Introduction to Health Inclusion : why it matters?

Webinar

19th June 2024

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Webinar
Introduction to Health Inclusion: why it matters?

Agenda - Wednesday 19th June, 13:00 – 14:30

Time	Item	Who
13.00	Welcome and housekeeping	Fatima Sayed, Principal Public Health Practitioner, Public Health Wales
13.05	Introduction to Health Inclusion: why it matters?	Kerry Bailey, Consultant in Public Health, Public Health Wales
13.15	Overview of Cardiff & Vale UHB Inclusion Health Service	Heledd Jones, Assistant Clinical Director, Cardiff and Vale University Health Board
13.25	Break & attendee views on additional Health Inclusion webinars	
13.35	Overview of Aneurin Bevan UHB Inclusion Health Service	Star Moyo, Health Inclusion Service Senior Nurse, Aneurin Bevan University Health Board
13:45	A nurse-led homeless service – learning curves and success stories	Rebecca Bullingham, Advanced Nurse Practitioner, Oakfield Surgery
13.55	Question & Answer with Panel	Presenters Lorraine O'Leary, Operational Nurse Manager, Swansea Bay UHB) Janet Keauffling, Nurse, Abertawe Medical Practice
14.25	Closing remarks	Kerry Bailey, Consultant in Public Health, Public Health Wales

Primary Care Division PHW

Introduction to Inclusion Health

Dr Kerry Bailey, Consultant in Public health, Public Health Wales, & GP Health for Homeless

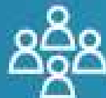
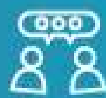
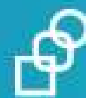
Acknowledgements – Fatima Sayed, Victoria Tice, Harvey Carmen, Holly McAnoy, Sian Jones, Zoe Wallace, Charlotte Grey, Huw Brunt, Steph Perrett and many others

External - Ayla Cosh, Karen Gully, Nurses Health Inclusion Group

05/06/2024

Overview

- Introduction to Inclusion health and Primary Care
- Supporting development of primary care health inclusion services and a place based specification
- Approach
- Training resources
- Key messages
- Handover to colleagues for examples - primary care services designed and adapted for people most in need

Protected characteristics

Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation

Socio-economic deprived population

Includes impact of wider determinants, for example: education, low-income, occupation, unemployment and housing

Inclusion health and vulnerable groups

For example Gypsy, Roma, Travellers and Boater communities, people experiencing homelessness, offenders/former offenders and sex workers

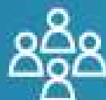
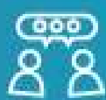
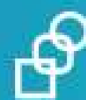
Geography

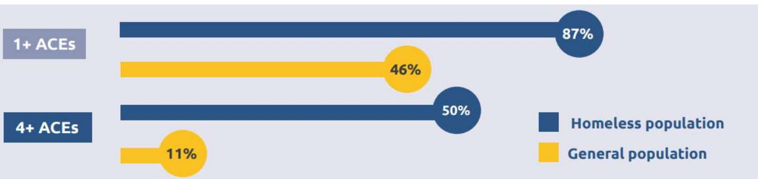
For example, population composition, built and natural environment, levels of social connectedness, and features of specific geographies such as urban, rural and coastal

Inclusion Health? Who?

‘Overlapping severe and multiple disadvantage’

- People experiencing or at risk of homelessness, including:
  - Those in temporary and unstable accommodation,
  - Young people or care leavers at risk of homelessness.
- People in regular contact with the criminal justice system.
- People seeking asylum, refugees, vulnerable migrant workers and undocumented or trafficked migrants.
- Sex workers.
- Roma, Gypsy and Travelling people.
- * adapted from the Faculty of Inclusion Health



Overlapping multiple risk factors for poor physical & mental health

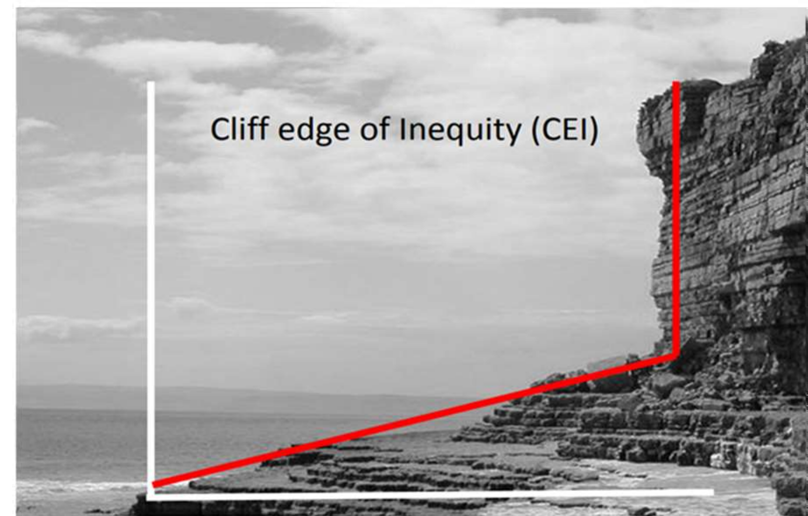
Increased health need

Barriers to access health care

- Stigma
- Fear
- Poor past experiences
- Language
- Service delivery
- Professional

