

Health Literacy: A Whole of Society Approach

Developing health literate 'hearts and minds' in communities'



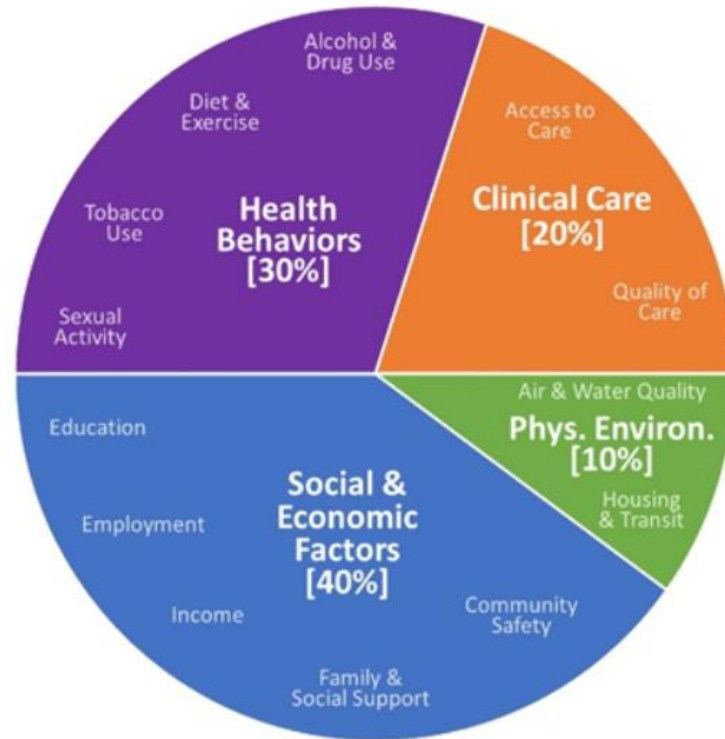
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Why do we need to change?

50% increased likelihood of survival for participants with stronger social relationships. This finding remained consistent across age, sex, initial health status, cause of death, and follow-up period.



Source: Adapted from the University of Wisconsin's *County Health Rankings* model (2014)

Citation: Holt-Lunstad J, Smith TB, Layton JB (2010) Social Relationships and Mortality Risk: A Meta-analytic Review. *PLoS Med* 7(7): e1000316. <https://doi.org/10.1371/journal.pmed.1000316>



