AGENDA ITEM NO: 15

Report To:	**Inverclyde Integration Joint Board**	**Date: 28 January 2019**
Report By:	**Louise Long Corporate Director (Chief Officer) Inverclyde Health & Social Care Partnership**	**Report No: IJB/15/2020/AS**
Contact Officer:	**Allen Stevenson Head of Health & Community Care**	**Contact No: 01475 715283**
Subject:	**SOCIAL PRESCRIBING REPORT OCTOBER 2019**	

1.0 PURPOSE

1.1 The purpose of this report is to update the Integration Joint Board on the range of social prescribing activity in Inverclyde.

2.0 SUMMARY

2.1 There is a range of social prescribing activity in Inverclyde and the attached report outlines some of the activity undertaken within third sector.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to note the comments in the report.

Louise Long
Chief Officer

4.0 BACKGROUND

4.1 There is a range of social prescribing activity which takes place across the communities of Inverclyde. This report outlines the activity undertaken by two local providers:

- Your Voice Inverclyde
  - Community Connectors
  - Spring Social Prescribing Project
  - Macmillan Information and Connect

- CVS Inverclyde
  - Community Link Workers

4.2 The attached report outlines the background and activity to each service delivered. These contribute to our vision "Inverclyde is a caring and compassionate community, working together to address inequalities and assist everyone to live active, healthy lives". In particular:

- Big Action 1. Reducing inequalities by building stronger communities and improving physical and mental health

- Big Action 4. We will support more people to fulfil their right to live at home or within a homely setting and promote independent living, together we will maximise opportunities to provide stable sustainable housing for all

- Big Action 6. We will build on the strengths of our people and our community

4.3 Funding is from a variety of sources including HSCP, charity (Macmillan) and National Lottery. Commissioning processes are underway for both Community Connectors and Community Link Workers with these expected to be completed by Summer 2020.

5.0 IMPLICATIONS

5.1 **FINANCE**

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

Annually Recurring Costs / (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From	Other Comments
N/A					

LEGAL

5.2 There are no specific legal implications arising from this report.

HUMAN RESOURCES

5.3 There are no specific human resources implications arising from this report.

EQUALITIES

5.4 Has an Equality Impact Assessment been carried out?

	YES
X	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

5.4.1 How does this report address our Equality Outcomes?

Equalities Outcome	**Implications**
People, including individuals from the above protected characteristic groups, can access HSCP services.	Social prescribing is available to everyone within Inverclyde through ease of access.
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	Practitioners carry out equalities sensitive practice and all social prescribing services will ensure discrimination is reduced.
People with protected characteristics feel safe within their communities.	People are supported to address issues which concern them through access to appropriate support both statutory and none statutory as appropriate.
People with protected characteristics feel included in the planning and developing of services.	Providers are expected to engage a range of people in service planning.
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	Training and support for this should be available to all social prescribing practitioners.
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	If GBV is raised then social prescribing practitioners would follow the appropriate guidance in order to seek support.
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	New Scots are actively supported through the social prescribing services.

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

5.5 There are no clinical or care governance implications arising from this report.

5.6 **NATIONAL WELLBEING OUTCOMES**

How does this report support delivery of the National Wellbeing Outcomes?

National Wellbeing Outcome	Implications
People are able to look after and improve their own health and wellbeing and live in good health for longer.	Social prescribing develops the skills people require to support this.
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	This is done by connecting people to appropriate support through formal and informal methods.
People who use health and social care services have positive experiences of those services, and have their dignity respected.	Feedback from those using services is overwhelmingly positive.
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Social prescribing develops the skills people require to support this.
Health and social care services contribute to reducing health inequalities.	Improved access to information, support and skills contributes to reduction of inequalities.
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	Both carers and the cared for individuals are able to access social prescribing.
People using health and social care services are safe from harm.	There are clear roles and responsibilities within the services provided.
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	All social prescribing practitioners are highly enthusiastic about the role and have access to a range of training and support.
Resources are used effectively in the provision of health and social care services.	Community Connectors and Community Link Workers are subject to a commissioning process in 2020.

6.0 DIRECTIONS

6.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	X
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	

7.0 CONSULTATION

7.1 The report has been prepared by the Chief Officer of Inverclyde Health and Social Care Partnership (HSCP) after due consideration with relevant senior officers in the HSCP.

8.0 BACKGROUND PAPERS

8.1 Social Prescribing Report October 2019

APPENDIX

Social PRESCRIBING

Update Report
October 2019

Social Prescribing Projects

Community Links Workers | Pages 4 - 7

Funded by

Managed by

Community Connectors | Pages 8 - 15
& Volunteer
Community Connectors
Pages 16 - 17

