

# Whole-Person Health

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Whole person means to us that all health issues are connected, that you can't separate one issue in isolation from the rest. It is why one patient with a 12-year history of anxiety and four months of severe low back pain wasn't improving, despite physio, psychology and medication. Then she was asked how she was doing spiritually and it all came out. Without being able to adopt the proscribed Islamic prayer positions, she had stopped praying. She knew it was permissible to pray in any position if she had a medical reason to do so, but she just couldn't connect with God properly that way, and so she had drifted away and felt unable to express her spiritual self. What she needed was support to find non-physical ways of spiritual expression until she felt more mobile; indeed she might not become more mobile until she did so. We couldn't provide that for her, but there was someone outside the surgery who could, if we could find them...

We have come to believe that there is more to our vocation and purpose as community generalists than just fixing the problems people present to us. We also need to consider the context of the person who brings them, the family and social circumstances they live in, the community around them, their society and culture, and their beliefs to name just a few. In fact, we have concluded that we cannot fix these problems, nor is it our business even to pretend to try. What we want to achieve this afternoon is an injection of hope in a complex and potentially frightening political climate in healthcare. We would like to encourage everyone to lift our eyes from the conveyor belt of work that is put in front of us, not because there are easy answers, but because we should be asking more questions and making fewer assumptions

The Mission Practice is 115 years old, initially set up by Annie McPherson as a medical mission for the residents of Bethnal Green, whose health was determined by the material poverty in which they lived. We hold many values which determine the ways in which we work, but they could all be condensed down to a desire to facilitate wholeness and well-being in our patients; that being health not just physical, but emotional, social and spiritual. This can be seen in our Mission statement, written a few years ago:

*At the Mission Practice, we are committed to providing an excellent medical service for all our patients; walking alongside our community, patients, staff and colleagues in Bethnal Green.*

*We recognise that we are all on a journey in life growing and developing all the time, and we understand that health is not just about lack of illness, but being well in body, mind and spirit.*

*We seek to empower people to live life in all its fullness and we are committed to caring for the whole person; encouraging faith instead of fear and working together instead of alone.*

*We believe that we are called by God to serve and care for our patients, and we recognise that this needs prayer and God's strength and guidance.*

Although our landscape and context has shifted enormously in the last century, we had come to realise that an intentional change in the model of care we offered was needed in order to provide this; but also that this had the potential to address some of the huge capacity issues which had started to swamp primary care. Therefore, we designed a piece of work that flowed out of the following three values:

1. Care that was 'whole person' in order to integrate physical, emotional/mental, social and spiritual health (spiritual being what gives meaning and purpose, and connects patients to the 'bigger' - or transcendent).
2. The relationship and the patient's story being paramount
3. Striving for community-based solutions to enable sustainable transformation.

It was important to remind ourselves what we meant by 'health', so we could articulate what changes we were wanting to facilitate within our patient population. We were all able to buy into this definition written by Dr Mike Sheldon.

*Health is a dynamic in which we grow and mature throughout our lives, and is the strength we have to enable us to live life to the full and complete the tasks which are important to us for our self-fulfilment. It involves creating an equilibrium between ourselves, the world around us and our lifestyles which is based on right relationships and values, such as respect and loving-kindness. Health is therefore a journey through life and into death where we always seek to adapt to disability and cope with pain and difficulties in a way which matures us as whole people.'*

At this point, it might be helpful to put this thinking into the context of the landscape and politics around us in 2013.

Firstly, we were aware of the mismatch between the vast provision of, often undersubscribed, voluntary sector services locally and the overwhelming demand of (often inappropriately medicalised) patients on GP services.

Secondly, that as Primary care staff, we could never keep up with the full extent and turnover of voluntary services and of how to access them, and that even a database could not keep pace. We realised that we actually needed a human being to network and build relationships with those services and to help people access them, since even signposting wouldn't be adequate.

Thirdly, that this was more than just a capacity issue. Our desire was to empower patients within the context of a sustainable and supportive community, from which they could draw support going forwards and hence reduce dependency on us as professionals, because this was ultimately of greater value.

What we had unwittingly stumbled upon was a concept called social prescribing, now gaining ground in the mainstream. We realised that we needed to address the wider determinants of health, and at a community level too. On the whole, disease was not an individual issue but a societal one. This meant that we needed to address those social issues, and to harness the power of community. This was also the way to facilitate good spiritual health. It was in the

community, not in the GP surgery, where people could discover that which gave their life purpose and meaning, to express it alongside others and thus connect to something bigger and more permanent than themselves.