Poorer access despite increased need

poorer health outcomes



Prevalence of homelessness in Wales

1 in 14 (7%) have lived experience of homelessness

People who sleep rough are more likely to die prematurely compared to the general population

Average age of death of people experiencing homelessness is

44 years for men

42 years for women

compared to

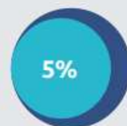
76 years for men

81 years for women

in the general population

Relative prevalence of the top 3 long term health conditions in homeless vs general population groups

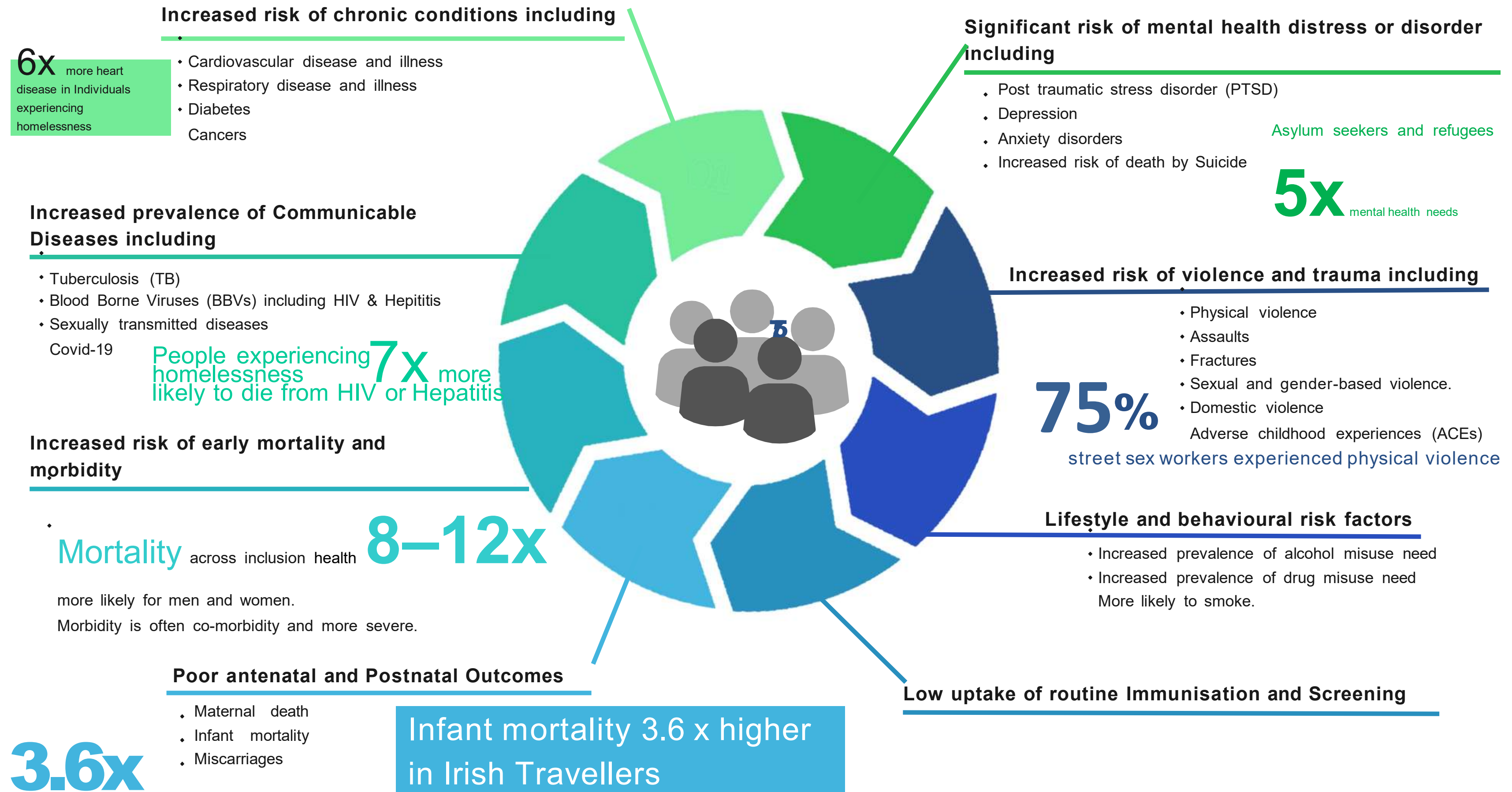
	Hypertension	Chronic pulmonary disease	Cardiac arrhythmias
General population comparison group	5%	3%	2%
Individuals with lived experience of homelessness	6%	10%	4%



