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Hants & IoW Social Prescribing Network Webinar

Winter & Social Connectedness

Thursday 25 January 2024, 1-2pm

NHS
Hampshire and Isle of Wight

Gosport Voluntary Action

Winter & Social Connectedness

- **Welcome and Programme Review** – Angela Gill (Hants & IoW Social Prescribing Network Facilitator)
- **Tim Houghton**, Chief Executive, **Community First**
- **Eleanor Spink**, Home & Well Adviser, **Citizens Advice Southampton**
- **Jessica Berry**, Personalised Care Programme Lead, **Hampshire & IoW Integrated Care Board**
- **Sara Nicholls**, Community Support Manager, **Brendoncare** and
  Di Castle, Community Development & Support Worker, **Brendoncare**
- **Dates** for the 2024 **Hants & IoW Social Prescribing Network Webinars / Networking & Showcase Event!**

A PERSPECTIVE FROM THE VOLUNTARY & COMMUNITY SECTOR

Tim Houghton

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Hampshire Children and Young People's Plan

(CYPP) 2022-2025

Hampshire Children's Trust

2023

Adults' Health and Care Strategy

Our vision for health and care – a five year journey

Hampshire County Council

hants.gov.uk/adultsocialcare

Hampshire and Isle of Wight

HAMPSHIRE AND ISLE OF WIGHT

INTEGRATED CARE STRATEGY

December 2022

- HCC Future Services consultation https://www.hants.gov.uk/aboutthecouncil/haveyoursay/consultations/future-services-consultation
- Proposed cuts to VCSE infrastructure and community grants , Community Transport, Homelessness services and Sexual Therapeutic services
- Value of working together, collaborating as a sector cannot be underestimated
- We need to demonstrate our impact and social value
- https://socialvalueportal.com/
- https://hact.org.uk/how-we-can-help/social-value/
- https://socialvalueuk.org/social-value-self-asessment-tool/
- Cooperation and collaboration across sectors must continue as we explore new ways of meeting the needs of people who need our help the most

- HIVCA is progressing. https://actionhampshire.org.uk/get-involved/networks-and-forums/hivca/
- Leadership Committee includes Becky McGregor, Mountbatten; Helen Fisher, Energise Me; Natalie Webb, No Limits and Rob Kurn, Southampton Voluntary Services and representatives for our work/partnerships around children and young people, and mental health are; Sally Arscott, Solent Mind; Dr Kim Brown, Nature Therapy CIC; Clare Ansell, Motiv8 and Natalie Webb, No Limits
- LCPs are effective cross-sector partnerships tackling the needs of families and children. Further development grants available.
- Healthier Together website is a valuable resource for families Home :: Healthier Together (what0-18.nhs.uk) Keeping your family 'winter strong' campaign and downloadable app
- Energise Me/HCC's Hampshire Active Health Programme is due to kick off soon https://www.energiseme.org/funding-support/hampshire-active-health-programme/
- Household Support Grant closes tomorrow 26th January https://www.hants.gov.uk/socialcareandhealth/childrenandfamilies/connectforcommunities/communitygrants-overview/communitygrants
- Live Longer Better funding available to District Councils https://www.hants.gov.uk/socialcareandhealth/publichealth/livelongerbetter

Home & Well

Community First
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Home & Well Adviser

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Home & Well

https://citahants.org/home-and-well/

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Jess Berry

Personalised Care Programme Lead

Hampshire & IoW Integrated Care Board

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HIOW Social Prescribing Network

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ICP Framework Social Connectedness

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Hampshire and Isle Wight Integrated Care Partnership Priority
Social connectedness

Ambition: Improve social connectedness and decrease social isolation across Hampshire and Isle of Wight by working with communities to understand their needs and to develop and ensure the sustainability of community assets.

We will aim to do this by:

- Taking a life course approach to improve social connectedness, thereby reducing social isolation and loneliness and building social capital through supporting organisations and individuals/communities across HIOW and addressing inequalities in specific communities.

- Improving mental and physical health for all ages and increase independence in older adults, reducing the need for health and care services as well as reducing unemployment and increasing productivity.

Purpose of this framework:

To be a resource for 'places' within HIOW in supporting development of place based actions to improve social connectedness.

Definitions

Social Connectedness: Social connectedness is a **sense of belonging** to a group, family, or community. It's about the relationships people have with each other and their engagement with the broader community. Social connection is an integral component of health and well-being. Source

Social Isolation: The inadequate quality and quantity of social relations with other people at the different levels where human interaction takes place (individual, group, community and the larger social environment) Source

Loneliness: An emotional perception that can be experienced by individuals regardless of the breadth of their social networks Source

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Why is social connectedness important

KEY DATA

Lacking social connection can increase the risk for premature death as much as smoking up to 15 cigarettes a day.

The lack of social connection poses a significant risk for individual health and longevity. Loneliness and social isolation increase the risk for premature death by 26% and 29% respectively.[37] More broadly, lacking social connection can increase the risk for premature death as much as smoking up to 15 cigarettes a day.[4] In addition, poor or insufficient social connection is associated with increased risk of disease, including a 29% increased risk of heart disease and a 32% increased risk of stroke.[38] Furthermore, it is associated with increased risk for anxiety, depression,[39] and dementia.[40,41] Additionally, the lack of social connection may increase susceptibility to viruses and respiratory illness.[42]

Source: Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community; May 2023

Further Information on the impact of loneliness:

Tackling the UK's loneliness epidemic | Nesta

Factors associated with loneliness in adults in England - GOV.UK (www.gov.uk)

Where do we want to be in 5 Years?

