SALFORD TOGETHER
Support to Stay Healthy and Well

Ref: 5.18.1

Health to Wellbeing GP Network update report
January - December 2016

INSPIRING COMMUNITIES TOGETHER
YOUR KNOWLEDGE, OUR KNOW-HOW HELPING MAKE A DIFFERENCE LOCALLY

Unlimited Potential

salford health matters

Salford CVS
Making a difference in Salford

1. Introduction

This report provides an overview of the work carried out by the health to wellbeing network team over the past twelve months. The interim six monthly report was presented to the GP Network group and received positive feedback. As can be seen through this update report progress is now starting to happen and a number of key learning points are starting to be developed. At the end of this report are the key learning points identified at this time and some recommendations for taking the learning forward over the twelve months along with costings for taking this work forward.

1.1 The aim of the Health to Wellbeing GP Network project is to improve health and wellbeing of the local population of Eccles and Irlam and reduce pressures on the primary healthcare system by signposting the population to more appropriate services across the city.

1.2 This will be done by increasing the quality of information, co-ordination and facilitation to enable a greater number of people to access Salford's community assets building on the work already taking place across Salford through the Salford Integrated Care for Older people Programme - Salford Together

1.3 **Key Concepts:** The 'Network' is based on 2 key concepts:

Table 1

A Funnel	**A Signpost**
Use the GP practice as a means of engagement based on the connections with local people and volume of activity… • 62,000 = Total number of registered patients in Eccles & Irlam Neighbourhood • 341,000 = Approx. number of consultations per year	Place resources in the GP practice so that people get access to the information, advice and support they need to access the community assets that will promote better health & well-being**.**

1.4 The Network in Practice

1.4.1 The network will aim to:

- Reduce social isolation in Salford
- Reduce number of non-medical related GP consultations

- Improve links between GPs and wider network of community assets

1.4.2 The project will run for one year from January – December 2016 and work across a partnership with each partner delivering one of the key deliverables outlined below.

1.5 The partnership delivery team

- The lead partner for the project will be Salford Health Matters who have extensive links with the GP Networks in Salford and will therefore help to reduce the difficulties of access
- Inspiring Communities Together (ICT) will deliver on objective one and oversee the day to day delivery of the project. This will ensure the link with Salford Together as ICT are the lead delivery partner for the Community Asset work stream of the Integrated Care Programme for Older People
- Salford CVS will deliver on objective two. The Volunteer Wellbeing Champion model has already been developed and tested as part of the Salford Together model and Salford CVS are the lead partners working with Inspiring Communities Together to deliver this model Salford wide.
- Unlimited Potential will deliver on objective three building on the model of wellbeing mentors which they have delivered across Salford over a number of years

Table 2

Salford Integrated Care for Older People (ICFOP)

To work towards achieving the aims of the ICfOP (delivering better care outcomes, improving the experience of service users and carers and reduce care costs). There are three component parts of the programme to deliver:

- Promotion and increased use of **Local Community Assets** to support increased independence and resilience for older people
- Establishment of an integrated **Centre of Contact** to support navigation, monitoring and support
- Establishment of **Multi-Disciplinary Groups** supporting older people who are most at risk, as well as a providing a broader focus on prevention and signposting to community support

Community Asset Vision: ***Using the knowledge and life experiences of older people to make life better by listening to and valuing their views: making sure this influences services to be better in future by building on community strengths. This will keep older people in Salford healthy, happy and independent for longer***

Community Asset Aim: Create greater independence and resilience within communities through increased use of community assets

1.6 National context

1.6.1 At a national level there is now much interest in the role of social prescribing models across the country and the impact it can have on individuals and reducing demand on services. A national network has been established led by the University of Westminster: The national network define social prescribing as ***social prescribing involves empowering individuals to improve their health and wellbeing and social welfare by connecting them to non-medical and community support services. It is an innovative and growing movement, with the potential to reduce the financial burden on the NHS and particularly on primary care.***

1.6.2 The national work has now developed a set of goals including:

- Expanding and consolidating the Social Prescribing Network, to drive local and national discussions on embedding social prescribing in the NHS
- Facilitating regional events to understand your experiences as well as how to better support members
- Translating the core principles of social prescribing into a framework for commissioning as well as standards to support quality of social prescribing delivered nationally
- Understanding the range of benefits of social prescribing, and working to develop better ways of researching and evaluating social prescribing
- Ensuring we have a process for ensuring patient and citizen involvement in all of our discussions

1.6.3 Whilst there is currently not a lot of evidence to demonstrate the positive impact of the model the network has also developed a framework for measurement which provides a valuable tool for the Health to Wellbeing network model of social prescribing.

Table 3

Physical and emotional health and wellbeing	Cost effectiveness & sustainability	Build on local community	Behaviour change	Capacity to build up VCS	Social determinates of health

Improve resilience	Prevention	Increase awareness of what is available	Lifestyle	More volunteering	Better employability
Self - confidence	Reduction in frequent primary care use	Strong links between VCS &health care	Sustained change	Volunteer graduates running schemes	Reduces isolation
Self-esteem	Savings across the care pathway	Community resilience	Ability to self-care	Addressing unmet needs of people	Social welfare law advice
Improve modifiable lifestyle factors	Reducing prescribing of medicines	Nurture community assets	Autonomy	Enhance social infrastructure	Reach marginalised groups
Improve mental health			Activation		Increase skills
Improve quality of life			Motivation		
			Learning new skills		

2. What are we trying to achieve locally?

2.1 **Promote access to the map of community assets for all -** All practice staff will have a resource available in the practice that provides a 'map' of community assets via the way2wellbeing.org.uk using tablets in the GP waiting rooms.

