SOCIAL PRESCRIBING AND CHAPLAINCY AT CAPE HILL MEDICAL CENTRE

Tackling Health Inequalities- multifaceted approaches.

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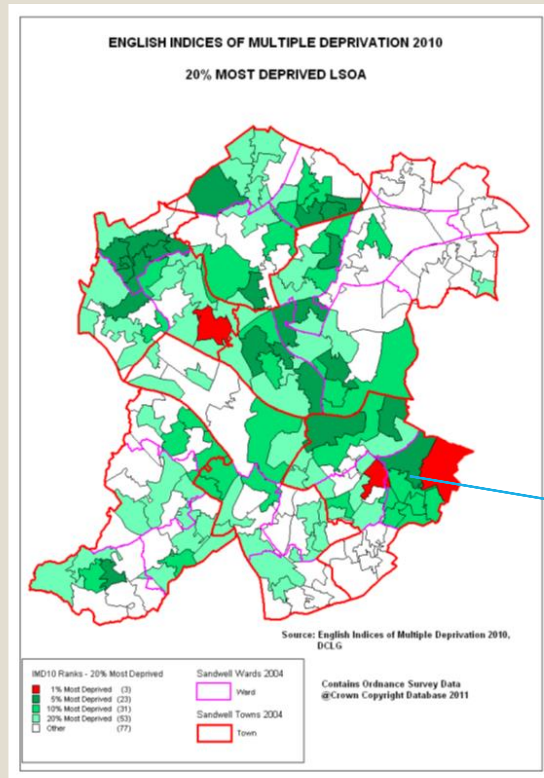
Aims of this talk….

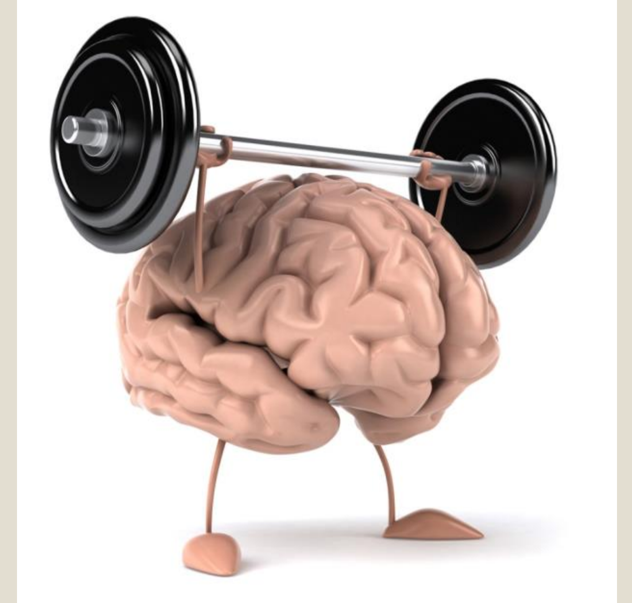
- 1. A brief background to the journey of Social Prescribing and Chaplaincy work at Cape Hill Medical Centre.
- 2. Illustrate the impact of each component- help for patients
- 3. The impact of proactive interventions for patients who were recognised on a computer search to be frequent attenders and to be at high risk of social isolation,- help for the health economy.
- 4. on going projects

Cape Hill Medical Centre



List size : >12,000
Culturally diverse
Marked Deprivation
Long history of work with Asylum Seekers and Refugees
Also manage Birmingham’s Homeless Service.

Holistic Care and Patient Need: What do our patients need?



Pressures in general practice

- As an example a Kings Fund report showed an analysis of 30 million patient contacts from 177 practices found that consultations grew by more than 15 per cent between 2010/11 and 2014/15.
- Over the same period, the GP workforce grew by 4.75 per cent and the practice nurse workforce by 2.85 per cent.
- According to the BMA in 2016 there were record numbers of practice closures in England, with more than one GP surgery closing every week (not including mergers)2
- More than eight out of 10 GPs in England say their workload is unmanageable
- The proportion of patients waiting for more than two weeks for an appointment has risen to a record high of 20% – up from 12% five years ago.
- The complexity of patients cared for in GP has also risen due to an ageing population with greater multi morbidity and policy changes which are directed towards moving care from secondary to primary care. Added to this, in areas of deprivation – such as our own the number of years of poor health before death is considerably more than in richer areas. A further complexity of this issue is the difficulty marginalised groups have in accessing primary care and the fact that the inverse care law is still as relevant today as when it was first outlined. These factors of equality and equity are at least in part responsible for the stark impact of deprivation and poverty on morbidity and mortality.

