FaithAction

# KEEPING PRESSURE OFF HOSPITALS

**Exploring the care and support offered by faith-based organisations within the local community**

FaithAction, 2017

## About FaithAction

FaithAction is a national network of faith and community-based organisations involved in social action. We empower these organisations by offering support, advice and training – we help the 'doers' do. We also have a key role in facilitating partnerships, sharing good practice between organisations and between sectors, and acting as a connector between government and grassroots organisations. We work to highlight the contribution that faith-based organisations are making to communities up and down the country. We know that the extent and impact of this work, and the reach of faith-based organisations into communities that are often marginalised, mean that faith is too significant to ignore.

FaithAction has been a member of the Health and Care Voluntary Sector Strategic Partnership every year since its inception in 2009, working with the Department of Health, NHS England and Public Health England. As the faith 'voice' within the Strategic Partnership, we ensure that faith is taken into account in the development of new health policies and initiatives. We believe that faith-based organisations have a role to play in raising health outcomes, particularly among communities that typically suffer from health inequalities. Our report, The Impact of Faith-Based Organisations on Public Health and Social Capital, looks at this issue in more detail. You can read more at http://www.faithaction.net/report.

## Thank you

We would like to gratefully acknowledge the Department of Health, NHS England, and Public Health England for their financial support for this work through the Health and Care Voluntary Sector Strategic Partner Programme.

This report would not have been possible without the individuals who took the time to tell us about their organisations' work. Any errors or omissions are, of course, our own.



Written by Rodie Garland

# Summary

The ways in which faith-based organisations (FBOs) help to keep pressure off hospitals can be categorised into seven broad types of provision:

1. Preventative or 'upstream' support
2. More direct care that prevents people from needing to go to hospital
3. Specialist services that support general health and wellbeing
4. Spiritual care that supports general health and wellbeing
5. Support for transfer from hospital to the community
6. Professional social care
7. Strategic initiatives

In terms of what would help FBOs to improve their work in this area, the major need is for better information and connections: between different FBOs, between FBOs and the wider voluntary sector, and between FBOs and the health and care system. Beyond this, we are able to make a number of recommendations. These can be summed up as follows.

**FBOs:** make the case for what you are doing; take the time to build relationships with the health and care sector; and adhere to relevant legislation and good practice.

**Commissioners / the health and care system:** build awareness of how FBOs operate; get to know local FBOs; and create space for faith and spirituality.

This report includes examples that illustrate some of the ways in which FBOs are keeping pressure off hospitals including, in the final section, a number of case studies:

- CareLink, Stoke
- Al-Khidmat Centre, Leeds
- Jami, London
- Namaste Care, London
- Parish Nursing
- An example from the US: The Memphis Model

# Introduction

The first in the Department of Health's list of priorities for 2016-17 is 'improving out-of-hospital care'.[1] In its widest sense, this refers to all kinds of health care that take place outside of the hospital setting. More commonly, the term is understood to mean social care or support that takes pressure off hospitals, either because it prevents people from needing hospital care in the first place or because it supports their transition from hospital to the community – and hopefully ensures that the community is where they are able to stay.

Out-of-hospital care overlaps with many current priorities in the health and care system, including the integration of health and social care and implementing care reforms, the focus on personalised care, primary care reforms, devolution, improving community mental health, and ensuring a better quality of experience for service users and carers. It features prominently in the Sustainability and Transformation Plans (STPs) currently being put into action in local areas throughout England.

FaithAction was asked by Jon Rouse, then Director General in the Department of Health (now Chief Officer of the Greater Manchester Health and Social Care Partnership), to comment on the role that faith-based organisations (FBOs) currently play in providing out-of-hospital care in England – and what role they could play in the future.

To help answer this question, FaithAction:

- Held three roundtable discussions, in Leeds, Greater Manchester and Hertfordshire. These gave FBOs the opportunity to highlight their work in this area, and also to meet with health commissioners and hear about local priorities for health and care.
- Used an online survey, and telephone interviews with selected FaithAction members, to ask FBOs about the work they are undertaking and the issues that they face.

Knowing that one of the major issues that FBOs face in seeking funding for their health work is being able to demonstrate what they do and its impact, FaithAction also ran three online webinars based on its guidance, *Making the case for faith and health: How faith-based organisations can evaluate their work* (available at www.faithaction.net/evaluation). It also provided mentoring for three FBOs, listening to their priorities and concerns and supporting them to start collecting evidence of their work.

This report summarises the key issues raised in the feedback received from FBOs, and provides some illustrations of the kind of work going on up and down the country that helps to take pressure off the hospital system. Of course, these are only brief snapshots; a key point to be made is that there is a huge amount of activity going on, not all of which is recognised by statutory agencies as work that contributes to health and wellbeing – and indeed, not all of which is recognised as such by FBOs themselves.

