Calderdale Clinical Commissioning Group

NHS

Calderdale Council

Staying Well in Calderdale

Improving health in older people

Staying Well

Covering…….

- Aims of the pilot
- Balanced assessment so far
  - wisdom of hindsight!
  - successes
- Initial evaluation findings
- Ongoing challenges
- Components of success
- Sustainability
- Voices of users

Staying Well

Aims of the pilot

1. Reduce loneliness and social isolation in Calderdale and positively impact on:
    a) Improving the health and wellbeing of individuals and communities, including reducing health inequalities
    b) reducing demand on GP practices and unplanned admissions to hospital
2. Create more connected communities
3. Improved inter-sectoral / systems working
    - Health
    - Social care
    - Neighbourhoods
    - Communities
    - Voluntary organisations

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Balance sheet

- Staying Well recognised as a brand
- Reaching older people across Calderdale
- Role of workers - navigators
- Leading role of hubs
- Building on community assets: micro-commissioning
- More groups and activities supported
- Mutual support between hubs

- Underestimated time to get off the ground
- Late start of social prescribers in GP practices
  - supported 30 people
- Slow referrals from primary care
- Digital challenges are challenging
- Too many cooks in decision-making?

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Wisdom of hindsight!

- Longer lead in time - takes time to build relationships
- More devolution to hubs earlier - recognition of their skills, capacity and uniqueness
- Braver in making decisions
- Different model of social prescribing
- Need to build and develop trust and honesty

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Success stories

- HOT
  - 1 new and 4 existing groups/activities
  - 82 opportunities created for individuals
  - Befriending project funded with 12 volunteers
- North Halifax Partnership
  - 9 new and 10 existing groups/activities
  - 314 opportunities created for individuals
  - Befriending project funded with 12 volunteers
- Elland District Partnership
  - 6 new and 10 existing groups/activities
  - Befriending funded
  - Transport trial
- Hebden Bridge Community Association
  - 36 new and existing groups/activities
  - 128 new opportunities created for individuals
  - 10% increase in sessions at Town Hall (June-Oct)
- Calderdale Help in Bereavement (CHiBS)

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What's worked for Hubs

Elland

- More connected community
- More diverse provision
- More awareness of issue of loneliness and social isolation

Halifax Opportunities Trust

- Through a hub based model listening to the community to find out their needs and then formulating solutions together
- Having a local and welcoming hub space
- Improved and proactive engagement and support provided to isolated and lonely clients who would most likely not seek or access support

Hebden Bridge

- encouraged statutory bodies, community groups, the voluntary sector, businesses and individuals to undertake partnership working and deliver a collaborative community project
- invested in new and developing activities for vulnerable adults in the town and supported the people that deliver the work.
- Given the Hebden Bridge Community Association an opportunity to support unmet needs of the client base and develop community support networks to ensure long term engagement

North Halifax

- Development of a local Hub and Health Alliance that encompasses anyone who lives works or volunteers - a clear local vision that *together we are stronger…*
- Local delivery plan with clear objectives and local communications plan. Good communication within the Hub.
- Integration of SW worker and NST worker within Neighbourhood Team and with co-located services