2.1.2 Provide low-level support for signposting & guidance for those with 'some needs' - Many people will be sufficiently active to just need information to access community assets. Often our practice staff just don't have the time or information available. We propose to create a team of social work students and volunteer wellbeing champions to be available in the practices with access to the Community Asset Map.

2.1.3 Shared Point of Access (SPoA) to more formal support - Some people may need more support to access community resources. Rather than 'referrals' to particular agencies – Health Trainers, Being Well Salford and Health Improvement Team - we will design a more slick & easy pathway. This can be initiated from any member of the practice team – GP, Practice Nurse, Reception, MDG, Social work students. The SPoA will engage the person with the correct service and notify the practice.

3. Objective one; Provide easy access to community information for all

All practices in Eccles and Irlam to have access to, and actively promote uptake of, the way2wellbeing.org in practice and have a method to enable pts to access easily.

3.1 Tasks:

- Design and print Postcards / business cards to link to way2wellbeing.org
- Design and print posters for GP practices to advertise way2wellbeing.org
- Create a publicity campaign, with associated PR to launch a campaign
- Identify practices who would like to volunteer to trial the approaches to IT in their practice
- Make available IT self-access in the waiting room of each practice.
- Deliver a series of health themed events throughout the year targeted at particular groups

3.2 Objective two: To recruit, train and support a team of Volunteer Wellbeing Champions

Volunteer Wellbeing Champions will help people navigate the way2wellbing.org portal and access the community assets they need

3.2.1 Tasks:

- Define the role of Volunteer Wellbeing Champion
- Trial the role in different styles. We have identified three methods: Receptionist, Social Student, Volunteer
- Identify 3 practices and trial these different approaches and learn about feasibility.
- Recruit, train, support and develop a team of 'Volunteer Wellbeing Champions' who will be available in each GP surgery to act as 'navigators'.

3.3 Objective three: To implement a quick and easy pathway for GPs and Nurses

To provide a 'Single Point of Access' for the additional support services available locally to help people better engage in community assets.

3.3.1 Tasks:

- Design a search to identify suitable frequent fliers– who are the highest users who have non-medical needs?
- Run the same search in each practice
- Design a suitable 'pathway' with key partners (Big Life Centre, HIT, & UP)
- 'Yellow flag' to initiate a conversation with GP or nurse
- Focus on key target groups: low mood / isolation, Learning Disabilities, Careers, Refugees and Asylum seekers

4. Objective one: Provide easy access to community information for all National outcomes: Builds up local community

Table 4

Output measures	Target all quarters	January - June	July	August	Sept	Oct	Nov	Dec	Total
Marketing material produced	1	1							1
Marketing material displayed in GP surgeries	8	0	4	1	0	0	0	0	5
Programme of campaigns agreed	12	12							12
Campaign material displayed in GP surgeries	8	3	1	1	0	0	0	0	5
Technology purchased	8	8							8
Technology accessible in GP surgeries	8	3	Wellbeing Mentors had access to the technology but this has had limited use in the practices						4

4.1 **Commentary** - The project continues to engage with the GP practices and it is hoped that the momentum will continue to grow as the impact is demonstrated. The marketing materials produced for the project are being well used by the team and the GP Practices have been able to see the benefit of the referral pads. The transfer of completed requests for support between the teams has been identified as an issue as sheets can get lost between visits. GP practices are visited on a weekly basis by members of the team to pick up any referrals, and ensure regular communication is maintained. Some practices have created their own systems including boxes whilst others have looked to the team for support. The material generated for the monthly campaigns are used by the Volunteer Wellbeing Champions to help with starting a conversation The tablet technology is not as popular as had been expected but is used when suitable by the Volunteer Wellbeing Champions. This is mainly due to the amount of time the volunteers have with one person. When more time is available they are a valuable resource.

5. Objective two: To recruit, train and support a team of Volunteer Wellbeing Champions
National context: Physical and emotional wellbeing, Builds up local community, capacity to build up the VCS, behavior change

Table 5

Output measures	Target all quarters	January - June	July	August	Sept	Oct	Nov	Dec	Total
Volunteer Coordinator recruited	1	1	2nd post holder recruited - August						1
Volunteer Wellbeing Champions recruited	20	8	0	1	0	5	1	1	16
Volunteer Wellbeing Champions' training sessions delivered	4	1	0		1	0	1	1	4
Wellbeing plans distributed	100	9	12	5	5	4	4	0	39
Wellbeing plans completed	80	8	5	1	0	0	0	0	14
Volunteer hours recorded	0	35	42	28	16	14	22	20	177

5.1 Commentary - This element of the programme has been through changes with the first post holder leaving and time then being spent on further recruitment. The second post holder took up post in August and has since then started to develop their knowledge of the project, started to build relationships with the current volunteers and other project team members and supported further recruitment and training of new volunteers**.** As part of the wider Salford Together Community Asset model the Volunteer Wellbeing Champion model continues to evolve and an updated training package has now been developed which takes place over one day and offers opportunities for volunteers to understand the different roles they may wish to take up. These volunteer opportunities include the GP Network. This coordinated approach has improved the messages and promotion of opportunities and means that the post holder works with a wider team for delivery of recruitment and training. In addition, the coordinated approach has enabled volunteers to volunteer on multiple projects, thus gaining wider experience and more knowledge of the wider determinants of health

which adds value to the GP Network programme. The volunteer coordination role is currently a part time post time and they focus on recruitment, support for volunteers and helping with the ongoing training of Volunteer Wellbeing Champions.