A Timeline of stories

Funding and Pandemic…

Health Coaching
Lifestyle Clinics
2021

THE WELL BEING
HUB
2016-2020

Adapting to
the pandemic
2020-on going

The Chaplaincy role is to provide spiritual support to those of all faiths and none. We have extended this to end of life care in Nursing Homes for patients in the last year of life.

12 month period 349 appointments were offered and 172 patients helped.

Story 1:

- Miss Y
- Refugee from a war torn zone
- Muslim
- Unknown trauma history
- Mute
- No improvement with antidepressants

- Chaplaincy in put
- Hand massage and pictures

10 years on:
Working in a pharmacy as an assistant.

Description

Story 2 –Shisha Bars and more

- Safe surgery principles
- **Interpreted- culture and language**
- **Worked with local NGOs to access necessary support.**
- **Link workers proactively went into the community to register patients**

Most vulnerable migrants with no recourse to public funds were registered and enabled to receive health care

PERSONALISED CARE-SOCIAL PRESCRIBING

The underlying mission is to impact on health by addressing its social determinants and to reduce health inequalities by directly addressing barriers to good health within our communities

No Going Back

- In 2014 we developed a permanent service to offer personalised support to all our patients who we recognised to have social needs as part of their presentation.
- Our highly skilled social prescriber tackles problems from debt to immigration issues, trafficking to homelessness. The results had an impact on our appointments- both showing an increase in accessing health care for long term conditions (Nurse practitioner appointments) and reducing GP appointments for this cohort.

Story 3: Start of a duty surgery…

- First patient Miss N arrived at the surgery with all her possessions in a bag
- Trafficked woman
- Escaped traffickers
- NFA
- No legal support
- Physical and mental need- no previous health care in the UK
- Referred to the link worker

By the end of the afternoon- the patient had a safe place to stay, had been referred to the appropriate support for trafficked women and had been referred for legal support- allowing the Dr time to start to address the physical and mental health needs.

Story 4: New trainees clinic

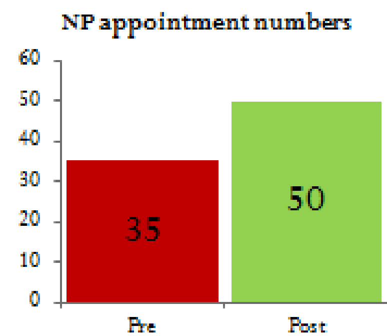
- Young person, newly homeless, frightened, very little sleep for a week due to street sleeping
- Suicidal ideation
- Beaten by bureaucracy
- Trainee's and patient's solution was medicine based- to increase the antidepressants

Social prescriber liaised with housing/job centre and after 6 hours- with the patient sleeping on a couch throughout – the patient had a bed for the night, an advocate for an interview at the job centre for the next morning and the promise of on going housing if he attended.
He went out 6 inches taller and making eye contact with the team which he had not done when he came in

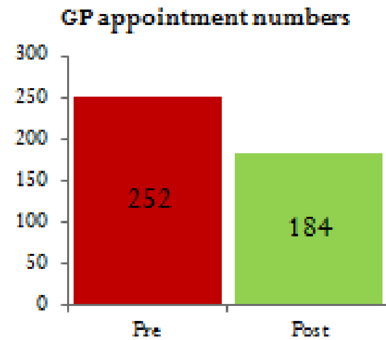
Impact

CHMC: Christine's Jan-Jun '17

- 66 pts seen
- Average link worker appts: 3.4
- Average GP/NP appts pre: 10.9
- Total F2F 117, total TC 106



