Calderdale Clinical Commissioning Group

NHS

Calderdale Council

Staying Well in Calderdale

Reducing social isolation and loneliness in older people

Staying Well

Today

- Share findings of the independent evaluation
- How Staying Well has been working in one area
- Successes and ongoing challenges
- Where next?

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A reminder – the 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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‘Staying Well in Calderdale’ : Draft Final Report

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‘Staying Well in Calderdale’: Final report

- Overarching objectives
- Methods
- Activity across the hubs
- Changes in:
  - loneliness
  - Health-related quality of life
  - GP appointments
  - Inter-sectoral working
  - Connected and cohesive communities

Overarching objectives

- **Primary objective(s)**
  - Reduction in loneliness and social isolation
- **Secondary objective(s)**
  - Improving individuals well-being (measured through health-related quality of life, health status, health state and quality of life).
  - Reducing inappropriate primary care use.
  - Strengthening cohesive communities.
  - Strengthening inter-sectoral working.

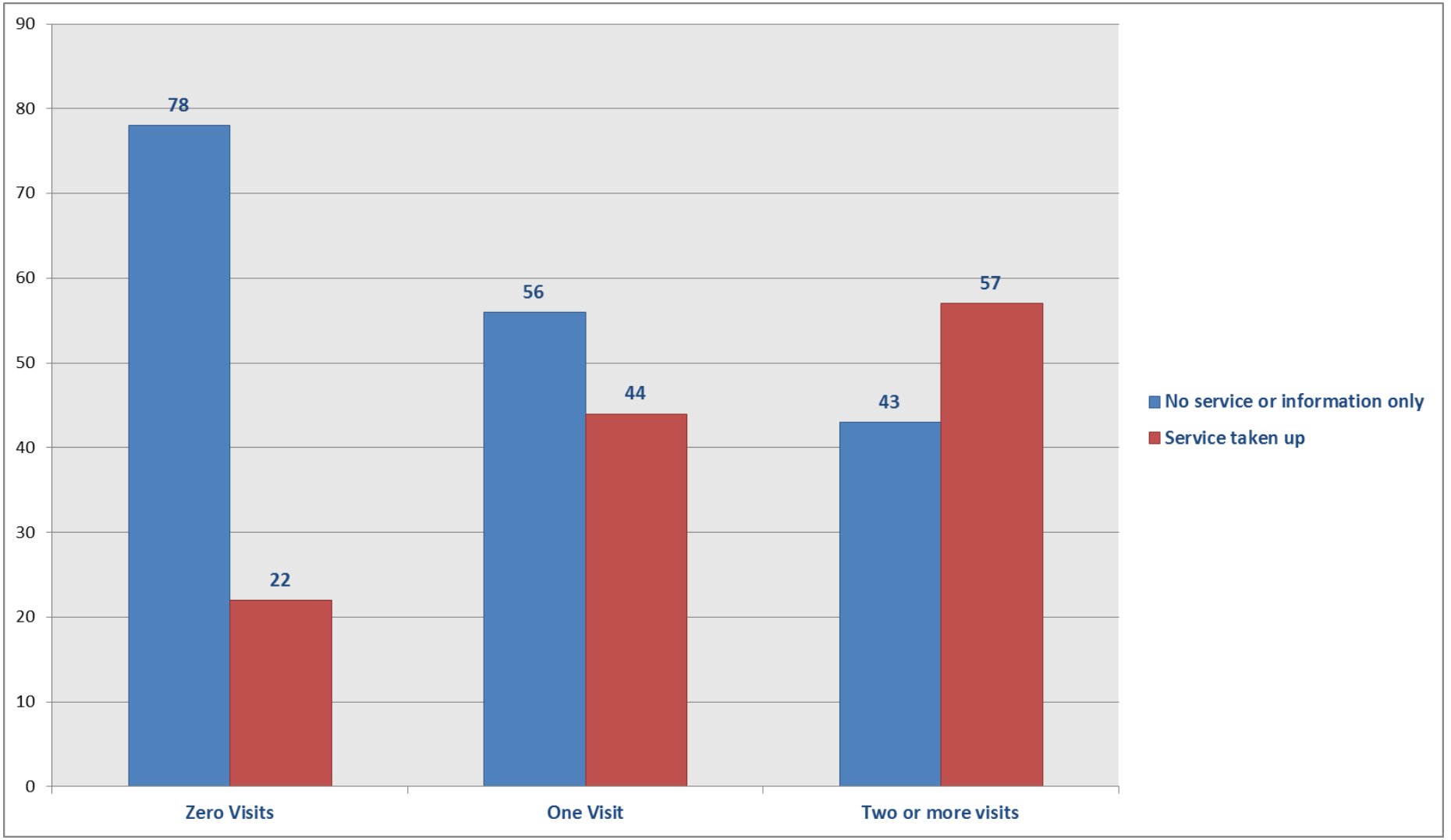
Methods

- Multimethod approach:
  - Interviews with strategic and operational staff over three time points (n=83)
  - Process mapping exercise (four hubs, social prescribing, n=19)
  - Secondary data analysis user records (n=799)
  - Structured questionnaires at two time points (n=378)
  - Financial records (Programme and hubs)

Activity across the hubs

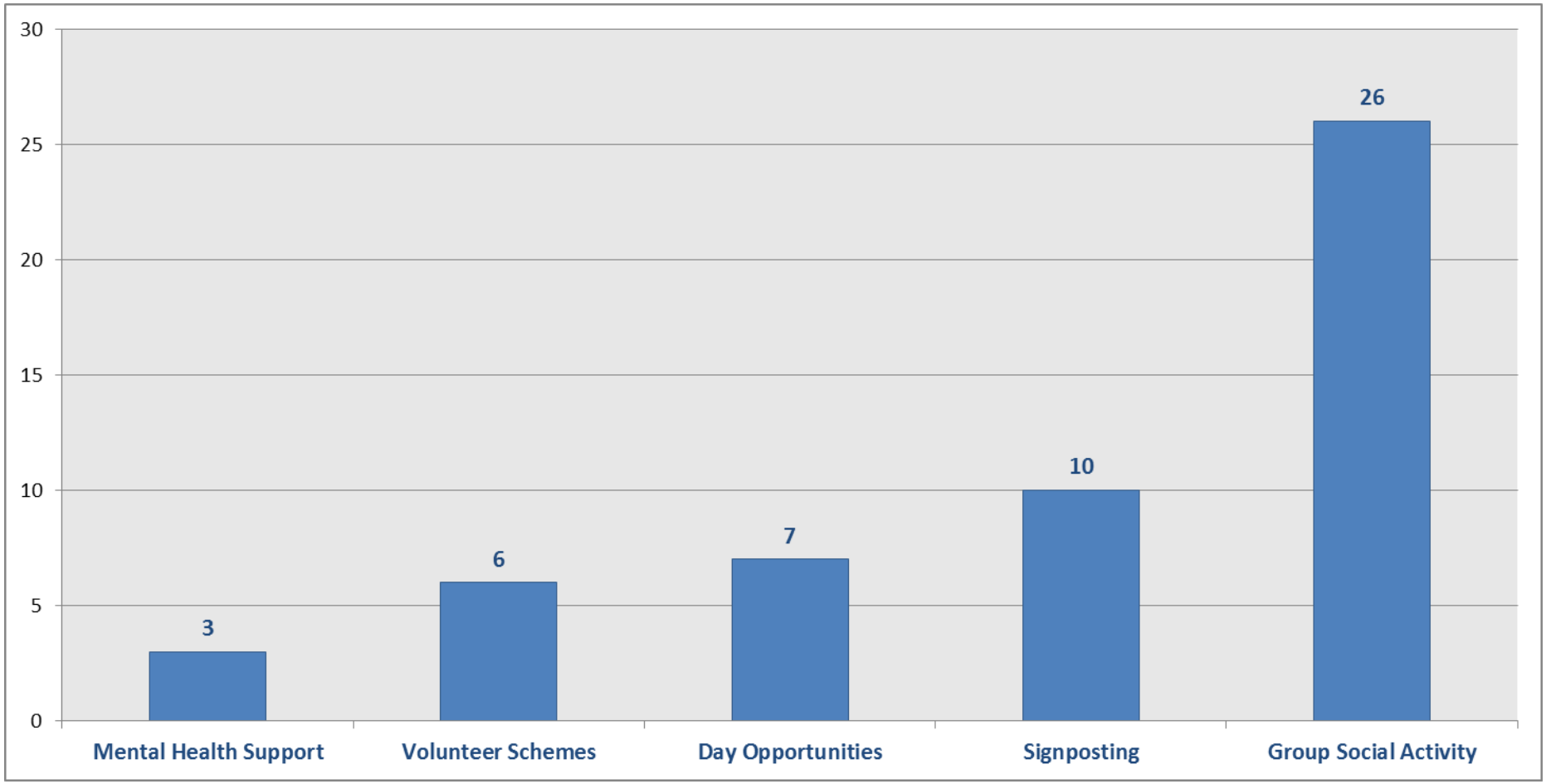
- 779 users referred to the programme (database).
- Almost the total sample (87%) reported (at least) one-long term condition.
- Over a third of users (37%) reported some form of cognitive or learning disability.
- Variations across the hubs included referral routes, ages, sex, cognitive impairment or learning disabilities.
- Number of ‘home visits’ to users varied across the hubs.
- Home visits took ‘on average’ 90 minutes
- Mean ‘activity’ (email, phone call, ad-hoc visits) per user was five (a total of 1,396 actions).