HEALTH INCLUSION PROGRAMME WALES

Health and wellbeing needs of inclusion health groups:

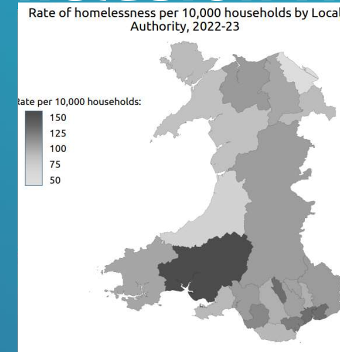
People Experiencing Homelessness | Refugees and Asylum Seekers | Gypsy, Roma and Travelling Communities | Sex Workers | Individuals in Contact with the Criminal Justice Systems

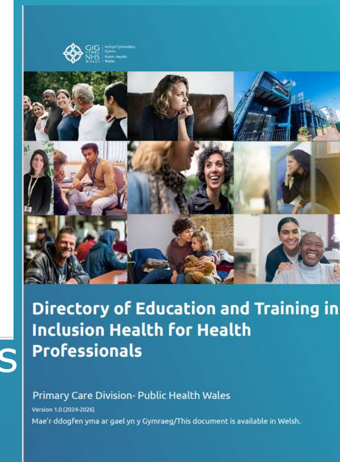


Health inclusion groups face specific and extreme health and wellbeing inequalities that are complex, often co-occurring and are unique to the circumstances and experiences faced by the individual but there are commonalities across.

Supporting the Implementation of Inclusion Health Services

Products





- Data and Epidemiology for planning
  - Numbers, needs, spend, all eligible groups
- Understanding all Services and gaps
  - All primary care services designed for vulnerable groups in Wales
- Directory of Education and Training
- New **Specification** for place based planning, based on NICE and Faculty of Inclusion Health, evidence and stakeholder engagement
- People - Systems working
- Communities of Interest – Nurse Inclusion Health, PH network
- WG - National Health Inclusion Group, NHS Health inequalities Group
- Engaging widely - Health boards, Academies, GP training schemes, 'safer surgeries', local authorities, third sector, criminal justice etc

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Support - Directory of Education and Training in Inclusion Health for Health Professionals - Primary Care One

- https://primarycareone.nhs.wales/files/150424directory-of-training-and-education-resources-pdf/

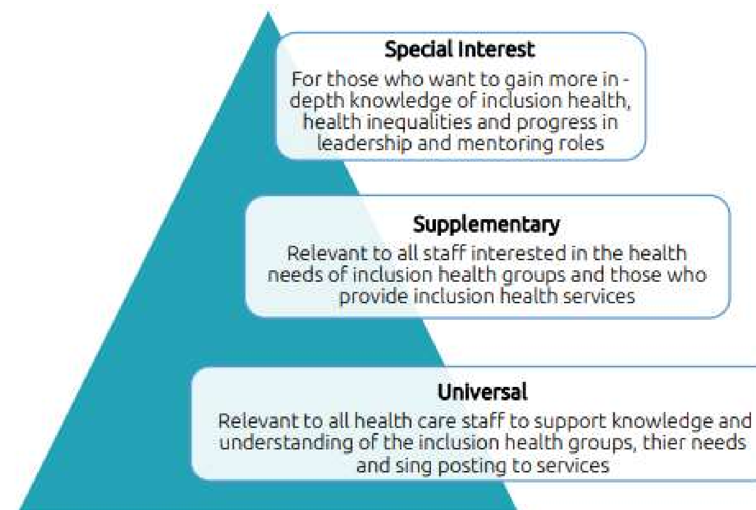

Figure 1: Hierarchy of training resources

This section is the most extensive in the directory and is made up of four tables:

Table 1 (Universal): Training courses, toolkits and resources relevant to all healthcare staff to support knowledge and understanding of inclusion health.

Table 2 (Supplementary): Training courses and resources relevant to all staff interested in the health needs of inclusion health groups and staff who provide inclusion health services.

Table 3 (Special Interest): Training courses and resources for staff who want to gain more in-depth knowledge of health inequalities and inclusion health as a sub-speciality.

‘An open-door approach to multiply excluded groups with a warm welcome based on the principles of trauma informed care and environments with cultural competence and sensitivity.’

Values and Approach

a. Person centred, empathetic and non-judgemental.
b. Continuity of care with trusting respectful relationships formed.
c. Services designed to reduce barriers to access – outreach, self-referral, low threshold, flexible appointment times, one stop shop.
d. Psychologically and trauma informed care and environments.
e. Cultural sensitivity.

