



REALISTIC MEDICINE

Doing the Right Thing

Chief Medical Officer for Scotland
Annual Report 2022-2023

Event Supporter



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Realistic Medicine: Doing the Right Thing

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Being Human



Six Principles of Action

1. We must hear and seek to understand the voice of those we serve in order to deliver the outcomes that matter to people we care for. Shared decision making sits at the heart of doing the right thing.
2. We must ensure the right balance between the science and the art of care.
3. We should give way on professional and personal prerogatives in order to be part of something greater.
4. Using a value based approach allows us to balance personal and population-based care better so maintaining, and making best use of, all our resources.
5. Measurement should be meaningful, proportionate, transparent and used for the purpose of improving quality; measurement should not drive transactional care and risks moral injury and harm to staff and patients.
6. We should reasonably expect the people and system in which we work to acknowledge and respect that we all have physical and emotional limits, ensuring that we are supported to practice compassionately and manage clinical risk appropriately.

Delivering Value Based Health & Care

A Vision For Scotland

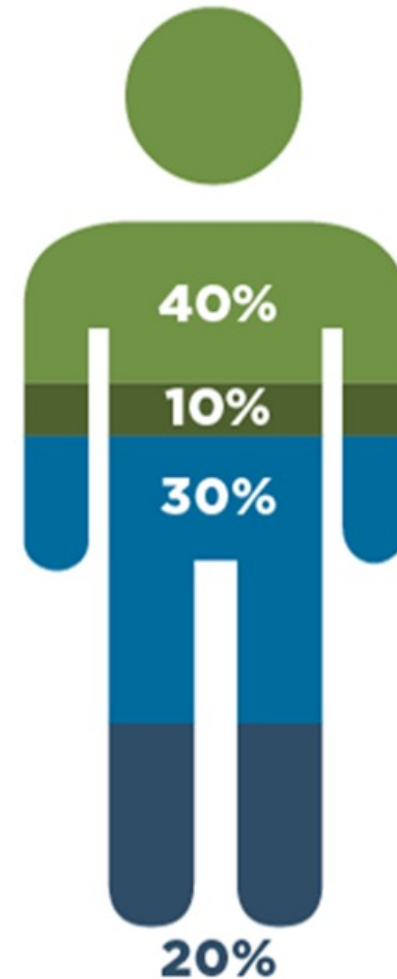


Value Based Health & Care: Sustainable Care that Matters



Health Inequalities: Turning the Tide

- Advocate
- Convener
- Anchor institution applying Community Wealth Building
- Contributor to maximizing wellbeing