[1] www.gov.uk/government/organisations/department-of-health/about We gratefully acknowledge the Department of Health, NHS England and Public Health England for their financial support for this work through the Health and Care Voluntary Sector Strategic Partner Programme.

## A note on 'faith-based organisations'

There are different types of FBO working in this field and discussed in this report. These include:

- Worshipping communities that provide support to their own congregations and/or the local community
- Faith-based or faith-inspired charities, which may or may not be linked to a particular worshipping community, and which provide some kind of service to the wider community
- Faith-based or faith-inspired providers of specific social care or health services
- Inter-faith groups and networks. These vary widely in terms of how active they are, but can provide a good 'way in' for the health and care system to engage with faith groups locally

For further discussion of how faith can be more or less central to different organisations, see Wharton and de Las Casas (2016).[2]

[2] Wharton, R. and de Las Casas, L. (2016). *What a Difference a Faith Makes: Insights on Faith-Based Charities*. London: New Philanthropy Capital. Available at www.thinknpc.org/our-work/projects/faith-based-charities

# How FBOs contribute to out-of-hospital care

Previous work by FaithAction has identified the health assets present in FBOs as being: a culture of volunteering, buildings, "substantial and distinctive social capital", skills and expertise, longevity within communities and an ethos of care, especially to the marginalised.[3] Groups providing feedback on how FBOs help to keep pressure off hospitals echoed these findings, emphasising in particular the large numbers of volunteers and volunteer managers involved, and the use made of faith venues – whether as meeting rooms, office space, venues for services such as blood donation, or even the use of volunteers' own homes. FBOs also reported collecting and/or donating resources to supply the activities being run. Among those providing feedback, it was relatively unusual to find those who were commissioned to provide their services; examples of services that did receive clinical commissioning group (CCG) funding were Street Pastors in Oldham, and the CareLink telephone befriending service.

The feedback we received has allowed us to distinguish seven broad categories of provision by FBOs of services that help to keep pressure off hospitals. These are outlined below.

## Types of provision

### 1. Preventative or 'upstream' support

This is the kind of support and activity that can help to keep people physically and mentally healthy, and mean that problems can be identified and dealt with before they develop into crises that might need hospital treatment. This kind of work may not necessarily be thought of by FBOs as something that helps to keep pressure off hospitals, even though it might have this effect, albeit indirectly. Likewise, it is difficult for FBOs to prove that this is the effect of such work.

Examples of this kind of support include: home visiting; befriending; activities to combat social isolation; community coffee shops; dementia cafes; practical support such as providing meals or getting shopping; promoting healthy lifestyles; exercise groups; providing opportunities for older people to stay active; emotional and spiritual support such as bereavement counselling; signposting to other services; community hubs (which might provide several of the above services).

> *"What we do keeps people accessing health services in a timely way and therefore only when needed. It is hard to demonstrate the good work we are doing in language [that] is respected by health and statutory bodies."* (FBO representative)

### 2. More direct care that prevents people from needing to go to hospital

This activity is more obviously connected with health, and so is somewhat easier to quantify. Examples might include: Street Pastors / Street Angels, who can prevent A&E admissions by caring for people who have had too much to drink; the Hatzola ambulance and first aid service provided by volunteers from Jewish communities; providing first aid training held in faith venues; helping people to understand their medication and take it properly; providing information on local health services including alternatives to A&E, including in languages other than English.

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[3] November, L. (2014). *The Impact of Faith-Based Organisations on Public Health and Social Capital*. London: FaithAction. Available at www.faithaction.net/report

## The Harpenden Hopper

A group of churches in Harpenden, Herts, have formed a Community Interest Company to provide a community bus, the Harpenden Hopper. The bus runs to a published route, which covers three doctors' surgeries and the cottage hospital. This came out of a desire by churches to help their local community, facilitated by a meeting with the Mayor and a Councillor who knew that the need for better community transport had been identified by the County Council.

» www.harpendenhopper.co.uk

### 3. Specialist services that support general health and wellbeing

Some FBOs provide services that support the health and wellbeing of targeted groups of people – for example, people experiencing domestic violence or abuse, refugees and asylum seekers, homeless people, sex workers, or those with substance misuse issues or experiencing pregnancy crisis. Some specialist services, such as debt or relationship counselling, may be less directly health-related but nonetheless deal with issues that can have a profound impact on an individual's wellbeing.

### 4. Spiritual care that supports general health and wellbeing

The NHS recognises the benefits of appropriate spiritual care[4] as part of healthcare that supports the wellbeing of the whole person. FBOs are natural sources of provision of this kind of care, which might include: chaplaincy; provision of religious services/ceremonies in care homes or in people's own homes; provision of drop-in facilities that are open to the public for listening and prayer.

