

Communities for Health



Review 2010

Linsley Charlton
HealthWORKS Newcastle

***‘Coming here has changed my life,
I wouldn’t get up in the morning otherwise.’***



Newcastle **NHS**
Primary Care Trust



The Lemington Centre

Newcastle
City Council



Table of Contents

Index of Diagrams and Tables:	3
Abbreviations	3
Steering group members	4
Acknowledgements.....	5
Executive Summary.....	7
Context	12
1. The aging population	12
2. Current approaches	12
3. Identify gaps in provision of services	13
4. Monitoring and evaluation	13
The Lemington Centre	16
HealthWORKS Newcastle	17
Search	17
West End Befrienders	17
Summary	19
Key staff:	19
Resources:	20
Measuring success:	20
Actions taken	21
Patient experience	21
Communities for Health and Joining the Dots	23
Level of Need	25
Data	27
Demographics	28
Gender	28
Geographical area:	30
Disability	31
Long term illness	31
Ethnicity	32
Low mood and social isolation	32
Costs	34
Programme development	34
Conclusions	37
Funding	38
References	40
Appendices	41

Index of Diagrams and Tables:

Figure 1: Area covered by the Communities for Health project by ward and15	15
by Index of Multiple Deprivation.....15	15
Figure 2: Route for patients referred in the outer west.....16	16
Figure 3: Diagram of route taken by inner west referrals18	18
Figure 4: Diagram showing the management structure of C4H in relation to JTDLevel of Need24	24
Level of Need.....25	25
Figure 5: Graphs showing age range.....28	28
Figure 6: Graph showing age range28	28
Table 1: Referrals by gender29	29
Figure 7: Graph showing geographical data HealthWORKS Newcastle inner west.....30	30
Figure 8: Graph showing geographical data HealthWORKS Newcastle outer west30	30
Table 2: Referrals by disability31	31
Figure 9: Graph showing wellbeing information from Search User Survey33	33
Figure 10: Map showing information regarding older people and poverty in the participating wards.....33	33
Table 3: Running costs for C4H.....34	34

Abbreviations

JTD	Joining the dots
C4H	Communities for Health
HT	Health Trainer
HWN	HealthWORKS Newcastle
LTC	Long term condition
PAT	Physical Activity Team
PCT	Primary Care Trust
QoLP	Quality of Life partnership
Search	The Search Project
TLC	The Lemington Centre
WEB	West End Befrienders
JSNA	Joint Strategic Needs Assessment
PCT	Primary Care Trust

Steering group members

Clare Bethell	Newcastle PCT
Linz Charlton	HealthWORKS Newcastle
Sarah Cowling	HealthWORKS Newcastle
Barbara Douglas	Quality of Life Partnership
Chris Drinkwater	Health Improvement Board
Eddie Graham	Health Improvement Board
Sandra Hillyard	Joining the Dots Project Manager
Karen Inglis	Adult Services Project Manger (Transformation team)
Malathi Natarajan	Newcastle PCT
Craig Nicholson	Newcastle City Council, Adult Services
Rachel Parsons	HealthWORKS Newcastle
Gerard Reissman	GP
Joyce Robinson	Community Voice
Jane Shaw	CAoH Community Involvement Team Leader
Jan Thompson	Public Health Specialist, North Tyneside PCT
Susan Tone	Community Voice, Health Improvement Board
Graeme Williams	Centre West, ex NDfC

Acknowledgements

With thanks to the invaluable contribution made by the volunteers on the Steering group:

- Eddie Graham - Community voice and the health improvement board.
- Joyce Robinson – Community Voice
- Professor Chris Drinkwater – HealthWORKS Newcastle Board and Health Improvement Board
- Susan Tone - Lemington Centre Board/community voice and Health Improvement Board

With thanks for the help and cooperation of;

- The Lemington Community association and their volunteer management committee in particular John Dawson and Liz Beck.
- The Search Project and West End Befrienders staff and volunteers in particular the contributions of Maggie Crane and Judith Green.

With thanks to Rachel Baillie and her team at Adult Social Care who oversee the funding of the pilot.

And lastly, Communities for Health would like to thank all of you who give your time freely as volunteers; your contribution is rarely acknowledged but is essential to the success of numerous projects around the city.

'I did not expect to feel the sense of belonging and get the choices and activities to meet people. Overall my stress and depression have lifted and I feel able to get on with my life.'

Executive Summary

By Professor Chris Drinkwater

Unlike many local authorities that used Communities for Health (C4H) funding to support a number of short term initiativesⁱ, Newcastle, through the Health Improvement Board and Newcastle New Deal for Communities choose to use the funding to support a single project delivered by HealthWORKS Newcastle in order to develop, and if successful, scale-up a sustainable approach to an area of unmet need. The approach was two-pronged: firstly to develop a model in which local people have a voice in designing and commissioning services, and secondly in response to locally identified needs and priorities to provide a range of accessible social activities in order to build supportive networks for vulnerable older people and people with long-term conditions.

