Community Connections
Social Prescribing Project

Aims

This project aims to reduce the health inequalities in the community by improving the health and wellbeing of local people in the South Ward of Weston-super-Mare by developing a Social Prescribing Service. The Community Connector will take referrals from local GP practices to connect people to non-medicalised support in their local communities.

Background

The Creative Connecting project is about using creative approaches and thinking to help join up the dots between strategic initiatives and local energy and potential. It will:

- Work in partnership with local organisations to strengthen existing efforts to develop community capacity.
- Support the connection between these and more formal health and public services by providing a Community Connector.
- Ensure GPs and other health professionals can refer patients to activities that are available within the community and led by the community – social prescribing + asset-based community development.
- Build on existing activities and support their sustainability
- Identify gaps in provision where we can seed fund further development
- Learn from this project and share learning across the region in order to develop similar initiatives elsewhere

South Ward of Weston-super-Mare is an area of high health inequality.

- GP practice has second highest prevalence of depression in the whole of the South West Strategic Health Authority.
- North Somerset Joint Strategic Needs Assessment (JSNA) identifies following priorities:
    - Particularly poor health outcomes and joblessness in certain geographical areas, especially Weston-super-Mare Central and South wards.
    - Poor outcomes in certain vulnerable groups, including those with a mental illness and on low incomes.
- High levels of hospital admissions for deliberate self-harm and historically high levels of mental health related incapacity benefit.
- 21% of people in North Somerset who have received an NHS Health Check are clinically obese. South Ward, 29% of people are 'Clinically obese'.
- JSNA Key Challenge 13 for health and wellbeing "Reducing the rising levels of obesity, particularly in deprived areas and high risk groups including pregnant women and diabetics."

Project Outline

The project is initially funded for 2 years and part funded in year 3 by the Tudor Trust through Arts and Health South West (www.ahsw.org.uk). It will employ a full time Community Connector who will develop a Social Prescribing service with a particular slant to working with and through creative and arts based approaches.

The Community Connector will be employed by the For All Healthy Living Centre. This will enable them to build trust with the GP practice, the GPs and other allied health professionals to ensure they are confident about referring their patients to community activities and support.

Social Prescribing is now part of the strategic plans for the region and the locality. It is anticipated that this project will form part of a wider Weston Social Prescribing Service. The sustainability of the project is dependent on linking in to the strategic initiatives and priorities that statutory services are focused on. In particular, the Clinical Commissioning Group's 'Healthy Weston' plans.

Social Prescribing aims to have three outcomes:

- Improve the health and well-being and reduce social isolation and loneliness of patients.
- Reduce the pressures on clinical services; GP Practices and A&E services
- Strengthen the voluntary and community sector to support people and build on their strengths locally.

The Community Connector will be the communication hub, communicating with healthcare referrers and building up local knowledge of the groups and services: what's new, what has closed down, what's good and what's not as good as expected. It is important for the healthcare referrer to know if and when the person receives the support they need. Referrals will need to be tracked and monitored.

The aim is to build a connected community in which people can be supported before they go in to see their GP, as well as to provide linked up connections so that people going to see their GP due to a 'social' need rather than a purely medical need can be helped to find support and connection in the local community. This project is about better connection between voluntary community provision and statutory services so that people are supported in a more holistic way and their personal story is at the heart of what happens next. The Community Connector will be an imaginative and empathetic listener, able to respond to individual's stories and help them to identify their own pathways to better health, supporting them in making choices about what they would like to do to improve their situation. Where appropriate, the Community Connector will use creative approaches to engage people in exploring their stories. Learning from other social prescribing initiatives regionally and nationally, the Community Connector will help develop a system that works for local people.

We can estimate that approximately 100 people will be referred per annum via health professionals at the For All Healthy Living Centre. These will be the direct beneficiaries. There will be additional benefits for families and carers.

In addition to this and working with Alliance Homes, the Community Connector will be well networked into the Asset-based Community Development work in the wider community and may well develop relationships that mean referrals can occur without involving healthcare professionals.

Our partner, Theatre Orchard, will be our main route to connecting the project to creative activities and artists. They work with communities to develop inspiring theatre, telling diverse stories in unusual indoor and outdoor spaces. They have a long-term relationship with South Ward and will help the project to be innovative and imaginative while remaining grounded in the local community.

The first three months

The Community Connector will be building relationships and identifying opportunities. Time needs to be dedicated to establishing relationships with health professionals. They will attend regular meetings in the GP Practice to build trust and discuss:

- The criteria for referral
- The criteria for the Community Connector to refer people back to the GP
- The criteria for referral onwards to adult social care

They will need to develop and maintain relationships with all agencies, statutory and voluntary community sectors.

In order to provide GPs and other health professionals with clear routes for referral they will need to map and understand existing provision. They will need to gather local intelligence from our partners and other networks in the community and establish where community led activities are sustainable and where there are gaps. Health professionals will be concerned to ensure that community providers are well organised and can manage any risks, that activities are well structured and, where appropriate, there is some form of evaluation in place. The Community Connector will need to establish relationships with the full range of groups and services to which people might be referred.

A system of three levels of support and intervention is emerging locally and nationally. For many people it is hoped that some straightforward signposting might be appropriate, a second cohort will need to meet and be supported into local initiatives, and a smaller number may need more intensive and medium term support to join in with what is happening locally.

The Community Connector may need to meet up with people several times to ensure that they are able to engage with the opportunities available and will support them until they can see that progress has been made towards improving their health and wellbeing. It may be that they are not ready to join a community group and will need several one-to-one sessions.

The Community Connector will need to support people with a range of experiences, some of whom may be experiencing acute crisis. Clinical supervision for the Community Connector to be able to debrief needs to be considered and will be provided where appropriate.

The Community Connector will be employed by the For All Healthy Living Centre and they will be responsible for managing the role. The line manager for the post will be Mark Graham, Chief Executive.

Sustainability

Although initially funded for 2 years and part funded for year 3. It is intended that the monitoring and evaluation of the project will demonstrate strong evidence of the benefits and social impact of an early intervention based approach. This will be used to seek further investment to continue and build the project. The project will be evaluated with support from the New Economics Foundation and a locally based evaluator.

The service has a steering group to help oversee its development and implementation. This currently consists of representatives from:

- Arts & Health South West
- The For All Healthy Living Centre
- A GP from the local practice
- Alliance Homes
- Age UK
- Theatre Orchard
- Local community members

August 2018