Funded by

Managed by

SPRING Social Prescribing | Pages 18 - 21

Funded by

Managed by

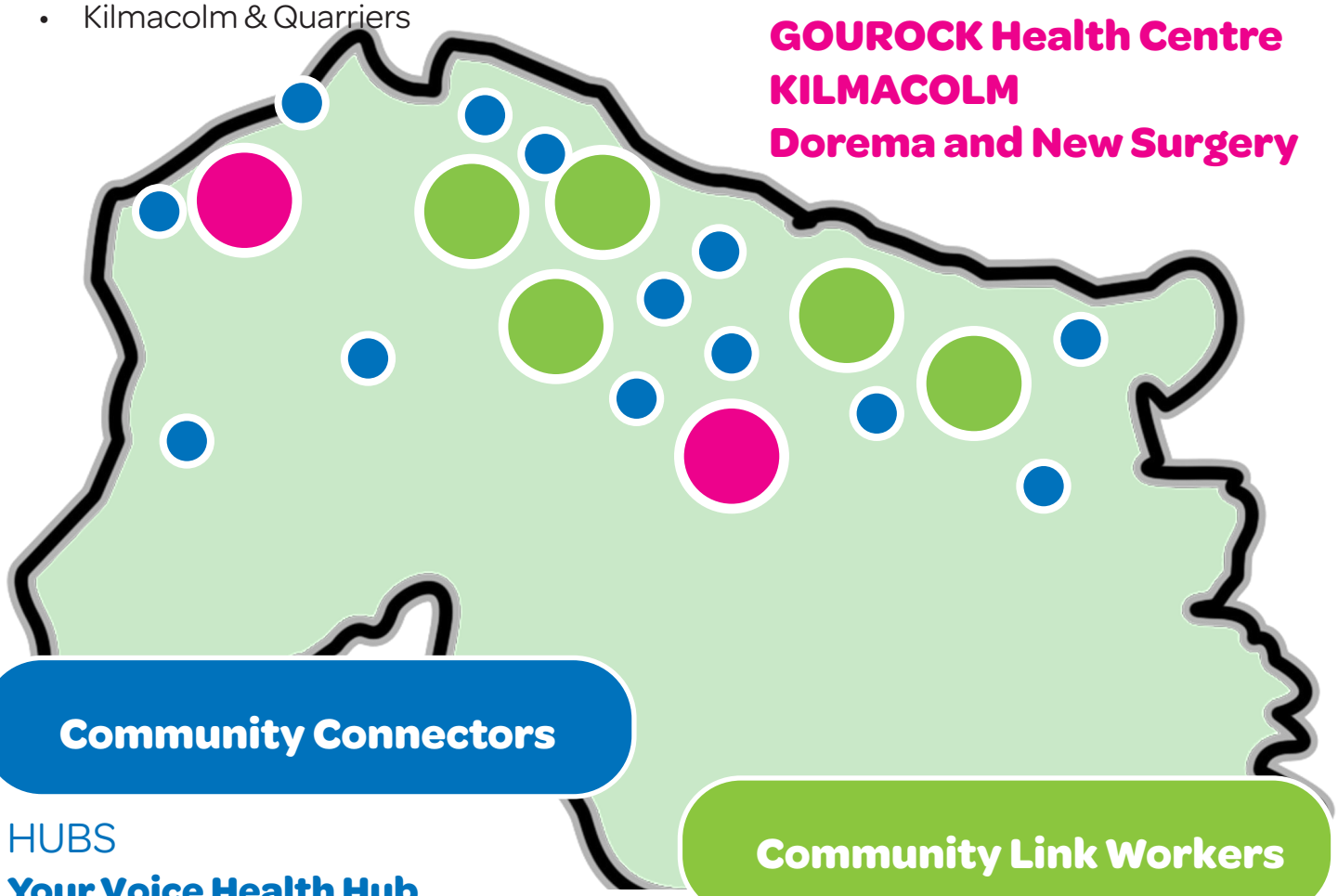
Macmillan Info & Connect | Pages 22 -23

Funded by

Managed by

INVERCLYDE
6 Localities

- Inverkip & Wemyss Bay
- Greenock West & Gourock
- Greenock South & South West
- Greenock East & Central
- Port Glasgow
- Kilmacolm & Quarriers



SPRING Social Prescriber

GP SURGERIES:

GOUROCK Health Centre
KILMACOLM
Dorema and New Surgery

Community Connectors

HUBS

Your Voice Health Hub
Inverclyde Royal Hospital
Port Glasgow Library
The Bothy, Gourock
Cardwell Garden Centre
Belville Community Gardens

OUTREACH POINTS

Greenock Central Library
Boglestone
Funworld
Sheltered Housing Complexes
Inverclyde Churches
Community Centres
Pharmacies

Community Link Workers

GP SURGERIES

STATION VIEW Health Centre
GREENOCK Health Centre
PORT GLASGOW Medical Centre
ARDGOWAN Medical Practice
PORT GLASGOW Health Centre
GOUROCK Health Centre
KILMACOLM
Dorema and New Surgery

NORTH AYRSHIRE, INVERKIP & WEMYSS BAY - 1 Worker

Community Links Workers

Funded by INVERCLYDE HSCP Health and Social Care Partnership

Managed by CVS Communities and the Voluntary Sector Inverclyde

6 Full time staff
1 Part time staff

Total Number of Referrals: **1823 People**

Overview

'A Community Link Worker (CLW) is a generalist social practitioner based in a GP practice serving a socio-economically deprived community, addressing the problems and issues that the individual brings to the consultation' (Scottish Government, 2017).

Aims of the Scottish Government CLW Programme:

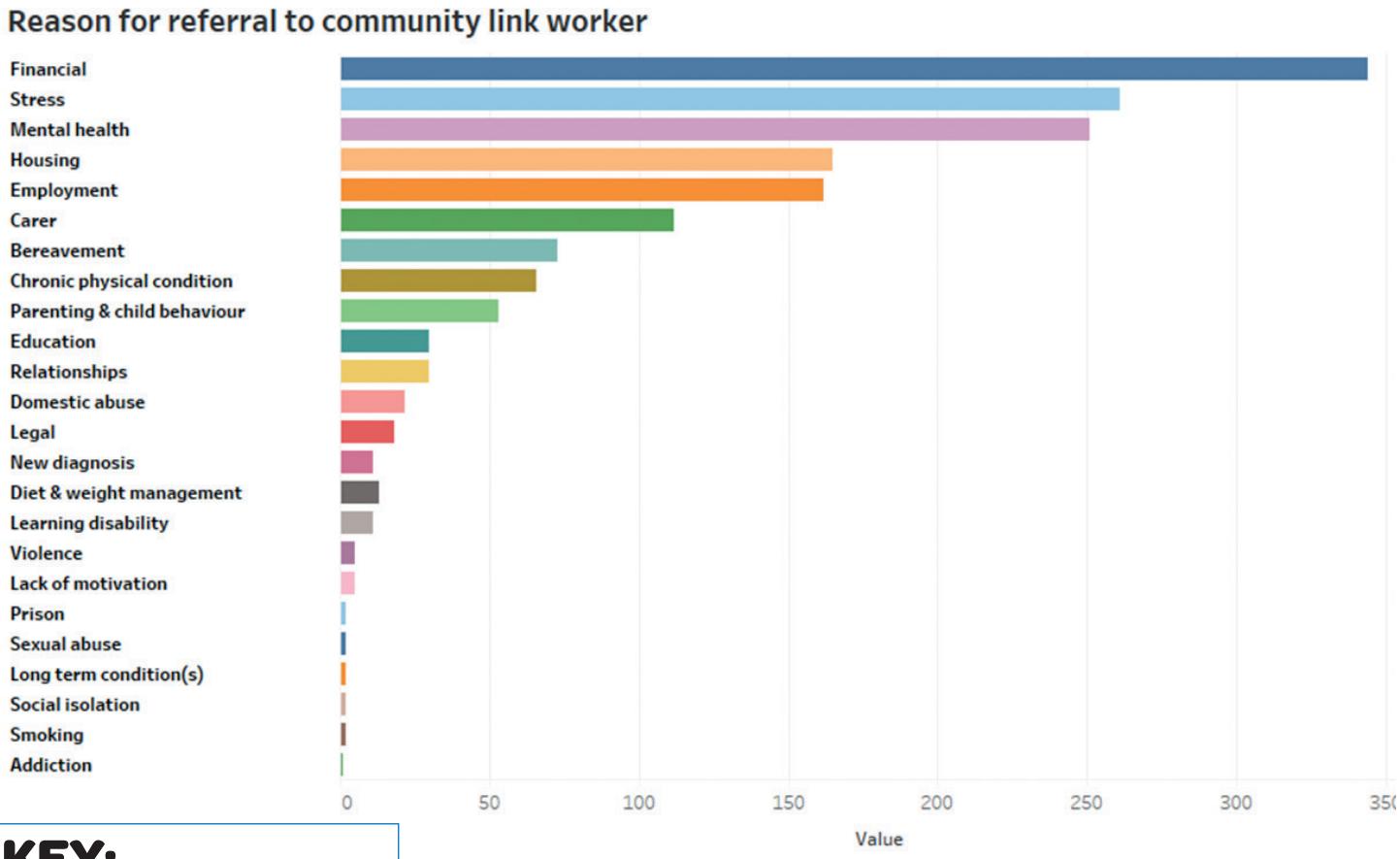
- **To support people to live well through strengthening connections between community resources and primary care**
- **To support GP practice teams working with individuals and communities who experience socio-economic deprivation**
- **To mitigate the impact of social and economic inequalities on health**
- **For CLWs to become members of the wider General Practice multidisciplinary team where appropriate.**

INVERCLYDE COMMUNITY LINKS WORKERS

The Community Link Worker programme in Inverclyde was established in November 2017 as a partnership between Inverclyde HSCP and CVS Inverclyde. Funded by the HSCP, the CLWs initially worked within 6 GP practices. This increased to 11 GP practices during the 2018-2019 financial year, with the final 3 practices gaining a CLW in November 2019.

