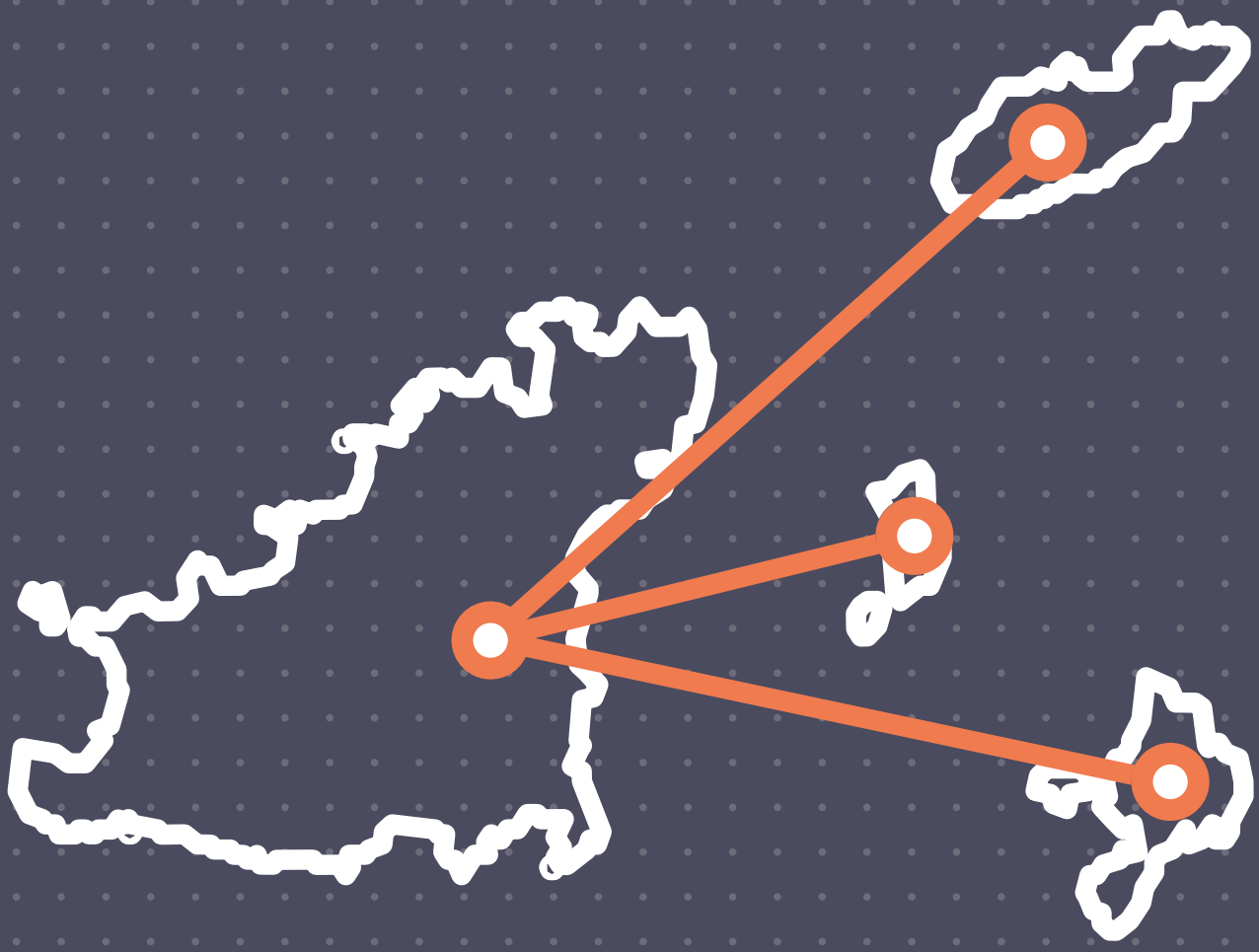
Business Plan

2019 / 2021



If you require the full business plan, please contact bella@healthconnections.gg

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health connections

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Executive Summary

Health Connections LBG is an innovative charity which supports an asset-based community approach and a social model of health and wellbeing, where people are connected to the support, services and activities that matter to them and can remain independent in their homes for longer.

