The Glue in Health & Social Care

1st Ever National Social Prescribing Link Worker Success Conference
&
Link Worker Day

8th July 2019

#SocialPrescribing #LinkWorkerDay19 #GlueInHSC
Giles Wilmore
Associate Lead for People and Communities
Greater Manchester Health and Social care Partnerships
@GilesWilmore
USING CROSS-SECTOR COLLABORATION TO ENABLE COMMUNITIES TO TAKE BACK CONTROL

Giles Wilmore
Associate Lead for People and Communities
Greater Manchester Health and Social Care Partnership

National Social Prescribing Link Worker Conference
8th July 2019
The Greater Manchester Model of Unified Public Services

A completely new approach to public service delivery. Breaking down the silos between public services, collaborating on prevention rather than individually picking up the pieces. Promoting a model of public service delivery that is truly preventative, proactive and person-centred.

- **A single programme of transformation and reform across all disciplines**
- **Further devolution, policy change, new regulatory environment**
- **Supported by place-based pooled budget**

- **Directed by one public service leadership team**
- **Universal services, like schools and GPs, are cornerstones of public services in their communities and are connected with other public services through integrated neighbourhood functions**

- **One integrated neighbourhood function** for each geographic footprint (30-50k). Frontline practitioners, pooling on specialist support.
  - Care coordinators/navigators
  - Community safety advisors
  - CRC workers
  - District nurses
  - Early years workers
  - Environmental health officers
  - Family support workers
  - Focused care workers
  - Health visitors
  - Housing officers
  - Key workers/early help workers
  - Mental health practitioners
  - Neighbourhood beat officers
  - Neighbourhood/community safety officers
  - Pharmacists
  - Police community support officers
  - Social workers
  - Substance misuse workers
  - VCSE sector workers and volunteers

- **A single commissioning function** for the locality
- **Integrated specialist/acute services** for the most complex and costly
- **Information is shared between agencies safely to support effective delivery and identifying those most at risk**
- **Working as one public service workforce, with redesigned roles and shared job descriptions across organisations**
- **The VCSE sector are part of the fabric of public services. Public services are delivered with local citizens, communities, businesses**
How many VCSE organisations are there in GM?

15,890
Total number of organisations in the VCSE sector in Greater Manchester

- 77%: 12,312 Micro (Under 10k)
- 12%: 1,983 Small (£10k-£100k)
- 8%: 1,221 Medium (£100k-£1m)
- 2%: 374 Large (More than £1m)

NOTE: Results from ‘State of the Sector’ survey undertaken by Sheffield Hallam University in June 2017
Our lifestyles, the communities around us and our personal situation are said to affect 90% of our health and wellbeing. We need to embrace the assets of our system, communities and citizens to keep people well.

On average someone with a long-term condition will spend 4 hours a year with a health or care professional, and 8,756 with their families and within their communities.

Therefore we need to:
- Support people to live healthier lives – *ie prevention*
- Support people to better manage their conditions – *ie self-care*
- Make better use of the help and potential in communities – *ie asset-based approaches*
Communities at the heart of health and wellbeing

- Listening to what matters to me
  Person-centred conversations

- Recognising the strength of my communities
  Asset-based approaches

- Designing my own support
  Personal budgets

- Solutions that are more than medicine
  Social prescribing

Greater Manchester Health and Social care Partnership
Person and Community Centred Approaches

To tackle the challenges both of the health and care system and in relation to our population’s health we must fundamentally reshape the relationship people have with their health, with the health and care system and with the people who work within it.

Why?
- Evidence highlights that as little of 10% of the things that contribute to keeping us healthy are linked to healthcare;
- Growing prevalence of long term conditions and multiple morbidities requires drive away from passively received, single disease modality healthcare;
- The power of people and communities in improving population health is substantial – the greatest untapped asset of health and care;

A system that recognises the importance of and facilitates access to support with the wider determinants of health.

