Devon Social Prescribing Conference.
Tuesday 18th November

Jan Cutting Healthy Living Centre.

Summary of Presentations :

Welcome & Context – Joe Harman

- Emphasised the conference as a platform to celebrate social prescribing work and build inter-sector relationships.
- Highlighted Devon's strong engagement in personalised care and social prescribing initiatives.
- Encouraged networking among attendees to share knowledge and facilitate collaboration across regions.

Opening Address – Councillor Mary Aspinall

- Welcomed attendees from multiple sectors: social prescribers, clinicians, commissioners, voluntary organisations, and academics.
- Reiterated the value of social prescribing in reducing GP appointments, improving mental health, increasing purpose and connection, and strengthening community resilience.
- Key local initiatives in Plymouth:
    - **Healthy & Active Programme:** Partnership between Plymouth Action, Wolseley Trust, and Public Health, promoting physical activity and wellbeing.
    - **Young Devon's Children & Young People Social Prescribing:** Trauma-informed, school-based and community support for youth mental health.

    - **Plymouth Cancer Champions Project:** Community-led support to reduce inequalities in cancer care.
    - **Age Positive:** Activities and community hubs for adults over 65, supported by a dedicated frailty social prescribing link worker.
    - **Blue Social Prescribing:** Leveraging Plymouth's National Marine Park for wellbeing initiatives.
- Acknowledged current challenges including rising cost of living, mental health demands, and social isolation.
- Outlined conference aims: learning, celebrating successes, connecting across systems, and exploring the future of social prescribing.

Keynote – Dr Michael Dixon

Social Prescribing: Vision and Impact Across Devon

- Provided historical context: Social prescribing originated in Devon, with the first link worker in 2009. Early evidence demonstrated reversal of diabetes and pre-diabetes through social interventions.
- Social prescribing has expanded nationally:
    - 3,300 link workers in England; 113 million patients served in the previous year.
    - Devon: 15,000 referrals in 2024, supported by 63 link workers (average caseload 238).
    - Voluntary sector is the largest employer of link workers in Devon.
- Emphasised breadth of social prescribing today: elderly, youth mental health, veterans, farmers, schools, prisons.
- Highlighted outcomes:
    - 20% reduction in GP and hospital demand in general, up to 80% in targeted populations (e.g., over-80s).

    - Local data: Joy system demonstrates 40% reduction in GP appointments for 10,000 patients, translating to £2–3.5 million savings.
- International perspective: Social prescribing models expanding globally (Netherlands, Singapore, Canada, Southern Ireland).
- Key challenges:
    - National advocacy vacuum, inconsistent funding, workforce stability, quality variation.
- Recommendations:
    - Demonstrate effectiveness, innovate community engagement, celebrate successes, and integrate non-medical interventions into health services.
- Concluded that social prescribing can transform biomedical approaches to a psychosocial model, improving individual and community health while promoting a sustainable, financially balanced health system.

Wolseley Trust Healthy Futures Service – The Strength of Partnerships

Presenter

- Joe Harman

Focus:

- Celebrating innovation in teams and partnerships with Primary Care Network (PCN) managers.
- Emphasising collaboration over "either/or" approaches: all roles complement each other for better patient care.
- Trust is central to successful collaboration and sustainable outcomes.

Key Messages

1. **Working in Harmony:**

- Different roles (social prescribers, community health & wellbeing, frailty link workers, etc.) work together to improve patient care.
- Evidence shows that patient outcomes are stronger when roles collaborate rather than operate in isolation.

2. **Building Trust:**
   - Relationships with patients, surgeries, and PCNs are foundational.
   - Trust is built through consistent presence, active engagement, and small gestures (e.g., attending meetings, face-to-face interaction).
   - Autonomy within a clear framework allows staff to tailor support to patient needs.
3. **Community Health & Wellbeing Teams:**
   - Frailty-focused social prescribing supports over-65s experiencing isolation or reduced mobility.
   - Roles include social prescribers, wellbeing coaches, and community health workers, often working alongside primary care teams.
   - Programs are designed to be flexible, resident-centered, and asset-based.

Notable Programmes & Innovations

1. **Health & Wellbeing Coach in the Community:**
   - Role piloted to embed coaching principles directly within communities.
   - Supports residents in a flexible, personalized way, bridging formal services and local community support.
2. **Active Health Referral Programme:**
   - Partnership with Life Centre and YMCA to provide free 8-week access to gyms and swimming pools for social prescribing patients.