By September 2023, we will have a better understanding of where we are now and can use this information to coproduce a set of shared values and ambitions these may include;

- Shared or aligned set of outcomes and measures at ICB, Place and Neighbourhood level
- Challenge and support the wider system to actively listen to communities
- Models of community asset based approaches embedded into how we work
- Reduction in health and social care utilisation (and economic benefits) through recognising the value of a shared approach through health and care organisations – including community and voluntary sector organisations
- Shared sense of purpose with communities and partner organisations of the importance of embedding social connectedness into ways of working

The national policy context supports working in this way:

- **Working in partnership with people & communities: statutory guidance** for ICBs, trusts & NHSEI, setting 10 key principles, building on design framework expectations for listening consistently to, and collectively acting on experience & aspirations of local people and communities
- **A community powered NHS, making prevention a reality**: A-Community-Powered-NHS.pdf (newlocal.org.uk)
- **Fuller Stocktake report:** Microsoft Word - FINAL 003 250522 - Fuller report[46].docx (england.nhs.uk)
- **Kings Fund explainer – Communities & Health**: highlights the need for NHS to work at place & neighbourhood levels to engage communities, gain insights, collaboratively design services and pathways and invest in community development; emphasises the role communities can play in improving and sustaining good health, citing research showing that investing in strengthening and improving the resilience of communities can lead to better health and wellbeing
- **OHID Whole system approaches to community-centred public health** (2020): taking a whole system approach to support scaling up & embedding Wider partners
- Plus lots more…

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Introduction

Social connection between people is important for physical and mental health and contributes to an improved quality of life. This Framework aims to increase understanding of social connectedness and support local 'place' plans to reduce social isolation.

The government's approach to talking loneliness aims to put the individual at the heart of the solution. Emerging Together: The Tackling Loneliness Network Action Plan is the work of the Tackling Loneliness Network and sets out recommendations to support organisations and individuals:

Supporting organisations to tackle loneliness

Supporting individuals to tackle loneliness

For further guidance for professionals working with loneliness, sign up and join The Tackling Loneliness Hub

In an effort to know where we want to be in 5 years, we need to understand where we are now. This framework includes a maturity matrix as a tool to assist places in applying this approach. This framework aims to provides information and resources to assist taking steps to gain greater insights to our place and the communities we work in by:

- ✓ **Understanding data -** Establish baseline data/metrics, analyse inequalities and geographical areas with poorer outcomes to guide prioritisation of local focus
- ✓ **Mapping Assets (anchor institutions, community assets, workforce) -** Mapping of anchor institutions, workforce and community assets, including accessibility and referral routes
- ✓ **Scoping relevance to existing initiatives / workstreams** – Aligning other ICP workstreams, sharing good practice and evidence base.
- ✓ **Building capacity:**
  - ✓ **Understanding Infrastructure -** Understand the current community/VCSE offer which is available to support social connectedness
  - ✓ **Workforce Development -** Identify areas for learning and development and improve workforce retention for example Social Prescribers
- ✓ **Engagement and Co Production -** Find out what's important to people, understand the barrier and impacts. How can we listen to those who are socially isolated?
- ✓ **Monitoring, evaluation and sharing best practice**

Maturity matrix

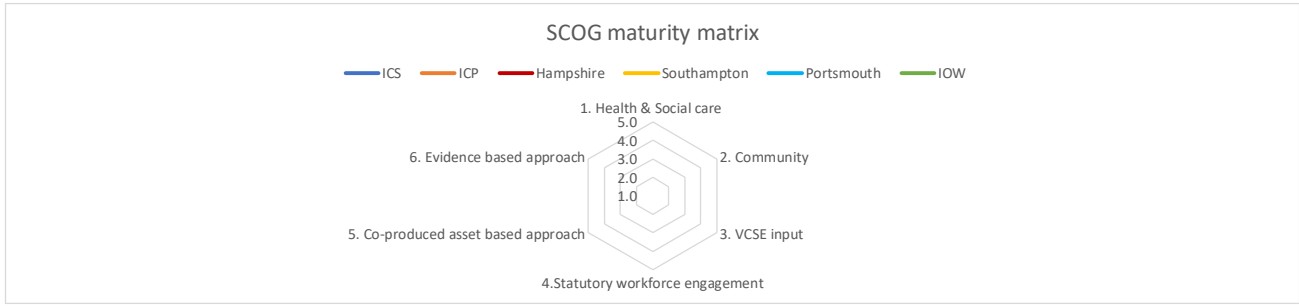
A tool has been developed which is intended to facilitate application of this framework at 'place' to support consideration of where to focus areas to further develop

Social Connectedness Draft Maturity Framework template

How to use this Matrix

involving civic, NHS and VCSE reps. The SCOG will provide an assesment on the ICP for actions that sit with the system. The ICS tab (in development) will track performance across the ICP & Place, identifying good work and highlighting areas of focus