Referrals to the CLWs usually come from the practice team including GPs, nurses and reception staff; however, individuals are also able to self-refer. Since 2017, the CLWs have received 1,823 referrals, with more than half of those referrals received during 2019. This demonstrates the increasing value and benefit primary care staff, and the service users themselves, place on the programme and the support it provides.

All CLW's are embedded in their practices where they have been given consultation space and time. While the CLWs use some of their time for community visits and mapping of local services, their presence in the practices has allowed strong relationships to develop between the CLWs and the GP practices. This has had a positive impact on how service users experience their interactions with the CLWs.



KEY:

- Financial
- Stress
- Mental health
- Housing
- Employment
- Carer
- Bereavement
- Chronic physical condition
- Parenting & child behaviour
- Education
- Relationships
- Domestic abuse
- Legal
- New diagnosis
- Diet & weight management
- Learning disability
- Violence
- Lack of motivation
- Prison
- Sexual abuse
- Long term condition(s)
- Social isolation
- Smoking
- Addiction

Top 6 main referral issues to the CLWs

- **Finance 30.5%**
- **Stress 23.1%**
- **Social prescribing for mental health 22.2%**
- **Housing 14.6%**
- **Employability 14.3%**
- **Carer issues 9.9%**

The individuals referred to the CLWs have complex psychosocial and socioeconomic needs. Consequently, the initial referring issue is often only one of many, with more than half of all referrals involving more than one issue. Through positive conversations, motivational interviewing and building strong therapeutic relationships, CLWs can support people to prioritise their concerns, develop an action plan and access the appropriate services. The CLWs have empowered people to engage with local organisations and services ranging from small church led groups to housing providers and local supports around mental health.

The CLWs collect quantitative data from EMIS, which is the GP IT system. Similarly, qualitative data about people's journeys and outcomes has been gathered through a focus group and questionnaires. A graphic of the focus group was produced to visualise the views of people who have used the CLW service. Additionally, the questionnaires address the key question – Where would you have gone if the CLW was not there? To date, 53.3% of people have responded that they would have returned to their GP.

Case Study

Mr J was struggling with debt and this was causing him anxiety. He was visiting the GP regularly as a safe space in which to express his feelings and concerns. Over a 5 month period Mr J's GP suggested several times that he take up the opportunity for a referral to the CLW based in the practice but each time Mr J refused because he was embarrassed about his situation. Due to strong buy-in by the primary care team, the GP was able to fully explain the CLW role and the possible benefits of engaging with them. Eventually, Mr J's agreed to the referral.

Because Mr J felt comfortable at his GP practice, he and the CLW agreed to meet there. He explained that he was in the final year of a debt plan but hadn't managed to make payments the past few months. He was receiving universal credit but did not receive enough money to cover the repayments for the debt in addition to his normal monthly expenses. He also spoke about his mother's death and that he was still struggling to come to terms with his loss. This also led him to disclose that he did not know how to use any of his household appliances because he had previously never had need to use them.

Having discussed Mr J's priorities, the CLW supported him to contact the debt company and explain his situation. Mr J was asked to send over proof of income and once this was processed, he was notified that he no longer had to make payments.

After the debt situation was resolved, Mr J said he needed support to manage his money better, learn to cook and keep a house. The CLW supported Mr J to access a cookery class at Belville Community Gardens and once his confidence grew, to ask his neighbour to show him how to use the washing machine. Because of this support, Mr J was able to save money on food and laundry facilities and was generally better equipped to manage his finances.

Mr J stated that he felt like a huge weight had been lifted off his shoulders. 'I wish I had come to see you earlier when the doctor first told me about you all those months ago'.

Next Steps

The work of the CLW team supports Inverclyde HSCP's 6 Big Actions. While this work more directly impacts some Big Actions more than others, everything they do promotes:

· Improving physical and mental wellbeing

· Giving children and young people the best start in life by supporting the parents of families with a range of complex issues

· Protecting the population by addressing the social disadvantages that can lead people to substance misuse, homelessness and offending

· People's right to live independently at home or in a homely setting by identifying support within the community for people facing homelessness, those who would benefit from anticipatory care planning and carers who need further support to continue in their caring role

Recovery services that are available across Inverclyde and linking directly with those supports offered by partners in the community.

'Knowing they are there in your diary helps you get through the dark moments'

Focus group participant

'I don't know what I will do if my next practice doesn't have a Community Link Worker!'

Locum GP

'I now feel like I can offer something to some of my patients that I've really not known what to do for the best'.

Inverclyde GP

CVS Inverclyde is the sponsor for Big Action 6 and core to our work is supporting the community to further develop our assets. As the third sector interface, CVS remit is to support community organisations to build their confidence and capacity to best serve the people of Inverclyde. Working within our compassionate community, the CLWs will be instrumental in addressing many of the aspects of Big Action 6 that are relevant to the complex needs of some of the most vulnerable members of our community

Community Connectors

Funded by INVERCLYDE HSCP Health and Social Care Partnership

Managed by your voice

2 Full time staff
2 Part time staff

Total Number of Referrals: **2163 People**

The Community Connector project was set up as a pilot in June 2016. The project is now successfully established and has developed partnerships with both HSCP staff and community groups and organisations across Inverclyde. Community Connectors enable local people to develop meaningful social support networks though person centred conversations and one to one support. Community Connectors work alongside people to identify their specific needs and appropriate interventions to reconnect with their communities.

Community Connectors work in the 6 localities across Inverclyde and deliver assistance to a wider range of local people. The emphasis of the Community Connector role is on creating opportunities to bring people together, maintaining, encouraging and creating networks and friendships, and promoting activities that help to overcome any barriers. With an ageing population, increasing loneliness, isolation and the increasing prevalence of poor mental health, there is a real need for this community-based approach.