Social & Economic Factors

- Education
- Employment
- Income
- Family & Social Support
- Community Safety



Environment

- Air & Water Quality
- Housing
- Transportation



Health Behaviours

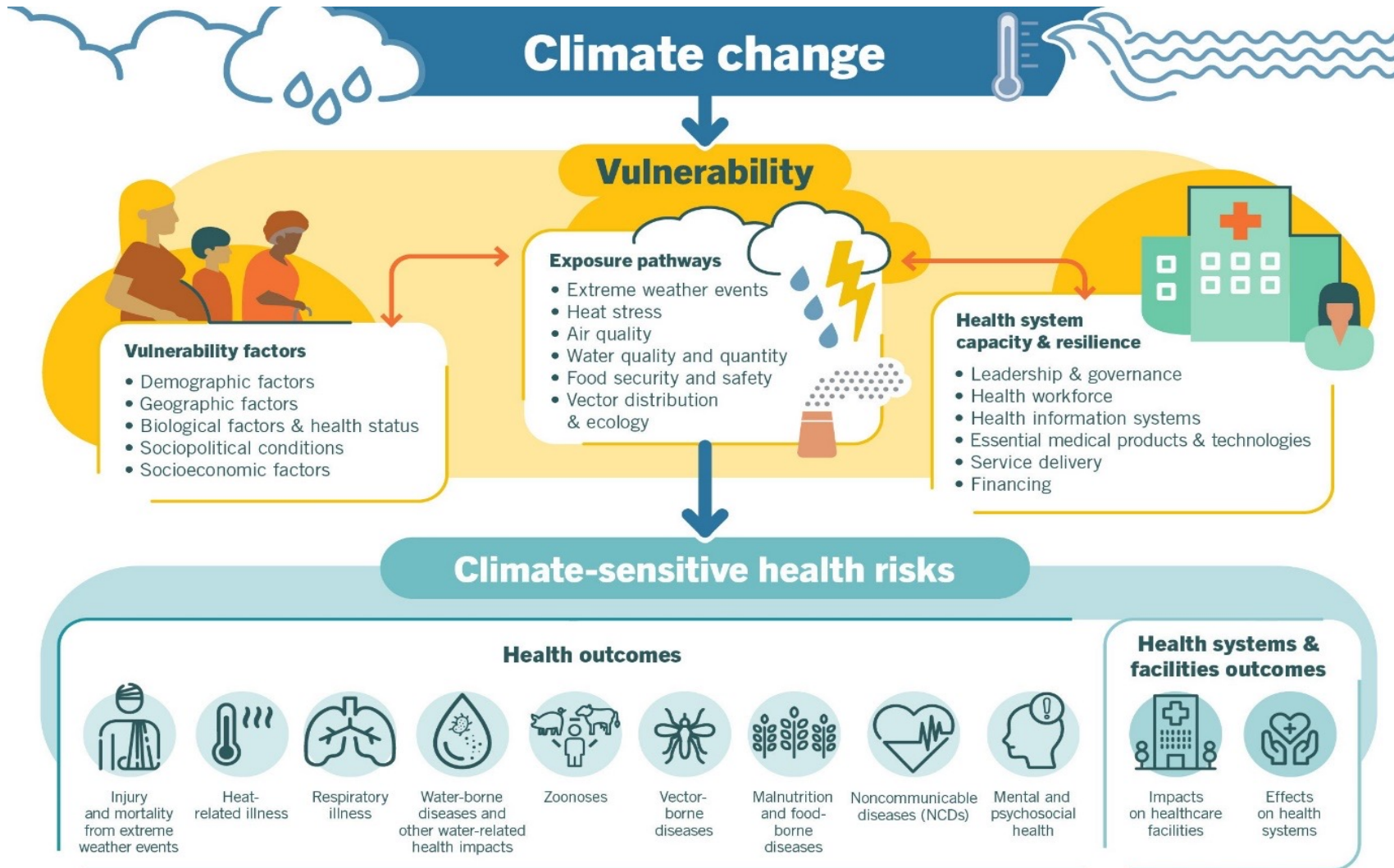
- Alcohol, Tobacco & Drug Use
- Diet & Physical Activity
- Sexual Activity



Health & Social Care

- Access to Care
- Quality of Care

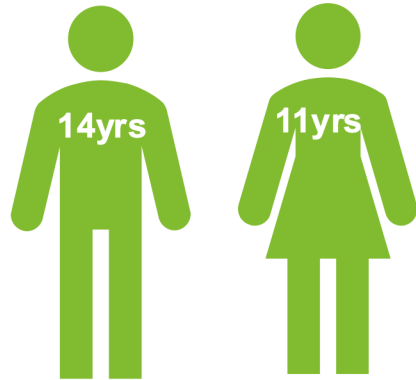
Climate & Health: Planet and People in Partnership