Exploring ‘living well’ insights and wishes of the patient promoting shared decision making

Primary Care Inclusion Health Programme

- Key messages - Everyone deserves the best achievable health

- **Drivers** of the health inequalities are outside Healthcare but health care can **mitigate** or **increase** inequalities depending on how they are delivered
- With overlapping sever multiple disadvantage there is a 'cliff edge' of risk for physical, mental, acute, chronic, communicable and non communicable disease – much of which is preventable
- **Evidence shows that for the cliff edge to be mitigated need specially designed services**
- This can happen universally in a person centred, respectful, non judgemental way
- We need every area consider the need, provision and funding for outreach, in reach multidisciplinary place based services
- Many services have short term, insecure and inadequate funding
- Some areas have no specific services for vulnerable people

-**Primary Care Health Health Inclusion Wales 2024**

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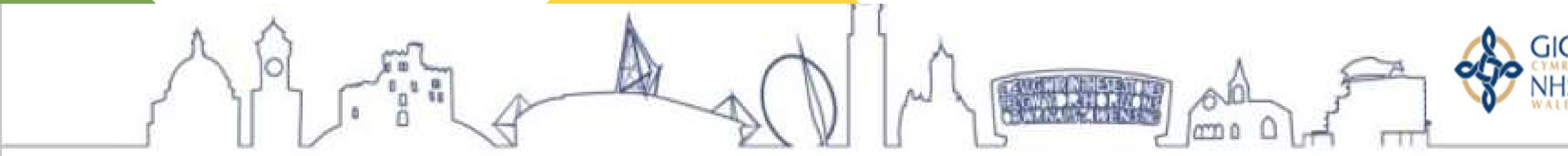
Thank you – and now to hear from the frontline

kerry.bailey2@wales.nhs.uk
Primary Care Health inclusion , Public Health Wales

Cardiff and Vale Health Inclusion Service CAVHIS

Dr Heledd Jones

GP, CAVHIS



Overview of CAVHIS

- CAVHIS hub, Cardiff Royal Infirmary
- St Athan clinic, Vale of Glamorgan
- Homeless outreach service, Cardiff
- EU homeless Inreach service, UHW
- Alternative Treatment Scheme (ATS) Service, Cardiff Royal Infirmary
- Teaching – students, GPs, hospital staff
- HealthPathways pages – Refugee and Asylum Seeker health, Homeless populations information
- Research

CAVHIS hub

- Asylum seekers, family reunion, homeless refugees, refugees – Ukranian and Afghan schemes
- Adult and paediatric nurses – Initial assessments, immunisations, chronic disease management, cervical screening, minor illness
- HCA – screening and investigative bloods, ECG, BP
- Midwife – antenatal and immediate post-natal care, FGM clinic
- Health Visitor – under 5's
- GP – primary care needs
- British Red Cross – support with any non-clinical issue, advocacy, referral to third sector e.g. counselling, GP registration, dental and optician referral, community orientation
- Infectious Disease clinic – for CAVHIS patients only, on-site with ID pharmacist and medications provided. Bimonthly
- Physiotherapy clinic – For CAVHIS patients who struggle with having to opt-in for service. Monthly
- TB clinic runs within same department, Department of Sexual Health in same building

Refugee and Asylum Seeker Initial Assessment

- Coding – refugee, asylum seeker, homeless, language, interpretation needs, literacy level
- PMH (including immunisation history, FGM), medication history, SH
- Dental or sight issues
- Cervical screening history/information leaflet provided
- Journey to UK – countries, mode, experiences
- Domestic violence, physical abuse, sexual abuse, torture, human trafficking, imprisonment, detention
- Body map of any injuries

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Cardiff and Vale University Health Board

CAVHIS

Cardiff and Vale Health Inclusion Service Initial Assessment Screening Protocol for asymptomatic adults

BLOOD TESTS FOR ALL	TB SCREENING
FBC Iron Studies Haemoglobinopathy Screening (Request and lab to process if MCV <80 and/or MCH <27) Folate, Ferritin & B12 U&E LFTs HIV Hepatitis B Hepatitis C Syphilis Strongyloides[1] Schistosomiasis[1] Trypanosoma Cruzi (Chagas) if from Central or South America[4] Hba1c - If hx of diabetes or CV Risk factors Vitamin D – Only if symptomatic – otherwise offer supplementation at 400iu daily	IGRA test if <65 years old Before offering IGRA, screen for symptoms of active TB: • Persistent cough for >3 weeks • Coughing up blood • Fever • Night sweats • Significant weight loss • Enlarged lymph nodes If symptoms present consider active TB, Request CXR and refer to TB team. If person from country with high prevalence of MDRTB request CXR as part of initial screening
	Stools for Ova, Cysts and Parasites (OCP) **If symptomatic of reflux/gastric symptoms:** Stool for H-Pylori (if patient taking a PPI, refer to GP prior to collecting sample)
	Height, Weight, Blood pressure
	Urine Chlamydia/Gonorrhoea NAAT for all <25s or if > 25 and history suggests appropriate to test. Extra-genital Chlamydia/Gonorrhoea if history indicates

If pregnant, give 400mcg daily folic acid for first trimester

REVIEW IMMUNISATIONS FOR ALL

Catch up immunisations – use PHE schedule for individuals with uncertain or incomplete immunisation status[2]

- DTP,MMR, Men C if >10 years old
- HPV females (born on/after 1/9/91), males (born on/after 01/9/06) until 25th birthday
- Check schedule if <10 years old
- Consider Hepatitis B vaccination if at risk[3]
- Cannot give MMR to pregnant women, if non-immune to rubella, for MMR after delivery of baby

Facilitate Covid and Influenza vaccinations as needed if appropriate.