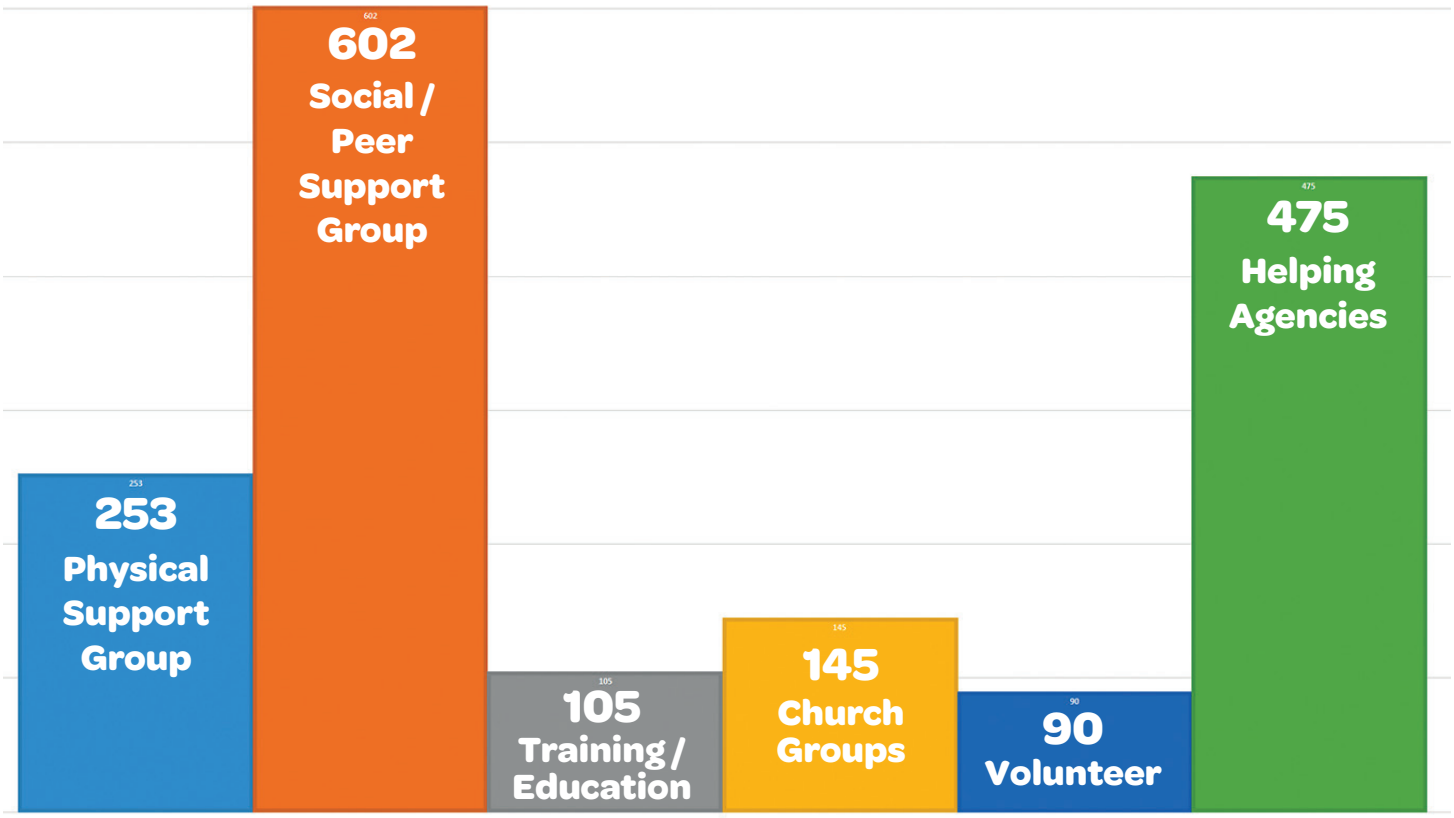
Community Connectors work with individuals for an average of 12 weeks. A breakdown is shown on the next page.

A clear referral pathway has been developed between the Community Links Workers, Social Prescribing Co-ordinator and the Community Connectors.

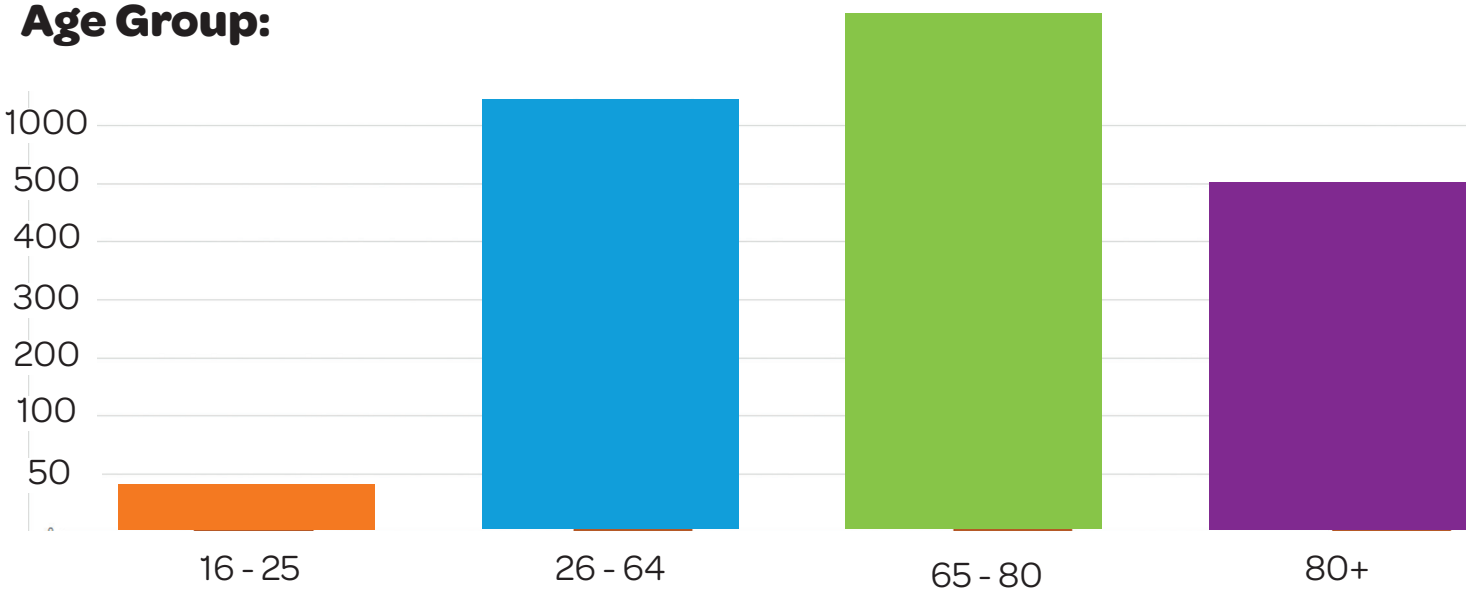
Feedback from some of the people who have accessed the Community Connector project is included on page 12.