Initially the project focused on older people with anxiety and depression in inner west Newcastle and people with long-term conditions in outer west Newcastle, but it subsequently became clear that there was considerable overlap between these groups and the criteria were changed to people over 50 suffering from low mood and/or social isolation with any long term condition. What were initially two projects with separate target groups, therefore became a single project with the key principle of providing a personalised and locally accessible response through a choice of activities delivered by voluntary sector providers.

Apart from providing a more personalised, and accessible service, the underlying hypothesis was that it would be less expensive and more effective in preventing and reducing demand for expensive medical services than current approaches. This approach had the added value of being consistent with national policy such as 'Putting People First' and with DH commissioning guidance for long term conditions and has clearly become increasingly important at a time of impending public sector cuts.

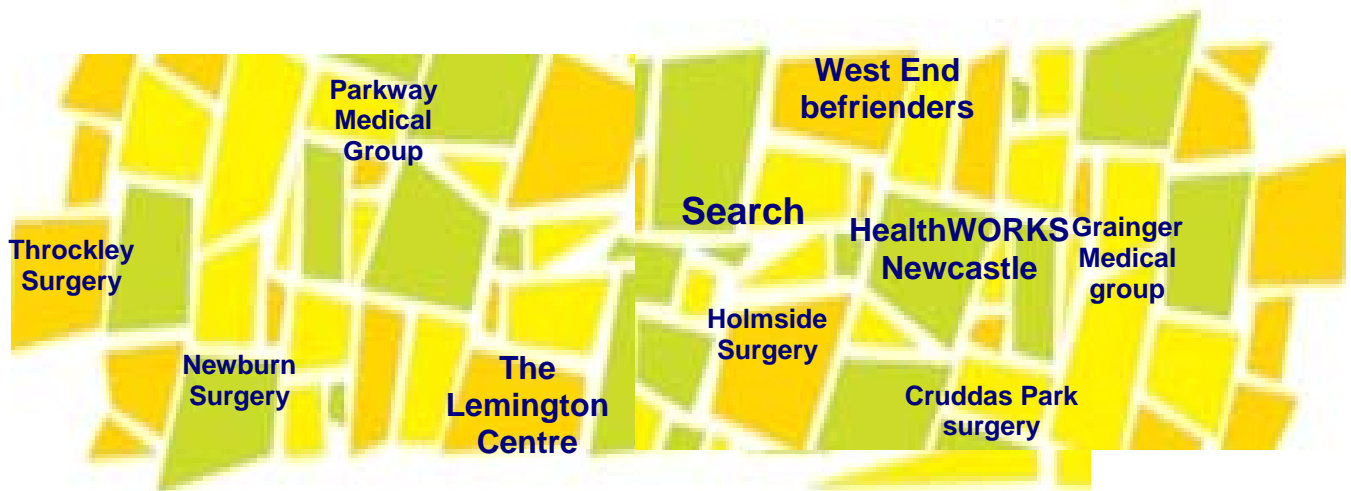
The outputs, outcomes and costs from an early independent evaluationⁱⁱ and from monitoring data demonstrate that the project is on track.

- Since 2008 over 345 older people have been referred by their GP and have participated in the project. All have suffered from low mood, and social isolation
- All have at least one long term medical conditions, the majority have multiple conditions
- Costs range from £244 per person per year for high level of support and £70 per person per year for low level/ preventative work.
- Savings to the NHS are at least comparable to those demonstrated in the Partnerships for Older People Projects evaluationⁱⁱⁱ which stated that 'community-facing' projects such as this showed increasing returns against economies of scale, such that the larger the project, the greater the saving.
- Over 180 previously sedentary individuals now taking part in regular physical activity.
- Over 1, 500 visits to Advice sessions (benefits, welfare, health)
- Over 1,700 people have benefited from the community investment

- 4 community organisations, promoting healthy lifestyles and tackling health inequalities in deprived areas, have been supported
- The project has benefited from the involvement of over 30 volunteers
- Employment opportunities have been provided for 2 people and increased working hours for 3 more people
- Good links have been established with GPs, Intermediate care, and many third sector organisations
- Proven to have a positive impact on mental health for the participants and GPs have reported some evidence of participants visiting them less and requiring less medication

The challenge now is to sustain and to scale-up the approach. In order to do this the project has combined with the Quality of Life Partnership as the 'Joining the Dots' Project. This has received joint funding from NHS and Adult Social Care Commissioners for a project development team which is a key element of transforming adult care in Newcastle. This is very welcome but the danger remains that unless funding can be found to support the activities once Communities for Health funding is exhausted in March 2011, then the project team will have nothing to develop.