42.9% increase in 6 month period

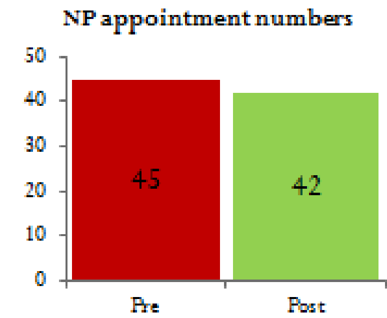


27% reduction in 6 month period

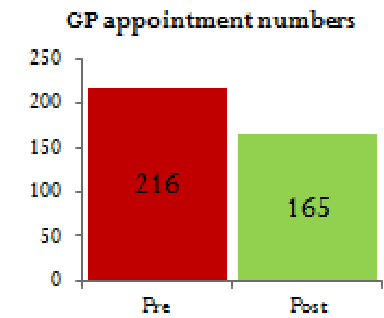
Overall: 18.5% reduction

CHMC: Christine's Jul-Dec '17

- 61 pts seen
- Average link worker appts: 3.2
- Average GP/NP appts pre: 14.4
- Total F2F 76, total TC 121



6.7% reduction in 6 month period



23.6% reduction in 6 month period

Overall: 20.7% reduction

2016- 2020

One afternoon a week

- Chaplaincy
- Counselling
- Social Prescribing
- Thrive to work
- Nursing/Doctor

Pilot project

AIM: TO EVALUATE WHETHER FREQUENTLY-ATTENDING PATIENTS WHO MIGHT BENEFIT FROM SOCIAL PRESCRIBING, CAN BE RECOGNISED THROUGH A COMPUTER SEARCH OF RISKS FOR ISOLATION, LONELINESS, OR SOCIAL PRESSURES AND WHETHER A SOCIAL INTERVENTION HAS AN EFFECT ON WELLBEING AND CONSULTATION RATE.

Method

Patients remaining n=19

Female 16 Male 3

Age range 33-90 Mean age 60

Well being score completed before and after a tailor made social intervention.

PATIENT WELLBEING QUESIONNAIRE

Please answer the questions below on a scale of 1-5

1) How do you feel?

Sad--Happy

1	2	3	4	5

2) How lonely do you feel?

Lonely--Not lonely

1	2	3	4	5

3) How supported do you feel?

Unsupported -- Supported

1	2	3	4	5

4) Do you feel like you're getting help with your problems?

Not getting help--Getting help

1	2	3	4	5

5) How confident do you feel in dealing with problems yourself in the future?

Not confident--Confident

1	2	3	4	5

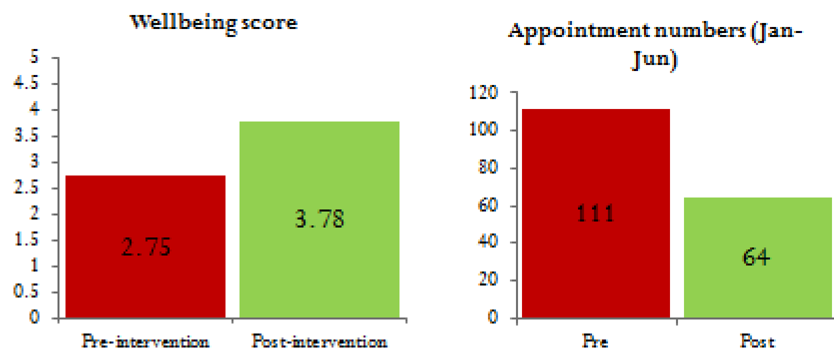
Patient Signature: .... Date: ....

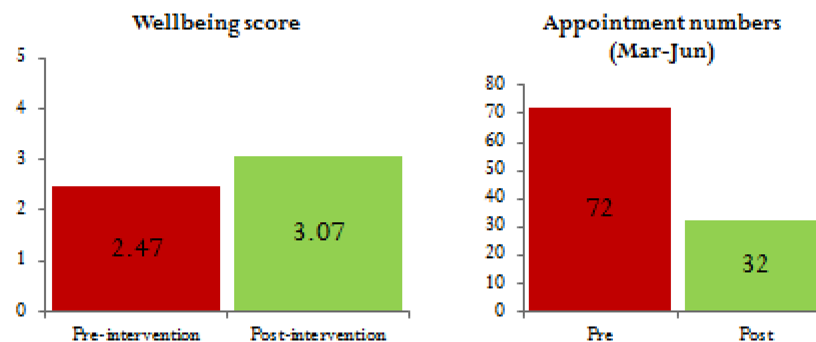
Link Worker Signature: .... Date: ....