We recognise the importance of working collaboratively and systemically with a wide range of organisations including our strategic partners, our directory partners, our funders and the people we serve across the sectors, in service of our mission.

This business plans sets out our goals/priorities for the next three years.

We aim to serve:

- Every person in the Bailiwick who wants to be sign-posted to and attend services and support which prevents ill-health, maintains good health and wellbeing, prevents early onset disease and improves their quality of life.
- Those individuals living with long term conditions (including support for mental health) who want to have one to one support & advocacy.
- Those who would benefit from having emotional and practical support while living with complex social needs which affect their wellbeing.
- Those who would like to be more socially connected, reducing their risk of loneliness and isolation.

Support offered by Health Connections:

We have developed a person-centred innovative “Directory to Doorstep” model to achieve our mission.

Support needed by Health Connections:

To enable us to develop and sustain this model we need the support of the private sector and statutory services for funding and to work systemically and in partnership to co-create and ensure we align policy and priorities.

Therefore, we need:

- To explore how Health Connections can consistently add value, fill gaps, increase connectedness and align with our partners priorities, purpose and projects.
- To increase our understanding of how we can continually provide support that reflects the current and future trends and needs of everyone in the Bailiwick and visitors to the islands.

- To expand our Directory and support our Network of Community and Health Connectors.
- To develop new income streams through Social Enterprise, Corporate, Public and Private Donations and Service Level Agreements.
- Volunteers who can join our team.

Our Management Team:

Our Board of Directors have approved a new strategic direction, an improvement plan for good governance, an outcomes framework and this business plan with financial forecast to achieve our goals.

We are delighted to have had the support, mentoring and learning from our local partners as well as other innovative, research based organisations e.g. Health Connections Mendips, Bromley-by-Bow and Nesta; the global innovation foundation.

Overview of Health Connections- Who are we?

Our Mission:

To ensure that people in the Bailiwick of Guernsey are connected to information and support that enables them to live healthier, happier and more fulfilling lives.

Our Vision

“Health Connections making connections that support you"

Our “Directory to Doorstep" model will, within 2 years, be a brand recognised and trusted by the whole community, working in collaboration with complimentary organisations in the charitable sector, primary and secondary care and statutory services.

It will have a reputation for reliability, working systemically in service of our mission, demonstrating impact and promoting professionalism and compassionate care and support.

Our Goals:

Year 1 (2019)

- HC map community assets and create a one stop online directory of support and activities which support health and wellbeing in the Bailiwick.
- HC Lead Community Connector trains 100 Community Connectors to improve signposting and connect people to support that matters to them on our Directory.
- HC provide 2 Health Connectors providing one to one support and advocacy at points of transition and off island treatment and care.
- HC develops the Health Connector role to include the Link Worker role to support Social Prescribing.
- Lead Community Connector develops the Talking Cafe Charter and identifies the cafe network with volunteer Community Connectors.
- HC Volunteer Timebank Lead develops a Timebank enabling people who volunteer or work with HC to earn time credits for themselves or to gift to others to increase practical support in their own lives.
- HC VCS Lead coordinates a HC Voluntary Car Service
- HC appoints ‘Social Prescribing Commissioning Manager’ appointed in September 2019, seconded to Public Health a part of an innovative ‘Partnership of Purpose’ new to the Bailiwick. A collaborative working relationship between HC and HSC which has the aim of positively impacting the populations health and wellbeing by developing and

implementing Social Prescribing pathways, and enabling the provision of quality initiatives for the Bailiwick.

Year 2 (2020)

- HC Directory coordinator keeps online Directory current, trusted and promoted.
- HC Lead Community Connector trains a further 100 Community Connectors.
- HC network of Community Connectors volunteer to implement and expand the Talking Cafe Network (10 GSY parishes and Alderney/ Herm and Sark/13 cafes).
- HC provides 3/4 Health Connectors / 1 providing off island support and advocacy, 2/3 providing Link Worker function supporting social prescribing.
- HC Timebank broker coordinates timebanking for Health Connections staff and Volunteers to produce a feasibility study for island wide timebank.
- HC Transport Coordinator develops a Centralised Voluntary Transport Service (which includes dial a Ride), enabling access for all to opportunities for social connection, health and wellbeing.
- HC Social Prescribing Commissioning Manager and HC lead Link Worker develop, implement and measure an accessible, equitable and quality Social Prescribing offer in The Bailiwick.