NATIONAL SCREENING PROGRAMME

- Offer Cervical screening to women aged 25-64 every 5 years

CAVHIS adult screening

Cardiff and Vale Health Inclusion Service Initial Assessment Screening Protocol for asymptomatic children

All children >2yrs to receive a stat dose of Albendazole 400mg for treatment of parasitic infection as per PSD.

All children <5yrs to receive a supply of multivitamins

BLOOD TESTS FOR ALL	TB SCREENING
FBC Iron Studies Haemoglobinopathy Screening (Request and lab to process if MCV <80 and/or MCH <27) U&E LFTs Ferritin Vitamin D HIV Hepatitis B Hepatitis C Syphilis Strongyloides[1] Schistosomiasis[1] Trypanosoma Cruzi (Chagas) if from Central or South America[4] If venepuncture failed at second visit to CAVHIS then liaise with Starfish. Give patient completed request forms, including IGRA bottles, to take to their Starfish appointment.	**Screen for symptoms of active TB**: • Persistent cough for >3 weeks • Coughing up blood • Fever • Night sweats • Significant weight loss • Enlarged lymph nodes If symptoms present consider active TB, Request CXR and refer to TB team. **Asymptomatic Screening:** • <2 years - Mantoux Test • >2 years - IGRA Bloods • No hx BCG or visible scar – Mantoux Test **Children from a country with high incidence of Multi-Drug Resistant TB**: • >11 years – CXR
	Stools for Ova, Cysts and Parasites
	Height & Weight
	Consider urine Chlamydia/Gonorrhoea NAAT if history suggests appropriate

REVIEW IMMUNISATIONS FOR ALL

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- Check schedule if <10 years old
- Consider Hepatitis B vaccination if at risk[3]
- Facilitate Covid and Influenza vaccinations as needed if appropriate

All vaccine DNAs need to be contacted and re-booked if still in Cardiff IA

CAVHIS paediatric screening

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Cardiff and Vale University Health Board

CAVHIS

CAVHIS Homeless Service

OUTREACH: Homeless nurses based in frontline hostels with cover to other hostels and street outreach. Monday-Friday.

- Direct clinical care
- GP clinic every Monday-Friday morning
- GP support from CAVHIS hub
- Council MDT (substance misuse, dietician, OT, mental health, counselling)
- Link with other services e.g. GP practice, secondary care, substance misuse, district nurses, wound care team
- Community Dental Service – once weekly homeless outreach clinic at hostel (not part of CAVHIS)

EU INREACH: Homeless nurse based in Emergency Department, UHW Monday-Thursday

- Referral from EU staff, ward staff, homeless nurses, hostel staff
- Advocacy
- Holistic approach
- Hospital bag scheme
- Housing needs
- Link with psych liaison, substance misuse, infectious disease team, hospital discharge team, acute pain team, trauma clinic
- Link to homeless outreach nurse and GP for follow up on discharge
- Teaching – staff induction

Internal evaluation of current service

What works well?

- Good links and communication between services
- Teamwork
- Proactive management of patients
- Flexible provision of care
- Time
- CAVHIS specific clinics

Gaps in the service

- Asylum seekers out of initial accommodation
- Homeless patients currently registered as temporary
- People released from prison (from December)
- People engaged in sex work
- Gypsy, Roma and Traveller community

Diolch
Thank you

Heledd Jones

GP and Assistant Clinical Director CAVHIS

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Introduction to Health Inclusion : why it matters?

Webinar

19th June 2024

Health Inclusion Service

Primary and Community Care Division
Aneurin Bevan University Health Board
Senior Nurse Star Moyo

Who are we?

- A nurse led service based in Newport covering the 5 health Board Boroughs
- The team consists of Mental Health Nurses, Registered General Nurses, Health Care Support Workers and a team administrator
- We support vulnerable groups including asylum seekers, refugees, the homeless, those engaged in sex work and the gypsy Romany/traveller communities
- The service provides person centred support to those who find it difficult to access healthcare in a traditional manner because of barriers they face. These include language barriers, chaotic lifestyles, poor mental health and a lack of understanding how best to access services

History of the service

Prior to HIS being established there was only nursing asylum seeker provision in Newport Borough

July 2020

A service redesign followed to cover the entirety of the ABUHB locality (Pan Gwent) and encompassed all the groups we now support.

Initially started as 1 nurse, 1 part time HCSW and 1 part time administrator.