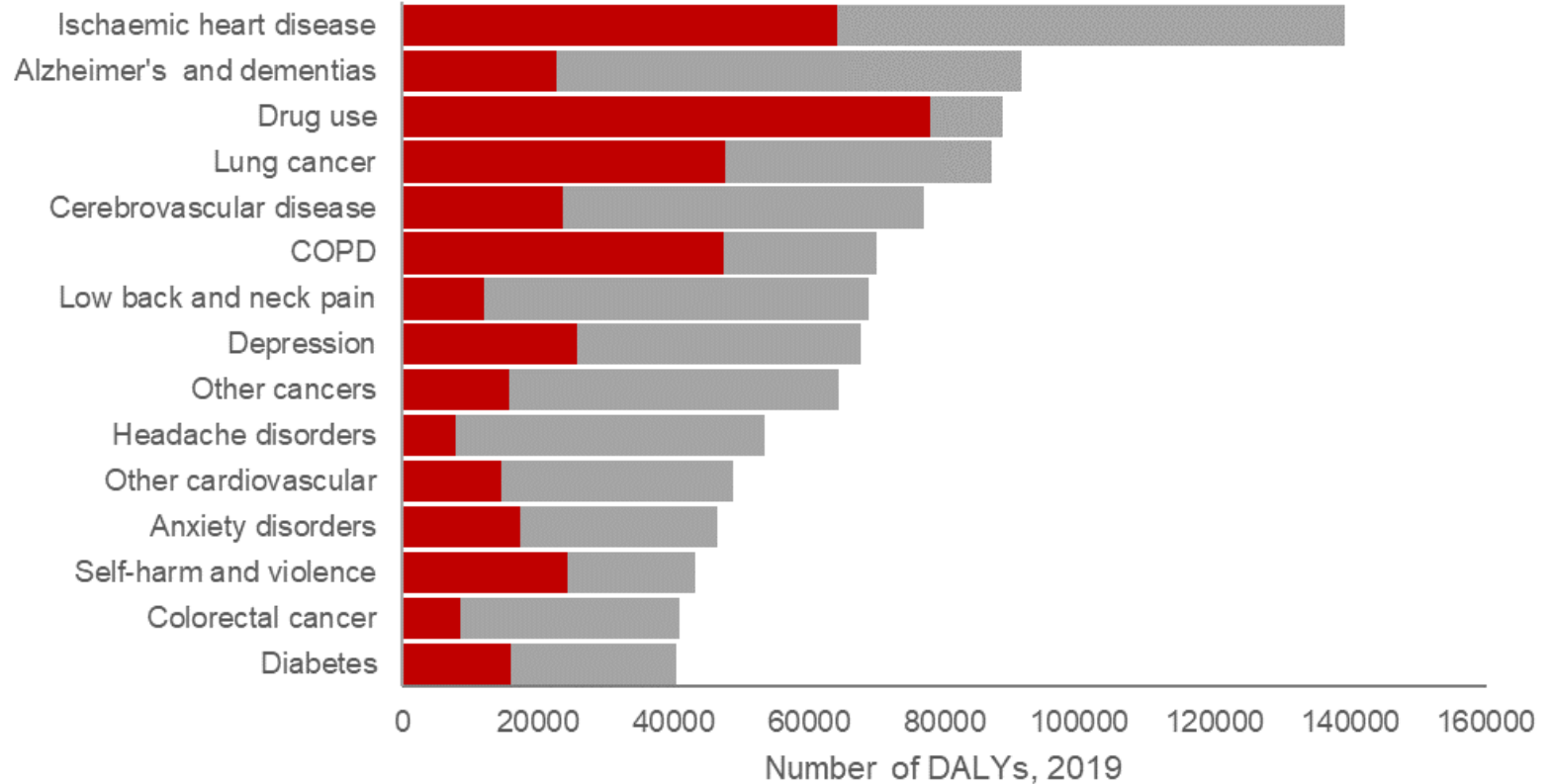
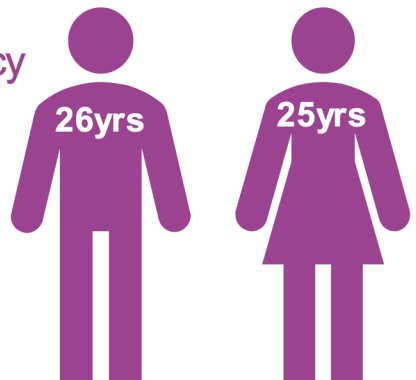
- Health Emergency
- Socioeconomic Emergency
- NHS Scotland approach
- Co-benefits and triple wins
- Action areas

The Health of Our Nation

Inequality gap:
 Life expectancy



Inequality gap:
 Healthy life expectancy



“By nurturing trust and belonging within our health and social care services we can re-connect to our purpose and deliver the careful and kind care that will create the fairer more sustainable system that we all wish to see.”

Social Prescribing in Scotland

Alison Leitch

Assistant Service Manager, Edinburgh Community Link Worker Network

Lead for Scottish Social Prescribing Network



What is social prescribing

- *Social prescribing is “a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription – a non-medical prescription, to improve health and wellbeing and to strengthen community connections.”* Establishing Internationally Accepted Conceptual and Operational Definitions of Social Prescribing Through Expert Consensus: A Delphi Study by Caitlin Mulhl, University of Toronto.



What does Social Prescribing look like in Scotland?