Year 3 (2021)

- HC Directory coordinator ensures Directory is current and explores need for app.
- HC Lead Community Connector trains a further 100 Community Connectors (CC) to create a network of 300 Community Connectors across the Bailiwick.
- HC network of Community Connectors volunteers implement the Talking Bus project to compliment and increase access to the Talking Cafe Network.
- HC provide 5 Health Connectors. (1 providing off island support and advocacy, 3/4 provide Link Worker function supporting social prescribing.
- HC Timebank broker rolls out our Timebank to our Directory partners enabling their volunteers to earn time credits for themselves or to gift to others to increase support in their own lives.
- HC provide a one stop Centralised Community Transport Service.
- HC Social Prescribing Commissioning Manager and HC lead Link Worker continue to develop, implement and measure an accessible, equitable and quality Social Prescribing offer in The Bailiwick. The Commissioning Manager increases the commissioning of grants locally to meet identified need in the community.

Target demographic- Who we work with.

We work with:

- Every person in the Bailiwick who wants to be sign-posted to and attend services and support which prevents ill-health, maintains good health and wellbeing, prevents early onset disease and improves their quality of life.
- Those individuals living with long term conditions (including support for mental health) who want to have one to one support & advocacy. We have provided face to face and phone support to 1200 people in the past 18 months and provided over 350 hospital packs this year so far to people going off island for treatment and care.
- Those who would benefit from having emotional and practical support (see Timebanking proposal on our website) while living with complex social needs which affect their wellbeing.
- Those who would like to be more socially connected, reducing their risk of loneliness and isolation We currently take 151 isolated people to support each week servicing over 90 journeys per week (over 4000 journeys per annum).

Health and Social Context

Health Connections' mission is a result of a strategic review carried out in 2018 by local charity Health Information Guernsey, which transformed into Health Connections in line with the new Health & Social Care (HSC) policy paper The Partnership of Purpose, The Disability and Inclusion Strategy and The HSC Transformation Academy.

Health Connections' goals & priorities fill a gap in our community, identified in the HSC 2019 Joint Strategic Needs Analysis, which is to:

- Improve signposting, provide support and encourage activities that matters to people.
- Provide one to one support based on individual needs and provide advocacy at points of transition and where it may be beneficial.
- Provide a centralised voluntary community transport service to enable access for opportunities for social connection health and wellbeing.

Aligned to The Partnership of Purpose policy, we will also:

- Provide practical support via our Timebank to transform lives.
- Support social prescribing and community based care that improves health and wellbeing.

We support the development of an asset based social model of health and well-being in the community where people are connected to the support that matters to them and can remain independent in their homes for longer.

We reference our work to be aligned to States Strategies and Plans i.e

- Supported Living and Ageing Well (SLAWS)- Carers Action plan
- Disability and inclusion Strategy
- Partnership of Purpose Policy Paper
- Future Guernsey

The want to support the transformation of health and care services in the Bailiwick of Guernsey, which is based on the key aims of:

- Prevention: supporting islanders to live healthier lives;
- User-centred care: joined-up services, where people are valued, listened to, informed, respected and involved throughout their health and care journey;
- Fair access to care: ensuring that low income is not a barrier to health, through proportionate funding processes based on identified needs;
- Proportionate governance: ensuring clear boundaries exist between commissioning, provision and regulation;
- Direct access to services: enabling people to self-refer to services where appropriate;
- Effective community care: improving out-of-hospital services through the development of Community Hubs for health and wellbeing
- Focus on quality: measuring and monitoring the impact of interventions on health outcomes, patient safety and patient experience;
- A universal offering: giving islanders clarity about the range of services they can expect to receive, and the criteria for accessing them;
- Partnership approach: recognising the value of public, private and third sector organisations, and ensuring people can access the right provider.
- Empowered providers and integrated teams: supporting staff to work collaboratively across organisational boundaries, with a focus on outcomes.