Team now consists of a Senior Nurse, a Mental Health Nurse, 2 General Nurses, 3 HCSWs and a team administrator.

What do we do?

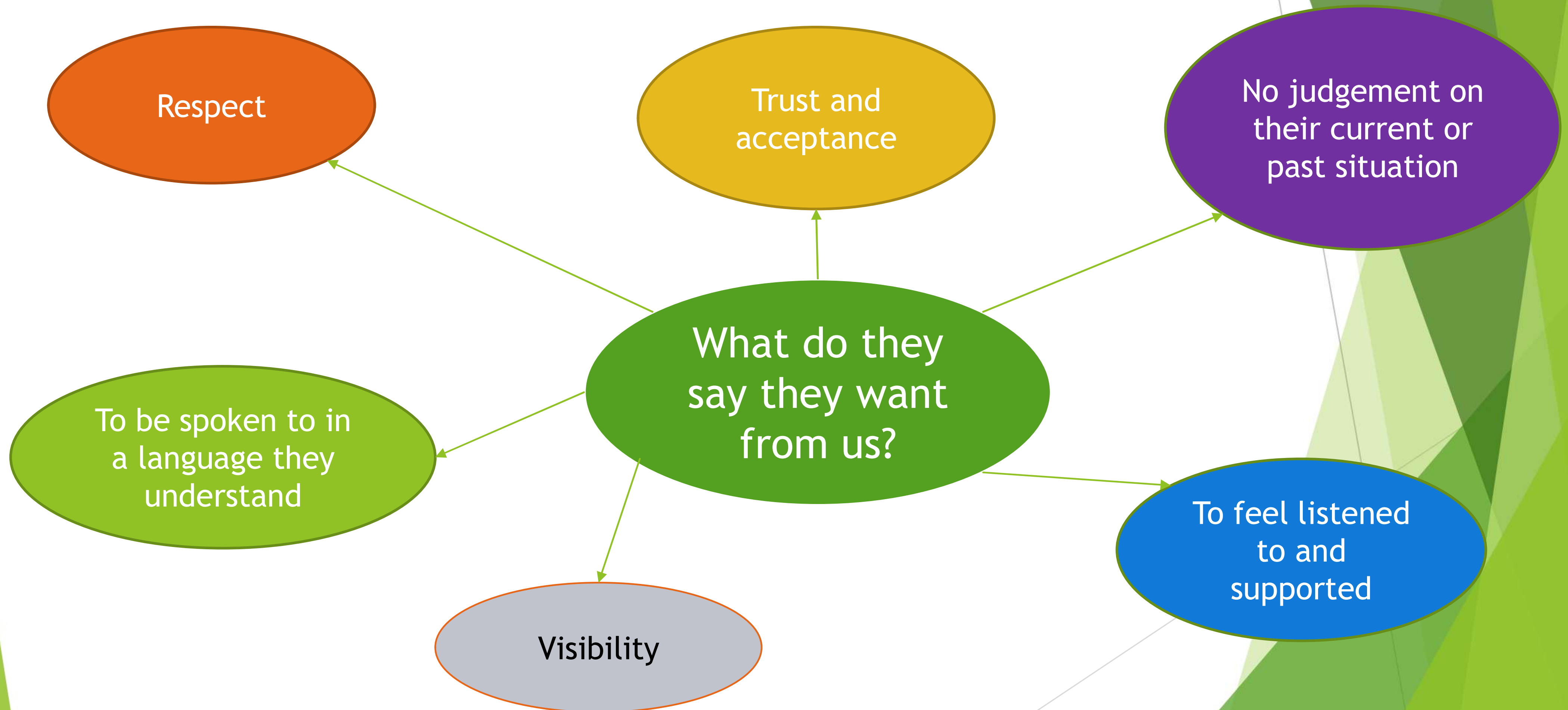
- Work with vulnerable individuals across the client groups to ensure inequalities in health are addressed and that those individuals are supported and empowered to access healthcare
- We work with many charity and 3rd sector organisations to ensure joined up working and best multi agency working to try and ensure the best outcomes for those in our care
- Provide initial health assessments for all asylum seekers arriving in ABUHB. This includes ensuring registration with a GP and a holistic assessment of physical and mental wellbeing
- We are also able to undertake complex assessments of physical and mental health for other groups to inform care planning. Often meeting these patients through assertive outreach or “drop in” clinics

Statistics

Database held since July 2020

- Asylum Seekers 1425
- Refugees 272
- Homeless 260
- Roma travellers 11
- Sex workers 3
- Ukrainian Refugees 274
- Afghan Refugees 57

Voice of the Service Users



Pictures of some of our work!