The shifts that need to occur

The DNA of the health and care system puts self-management and person centred care at its heart.

The voluntary and community sector is recognised, connected and resourced in relation to its impact on population health and wellbeing.

Our population understands its powerful role in improving community health and wellbeing.

The voice of the public is at the heart of everything we do.

Delivery Model

Self Management
Working alongside organisations, teams and pathways to embed systematic approaches to self management for people with LTC.
- Support includes:
  - Patient Activation
  - Person Centred Planning
  - Coaching and rapid improvement support for teams
  - Self Management Education

More Than Medicine
Approaches that connect the system to approaches supporting people with the wider determinants. Including:
- Social Prescribing;
- Collaborative Practice, connecting communities to General Practice;
- Asset Based Community Development – identifying, developing and building on community assets;

Engagement and Enabling
Building momentum around a public narrative of person and community centred approaches including:
- #CommunityWellbeing social movement;
- Partnership Engagement Network and Strategy;
- Communications;

Commissioning
Working alongside local and regional commissioners to ensure levers and incentives are compatible with person and community centred approaches

Organisational Development
Working to ensure our front line staff have the skills, knowledge and confidence to deliver person and community centred approaches. Our leaders have an empowering approach that encourages innovation.

Systems and Approaches
Ensuring the way we work supports person and community centred approaches.
James Sanderson
Director of Personalised Care
NHS England
@JamesCSanderson
The Comprehensive Model for Personalised Care

James Sanderson
June 2019
@JamesCSanderson

NHS England and NHS Improvement
Comprehensive Model for Personalised Care
All age, whole population approach to Personalised Care

**INTERVENTIONS**

**Specialist**
- Integrated Personal Commissioning, including proactive case finding, and personalised care and support planning through multidisciplinary teams, personal health budgets and integrated personal budgets.
- Plus Universal and Targeted interventions

**Targeted**
- Proactive case finding and personalised care and support planning through General Practice. Support to self manage by increasing patient activation through access to health coaching, peer support and self management education.
- Plus Universal interventions

**Universal**
- Shared Decision Making. Enabling choice (e.g. in maternity, elective and end of life care).
- Social prescribing and link worker roles.
- Community-based support.

---

**TARGET POPULATIONS**

**People with complex needs**
- 5%

**People with long term physical and mental health conditions**
- 30%

**Whole population**
- 100%

---

**OUTCOMES**

- **Empowering people**, integrating care and reducing unplanned service use.
- Supporting people to build knowledge, skills and confidence and to live well with their health conditions.
- Supporting people to stay well and building community resilience, enabling people to make informed decisions and choices when their health changes.

---

**Presentation title**
Personalised Care Operating Model

**WHOLE POPULATION**
When someone’s health status changes

**30% of POPULATION**
People with long term physical and Mental health conditions

---

**Shared Decision Making**
People are supported to a) understand the care, treatment and support options available and the risks, benefits and consequences of those options, and b) make a decision about a preferred course of action based on their personal preferences and, where relevant, utilising legal rights to choice.

(All tiers)

---

**Social Prescribing and Community-based Support**
Enables all local agencies to refer people to a 'link worker' to connect them into community-based support, building on what matters to the person, and making the most of community and informal support.

(All tiers)

---

**Supported Self Management**
Support people to develop the knowledge, skills and confidence (patient activation) to manage their health and wellbeing through interventions such as health coaching, peer support and self-management education.

(Initially Specialist, Targeted and Specialist)

---

**Personalised Care and Support Planning**
People have proactive, personalised conversations which focus on what matters to them, delivered through a six-stage process and paying attention to their clinical needs as well as their wider health and wellbeing.

---

**Review**
A key aspect of the personalised care and support planning cycle. Check what is working and not working and adjust the plan (and budget where applicable).

---

**Optimal Medical Pathway**

---

**Personal Health Budgets and Integrated Personal Budgets**
An amount of money to support a person’s identified health and wellbeing needs, planned and agreed between them and their local CCG. May lead to integrated personal budgets for those with both health and social care needs.