1270 people – for 1 to 6 weeks
357 people – for 6 to 8 weeks
536 people – for 8 to 12 weeks

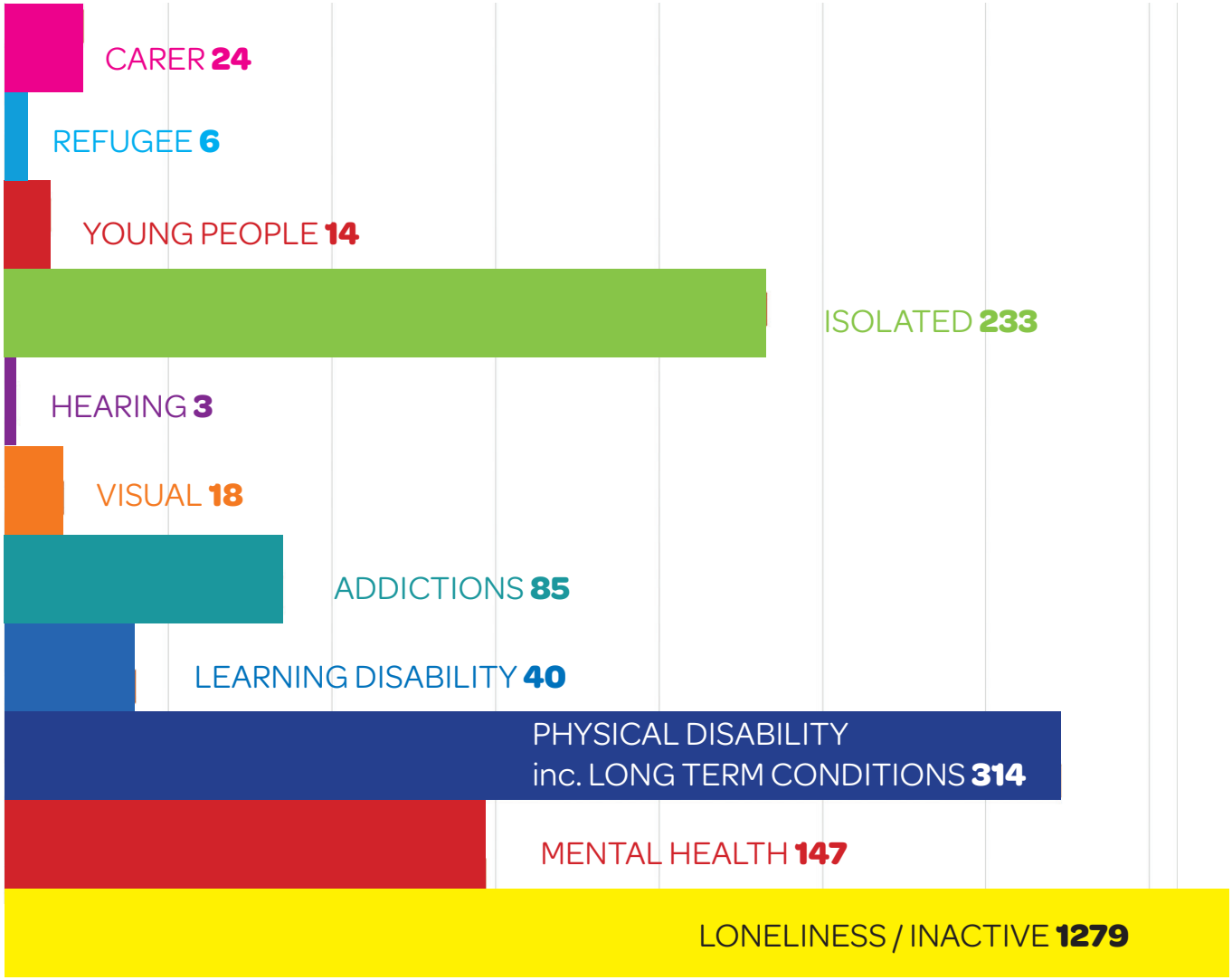
Connected to:



Age Group:



Category of referral



Referral Source

HSCP	368
Link Worker	12
Primary Care / GP	40
IRH/ Orchard View / Larkfield Unit	27
Voluntary Organisations	81
Housing	10
Outreach / Self	1625

Community Connector Feedback

From a GP:

"A huge success from Community Connectors with a patient of mine who is now engaged with Stepwell training programme. In the past 6 months I have seen more and more uptake of this resource."

— **Dr Luty**
Dorema Surgery

From an OT:

" just wanted to thank your service for the opportunities that you have now opened up for one of my community patients. She has been invigorated by the options that your service has offered to her. This in turn allows me to tailor my rehab in order to aim towards appropriate services that you can assist her to access. These community options will save time and money for community rehab services and also works towards a meaningful and valuable partnership. - Keep up the great work!."

— **Email received from Occupational Therapist**

From a Carer:

"My Mum has only been helped by Community Connectors for a few weeks but already it has changed her life. She loves going to Lyle Kirk Gateways and has made friends. The community Connectors are so helpful and friendly, so are the volunteers in the café. Keep up the good work"

"Community Connectors have made a huge difference to my mum. Mum was very low in spirits since moving to Wemyss Bay last August. But since we were put in touch with your team and she attends the Thursday social club she is a changed woman. Now she is upbeat, chatty and her confidence is starting to increase. I cannot praise yourself and Julie highly enough. You both go out of your way to help. Please continue!"

— **Elaine (Carer)**

What people said...

"I think this is a good project, it gets people out meeting others which is a good thing, otherwise you sit in the house feeling sorry for yourself, I like being out and meeting new people and talking to them"
– Julia

"If it wasn't for Community Connectors I would be lost. It has taken me out of the house, I have met lovely people and really enjoy my singing group. Loneliness can be horrible and that's why I feel the Community Connectors who work at The Voice do a wonderful job. Where would a lot of people be without them helping us? Keep up the good work"
– Shelia

"It has helped me come to terms with my husband's Dementia. I don't know how I would cope without them"
– Wilma

"A complete god send to me. I was housebound and unable to drive due to visual impairment, they arrange and book MyBus for me which allows me to go to Port Glasgow Shopping every week and get out this house"
– Isobel

"I previously accessed small group day care although I didn't really enjoy this, Community Connectors told me about Lyle Kirk Gateways. I now go every Tuesday and Thursday, it's great I have met new friends and we enjoy a blether"
– Sandra

"Having retired in 2017 I was at a loose end, I found the Community Connectors a great help in getting my life back in order. Since then I have done various jobs within the community, mostly volunteer driving. My thanks to all at Your Voice"
– Tommy

Community Connector Case Studies

Case Study - Azad

Azad was referred from the New Scots Project. Azad acknowledged he was isolated and would like to be more involved within his community as he as only lived here for 1 year.

Azad's interests include music, learning an instrument and video production. Community Connectors connected Azad to our peer support group – Music Connections, in partnership with local organisation Software Training Scotland (STS)

Azad has produced a mini documentary on behalf of Your Voice, highlighting our New Scots journeys to raise awareness within our Community. Azad continues to take part in the music group at Your Voice every week, and through Your Voice collaboration with STS to produce the documentary, Azad has now secured part time employment with STS.

