

Compassionate Communities in Shropshire: No man is an island

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Background

- Older people are at an increased risk of social isolation for many reasons¹
- An aging population is leading to increased demand on the UK's social and health services²
- It has been well documented that social isolation can cause significant health problems^{3,4}, but the solution to this is less clear

Aim

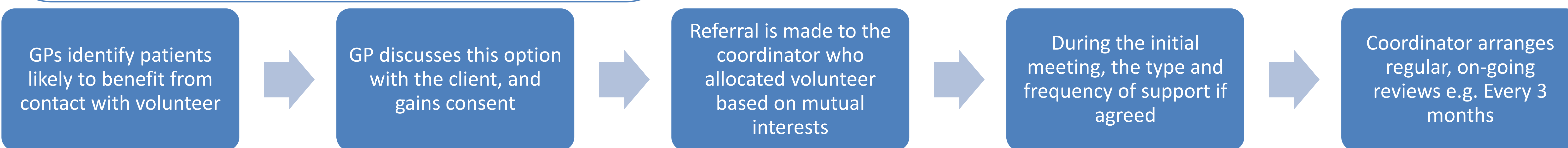
To help people get more connected to their community with a view to reducing subjective feelings of loneliness and reduce the incidence of a health 'crisis'.

The Compassionate Communities [Co-Co] Network

- Started in Church Stretton, Shropshire in 2010
- A partnership between GPs, the local community centre and the Severn Hospice, each with a specific role
 - GP practice: *identified patients*
 - Community centre: *coordinated allocation of volunteers*
 - Severn Hospice: *training and on-going support for volunteers*

The role of the volunteer

- Visit once weekly
- Help the client feel more connected with their community e.g. taking them to the shops, rather than doing their shopping for them
- Keep in contact via the telephone during the week
- DO NOT provide personal care



Data collection & Results

To examine the impact on local health care services, we reviewed the number of contacts each client had in the 6 months before and the 6 months after being allocated a volunteer. We reviewed the data of 24 clients following their involvement in the Co-Co scheme in Church Stretton.

Table: The number of times the clients accessed local healthcare services during the 6 months before and 6 months after commencement of the volunteer service.

Service accessed	Before Co-Co	After Co-Co	Difference
Practice Visits	133	117	-16
Home Visits	59	41	-18
Calls made to patient/family	143	109	-34
Referrals made	27	22	-5
Planned hospital admissions	43	48	+5
A+E attendances	8	4	-4
Emergency admissions	17	11	-6
Follow up calls/letters/internal communications	144	149	+5
Calls to/visits from OOH service	25	16	-9

Practice and home visits

- 4 clients made the same number of visits to their practice before and after being involved in the co-co project
- 13 clients made fewer visits to their practice
- 7 clients made more visits to their practice, although one of these clients had been referred because it was felt the was not accessing the practice adequately to address his health issues
- 5 clients had more home visits in the 6 months after commencement in the project, 8 had the same number of visits and 11 had fewer visits.
- When looking at the number of practice visits and home visits combined, 10 had more total visits and 14 had fewer total visits in the 6months after starting in the project. 2 clients saw an increase in both practice visits and home visits.

Access to emergency/OOH services

- 1 client made more visits to A+E after starting in the volunteer project
- The number of clients who didn't visit A+E at all increased from 17 to 21
- 2 clients saw an increase in emergency hospital admissions after involvement in the project
- 4 clients made more calls to the GP OOH service after becoming involved

Conclusion, Limitations and Recommendations

Introduction of the Co-Co Network has led to a demonstrable reduction in the total number of contacts with local health services, particularly unplanned care

This confirms previous suggestions that social connectedness leads to an improvement in health

This data only represents 24 of the clients involved in this project, more data needs to be collected and evaluated

Further qualitative research is also indicated to determine if Co-Co does make them feel more connected to their community

In order to continue the role out of this project, we need to consider the difficulties in recruiting and retaining volunteers

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3. House JS, Landis KR, Umberson D (1988) Social relationships and health. *Science* 241(4865):540-545

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2. Jacobzone S, Cambois E, Chaplain E, Robine JM. The health of older persons in OECD countries: is it improving fast enough to compensate for population ageing? Paris, 1999.