A mechanistic approach to healthcare had probably worked reasonably in the early days of the NHS when the main reasons for admission were acute infections, accidents and the need for surgery. Now we see vast numbers of complex problems. For example, multi-morbidity, with chronic disease generated or exacerbated by underlying issues such as obesity, depression, anxiety, smoking, and alcohol and drug dependency amongst other things.

Complex problems need to be viewed in their entirety. They cannot be fixed or controlled but worked with. In her book, *Humanising Healthcare*, Public Health Consultant Dr Margaret Hannah says, '*Medical technology cannot provide an effective answer to what are existential problems, related to who we are and how we live our lives, rather than how our bodies work (2015)*'.

So what we did we do? We worked alongside the 'Shoreditch Group', a network of churches and voluntary sector organisations in Bethnal Green, to apply for grant funding. This enabled us to have one year of 16 hrs a week funding for a 'Networker for Wellbeing'. Subsequently we were awarded another 12 months funding to extend her work to a full time role, including a three-month period in two other practices. Patients seeing any members of the practice team were referred to her if it was felt that they had needs unmet by our current provision - those whose health could be improved by community service involvement.

Specifically, our networker did three things:

1. Case working using health coaching model, to co-design goals according to patients' expressed concerns and referrers' identification of unmet needs. This could include taking them to a service if appropriate.
2. Networking with local services and develop a database for practice staff to use. This has extended to the formation of the E2 Breakfast, a monthly networking event for community organisations, which has enabled improved cooperation amongst them and is now being replicated in E1 and E3.
3. Educating the practice team on what is available locally and how to access it. Encouraging a new way of thinking about patients and how to empower them, and facilitating change through accessing community services.

Our networker is fully embedded in our practice team, participating in clinical meetings and contributing to the multi-disciplinary team to find solutions for complex patients. She also proactively engages specific groups of patients felt to be in need of extra support, such as frequent attenders, poorly controlled diabetics, mental health patients amongst others.

Our data confirmed what had and continues to be known about the impact of the use of the community in healthcare. We saw:

1. Of those who had seen the networker, a reduction in attendance rates for three months afterwards when compared to the previous 12 months.

2. Change in attendance pattern from fewer face-to-face meetings and visits, to more telephone appointments, suggesting increased confidence and reduced dependency.
3. A and E attendees dropped by 20% amongst those who had seen the networker.
4. Frequent attender pattern practice-wide showed a drop, contrasting with increasing attendance figures nationally. We attribute this to a change in practice ideology around the use of the community sector and increased signposting by all practice staff.
5. Qualitative data confirmed that 75% patients felt the networker had improved their health and wellbeing. Negative perceptions around health dropped from 53% to 13% following engagement with the networker.

In addition, we have seen the germinal development of patient champions, who have made changes in their own health and who want to work with others in a peer setting to enable the same for them. This started with a menopause support group which now includes patients from several other neighbouring surgeries and which is funded by public health.

Why is this significant and what lies in the future?

We want to recommend the use of social prescribing of a networker role between Primary Care and their communities, embedded in practices and encouraging a whole person approach to patient care. However, there is a deep ideological significance in this model, which could be missed if this service becomes replicated elsewhere.

It is in enabling our patients and staff to look *out* to the community as a source of strength and support that enables the sustained and transformative change for those who are stuck in their own situations. It is not about improving the service we offer, but of enabling the use of the services that are already out there already as places where better health can be sought.

These communities provide the sustainable, 'real' relationships, which are going to carry patients and their families through the ups and downs of life. They are the spiritual source that provides meaning and purpose, connecting people to something bigger and more permanent than themselves and so providing transcendence. They are the *powerhouses* for individual and corporate transformation. We, as powerful health professionals, need to engage with and facilitate their work, in order for our patients to become more empowered, engaged and proactive citizens within such functioning communities.

We are only just starting to see the value of community in whole-person health and wellbeing, and in connecting traditional healthcare provision to the messy, fluid but very real expression of life that is 'out there'. There is much talk of *parity of esteem* between physical and mental health. Having seen the success of development of networking relationships within community organisations in the E2 breakfast, we are thinking about a parallel forum for those who are at the health/faith interface in our local area. We want to see such parity amongst all of us who provide support in the journey of health. We are already seeing patient champions who are developing skills to share with others, enabling their own growth and facilitating that of others. As health professionals, we need to shine a light on the assets that already exist around us, as a source of hope in difficult times.