	Level of Maturity	Definition of Maturity
1	1. Emerging	This element is patchy and not currently a priority to develop further across the system
2	2. Developing	This element of social connectenness is under discussion but not yet in active development,
3	3. Maturing	This element of socialconnectedness is in active development and in the process of being implemented
4	4. Embedded	This element of social connectedness is fully embedded and will be sustained even in the event of a change of operational or strategic leadership
5	Innovative	This element of social connectedness has been fully embedded for a period of time and implements new innovations, ideas and projects, may be involved with research, and it is recognised that the organisation/place is a leader in this field



Theme		Grade					
		ICS	ICP	Hampshir	Southamp	Portsmout	IOW
1. Health & Social care	1. Commitment and leadership to improving social connectedness from health and social care system partners	1.0	1.0	1.0	1.0	1.0	1.0
2. Community	2. Thriving community empowered to identify and address own needs and wh	1.0	1.0	1.0	1.0	1.0	1.0
3. VCSE input	3. Local voluntary and community organisations are able to support people and communities be socially connected	1.0	1.0	1.0	1.0	1.0	1.0
4.Statutory workforce engagement	4. Identified workforce within statutory organisations who see improving social connection as part of role	1.0	1.0	1.0	1.0	1.0	1.0
5. Co-produced asset based approach	5. Co-produced asset based approach is embedded to improve social connection	1.0	1.0	1.0	1.0	1.0	1.0
6. Evidence based approach	6. A robust evidence based approach is developed based on a understanding of local and reigional data, understanding of inequalities in social connection and research	1.0	1.0	1.0	1.0	1.0	1.0
Average		1.0	1.0	1.0	1.0	1.0	1.0

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Data - where are we now

National data

National data would suggest around 1 in 20 (6%) of adults reported feeling lonely always or often in the latest period (5% in the previous period). This increased to around a quarter of adults (25%) reporting feeling lonely always, often or some of the time in the latest period (23% in the previous period).

This proportion appears to vary slightly by age, with 26% of those aged 16 to 29 years, 30% of those aged 30 to 49 years, 23% of those aged 50 to 69 years and 19% of those aged 70 years and above reporting feeling lonely always, often or some of the time in the latest period. 2022 data – 2023 can be extrapolated from here

HIOW data

Available at: Public health profiles - OHID (phe.org.uk)

Decrease the % of adults who feel lonely often or always or some of the time (PHOF 2019/20 baseline)
Available by ethnicity, employment status, disability, deprivation, age and sex (see next slide)

Increase % adult carers & social care users who have as much social contact as they would like (PHOF)

Improve self-reported wellbeing: satisfaction, worthwhile, happiness, anxiety (PHOF)

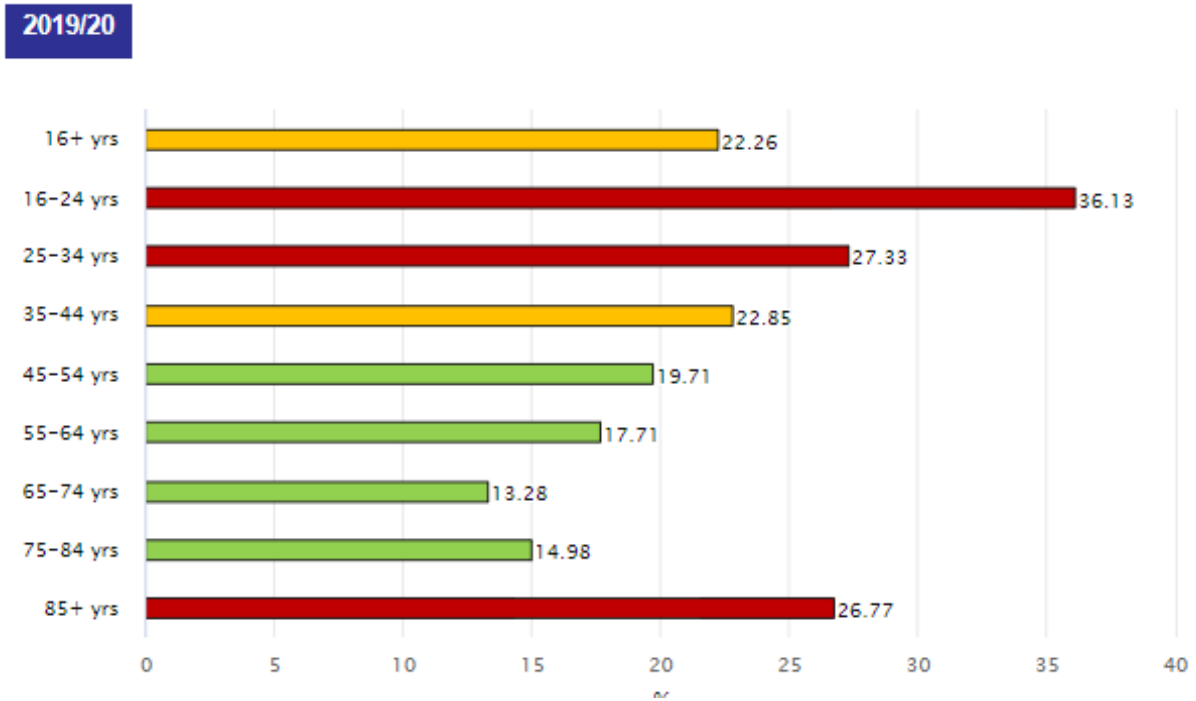
Percentage of people in employment (PHOF: 16-64 years and 50-64 years)