---

**Cohorts proactively identified on basis of local priorities and needs**

---

**Leadership, Co-production and Change Enabler**

---

**Workforce Enabler**

---

**Commissioning, Contracting and Finance Enabler**

---

**Digital Enabler**
Significant delivery of Personalised Care

**Shared decision making**

In 2017/18 SDM was embedded into:
- Musculoskeletal elective care pathways across 13 CCGs
- Respiratory elective care pathways in 8 CCGs

**Personalised care and support planning**

- 142,904 people had a personalised care and support plan between April 2017 and September 2018
- Over 204,000 people supported by integrated, personalised approaches

**Enabling choice**

- 97% of CCGs have now completed Choice Planning and Improvement self-assessment
- Of these, 85% report compliance with at least 5 (of 9) choice standards

**Social prescribing & community-based support**

- 68,977 referrals in 2017/18
- 331 link workers employed in local areas

**Supported self management**

- 101,637 patient activation assessments by September 2018
- Over 44,093 people referred to community-based support
- Over 59,545 people referred to self-management education or health coaching

**Personal health budgets & integrated personal budgets**

- 32,341 PHBs by September 2018
- Up 110% year-on-year in 2018 (to end Q2)
- 23% jointly funded with social care
- 55,511 Personal Maternity Care Budgets delivered by September 2018 across 36 CCGs
The difference personalised care makes

To people’s experiences

- 86% of people said they achieved what they wanted with their PHB. 77% of people would recommend PHBs to others with similar needs.
- Independent reviews have found evidence that people’s well-being, satisfaction and experience improves through good personalised care and support planning, including for people with cancer.
- 75% of people who booked hospital outpatient appointments online felt they were able to make choices which met their needs.

To the system

- Monitoring of costs for PHB holders receiving NHS CHC home care packages found an average saving of 17%.
- An independent evaluation found that PHBs were overall cost neutral. People with a PHB had lower indirect costs through less use of secondary healthcare (average £1,320 per person per year).
- In one site, IPC was implemented at scale alongside other interventions. Following the 100-day challenge in 2017 the site saw a reduction in emergency admissions of 12%, as well as a 24% reduction in A&E attendances for the two practices which took part.
- An independent evaluation found that people who had the highest knowledge, skills and confidence had 19% fewer GP appointments and 38% fewer A&E attendances than those with the lowest levels of activation. This finding was corroborated by a Health Foundation study which tracked 9,000 people across a health and care system.

To people’s outcomes

- People and professionals consistently overestimate treatment benefits and underestimate harms. Shared decision making helps reduce uptake of high-risk, high-cost interventions by up to 20%.
- Local evaluations of social prescribing have reported improvements in quality of life and emotional wellbeing, as well as lower use of primary care and other NHS services. Systematic reviews have found that the quality of evidence is variable and there is a need for more evidence on the effectiveness of social prescribing.

To the workforce experience

- Personalised care and support planning has been shown to improve GP and other professionals’ job satisfaction.
Joe Lyons
Chief Executive Officer
West Ham United Foundation
@WHUFoundation
Based in Newham, the West Ham United Foundation is the club’s community outreach vehicle and as such is uniquely placed to deliver programmes that tackle local need and inspire better futures across East London and Essex.
Vision: To be the leading social and community outreach organisation in East London and Essex, using the power of the West Ham United brand to provide inclusive, life-changing opportunities for individuals and wider society.
**Mission:** To promote health and economic wellbeing by providing the best inclusive community engagement programmes in sports, education and inclusion by promoting individual success and raising achievement and aspiration among the communities it serves

**Mission Description**
The Foundation will work to achieve the following targets:
- Providing Opportunities
- Creating Pathways
- Changing Lives
What is the 150Club?