    - Trauma-informed, personalized approach: tailored timings, introductory support, and gradual transition to discounted membership.
    - Focuses on creating opportunities for physical activity in a welcoming environment, fostering sustained engagement.
3. **Case Studies & Impact:**
    - Stonehouse area: high-deprivation neighbourhoods supported by Community Health & Wellbeing teams.
    - Cancer champions and social prescribers collaborate to provide personalized, community-led interventions.
    - Success built on strong, trusting relationships with PCNs, patients, and community organizations.

Key Principles

- **Collaboration over Competition:** Roles are complementary, not interchangeable.
- **Trust & Relationships:** Both strategic (PCN managers, digital transformation leads) and relational (patients, staff) trust are crucial.
- **Personalized, Patient-Centered Support:** Flexible frameworks allow teams to respond to individual needs.
- **Asset-Based & Community-Led:** Emphasis on leveraging existing community resources and resident strengths.
- **Continuous Innovation:** Programs evolve through feedback, trial, and reflection to improve outcomes.

Takeaway: Greater collaboration and partnerships across sectors enable stronger support for patients, fostering well-being, resilience, and connection.

Community Collaboration Spotlight - Wellbeing Exeter connecting

people, building community

Presenters

- Andres Rees, Edward Shaw, Ebbie Peters (Co-lab Exeter)

Partner Organisations:

- Co-lab, Exeter Community Initiatives, Exeter City Community Trust
- Funded by Exeter City Council

Programme Overview

Wellbeing Exeter focuses on community social prescribing through four key roles:

1. **Community Builders:** Strengthen neighbourhood connections and networks, inspire local actions, and identify community strengths.
2. **Community Connectors:** Provide one-to-one support, linking residents to local opportunities, activities, and networks to improve well-being.
3. **Local Development Coordinators:** Facilitate initiatives such as Local Links and Nature Links, leveraging existing community strengths.
4. **Community Physical Activity Organisers (CPAO):** Encourage residents to become active through existing or new community-led activities.

Core Principles: Inclusion, collaboration, asset-based community development, and focus on lasting impact.

Key Initiatives & Stories

1. **Sylvania Community Store & Café:**
    - After a local shop closed, community builders engaged residents via listening posts to identify existing skills and resources.

    - Residents formed a committee, volunteered, and successfully reopened the store in 2021.
    - Now run by 10 staff and 60 volunteers, offering social spaces, creative activities, and community events.
    - Demonstrates asset-based community development: residents lead, connect, and sustain initiatives.

2. **Inclusive Walking Football Group:**
    - Led by CPAO Georgie and community support, enabled residents previously unable to play football to participate.
    - Sessions initially hosted at Saint James's School and now self-sustaining, inclusive of all ages, abilities, and backgrounds.
    - Highlights how small, tailored physical activity initiatives foster connection, purpose, and well-being.
3. **Individual Case – Adam:**
    - Isolated resident with limited mobility received one-to-one support from a community connector.
    - Through guidance and access to resources (e.g., electric wheelchair, venue), Adam started a social activities group including games nights, cinema, and peer support.
    - Example illustrates impact of personalized support combined with asset-based, community-led engagement.

Approach & Impact

- Combines personal support with community development rather than only signposting services.

- Focuses on residents' strengths and encourages sustainable, resident-led solutions.
- Supports lasting connections, resilience, and inclusion across Exeter.
- Guided by principles of collaboration, listening, asset-based development, and shared community resources.

  Takeaway: Demonstrates that small interventions, personalized support, and community collaboration can create lasting change, strengthen neighbourhoods, and enhance well-being.

Presenters

Dr Daisy Robinson (Con Valley Primary Care Network)
Beth Branwell (Young Devon)

Partner Organisations

- Con Valley Primary Care Network (CVPCN) – five practices across nine sites.
- Young Devon – delivering the Youth Link Worker model.
- Collaboration with schools, Children's Services, police, community groups, councils, and wider VCSE partners.

Programme Overview

CVPCN identified a growing need for early-intervention support for young people, particularly around anxiety, isolation, confidence issues, school avoidance, and neurodiversity-related challenges.
To respond, the PCN facilitated cross-sector networking sessions to map challenges and priorities, leading to the creation of the CVPCN Youth Forum Charter.
Young Devon now provides dedicated Youth Social Prescribing for 11–18-year-

olds, offering flexible, relational, non-clinical support, with referrals largely through GP practices via Joy.

