

# Hills, Brook & Dale PCN

# Women's Health Network – October 2023

'Addressing health inequalities by proactively engaging patients; to encourage supportive community connections & raise awareness of how to better manage their health'

Supported by:









## **Social Prescribing Innovators Programme**

HBD Women's Health Network was initially developed as a six month quality improvement pilot project and funded by Transformation Partners in Health and Care as part of their Social Prescribers Innovators Programme.

#### The SPIP programme offered us;

- Seed funding, project management support, QI training, community of practice sessions, access to QI coaching
- The opportunity to use our experience and learning
- Encouragement to be creative and test new ways of working

#### By participating in the programme we have;

- Increased our knowledge of approaches to QI (PDSA cycles, theory of change, evaluation methods)
- Made better use of the wider experience, skills and interests Link Workers bring to primary care
- Been able to work more closely as a social prescribing team and identify additional training needs
- Explored how we can further draw on the relationships we have with local community partner orgs/services
- Encouraged greater collaboration between clinical colleagues and the social prescribing team in our PCN
- Secured additional funding to continue and scale the WHN via a local health partnership and a financial commitment from our PCN





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What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?





### **Project Development**

We wanted to use our knowledge and trusted relationships with patients to test a holistic approach to 'bridge the gap' between Link Worker support and community based support options.

- We understand that meaningful patient activation and behaviour change through personalised support and health education, takes time.
- We asked ourselves some questions.

#### Looking at the our referral data;

- Which cohorts of patients are mostly being referred to us?
- What trends can we see in the referrals/repeat referrals?

#### Listening to patients & colleagues;

- Why aren't patients accessing the community support available to them? What other support would be helpful?

#### **Exploring the challenges;**

- What are the health inequalities faced by patients in our area?
- What is the impact on patients?
- Does a 'reactive' Link Worker support service nurture patient insight, confidence and resilience?
- What impact does the wholly 'reactive' approach have on Link Worker capacity, job satisfaction and wellbeing?











## **Project Delivery & Achievements**

The WHN offers patients diversified access to both health and social prescribing support in a local, community venue.

- Our bi-monthly sessions offer health checks and conversations, accessible health education workshops, exercise taster sessions, opportunities to engage and sign up with community organisations/services, access to Link Workers and social interaction.
- Our educational workshops have covered a range of subjects including: healthy eating & nutrition, cost of living support, mental health & wellbeing, managing persistent pain, managing diabetes, support for carers and community involvement opportunities.
- 20, well attended sessions have been delivered since October 2022, with 424 patient attendances over this period.
- We've partnered with 17 community projects & services from our local network so far, some of which have been keen to come back to run additional sessions.
- We've been supported by primary and secondary care clinical colleagues (offering health checks, general health conversations and facilitating workshops around particular health conditions).
- Our session invites are currently sent to approximately 750 patients each time, which has extended our reach.









- We've listened to attendees and now also facilitate smaller Peer Support Groups around specific health issues outside of the larger group sessions.
- We've secured additional funding via a local health partnership and our PCN to continue the project throughout 2024.

### **Development, Evaluation & Next Steps**

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- We've gathered continuous feedback from attendees and colleagues who support the sessions to make improvements where possible.
- We've worked with *Kings Health Partners, Women's & Children's Health Institute* to complete a Process Evaluation of the initial six month pilot period.
- We are currently undertaking a Qualitative Evaluation, which will provide:
  - further insight into the benefits to patients who attend via detailed case studies
  - other examples of the impact of engaging with patients in a different way on both patients and staff
  - additional feedback from our clinical colleagues and community partners
  - a summary of what the potential cost savings are through engaging cohorts of patients in this way
- The project is being rolled to another area within our PCN so that we can engage patients from other practices in November 2023.
- We are committed to sharing our learning and development more widely and welcome contact from colleagues across the system who would like to develop similar models of engagement.



What do patients like about this approach?

Taking time out from home for myself Finding out about the variety of services offered

Having people to talk to face to face

The sessions are thrilling, everyone is enthusiastic & it's always very practical







### **Questions & Reflections**



#### **Contact:**

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Really valuable thing you guys have put together here, each woman mentions it in each discussion

PCN Pharmacist who has supported 2 sessions

A patient commented that attending the WHN sessions is the best thing she'd done since Covid & that she no longer needed her anti-depressants

GP from a participating practice