• 24-week GP referral programme targeting Newham residents aged 18+ who are at risk of developing Type 2 Diabetes and/or Cardiovascular Disease

• Aims to increase physical activity/healthy behaviours by supporting participants to achieve the recommended 150 minutes per week.

• Over **80 weekly sessions** provided by wide variety of community organisations; Bonny Downs, London Tamil Sangam, Trinity Centre, Chinese Association, African Caribbean Resource Centre and local leisure providers.

Sessions include: Group cycle, supported gym, line dancing, swimming, yoga, Zumba, walking football, running and many more.
Our Lifestyle Advisors provide ongoing mentoring to all participants.

- Initial meeting
- Continued support
- Person-centred, bespoke approach
- Maximum impact
Community Prescription

- Bringing community together
- Working with over 20 organisations
- Referring to their existing sessions
- Money follows the patient; session fee and completion bonus paid monthly
- Quality Assurance provides safe sessions and supports small organisations
- Instructor CPD programme
- Tackles social isolation and loneliness
- Encourages volunteering
Almost 500 completers of the programme so far

61% of participants complete the 24 week programme

87% of those reaching 12 weeks, will complete 24 weeks

325% increase in Self-reported Moderate Physical Activity

Decrease in average blood pressure from 132/83 to 126/80

Increase in Hand Grip test 23% and 19% in Warwick Edinburgh MH Scale

70% of completers take out a discounted Leisure Centre Membership

‘Ripple Effect’ as participants’ families get active
150Club Opportunities

There are plenty of opportunity to develop more strands by adding Lifestyle Advisors with specific expertise and expanding the weekly ‘session menu’.

Potential strands:
- Mental Health
- Diabetes
- Cardio Rehab
- Other lifelong conditions
150Club Awards & Nominations

**Awards**
Winner of BT Sport Industry Awards – Best Community Programme

Silver at Global Good Awards - Best Partnership in the Community

**Nominations**
Sports Business Awards – Category: Best Community Scheme

UK Active – Category: Healthy Communities
Anne-Marie Trott
Project Manager
Music for Dementia 2020 Campaign
@music4dem2020
Anne-Marie Trott  
*Project Manager*

1st ever national social prescribing link worker conference

*8 July 2019*
“Making music accessible for everyone living with dementia by 2020”
WHO WE ARE

- Music for Dementia 2020 - campaign founded by The Utley Foundation.

- Established in 2014, exists to advance social causes.

- Music is a personal passion of the founders and trustees.
Listening to personally meaningful music can help alleviate the behavioural and psychological symptoms of dementia
Lauren Laverne shares personal reason she decided to back campaign to make music free for dementia patients

Music for people living with dementia is a necessity’, says new national campaign

Dementia study adds to calls for more funding of music therapy

Campaign to Make Music Free For People With Dementia Launched in UK

Why it’s worth striking the right note for people with dementia

BBC presenter Lauren Laverne backs Music for Dementia campaign

Music and dance therapy should be offered to dementia patients, research shows

Dementia patients should be prescribed 'personal playlists' to trigger happy memories
OUR MISSION

Ensure that everyone living with dementia can access the right music, at the right time and in the right ways for them.
Your musical menu

- Listen to recorded music
- Listen to live music
- Experience & participate in live music making
- Join a singing group/choir
- Create a playlist with someone & listen to it together
- Music therapy delivered either 1:1 or in a group setting, by a qualified & registered music therapist
WHAT’S MUSIC FOR DEMENTIA 2020 ROLE?

- Creating a hub of information – website
- Increasing awareness & understanding – promoting benefits
- Connecting people - musical map
- Bringing about culture change in how music is understood in context of dementia care
- Influencing decision makers
- To make music available for everyone living with dementia
WHAT CAN WE ALL BE DOING NOW?