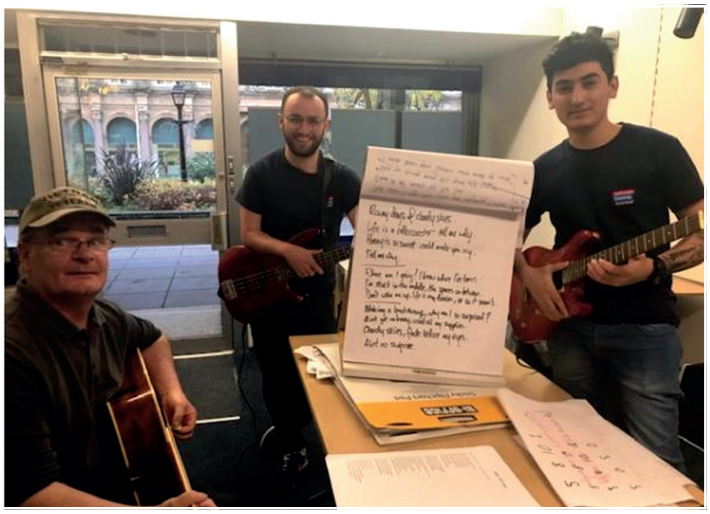
Case Study - Joshua

Referred by his GP, Joshua was lacking in confidence and had no routine within his week.

Joshua explained he would like to learn new skills which would possibly result in future employment and create a routine where he is kept busy on specific days.

Community Connectors connected Joshua to Stepwell Whole Life Employability programme, arranged an informal meeting with Stepwell manager to discuss the cohort.

Joshua completed the 6 month academy at Stepwell. Joshua is now employed by Stepwell franchise and working within the local Fresh Café branch



Case Study - Pearl

Pearl is a lady who receives HSCP services including Homecare and as a victim of crime, was reluctant to get out and about - she was feeling particularly isolated and vulnerable.

Together we discussed various opportunities available within the community and Pearl expressed she would like to access somewhere to learn how to use her recently purchased iPad.

Pearl decided she would like to come along to the Your Voice Digital Peer Support Group, and hasn't looked back since - she attends every week and has made lots of new friends, and learned new digital skills.

Community Connector Case Studies

Case Study - Tommy

Tommy recently retired and was looking to keep busy, and to get out to meet new people as the only social contact he had was in the pub. Tommy confirmed that he had an alcohol issue and was concerned that due to him being retired this would lead to him drinking more.

Initial conversation revealed Tommy drove for a living for many years, we identified Inverclyde Council for Voluntary Transport as they were looking for volunteer drivers. We also discussed various groups - Recovery Jam, Digital Groups and Mens groups - which would allow Tommy to become more sociable; and also learn new skills.

We assisted Tommy to meet with ICVT manager to complete a PVG, which was successful. Tommy is now volunteering four days a week which he is really enjoying.

Tommy has attended the digital group, recovery jam and men's group, however due to his volunteering commitments he is unable to attend the groups as much as he would like to.

He keeps in regular contact with us and confirmed that he wouldn't have known what to do/where to go if it wasn't for the Connectors getting him involved.

Tommy also expressed that his family members have seen a big change in his mental health and wellbeing, they were so happy that he isn't drinking anymore

Tommy thanked the Community Connectors for getting him involved in volunteering and attending groups, as this has changed his outlook in life. He says if he wasn't doing the volunteering then he would have never stopped drinking - due to the work that the Connectors have done Tommy does not need to contact alcohol services.

Case Study - Gordon

Gordon has additional support needs and was referred by his mother as he wasn't socially active and had very little to do with his time. Community Connectors identified the Chat Cafe Group at Your Voice as something that would be of benefit to get Gordon out of the rut he was stuck in.

Gordon came along to the group and really enjoyed it - since coming to Your Voice, Gordon's confidence has grown massively, he has been reunited with old friends, and now has a busy social life. He attends the group every week and, with support from our volunteers, attended days out in the community and lots more.

With support from Community Connectors, he has also now secured a volunteer position with Inverclyde Voluntary Transport 2 days a week, he loves to visit the Connectors to show off his expenses pay packet - Gordon says he can't thank the Community Connectors enough!!!

Community Connector Case Studies

Case Study - Libby

Libby contacted the Community Connectors after an office visit – she regularly attends Your Voice Peer Support Groups and enquired if Connectors could in any way help her with difficulties she was facing with her domestic power accounts as she was in a state of some distress - her supplier insisted that she handle things online, which she was frightened to do as she is not digitally confident.

Connectors met Libby agreed and set up a meeting with Your Voice Digital Communications Officer who explained how to switch her energy supplier and tie into one account for all her energy needs

We assisted with regulating her existing bill to a manageable level so it could be paid off, assisted with switching her account to a cheaper and more accommodating supplier; showed her how to use that supplier's online app on her iPad to set up regular direct debits at a manageable level to her income.

Libby is paying approximately half of what she was previously being charged for her power, which she finds fantastic – she is no longer worried about the expense of using her heating over the winter months.

Libby is more digitally confident and can track her monthly expenditure and keep on top of her energy usage using her iPad.

Case Study - Isobel

Isobel was referred by the Reablement Team. She lives in Kilmacolm and due to her poor mobility and deterioration in vision was no longer able to use her car. Connectors met with Isobel and she expressed her love of shopping and disappointment that she is no longer able to do this, Isobel stated "There's a reason that they call solitary confinement a punishment ". CC suggested she register with My Bus and she was eager to give this a try. As a result of this, Isobel now uses My Bus every Wednesday and says that the Community Connector have given her her life back. The Community Connectors keep in touch with Isobel and she loves to hear from the Team.

Case Study - Tom

Tom, a local Artist, approached Your Voice eager to volunteer providing Reminiscence Slide shows throughout Inverclyde. To enable Tom to provide this service to our network he required updated equipment which Your Voice funded. The slide shows have proven to be a great success with 38 shows delivered in the last year. Not only Tom has benefited from his Volunteering role, many of our older community and carers have provided feedback stating that the slideshows have sparked many happy memories, generated conversation and given them something to look forward to.

Volunteer Community Connectors

We have recruited and trained 51 volunteers. Volunteers are a valuable asset, with various roles including; Community Connectors, Peer Support Group Facilitators and Peer Evaluators.

Volunteers are also involved in our Health Hubs and pop up stalls across Inverclyde providing local people with information and signposting them to the right services and / or support.

Thomas

Thomas met one of our Community Connectors and offered his services as a volunteer.

He has built a great relationship with one of our SPRING referrals Craig who has mild learning difficulties. They have been taking part in multiple activities, TAI CHI, Art Group and Walking. This has opened a whole new world for Craig. Thomas is also helping Craig with his literature skills. Craig loves spending time with Thomas and says he is feeling fitter and loves being out and about with company as he was very lonely. At his initial review, Thomas says he loves the feeling of giving something back to the Community.