Outcomes

We record our output in an online data workbook to measure our impact. Our Outcomes Frameworks have clear Key Performance Indicator's.

Reports demonstrating our impact will be published annually.

We will work in partnership with others to support their priorities and to achieve the following outcomes, which include:

- Increased health equity and personalised care.
- Improved quality of life and wellbeing for individuals referred to the service.
- Easy referral to Health Connectors from a wide range of local agencies.

- Strengthened community development and assets, some achieving a Social Prescribing kite-mark.
- Improved access for all to support leading to increased equality and inclusion.

Equality in Health is treating everyone the same; in health not everyone needs the same thing therefore equity involves giving or getting health treatment and care needed to achieve best possible outcome. Access (signposting and transport) is an area in which equality can be provided.

Legal structure

Health Connections is a registered charity and has had LBG status since June 2018.

Our services:

1. Directory - What support is there in the Bailiwick?

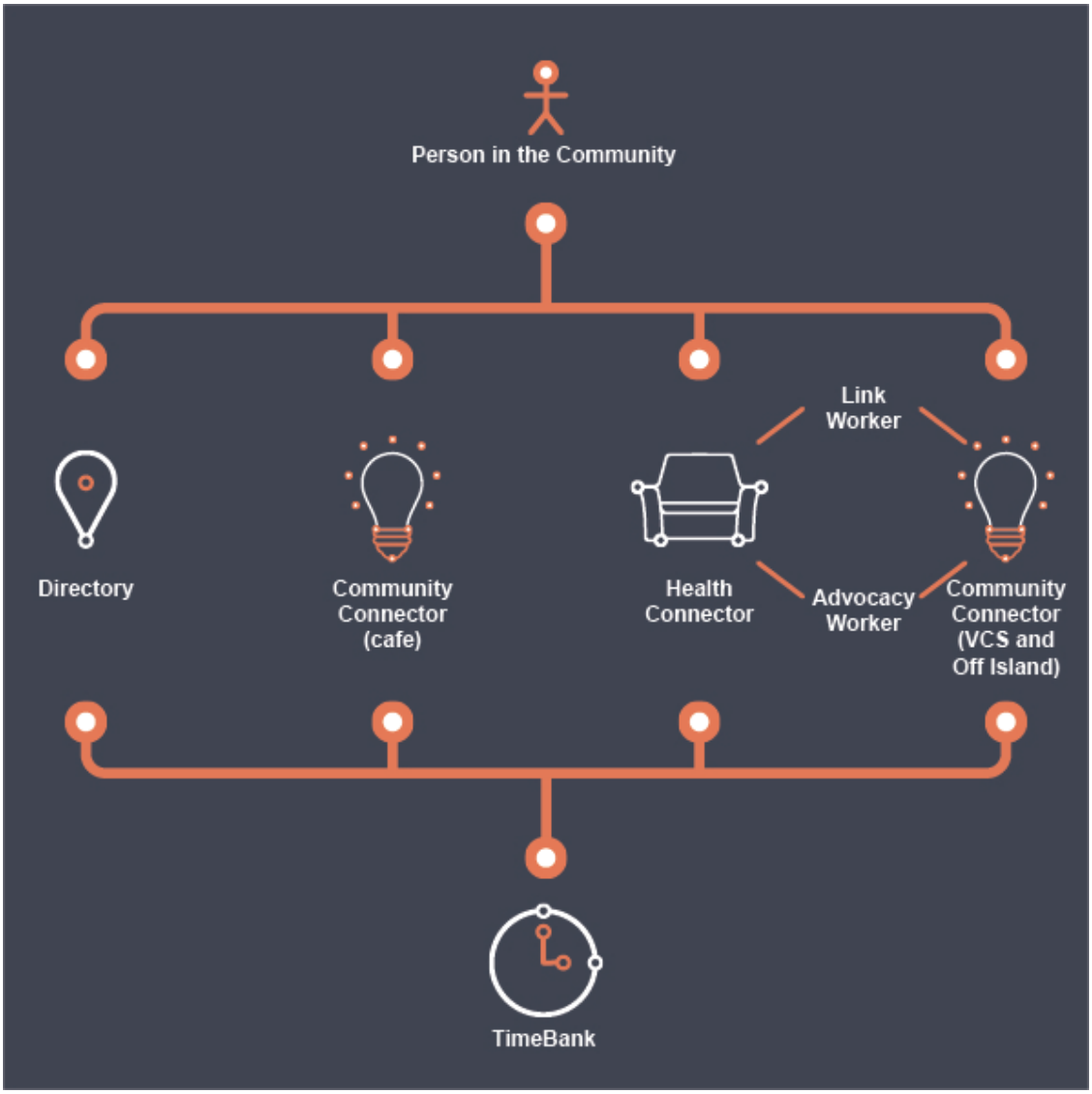
People in the community were unsure where to go to get the support, information or activities that they required to support their health and wellbeing.