5.2 **Recruitment has to date included**: There are three main approaches for recruitment: Digital outreach, Physical outreach and Networking. The digital outreach has included adverts posted on Do-It and on Advantage (University of Salford website) and via Salford CVS website, Facebook and Twitter and Salford CVS Health & Social Care e-bulletin. Physical outreach has included targeted poster/leaflet campaigns in the Eccles, Irlam and Cadishead, and this has resulted in direct enquires. The networking approach has proved most fruitful. A number of the volunteers recruited have come through the programme either as current or former students from public health type degrees. This has shown there is a particular vocational relevance for this type of volunteering opportunity, as they gain experience from dissemination of health information within community settings to members of the public. As a result the Volunteering Coordinator has met with the course lead from Salford University Public Health Course and they are keen to share this volunteering experience to their students. In November the Volunteering Coordinator will be giving a talk to Public Health students. Through the Community Assets meeting links have been made with a Lecturer in Nursing at Salford University and they have been able to disseminate information about the volunteering through their internal system and academic leads. Clearly having support from the academics endorses the vocational relevance of the volunteering opportunity to students. The Hamilton Davis Trust has been a vital link to recruiting in Irlam and Cadishead and this work has been supported by two of the wellbeing Mentors who have come along to meetings with the volunteer coordinator. The December training was hosted at the Hamilton Davis Trust. In addition as the Volunteer Coordinator is based at Salford CVS they have been able to develop a good relationship with the Volunteer Centre Coordinator and they offer this opportunity to people who enquire about volunteering through the centre. Whilst we have had a good response through the digital outreach, the conversion rate has not been as good as we anticipated. However the outreach and in particularly the networking has been far more effective and worth the additional time it takes to do this.

5.3 **Training has to date included –** The previous training package was delivered up to July and no training was delivered in August due to holiday period. A Volunteer Wellbeing Champion one day training session was delivered at Pendleton Gateway in September for all potential Volunteer Wellbeing Champions. 3 of the Health to Wellbeing Project volunteers attended the Reminiscence and Dementia Awareness training held at Salford Museum in November. ***Volunteers who attended the training said they found it really worthwhile and they felt they had a better understanding of Dementia and also how to use reminiscence tools.***

5.4 **Delivery** – In the initial stages of development the Volunteer Wellbeing Champions were supported to deliver at times and venues identified by them. As the model has

developed we have identified that the best outcomes are where the Volunteer Wellbeing Champions are collocated in the GP Practices with the Wellbeing Mentors. This approach provides a much improved and joined up model which enables signposting between the two approaches. This has taken time to develop but from September Volunteer Wellbeing Champion sessions at St Andrews coincide with Wellbeing Mentor sessions. Due to the nature of volunteering and external commitments of volunteers there has been some reduction in the number of Volunteer Wellbeing Champion sessions in September and October. Two volunteers are having a break due to health and personal issues and two volunteers have returned to University outside of the area. On a positive note two of the recruits are also now volunteering on other Salford Together projects including tech and tea and supporting other community sessions in their own neighbourhoods. During November an informal focus group session will also be taking place with those who have completed a wellbeing plan and the volunteers to understand what if any improvements have been made to their own health and wellbeing. The GP environment can be a factor in engaging in wellbeing conversations and engagement is often brief as people are focused on their appointments. We are looking at whether engaging people as they leave the surgery is a more realistic option and how we can utilise the space available in the GP Practices to facilitate this option. In addition we are now investigating the feasibility of working in pharmacies attached to GP practices to see if there is a possibility to use these spaces to engage in wellbeing conversations whilst people are waiting for prescriptions to be filled.

Table 6

R, a female in her mid-30's, was interested in becoming a Volunteer Wellbeing Champion for the Health to Wellbeing GP Project. She had a Social Work degree and was studying for an MA in Public Health at the University of Salford. She had recently moved from Africa. R was keen to get experience of volunteering for a health promotion project whilst studying for her MA in Public Health. After undertaking Wellbeing Champion training in May 2016 R started volunteering as a Volunteer Wellbeing Champion at Eccles Gateway. R was initially quite nervous about having conversations with people as she was concerned that they might not understand her because of her accent. Gradually, with support and encouragement, R started to gain confidence in talking to people about their health and wellbeing and encouraging them, when appropriate, to complete a My Wellbeing Plan. When a new volunteer started in October R supported them during their first couple of weeks at Eccles Gateway. When completing an informal review of the project R commented that she had increased her confidence when talking to the public and enjoyed supporting the Wellbeing Champions stall with None of the other volunteers. She had increased her awareness of what was out there in the community for people. R successfully completed her MA in Public Health and

graduated in December 2016. After she completed her degree R decided to also volunteer on the Tech and Tea Project and is really enjoying supporting people over 65 to learn how to use a computer and complete the online My Wellbeing Plan. R is continuing to volunteer as a Wellbeing Champion for the Health to Wellbeing GP Project and Tech and Tea sessions whilst applying for jobs in Public Health. "*I feel I have increased my confidence when talking to the public since I started volunteering as a Wellbeing Champion as I was anxious about whether people would understand me*"