Tammy

Tammy moved to Kilmacolm in March 2019 after living in America for 34 years and felt very lonely and isolated. She was referred to the Social Prescribing project by her GP and at an initial meeting showed an interest in Volunteering.

Mary is an elderly lady who was isolated. Mary was unable to get out after having fallen a few times and had no family or friends nearby. Tammy meets Mary every Monday afternoon for a cuppa and a chat. The relationship is going very well and both parties are enjoying the benefits of their weekly visits.

Betty

Betty is our latest Community Connector Volunteer Betty was introduced to Rose whose mobility is poor and preventing her getting to social activities. Betty accompanies Rose on MyBus to her weekly coffee morning. Rose said she is delighted with this and is looks forward to meeting her friends and socialising again.

Volunteer Community Connectors

Margaret

Margaret is a carer for her daughter and volunteers with both Macmillan Info & Connect and Community Connectors- she has an interest in Volunteering. Margaret was keen to help with both MacMillan Info & Connect and Community Connector Volunteer. Margaret has been replenishing MacMillan booklets throughout Inverclyde. She has also built relationships with two Community Connector referrals, providing companionship and friendship. Margaret said that she was loving getting out and about and getting to know her "two lovely ladies".

Louise

"I've been volunteering with Your Voice since October 18, helping out at the Cardwell Garden Centre Health Hubs and at various Pop Ups. I really enjoy the role, it's helped my confidence to talk with others and I love that I can help just by listening and being able to help connect people with services and support available. I've since gained employment with Your Voice as an Admin Support Worker but I'm pleased that I can still carry on with my volunteering role"

51 Active Volunteers
26 Community Champions

Community Champions

We currently have a total of 26 Community Champions. Community Champions are members of the community in roles such as Shopworkers, Hairdressers, Taxi Drivers etc, who in their day to day role help customers, friends neighbours find support in their communities connecting them to the Social Prescribing Team. We are in the process of organising car and door stickers to raise awareness of establishments that promote Social Prescribing.

SPRING Social Prescribing

A community Approach to Health & Wellbeing

Funded by COMMUNITY FUND

Managed by your voice

1 Full Time Staff

104 Primary Care referrals:

Dorema / New Surgery Kilmacolm, Gourock Practice, and other primary care professionals

Social Prescribing aims to help people aged 18+ to address; social, emotional and practical needs, by connecting them to sources of support within their community with the aim of improving their health & wellbeing.

The Project is a partnership that brings together partners from across Scotland and Northern Ireland to deliver SPRING Social Prescribing. This is currently the largest coordinated project of its kind and is funded by The National Lottery - Community Fund. Key lead partners are The Healthy Living Centre Alliance (HLCA) and Scottish Communities for Health and Wellbeing (SCHW) who have identified 30 community-led health organisations to deliver this project. Your Voice was selected as a partner having a strong track record of delivering health and wellbeing outcomes for local people.

How does SPRING Social Prescribing work?

SPING Social Prescribing Project enables a GP or Primary Care Health Care professional to refer patients who suffer from; social isolation, low mood, mild depression, long term conditions or physically inactive and connect them to community based support programmes and activities.

SPRING Social Prescribing addresses the individual needs of a person using a holistic approach to health. A social prescription is an alternative support which empowers people to take greater control over their own health and wellbeing. People experience numerous health benefits such as better social connections and improved physical and mental wellbeing.

The project utilises a shared online system (Elemental Software) to monitor the progress of participants and to measure and report on health and wellbeing indicators using tools such as WEMWBS and Wellbeing Outcome Star, with all delivery partners, health professionals, and community providers having access to the system if required. A detailed map of the progress of the project can be produced – detailing impact on individual participants.

SPRING Social Model of Health

Total Prescriptions 226 | Total Interventions 902

Clinical Support	2	0.9%
Mental Health	48	21%
Diet & Nutrition	8	3.5%
Social Support	159	70%
Education	9	4.0%
Mobility Services	32	14%
Peer Support	112	50%
Addiction Services	2	0.9%
Physical Exercise	46	20%
Welfare Benefits	5	2.2%
Volunteering	13	6%

» Compassionate Inverclyde Hub (Tuesdays)	21	9%
» BFG Friendship Group	19	8%
» Lyle Kirk Gateways	16	7%
» MyBus	13	6%
» Ladies Craft Group	9	4.0%
» Mind Mosaic	8	3.5%
» Inverclyde Men's Shed	8	3.5%
» Inverclyde Carers Centre	8	3.5%
» Elim Church	7	3.1%
» Stress and Axiety Group	5	2.2%
» Art Peer Support Group	5	2.2%
» Mobility Scooter Hire	5	2.2%
» Back Home Box Volunteering (CI)	5	2.2%
» Your Voice Health Hub	4	1.8%
» Community Connector Volunteer	4	1.8%
» Inverclyde Recovery Cafe	3	1.3%
» MS Support Group	3	1.3%

Reasons for Referral

Low Level Mental Health	**77**	**50%**
Mild anxiety	25	16%
Mild depression	24	16%
Low self-esteem and confidence	49	32%
Stress	11	7%
Personal Development	10	6%
Social Isolation	**112**	**73%**
Interest in engaging in new activities/programmes	106	69%
Befriending	14	9%
Need for debt advice	**2**	**1.3%**
Benefit advice	2	1.3%
Housing support	0	0%
Diabetes	**1**	**0.6%**
Diabetes - Type 1	0	0%
Diabetes - Type 2	1	0.6%
Pre-diabetic	0	0%
Physical Inactivity	**26**	**17%**
Physically Inactive	10	6%
Weight reduction	2	1.3%
Poor mobility	14	9%
Falls prevention	4	2.6%
Nutrition Support	**3**	**1.9%**
Weight reduction	2	1.3%
Healthy eating advice	1	0.6%
Chronic Pain	**7**	**4.5%**
Fibromyalgia	4	2.6%
Chronic back pain	2	1.3%
Arthritis	1	0.6%
Other Chronic Pain	2	1.3%
Other Reasons	**22**	**14%**
Chronic Illness	13	8%
Other	9	6%

Billy
SPRING Case Study

One of our biggest social prescribing success stories, Billy has been coming to Your Voice since the project began and has been connected to the Recovery Music Jam. Billy suffers from depression and low mood, he has found a real sense of purpose and direction in his day to day life. Billy's mood has improved and he looks forward to getting out of the house, whereas before he couldn't face even doing simple things like picking up the telephone. Billy has even gained the confidence to perform on stage with the Recovery Band at several events!

Derek
SPRING Case Study

"I feel that Social Prescribing is a force for good. The Tai Chi classes Sean encouraged me to attend have enabled me to perform much needed exercise at a time when my mobility was limited. I am still far from anything like rigorous exercise so I will continue to attend"

From a GP...