Key Initiatives and Stories

- 1–7 structured sessions per young person, focused on emotional regulation, confidence-building, and personal goals.
- Flexible, youth-led delivery across rural and town settings, meeting young people in safe neutral spaces.
- Co-created wellbeing opportunities including cooking groups, art workshops, outdoor activities, creative sessions, and youth-friendly fitness.
- Development of drop-in wellbeing sessions for those not yet ready for group work.
- Dual approach to "prescribing":
    - *Targeted support* such as counselling, CBT, coaching, substance support and equine therapy.
    - *Interest-based activities* including sports, art, volunteering and youth clubs.
- Strong communication pathways between GP teams, schools, youth services, and community organisations.
- Approximately 100 referrals per year with an 80–90% engagement rate.

Approach and Impact

- Early-intervention approach prevents escalation and reduces demand on crisis services.
- Youth-led, relational practice increases trust, improves engagement, and meets young people at their pace.

- Young people report improved emotional regulation, confidence, and re-engagement with hobbies, friendships, and school.
- Parents and carers notice improved communication and stability at home.
- GPs and schools benefit from clearer referral routes and reduced repeat presentations.
- Co-design with young people leads to more sustainable wellbeing outcomes and smoother pathways into specialist services where required.

Takeaway

- Youth social prescribing must be flexible, relational, and developed in partnership with local services.
- Building trust with young people is the foundation of engagement and change.
- Cross-sector collaboration strengthens pathways and makes support more accessible.
- Small steps are meaningful; progress at a young person's pace is key.
- Consistency, creativity, and listening deeply are central to effective youth social prescribing.

Better Together: Social Prescribers and Health Coaches in Collaboration

Presenters

Jake Price – Health Coach, South Dartmoor and Totnes PCN

Partner Organisations

- South Dartmoor Topnest Primary Care Network (PCN)
- South Hams PCN

- Totnes Caring (charity employer of health coaches and social prescribers)
- Linkages with Citizens Advice, local councils, leisure centres, and other community services

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Programme Overview

The programme integrates social prescribers and health coaches into a single team, delivering collaborative, holistic support for adults (18+) with a range of health, social, and lifestyle needs.
Referral criteria: willingness to engage, not currently receiving ongoing statutory mental health or social care input.
Common presenting issues: mental health, loneliness and isolation, long-term health conditions, financial challenges.

Key Initiatives and Stories

- Team jointly collects referrals through the Joy App, allowing direct pickup by either social prescribers or health coaches, reducing delays.
- **Case Study 1**: Client struggling with anxiety and social isolation received six health coaching sessions to build motivation before connecting with social prescribing activities.
- **Case Study 2**: Client wanted to exercise and socialise but preferred to continue working with the same health coach. The team coordinated with social prescribers to enrol him in local groups without changing his contact, maintaining continuity.
- Collaborative approach allows fluid movement between services, tailoring support to individual readiness and motivation.

Approach and Impact

- **Shared team philosophy** ensures consistent, holistic support, avoiding conflicting advice.

- **Joint care planning** addresses patient activation levels; health coaches often support clients with lower activation before social prescribing engagement.
- **Mutual education** and weekly meetings facilitate knowledge-sharing and enable swift, informed referral decisions.
- **Connection + tools = empowerment**: social prescribers provide connections to services and groups; health coaches equip clients with skills, motivation, and confidence to engage.
- Streamlined communication reduces waiting times and enhances patient experience.
- Improved engagement with lifestyle changes, social activities, and mental health support.

Takeaway

- Integrating health coaches and social prescribers into one collaborative team enhances responsiveness, consistency, and outcomes.
- Early, flexible intervention tailored to client readiness improves motivation and engagement.
- Joint working enables streamlined referral pathways, reducing delays and maintaining continuity.
- Combining connection and empowerment supports sustainable behaviour change and overall wellbeing.

Presenters

Camilla Rooney – Wellmore, North East Dartmoor (VCSE organisation)

Partner Organisations

- **Wellmore** – VCSE organisation delivering health and well-being initiatives
- **North East Dartmoor Primary Care Network** – coordinated social prescribing support
- **Health and Well-being Alliance** – NHS-funded collaboration across three rural health centres
- Local community volunteers and organisations, including community allotments, parish councils, and memory cafes

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Programme Overview

Wellmore operates in a **rural, tight-knit community** with barriers including limited transport, digital access, and an older population.
Social prescribing was introduced via a **Community Connector** role (Becky), coordinated within the North East Dartmoor PCN. This role connected residents to services, projects, and support.

Key Initiatives and Stories

- **Loneliness Project**: Community consultation identifying social isolation and barriers to connection; led to the creation of the Community Connector role.
- **Household Support Fund**: Assisted with fuel, food, and digital befriending referrals.
- **Strength and Balance Classes** and **GP referral to gyms**: Promoted physical health and social engagement.
- **Friendly Fridays**: Well-being café with carer support.
- **Community Allotment**: Green prescribing initiative promoting engagement with nature and healthy activity.