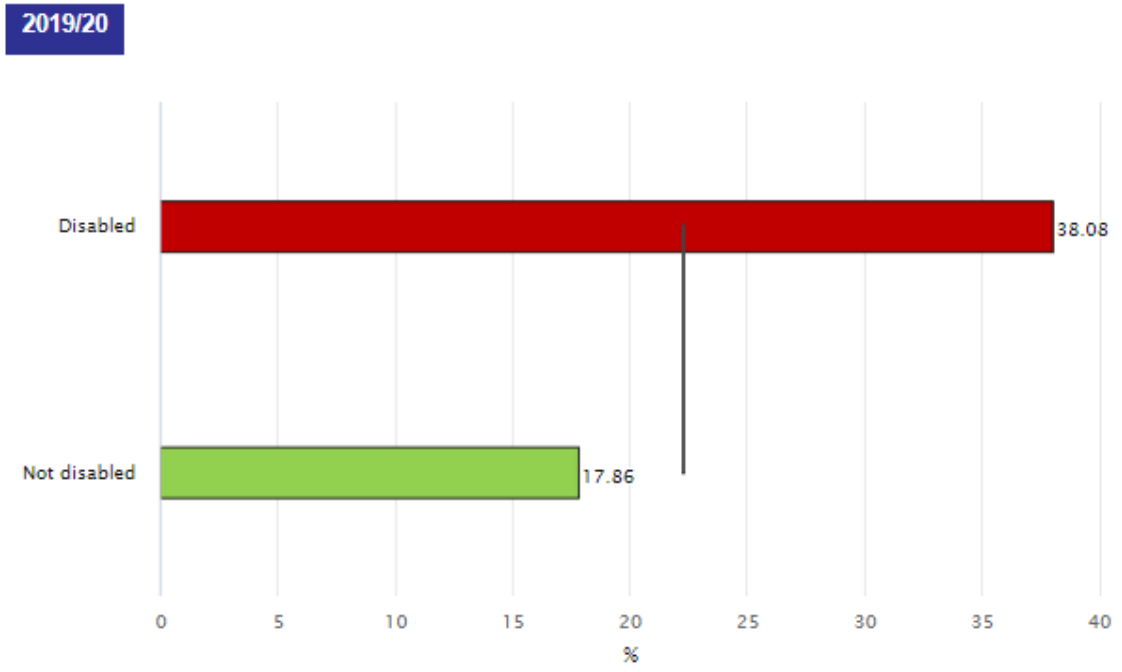
Public Health Outcomes Framework	% of adults who feel lonely often or always or some of the time 2019/20	Comparison to England
Hampshire (data available for districts/boroughs)	20.24%	Better
Isle of Wight	18.97%	Similar
Portsmouth	28.61%	Worse
Southampton	26.00%	Similar
England	**22.26%**	

Prioritise areas of focus geographical, socio-demographic characteristics and population groups

% of adults who feel lonely often or always or some of the time (Public Health Outcomes Framework)

National data:





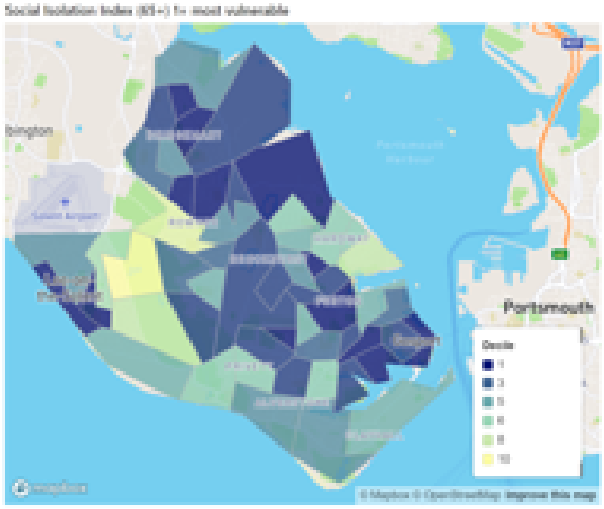
[Public health profiles - OHID (phe.org.uk)]

Prioritise areas of focus geographical, socio-demographic characteristics and population groups

- Official -

Social isolation (65+) district comparison

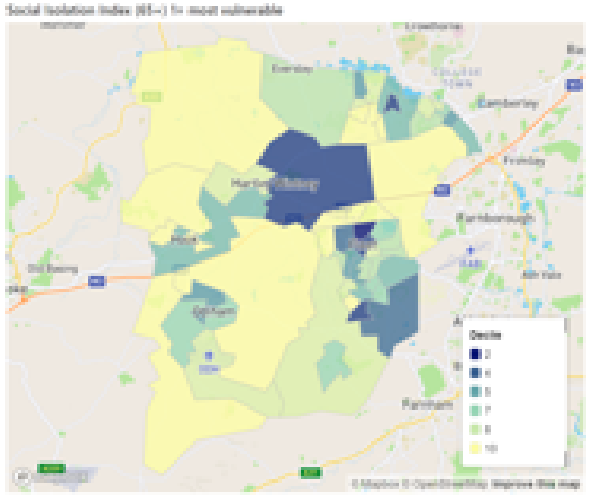
Gosport



Gosport
- 23.2% (13) of the areas are ranked in decile one as the most vulnerable
- Only 1 area is ranked in decile 10 as the least vulnerable
- Almost 50% of the district is ranked in decile 1 and 2

Hart
- No areas in the most vulnerable decile one.
- Almost one third of areas in the least vulnerable decile 10.