We have designed and created an online Directory of services, support and activities which our partners organisations members/ beneficiaries / patients actively engage with.

This is valuable to both professionals and people enabling them to engage fully in their communities and live a happier, healthier and more fulfilling life.

Without our directory, a one stop signposting service for all people in the Bailiwick does not exist.

It will continue to be developed to support the provision of services for social prescribing.



2. Community Connectors - Making Connections to support you.

We will recruit, train and manage a network of 300 Community Connectors (active sign posters) to ensure all people are connected to support that matters to them.

Effective signposting will require support from the network of Community Connectors who signpost people to the directory. They also unearth often hidden assets in the community and keep the directory current and trusted. They will Coordinate the Talking Cafe and Talking Bus project.

Without Community Connectors, more and more people risk being lonely and isolated and more dependent on statutory services at points of crisis.

Unique Features

Community Connectors map the abundant and often hidden assets in our community and co produce the Health Connections Directory.

Community Connectors will enable the community to access support and information in the ways that suits them best:

- by phone or face to face from HC office / pop up locations.
- in the community using our online directory.
- at Talking Café's and in Talking Buses.
- through our Voluntary car service drivers who will train as Community Connectors.
- through our Timebank broker.
- using local media, printed material and events.
- by hosting HC Directory Partners Network meetings.
- by liaising with Statutory services, healthcare professionals and community services and support.

Impact Evidence

We have developed an outcomes framework with clear Key Performance Indicators:

- 300 Community Connectors trained in the next 3 years.
- 1200 + Signposting conversations per annum.
- 13 Talking cafes* in next 3 years.

Intellectual Property Evidence Base for Effectiveness

- Improved Signposting increases access to support.
- People can choose how to take responsibility for their own health and wellbeing.
- Encourages self referral for early intervention and support for long term conditions.
- Increases social connectivity reducing loneliness and isolation.

*We are developing the Talking Cafe charter which will be adopted by a network of local cafes. Our Community Connectors will attend these cafes at specific times enabling more people to make connections and access support, health information and respite in local cafes.

Our Community Connectors will also sit on buses and have signposting conversations.

Community Connectors are recognisable by their orange branded t-shirts if working in Cafes or buses. There are also badges and pin badges for our wider network of Community Connectors, which are received following training.

3. Health Connectors- What matters to you?

We will develop a network of 5 Health Connectors to provide one to one and group support to help improve and support health and well being in service of enabling people to live happier, healthier and more fulfilling lives.

Health Connector off-island support

For some, the initial touchpoint with us is when they are referred off island for treatment or care.

Our off island Health Connector provides up to date off-island hospital information packs and one to one support with care and compassion. We have provided over 350 hospital pack this year.

Without this support people going off island would feel much more vulnerable at an exceptionally stressful time in their lives.

Health Connectors on-island Support

Often people require one to one support and advocacy at points in transition in their care.

Our Health Connectors will have a health navigator / link role supporting people to decide what matters to them.

This service is valuable to people as it supports them in their choices about what matters to them to stay well, recover, flourish, receive better care or take better care of themselves or their loved ones.

Without Health Connectors people will feel less supported and in control of their own health and wellbeing.

Unique Features

We will develop and deliver the Health Connector service, supporting clients and recruiting and coordinating a team of effective Health Connectors to:

- Provide one to one coaching to support people at points of transition in their care and to help build the knowledge, skills and confidence they need to help improve their health and wellbeing or manage their long term health.
- Provide advocacy for the most vulnerable in our community.
- Ensure all people going off island for treatment and care receive support and off island hospital information packs
- Provide link workers* to support a person-centred, holistic and integrated social prescribing service.