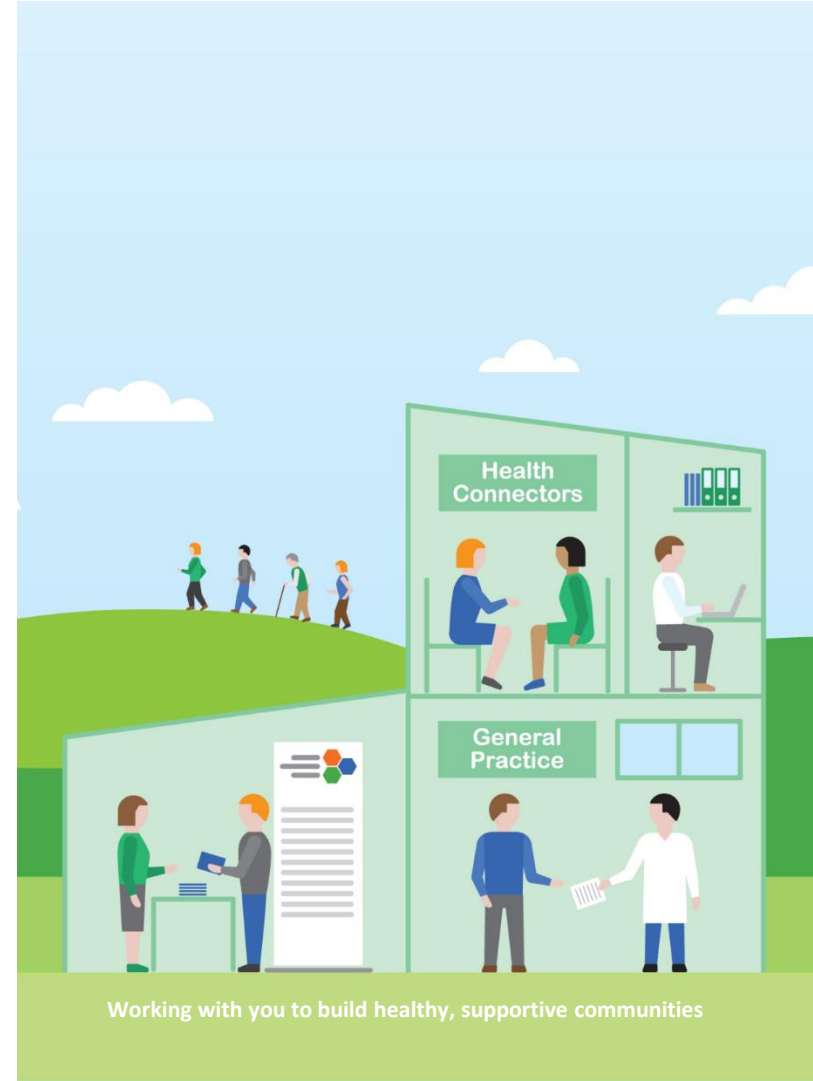
Primary common experience of ill health

- Increasing fatigue leading to decreasing mobility
- Decreased social contact-loss of work and role
- Loss of sense of purpose – meaning and value in life
- Loss of well being.

Frome Model of Enhanced Primary Care



- Practice population of 115,000
- 11 GP practices
- Whole team employed by Frome Medical Practice on behalf of the 11 Mendip GP practices.
- 2.5 FTE Area Leads (Com Dev and line manage HCs)
- 7.5 FTE Health Connectors
- 1 Service Lead
- 912 Community Connectors



- Shared decision making
- Self management education
- Peer support
- Health coaching
- Social prescribing
- Community development
- Hospital Discharge review
- Shared care record
- Quality Improvement
- Multi Team working

All underpinned by “better conversations”

“what matters to me”

Brings together town council, community, social care
and health



There is so much support out there – website not enough

- ◊ Phone line manned 5 days a week
- ◊ Newspaper articles
- ◊ Social media
- ◊ Monthly radio slot
- ◊ Awareness raising stalls
- ◊ Community Connectors
- ◊ Talking Cafes

CONNECT



Community Connectors

Community Connectors are members of the community who know what's out there and signpost friends, family, colleagues and neighbours to support in their own community.



CONNECT Anyone can be a Community Connector



- ⬢ Church congregations
- ⬢ Supermarket staff
- ⬢ Hairdressers
- ⬢ Sixth form students
- ⬢ Support group members eg Stroke Support group
- ⬢ Drug and alcohol peer support workers
- ⬢ Café staff
- ⬢ Residents in sheltered
- ⬢ Volunteer drivers
- ⬢ Police Community Support Officers.
- ⬢ Care home staff/care workers
- ⬢ Taxi drivers
- ⬢ Park Rangers
- ⬢ Town Councillors
- ⬢ Social Workers
- ⬢ Job Centre Staff
- ⬢ Young mums' group
- ⬢ Youth workers



CONNECT 912 Community Connectors



The number of Community Connectors is ever increasing.

- 🟡 Average of 20 signposts a year per Connector
- 🟡 18,240 signposting conversations a year
- 🟡 Number of Community Connectors is increasing weekly
- 🟡 Frome Town Council contributes to the post
- 🟡 District council has now given one day a week of their staff time to support the work
- 🟡 Public Health are coming on board – we are training their staff to cascade the training.



Working with you to build healthy, supportive communities

Talking Cafes



5 weekly Talking Cafes
224 a year
and.....



