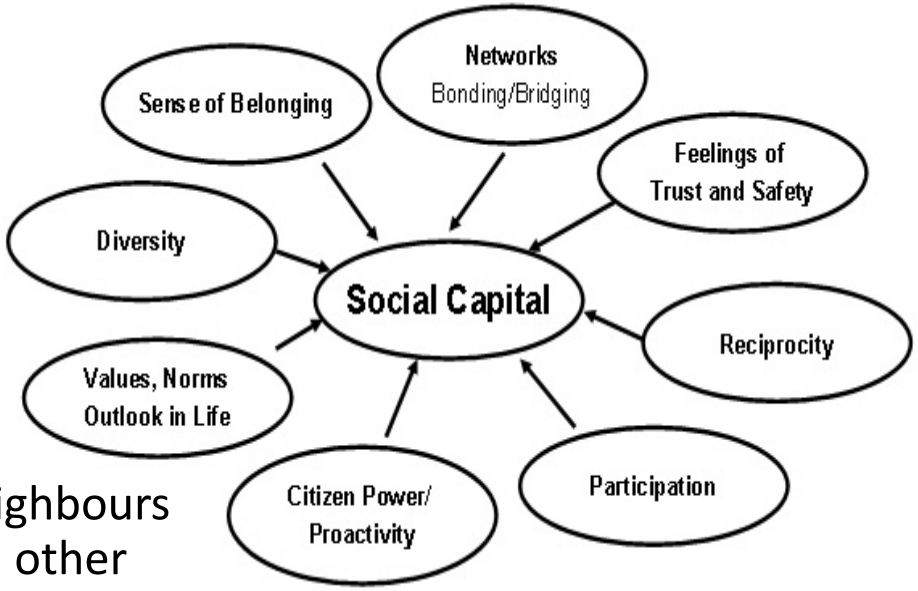


- What would you suggest are the key determinants of health and wellbeing for your community?

What is Social Capital: Does it support 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



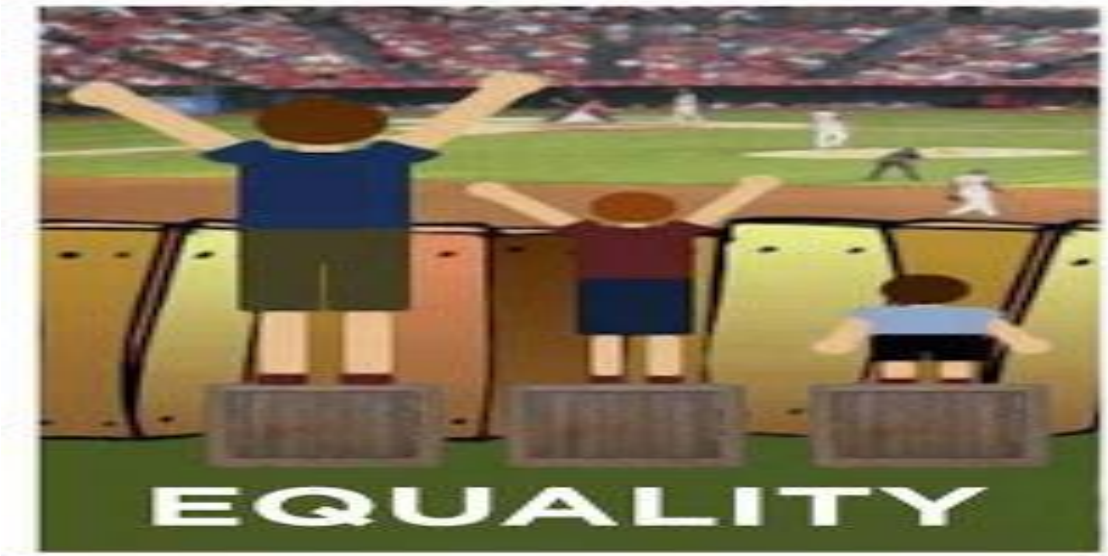
- Social capital was measured by ONS in 2019
- Based on 5 questions in APS asking degree to which people:
  - feel that people in their neighbourhood can be trusted
  - feel that people around where they live are willing to help their neighbours
  - feel that people in their neighbourhood do not get 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.