- Directing to: [www.musicfordementia2020.com](http://www.musicfordementia2020.com)
- Following us on social media
- Encouraging awareness of what’s already available
- Signing up to the M4D2020 taskforce
- Having conversations – joining the dots – GPs, Link Workers, MPs
- Promoting benefits
- Get musicking
Come and join our musical movement?

anne-marie@m4d2020.com
www.musicfordementia2020.com
John McMahon
National Lead for Health and Wellbeing
Arts Council England
@JohnMcArts @ace-national
Harnessing the power of the arts in social prescribing
NALW Conference 2019

John McMahon / @JohnMcArts
Senior Manager, Policy & Research
Who we are

Arts Council England is the Arts and Cultural Development Agency in England

Annual budget £622m, from Grant in Aid & National Lottery

Staff across the country in five areas
North, Midlands, London, South West, South East

With specialist skills

- Dance
- Libraries
- Literature
- Music
- Museums
- Theatre
- Visual Arts
- Combined Arts
- Audiences and Engagement
- Children and Young People
- Creative Media and Digital
- Touring
- Diversity
Our footprint

- **829** National Portfolio Organisations, including galleries, theatres, concert halls, arts centres
- Over **3,000** National Lottery Project Grants p/a
- Over **2,500** accredited museums in England
- Over **3,000** public libraries in England
- Over **32,000** formally constituted voluntary arts organisations (England, Wales & NI)
- Innumerable (!) independent creative practitioners
Arts and health
“[Culture is] not some kind of eccentric add-on – it should be part of the mainstream in both health and social care”

- Alan Johnson MP
Secretary of State for Health
September 2008
We shouldn’t only value [the arts] for the role they play in bringing meaning and dignity to our lives. We should value the arts and social activities because they’re essential to our health and wellbeing.”

- Matthew Hancock MP
Secretary of State for Health
November 2018
Areas of particular strength:

- Impact of the arts on mental health
- Benefits for dementia and healthy ageing
- Improved social wellbeing
- Reduced loneliness and isolation
- Increased confidence and self-efficacy

Further building the evidence base for:

- Impact on physical health
Project examples
Project examples
Project examples
Project examples
Arts Council England investment in health and wellbeing

- £12.94m to support 54 national portfolio organisations doing core work in the field
- £72.29m to support 64 NPOs doing secondary work in this field
- £7.33m on 326 project grants in 2017/18
- £3.19m via strategic funds in 2017/18 (including Celebrating Age)
- Culture, Health & Wellbeing Alliance as a new sector support organisation
Finding out more, and linking to your local offer
Key recent Publications

**Creative Health** report, APPG for Arts, Health and Wellbeing, July 2017

*A connected society: a strategy for tackling loneliness*, HM Government, October 2018

*Arts and culture in health and wellbeing and in the criminal justice system: a summary of evidence*, Arts Council England, November 2018

*Social prescribing and community-based support: Summary guide*, NHS England, January 2019
Your opinion matters

Care about culture and creativity in England? Make your voice heard:

artscouncil.org.uk/nexttenyears
#AnACEfuture

Image © Idil Sukan, Image © Keiko Ikenchi for Museum of the History of Science
Thank You!

john.mcmahon@artscouncil.org.uk

@JohnMcArts

@ACE_National
Rosenn Logan
Programme Manager (Links worker programme)
Health and Social Care Alliance Scotland
(the ALLIANCE)
@Rmakeslinks @ALLIANCEScot
“Our vision is for a Scotland where people who are disabled or living with long term conditions and unpaid carers have a strong voice and enjoy their right to live well.”
2020 Route Map to the 2020 Vision for Health and Social Care

The ALLIANCE projects
Role of the CLP

- One-to-one solution focussed interactions
- Practice development work
- Community network building
#makeslinks
Record of Learning
Series 2

‘Links Worker’ Roles
exploring identity, evolution and expressions of the role within
and across five programmes
• Identify the networks of family and friends that comprise their key relationships from which social support is gleaned

• Ask about the person’s mental and physical health

• Gain understanding of their capacity for self-care and management of any conditions