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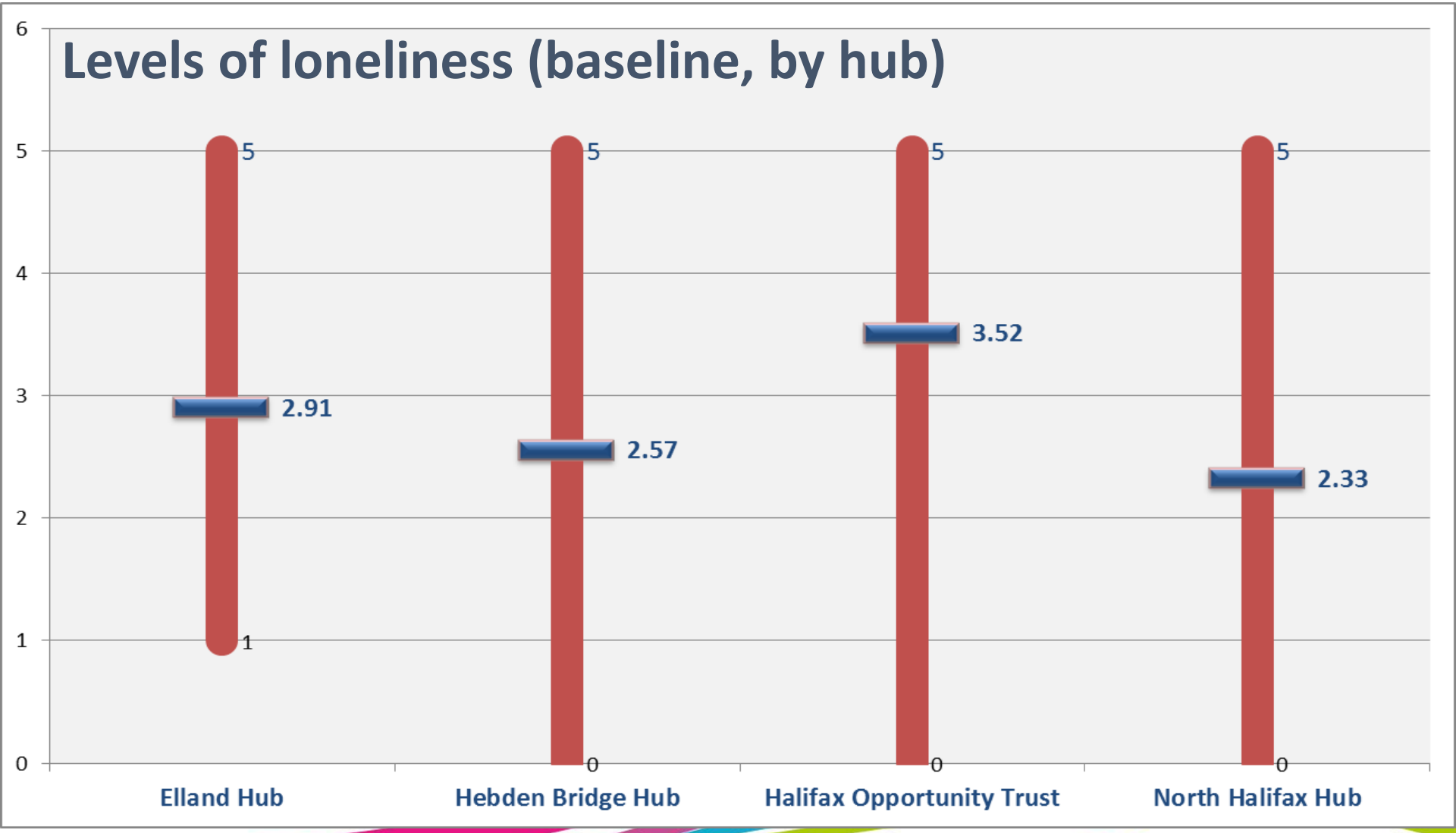