Benefits of the Team

- Holistic approach to care needs and planning
- Team trained in therapies and can deliver a person-centred approach
- Trauma informed approach
- Strong inter agency working relationships
- Advocacy
- Wide range of knowledge, experience and skills

Case Study 1- Miss Z

Miss Z was seeking asylum and was moved to Newport. The referral was sent through a partner agency- Clearsprings Housing

Presenting problems:

Severe trauma, malnutrition and poor mental health

- Miss Z was assessed by HIS HCSW and referrals made to appropriate agencies including dental, BAWSO, dietician, GP and she commenced counselling.
- Through continued support and engagement with HIS she grew in confidence. Took up ESOL lessons and joined her local church group.
- She is now working part time for a care agency and is in the process of training to be a mental health peer supporter within the church group.
- She now positively impact our community and has a bright future. Telling our HCSW “I want to be just like you”

Case Study 2- Mr A

Mr A was a homeless gentleman bought to the attention of HIS by Salvation Army and seen at HIS drop in clinics

Presenting problems:

confusion, loss of speech and eviction from his temporary accommodation due to the smell of urine

- Mr A had prior admissions for confusion which did not resolve in hospital and self discharged
- Multiple calls made to 999 by concerned members of the public regarding his welfare as sleeping in puddles
- Admitted to hospital through flow centre but self discharged. Returned by police and following an MDT instigated by HIS was placed under a DOLS
- Investigations including CT head had been undertaken and were normal, however no MRI had been performed. His trainee ANP acted as advocate for Mr A and requested MRI
- MRI concluded frontal-temporal degeneration and Mr A's lack of speech, incontinence and poor balance was then explained
- Mr A remains safely in hospital, awaiting appropriate discharge planning taking into account his individual needs

Some of the Feedback received from our clients so far

“You made me feel normal”

“thank you for listening”

“A big thank you for all our Christmas it makes me and the children have the best Christmas this year”

“if it wasn’t for you, I would have still been on the streets I can’t thank you enough”

“You have blessed my life”

Are we there yet?

We still have a long way to go to maximise service potential, examples of what could be achieved include:

1. Accessible venue for the team in the community that is accessible for the communities that we support
2. Further diversity in the workforce to improve trust and increase engagement
3. Increase in workforce to be able to reach more people in our client groups
4. Imbedding of Inclusion Health into strategic planning as one of ABUHB priorities
5. To have more service visibility with GP practices, hospitals, mental health services and education establishments
6. To start looking at pathways for Unaccompanied asylum-seeking children and leaving care pathways
7. Robust data analysis to support future service development/redesign

Meddygfa
Oakfield Street
Surgery

A nurse-led homeless service – learning curves and success stories

Dr Rebecca Bullingham

Advanced Nurse Practitioner

***Email:* Rebecca.bullingham3@wales.nhs.uk**

Oakfield Street Surgery, Ystrad Myanch, Caerphilly.

People experiencing homelessness
are not ‘hard to reach’

Services are ’hard to reach’ for
people experiencing homelessness

McNeill, S., O’Donovan, D. & Hart, N. (2022)

Why was the service created?

We were approached by statutory homeless services in the area

- **Homeless residents with worsening health**
- Untreated wounds
- Mental health
- Public Health concerns
- Preventing their housing options
- **Difficulty in accessing primary care**
- No address
- No telephone to make appointment
- Illiteracy
- Reluctance to attend due to past experience

Rydw i yma i gofrestru gyda meddyg teulu. Mae gen i'r hawl i gofrestru gyda meddygfa a chael triniaeth.

- **Gall unrhyw un yng Nghymru gofrestru gyda meddyg teulu i gael triniaeth**
- **Does dim angen imi gael cyfeiriad sefydlog na dull adnabod**
- **Gall unrhyw un yng Nghymru sydd wedi cofrestru gyda meddyg teulu gael presgripsiwn am ddim**
- **Mae gen i'r hawl i ofyn i ddarparwr gofal iechyd am gyfieithydd, a'r hawl i gael y gwasanaeth hwnnw HEB UNRHYW GOST.**

I am here to register with a GP. I have the right to register and receive treatment from a GP practice.

- **Anyone in Wales can register with a GP for treatment**
- **I do not need a fixed address or identification**
- **Anyone in Wales registered with a GP can get free prescriptions**
- **I have the right to request and be provided with an interpreter by healthcare providers AT NO COST.**

Os oes gen i unrhyw broblemau, gallaf ffonio **111** yng Nghymru (rhif ffôn am ddim) neu **0845 46 47**.

Os byddaf angen rhagor o wybodaeth gallaf fynd i: **https://111.wales.nhs.uk/default.aspx?locale=cy** a **https://noddfa.llyw.cymru/iechydalles**

- ○ **Efallai y byddaf angen help i lenwi ffurflenni.**
- ○ **Efallai y byddaf angen help i ddarllen a deall.**
- ○ **Hoffwn siarad gyda rhywun yn gyfrinachol.**

If I have any problems I can call **111** in Wales (which is free to call) or **0845 46 47**.

