To: Community Care Health and Wellbeing Thematic Board

On: 25th October 2016

Report by:

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Community Connectors

1. Summary

In August 2015, Renfrewshire HSCP approved funding from the Integrated Care Fund (ICF) for four pilot projects designed as *infrastructure investment* projects, building capacity in the local third and community sectors to engage in health and well being activity. The HSCP's interim Integrated Care Fund Sub Group worked with four third sector organisations to develop the projects as a partnership pilot programme known as Community Connectors.

2. Recommendations

It is recommended that the Board

a) Notes the progress to-date and the need for work to connect people to non-medical sources of support and activities in the community as a means of preventative work.

3. Background

3.1 Community capacity-building in Renfrewshire

The ICF Sub Group and the four project lead organisations, in consultation with a wide range of stakeholders, identified key criteria for the Community Connectors programme which would demonstrate not only the delivery of high quality local services for people but build new partnerships and networks locally between all parties involved in, and concerned with, health and well being in local communities. These include:

- the development of partnership working, sharing responsibilities and resources in delivering coordinated support for local people
- developing further and promoting opportunities for local people and local organisations to become more involved in health and well being in their local areas

- building and strengthening partnerships between the local third and community sectors and the statutory health and care services, particularly with local GP practices
- developing sustainable models of services for long term impact in localities and communities.

Collectively, the pilots are the "Community Connectors" programme. Individually, they are known as:

Community Health Champions programme - recruiting, training and supporting local people in their communities to become community health champions, supporting local health and well-being activity and developing links between communities and local health and care services (partnership initiative in Linwood and Johnstone being led by Active Communities)

Community Link Workers programme – a pilot providing social prescribing in a number of GP practices to link patients with non-medical supports in their own communities (partnership initiative in Linwood, Johnstone and Bishopton being led by RAMH)

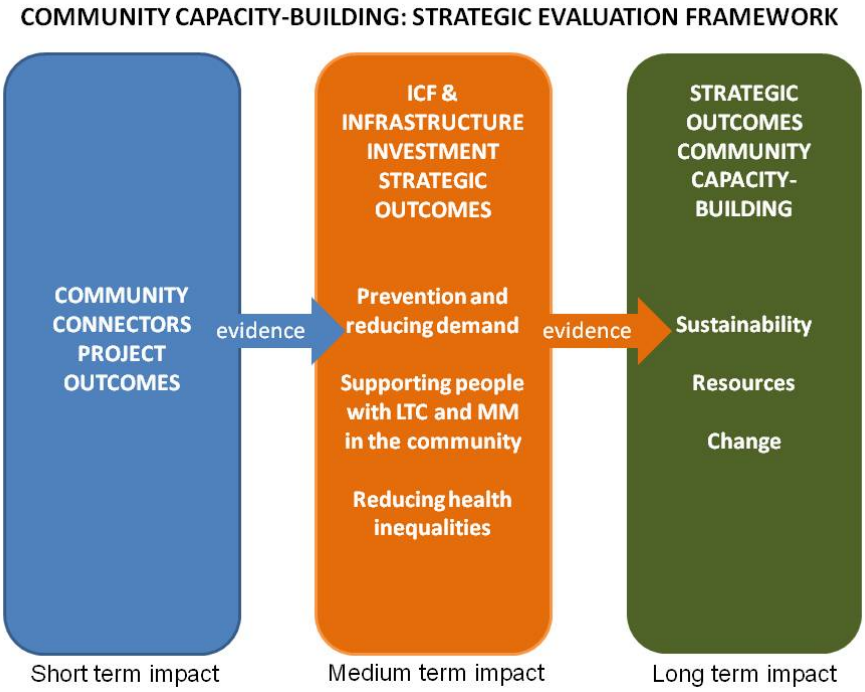
Housing and Health Information Access Points – piloting the delivery of access points of information for people about health and well being and health-related housing issues in local communities in points which the public are likely to use (Partnership initiative in Linwood and Johnstone being led by Linstone Housing Association).

Live Well, Stay Well Lifestyle Management Programme - support for people with long term conditions, setting up a pilot to test referrals from GPs, the Social Prescribing Scheme and other health and care providers into a structured self-management course and linking to local community supports (partnership initiative in Renfrew to be led by the Thistle Foundation)

3.2 Outcomes

The projects' impacts are assessed in terms of what lessons we will learn about how to support a wide range of stakeholders to be involved in future planning and delivery of health and care services in their localities. The three areas of interest are:

- Sustainability: the growth of viable locality-based networks and relationships around the health and care agenda in their areas
- Resources**:** what can we learn about the cost effectiveness of new ways of doing things
- Change**:** the potential for changes for improvement in service planning and delivery processes in localities