### 5. Support for transfer from hospital to the community

Some FBOs provide practical support around hospital discharge, including transport and home visits. FBOs might also provide advice and information or advocacy to help people transferring into the community and ensure they have access to the services they need.

### 6. Professional social care

This category of work includes faith-based providers of social care such as Jewish Care, Catholic Care and MHA (the Methodist charity and housing association), as well as more local organisations serving particular communities where people are likely to share a common faith, such as Peepal Care, which works primarily with the Gujerati community in north-west London.

## Lifesavers

The British Islamic Medical Association (BIMA) runs the Lifesavers project, in collaboration with the British Heart Foundation and Muslim Council of Britain. The project involves mosques across the UK opening their doors to host training in CPR and basic life support skills. On one day in 2016, in the third year of the project, the training was delivered to over 3,000 people by Muslim health professionals volunteering as trainers. There are over 23,000 cases of out-of-hospital cardiac arrests occurring each year in the UK, and while the average survival rate is around 8%, the experience of other countries has shown that this can increase to over 25% with effective public CPR education. BIMA Lifesavers is on track to become the largest free, accredited national basic life support training programme in the country.

» www.mcb.org.uk/mosques-across-the-country-open-doors-for-life-saving-training

[4] See for example *NHS Chaplaincy Guidelines 2015: Promoting Excellence in Pastoral, Spiritual & Religious Care*, NHS England, 2015. Available at www.england.nhs.uk/wp-content/uploads/2015/03/nhs-chaplaincy-guidelines-2015.pdf

### 7. Strategic initiatives

It is also worth noting that pressure on hospitals can be relieved at a more strategic level by organisations working better together. For example, Manchester's Homelessness Charter has been led by faith-based charity Mustard Tree and has brought together city leaders, faith groups, the voluntary sector, businesses, the police and fire services, CCGs and Manchester City Council to tackle homelessness in the city.[5]

The Faith Covenant, developed by the All-Party Parliamentary Group on Faith and Society with FaithAction,[6] is a further initiative aimed at promoting joint working between local authorities and other commissioners on one hand and FBOs on the other. It has so far been adopted by six local areas, with more in the planning stages. In Barnet, the Covenant is cited in the borough's Joint Health and Wellbeing Strategy in recognition of the contribution of FBOs to health and wellbeing, while in Solihull the Covenant is set out as a partnership agreement that specifically includes health agencies alongside the local authority.

## Other ways in which FBOs contribute to out-of-hospital care

From FaithAction's experience we know that FBOs also undertake less direct activities that nonetheless contribute to keeping pressure off hospitals. These include providing encouragement and support for volunteers to take part in services run by other organisations, as part of their general culture of volunteering; and being a source of intelligence for commissioners on health needs and gaps in provision.

One person contributing to this project, who came from a South Asian community, said that in their opinion, their community had little awareness of the facilities available through the social care system: "They do not like to demand services and also do not know how to." This illustrates the fact that in some cultures there is no tradition of using care homes to care for family members, with all care being undertaken by the (often extended) family. While it is clear that this tendency will to some extent mean that demand for social care is lessened, it can also create problems: people may not receive services that will help them because the family is not aware of what is available and their rights to it; and families can become over-burdened with caring responsibilities, which can result in carers also developing physical and mental health problems.

### Nishkam Healthcare Trust

The Nishkam Healthcare Trust was launched by Guru Nanak Nishkam Sewak Jatha (GNNSJ), a Sikh organisation, in response to observations of health inequalities and difficulties in accessing culturally sensitive health and social care in the Handsworth area of Birmingham. The healthcare centre runs a charity-owned pharmacy, funded by donations from the community, a foot-care clinic, befriending and chaplaincy services. Its staff also proactively deliver various health education and awareness initiatives for the public. The centre promotes faith-inspired, values-driven healthcare, and aims to empower patients and foster compassion among health professionals. In addition, GNNSJ supports older people through services including: provision of free hot meals (of the 20,000-25,000 meals served weekly, 60-70% are served to elderly members of the community); counselling and guidance; opportunities to undertake *Nishkam Sewa* (selfless service), e.g. in prayer services, cooking, cleaning, or infrastructure work; and provision of a gym in a culturally sensitive environment.

» www.nishkamhealthcaretrust.com

[5] https://charter.streetsupport.net

[6] www.faithandsociety.org/covenant

Overall, FBOs saw the need for the services they offered, and many expressed the desire to expand these, although this was dependent on the availability of funding and volunteers. They tended to recognise the actual or potential contribution of their services to promoting health and wellbeing, as the following quotations illustrate, even if they did not make the direct link with keeping pressure off hospitals.