Table 7

Collective data to date				
Location	**Days attending per week**	**Number of volunteers attending each session**	**Number of volunteer hours total**	**Number of wellbeing plans distributed Total**
Monton	1	1	26	9
Springfield	0	0	0	0
Eccles gateway	1 x 2 session Am and PM	Varies 1-2 per session	105	20
St Andrews	1	2	64	10

6. Objective three: To implement a quick and easy pathway for GPs and Nurses National context: Physical and emotional health and wellbeing, builds up local community, behavior change, capacity to build up the VCS, social determinates of ill-health

Table 8

Output measures	**Target all quarters**	**January - June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Total**
initiate GP engagement and introductions	12	12							12
Utilise H2WB literature and take to GP	12	7	12						12

practice staff meetings – ensure WBM has appropriate 'intro' script and materials Assist with Health Campaign promotion								
Allocate 1-2 hours per week per practice for each WBM – develop plan to sustain relationship with GP practices	12	7	12					12
Produce 'Assessment plan' – combination of Outcome Star and Wellbeing Plan for appropriate Triage	1	1						1
data inputted onto appropriate system – DCRS *(name / contact details / appointment / signposting / outcome star / text)*	100	22	5	23	56	38	26	110

6.1 **Commentary:**. As the referrals have picked up, the Wellbeing Mentors have received a wider range of clients with varying needs. Overall, there has been a good ratio of people being referred and attendance at initial appointments with the Wellbeing Mentors. This could be due to the fact the majority of referrals have come from their

GP or nurse, and therefore they have taken the referral more seriously. The time allocated to each GP Practice varies, as some GP drop-in times have been merged with the agreement of the practice managers. Another reason for this is that some of the GP Practices, specifically in Irlam, are quite limited in size and therefore do not have the capacity to allocate a room or space within their premises. As can be seen from the data, however, some GP Practices have still to make any referrals even with regular contact. After the initial influx of referrals from Eccles, incoming referrals have now slowed having only received 5 from Salford Health Matters and 1 from Monton over the October period. This may be as the team are working more closely within the practice, seeing people as and when needed in the aforementioned time slots rather than receiving referrals and making appointments. Irlam referrals have continued to be steady, with a noticeable increase at Chapel medical and mossland medical centre. Most referrals are still being generated from Dr Whites practice, however referrals are now coming from the Dr's themselves rather than coming from other staff within the GP Practice such as, practice nurses. During the Christmas period referrals declined and a significant of people have chosen to book appointments in the New Year.

Table 9

Feedback from Sister Julie Trenbath, Practice Nurse at Dr. White's practice at Irlam Medical Centre (email 9 October, 2016):

"I'm finding the referral forms really useful. It's great to be able to signpost patients to you to utilise local amenities and voluntary organisations locally more effectively. I am actively encouraging my colleagues to use your service. It does save me time as I don't need to do a referral, the forms are simple and quick to complete and I'm grateful for your support and service."

Feedback from receptionist at Dr White's practice – *" I appreciate the fact that I can easily refer someone into the service if needed, as some times patients would stop to discuss their difficulties with me, the referral pads are very and easy to use in conversation with people"*

Table 10

Collective data to date January - December								
Location	**days attending per week**	**number of hours attending each session**	**number of assessment plans completed**	**number of new referrals**	**number of repeat attendees**	**referral points**		
						GP	**Vol**	**Other**
Eccles Gateway	0.5	3	0	0	0	0	0	0

Salford Health Matters	0.5	3	12	17	0	13	4	0
Monton Medical Centre	0.5	2	5	7	1	4	0	0
Springfield Medical Centre	0.5	2	2	1	0	0	0	1
St. Andrew's	0.5	2	0	0	0	0	0	0
St. Andrew's	0.5	2	1	1	0	1	0	0
St. Andrew's	0.5	2	1	1	0	0	0	1
Chapel Medical Centre	0.5	3	2	2	1	2	0	0
Irlam Group Practice	0	0	1	1	0	1	0	0
Irlam Health Centre	1	3.5	19	24	6	22	2	0
Mosslands Practice	1	3.5	8	8	2	9	0	0
Irlam Clinic	0	0	0	0	0	0	0	0

Table 11 - **Allocate 1-2 hours per week per practice for each WBM** – The following table identifies the days/times that wellbeing mentors are in each practice

Practice	**Lead GP**	Day	Time
St Andrews 1	Dr P Budden	Wednesday	10am-12pm
St Andrews 2	Dr M Yates	Wednesday	10am-12pm
St Andrews 3	Dr J Bahardien	Wednesday	10am-12pm
Salford Health Matters	Dr C Gibbons	Monday	9am-12pm
Eccles Gateway MP	Dr H Singh	Monday	9am-12pm