'I can't tell you how much different I feel even after such a short time! I was feeling so stuck I didn't know what to do'^{iv}



¹ Department of Health. *Communities for Health: Unlocking the energy within communities to improve health*. October 2009

¹ Iain Kitt. *Communities for Health Project: evaluation report*. May 2009

¹ Personal Social Services Research Unit. *The National Evaluation of the Partnerships for Older People Pilots*. 2009. (www.pssru.ac.uk)

¹ Female with cognitive damage due to repeated cardiac events, very low mood

'They made me feel valued.'

Introduction

The Communities for Health project developed from a 2007 DoH initiative across the country, with local delivery commencing in January 2008. It originated as a small pilot project but its impact has been far reaching, changing the way that services are delivered in the locality and informing the Joining the Dots programme of system change.

The value of the project needs to be robustly presented to commissioners in order to secure the long term investment that the project needs in order to develop an effective model for city wide roll out. Roll out will provide the commissioners with the industrialized scaling that they require to make this a cost effective intervention across the city.

Proof of effectiveness on such a small scale project is difficult to provide in an acceptable format to those used to considering large scale research studies. Fortunately reference can be made to several large studies for similar interventions and even separate parts of the intervention (e.g. physical activity)¹ with the Department of Health's own research papers. There are various reports and papers that point to the effectiveness of the approach taken by C4H in improving patient outcomes and cost savings;

- The National Evaluation of Partnerships for Older People Projects POPPS (DoH)
- Summary NHS Operating Framework 2010/11
- Systematically Addressing Health Inequalities (DoH) June 2008
- Improving the Health and Wellbeing of People with Long Term Conditions (DoH) Jan 2010
- Joint Strategic Needs Assessment - Newcastle upon Tyne 2009
- New Horizons -a shared vision for mental health (DoH) December 2009
- Lets Get Moving – commissioning guidance (DoH) October 2009
- At Least 5 a Week- chief medical officer (DoH) April 2008
- The Marmot Review (DoH) February 2010
- Putting People First – (DoH) Dec 2007
- Everyone's Tomorrow - the Strategy for Older People and an Ageing Population in Newcastle (LA 2008)

The National Evaluation of Partnerships for Older People Projects (POPPS) provides a direct comparison with the C4H project, and has results based upon a large scale intervention. The POPPs projects ranged from

'.... low level services, such as lunch-clubs, to more formal preventive initiatives, such as hospital discharge and rapid response services'

'two-thirds were primarily directed at reducing social isolation and exclusion or promoting healthy living among older people ('community facing')'.

The main difference from the POPPs project and the C4H is one of funding. For POPPs £60million was shared between 29 local authorities which equates to over £2million per authority over a period of 3 years. The C4H project will have spent less

¹ Let's Get Moving –commissioning guidance 2009

than £400, 000 over the same period of time and has not only delivered positive outcomes but supported 4 x third sector organisations.

The following key headlines from the POPPS report show demonstrable **savings in acute care**;

‘The reduction in hospital emergency bed days resulted in considerable savings, to the extent that for every extra £1 spent on the POPP services, there has been approximately a £1.20 additional benefit in savings on emergency bed days. This is the headline estimate drawn from a statistically valid range of an £0.80 to £1.60 saving on emergency bed days for every extra £1 spent on the projects’

‘Overnight hospital stays were reduced by 47% and use of Accident & Emergency departments by 29%. Reductions were also seen in physiotherapy/occupational therapy and clinic or outpatient appointments with a total cost reduction of £2,166 per person’

Also demonstrated was the **increase in participant’s quality of life**;

POPP services appear to have improved users’ quality of life, varying with the nature of individual projects; those providing services to individuals with complex needs were particularly successful, but low-level preventive projects also had an impact’

And **improved links** between health agencies and the third sector;

‘Improved relationships with health agencies and the voluntary sector in the locality were generally reported as a result of partnership working, although there were some difficulties securing the involvement of GPs’

It is interesting to note the difficulties involving the GPs as this is an area that the C4H project has been successful, largely due to the work done by Dr Gerard Reissmann and to the existing relationships with the local GPs which have been built on over the last 5 years.

The Newcastle city council in partnership with Quality of Life partnership produced a very useful strategy document entitled ‘Everyone’s tomorrow’. The overarching aims of the strategy for older people are as follows:

- ‘1. Making a positive contribution (active citizens)*
- 2. Accessing information, advice and advocacy*
- 3. Physical, mental and emotional health and well-being*
- 4. Enjoying older person friendly environments*
- 5. Financially and materially secure’*

The Communities for Health project is also helping to achieve these aims by supporting organisations that heavily rely on volunteers either to manage, and/or deliver services and providing opportunities to volunteer; providing advice and information; supporting individuals to improve their physical, mental and emotional health and wellbeing; and supporting organisations that provide older person friendly environments. This will be evidenced in the body of the report.

Context

'Newcastle is ranked the 37th most deprived local authority area in the 2007 English Index of Multiple Deprivation and lies within the fifth of local authorities with the worst health and deprivation indicators compared to the population of England as a whole.

