Community Health Connections, Fife

What is it?

Funded by the Community Planning Partnership (CPP) since May 2014, the Community Health Connections two year pilot programme helps individuals identify important influences on their mental health and wellbeing and to take action to improve the quality of their lives. General practitioners can refer patients to a Health Coach, who supports three GP practices based at Lochgelly Medical Centre, Fife. The Health Coach supports access to information as well as referral to appropriate interventions, depending on the individual's needs. . The CPP wants to promote positive mental health and community resilience by supporting innovative new local partnerships that will improve the quality of people's lives. They are keen to roll out this programme in other areas of Fife.

How does it operate?

The Health Coach enables improved access to other services by co-ordinating a referral process that leads to non-clinical community based sources of support. They also liaise with a range of organisations that provide social, recreational or therapeutic support. Key aspects include referral pathways to Urban Therapy Counselling Service, Link Living (CBT) and Community Connection Active pilot (supported by a Health and Physical Health Activity Co-ordinator from Fife Sports and Leisure Trust), with appropriate guidelines for GPs. Referrals lead to opportunities for learning, volunteering, employment and physical activity, as well as support for those overcoming bereavement or those with stress, benefit and debt issues.

Community Health Connections seeks to be inclusive whilst taking care not to act as a substitute for other forms of healthcare provision. The Health Coach will meet with patients for up to four sessions, plus one follow up session, and will accept patients 16 years old or over who meet the following criteria:

- Poor mental wellbeing affected by their social circumstances
- Mild to moderate depression and anxiety
- Long term physical conditions (when poor mental wellbeing persists)
- Mental health problems

The following patients are excluded from the scheme:

- People experiencing acute episodes of psychosis
- People with ***primary*** issues of drug or alcohol misuse

If patients are receiving medication on repeat prescription, they are offered a medication review appointment with a Pharmacist prior to their last Community Health Connections appointment. This is to check that all medications are appropriate, relevant and that the patient understands why they are taking them. Patients are reassured that they are not going to have medication taken away from them if they are still needed.

A review meeting will be held with clients six months following their final appointment to see if involvement with Community Health Connections has improved their situation or if the patient has returned to the GP for a pharmaceutical intervention.

What outcomes does it seek to achieve?

By working with individuals, the programme aims to reduce levels of frequent GP attendance (defined as more than 12 visits per year) and reduce prescribing levels for antidepressants. It is the improved personal outcomes for patients which makes this programme so worthwhile, and this has a 'ripple effect' out into the wider community.

Key Learning Points:

- A Health Summit involving Primary Care staff in February 2014 was vital in developing the Community Health Connections pilot programme.
- GPs and local councillors in Lochgelly were highly supportive of this pilot programme. They recognised that a high proportion of GP appointments were attended for social issues or mild to moderate mental health issues, e.g. stress, anxiety, emotional, bereavement and debt issues, etc. Many GPs felt they didn't have either the time or sufficient knowledge to refer patients to non-medical sources of support.
- Building relationships and developing referral systems jointly with GPs is vital to the roll out of this programme. The Health Coach has access to the GP electronic patient records in order to provide immediate feedback to GPs on the outcome of sessions.
- It's important to invest time in building confidentiality and trust between Health Coaches and individuals referred. Everyone receives a pre-appointment introduction phone call, confirming the reason for referral and appointment details. Keep Well administrators send appointment reminder texts to patients 24 hours prior to appointments.
- The Health Coach ensures people understand the referral process and what it will involve, using accessible, appropriate language. The Health Coach makes consultations as supportive and friendly as possible, sitting alongside individuals rather than across desks.
- The Health Coach uses a very person-centred approach. At the first consultation appointment, the patient is asked what issues they would like to focus on. Depending on patient needs, there is flexibility around frequency and number of follow-up appointments with the Health Coach.
- The Health Coach is able to refer patients via the Fort online referral system (Fife wide information sharing system), which is an efficient and successful way of referring clients quickly to other support organisations.
- Health Coach appointments are held within the GP practice. This is important as patients perceive this as a safe and comfortable place to come.

Contact:

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