Hart



Indicator	Lowest LSOA	Highest LSOA
Population aged 65+	5.0%	53.6%
No cars/vans in the household (66+)	20.0%	77.6%
One person household (66+)	3.4%	38.6%
Provides unpaid care (65+)	6.0%	17.6%
Partnership status – divorced or widowed (66+)	17.5%	55.5%
Bad or very bad health	6.0%	22.1%
Disabled (65+)	23.9%	47.0%
IDAOPI (65+)	2.2%	32.2%

Gosport - higher percentage of the population aged 65+ and living alone. Higher percentage with no car and higher proportion of older people affected by income deprivation.

Hart has a wider range of people reporting bad health or disabled but less older people affected by income deprivation. Protective factor delays onset of LTCs.

Need to consider accessibility to services, Hart is more rural versus urban areas of Gosport

Indicator	Lowest LSOA	Highest LSOA
Population aged 65+	4.7%	33.8%
No cars/vans in the household (66+)	0%	58.6%
One person household (66+)	2.2%	25.9%
Provides unpaid care (65+)	5.3%	15.9%
Partnership status – divorced or widowed (66+)	19.1%	52.8%
Bad or very bad health	2.7%	24.2%
Disabled (65+)	18.4%	40.2%
IDAOPI (65+)	1.5%	16.4%

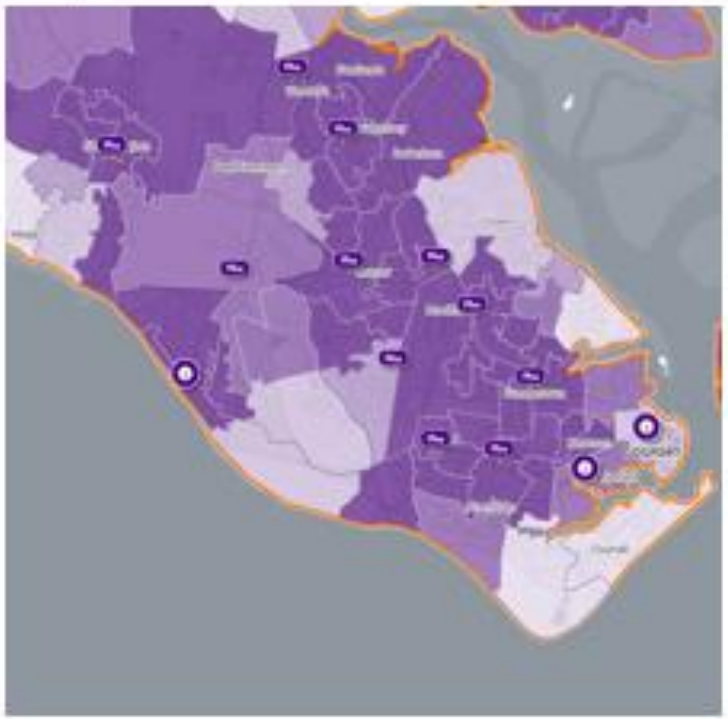
Prioritise areas of focus geographical, socio-demographic characteristics and population groups

- Official -

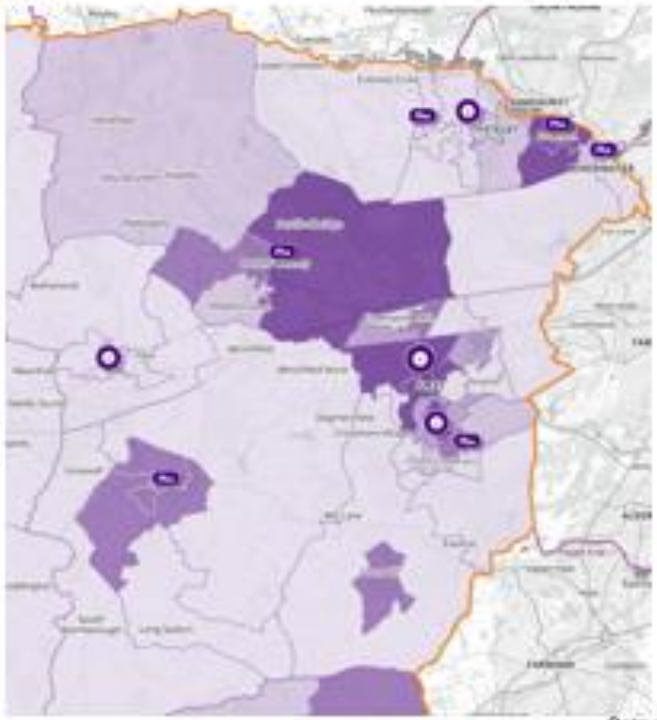
Social isolation (65+) and accessibility

Percentage of households with access to GPs within 15mins by public transport or walking

Gosport



Hart



Data source: SHAPE

Next steps explore areas vulnerable to social isolation due to poor accessibility to services and/or digital isolation.