Newcastle has around 270,000 residents. It has a culturally diverse population; 6.9% of the total population in 2001 were from Black and Minority Ethnic (BME) communities...'

'The indicators ... show that there are a number of factors contributing to a high prevalence of mental ill-health in the city. Incapacity benefit claimants, homelessness, number of young people in the 'Looked After System', dementia, common mental illness predictions, suicide rates are all higher in Newcastle than the average for the region....'

'Improving mental and emotional wellbeing was identified as the top priority in a citywide consultation undertaken to inform the Ten Year Health Improvement Strategy for Newcastle'²

In his discussion paper for 'Joining the Dots', Professor Drinkwater outlined the other key issues of national and local importance which broadly can be categorised in the following areas;

1. The aging population

- Less of the population of employment age- generating less income
- More demand for NHS services acute care and longer term
- Increased social care costs
- Increase in the number of the population living with long term medical conditions
- Possible increase in social isolation and mental health problems

'Due to an aging population, it is estimated that by 2025 there will be 42% more people in England aged 65 and over. This will mean that the number of people with at least one LTC will rise by 3 million to 18 million.People with LTCs account for a significant and growing proportion of health and social care resources.....almost £7 in every £10 spent'³

In Newcastle upon Tyne, 52% of the over 65's are suffering from limiting long term illness and this is set to rise to over 54% in 2025. In the over 85's the picture is even more grim with those living with a limiting long term illness set to increase by 50% in 2025.⁴

2. Current approaches cannot be sustained and are not the best use of resources. Redesign of services needs to;

- Be cost effective building upon existing local capacity, avoiding duplication and overlap
- Build upon existing third sector provision
- Integrate services effectively
- Be person centred and holistic in its approach

² Draft mental health profile Newcastle 2008

³ Improving the health and well-being of people with long term conditions (DoH) Jan 2010

⁴ source Newcastle JSNA 2009

- Be focussed upon keeping older people active and part of the community and targeting resources to prevent vulnerability becoming dependency⁵

*'In the current economic climate, delivering more of the same is not an option and this is particularly relevant to LTCs. We know that more proactive, preventative and personalised approaches can improve patient experience and reduce unscheduled use of hospital care.'*⁶

3. Identify gaps in provision of services

There is a need for a citywide strategy to assist with the dilemmas faced in providing for the increasingly elderly population. 'Joining the Dots' is a project working on highlighting this issue and attempting to determine new ways of working by developing a mechanism (through system change) by which to bridge provision by the health service, the PCT and existing third sector provision.

*'Gaps in provision need to be identified and prioritised through the JSNA'*⁷.

4. Monitoring and evaluation

'there needs to be better sharing of information and a move towards standardised monitoring systems so that the impact and cost-effectiveness of service re-design can be measured in the long term'.⁸

This is an issue that may be key to the success of '**Joining the Dots**'. Each third sector organisation collects data differently and collects different types of data. This creates serious challenges for monitoring and evaluating effectiveness. However some of the organisations point out that by collecting data differently they might change the relationship with the participant and that this may not be appropriate or effective for community engagement. This dichotomy needs to be explored and acceptable solutions identified. Other areas that will need to be considered within the third sector are:

- Training and support for volunteers when collecting information and data
- Administrative costs need to be built into the business plan
- Identification of systems that work across different projects and are simple to use
- Sustainable funding

Newcastle upon Tyne has a high level of illness and disability with 9.5% of the population being on incapacity benefit or disability allowance, 46% of those for mental health problems. Commissioning services such as C4H represents real value for money and an increase patient satisfaction.⁹

⁵ Précis from Prof Chris Drinkwater's discussion paper Joining the Dots 2009

⁶ Improving the health and well-being of people with long term conditions (DoH) Jan 2010

⁷ Prof Chris Drinkwater's discussion paper Joining the Dots 2009

⁸ Prof Chris Drinkwater's discussion paper Joining the Dots 2009

⁹ Reference to costs page 27 and to the independent evaluation by Iain Kitt 2009

*'All PCTs and local authorities should have joint systems for reaching vulnerable patients at highest risk, who may be demotivated and not in meaningful contact with services. These systems should be of sufficient scale to make a difference.'*¹⁰

The merging of C4H and Joining the Dots (JtD) does exactly that. What follows is an attempt to explain the C4H pilot project, its relationship with JtD, what has been achieved so far and how it may be rolled out city wide in the future.

'The staff are very respectful to individual needs and make everyone feel special. They empowered me to make choices about my lifestyle and did not judge when things may go wrong'

¹⁰ Systematically addressing health inequalities (DoH) June 2008

History

Communities for Health initially started as two small pilot projects, in the inner and outer west of Newcastle upon Tyne, with money from the Communities for Health Department of Health. Community representatives identified the need for a service to provide support for those who needed help to manage their health but were struggling due to low level mental health problems or social isolation. These were to be the hard to reach, and those not engaging well with services.