> *"Church community engagement activities often fit comfortably under the 'Health and Wellbeing' banner, making them natural partners in social prescribing."* (FBO representative)

> *"I have worked as a Non-Executive for an NHS Trust … the Faith Sector could do more if it was invited as an equal partner."* (FBO representative)

# Improving FBOs' contribution to out-of-hospital care

The major need identified from the feedback we received from both FBOs and those involved in the health and care system was the need for better connections: between FBOs themselves, between FBOs and other VCS organisations, and between FBOs and statutory services. FBOs wanted information on existing networks that they could feed into, and services they could refer people on to – as well as wanting the wider system to be able to refer people to them. They also wanted more information on the needs and opportunities locally. For example, it was thought that there are likely to be people within faith groups who would readily volunteer within health and care if they knew better how to go about it. FBOs might want – and be able – to respond to needs such as when a patient is discharged from hospital to go home alone, or even without a home to go to, if there were a way of alerting FBOs to the need. For an example from outside the UK of such a scheme, see the Memphis case study below.

The feedback has allowed us to make the following recommendations with a view to enabling the faith sector to better contribute to keeping pressure off hospitals.

## Suggestions for FBOs

### 1. Make the case for what you are doing

- Be able to articulate what you are doing to potential funders: consider your activities and record which of them contribute, directly or indirectly, to out-of-hospital care in any of the ways described above.
- Learn to express what you do in language that commissioners understand. Local voluntary and community sector (VCS) networks may run training on commissioning, and FaithAction also offers advice and training.
- Be able to demonstrate your impact: FBOs need to show how their work is cost effective. However, qualitative information is valuable too, and case studies can be a powerful way of demonstrating impact. For further help see FaithAction's guidance on evaluation.[7]
- Be clear on whether and how your organisation seeks to share its faith values, and articulate this, to allay suspicions about proselytising.

### 2. Build relationships with the health and care system

- Take the time needed to build ongoing relationships and trust, attend meetings and engage with the out-of-hospital care agenda locally. When people know who you are as an organisation, they will be more willing to refer people to you – and you will be able to serve people better if you are aware of what is going on locally that could help them. It is worth developing relationships with commissioners ahead of applying for tenders or large grants, as you will be more aware of what they are looking for.
- Inter-faith group leads and other FBOs could write to commissioners and ask to join local partnerships or offer sessions to raise awareness about what FBOs can offer, the importance of spiritual aspects of wellbeing, and the overlaps between faith and culture.

> *"We have had a limited amount of GPs allow us to come in to explain our services and they refer, at times, but then seem to forget about us."* (FBO representative)

[7] FaithAction (2016). *Making the Case for Faith and Health: How faith-based organisations can evaluate their work*. London: FaithAction. Available at www.faithaction.net/evaluation

### 3. Adhere to relevant legislation and good practice

- Inform yourself on how the Equality Act 2010 affects your organisation.[8]
- Ensure that those working with children or vulnerable adults are checked by the Disclosure and Barring Service (DBS).[9]
- Funders often ask for written policies on health and safety, equality and diversity, safeguarding and child protection, so ensure these are in place. FaithAction can offer advice on these.
- Be aware that statutory services can lack confidence in approaching faith groups in case they make a mistake and cause offence. Be part of creating a culture where it is okay to make mistakes as long as people learn from them and remain open to engaging with one another.

## Suggestions for commissioners / the health and social care system

### 1. Build awareness of how FBOs operate

- Be aware that the majority of FBOs provide services to the wider community, not just those who share their faith;[10] be willing to focus on an organisation's work, not its status as an FBO.
- Be wary of seeing FBOs merely as another channel for disseminating healthy lifestyle messages. Faith groups can be places that vulnerable people turn to in the hope that they will not be judged or lectured, so it is important to work with the group to ensure that messages are put across in an appropriate way.

### 2. Get to know your local FBOs

- FBOs often represent and/or work with marginalised communities and those whose voices are seldom heard within the health and care system. However, they are not always part of local VCS networks, so any engagement with such networks needs to be supplemented by intentional engagement with FBOs. Take the time needed to build ongoing relationships and trust.
- Make clear who is available within the organisation for FBOs to talk to or contact, whether about getting involved in commissioning, or about health issues their community might be facing.
- Consider providing information on what FBOs need to do in order to be commissioned – such as how to express their outcomes and impact in meaningful ways.