Number of home visits by ‘service’ take-up (%)



$\chi^2(2) = 18.729, p = <0.001$

Types of services users attended (%)

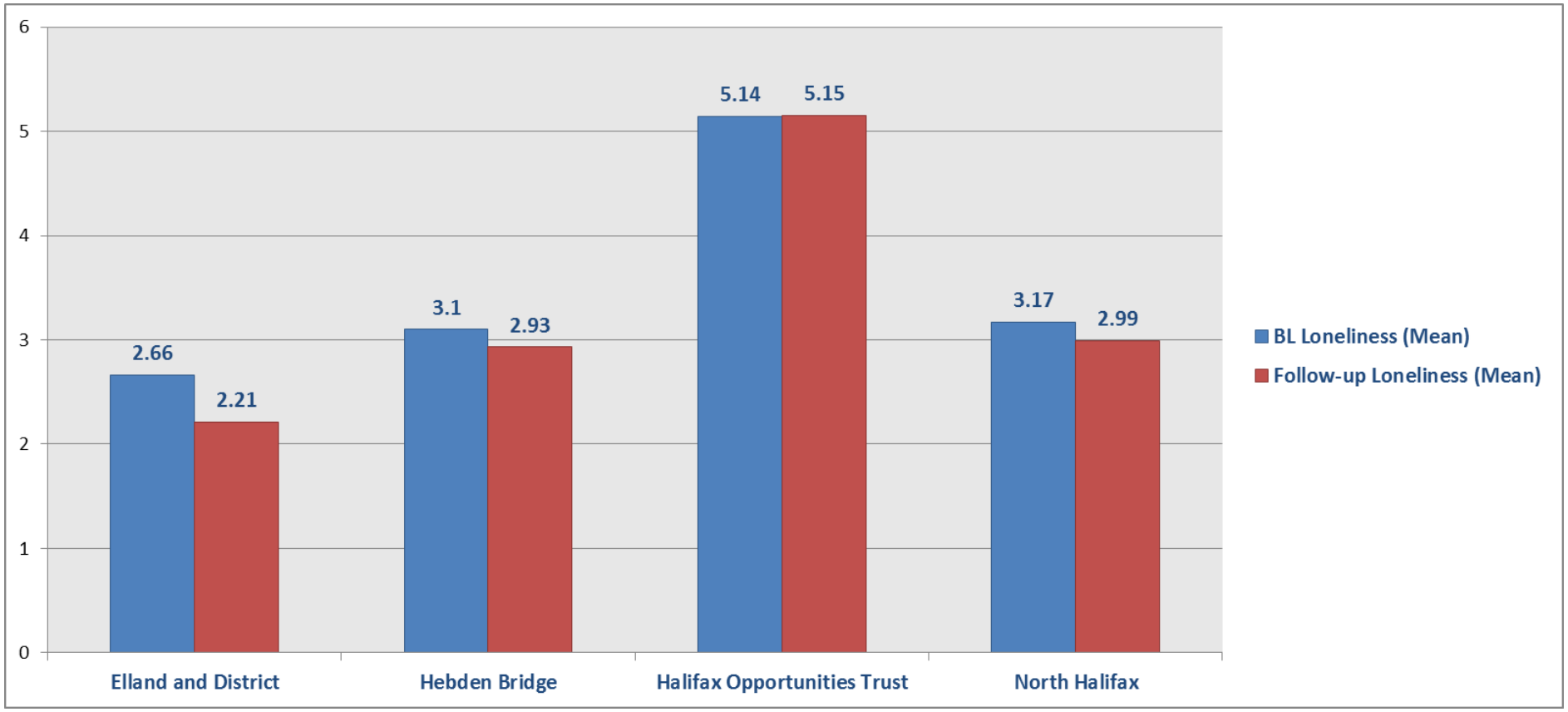


Development of local provision

- Micro-commissioning to extend existing groups and develop new 'provision'.