This first phase of the pilot was carried out by two separate charity organizations; The Lemington Community Association and HealthWORKS Newcastle.

Operating different delivery models, reflecting the differing demographics and resources available in each area, the overarching theme was providing a holistic approach to health for the participants with particular regard for their mental wellbeing.

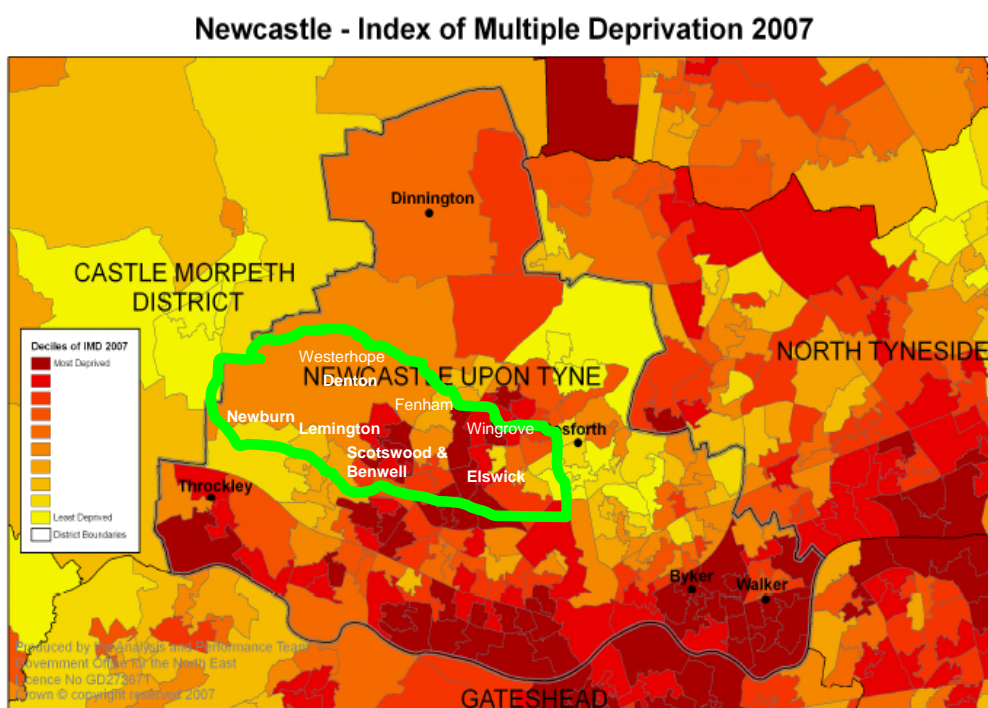


Figure 1: Area covered by the Communities for Health project by ward and by Index of Multiple Deprivation¹¹

'Communities facing multiple deprivation often have high levels of stress, isolation and depression'¹²

The above ward map shows where the 'Communities for Health' project is based in the city. The green outline indicates the whole area covered. The names of the participating wards are in white.

¹¹ Demographic data from the Newcastle JSNA 2009

¹² The Marmot Review 2010

The Lemington Centre serves the outer west and includes Lemington; Newburn; Denton and Westerhope Wards.

The GP's practices involved were:

- Newburn Surgery
- Throckley Surgery
- Parkway medical group

Referral criteria: 25 - 70yrs with one of or a combination of IHD, Diabetes or Obesity *plus low mood and/or socially isolated*

Venue: The project in the outer west would be administered from The Lemington Centre, a Healthy Living Centre opened in 2005. A volunteer led resource driven by the *Lemington Community Association* which had been active in the community for over 30 years. The building houses a healthy living café, health suite, community gym and internet cafe as well as being a Children's Centre. It hosts many community activities and operates an 'Exercise on Referral' scheme and has strong links with the local GPs.

Staff: The physical activity team at Lemington were already involved in the management of LTCs and so it was decided to develop their capacity and expertise. Staff perform the assessments and sign post the participant to a range of activities within the centre or to other activities in different areas of the community (no Health Trainer involvement in the initial stages). They review at 3, 6 and 12 months reporting back to the GPs at each stage.