- Scottish Government funded GP based Community Link Worker (CLW) programme was established following the 2016 manifesto pledge for 250 CLWs
- SPRING Social Prescribing – National Lottery-funded programme across Scotland and Northern Ireland – due to end next month
- mPower – ended last year. An EU-funded project that covered Scotland, Northern Ireland and the Republic of Ireland – funding has continued for Ireland, north and south and discussions are taking place to see if this can be resurrected in Scotland.
- Many other programmes exist under various guises such as community navigators/connectors, local area coordinators or social prescribing.



Edinburgh CLW Service

- Established in 2017 as an early adopter site of the SG funded programme
- Joint partnership with HSCP and third sector
- 24 CLWs, covering 45 practices, employed by 10 different third sector organisations. 21 of the practices are in areas of high deprivation with the aim of tackling health inequalities, the remaining practices choose to use PCIP funding for a link worker.
- CLWs work in a maximum of 3 practices
- Work with patients 3-4 sessions, the average appointment time is an hour
- GP lead in each practice, two GPs act as advisors to the service, and an external psychologist is employed to provide clinical support to CLWs.
- Monthly statistics produced and annual report published each year



Edinburgh CLW Service

- Commissioned training from Bromley By Bow for new CLWs – shared nationally
- Work with the University of Edinburgh Medical School for the last 3 years introducing link working to 1st-year medical students
- Selected to take part in a University of Manchester UK-wide research project into CLW alongside 7 other sites. Over 100 sites were originally considered.
- Successful funding applications with primary care and third sector via NHS Lothian Charity to run courses for CLW patients.
- Took part in training with RSPB to promote green prescribing – looking to replicate this around the country.
- Taken part in research looking at blue and green prescribing.
- Worked with NES to create a social prescribing space on Turas.



5 years of link working in Edinburgh

- Between 2018 – 2022
 - 15,071 referrals
 - Mental health 6,512
 - Social isolation & loneliness 4,032
 - Housing 1,409
 - 34,527 engagements
 - 23,163 links made
 - 2,385 activity based
 - 2,249 mental health support
- 2022 – just under £100,000 was applied for in small grants, up from £28,482 in 2021.
- Well established as part of the MDT with practices
- Change in role reflecting the challenges of the last 3 years



GP thoughts

- *“The GP’s feel the service is really valuable to the practice and there has been a lot of positive feedback from patients – one of the docs mentioned a particular patient feeling positive for the first time in a long time after meeting our CLW”*
- *“Our experience has been very positive. Our CLW has settled in very well to the team and has quickly adapted to our way of working. CLW is professional and proactive and has very much been a great addition”*
- *“It’s refreshing to have our CLW based at the practice too, our CLW is a good communicator and has integrated well with our team. We are pleased to be able to offer a Link Worker service to our patients.”*



Practice manager thoughts

What our Link worker means to us

- *Someone to help us understand the rich resources in our local community that can bring a wealth of benefit to our patients*
- *Someone to remind us that a prescription for medicine isn't the only answer*
- *Someone to help us REALLY bring to life our commitment to ask patients 'what matters to them' without the fear of not being able to respond with something helpful*



Patient thoughts

- *"I really appreciate your help and support. I feel so much calmer now and have regained some confidence that things will be ok soon!"*
- *"Getting along to the lunch club each week has been great, I am enjoying the company"*
- *"I had no idea that there was support out there, no one tells you. Things are better now so I don't have to go to my GP as often."*
- *"My link worker didn't try to do things for me, she asked what was important to me and what she could do to help me make changes"*
- *"I liked that the link worker was able to come along to the group with me for the first time, I would never have made it on my own."*
- *"The worker gave me help with not just my benefits but with housing, the council, schools for my kids, and information about what was going on in the community and how to make new circles of friends. I cannot thank her enough"*



Annie

Female in her 70's



Referral from her GP:

- Housing
- Mental health – anxiety/stress from living arrangements
- Finances

What did support entail?

- 7 x 1-hour appointments – both in the practice and in community settings
- Registered with housing associations that were not part of Edindex (Edinburgh Council housing system)
- Contacted council housing departments (the patient was moving to a different local authority).
- Introduced patient to local community groups to reduce isolation and help with mental health whilst waiting on house move.

What services, groups, and activities was Annie supported to access?

- Housing associations
- Trust fund application for a grant towards moving costs and white goods.
- Welfare rights advisor to ensure the patient was receiving everything she was entitled to
- Community groups



Panel Discussion

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Consultant
Cardiologist
and Realistic
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National
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Adviser



Alison Leitch
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Project







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