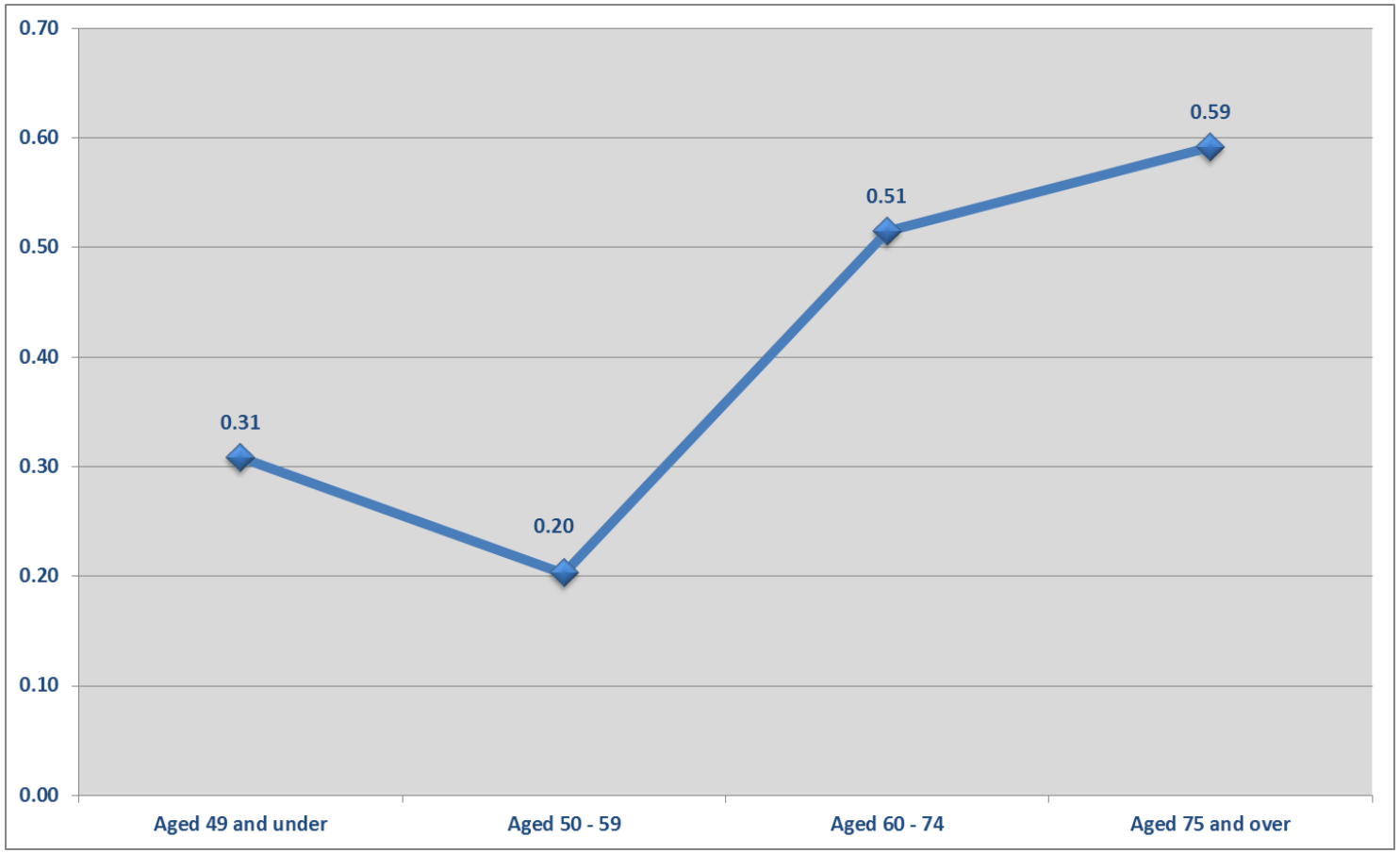
Hub	Support of existing community initiatives	New interventions
Elland and District	• Elland and District Partnership: including 'All about Elland' market. • Prospect House Social Club: to support four 'day trips' and address sustainability of the group • Elland Tuesday Club: to support 'day trips' and sustainability of the group. • Able and Disabled Club: to support funding of coach hire and sustainability of the group. • Cartwheel Lunch Club: new equipment and the employment of a carer at each session to ensure those with higher level needs could attend. • Bethesda Ladies Group: support to link members to community transport and a range of events. • 'Chit Chat Group' trips and music classes' • Clay House Park Gardening Group: funding for new equipment, financial and practical support to publicise and recruit volunteers. • Elland Golf Club T'ai Chi: initial support with marketing and funding of tutor hire. • Cross Hills Methodist Church: addressing transport issues and explore ideas for further social provision. • Community Transport Calderdale: to develop specific transport support in Elland, recruit volunteers and link together community groups.	• "It's Only Me Befriending': one-to-one befriending service for over 50s in Elland and surrounding areas. • 'Elland Transport': dedicated community transport service linked to social groups in Elland to provide free transport to and from community groups. • 'Dementia Reading Champions': providing sessions in a range of care settings (e.g., care homes, sheltered housing) and focusing on reminiscence through poetry and song. • 'Let's Just Do It for Elland': (Christmas): volunteer provided Christmas dinner. • 'Adult Brass': beginner's lessons for older people to take up an instrument. • 'Cake and Company': Coffee morning. • 'Staying Well trip's: Six assorted trips throughout the year including e.g., theatre, flower shows, concerts. • 'Church House Games afternoon': weekly games activity. • 'Southgate Holiday at Home': three days of activities themed around different holiday destinations. • 'Restart Fitness': weekly exercise group for female cancer patients/ survivors. • 'Diabetic Support Group': weekly support group for diabetics. • 'Staying Well Games Morning': weekly games morning. • 'Sing Out Loud': fortnightly singing group for individuals living with dementia. • Wheel Chair Enabling Society: peer to peer support across the group and for those with disabilities.

Project aims: Changes in loneliness (hub)