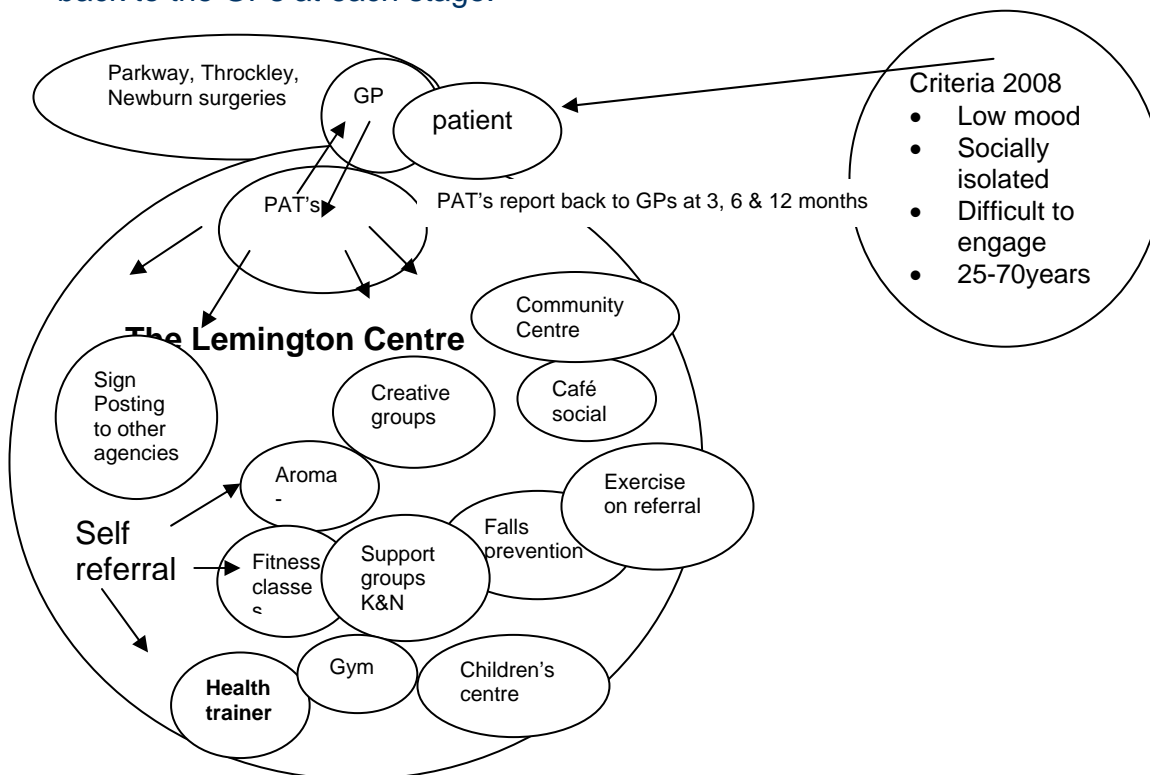


Figure 2: Route for patients referred in the outer west

HealthWORKS Newcastle was commissioned to deliver in the inner west, which encompassing the following wards; Benwell and Scotswood; Elswick; Fenham and Wingrove.

The GP's practices involved were;

- Holmeside surgery
- Grainger Medical group
- Cruddas park surgery
-

The referral criteria: over 65yrs of age and **with low mood and/or socially isolated**

*'Tyne and Wear is one of the four areas in the UK with high levels of loneliness and depression amongst older people: 23% of older people report feeling depressed for much of the last week and 18% report feeling lonely for much of the last week.'*¹³

HealthWORKS Newcastle is based at the Health Resource Centre in Benwell. It was opened in 1996 to provide services and activities to enable local people to take more control over their health and quality of life. The centre sits in the middle of the busy shopping centre and provides a community gym and studio, a training kitchen and office space. **The Community Health Trainer team** (managed by HWN) were to be the first point of contact for referrals in the inner west. The Department of Health paper published in June last year highlights the importance of the Health Trainers in targeting the socially isolated;

*'A comprehensive engagement system is needed to interact not only with community groups but also with socially excluded individuals and families, e.g through **Health Trainers**, community ambassadors and community health educators'*¹⁴

Using a community development model and building upon existing community resources HWN has commissioned **The Search Project**, and the **West End Befrienders** as delivery partners in this pilot.

Search is a community based charity at a resource centre for older people and their carers in West Newcastle, based on Adelaide Terrace in Benwell. They offer a range of community health activities, leisure and learning opportunities, advice and help with claiming benefits and accessing services. Most of their services are for people aged fifty and over, except for the advice and information work which is for people over pension age and for carers of pensioners. In her report to the Communities for Health steering group Judith Green estimates that 20% of the participant's to Search's services fit the project's criteria, although this is likely to be a conservative estimate.

West End Befrienders is a voluntary organisation and registered charity which has been operating in the West End of Newcastle since 1984. The aim of the project is to help frail, older and disabled people to live more independently within the community. This charity has a great deal of expertise in working with the BME community. This area of expertise is highlighted as being effective in the POPPs evaluation

¹³ Newcastle joint strategic needs assessment 2009

¹⁴ Systematically addressing health inequalities DOH (June 2008)

*'some difficulties were experienced however, in providing access to 'hard to reach' people and some services were felt to be insufficiently responsive to the needs of black and minority ethnic (BME) groups.....Where services were dedicated expressly to BME groups, engagement was much more successful.'*¹⁵