RESULTS

- WELL BEING SCORE:
  - 10/19 patients completed the well being score before and after the intervention.
- An increase of 0.8/5 was seen.

Initial results….



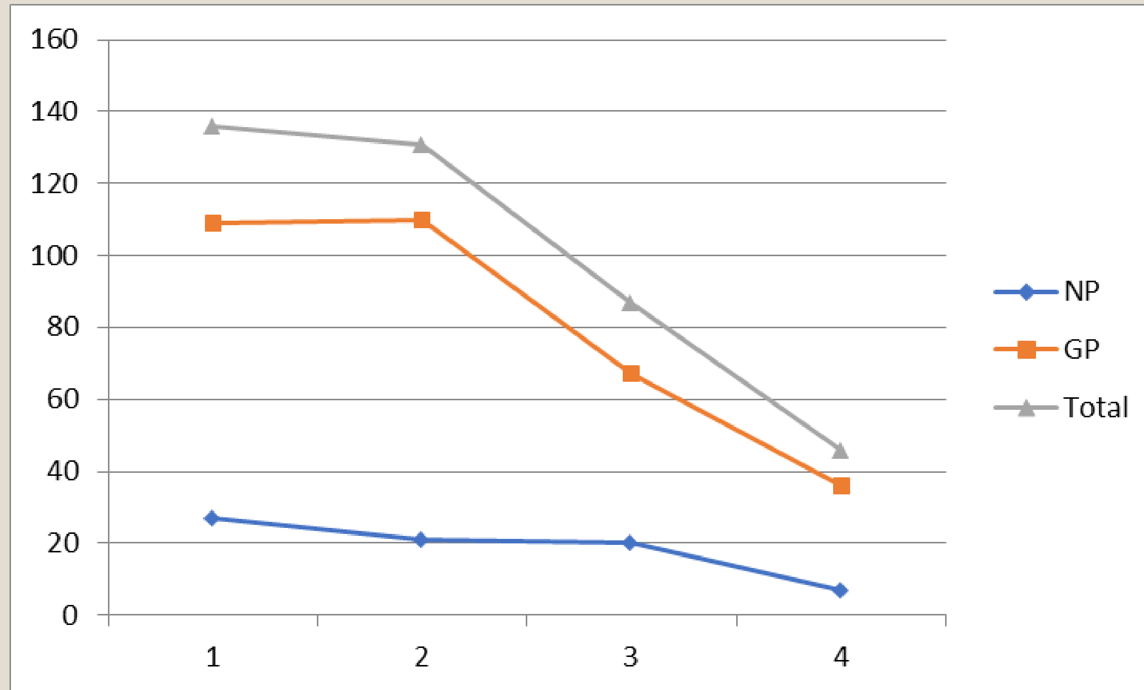


Rate of Change

- Comparison of rate of change of appointments before and after the intervention

The graph below illustrates an almost static number of appointments attended before intervention compared with after intervention, and that the reduction following the intervention continued over the following 6 months.

Graph 3



Discussion: General

- The numbers in this project are small- so no statistical analysis can be made. Also it was not possible for us to do a project that was controlled or blinded.
- Nevertheless, there are trends to recognise in the results.
- The results suggest a positive impact on the well-being and the consultation rates of a selected group of frequent attenders at an inner-city GP practice.
- The results suggest a reduction in appointments after a social intervention through the link worker service, where the demand for appointments before the service had been static.