Monton MP	Dr J Borg-Constanzi	Monday	1pm-4pm
Springfield MP	Dr N Whittaker	Wednesday	1pm-3pm
Mosslands MP	Dr B Hope	Monday	9am-3pm
Chapel MP	Dr V Joshi	Wednesday	10am-12pm
Dr White and Partners	Dr J White	Monday	9am-3pm
Salford Care Centre Irlam	Dr C Malcomson	No space	No space
Irlam Group Practice	Dr D Dillon	TBC	TBC

Table 12 – referral points

Referral points January – June 2016												
HIT	BWS	AL	CCBT	SD	SCL	START	Call +	DS	UC			
2	**4**	**4**	**4**	**1**	**1**	**3**	**1**	**3**	**3**			
Referral points July – August 2016												
HIT	BWS	AL	CCBT	SD	SCL	START	CALL +	DS	UC	AA	CG	DC
1	**0**	**2**	**0**	**0**	**1**	**3**	**0**	**1**	**0**	**0**	**0**	**1**
Referral points September 2016												
HIT	BWS	AL	CCBT	SD	SCL	START	CALL +	DS	UC	AA	CG	DC
2	**4**	**4**	**4**	**1**	**1**	**3**	**1**	**3**	**3**	**0**	**0**	**0**
Referral points October 2016												
HIT	BWS	AL	CCBT	SD	SCL	START	CALL +	DS	UC	AA	CG	DC
16	**8**	**12**	**6**	**1**	**1**	**11**	**1**	**3**	**3**	**0**	**0**	**0**
Referral points Nov-Dec 2016												
HIT	BWS	AL	CCBT	SD	SCL	START	CALL +	DS	UC	AA	CG	DC
8	**3**	**7**	**2**	**1**	**1**	**5**	**1**	**3**	**4**	**1**	**3**	**0**

Referral point codes

AA – Aids and Adaptation Team
AL – Active Lifestyles
BWS – Being Well Salford
CALL+ – Call Plus, Langworthy Cornerstone

CCBT – Computer Cognitive Behavioural Therapy
CG – Community Groups
HIT – Health Improvement Team
SCL – Salford Community Leisure
SD – Six Degrees
START – Start Art
DS – Dietary Support (UP)
DC – Diabetic Clinic

7. Case studies – Volunteer Wellbeing Champions

Case study: HS (male aged 30 – 40) and HT (female aged 30 – 40) visited the Volunteer Wellbeing Champions stand at Eccles Gateway after they were attended a GP appointment on 17th August. They are a couple with a child, approximately 9 months old. Through an informal conversation the Volunteer Wellbeing Champions they were able find out that HS and HT has a number of concerns regarding their health and wellbeing. This included issues with their weight - HS struggled to put weight on and HT found it difficult to lose weight , also HS explained he needed support with learning as English was not his first language. He also smoked but was keen to get support to reduce/stop smoking. The volunteer wellbeing champions were able to inform HT and HS about the wellbeing mentors and completed a signposting sheet with each of them. For HT – signposting for support with weight management, smoking and learning/education. The wellbeing mentors have now made contact with HT and HS and are arranging to meet with them. This approach has highlighted the importance of the volunteer wellbeing champions and the wellbeing mentors working closely together and the role of the signposting sheets when they are volunteering in the GP practices.

J is a woman in her early 30's who had visited her GP at Eccles Gateway. She came over to the Volunteer Wellbeing Champions stall and asked the volunteers what they were doing. One of the volunteers explained about their role and J said she was interested in losing weight. During the discussion J got visibly upset as she said she hated her body and had also lost her mum in the last few months. J also smoked and was keen to get support to stop smoking J felt she had such low self-esteem and body image and she was also struggling with the loss of her mum. She said as a result she didn't eat properly and was always tired. The Volunteer Wellbeing Champion listed carefully and explained about the role of the Wellbeing Mentors and the range of support they could offer. J then completed the Wellbeing Mentor signposting sheet. The Wellbeing Mentor has been in touch and arranged to meet J.

S, a woman in her mid 40's approached the Volunteer Wellbeing Champions stall at Eccles Gateway interested in finding out why we were there. After having a conversation with her about her health and wellbeing she agreed to take a My Wellbeing Plan. S explained she had a hectic life with two young children and was concerned about her husband who had some issues with alcohol and he also smoked but was considering giving up/cutting down. S admitted he knew he had a problem with his drinking but was managing it. Gave S info about the Wellbeing Mentors and she agreed to have a chat with her husband to see if he would be interested in being referred for support around alcohol and smoking. S said she would have a chat with her husband about referral to a Wellbeing Mentor and was enthusiastic about taking the My Wellbeing Plan away and completing it. She agreed to be contacted in 3 months to discuss how she was getting on with completing the plan and how she felt about it.

These examples shows how the wider determinants of health are important in health and wellbeing and how it can be negatively impacted on through a variety of factors including language barriers, low self-esteem, relationships and bereavement.

7.1 Case studies – Wellbeing Mentors

E is a 24 year old female from the Irlam area. She was referred to the service for support with her weight management as she had gained significant weight after pregnancy. She was at the time attending a boot camp which she was finding difficult due to the location and level of fitness required. She did not want to join a gym due to financial reasons – following further discussion it was arranged for me to take E to the local Zumba class, refer her to Salford Active Lifestyles team and sign post her to baby swim. To date we have attended the Zumba class and E is awaiting an appointment for the active lifestyles team. E was very pleased with the links she had now made into community activity as she had only recently moved into the area.