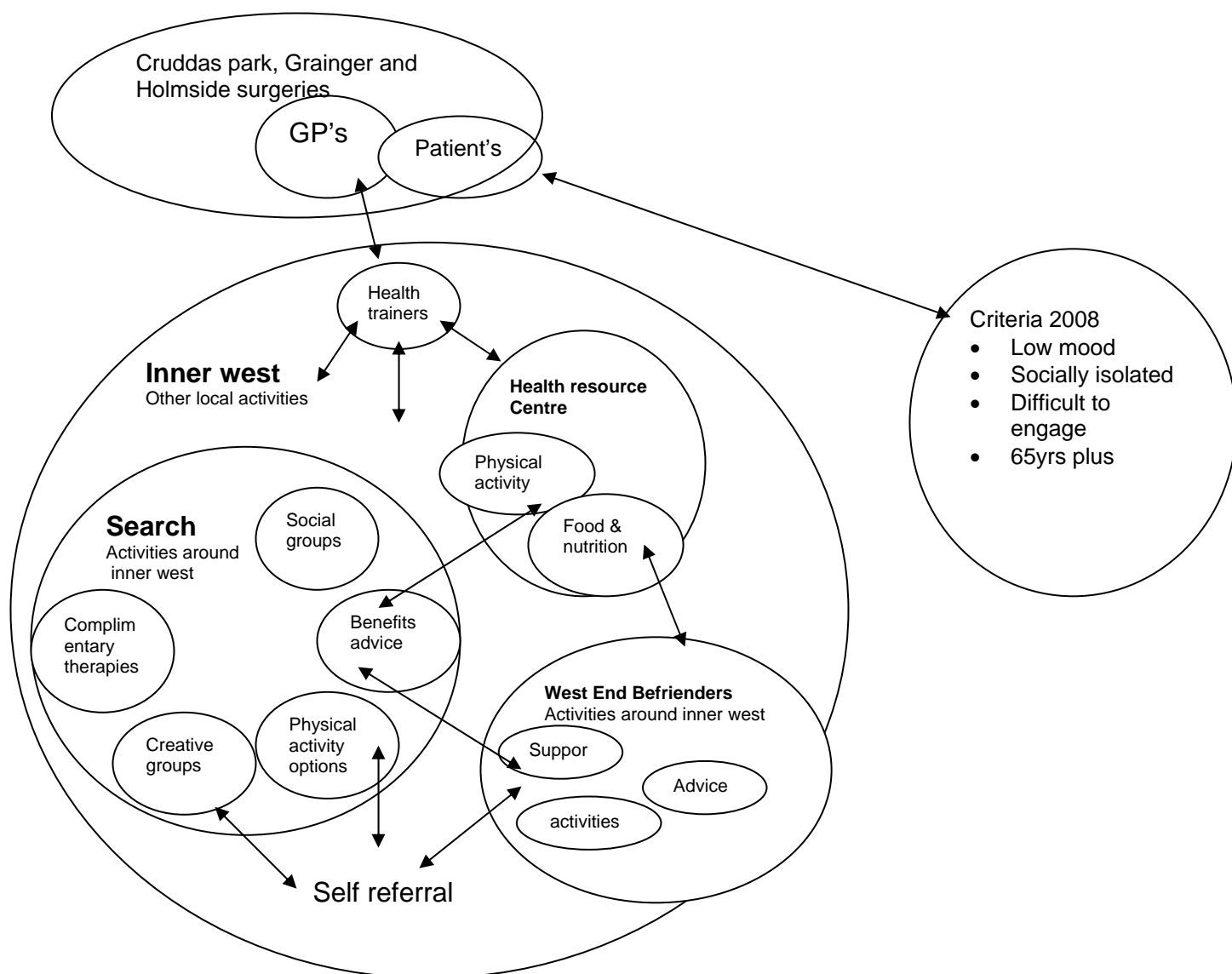


Figure 3: Diagram of route taken by inner west referrals

Both HealthWORKS Newcastle and the Lemington Centre utilised GP practices to refer into them¹⁶. Dr Gerard Reissmann was commissioned to work with the participating practices to ensure that they understood the project and that referral routes were as easy as possible. One of the outcomes was to ensure that the different referral forms were put into one document so that the GPs did not have to search for the right paperwork. The early work that Gerard did with the practices was one of the critical success factors and would need to be taken into consideration for any roll out.

¹⁵ The National evaluation of partnerships for older people projects; Executive summary (Oct 09)

¹⁶ Self referrals were accepted in the inner west

Summary

Referral Criteria: Both projects were tasked with engaging the hard to reach – those suffering from low mood and socially isolated. Other criteria were very different.

- The inner west had a much older frailer population (65years plus)
- The outer west had to engage with a wider span of ages (25 –75years) and with specific long term conditions

After the referral has been received the participant is contacted directly and a suitable appointment time made. The assessment covers key areas of the patients life:

1. Mood
2. Social contact
3. Relationships
4. Money
5. Pain
6. Ability to carry out daily tasks
7. Confidence to exercise
8. Healthy eating
9. Hobbies
10. Managing Health

From this discussion the client sets goals and supported in making an action plan. A menu of activities are available (please see ‘ Resources’).