If I need more information I can visit: **https://111.wales.nhs.uk/** and **https://sanctuary.gov.wales/healthandwellbeing**

- ○ **I may need help filling in forms.**
- ○ **I may need help reading and understanding.**
- ○ **I would like to speak to someone confidentially.**

- **Application for inclusion in a list of patients**
- (Clause 173)
-
- 173. Subject to clause 174, an application for inclusion in the *Contractor's list*
- *of patients* must be made by the applicant, or a person authorised by the
- applicant, submitting to the Contractor an application form (including an
- electronic application form). The Contractor must not make proof of
- identification or address a prerequisite for an applicant to be included
- in the *Contractor's list of patients* (or make an application conditional upon
- the production of such proof of identification or address).
-
-

Do we have many homeless residents in Caerphilly?

Background

Caerphilly homeless demographic: 2021

Categorization of homelessness	Current known number of people
Bed and breakfast	121
Emergency unit for homeless	44
Temporary housing young people aged 16-24	38
Rough Sleepers	35
Emergency accommodation for domestic violence – women and children	21
259	

2024 - 760

Accommodation filled to capacity with a waiting list

Background continued..

- Top 5 (5/20) most populated districts in Wales
- Consistently one of the top two most deprived areas of Wales
- No direct service access for homeless residents
- Relies solely on outreach services

No dedicated healthcare access for homeless patients in the borough

What we did

- Consulted with **homeless agencies** “what do you need”
- Consulted with **homeless residents** “what do you need”
- Approached health board for an **‘enhanced service’** status
- Formed a separate pathway within the practice for **easy access**

Whole practice approach!

Access with a ‘can do’ attitude

- No VIP’s **Anyone** can refer a new homeless patient – agencies have direct number and email.

- Brief details taken, assessment slot allocated within 1 week.

- Urgent and emergency issues seen within 24 hours (Monday-Friday).

Registration and Assessment

- Patient attends and **registers as permanent patient**. Help is given if needed.

- C/O address often used.

- Previous GP contacted (if applicable).

Registration and Assessment

- An adapted electronic version of the **Queens Nursing Institute homeless assessment used:**

Past (Previous medical history, family health, mental health, drug use, social issues, violence)

Present (physical health issues, blood profiling inc BBV, family health, mental health, drug use, social issues, violence)

Future (Health plan, referrals, vaccinations, social plans)

Aim for a **'one stop shop'** consultation.

GMS service access

- Detailed assessment on records – **no need for patient to repeat history.**

- Immediate issues usually dealt with which **reduces lengthy GP follow ups.**

- Plan of action on records (if applicable) for **continuity of care.**

- Access GMS services as needed, care agencies can book using dedicated line if needed.

Service stats

- The service has facilitated over **233 new patient assessments in 45 months –**

  > 5 a month

- We have **95 homeless patients currently registered (over 40%)**

- The **majority** of the static case load are regular **rough sleepers**

- Over **95%** of all assessed patients are **survivors of violence**

- Over **75%** of the patients are using **mental health medication**

- **Most have not accessed primary care** services **effectively** prior to registration

- **Blood borne viruses, diabetes, cancer, cardiac** and **genetic disorders** are a few examples of health issues identified amongst patients.

A **55yr old lady** street homeless and sofa surfing for nearly **10 years**. Previously **not engaged well with primary care,** attended the service due to increased breathlessness and fatigue. The assessment identified a **family history of cardiac disease and a young mortality rate**. It also identified a low pulse pressure with a Blood Pressure of **128/100 and an irregular heart rate**. Further blood profiling identified a **total cholesterol of 8.9 mmol/l (unchanged when repeated fasting) and vitamin D deficiency of 19 nmol/l**. This patient was referred and **seen by cardiology**, medicated appropriately and was found to have **several cardiac complications** that she would likely have had for many years. She is **now stable** on her medication, **engaging well with health services** and is making a conscious effort to amend her lifestyle.

Patient story 2

25yr old rough sleeper:

- Tent burnt down 3 times.
- No family contact due to his behaviour.
- Briefly had a GP on a behaviour contract – no active contact as he felt ‘watched’ and ‘judged’.
- Regular A&E attendance.
- Buying diazepam to help with mental health and living situation. No contact with family due to behaviour.

Since engaging with our service.

- **Started on an SSRI and engaging well.**
- **No A&E attendances in 1 year.**
- **Engaging with family.**
- **Housed.**
- **Employed!**

Feedback

"This service is **allowing people back in to the general population** and back in to accessing key services. It's a ground breaking service and the **first of it's kind** in Caerphilly Borough"

Cornerstone Homeless Service

"The service offered by Oakfield street surgery has helped all our families a huge amount and they **are someone they can trust and rely on and always there** to help when needed."

Domestic Violence shelter

"This initiative really demonstrates the **strength of partnership working** and is helping to support our most vulnerable. The first of it's kind in the borough, **it has literally saved lives in some cases**"

Counsellor Caerphilly Borough

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Public Health Wales

Introduction to Health Inclusion : why it matters?

Thank you!

Webinar

19th June 2024