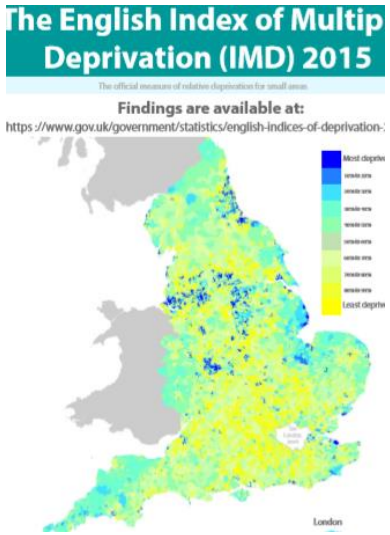
Why is Improving Equity Important?

- 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



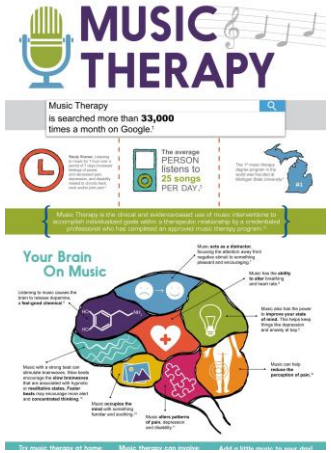
Measuring Impact on Equity

- 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



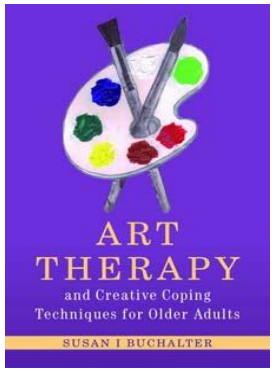
- The IMD is useful for urban areas but is less useful in rural areas, an index of rural deprivation is also available see here. But objections have been raised because such measures seem to assume that communities are deficient in some ways. It is stressed that each community has its own values which 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)



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



Integrated Health and Social Care for Wellbeing

- Integrated care creates social value and wellbeing
  - 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