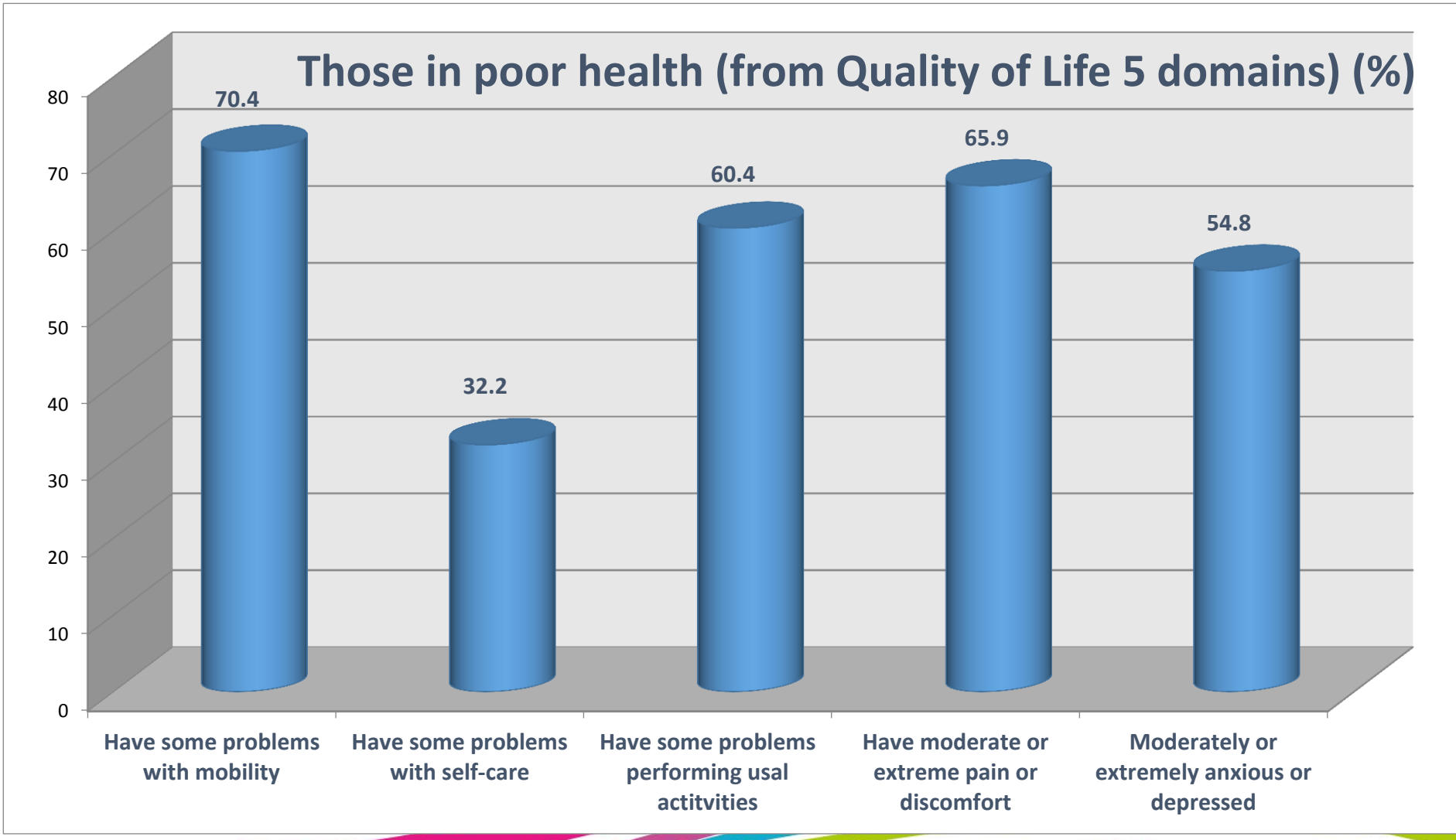
Initial evaluation findings (1)