AB is a 27 year old female who is new to the area and works full time. She was referred via the practice nurse for support around losing weight and getting healthier in general. The wellbeing mentor was able to support her to identify classes which were available at times to suit her work life and referred AB to active lifestyle and offered one to one gym support, alongside initially accompanying her to weight support classes. The support is still ongoing and will be attending the gym twice a week, alongside attending a weight support class once a week. AB was also provided with support around a career change and going into cake baking full time, as was not enjoying current job role. AB is happy with the support received and felt having someone to accompany her initially made a huge difference to their motivation

MD is a 55 year old male from the Eccles area. On meeting he explained that he had been referred to a wellbeing mentor due to the chronic pain he was experiencing daily. He felt that

the many different forms of medication he was taking to manage his hypertension and diabetes were the cause of this pain in both his back and knees. MD stated that he had experienced depressive type symptoms due to this pain as it was limiting his daily function and task that he could previously complete he was now unable to. The wellbeing mentor referred him to active lifestyles to help better manage his symptoms of pain. With the long term goal of reducing symptoms associated with diabetes and hypertension through the exercise programme in turn reducing reliance on medication. MD was supported to his initial active lifestyles session by a wellbeing mentor and has continued to attend his sessions reaping the many benefits of the programme. His pain has reduced and he is now able to complete day to day tasks more effectively. MD explained that he is very happy with the exercise programme and the benefits he is experience. He is arranging for his wife to see her GP about being referred for the support of the wellbeing mentor for similar support. MD is also now more socially engaged through the programme whereas previously he was quite isolated. MD was unaware of the exercise service and felt he would still be unaware without the Health to Wellbeing Networks intervention. MD explained that he had been on medication for many years and that he was unaware his conditions could be managed in this way.

A is a 17-year-old female from the Irlam area. A was referred by her practice nurse for support around weight management and exercise. She wanted to learn more around losing weight and feeling healthier as she had started to gain weight over the past year, felt self-conscious about this and wanted to lose weight before going to university. A's BMI was 4 points over the recommended health range, so a target was set to slowly lose weight over the next couple of months through a balanced diet and exercise. The challenge was that A was not eligible for a lot of the services that she wanted to access due to her being under 18 years of age, such as Being Well Salford and Active Lifestyles. She was therefore unable to get the free 8-week gym pass from Active Lifestyles or access Being Well Salford until December when she will be 18 years of age. Wellbeing mentor however found the price ranges to join Salford Community Leisure for under-18s. This turned out to be quite reasonable and, as my A worked part-time, she was able to afford this. Another challenge was that she worked in a restaurant that offered her free meals as an employee. She often ate there and said she would struggle not to eat there. I therefore researched the menu for the restaurant and recommended the healthier alternatives for her to choose from if she wanted to eat at work. She has so far lost half a stone and feels very confident within herself. She is following a balanced diet that I have reviewed to make she is getting in a good range and amount of food. She is enjoying more physical activity and says she feels more energised for work and college as a result of this. Her family have also got on board as she has started cooking and planning meals with her mum. She said this has really helped her out as she will have to cook for herself when she moves out for university, and has therefore found this to be great preparation for when she does. She is also developing Life skills around cooking and awareness of how much meals cost, as she has started making her own shopping list and accompanying her mother on the family food shops. A said she also felt significantly more educated around healthy food choices and leading a balanced lifestyle. She enjoyed the fact that food and treats weren't cut out, but understood that an awareness of how much junk food we eat. She also changed habits around snacking or skipping meals

whilst in college, and began taking in healthy snacks to avoid getting progressively hungry throughout the day.

R is a 41-year-old male living in the Irlam area. He was referred via his GP for support around his mental wellbeing. R wanted support around increasing motivation and reducing low moods. R was off work on sick leave due to anxiety that started at work. He had come on and off sick leave for the past 18 months. Through discussion, it was agreed that R needed to use the time off to look for a different job, or a complete career change, as his anxiety worsened to the point of panic attacks every time he went back to work. R has been looking for new job roles and says he feels a little more hopeful. R used to be an active cyclist but had completely stopped doing this as he could no longer find the motivation to do it. Through discussion, it was suggested that this could be due to his passion for cycling turning into a chore, as he would often push himself to cycle upwards of 40 miles a day. It was also suggested that due to his negative feelings at work, the motivation to then cycle was probably being deflated. A men's cycling group was identified for R to attend in order to initially build his confidence and transition back into cycling. Also a family cycling group was located as R said he wanted to try and do more things with his family. R also wanted to join a gym and try out new classes, as he felt he had gained weight due to no longer cycling and that this was reducing his confidence in himself further. R had joined several gyms in the past but had never taken to them as he did not enjoy the weight training side of things or the atmosphere in gyms, as he was more into high intensity workouts, such as his cycling. R was referred to Active Lifestyles for an assessment and access him more information around the classes they run, however R did not feel like he needed any support into the classes, but appreciated the support of being referred and the information as he said this motivated him to at least give it a go. R was also referred into Being Well Salford for more long-term support around maintaining his goals, motivation and working on his low moods. Being able to talk about his work and how much this had affected him R was able to explore the possibility of leaving the job he had done for the past 14 years. He is currently weighing up the pros and cons and actively looking at other career options. R was not referred for support around employability, or even support around exercise, but he complete the outcome star and discussed his general wellbeing in more detail, it meant that he was able to fully assess his own needs and what support he actually wanted. R said he was glad he made the first step to see his GP and mention his depression/anxiety and was glad that his GP thought to refer him to the Health and Wellbeing network programme.