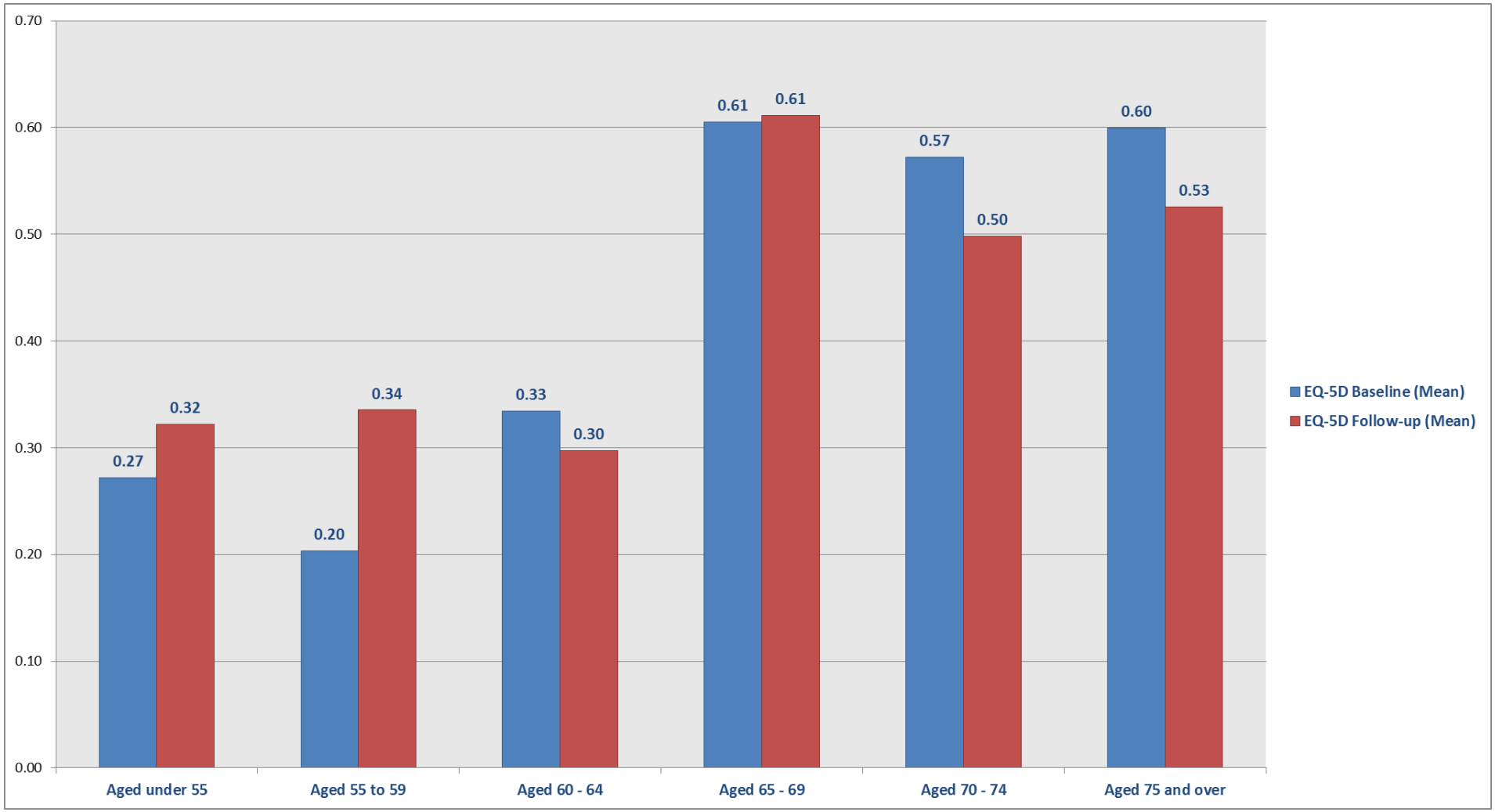
Elland and District hub (*t*(41)=2.215, p=<0.04)

Health-related quality of life



Age Range of User	Overall Population	Staying Well' in Calderdale
Aged 55 - 64	0.80	0.20
Aged 65 - 74	0.78	0.57
Aged 75 and over	0.73	0.59

Project aims: changes in health-related QoL by Age



Changes in primary care service use

- An increase in the number of GP appointments was seen following the intervention; BUT

Number of GP appointments	Number of Long-term conditions (mean)*	IMD Rank (mean)**	Total loneliness Score (mean)***
Zero appointments	1.73	14856	2.77
One appointment	1.95	12684	3.75
Two or more appointments	2.5	9453	3.98

* $F(2) = 3.62$ $p = <0.03$ ** $F(2) = 6.42$ $p = <0.003$ *** $F(2) = 5.62$ $p = <0.005$

Changes in GP service use

- Loneliness did not seem to be a factor in attending the GP
  - Those with a higher number of long-term conditions were 1.4 times as likely to attend two or more appointments (p=<0.03)
  - Those from deprived areas were 1.6 times as likely to attend two or more appointments (p=<0.002)
  - Those with a higher EQ-5D SCORE (better health) were 84 per cent less likely to attend two or more appointments (p=<0.05)

Improved inter-sectoral working

It [the Staying Well Programme] has enabled other organisations who once wouldn't have crossed paths to now be working together'.