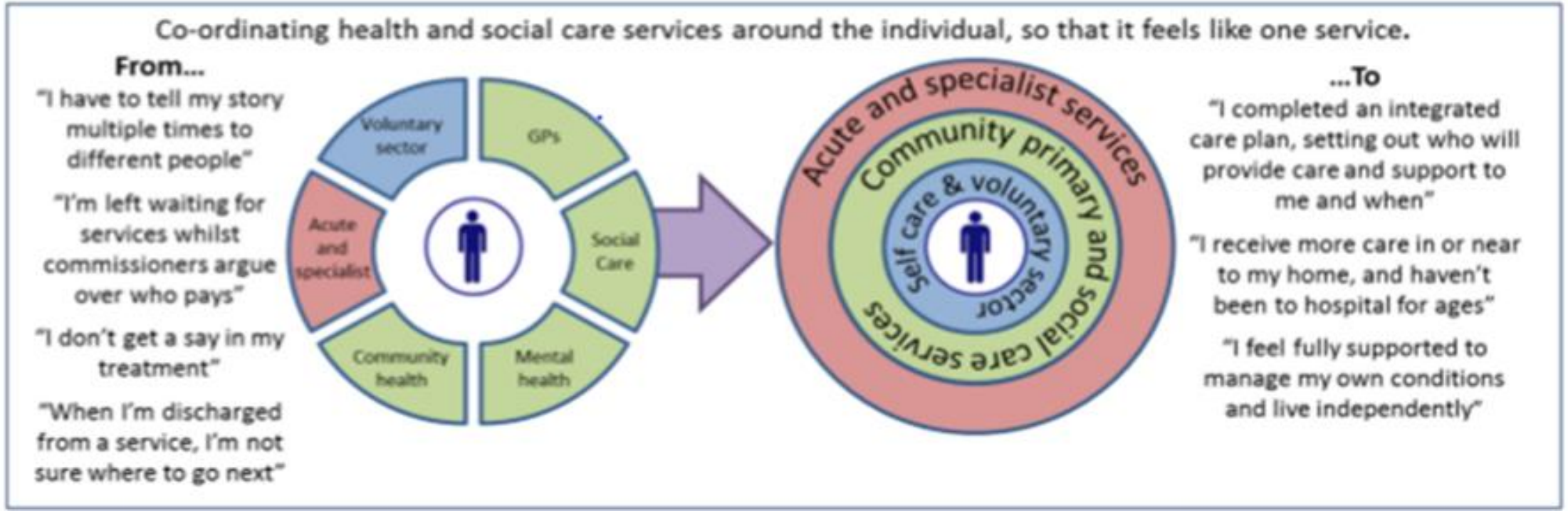
Developing a Community Hub

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 Social Prescribing see here.
- Early consultation on these plans encouraged our Chalfonts and Gerrards Cross Hospital League of Friends to consider how community action could support a Community Hub and Social Prescribing for our communities
  - Our hospital is at the centre of the border of South Bucks and Chiltern (pop 160,000)
  - Our local Primary Care Network (the Chalfonts PCN) serves 33,000 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)
- Integrated Teams: Primary, Acute and Social Care for physical and mental health
  - Serving communities of 30-50,000 people (e. g. catchment of our local Primary Care Network)
- Support for self care and Voluntary, Community and Social Enterprise (VCSE)
- 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 Network serving Gerrards Cross and the Chalfonts 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

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

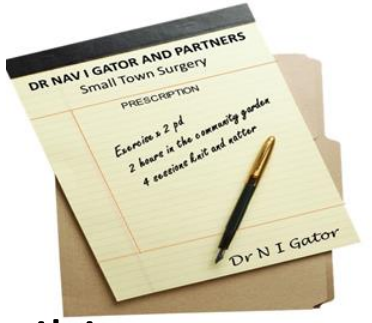
Towards Social Prescribing

- 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

The Social Prescribing Team

- Social Prescribing is part of 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 Link Workers or Community support groups
  - Link workers who may meet the client 3-6 times and refer to local community groups
  - Signposting by Care Navigators or Making Every Contact Count
  - A Care Navigator 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 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 working together for Community Health and Wellbeing

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

Active Signposting for 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

Questioning Skills for Social Prescribing

- The art of 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

Social Prescribing for People who are Physically and Mentally 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.
- 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.
- A Frailty Support Team as proposed by the Chalfonts PCN can be of great value in address the health and care needs; monitoring their care, treatment and support, ensuring their medication is taken as needed.
- A Link Worker can also put them in touch with community support groups and talk to them about issues of self confidence and purpose in life.