JW is 50-year-old male. He was referred by his GP because of his alcohol use. JW wanted help/support to reduce and then stop his alcohol intake. JW was very nervous, playing with his hands, had his head down and wouldn't make eye contact on the initial meeting. Currently JW is drinking all day every day which is affecting his health and wellbeing: he feels depressed as he does not feel in control of his life, as he needs to drink. JW isn't happy with this and says he won't be here much longer if he carries on drinking, as it's a matter of time before his health problems get worse, as he has already had a heart attack. I reassured JW that he had taken the first step by coming to the appointment today: he was doing great and it's 'one step at a time'. I reassured JW that there was help out there and that I could support him. I told him about Achieve (a drug and

alcohol service) and explained how they could help him. JW was happy for me to refer him. We gave Achieve a ring and arranged an appointment for an assessment the following week. JW wants me to go with him to the assessment for support as he doesn't feel confident going on his own. He is now looking forward and is more positive about the future as he feels there is help and support out there. Additional support was an important point in this case as JW was very nervous and anxious. He didn't feel that he had the confidence to arrange or go alone to his assessment at Achieve. JW told me he was very nervous when he first came to see me. He was thinking for days about what to say to me. He said that I made him feel very comfortable and didn't feel like he was being judged. He sent a text that evening thanking me for the support he had received.

PW is a white male aged 47 years old. He was referred by his nurse who is based at his GP surgery. PW was referred because he suffers with low mood. He has fibromyalgia and wanted some information about this, as he didn't know anything about it, only that it made him tired and gave him pain. As we were doing the outcome star, it came out that PW was struggling financially. He has his own business and only works part-time due to his condition. PW and his partner had recently had a baby. His partner is currently on maternity leave until early October and is not going back to work due to childcare costs, as they can't afford it. PW and his partner have no other income than from his part-time work. This is putting a lot of pressure on PW, causing him anxiety as he is struggling now and doesn't know how he will manage when the maternity pay stops. PW has a great support network. He has a supportive partner and friends, but feels isolated as he feels that he has no one to talk to who really understands about the fibromyalgia. When he does talk to others, he feels like he is moaning. This is affecting his mental wellbeing I suggested the Salford Fibromyalgia Support Group, as there he can talk to people with the same condition and can learn about fibromyalgia from the speakers who attend the sessions to give people information. I have referred PW onto Welfare Rights and they are supporting him with his finances.. PW suffers with low mood. Initially, this was just about fibromyalgia, but as we got talking and did the outcome star, it identified that his financial difficulties were causing him low mood more than the fibromyalgia. When doing the outcome star we got to the feeling positive part. PW rated himself at a 4. He said that before talking to me, he would have rated it at a 2... He said speaking to someone has made him feel a lot more positive and having someone letting him know what's out there is great.

L is a 30-year-old female from the Eccles area, referred by Salford Health Matters. L has numerous health conditions which were limiting her daily activity. She specifically explained about her narcolepsy and bloating after eating. L explained that the bloating was due to irritable bowel syndrome (IBS) and that she had been through every dietary intervention possible to try and correct this, such as cutting out wheat, lactose, etc. The Wellbeing Mentor attempted to explain that IBS is usually down to stress, which L found hard to fathom and was adamant it was diet-related. However, this prompted L to further divulge that she experiences health and social-based anxiety. The Wellbeing Mentor explained that there may be a correlation between this stress and her IBS. L was unsure that this was the case, but agreed to attend computerised cognitive behavioural therapy (CBT) sessions, alongside mindfulness. After two months of attending both CBT and mindfulness, L feels much more

at ease practicing daily the techniques learned. Although she still becomes anxious, she feels that she is generally much more at ease. Both the therapist and Mind have supported the view that stress can provoke IBS, L still has a limited diet, but has been provided with a coeliac-based nutrition plan from the Wellbeing Mentor to test alongside her new therapy to see if flare-ups continue. L and her partner really appreciated the intensive support that the intervention could offer. They explained that previously their therapies had solely been based around improving diet, without acknowledging the link with mental health.

M is a 72-year-old male from the Monton area. He was referred by his GP at Monton Medical Centre. M had previously been very active, but had stopped due to his 'age' and was becoming increasingly worried about his deteriorating health (hypertension, pacemaker). As M had previously been active, the explanation around the exercise referral scheme did not appeal, seeming much slower and 'old' than he was used to previously. The Wellbeing Mentor explained that, although the exercise was much less intense, the reason behind this was to cater for the symptoms that M was experiencing and to not aggravate the condition further. M was not convinced, but agreed to a referral to Active Lifestyles. After one month attending the Active Lifestyles sessions, M met with the Wellbeing Mentor at Monton Medical Centre. M feels much better for attending the sessions and explained that he had already seen an improvement in his knees, as he was previously experiencing pain. He will continue to attend the Active Lifestyles sessions and is enjoying the engagement. Aside from the exercise-based benefits of improving physical symptoms, M's second assessment revealed that he had become quite lonely after recently losing his wife. M explained that the Active Lifestyles group has given him an outlet to meet new people and socialise outside of the group, which he is really grateful for. "My knees don't hurt as much anymore." "I really enjoy being around people again."

