Health Connections Mendip – an innovative service which promotes individual and community resilience.

Health Connections Mendip (HCM) is an innovative service that is increasingly cited nationally and internationally as a successful and effective model of community development and social prescribing. Based in the Somerset district of Mendip, the initiative offers a range of services, including community development, peer support, a website directory, EMIS patient record system, social prescribing, one-to-one support and Community Connector training to enable people living in Mendip to improve personal and community resilience. The Health Connections Mendip team is hosted by Frome Medical Practice on behalf of the 10 Mendip GP practices with a total practice population of over 115,000 patients.

Using a combination of interventions, HCM aims to reach as many people as possible and as such has multiple points of access. Although primary care is at the heart of the model, services are not solely accessible via a healthcare professional. Members of the public are able to access services directly and can self-refer, or even undertake training in order to signpost other members of the community to services during their day-to-day conversations. For more complex cases, there is also a team of Health Connectors who offer one-to-one support. The HCM team also run peer support groups and Talking Cafes. Where gaps are identified by the community, HCM supports the community by guiding them through the process and facilitating the start-up of new groups that will ultimately become self-sustaining.

How it works:

HCM has something for everyone, depending on the level of support required or involvement wanted. Health Connections is patient-led and individuals are able to decide how they would like to get involved with HCM. The work is ever evolving so things change and improve as we go along.

1) How it works - Simple signposting

Some members of the community want to be signposted to support in their community. There is so much support available but people often don't know about this support or how to access it. Health Connections Mendip tries to support people to know about this information in a variety of ways – we have tried to create ways of finding out information to suit different people's needs and wants.

Signposting in the community, this may done via:

- Community Connectors – real people who know how to signpost.
- Health Connections Mendip directory of services – website for those who want to access information via the internet.
- Talking Cafés – a regular place where people can go to speak to someone to find out information about what support is out there.
- Community Connections area at Frome Medical Practice – another regular place where people can speak to someone about support.
- Telephone – good for those who want to find out about support on the phone.
- Social media
- Let's Connect newsletter and mailchimp (sent to 100s of people every month).

Stats: Health Connections Mendip website directory had 73,736 website hits over 18-19. 49% on the previous year.

Simple signposting/social prescribing in GP practices:

- General Practice staff have access to the Health Connections Mendip website directory. This is embedded in EMIS the patient record so members of staff have social prescribing/simple signposting at their fingertips. GPs and practice staff are able to use the website directory as a resource during conversations, enabling staff to open up conversations that they might not previously had due to lack of knowledge of support in these non-medical areas. This signposting is then coded automatically on EMIS.

Stats: In 2018-19 Mendip medical practices (excluding HCM staff) signposted via website 7,660 times.

2) How it works - Health Connector One to One Support

Some people require/want more intensive 1:1 support and assistance in navigating the services on offer, or they may need longer term assistance from the Health Connector who can support by starting with 'What's Matters to You?' This may be network mapping and network enhancement, goal setting, advance care planning and/or exploring self-management techniques. HCM sees people one to one in GP practices, in a patient's home, in hospital or in a care home. All information is imputed on an umbrella EMIS patient record which links in with all the Mendip practices. This means that the rest of the general practice team can see the notes that the Health Connections Mendip input alongside their own EMIS notes. The HCM team work closely with the Care Coordination Teams across Mendip who are also employed by the Mendip practices. This close relationship between the two teams is facilitated by them working in shared offices, attending MDT meetings and working on the same EMIS care plan which is called My Life Plan.

Stats: Between 18-19 HCM had just over 5.5 FTE Health Connectors. **They saw 1,469 patients over the year with 3,243 appointments.** NHS England recommends seeing 200-250 one to one patients a year per 1 FTE. This does not take into account the groups that we run for those for whom a one to one appointment is not what they want/suitable.

3) How it works - Health Connections Mendip group support

HCM recognises that not everyone will want one to one support. Also some people would like to move on from one to one support but need a stepping stone group. Or they may just want to go straight to a group. We try to offer groups which will suit different people with different wants and needs.

- Talking Cafes – community based drop ins where people can make friends or be signposted to support in the community.
- On Track Goal Setting Groups – based in GP practices, these are for people who want to stay on track with the support of others who know what they are going through.
- Self-Management Programme (not funded)
- ESCAPE Pain – for people with osteo-arthritis. Group education and exercise. Piloted in Frome by Frome PCN Link Worker.
- Healthy Lifestyles – Piloted in Frome. Suitable for roll out. Information sessions and peer support. Rolling programme of monthly sessions.
- Couch to 5K and Walk and Talk – Piloted in Frome. PCN Link Worker works alongside the GP Mental Health Nurses.
- Group Consultations – Frome PCN Link Workers facilitate some of these groups while the clinician does the clinical side of the consultation.
- Ideas Cafes – Piloted in Frome. Suitable for roll out. HCM runs Ideas Cafes in the community where people can share ideas and plan to make things happen in their community.