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

Mental Wellbeing and Social Prescribing

- Many clients of SP 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

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

The Client who feels lost

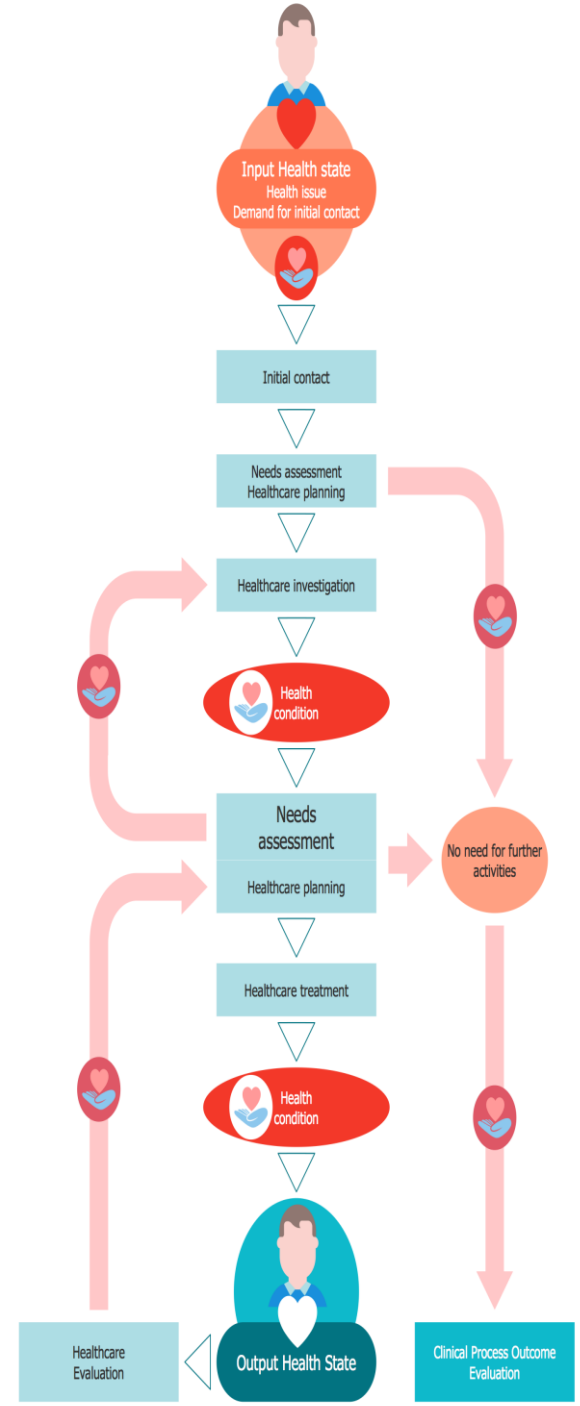
- Bereavement, depression or loneliness can lead to
  - A feeling of aimlessness, loss of joy in life, being lost….
- The issue is not just what they should do but why do anything
- This is a difficult conversation, the client needs help to find
  - Perhaps their purpose or faith and how they can connect 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

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.

Continuity of Care and Social Prescribing

- Continuity of Care is a basic strength of UK Primary Care, requiring
  - A continuing relationship with a GP who 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 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
- The role of a Link worker in CC must be agreed within the PCN see here



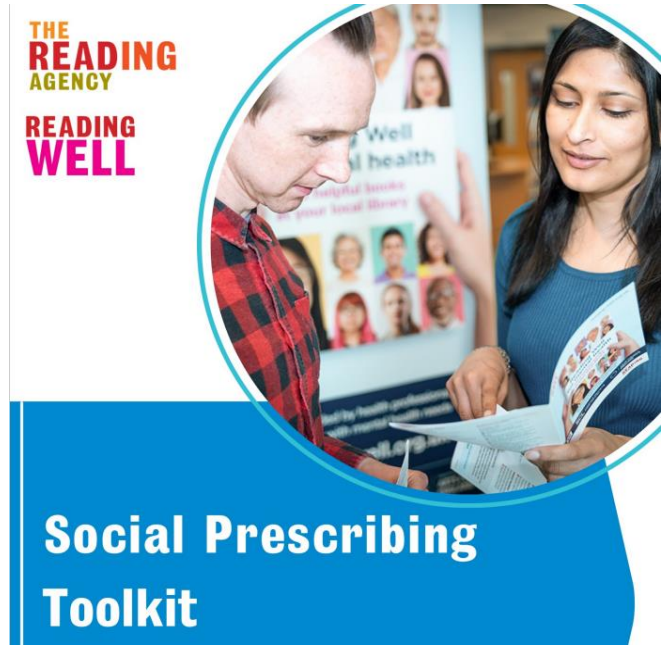
Community Engagement for Social Prescribing

- Social Prescribing requires 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
- Link Workers 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 Social Prescribing

- Practical steps that can be supported by Social Prescribing 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

Working with Community Groups and Libraries



- Social Prescribing could work with Friends of Chalfonts and GX Community Hospital to encourage community action.
- There are some 200 local organisations and groups many of which have already shown interest in befriending.
- We also know many national and county patient support organisations that are not represented in our area perhaps because until recently Gerrards Cross did not claim “Town Status”.
- 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 social health and wellbeing.
- This could also provide batter access to ehealth resources as the libraries provide free online computer access for one hour.