*The Link worker role is to connect people with services in the community and working in partnership with the person, assist them to set health- related goals and support them to make sustainable changes.

They also work with groups and teams to help build social capital, helping to develop new services and projects in service of a healthier and happier community.

Impact Evidence

We have developed an outcomes framework with clear Key Performance Indicators for our Health Connectors see Outcomes Framework attached.

Part of the development of the Social Prescribing service will be to create outcome measurements to measure the impact of the service in line with NHS England's Common Out-comes Framework. We are keen to develop the KPI's with HSC for social prescribing.

Intellectual Property Evidence Base for Effectiveness

The three key intended outcomes of Social Prescribing are:

1. Improvement in health and wellbeing of Bailiwick residents.
2. Reduction in use of Health and Social Care services resulting in a reduction of costs.
3. Strengthened community, improved community development and resilience to help address the wider determinants of health.

Health Connections will employ a Social Prescribing Services Lead to ensure the provision of a quality assured and evidence based, social prescribing program is available from the community assets in our Directory.

The Social Prescribing Services Lead will work with the HSC Public Health team to ensure partnership between HC and HSC on developing this service and delivering co-created outcomes across the Bailiwick.

They will also work alongside our Lead Health and Community Connector, who will be coordinating the Link workers.

4. Voluntary Community Transport Service- Access to opportunities for social connection, health and wellbeing.

Service Idea

There is a segment of our community who need to use a Voluntary Transport Service because they are unable to use public transport, may not be able to afford taxis and may not have friends or family available to transport them.

Currently we have 18 volunteer drivers serving 151 people this year to date, doing approx 90 journeys p/w.

Without this service these people would not remain independent in accessing medical appointments and opportunities for social connection, health and wellbeing.

Unique Features

Healthcare professionals can refer their patients to our service to ensure they can easily access their appointments.

Self referral on line via our website or by telephone.

We take people to services and support that matters to them.

Our drivers are reliable and caring and accredited passenger assistance trained (PAT).

Car service is free to our passengers.

Impact Evidence

See impact report available on request.

Intellectual Property Evidence Base for Effectiveness

Enabling access to opportunities for social connection, health and wellbeing reduces the problems associated with loneliness and isolation and enables people to remain independent in the community for longer.

It also improves access to medical support, reduces missed appointments and the need for home visits by primary and statutory care.

Service Development

We will:

- Continue to develop the transport service to ensure access to support is provided in an efficient and caring manner.
- Recruit and develop a team of 30 voluntary drivers trained in A Passenger Assisted Transport (PATs) accredited programme.

- Liaise with directory partners to develop a Centralised Community Transport Service which will incorporate a Dial a Ride service; extending the service to include food shopping, library, social gatherings and what matters to our passengers.
- Utilise existing community transport to ensure a fleet of accessible transport options provides an inclusive service and an efficient use of existing transport.

5. Timebank - Exchanging time credits for support

Service Idea

We want to offer a Timebank enabling people who volunteer to earn time credits for themselves or to gift to others to increase practical support, independence, capacity, meaning and purpose and abundance in their lives.

Currently, we have a volunteer Timebank broker who is doing a feasibility study for a local Timebank.

This service is important because it will encourage people to volunteer with us and our Directory Partners. It will also encourage a narrative of community participation where everybody especially the ageing cohort may be a contributor to the community.

Without a Timebank the decreasing number of volunteers is likely to continue and the most vulnerable will not be able to access the practical support they need to be able to stay independent in the community for longer.

We have published a detailed proposal for the Health Connections Timebanking project on our website.

Unique Features

Enables our volunteers (Community Connectors, Health Connectors, drivers and shop assistants) to feel recognised and valued by enabling them to earn time credits for themselves or to gift to a loved one.

The core values of Timebanking are:

- We are all assets and can contribute in our community.
- All work can be rewarded equally.
- Co production encourages sustainability.
- Reciprocity and co creation “How can we help each other” builds stronger communities.
- Values social capital.
- Engenders inclusion and respect for all.