Stats: HCM runs over 250 groups a year.

4) How it works - Health Connections Mendip Community Development

Some people may not want one to one support or group support, they may want to set up a group. Where the community note a gap in service provision HCM will help set up groups. We support people to set up these groups with the intention that they become self-sustaining.

Groups set up to date:

- Café Connect for people with dementia and their carers.
- Stroke Support Group
- 2 x Hearing Support Café
- Diabetes Peer Support
- Youth Patient Participation Group
- Amyloidosis Peer Support
- Meniere's Support Group
- Macular Degeneration group,
- CHILL – support group for people with long term conditions.
- Stroke Support group
- Bereavement Support Groups x 2 (partnership working to help set up)
- Stoma Support Group (partnership working to help set up)

Stats: HCM has helped set up scores of peer support groups with 100s of people attending every month.

5) How it works - Community Connectors

We recognise that many people want to get involved in their community or in HCM but don't want to be formal volunteers so we developed the Community Connector training. Community Connectors are people who are trained to signpost people within the community during their daily encounters with members of the public. Anyone can train to be a Community Connector, the idea being that if an individual finds themselves in a conversation that produces an opportunity to signpost someone then the Community Connectors are able to do so. We don't want people to say "If only I had know that" we want people to say "I know that there is something out there for you". Community Connectors come from all walks of life, from hairdressers to taxi drivers, supermarket staff and sixth form students to peer support group members and people who have been involved in one to one or group HCM support. In this sense these are a network of people – an outreach team who may be able to support members of the community without there being the need to professionalise signposting. Many people who have been through other HCM support go on to become Community Connectors. This work has been funded by Frome Town Council and funding is now finishing.

Stats: We have 1,471 Community Connectors which means if they do on average 20 signposting's a year that would be 29,420 signposting conversations in a year.

6) How it works – MDTs

HCM are employed by Frome Medical Practice and we are now an established part of the primary care offer. The HCM team attend MDT meetings across Mendip and bring expertise about non-medical psycho-social support to the wider team. Helping to bring community based support/initiatives into primary care and visa versa. The team also attend other MDT meetings such as the One Team meeting. We lead on the three monthly Mendip 1:1 Workers meetings which is where people from different organisations come together to promote joint working . We have created a networking and sharing space on the SWAHSN Models of Care site. We have invited all the Mendip one to one workers to join this space so we can together and collaborate.

Stats:

- Using the Patient Activation Measure (PAM) as an outcome tool 83% increased their PAM score,
- WEMWEBS 81% of HCM patients saw an improvement in their wellbeing.
- 93% of patients said they felt more able to access support in the community;
- 94% of patients said they felt more able to manage their health and wellbeing,
- 92% of GP practice staff report that they now feel confident that their patients benefit from being signposted to HCM.
- A further 91.4% of GP practice staff feels that HCM adds value to the service they provide to patients.
- 56% of patients said they felt they saw the GP less often. *Those who used an HCM service asked over a 2 week period.

Lessons learnt:

It is important to understand that the success of Health Connections Mendip lies in a systems change approach, and that none of the initiatives described here would enjoy such success if they operated in isolation. Services need to be built in partnership with existing organisations and everyone in the system needs to be as open as possible to new ideas - services that are run in partnership with other existing organisations are more successful, for example. Furthermore, this approach to healthcare straddles both primary care and the local community, and the two are no longer seen as distinct entities in treating the health and wellbeing of the local population. There are lots of opportunities to add to the work that HCM does however the team need to be protected and work within the current funding in order to avoid overload and taking on too much.

Conclusions:

This system is successful because the whole is greater than the sum of its parts. It acknowledges that within the community there are numerous levels of need and there is no ‘one size fits all’ approach to primary healthcare. Services provided are driven by local need and are built to be sustainable. HCM works with and provides services for everyone, making it truly accessible to all members of the community and centred around what is right for the individual. This person-centred approach potentially reduces the need for unnecessary medical intervention and indicates that services in the community can produce even greater and potentially long-term results for the individual.

With a successful, innovative model has come a great deal of interest. This interest has created a big demand on our time.

The way we work is not static. We continue to have innovative ideas and we are currently looking for funding to support these new innovations.

For further information please contact Jenny Hartnoll on j.hartnoll@nhs.net or call on 01373-468366