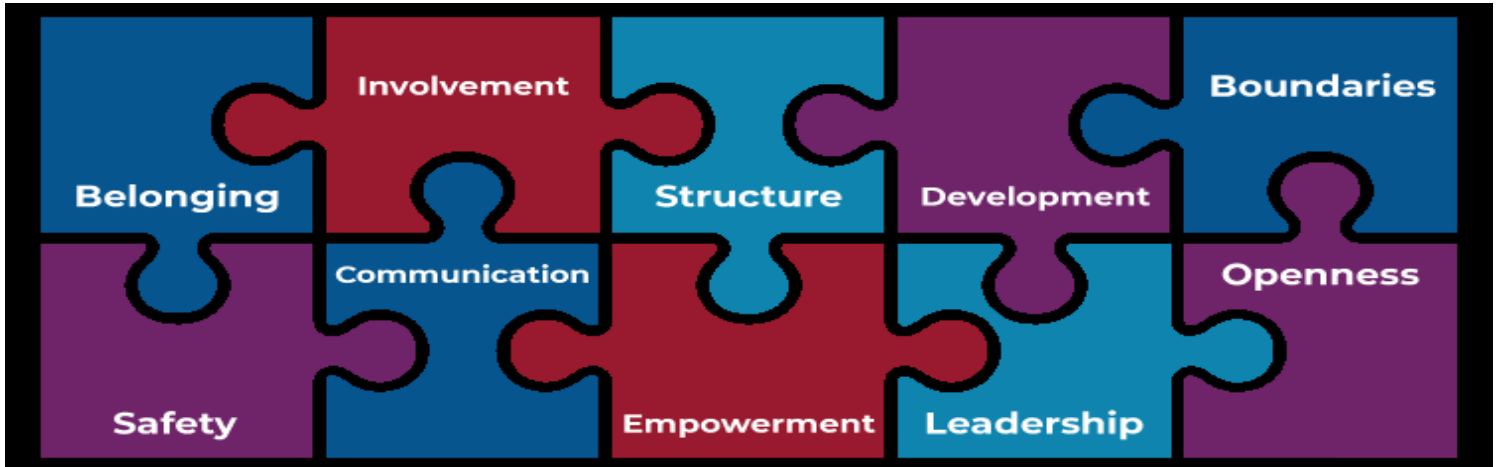
Navigating the Health Web and IT: A Digital Health and Wellbeing Centre

- 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
- Social Prescribing can help to provide a human face to this technology by guiding people in the use of digital services or helping them find online 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)

An Enabling Environment for Social Prescribing

- Social Prescribing flourishes in an enabling environment, within the PCN and in the wider community served. This requires a combination of:

- Belonging – quality of relationships
- Boundaries – behaviour is managed
- Communications – in different ways
- Development - opportunities for all
- Involvement – shared responsibility
- Safety – support for everyone
- Structure - engagement at all levels
- Empowerment – power is discussed openly
- Leadership – to maintain enablement
- Openness – to ideas, people and groups