• Identify any groups or services they may currently or have previously attended

• Endeavour to create a space in which individuals feel comfortable in sharing details of any aspects of their lives that impact their health and wellbeing
I run a cycling group

Men's shed
It’s All About Relationships
Thank you @Rmakeslinks
Lydia Hayes
Pathways Advisor
The Life Rooms- Mersey Care NHS Foundation Trust
@Mersey_Care @LifeRooms_MC
The Pathways Advisor Role
The Life Rooms Model

Lydia Hayes – Pathways Advisor
The Life Rooms

Offering a social prescribing service that sits as part of Mersey Care NHS Foundation Trust. The Life Rooms aims to provide social and wellbeing opportunities for Mersey Care service users and carers, as well as the wider community.

The Pathways Advisor Role

Pathways Advisors offer a one to one service, assisting people to think through any issues that are affecting their health and wellbeing. They help to prioritise the issues raised and offer practical advice, signposting and onward referrals to one or more of our partners to help resolve those issues. Common areas of support include volunteering, employment, benefits and money, mental and physical wellbeing, family/caring role, social interactions, and housing.

- No referral criteria and no formal referral required
- Client journey starts in either Mersey Care clinical services or in the drop in service in the community
Brian’s journey

Clinical setting

- Brian is a patient on in a Merseyside Mental Health Unit with little support in the community
- Pathways advisor arranges to meet with Brian in the Hospital
- Pathways Advisor supports Brian to identify his needs and makes appropriate referrals
- Brian is safely discharged from hospital

Community setting

- Brian attends the Pathways Advisor drop-in at one of the Life Rooms sites
- Brian is supported to select appropriate learning and social opportunities at the Life Rooms and also to complete a Mersey Care volunteer application form
- After attending a number of courses, Brian commences volunteering supporting Life Rooms session delivery
- Brian becomes an active member of the Life Rooms, participating in the Life Rooms Advisory Group (LRAG) and helping to develop the service based on his experiences
- Brian revisits the Pathways drop-in to discuss his desire to gain employment
- Lydia refers Brian to the Mersey Care IPS service who support Brian to become work ready
Impact

Health and care system

• Exploring clinical impact of Mersey Service users coming through the Pathways Advice service

The person, their carers and families

• Qualitative work to explore the experiences of those that use the Pathways
• Outcomes measure (SWEMWBS)

The community

• Over 100 community partnerships
Ray Hautot
Social Prescribing Coordinator
Merton Voluntary Service Council
@sprescribing
SOCIAL PRESCRIBING IN MERTON

The early years
HOW WE STARTED

➢ Two Surgeries Tamworth and Wide Way Feb 2017
➢ 1 Year Pilot
➢ Evaluation demonstrated the project was a success
➢ CCG invested in one more SPC from July 2018
➢ Became a team of 3 in Feb 2019
REFERRAL PROCESS

‘Link worker’ – aka Social Prescribing Coordinators (SPC)

- GP refers patient to link worker with criteria:
  - Socially isolated
  - Frequent GP attenders
  - Mild/ moderate mental health issues
  - Social needs
  - Recent hospital admission
PROCESS

Link worker is based at the practice

➢ GP: - Completes referral form

➢ Gives SP booklet to patient

➢ Link worker reviews patient and documents on EMIS

➢ Works with patient to help them complete a wellbeing star

➢ Advises/informs and signposts
SOCIAL PRESCRIBING SERVICE KEY AIMS

To connect people with local activities and services across Merton which can make life more enjoyable and/or provide practical support

MAIN REASONS FOR REFERRAL TO THE SERVICE
From 620 appointments with patients seen to date

- Social Needs 258
- Mental Health 170
- Social Isolation 130
SOCIAL PRESCRIBING IN ACTION

Patient B seen before Christmas 2016 for Depression and medical certificates.
Seen monthly for 4 months
- Saw Ray. Identified he work as chef and other
- benefits. Job at community centre
  ( Photo July 2017)
- Currently working and off medication and
- No more medical certificates.
  - Self esteem
  - Resilience
  - Supporting community
  - Reduced use primary care
Patient C