B is a 55 year old male from Eccles. B spoke to his receptionist at Springfield Medical Practice about his current issues, the receptionist explained that the Wellbeing Mentor may be able to support. B then made contact to arrange an appointment. B had lost his mother a few years ago and felt he was still feeling the effects. This alongside issues at work had led to him coming out of work on sick leave further adding to his depressive state. B has already accessed numerous services throughout the city for support, having a previous role in the council he was very aware of what was available. The Wellbeing Mentor looked at the issues which didn't seem as problematic from B such as smoking and weight management. B agreed to a referral to Being Well Salford for support around smoking but felt that gym support, for now, may be too much. B now feels that he is on the right track to reducing his cigarettes smoke, also finding talking with his Being Well Coach 'therapeutic' and an outlet to speak openly without someone who doesn't seem as professional or with the same agenda as a counsellor or practitioner. Now that Being Well is supporting B, there is an opportunity to revisited areas, such as weight management.

L is a 42 year old male from the Ellesmere Park area of Salford. L had experienced quite a traumatic time over the past year which has affected his confidence in going out socially, he also had issues with the family which had resulted in him being scared for his own life – L was initially hesitant of opening up as his family issues had been well documented and he

afraid that if more people were aware this could make matters worse. L had lost contact with his friendship group and had taken time off work due to all the family issues. L is now engaged with CCBT and feels he has started to develop some coping mechanisms – he now feels more at ease and more able to cope.

8. Key learning points

8.1 **Learning point one – Time scale needed to build relationships and trust**
As can be seen from the report the referals via the GP Practices are continuing to grow with some very positive feed back from the GP Practices. For some practices the opportunity to build the model into their daily surgeries seems to work well whilst others can see the benefit of the refferal process. Indentifying a advocate for the project such as the practice manager or nurse has also been key to the success of the approach

8.2 Learning point two – develop a share understanding of roles and responsibilities
The team has continued to build their own roles and responsibilites and the relationship between the Volunteer Wellbeing Champions and the Wellbeing Mentors has also started to develop which makes the model work better within the practices. The project was also set up monthly project team meetings to enable some shared learning and development of the model.

8.3 Learning point three – Ownership of the model
We continue to see engagement through the GP Practice staff and for some this has been a very positive experience for others it has taken longer to develop the understanding of the opportunities this project can bring to the staff as well as the indiviudals attending the practice wil hopefully start to be seen over the next few months.

7.4 Learning point four – Collection of evidence to demonstrate impact
As outlined in the report we are starting to see some output measures but still need to build the case for outcomes and impact on the GP practices. We continue to collect our case studies but will also be carrying out some interviews with people who have accessed support to try to understand what the impact has been on their own health and wellbeing and if they now feel more able to manage their own health and wellbeing better.

7.5 **Learning point five – Colocation in GP Practice**
Being located within a GP Practice has enabled a joined up model to be developed and the approach is now starting to be seen as part of a wider service offered within the practice. This has help to reduce the number of no shows.

7.6 **Learning point six – The environment needs to be right**
The environment of the GP Practice is a major factor in the success of the project. If there is no space for the Volunteer Wellbeing Champions and Wellbeing Mentors it makes it impossible to build relationships and delivery the model well. As there are a number of pharmacies linked to GP Practices this could be a space that could be

utilised to engage with people, whilst they are waiting for their prescriptions if no space is available in the Practice

7.7 **Learning point seven** – **Demand reduction**
Whilst we cannot provide any evidence at this time of demand reduction we can offer some anecdotal evidence the service provides space for people to talk about their own health and wellbeing without the restriction of time to talk. If the model was developed further this could lead to demand reduction on booking non-medical related time with the GP.

9. Key asks for the next twelve months

9.1 The pilot has started to produce some positive outcomes based on the social pescribing framework. The model has been regularly reviewed and shaped. Although the model started with three elements it has become clear that they are all interconnected and work well together.

9.2 Going forward the ask would be that the model is further developed and tested for another year by:

- Continuing to work with those GP Practices who are already enaged and asking if further would like to join the model (we have already been approach by Little Hulton and this could be an opportunity to build on the flue work in Broughton)
- Ensure the ask and offer is clear from the start – eg provsion of space for wellbeing conversations, access to staff meetings to promote the work (be seen as part of the team)
- Test the approach in healthy living centres where GP Practices are based as this model would provide better space for volunteer wellbeing champion conversations
- (we have already been approached to test the model in the Angel Health Living Centre)

9.3 In order to test the model further funding would be required of approximately £50,00 as set out below

Item	**Budget**
Project Lead	7,836
Wellbeing mentors	39,000
Volunteer wellbeing champion development worker	23,579
Marketing/Health campaign materials	3,000
Sub Total	**73,415**
Volunteer wellbeing champion development worker (cost met through CA Salford Together – nnot yet confirmed)	-23,579
Underspend on current project (social work students not recruited/theme	-14,000

one underspend)	
Budget requested from GP Network	**35,836.00**

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