See the Royal College of Psychiatry introduction to Enabling Environments here

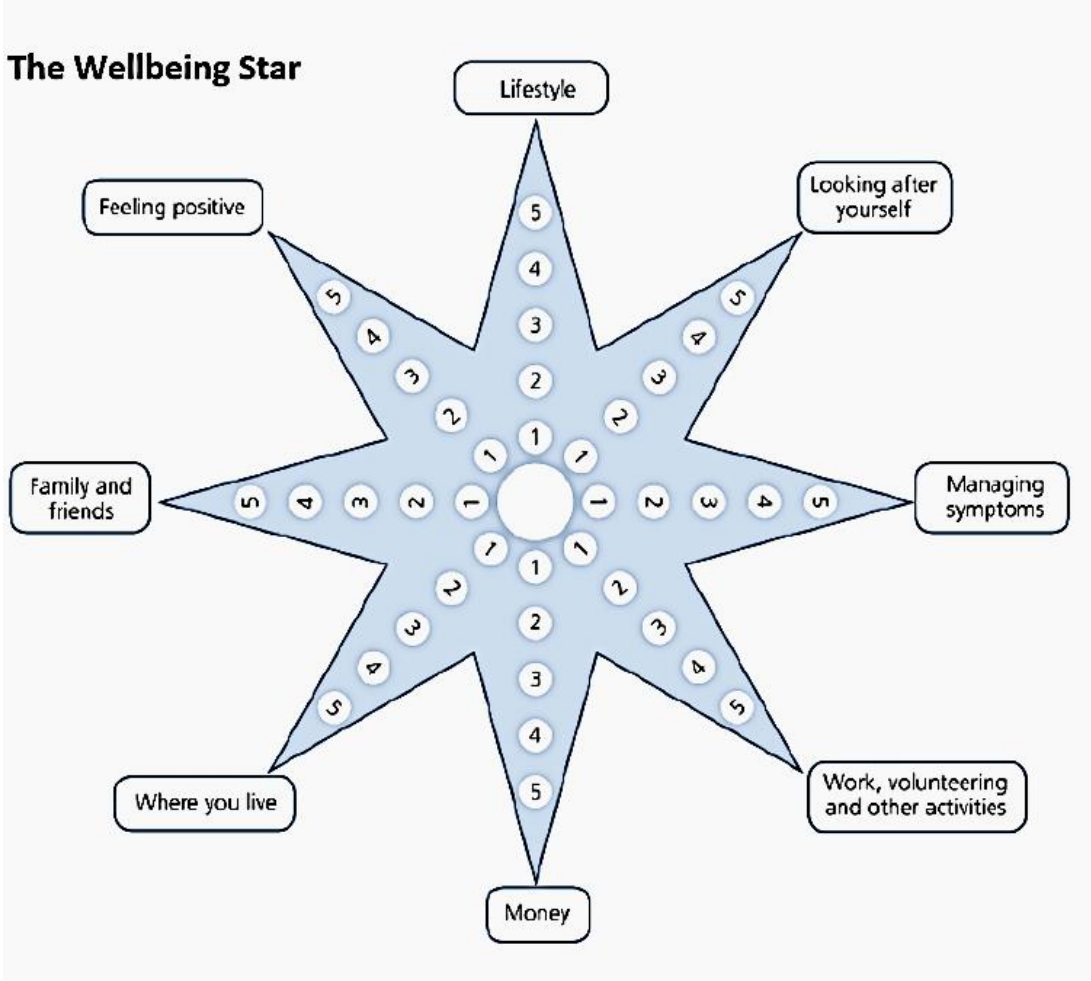
Evaluating Social Prescribing

- Social Prescribing is seen by NHS England as essential to personalised care and self-care
- 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

First Steps in Social Prescribing

- Social Prescribing 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 of Social Prescribers 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 SP 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

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 must be supported by 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

A Local View

- Lynne Hunter Social Prescribing Project Lead of the Community Development Team at Chiltern & South Bucks District Councils helped organise a very well attended meeting to discuss the development of Social Prescribing in our area
- Angela Jessop of Bucks CCG explained national and County policy aims for SP
- Paul O”Hare described how SP was successfully developed in Hertfordshire
- Dr Cath Collier described the transformative benefits of SP to her as a GP
- Diane Rutter described the support Community Impact Bucks offered for SP
- The overall message was great commitment and support for SP from speakers
- And from over 100 attendees from local community organisations

My Conclusion

- Social Prescribing is not a “Silver Bullet” to solve all health problems, but
- It is an important part of a transformation of health and social care services
- Including the development of a Local Hub for Health and Wellbeing
- With Community Assessment and Treatment, home care and Frailty Support
- With local clinics and services and links to diagnostic and treatment centres
- Coupled with use of technology to support patients and carers
- It must engage and empower carers and community organisations and groups