> *"We have been in the hospital for 9 years … but we could save the hospital time and money if the GPs referred to us while patients are waiting for the [hospital] appointments."* (FBO representative)

> *"Our CCG does not recognise faith based organisations as VCS organisations even though they have an extended reach in an area with 60% BAME [black, Asian and minority ethnic] population."* (FBO representative)

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[8] For information on the Equality Act 2010 see www.gov.uk/guidance/equality-act-2010-guidance. Citizens Advice provides good information on exceptions to the Act relating to religion and belief, and on where discrimination by religious organisations is allowed in the provision of services: see https://tinyurl.com/hrnjklo and https://tinyurl.com/hs7dxca

[9] www.gov.uk/disclosure-barring-service-check/overview

[10] Wharton and de Las Casas (2016), as above.

### 3. Create space for faith and spirituality

- Foster a willingness among health professionals to talk about aspects of wellbeing beyond just physical health. People can be afraid of causing offence, but simply asking someone what is important to them is a way of giving them space to talk about spirituality if they wish to.
- Statutory services can lack confidence in approaching faith groups in case they make a mistake and cause offence. Be part of creating a culture where it is ok to make mistakes as long as people learn from them and remain open to engaging with one another.
- Make it clear that you value FBOs as an important part of civil society and that they can play a part in system-wide approaches to promoting health and wellbeing.
- Be clear that not being permitted to "promote religion" does not mean that you cannot commission FBOs to provide services. Commissioners could use the Faith Covenant, developed by the All-Party Parliamentary Group on Faith and Society and FaithAction, as a basis for working with faith groups.[11]
- A specific suggestion was that where FBOs or faith leaders are aware of a person's advance wishes about care the end of their lives, this could form part of the person's record and be shared with clinicians, if the person agrees – which could save difficult conversations being had multiple times.

> *"Silo thinking across health and social care means that strategic planning with the VCS in very difficult"* (Faith-based provider of CCG-funded service)

[11] www.faithandsociety.org/covenant

# Examples of faith-based out-of-hospital care

## CareLink, Stoke

CareLink, run by Stoke-based Christian charity Saltbox, provides a free telephone befriending service for anyone aged 50 or over who feels lonely or isolated and is registered with a Stoke GP. The aim is to keep people healthy and independent in their own homes for as long as possible: Saltbox says that of the 40,000 people aged over 65 in Stoke-on-Trent, around one-third regularly go through the week without speaking to another person.

A person requesting the service will be called by a volunteer on a regular basis (up to five times a week) and at times convenient for them. This allows a friendship to build up and helps the person to feel that somebody cares about them. The regular contact means that volunteers can identify a health and welfare issue before it becomes a crisis, helping the person to access the right support. Concerns are passed onto paid staff at the charity, who can offer support or refer to other services. They can also help the person to link into community groups.

CareLink's 20 volunteers make over 400 calls a week to almost 200 service users. Support is offered over the short, medium and long term: it can cover periods of a few days or weeks when family or carers need a break; it can provide support over weeks or months to help manage the transition from hospital to home or during recovery from an illness; and can continue over years, for example if someone is experiencing declining health or confidence.

The core service is funded through Stoke CCG, with other sources (trusts, foundations and commercial organisations) funding different aspects of the work including a volunteer coordinator post, to strengthen the service offered to volunteers. CareLink also helps people to socialise and reconnect with the community, and has received grants from the Big Lottery Fund and One Stop Stores to take small groups of service users on heritage trips to different places around the city.

» www.saltbox.org.uk/carelink

## Al-Khidmat Centre, Leeds

The Al-Khidmat Centre is a day centre working with elderly people who come primarily from the Asian Muslim community in Leeds. It also runs a lunch club that is open to all. It is situated in Chapeltown, an extremely diverse area that also ranks as very deprived. The centre runs a number of health and wellbeing activities that are focused on helping people to stay out of hospital.

These include a dementia café each Wednesday, where activities might include sharing old photographs, games that people played as children, or sharing experiences of life when they first moved to the UK. The session focuses on raising awareness about dementia and the role that families can play in supporting people living with dementia, as well as supporting carers themselves. Most of the families do not habitually engage with mainstream health and care services, although they do engage with faith leaders. They may need a link to facilitate engagement with services, especially where women are involved. The centre manager sees his role not as trying to 'make' carers engage with mainstream services, but to empower them to take responsibility for themselves. In particular, people are encouraged not to keep things to themselves if they are worried about their own or a family member's health.

Other health-related activities that the centre has been involved in include raising awareness around bowel cancer, transplant and organ donation, blood and platelets donation, diabetes, weight, diet and mental health. On mental health, the centre has run a joint project with community mental health organisation Touchstone,[12] recognising that social isolation and loneliness are major threats to health.

The centre manager comments that having large numbers of elderly people within the Asian community in the UK is a relatively new phenomenon, and that he was shocked at the level of need that the centre has uncovered. Currently the centre is open three days per week; while the manager's goal is to move to four-day opening, he estimates that this would require an additional £25,000-£30,000, and the funding situation is precarious.