- Hardly went out of his house, not able to use public transport to attend services
- Put in touch with local community centre for some support with living skills, would not access services, isolated, poor diet and low self esteem.
- Now attends services to help his own mental health and there travels on a bus
- Volunteers at the community centre helping out at the local food bank
- Agreed to be filmed for our video to promote our service
Patient D

Patient came to me with a poor relationship with her mother, who lives 200 miles away in Manchester, has dementia with no local support. This was affecting her self esteem and ability to address her own health needs.

➢ Mum is now in touch with local agencies who can support her.
➢ Patient is in touch with local cares support group to help her help her mum.
➢ This is led to a reduction in patient’s levels of stress and anxiety.
➢ Improved relationship with her mother
➢ Able to focus more on her own physical needs
Patient stories

- Wellbeing Star (used at baseline and follow up)
  - To date 145 patients have completed two stars
  - Average increase from 2.9 to 3.6. With an average increase in overall wellbeing score of 0.7, which is statistically significant
  - As you can see, 6 of the 8 sections saw an improvement of 0.7 or more all significant.

### EVALUATION (QUALITATIVE)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Initial</th>
<th>Last</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your lifestyle</td>
<td>2.5</td>
<td>3.3</td>
<td>0.9</td>
</tr>
<tr>
<td>Looking after yourself</td>
<td>3.1</td>
<td>3.8</td>
<td>0.7</td>
</tr>
<tr>
<td>Managing your symptoms</td>
<td>2.8</td>
<td>3.7</td>
<td>0.9</td>
</tr>
<tr>
<td>Work, volunteering and other activities</td>
<td>2.2</td>
<td>3.1</td>
<td>0.9</td>
</tr>
<tr>
<td>Money</td>
<td>3.1</td>
<td>3.7</td>
<td>0.6</td>
</tr>
<tr>
<td>Where you live</td>
<td>3.4</td>
<td>3.9</td>
<td>0.4</td>
</tr>
<tr>
<td>Family and friends</td>
<td>3.0</td>
<td>3.6</td>
<td>0.7</td>
</tr>
<tr>
<td>Feeling positive</td>
<td>2.7</td>
<td>3.7</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>2.9</strong></td>
<td><strong>3.6</strong></td>
<td><strong>0.7</strong></td>
</tr>
</tbody>
</table>
THE FUTURE

➢ We currently cover all GP surgeries in East Merton

➢ Some surgeries in West Merton

➢ We plan to recruit 2 more to the team to cover the rest of West Merton very soon.

➢ We will continue to work closely with the neighbouring borough Wandsworth, whose service was launched recently and is based on the successful Merton Model.
Layla McNeilly
150Club Lifestyle Advisor/Coordinator
West Ham United Foundation
@WHUFoundation
150Club

Newham Community Prescription
Patient Journey

150Club
Newham Community Prescription
Patient Journey

EPCS Primary Prevention Annual Review
GP Referral
- GP practice identifies patients 38+
- HbA1c ≥4.7 mmol/L or BMI ≥45 (pre-diabetes register)
- History of GDM
- CVD Q-Risk≥20%
- Primary Prevention referral form via the nhs.net

Providers email declined data to GP practice

Initial Assessment with 150Club Lifestyle Advisor
- Wellbeing Questionnaire (WEMWBS)
- Self-reported physical activity diary to be measured
- Grip or step test to measure cardiopulmonary fitness
- Discussion of physical activity options
- Setting goals and doing risk stratification

12 weeks of free weekly Physical Activity Sessions delivered by
- Variety of community organisations such as Newham African Caribbean Resource Centre, London Tamil Sangam, Newham Chinese Association, Ascension Trust etc.
- Local leisure provider Active Newham
- Barry McGurkin Boxing Academy
- Food Academy
- West Ham United Foundation