A strategic evaluation framework has been developed, designed to measure the collective impact of the four projects on the longer terms aims of the HSCP and the Integrated Care Fund. The Strategic Evaluation Framework will comprise quantitative and qualitative data and analyses measuring the impact of the programme through five sets of indicators:

- Levels of health-seeking/supporting activities in the local populations
- Levels of use of non medical supports to address health and well-being needs
- Levels of community-led health and well being engagement and action
- Potential changes to future service development and delivery processes
- Potential impacts on costs and cost effectiveness of preventative action in the community

Key elements of the Renfrewshire Strategic Plan 2016-2019 to which this evaluation will contribute are:

- Enable people to be better connected
- Support Tackling Poverty Programme
- Support and signpost to employment services
- Access to financial advice services
- Community capacity-building

3.3 Progress to date

To date the Community Connectors pilot project is progressing well with all targets either being exceeded or on target. Case studies are being gathered to give a qualitative picture and quantitative measures of success so far include:

- Community Champions recruited – 15 (annual target 10)
- Holistic Needs Assessment carried out (GP Social Prescribing) – 318 (annual target 60)
- People seen at the community hub – 67 (annual target 100)
- 2 Live Well Stay Well (long term conditions) practitioners in post and 58 referrals to-date (no targets set)

To best demonstrate the impact the service has had on individuals' situations, a number of case studies and qualitative information has been provided below. All the names have been changed to ensure anonymity.

Community Link Workers (GP Social Prescribing)
The service employs 3 Workers for 22.5 hours each week deployed at Johnstone, Linwood and Bishopton. Each GP practice has a dedicated, named worker. Each worker spends approximately 15 hours in the practice with the remaining hours supporting service users to engage and signpost and for admin tasks. The service in each practice is established, and feedback gathered from referrers is excellent.

The service has captured significant data with detailed outcomes and evaluation feedback. Outcomes recorded show that service users present with wide ranging issues, the highest needs being signposting to appropriate services and mental health issues followed by finance/budget issues.

The service works very closely with the 3 partner agencies and makes regular referrals, as appropriate to these services. However there are an extremely wide range of services which service users require. Significant signposting to the correct agency is an important outcome for this service, and gaps have been identified in community services to meet the needs and outcomes of service users, however the partner agencies have been able to respond to some of these, eg. buddying individuals to activities (Active Communities).

Anonymised case studies have been provided by the workers, however due to the sensitive and confidential nature of them the workers have requested that they are not shared at this time. It can be seen from the case studies that a wide range of interventions and supports are being utilised to improve the wellbeing and connections of individuals. Early findings from reviewing them demonstrates that while contacts with the practice may not change or may even increase initially, actual contacts with the GP practice appear to reduce and a significant number of the contacts are now with the Community Link Worker, rather than the GP or other practice staff.

Housing and Health Information Hubs
The Hubs provide local access to information and support across a range of issues that may be impacting on people's well-being. The Hub offers on site support re housing issues and also links people to other services such as financial advice, social and well being support groups, statutory and third sector services.

Case Study

Miss P was referred to us by the Link Worker based at her GP surgery. She is 22 years old and has one child aged 2. She is currently a Renfrewshire Council Tenant.

Miss P had a range of issues giving her concern, including dampness in her home and financial problems linked to a difficulties around tax credits, council tax and fuel arrears.

Her immediate desire was to move home.

The Hub staff acted on her behalf in chasing up housing issues and referring her to RAMH's financial literacy service and advised Miss P on how to deal with her fuel issues.

A follow up call was made to Miss P approximately a month later and a number of improvements had been made. While the dampness had not been resolved in her property as yet, repairs had been carried out to her windows and investigations into the dampness were ongoing.

Miss P had previously applied to Linstone for rehousing but following the support she was receiving decided to cancel her application as she actually would rather remain in her current property now that she feels the issues with repairs are being addressed.

Community Health Champions (CHCs)

Active Communities recruits, trains and supports local individuals to engage in and lead social and well-being action in a range of community based, fun-oriented group activities. It is successful in recruiting people across a wide range of age groups and backgrounds.

Case Study

Mr A came along to the 'Feel Good about You' (FGAY) programme having seen it advertised at one of the Johnstone Town Hall roadshows. He had a keen interest in walking/swimming and was at a loose end since retiring. He bonded well with other members of the group, and showed himself to be very personable. When we held CHC info sessions we asked if he would like to come along, he did and has become one of our most active CHCs. Mr A is now a busy volunteer across a number of community based activity and he has participated in a range of training events, including walking leadership and mental health awareness training. He is planning his future activities and is keen to develop programmes specifically aimed at men.

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CHC coordinator reports: “Mr A is a fantastic all-rounder. He is up for most challenges, gets on well with any group of people you introduce him to and genuinely seems to enjoy volunteering and training. He is of a good fitness level and his local knowledge of walking routes around the Johnstone area has proved invaluable to our walking group there. He has also brought to our attention some other groups in Johnstone which we have used to signpost people onto, and his knowledge of the area in general has proved to be very useful. He is also proving to be a very good ambassador for Active Communities and Community Connectors with the male population and especially those of retirement age – a notoriously difficult demographic to link in with. I see no end to Mr A’s potential in this role and consider him to be a real asset.”