"I'm finding Social Prescribing great so far – the more I've referred the easier it gets and I'm getting good feedback from the patients I've seen back. I even referred my first male patient today, woo hoo!"

- GP Audrey Francis

Thanks...!

"We've been meaning to thank you for your considerable help.

When we were referred we didn't know what to expect. The response was not only fast, it was so well tailored to our needs.

We have both felt the benefit of both physical activity and widened social contact. Local activities suit us better, we have found simply because we are not early risers and local sessions we use are later on in the day.

Dealing with you has been a real joy, with a lot of humour overlaying the fact that we all get old and sometimes a bit lonely.

Once again thanks for your help. See you again sometime!"

— Alvin & Liz

Mary

SPRING Case Study

"After my diagnosis of a long term condition, I was referred to the Social Prescribing Project by my GP. I wanted to engage in new activities but felt I was limited in what I was capable of; I'd lost confidence and was feeling generally isolated. We explored various options for me and I have attended various peer support groups, which I really enjoy. I have a routine and am much more confident in my life".

ELEMENTAL

The social prescribing people

The Social Prescribing team utilise the Digital Elemental Platform which allows us to refer individuals in under 60 seconds and track progress, impact and outcomes for the individuals referred to the project. Key features include:

- Social Prescription Generator
- Links to local services and support
- Attendance Tracker and Health Impact Measurement tools such as WEMWBS, Wellbeing Star and GP attendance.

Early indications evidence that 27 individuals have had a reduction in accessing their GP inappropriately.

We continue to develop and improve our monitoring, evaluation and recording systems to ensure we adapt provision to meet individual need and seek further opportunities to develop and expand the existing service.

This is supported by utilising our quality framework and completing a MQuiSS* assessment, assisting to identify development areas.

**Macmillan quality in information and support services*

Macmillan Info & Connect

Funded by

Managed by

1 Full Time Staff
1 Part Time Staff

A series of Pop Ups were hosted across Inverclyde predominately with a focus on Port Glasgow and Gourock, as suggested by local residents, to help determine best suitable locations for future Macmillan Info & Connect Hubs. After a year of piloting venues we now have 4 Hubs established with 253 Hub Visits and 18 Info Points located across Inverclyde;

- **Port Glasgow Library, Tuesdays 1.30pm to 3.30pm.**
- **Gourock Cardwell Garden Centre Wednesdays 11am to 1pm.**
- **Inverclyde Royal Hospital, Wednesdays 10am to 1pm**
- **Your Voice, Thursdays 1.30pm to 3.30pm.**

LEARNING AND REFLECTION

A restructure at Your Voice presented us with an opportunity and the decision was taken, following a lengthy period of monitoring usage and discussions with partners, to move the Hub from Greenock Central Library, to a dedicated shop front premise at Your Voice (provisionally opening in August 2019). The Your Voice Hub is utilised by many community groups all lending to a more robust complimentary community provision.

ACTIVITY ANALYSIS

1518 people reached via awareness raising & connecting people to info, support & services

29 volunteers recruited to date

18 active Information Points

4 Info & Connect @Inverclyde Hubs

45 Pop Ups in 25 locations

VOLUNTEERS

As the service continues to grow and expand we are particularlyt fortunate to have a committed core group of volunteers who support and shape the development and day to day delivery of Hubs, Pop Ups and Info Points. We have recruited 29 volunteers to date.

All volunteers are supported to access a programme of continued learning and development to enhance their skills, confidence and capacity and to ensure the time spent volunteering is a rewarding and satisfying experience, not only for visitors to the service, but for the volunteers themselves.

Training & Info Sessions include:

- Scotland's Service Directory / Macmillan funded Info for Me Tool / Click to be Contacted pilot
- Macmillan Safeguarding Training
- Sage and Thyme Training
- Ardgowan Hospice medical students engagement
- Sessions on local service provision/ exploring gaps and needs
- NHS Inform

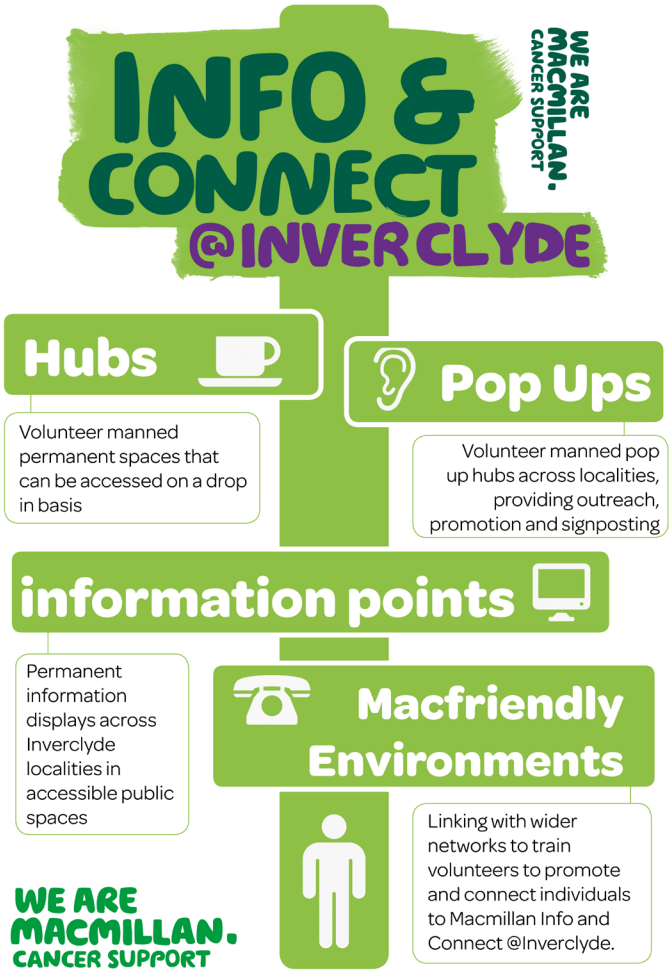
FUTURE DEVELOPMENTS

We have focussed on developing our links to identify Macmillan Champions; linking with wider volunteer networks, providing training, thus enabling us to promote and provide the service in 'Macmillan Friendly Environments' including; The Bothy 'Macmillan Friendly Walks, Community Centres, Compassionate Inverclyde Hub, Sport Centres, local post offices and pharmacies to name a few.

Case Study - Pauline

Pauline is currently living with cancer and is undergoing treatment with surgery planned in the near future. After speaking with Mac Info & Connect, it was clear Pauline was worried about her 25 year old daughter who has Learning Difficulties - the stress of how she would cope unsupported together with undergoing treatment was taking it's toll.

Outcome: Volunteers connected Pauline to HSCP Learning Disabilities Team. Her daughter is now living in supported accommodation with support plan and daily needs accommodated and Pauline has peace of mind.... and can now focus on her own wellbeing.



Social PRESCRIBING Project Update Report

OCTOBER 2019