Staying Well

Initial evaluation findings (2)



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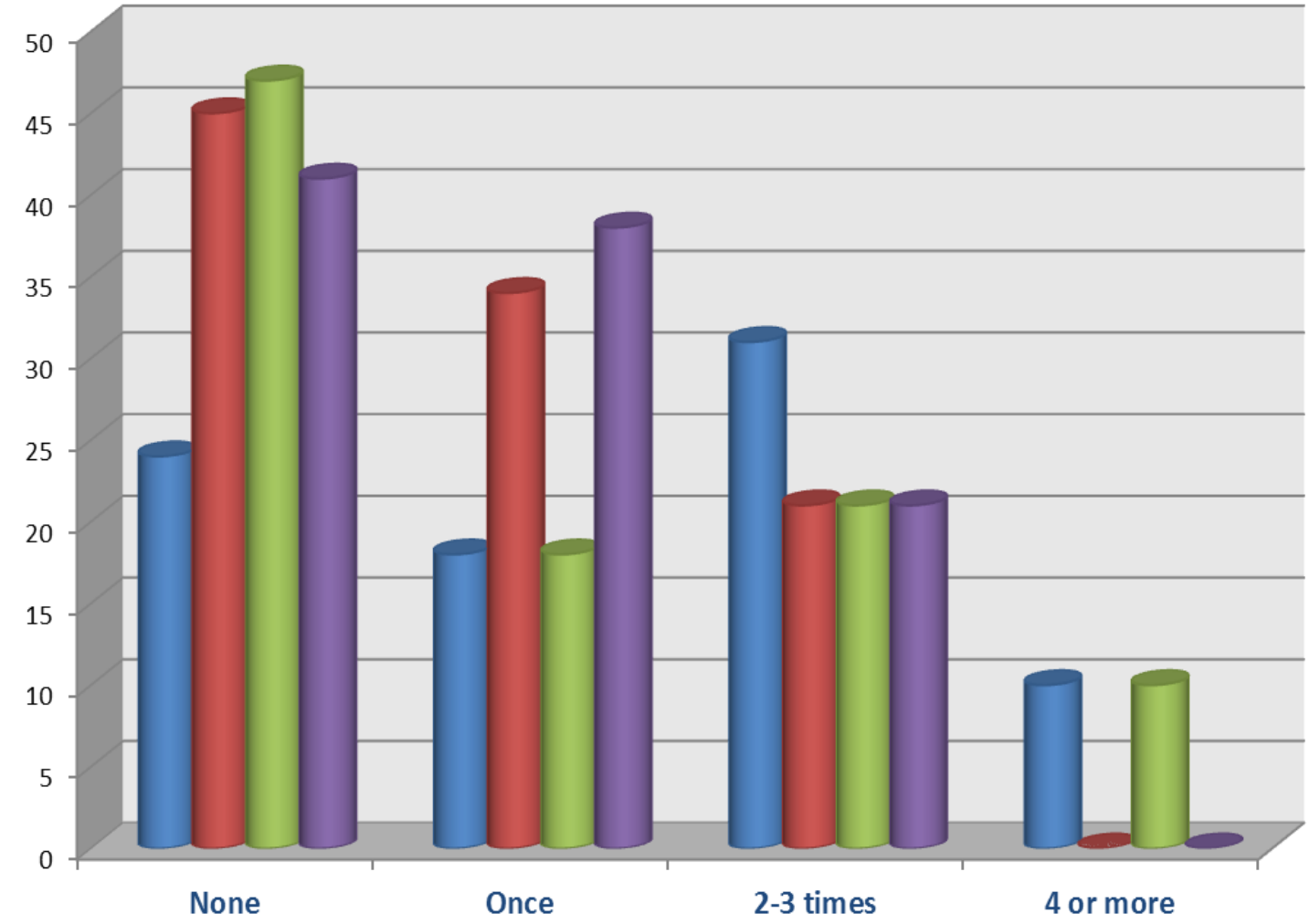
Initial evaluation findings (3)



GP service use by hub (%)

- Elland
- Hebden Bridge
- Halifax Opportunity Trust
- North Halifax

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Initial evaluation findings (4)

- Those living alone healthier than those living with relatives
  - possibly ill-health necessitated living arrangements
- (Not surprisingly) healthier respondents at lower risk of social isolation
- Those extremely anxious or depressed at greater risk of loneliness and social isolation
- Some evidence of more connected communities and more interconnectedness
- Too early to assess whether isolation and loneliness reduced or reduced demand on GP services

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On-going challenges

- After 11 months, building up momentum and referrals
  - takes time to establish
- Significant proportion of referrals people with complex needs from existing agencies
- Self referrals more appropriate to original target population
- Embedding co-production into the project
- Supporting primary care

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Components of success (IBM visit)

• Community need	**Yes**
• Community resources	**Yes and no**
• Community and Council	**Improving**
• Community leaders	**Yes**
• Community driven initiatives	**Yes**

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Sustainability

- Project extended to March 2016
- Evaluation extended – for more data
- Who do we focus our efforts on?
- What do we do more/less/differently?
- Who else do we need to work with?
- Consideration of alternative funding
- **Appetite and determination to continue**

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……. and not least

- Voices of users