The centre is powered by volunteers, who include a chef and assistant chef, and two development workers. Their expenses are paid from a £12,000 grant. The centre pays a low rent to the mosque it is attached to, and the mosque covers the insurance for the centre. In terms of facilities to support the work, there is no internet connection at the centre, so the manager uses his own internet at home for centre business, and staff use their own cars and phones.

The manager expresses his frustration at the commissioning system, which he says tends to favour bigger organisations that come across well 'on paper', and disadvantages small groups, despite the fact that they are in great demand from communities that mainstream services do not reach. He believes that commissioners should do more to fund dementia and end of life services to engage with mosques and imams, as cultural and language barriers can currently prevent people from the Asian community from using these services.

» http://leedsdirectory.org/venue/al-khidmat-centre-2

[12] www.touchstonesupport.org.uk

## Jami, London

Jami is a mental health charity which supports the Jewish community, working in four areas across London. 98% of Jami's service is voluntary funded (it also receives a small amount of statutory funding). The organisation helps members of the community who might be affected by mental health issues such as bi-polar affective disorder, schizophrenia, depression and eating disorders. Jami focuses on recovery and provides the resources and support to enable people to live the lives they want to live. The services Jami offers include:

**Head Room**, which is a programme of seminars and events to educate the community about mental health and wellbeing. Alongside these are a range of courses to support personal development and to help people living with mental health conditions on their recovery journey. Jami is an accredited provider of Mental Health First Aid (adult), Mental Health First Aid (youth) and Mental Health First Aid for schools.

**Independent living support**, through a team of social workers and occupational therapists who help people manage their mental and physical health and daily routine, and improve their independent living and social skills.

**A carers support service,** which can include one-to-one support, support groups and information and guidance.

**Hospital visiting** for people who are feeling isolated while in mental health units or residential care homes. The visitors are volunteers, managed by a coordinator who liaises with the relevant chaplaincy departments. The team offers people in hospital encouragement and a link to the outside world, and also organises cultural events such as celebrations of Jewish festivals.

**A befriending scheme** for socially isolated individuals, through volunteer befrienders who help people to make use of social, cultural and educational facilities within their local community, and develop social skills, self-esteem and a sense of connection. Volunteers receive Mental Health First Aid training and regular learning and development opportunities.

**A recovery and peer support service**, delivered by people who have lived experience of mental ill health who can support and encourage others along their recovery path. The service includes closed and open groups, one-to-one support and drop-ins.

**An employment service**, offering advice and assistance with job searching, volunteering, re-training and managing work-life balance.

**Jami Enterprises**, which creates opportunities for people to make a meaningful contribution to the local community. Jami Enterprises operates an eBay shop selling donated goods online, and also stocks and supports the vintage boutique situated within Jami's Head Room café.

» www.jamiuk.org

## Namaste Care, London

Namaste Care Community Interest Company (CIC) provides person-centred support for Asian people with long-term conditions, including dementia. It also helps people to navigate the health and care system. It is based in Harrow, north-west London, where South Asians make up nearly 30% of the population.

The CIC was founded by Varsha Dodhia following her own experiences of caring for her parents-in-law. When her father-in-law developed dementia, he lost the ability to speak English, so Varsha set up a weekly Gujarati and Hindi language dementia café that would allow people with dementia to enjoy positive time together, sharing music and activities such as armchair yoga. This also gave their carers the opportunity to have a break, as well as to meet other carers and develop a circle of mutual support.

From initially running the café voluntarily in her own home, Varsha saw the need for greater support for Asian families and eventually set up Namaste Care as a social enterprise which acts as a bridge between local communities and the health and care system. She is now employed by a GP network and shared between four GP practices as a care coordinator, and specialises in dementia in BAME communities. With her expertise as a community navigator, she is also a Lay Partner Advisor for North West London Whole System Integrated Care and a member of the STP planning group, and a member of the Equalities and Engagement committee of Harrow CCG.

This work has enabled Varsha to bring a faith perspective to the health and care system, particularly around areas such as dignity, the last phase of life and what makes for a 'good death', as well as highlighting the importance of people's beliefs in their decision-making. For example, in the Dharmic faiths (Hinduism, Jainism, Sikhism and Buddhism), belief in karma affects beliefs around the end of life and a good death, as well as views of dementia and disability. There is also a strong tradition within Asian culture of looking after elders within the family, which can sometimes put great pressure on carers. From Varsha's perspective, the importance of *sewa* (selfless service, which is believed to nourish the individual) and a responsibility to oneself within the wider community must be balanced with the core principle of non-violence. A carer who is miserable and angry at themselves and others might be resorting to inner violence, which would defeat the purpose of caring. Service provision that recognises the need for culturally appropriate support for those who take on the burden of care can help to make the caring role both rewarding and sustainable.