Mapping Assets to support Social Connectedness

Anchor Institutions

Anchor institutions are large organisations that are unlikely to relocate and have a significant stake in their local area. They have sizeable assets that can be used to support their local community's health and wellbeing and tackle health inequalities.

Anchor institutions can include (but not limited to):

- Integrated Care Boards/NHS
- NHS Providers and Trusts
- Local Authorities
- Universities
- Police
- Fire and Rescue

Workforce

What workforce have we got across the Integrated Care Partnership to support social connectedness?

- Social Prescribers – See map of social prescribing services here
- Community Connectors/Builders
- Primary Care (ARRS) and Community providers
- Voluntary organisations and charities
- Hospital Discharge Teams
- Volunteers
- Consider local economy and businesses for example Post Office – example here

Asset-Based Community Development

Asset-Based Community Development (ABCD) is a global approach to working in community and citizen spaces. ABCD recognises, connects and mobilises the strengths, gifts, talents and resources of individuals and communities to build stronger and more sustainable communities.

For further information about ABCD

About ABCD - Nurture Development

Asset_Based_Community_Development.pdf (nesta.org.uk)

Strong communities, wellbeing and resilience | The King's Fund (kingsfund.org.uk)

Some example of community assets may include:

- Local CVSs and Charities/ Voluntary sector
- District and Parish Councils
- Community Centres
- Energise Me
- Libraries and community hubs
- Citizens Advice Bureau (including Home & Well)
- Safe and Well (Fire and Rescue)
- No Wrong Door local community projects

Assets at neighbourhood

- Lunch clubs
- Warm spaces
- Physical activity
- Food Banks/Pantries
- Community gardening projects

Enablers:

Connect to Support Hampshire

Southampton Voluntary Services

Directory Search | HIVE Portsmouth

Isle of Wight

Home - Genie (genie-net.org)

Community Asset Mapping Tools

headhandsandheartassetbasedapproachesinhealthcare_inbrief.pdf

0df445_c69e564bd8ac4c10a76f61ee61d0e94a.pdf (abcdinleeds.com)

Scoping Existing Workstreams

Avoid duplication and learn from others. Explore 'Place' based examples of good practice/evidence base. Align projects with ICP Local Integrated Care priorities:

- Children and Young People
- Mental Wellbeing
- Good Health and Proactive Care
- Our People
- Digital solutions, data and insights

May also include Health and Wellbeing Board priorities or other areas such as Social Value

Suggestions to consider:

- Where social connectedness may implicitly or explicitly be part of existing projects / workstream / areas there may be opportunity to link and optimise community centred approaches (new initiative or 'business as usual' activities)
- What is the motivation for communities to be part of additional work in this area

Consider existing workstreams and strategies of partners, for example;

- Community Champions programmes
- Community outreach events
- Core20Plus5
- Inequalities projects
- Proactive Care and Case Management
- Local Authority, Mental Health and Wellbeing Strategies
- Energise Me- We Can Be Active Strategy
- Live Longer Better
- The Mid Life MOT

Workforce Development

Explore workforce training and development needs and provide opportunities for the workforce to:

- Understand the importance of loneliness and social isolation as a risk factor for negative health outcomes,
- Be able to recognise people at risk of loneliness and social isolation
- Gain knowledge of the available range of evidence-based interventions for loneliness,
- Know how to refer or signpost those identified at risk of loneliness and social isolation
- Understand the benefits of volunteering, including encouraging employers to support their employees to volunteer

E-Learning Training Resources

Loneliness and Social Isolation | Health Education England (hee.nhs.uk)

Personalised care support planning

Engagement and Coproduction

Those best placed to understand what they need, what is working and what could be improved are the individuals and groups who live in our communities. We want to develop how we reach, listen to, involve and empower our communities to ensure that their voices are truly at the heart of everything we do

Find out what's important to people, understand the barrier and impacts. How can we listen to those who are socially isolated?

- Establish a key stakeholders' group to include Patient Participation Leads from provider trusts, social prescribers, community connectors and other relevant local authority roles, voluntary sector and local community groups
- Develop a Community Asset based approach to community engagement to enable citizen led solutions
- Work with the ICB Community Involvement Team and make use of the resources available on Stay Connected or other high quality resources from national or local organisations
- Use awareness campaigns to raise awareness such as Loneliness Awareness Week and Lonely Not Alone and have 'discovery' conversations with communities

Further information at NHSE Coproduction

Infrastructure

Strong local infrastructure enables communities to influence decision-making, builds partnerships and networks, and encourages volunteering opportunities. When this support is accessible locally, individuals and communities thrive.

Council for Voluntary Service (CVS) is an organisation that supports local voluntary and community organisations speak to each other. They provide infrastructure support and offer a wide variety of services and support for other local organisations, for example training, or advice on funding.

They will typically provide forums for organisations and individuals to meet, for example Community First hosts a network of Social Prescribers and Community & Voluntary Sector, Health and Local Authority representatives across Hampshire and Isle of Wight.