Young People's Talking Cafe



GROUPS



- ◊ 6 week Self Management Programme. 4 programmes a year.
- ◊ 'On Track' goal setting groups. 3 groups every other week. 78 groups a year
- ◊ Exercise groups for people who would not otherwise exercise. 96 a year.

Minimum of 440 groups run by Health Connections Mendip (excluding the self sustaining groups)



BUILD Self Sustaining Groups – working with community members to set up



- 🟡 Leg Ulcer Club
- 🟡 COPD Support Group
- 🟡 Macular Degeneration Support Group
- 🟡 Diabetes Support Group
- 🟡 Fibro, ME/CFS Support group
- 🟡 Stroke Support group
- 🟡 Café Connect for people with dementia and their carers

100s of people attend every month.





BUILD



Just those things that bubble up!
Working together with.....

Community Fridge
Library of things
Sheds



Working with you to build healthy, supportive communities

CONNECT Health Connectors



Health Connectors offer one-to-one appointments and do care planning

- ◊ Listen to patients and their carers to find out what is important to them
- ◊ Connect people into support in their community
- ◊ Support patients in managing a long-term conditions
- ◊ Assist them in setting goals and making changes that are meaningful to them
- ◊ Network creation, network mapping and network enhancement
- ◊ Being the glue but not necessarily the experts.

WHY IT WORKS



- ◊ Different ways to get involved
- ◊ Different places we support people 1:1
- ◊ Different ways into the service
- ◊ Different tools used
- ◊ One foot in primary care, one foot in the community.
- ◊ Shared EMIS services across the 11 practices where Complex Care GPs, Nurse Practitioners, HCAs and Health Connectors can all input on to the shared care plan.

WHY IT WORKS

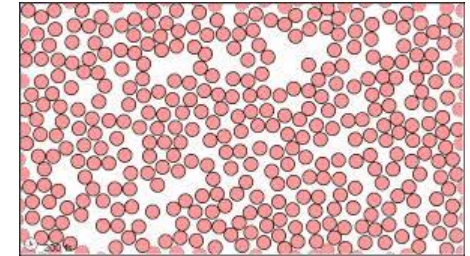
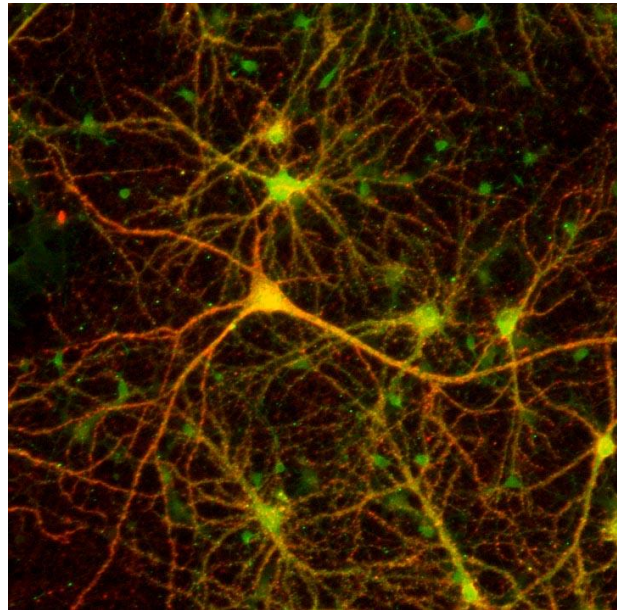


- ◊ We are trusted
- ◊ We do what is best for the person
- ◊ We look for opportunities
- ◊ We are allowed to be creative
- ◊ We do things differently
- ◊ We make mistakes and learn

from them

- ◊ Patients feel it belongs to them
- ◊ Staff enjoy their work

Organic Ecosystem



So what?

- Reduced costs
- Improved health and well being and Health Literacy
- Improved job satisfaction
- Sense of community and belonging