- **Morton Hampstead Community Shed**: Volunteer-led project targeting men's mental health, including skills workshops and community restoration projects.

Approach and Impact

- Social prescriber acted as **bridge between Wellmore projects and community members**, enabling access, referrals, and more effective targeting of support.
- Social prescribing facilitated **funding opportunities** for Wellmore projects, enhancing sustainability.
- Role helped address **social isolation, mental health, and practical needs**, especially in rural areas with limited services.
- Redundancy of social prescriber highlighted **service gaps**, particularly for vulnerable men and those requiring holistic, personalised support.
- Current strategies include a **community builder role**, NHS Health and Well-being Alliance, and partnerships with volunteers to partially fill gaps.
- Limitations without a social prescriber: reduced personalised support, evidence-gathering challenges, and difficulty reaching the most vulnerable.

Takeaway

- Social prescribing **enables tailored, holistic support** and improves community engagement, particularly in rural areas.
- Removal of a social prescriber creates gaps in **vulnerable populations' access to support**, highlighting the importance of dedicated roles.
- Collaboration between **VCSE organisations and social prescribers** enhances effectiveness, sustainability, and funding opportunities.
- Structured evidence-gathering and evaluation are crucial to demonstrate impact and secure ongoing support.

Integrated Neighbourhoods

Presenters

- **Nikki Taylor** – Health Innovation Southwest
- **Martha Rees** – Health Innovation Southwest, Program Manager

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Partner Organisations

- Health Innovation Southwest (formerly Academic Health Science Network)
- NHS England & Integrated Care Boards (ICBs)
- Local authorities, community organisations, VCSE sector
- Private sector innovators and housing providers (for technology co-design)

Programme Overview

Health Innovation Southwest is a **regional innovation hub** supporting piloting, testing, and scaling of health and care innovations across rural and coastal areas. They focus on:

- Identifying proven innovations and evaluating real-world impact.
- Supporting NHS, local authorities, and VCSE partners in adoption.
- Creating conditions for innovation through networking, funding support, and co-design initiatives.

Key emphasis is on **non-clinical innovations** and technology-enabled solutions, including digital health coaching, sensors, and AI-based preventive care tools.

Key Initiatives and Stories

- **Brave AI**: AI-based risk stratification to support preventative interventions in primary care; £2.3M funding allocated.

- **Accelerated Reform Fund**: Government-backed funding to support unpaid carers and local community initiatives (£3.2M).
- **Healthier at Home**: Technology-enabled care to keep people healthier at home, including sensors, digital coaching, and remote monitoring.
- **Neighborhood Health Implementation Programme (N-HIP)**: NHS-backed initiative to develop, implement, and evaluate neighbourhood-level health solutions across Devon, Cornwall, and Somerset.

Approach and Impact

- **Collaborative Co-Design**: Health Innovation Southwest acts as facilitator, connecting innovators, social prescribers, VCSE organisations, and health/social care providers.
- **Evaluation & Scaling**: Innovations are tested, piloted, and scaled regionally with rigorous evaluation of both technology and user experience.
- **Community Engagement**: Surveys, workshops, and deep-dive research ensure solutions reflect local needs, not just national guidance.
- **Funding Enablement**: Supports large-scale funding bids and resource allocation to enable sustained innovation adoption.
- **Knowledge Sharing**: Creates networks and platforms to share learning, prevent siloed pilot projects, and ensure scalable impact.

Takeaway

- Health Innovation Southwest bridges innovation and local implementation, particularly in rural/coastal areas with unique challenges.
- Successful innovation requires co-design, community engagement, and evaluation, not just new technologies.
- Partnership and collaboration across healthcare, social care, VCSE, and technology providers are critical to scale solutions effectively.

- Neighborhood-level initiatives benefit from contextual understanding of local needs and structured mechanisms for adoption and evaluation.

Green Social Prescribing/Therapeutic Garden – Growing Well Garden at Bow Medical Practice.

Presenter

- **Susan Taheri** – GP and founder of Growing Well Garden

Partner Organisations

- Local Primary Care Network (PCN) – provided £5,000 seed funding
- Volunteers – support garden sessions and patient engagement
- University of Exeter – medical student placements (special study unit on lifestyle medicine & social prescribing)
- BBC Gardens World – media feature
- National Garden Scheme – funding for polytunnel

Programme Overview

- **Growing Well Garden** is a **nature-based social prescribing project** based at a GP surgery in Bovey, Devon.
- Aim: Promote **well-being, reduce social isolation, and encourage connection to nature** for patients of all ages.
- Inspired by personal and professional experiences: Susan's lifelong engagement with gardening, frustration with limitations of clinical care in addressing root causes of ill health, and evidence linking green space with mental/physical health.