Supporting Infrastructure

- Understand the current local 'Place' community/VCSE offer, what is available to support social connectedness and identify any gaps
- Support the development of HSIOW plan to ensure the infrastructure is in place to ensure community resilience.

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Evaluation measures

Action Hampshire have produced a guidance booklet suitable for all and particularly aimed at VCSE organisations containing practical tips and tricks for successful impact measurement:
Introducing...the new Impact Measurement Guidance Booklet! - Action Hampshire

The Office for National Statistics has produced guidance on using survey measures for loneliness:
Measuring loneliness: guidance for use of the national indicators on surveys - Office for National Statistics

Quantitative measures

Could include local survey measures

National Survey Data: Available at: Public health profiles - OHID (phe.org.uk)

- Loneliness: Percentage of adults who feel lonely often or always or some of the time
- Self-reported wellbeing - people with a low happiness score
- Self reported wellbeing: people with a high anxiety score

Office for National Statistics

Measuring loneliness: guidance for use of the national indicators on surveys

Methodological guidance on how to use the recommended loneliness questions for adults and children and how to interpret and report the findings.

Qualitative measures

Could include interviews, stories etc as well as academic methodologies e.g. realist evaluation

Three Good Friends - Three Good Friends – YouTube

Examples of Best Practice: Hampshire

The **Thrift Shop and Comfort Café** in King Arthurs estate Andover opened in January 2023.

Initiative came from residents, as part of the Andover Healthier Communities project.

Residents can sell pre-loved clothes and receive 80% of sale, the other 20% goes towards running of a breakfast club/comfort café.

50 guests (approx. 40 adults, 10 children, plus local volunteers between Jan-July 23).

Increase in the number of volunteers recruited.

Good feedback from residents (members)

'Thrift Shop allows me to exchange clothes in affordable price. Comfort Café is a place I can bring my child to play and relax.'

Examples from Hampshire Assembly: Social Connectedness event 15th June 23

Action Hampshire: Communities Tackling Loneliness with Transport

- Reduce loneliness in over 50's
- Investment in sustainable transport
- Test different sustainable transport method e.g bike, car, minibus – volunteer–led/paid, urban/rural

Contact: nicky.judd@actionhampshire.org

Connect4Communities: Community Pantries

Community Pantries provide a range of fresh, frozen, cupboard and general groceries at a lower cost than supermarkets or shops. The items available can range from week-to-week and even season-to-season which also helps to reduce food waste.

Contact: Hayley.Heinze@hants.gov.uk

The Princess Royal Trust for Carers

Coffee morning, Virtual exercise classes, book clubs, baking classes, singing groups Central Hubs and workshops for Carers

Contact: info@carercentre.com

Examples of Best Practice: Isle of Wight

- Living Well Early Help is jointly funded initiative by IW Council and HIOW ICB
- Managed by Aspire (a community-based organisation).
- Commissioned in April 2022 it has so far helped at least 2390 island residents at its 4 local hubs
- Increasing social contact and building support circles through referrals to community groups or statutory services like housing, health and care and job centres, and other support provided by VCSE organisations such as Cost of Living support
- Recently helped to increase support to rurally isolated communities through its mobile support hub
- Awarded as ‘Gold’ in the Transformation in Health and Social Care category of the iESE Transformation Awards.

Contact: Sandy Belfitt: SBelfitt@actioniw.org.uk

Examples of Best Practice: Portsmouth LiveWell events

Current delivery
The Live Well programme has focused on four city locations; Landport, Somerstown, Portsea and Paulsgrove. The sessions have taken an asset based approach in being delivered alongside either a food pantry, larder or food bank.

In addition to the focused areas, bespoke sessions have been delivered with communities, for example two sessions have been delivering at Trafalgar School, one at the Jami Mosque and one at St George's Primary School.

Service offer
The model is flexible and has adapted over time to ensure that it is developed with the community.

The goal is to talk people and connect them into services who can support them with aspects of their daily life. This aims to empower and strengthen local communities by ensuring local support and services reaches into communities.

The Live Well programme has been an excellent example of integrated working with services coming together from within Portsmouth City Council, the NHS, the Voluntary Sector and providers like Southern Water, Advice Portsmouth, housing organisations and education (to name a few).

Evaluation
Between March and August 2023, 13 sessions have been delivered. The number of people engaged with has totalled 751 (if people talked to more than one service, they would have been recorded by each service.

As part of the evaluation, services are asked

- *if they feel like they have made a difference to one person*, on most occasions, services have recorded this to be 'yes' (74)
- *if they felt their attendance has been worthwhile*, 70 services said 'yes'

The next stage of evaluation will seek feedback from those in attendance and who have sought help.

We offered a healthy wrap demonstration at a Live Well session in April, people were able to make a wrap and take it home.

Southern Water and Switched on Portsmouth in attendance at Portsea Live Well.

Examples of Best Practice: Southampton

Scaling community centred approaches during the Covid-19 pandemic

Authors: Jack Lewis Public Health Practitioner Southampton City Council, Robin Poole Consultant in Public Health Southampton City Council, Kate Harvey Consultant in Public Health Southampton City Council.

Aims and Introduction

Southampton is a port and university city on the south coast with a diverse population of just over 261,700 (68% white British).

Community centred approaches can help:

- **Build**, **connect**, and **empower** communities.
- **Reduce** health inequalities.