Feedback to GP Practice
150Club and Healthier You Providers submitting attendance and completion date to GP practice

Staying Active
- Carry on with the Physical Activity provider for free/small cost
- Discounted Active Newham Membership

Final Assessment with 150Club Lifestyle Advisor

Middle Assessment with 150Club Lifestyle Advisor
- Measurements as Initial Assessment

Commissioned by:
NHS Newham
Clinical Commissioning Group

Outcomes
- 61% complete the 24 week programme
- 84% of those reaching 12 weeks, will complete 24 weeks
- 68% increase in fitness as measured by Step Test
- Decrease in average BP from 132/85 to 126/80
- All completers testify they will continue with their activities
- 70% of completers take out a discounted Leisure Centre Membership

Patient Record
Referral and attendance information to be entered onto patient record via Primary prevention Template coded as Referred/Declined/Completed/Not Completed

Newham 2017/18
- 27,409 with diabetes
- 14,374 – Individuals of prediabetic/CVD risk > 20%
- 2,068 newly diagnosed with diabetes
- 1 out of 8 at risk of developing diabetes

Aims of the 150Club
- To increase healthy lifestyles and physical activity levels for those people ‘at risk’ of developing diabetes or Cardiovascular Disease (CVD) across the borough of Newham
- To support service users to achieve the recommended 150 minutes per week
- To help reduce the progression to type 2 Diabetes or CVD.
Social Prescribing Link Worker professional practice
What social prescribing link workers do?

Social prescribing link workers use strength-based approaches to increase people’s confidence to take control of their health and wellbeing.

They work in partnership with people, actively listening to understand what matters to them from a holistic perspective, cocreating action plans and goals to meet their needs and enabling access to support.

This means they need to gain and maintain people’s trust and confidence.
Today, we are calling for social prescribing link workers to be supported to lead MDT meetings.

Link workers are integral part of the MDT, delivering holistic service to patients and improving the health of the local population. They bring a fresh perspective to the MDT.

The link worker within the MDT is the only person that can make observations from a holistic perspective, social and wider determinants of health. They enable MDTs to move to a social model of health and act as the glue between community, health and social care, joining it all together.
There is a need to understand and preserve the nature of social prescribing link workers’ roles. The role is rich and varied, extending through many disciplines.

We need to create and maintain public confidence and trust in the link worker profession, so that it can deliver improved health and wellbeing outcomes for people using services, carers and communities. Preserving the integrity of the role and ensuring quality across the profession is important.

Our Code of Practice sets the core standards expected of high-quality social prescribing practice. It is non-model specific which increases consistency in professional practice, ensures professional competence and public confidence.
A social prescribing link worker is a key component of the social prescribing programme. The social prescribing programme encompasses building relationship and trust key local stakeholders and coproducing the local model with the community and workforce assets.

It is advisable to allow social prescribing link worker time to establish, research and maintain relationships with the community assets.
Personalised social prescription and building community resilience

Social prescriptions need to be person–centred and offer choice and control to the person. It is essential that people are prescribed solutions based on their individual needs, preference, strengths and abilities. Social prescriptions must be coproduced with the person.

It is important that there are Voluntary, Community and Social Enterprise (VCSE) and Volunteer infrastructures for the link worker to connect and link people to. 74% of link workers that responded to our survey in 2019, identified a lack of resources and/ or funding was the most challenging aspect of their role.

Resourcing the VCSE to be able to provide long term support to the individual is essential.
Social prescribing unites us

It brings us closer to getting to know our communities and each other at an individual level.

It activates our Individual and community assets.

Social prescribing is good for us all.

Let us work together to improve our lives and that of those we serve.
Reference materials

NALW_checklist for setting social prescribing link workers up for success

NALW_who is a social prescribing link worker

Released_NALW_Code of Practice for employers of social prescribing link workers and social prescribing link workers_12 June 2019

Released_NALW_link worker report_March 2019_updated