Impact Evidence

There is much evidence to support Timebanking (see www.timecredits.com, www.timebanking.co.uk, www.timebanks.org).

Our proposal for a local Timebank is published on our website.

www.healthconnections.gg/timebank

Evidence Base for Effectiveness

- Increase the number of people volunteering.
- Improves intergenerational social participation.
- Enables better physical and mental health.
- Reduces loneliness and social exclusion.
- Develops skills and capacity and increases peoples employability.
- Increases social capital and equality.
- It is aligned to SoG policy: the HSC Partnership of Purpose refers to the need for Community Credits.
- The Carers Action Plan (published in Guernsey, May 2019) have named Health Connections as the lead for Timebanking.

Service Description

- A Timebank broker develops the Timebanking platform with support from time banking UK which will be accessed through the Health Connections Website or from one of the Health Connections offices.
- The Timebank broker recruits and links members up and liases with Health Connections and its partners to initiate projects to involve members in health and wellbeing intergenerational activities to achieve our collective objectives.
- Members of the Timebank earn one hour of credit for each hour they spend volunteering (everyone's time is valued equally).
- This can be credited to the Tmebank and can be spent receiving one hour of someones else support.

6. Commissioning Bailiwick Social Prescribing Provision

Service Idea

HC will partner with HSC/Public Health to deliver an innovative and equitable pilot programme of commissioned quality and evidence-based community 'social prescribing' activities which can positively benefit health and wellbeing in the Bailiwick.

What is social prescribing?

Social prescribing is a means of enabling a person to be referred by a link worker to a range of local, non-clinical services which may positively impact their health and wellbeing.

Acknowledging that health is determined primarily by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health.

Social prescribing schemes can involve a variety of activities which are typically provided by voluntary and community sector organisations. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating and a range of sports.

Social Prescribing aligns with the HSC "Partnership of Purpose" principles of a partnership approach, prevention and user-centred care.

Social Prescribing also aligns with the following States of Guernsey Strategies: Mental Health and Wellbeing, 2020 Vision, Disability and inclusion, Living Well and Ageing Well.

Evidence Base for Effectiveness

- Reduced loneliness/Improved Social Connection
- Improved Mental Wellbeing/Mood
- Improved Self-Care
- Reduced Loneliness/Improved Social Connection
- Improved Memory & Brain Health
- Falls Prevention
- Improved Physical Health
- Improved Mental Wellbeing/Mood
- Healthy Food Choices
- Improved Sleep
- Improved Self-Care
- Reduced reliance on drugs and alcohol
- Reduced need for prescription medication

Within the community outcomes can include:

- Increase in health professionals referring to link workers
- Increase in people being signposted to an effective initiative that addresses underlying determinants of health
- Increase in the success rate of Public Health strategies, for example healthy weight, substance misuse reduction, increased physical activity
- Genuine engagement with health and wellbeing initiatives
- Peer-led support networks
- Improved community resilience
- Learning of new skills
- Sustained change
- Improved motivation
- Increase in volunteering
- Enhanced social infrastructure and networks
- Building of trust
- Educational opportunities for young people wanting to work within the HSC, health and wellbeing areas

Service Development

Commissioning of Social Prescribing provision is a new initiative for the Bailiwick. We aim to initially extend a pilot of commissioning four evidence-based activities in The Bailiwick which adults can be signposted to by a link worker. Self-referral will also be possible. The emphasis will be on fun and enjoyment of joining in a relaxed community group activity which can positively impact on a participant's health and wellbeing. The pilot will be accessible; lack of experience nor ability to pay should not be a barrier to attending, however those who are able to pay are expected to do so at each session attended through a voluntary donation.

2020-21 –Provision of Singing For Health, T'ai Chi/Qi Gong, Body Balance, Art for health and Mindfulness Basics (and other based on need) classes made available at 3 sites in Guernsey including the established programme at Styx Centre and start to roll out.

2021-Singing For Health, T'ai Chi/Qi Gong, Body Balance, Art for health and Mindfulness Basics etc classes also made available across the bailiwick.

2022- Increase the commissioning of grants locally to meet identified need in the community.