HEALTH COACHING
AND LIFESTYLE

Twice weekly clinics

- Self referral or clinician referral
- Weight management according to NICE Guidelines
- Smoking cessation support
- Alcohol brief interventions
- Exercise advice

ASYLUM SEEKER SUPPORT

Innovative Model- Cape's Welcome Project

- Extended New Patient Health Checks and on going care
- Hotel Gang
- - interested clinicians from across the patch
- - students and other volunteers- to help with orientation to NHS, directing to useful NGOs and completion of the HC1 form
- - training and support by our own GPs, nurses and social prescribing team.
- On going expert care for this client group- whose stories reveal unmeasurable suffering.
- CHMC now offer a service to one of the hotels in West Bromwich- with support from the CCG and in house expertise and a long term locum with expertise in the field.

PLANS FOR THE FUTURE

Developing plans to build on each of these elements- to develop group work- our aim is to be a centre for health and community cohesion- not just a health centre.

Complete Care Community

- • Complete Care Community is a national programme which supports Primary Care Networks to identify and narrow health inequalities in their local area.
- • The programme encourages local networks to adopts a systematic approach to addressing the wider determinants of health inequalities including using data to inform action.
- • The Complete Care Community programme is delivered by Healthworks with NHS Arden & GEM. Complete Care Community's relationship with NHSE&I?
- • The Complete Care Community programme receives funding from the National Healthcare Inequalities Improvement Programme at NHS England and NHS Improvement.
- • The programme supports Core20PLUS5, the national NHS England and NHS Improvement approach to reducing healthcare inequalities.

Insanity is doing the same thing, over and over again, but expecting different results.

Albert Einstein

quotefancy

- 2022 PROJECT : The original plan
- Offering social prescribing input of choice (personalised social prescribing- including Chaplaincy care, lifestyle or group work) to individuals who are either recognised in the consultation or who are recognised from computer searches and score highly with regards to their social need/isolation and are:
  - **Individuals who are high attenders and/or**
  - **Individuals who have not accessed preventative care- such as immunisations or smears and/or**
  - **Individuals who are consistently out of target for their HbA1c/Cholesterol and BP readings.**
- Within this model we will look to promote healthy lifestyles- diet and exercise for example, mental health first aid and support for positive parenting- linking with local Health visitors and the family service unit.

Organically growing

- What we have learned:
- That just when you think you know what you are doing you find you have no idea !
- How to identify those suffering the greatest levels of deprivation
- The need for a health literacy lead for every project
- The 80:20 ratio
- Sustainability of any project
- Co- working makes us stronger- Public Health and patients
- Patient perspectives- moving to a patient led project
- ''WHAT STOPS YOUR COMMUNITY FROM BEING HEALTHY?''

What if- community group education...what if gardening groups...what if support for good food and cooking

Vision: 20:80 vision!

- THAT THE SURGERY TRUELY BECOMES A CENTRE FOR HEALTH
- Our patients are free enough from their poverty to be able to make healthy life choices
- Our patients are free enough from their poverty to be able to feel less stress
- Our patients have access to things that allow them to have healthy lives
- Our patients have access to knowledge that helps them to live healthy lives

- The surgery can facilitate reduced poverty
- The surgery can be a focus of cohesion- that promotes and enables healthy choices through activities and knowledge
- The surgery has a better way of providing access that is needs based

- That the surgery has adequate staff to give this provision

- That the result is that our patients get access for acute problems when they need it- with the correct practitioner and that the patients get health promotion and prevention- reversing the inverse care law.

NHS

REDUCING HEALTHCARE INEQUALITIES

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in health inequalities improvement

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

Target population

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

CORE20 PLUS 5

Key clinical areas of health inequalities

1 MATERNITY
ensuring continuity of care for **75%** of women from BAME communities and from the most deprived groups

2 SEVERE MENTAL ILLNESS (SMI)
ensuring annual health checks for **60%** of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities)

3 CHRONIC RESPIRATORY DISEASE
a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

4 EARLY CANCER DIAGNOSIS
75% of cases diagnosed at stage 1 or 2 by 2028

5 HYPERTENSION CASE-FINDING
to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke

Mini projects that are emerging

- Vulnerable pregnancies project- Mums matter.
- Cervical screening project
- Childhood immunisations project
- Asylum seeker outreach work
- Feel known , feel cared for project- tackling social isolation
- Focus on health literacy- Be part of the conversation

Dreaming dreams

More space…and working with patients, communities , third sector groups and local author=ity groups

Thank you for listening- any questions?