Southampton Covid-19 Community Champions and Covid-19 Vaccine Champions programmes were established in September 2020 and January 2022 respectively during the Covid-19 pandemic to:

- **Support** the city Local Outbreak Management Plan (LOMP).
- **Prevent** the spread of infection.
- **Protect** the most vulnerable communities.
- **Reduce** inequality in uptake of the vaccine.

Methods

- The Covid-19 Community Champions network and Covid-19 Vaccine Champions are made up of **individuals** who live, work, and learn in the city, including **local businesses** and **Voluntary Community Sector (VCS) organisations**.
- The two programmes have been coordinated by **Community Engagement Officers** with support from **Public Health**.
- The Covid-19 Community Champions network is a low-cost model, whilst the Vaccine Champions programme is funded by a grant from the Department for Levelling Up, Housing and Communities (DLUHC).
- Both programmes include two-way sharing of information via forums, drop-in sessions, and regular email bulletins.
- The work of the Vaccine Champions included delivery of a communications campaign and development of a multilingual library of assets for use by champions, such as weekly flyers which signposted towards local roving vaccination provision.

Results

To date, the Covid-19 Community Champions network has **451 registered champions**. Mosaic data showing the make up of the Covid-19 community champions is shown in figure 1. Information and community insights were shared across **64 Covid-19 champion forums**, **130 bulletins**, and designated **social media platforms**.

The Vaccine Champions programme have recruited **105 unpaid champions** and supported **27 organisations** with grant funding for projects aimed at reducing inequality in uptake of the vaccine and addressing wider determinants of health.

Results continued

- Activities included **sharing information** about local vaccination provision, holding focused information sharing sessions to **dispel vaccination myths**, **addressing cultural barriers**, and hosting additional vaccination pop ups in **trusted community places**.
- Vaccine uptake data between January and October 2022 shows **6,721 first doses** were administered to Southampton residents. Of these, **65%** were administered to residents residing in the **four (ward) areas with lowest uptake, 60%** to **residents living in the most deprived areas (4th and 5th local deprivation quintiles)**, and **72%** to residents from **minority ethnic backgrounds**.
- Whilst this data cannot be solely attributable to the work of the Vaccine Champions programme, it aligns with populations targeted to increase confidence and convenience and reduce complacency.

Conclusions

- Community centred approaches have formed a key part of the Covid-19 pandemic response in Southampton.
- Engaging communities in delivery of specific elements of the outbreak response has supported targeted work, and information sharing approaches have strengthened relations and provided valuable community insights.
- Understanding impact on outcomes within wider complex approaches is challenging.

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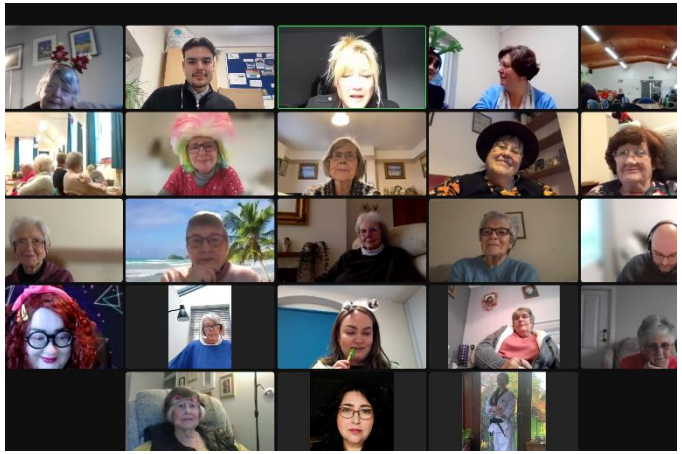

Community Membership Scheme

- 70+ Community Clubs
- Support over the telephone
- Online clubs and events
- Help to get online
- Discount on respite stays
- Free taster sessions
- Free memberships

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Get in touch!

Make an enquiry via website
www.brendoncare.org.uk
Communities and Clubs page

Email clubs@brendoncare.org.uk

Community First
making life better for everyone

- **Thank you** to all presenters, Jane Bray and you the audience too!
- **If** you didn't have time to ask a question or make a comment via Chat, please email the presenter
- **Please feedback** - share your Social Prescribing theme or presenter ideas via 'Chat' or by email to Jane Bray

This **Webinar**, the **PowerPoint** and any corresponding documents, will be available via the **Community First** and **Gosport Voluntary Action websites** within a week.

HIOW Social Prescribing Network

Hants & IoW Social Prescribing Network Dates...

- **Tuesday 12 March, 9.30am-2pm (Networking and Showcase Celebration Event)**
- **Wednesday 5 June, 1-2pm (Webinar)**
- **Wednesday 9 October, 1-2pm (Webinar)**
- **Wednesday 4 December, 1-2pm (Webinar)**

Remember – National Social Prescribing Day -

Thursday 12 March 2024!

Wishing you all a Happy and Healthy Spring!

The recording will now stop. Thank you everyone.

Website Addresses:

- ✓ **Community First**:- www.cfirst.org.uk
- ✓ **Gosport Voluntary Action**:- www.gva.org.uk

If you have any information to share, please contact **Jane Bray**:- healthforums@cfirst.org.uk