Mr A says: “I was worried retirement would be a letdown for me. I was keen to maintain my fitness, but wasn’t sure how I would fill my days. Since getting involved with Active Communities I feel I have a new lease of life! It’s great to feel needed and that your experience counts for something. I have really enjoyed the training and volunteering and have made some great new friends, as well as meeting lots of different people when we are out and about. I am looking forward to taking part and leading some groups and it’s great to wake up every day with a purpose!”

Live Well, Stay Well (long term conditions)

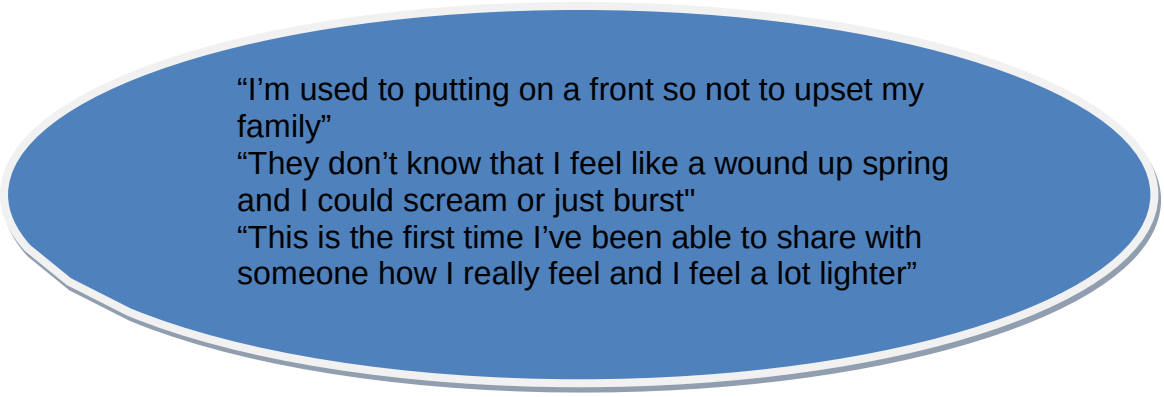
The Thistle Foundation delivers a lifestyle support programme at a number of GP surgeries, starting in Renfrew and now rolling out to Paisley. GPs refer individuals with long term conditions, who get a mixture of one-to-one sessions, group training activities and peer support to help them improve their management of their health conditions. Some individuals develop their own skills as volunteers to become peer supporters.

Feedback from people:
People are reporting the following as a result of support:

- Reduced physical symptoms, improved pain management
- Reduced psychological symptoms (depression, suicidal ideation, anxiety, loneliness, agoraphobia)
- Improved mood, as measured by WEMWBS.
- Improved confidence, coping and best hopes scores
- Increased skills and confidence to manage health problems
- Recording daily pain, rating pain (0-10) noticing patterns, triggers
- Compliance with prescribed medications
- Readiness to begin Pulmonary rehab/lifestyle management course
- Improved health outcomes such as weight loss

- Lifestyle modifications like becoming regularly physically active/making healthier food choices
- Stopping smoking, smoking less
- Reduced alcohol consumption
- Making social connections

Quotes :



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3.4 Conclusions

In the longer term, in terms of sustainability, the strategic evaluation framework includes the development of indicators around cost effectiveness and service change (to be fully developed in 2017) which will allow considerations of, for example, the potential to:

- release other, perhaps mainstream, resources to maintain the services under future contracts or service agreements, on the grounds that there will be evidence to show reducing demand on statutory services as a result of the services provided by the Community Connectors,
- come up with ways of developing new funding sources for community led health action e.g. lottery funding
- integrate Community Connectors services with cluster-based activities to support the services through packages of funding based on deliverables around the prevention agenda as outlined in the Strategic Evaluation Framework.

4. Resources

Funding for the Community Connectors projects pilot is currently provided from the Integrated Care Fund, a temporary programme of funding made available from the Scottish Government to HSCPs to support integration, with particular reference to:

- Reducing future demand on statutory services through preventative action

- Supporting people with multi-morbidity in the community

- Providing care for people most in need (addressing health inequalities)

Each of the Community Connectors projects brought resources to the pilots, some financial and some in kind, demonstrating the commitment of the local third sector to working co-productively with partners in bringing new services to local communities which are maximised through partnership working.

The Integrated Care Fund is scheduled to end in March 2018, and the Community Connectors project leads are preparing, through the implementation of the strategic evaluation framework, to develop business cases for the development and roll out of the services. Various funding options for 2018/19 onwards will then be explored.