- www.namastecare.org.uk

## Parish Nursing

Parish nurses are registered nurses who are employed or appointed by a local church to offer health-related help to people of all ages and beliefs, sometimes supported by volunteers from the church. Over 90 churches in the UK, from all denominations, currently have a parish nurse. Some work solely as parish nurses, while others work part-time within the NHS in addition to their parish nursing hours, for which they are line-managed by the church or charity that appoints or employs them. They remain accountable to the Nursing and Midwifery Council, and they follow the Code of Practice for registered nurses. Each parish nurse has a professional supervisor and also a spiritual mentor.

In parish nursing the focus is on the whole person rather than on treating a specific medical condition, with nurses offering one or more of the following services:

**Health education** for congregations and the local community, around general lifestyle issues. For example, the nurse might run a chair-based exercise group, help young people to understand healthy behaviours, or organise events such as a men's health breakfast with a talk from a GP, or a course on stress management for busy executives.

**Support for individuals at risk** of isolation, or those with a short-term illness who need a bit of extra help.

**Help with self-management** for people with long-term health conditions.

**Help at the end of life**, through non-specialist support.

Parish nurses do not deal with treatments, dressings or injections, or help with personal care, but they can be a link with the health and care services that do provide these, ensuring that people use the services appropriately and understand their medication, care and condition. They might provide extra support during a medical crisis, signpost people to other support or medical services, pray for people, clarify medical procedures or issues, or just listen. They can follow up with people who have been discharged from hospital, are at risk or have early signs of health problems – potentially preventing hospital admissions. They also train and coordinate volunteers to help combat loneliness and to provide extra support during times of crisis. All of their work has an element of spiritual care, even if this is as simple as – for example – sitting with someone or talking about hope; something that mainstream healthcare services are not always able to offer.

Parish nurses also build relationships with local GP practices and health professionals, so that referrals can be made to and from the primary care team or other health providers and agencies. Some have developed relationships with the local CCG and with hospitals. Parish Nursing Ministries UK, the charity that promotes parish nursing and helps churches and nurses to develop the concept, is working to ensure that the process of development, accreditation and ongoing service improvement for parish nurses is standardised and robust. This will make it easier for other parts of the healthcare system to understand parish nursing and how it fits within the system, as well to be assured of the quality of parish nursing services. The charity is keen that that the spiritual element of the service is not compromised, since it sees spiritual care as a very important part of health promotion, community cohesion and disease management.

» http://parishnursing.org.uk

## An example from the US: The Memphis Model

The Memphis Model has developed from the International Religious Health Assets Programme at the University of Cape Town.[13] Under the model, existing health assets (such as the caregiving traditionally provided by the around 2000 mainly Christian congregations in the city) were identified and steps were taken to integrate them with traditional healthcare and hospital-run initiatives, to create a system of health built on "human webs of trust and caring".[14] The result was the Congregational Health Network (CHN), an extension of the care that would otherwise be confined within hospital walls.

Methodist Le Bonheur Healthcare runs seven hospitals. It employed a Director of Faith and Community Partnerships, under whom the project has recruited 12 'navigators', located within the hospitals and employed by them. It is the job of these navigators to identify and make links with local congregations and the webs of trust that they represent: around 600 congregations have been engaged.

Each congregation involved in the programme undertakes to train a minimum of two volunteers, who act as liaisons with the healthcare system. These people, who must be individuals trusted by their faith communities, are trained by their linked hospital in areas such as recognising the early symptoms of disease, healthy eating and navigating the welfare system. Over 700 volunteers have been trained so far, who provide community caregiving for the 20,000 individual members of the CHN. Each of these individuals is logged in hospital records as a member of the CHN, which means that if they are admitted to hospital, their membership is flagged up and their liaison volunteer is notified. This means that the practical and spiritual support offered by their congregation can immediately swing into action to contribute to the care the person receives both in hospital and once they return home.

The programme shows measurable outcomes that include significantly longer time before readmission to hospital for CHN patients as compared with non-CHN patients, regardless of their health condition(s) (CHN=426 days vs. non-CHN=306 days). Mortality rates for CHN patients were significantly lower than for non-CHN patients.[15]

It is perhaps more natural for such an initiative to have developed in the USA, which has a widespread system of faith-based 'mainstream' healthcare, than in the UK. However, the apparent effectiveness of the Memphis Model suggests that this kind of initiative would be worth exploring in a UK context.

» https://faithandhealthdotorg.wordpress.com/tag/memphis-model

[13] www.irhap.uct.ac.za

[14] Gunderson, G. and Cochrane, J. (2012). *Religion and the health of the public – shifting the paradigm*. New York, NY: Palgrave Macmillan, p.51.