'if nothing else it [the programme] will have enhanced the understanding and the skills we have with the group of partners. Good networks and infrastructure has been established that will help further and future partnership working'

Has been and is still 'variable' at times. But, overall positive responses to achieving strengthened intersectoral working.

Connected and cohesive communities?

- Effective micro-commissioning.
- Identifying and supporting existing community projects, enabling each to 'know' the other and work together.
- Involving community organisations and organisers on each hub 'Steering Group'.

'there were many groups that existed in isolation.. What we've been able to do through the 'Staying Well' programme is to get them working together. And, when you have people working together, everyone delivers their best. That is what 'Staying Well' has allowed us to do. Whatever happens with the funding, we will have had a long-term impact here'

In conclusion…….

- The ‘Staying Well’ programme as a ‘brand’ is well-recognised and accessed across the different localities.
- The ‘Staying Well’ project workers were successful in identifying lonely and socially isolated individuals.
- The continuing lack of GP engagement limited the numbers of referrals and impacted on the rate of referral.
- The micro-commissioning exercise was particularly effective.
- The ‘Staying Well’ project workers provided efficient, effective and long-term support to users.
- The innovative accompanied visits alongside users ensured individuals could ‘test out’ a range of activities and opportunities.
- Positive changes for some users were found across a number of outcomes: loneliness, health status, inter-sectoral working and community cohesion.
- All those indicators not yet achieved are in the right ‘direction of travel’.
- It is recommended that the programme is continued.

Successes

- Reducing loneliness and social isolation and reaching those at greatest risk
- Staying Well recognised by agencies / public
- Integrated role of Staying Well and Neighbourhood Scheme team workers
- Building on community assets through micro-commissioning
- Crucial role of hubs in leading the work and mutual support between hubs
- More groups and activities supported
- Improved cross partner working

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What's worked for Hubs

Elland

- Having a central worker in the community to help bring together groups, projects and initiatives – facilitating links and opportunities
- The establishment and development of a community steering group who influenced project delivery on a local level
- Micro- commissioning – having a fund allocated and influence through local decision making

Halifax Opportunities Trust

- Created a social space for isolated/lonely people to access and successfully engaged hard to reach individuals & enabled diverse communities to come together to tackle isolation and loneliness
- Taken a user led approach to micro commissioning funding in designing & delivering solutions that work locally
- Developed an advisory function to allow lonely and isolated people access support from a range of relevant services

Hebden Bridge

- Micro-commissioning led to increased activities to reduce isolation and loneliness in our Hub and the Community by 72% and 44% respectively
- Community-led direction of the project has led to meeting this community's needs – making the point that one size doesn't fit all
- Even in an area with perceived low levels of IMD the project was effective in targeting those drawn from more deprived areas

North Halifax

- Community management of the design and delivery of the local pilot
- Co-location with locality neighbourhoods services (Ovenden & Mixenden Initiative, housing, police)
- Men's provision and involvement

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Voice from a hub: Elland & District

- Initial wariness from community – lack of anchor organisation and hub premises
- Importance of existing community organisers forming local steering group – local voice brought to the project
- Establishment and development of Elland ‘virtual’ Hub network –cross sector relationships
- Micro-commissioning guided by local steering group – focused on reducing barriers to social engagement as well as creating new social opportunities.
- Increased engagement from the community and increased social opportunities have meant more success stories!

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Continued challenges

- Started in November 2014 - took time to get going so not realised full potential
- Where able to reach people early (younger/fewer health conditions) made significant improvements
  - but also dealing with people with complex needs who already involved with services
- Not seen as a social prescribing model – need to sell it to health colleagues to get them involved better
- Uncertainty of funding – initially one year then extended several times
  - now funded until March 2017 for core activities
  - no current funding available for micro-commissioning
  - some support from Vanguard to develop roles
  - streamlining workers

Where next?

- Should Staying Well be continued past March 2017?
- Where do we focus our efforts?
- **Enthusiasm and commitment from all partners to continue:** *"Capacity is tremendous – but can do so much more"*

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