Key Features & Activities

- **Open garden drop-in sessions:** Tuesdays and Thursdays for patients to self-refer or be invited by the healthcare team.
- **Volunteer support:** Volunteers host and support patients in the garden, fostering community and social connection.
- **Targeted sessions:** Closed sessions for specific groups (e.g., teenage girls excluded from school).
- **Activities:** Gardening, Tai Chi, seed swaps, community engagement events, and workshops.
- **Growing Well Shed:** Patients can take home flowers or vegetables for a small/no donation, connecting them to the garden even when not attending sessions.
- **Medical student involvement:** Special study units allow students to learn about lifestyle medicine and social prescribing in practice.

Health & Well-Being Benefits

- **Physical activity:** Gardening provides functional movement, cardiovascular benefit, and caloric burn.
- **Mental health:** Reduces stress, lowers cortisol and blood pressure, increases serotonin and dopamine.
- **Social capital:** Builds connection, communication, shared goals, and resilience.
- **Nutrition:** Encourages healthy eating through growing own food.
- **Environmental & planetary health:** Patients develop connection and awareness of nature.
- **Evidence base:** Professor Ruth Garside's studies – over 8,000 patients linked to green social prescribing, showing improved mental health outcomes.

Funding & Resources

- Initial seed funding from local PCN: £5,000 (non-recurring).
- Additional funding from National Garden Scheme for polytunnel.
- Future aspiration: expand to social and therapeutic horticulture and counselling spaces.

Impact & Anecdotes

- Patients report improved mental health, social connection, and confidence, especially in vulnerable or isolated groups.
- Longitudinal engagement helps patients manage anxiety and isolation; example: patient Michael attends regularly despite challenges, showing sustained resilience growth.
- Positive cultural and community impact – garden seen as a source of beauty, nourishment, and informal health conversations.

Takeaway

- Green social prescribing provides holistic health benefits beyond what traditional clinical care can offer.
- Small, community-focused interventions can have longitudinal and meaningful impacts, particularly in reducing social isolation.
- Combining nature, social connection, and structured activities is a powerful model for preventative health.
- Potential to scale the model nationally through a Growing Well Garden network.

MySoc Social Prescribing App

Presenter

- **Gavin Jones** – Head of Innovation at Elixel

Project Background

- Originated with Professor Anthony Caleshu and colleagues exploring arts and social prescribing in Plymouth.
- Focus: Improving mental well-being through arts, writing, and storytelling.
- Motivated by evidence that creative engagement reduces loneliness, isolation, and vulnerability, and promotes optimism.

Project Overview: MISOC

- **MySoc** is a digital journaling platform designed to support individuals on their social prescribing journey.
- Users can log daily moods, activities, and experiences.
- Aims to:
    - Improve self-awareness and reflection
    - Enhance link worker conversations
    - Track progress over time
    - Provide evidence of impact for organisations and participants

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Key Features

- **Daily journal prompts:** Curated, randomized questions to prevent overwhelm.
- **Dynamic content:** Categorizes activities (e.g., arts, sports) for meaningful insights.
- **Story generation:** After six weeks, users can generate a "story" of their journey (similar to Spotify Wrapped), summarizing mood trends, activities, and insights.
- **Downloadable summaries:** Users can share their journals with link workers to inform social prescribing discussions.

- **Dashboard for organisations:** Provides aggregate insights on participant moods, activity impact, and engagement over time.

Pilot Testing & Findings

- **First pilot:** Small cohort, six-week trial.
    - Participants reported peace of mind, perspective, and recognition of positive moments.
    - The summary feature was particularly impactful.
- **Current pilot:** Three-month trial with broader participation.

    - Evaluating:
        - Engagement and continued use
        - Impact on social prescribing conversations
        - Organizational insights for measuring outcomes

Next Steps

- Post-pilot: Evidence the impact of MISOC.
- Expand platform access to more organisations and participants.
- Aim to enhance social prescribing journeys through technology-enabled reflection and tracking.

Key Takeaways

- MISOC combines digital journaling with social prescribing to support mental well-being.
- Enables longitudinal tracking of mood and engagement for participants.
- Supports link workers with evidence-based insights to guide interventions.

- Shows potential to scale and improve social prescribing at organisational level.