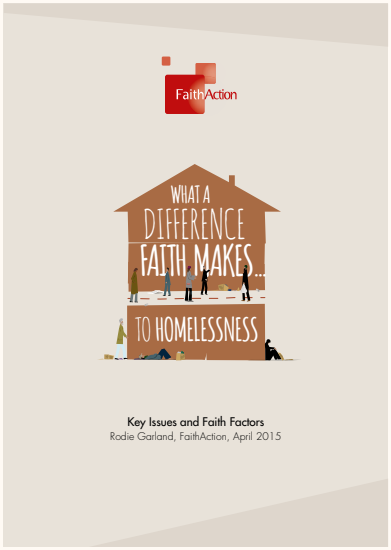
[15] Cutts, T. (2012). *The Memphis Model: Community-wide Faith-Based Collaboration Prevents Re-admission*. Presentation at The National Medicare-Medicaid Re-admissions Summit, May 30, 2012. Available www.ehcca.com/presentations/mmpaysummit1/cutts_pc2.pdf (Accessed 02.03.2017)

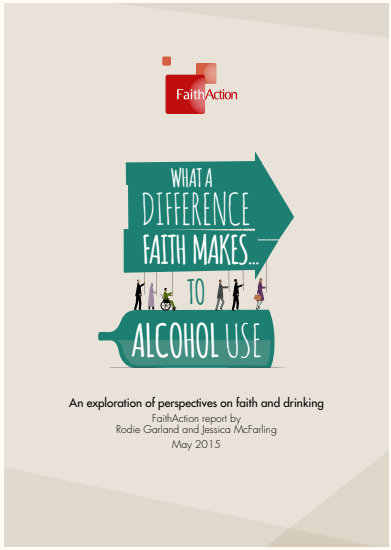
# FaithAction's Health and Social Care Work

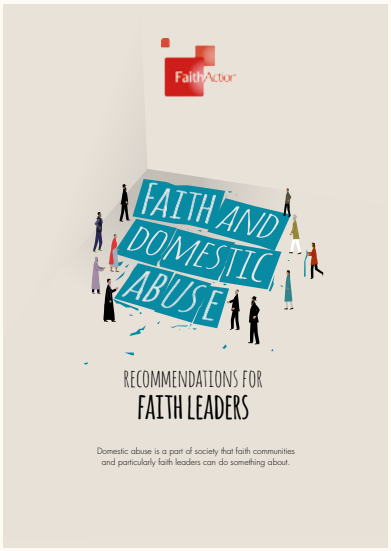
FaithAction works to highlight the difference that faith makes, and to support and inspire faith-based and community organisations to improve health and wellbeing in their communities. Our **Making the Case for Faith and Health** guidance helps organisations to evaluate their work and show its impact.

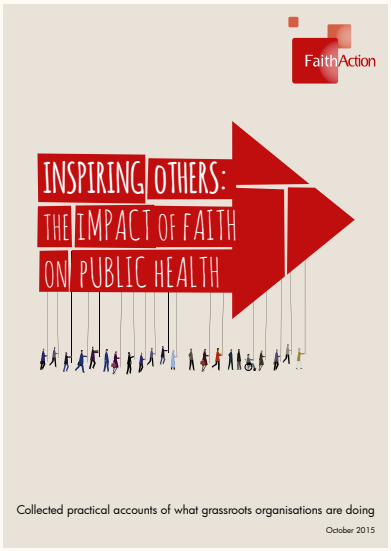
Further information and publication are available at www.faithaction.net.

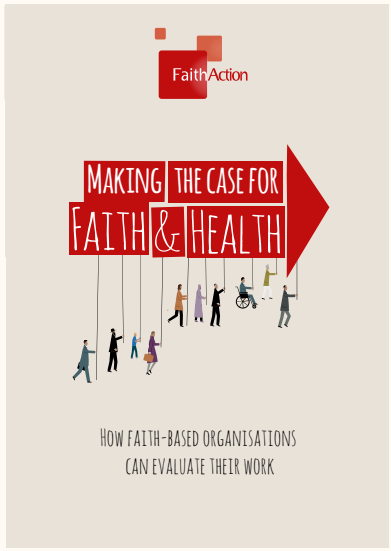
Contact us at info@faithaction.net or 0845 094 6350.


Friendly Places

Friendly Places is FaithAction's initiative to raise awareness of the significant and positive role that faith communities can play in the support of mental health. Sign the Friendly Places pledge and find articles, tips and resources to help your faith group become more mental health friendly at

www.faithaction.net/friendlyplaces

FaithAction

**Because faith reaches the parts that nothing else can**

# www.faithaction.net

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