Key staff: Physical Activity staff -experienced in working with long term conditions and older people. The Community Health Trainers experienced in working with older people and with many community agencies. Both carried out **an initial assessment** with the participant and from this information helped them set goals and guided them to the relevant activities. Using staff from different teams has highlighted the differences and similarities of methods of working. Both teams employ a holistic approach to health

Physical Activity staff

- centre based; cannot accompany people to activities based at other venues or meet people in their own homes
- Have the knowledge and skills to motivate those who find exercise difficult. (Physical Activity is a cornerstone of the management of many long term medical conditions)

Health trainers

In Choosing Health (DoH 2004) Health Trainers were identified as a means of providing advice, motivation and practical support to individuals in their local communities.¹⁷

“in keeping with a shift in public health approach from’ advice from on high to support from next door’, health trainers will be drawn from local communities, understanding the day-to-day concerns and experiences of the people they are supporting on health. They will be accredited by the NHS to have skills appropriate to

¹⁷ Please see attached appendices for more information regarding this role

make they changes they want, in touch with the realities of the lives of the people they work with and with a shared stake in improving the health of the communities they live in, health trainers will be approachable, understanding and supportive.”

- local people recruited to work within their communities
- community based; can accompany participants to activities in different venues
- input data onto a national data set

Each member of the team (PATs & HTs) have excellent interpersonal skills and are experienced in their respective areas of work. It could be argued that they have been working in the model of link worker currently being looked at by the Putting People First and Joining the Dots programmes.

‘The link worker role could prove to be key in the development of closer multi-agency working. Many teams suggested that if they had a dedicated representative to the Community/Voluntary Sector, more ‘trust’ could be established and knowledge improved of appropriate services for the older person in Newcastle.’¹⁸

‘it was also important to acknowledge that (even well-intentioned) GPs and PHCTs can’t keep up with what is available locally and a key component is someone – advocate, motivator, enabler, sign-poster.....to help the client’¹⁹

Resources: both projects used appropriate community resources and built upon existing capacity. This was evolution not revolution. Each project had a similar variety of activities to refer to, the groups could be broadly categorised:

- creative groups (e.g. art/craft)
- complementary therapies
- suitable physical activities (mainly in social settings)
- advice (benefits/housing/health etc)
- support groups
- social groups

‘As well as physical places, the communities social networks to which individuals belong over their life course also have a significant impact on health and health inequalities. The links that connect people within communities, often described as social or community capital, can bring a range of benefits. Social capital can provide a source of resilience, a buffer against particular risks of poor health, through social support and connections that help people find work or get through economic and other difficulties. The extent of people’s participation in their communities and the added control over their lives that this brings, has the potential to contribute to their psychosocial well-being and, as a result, to other health outcomes.’²⁰

Measuring success: a range of methods have been used to try to demonstrate the effectiveness of the intervention; however there have been some difficulties with some areas of this process.

Quantitative data collection

¹⁸ Compiled by Jeanette Robson October 2009 Providing community healthcare services for Newcastle and North Tyneside Primary Care Trusts

¹⁹ Dr Gerard Reissmann work report for Communities for Health January 2010

²⁰ The Marmot Review 2010

- Each of the organisations taking part had their own method of collecting data and collected diverse information
- Not all of the organisations collect personal data
- Not all of the organisations ‘assess’ the participant and it may not be appropriate for them to do so. For example Search could be seen as mainly preventative with many of their clients self referring to groups. The HealthWORKS team work with the mid to high dependency participants who are generally referred to the scheme by their GPs, and in need of a fairly high level of support. The West End Befrienders are at the top end of the scale, working closely with a small number of very dependant participants. This is a simplistic picture and there is a degree of overlap in all of the interventions.

N.B. The data collected is presented later in this report.

Qualitative data

Some methods have proved to be too blunt a tool and have not revealed the changes that have been observed by staff and reported by participants e.g. the HAD scores, (Hospital Anxiety and Depression Scores). Data from focus groups, user surveys and case studies have demonstrated the high value that participant’s place on the service.²¹

“It has been very good. It has made me come out and mix with other people. I have been working in the gym, something I have never done before. I think it is a very good idea and will help to get people out of their homes”

Actions taken

- an administrator has been employed to collate the data over the different projects and to eventually standardise some data collection (where appropriate)
- the identification and trial of a different method of measurement. **The Outcome Star**²² is far simpler than the HAD score and is currently being adapted. We hope that it will prove to be a more responsive tool for the future
- The use of focus groups, user surveys and case studies to continue, to show the ‘human’ impact of the project²³
- An independent evaluation has been carried out²⁴

Patient experience

‘I wish to thank you for my certificate, I have enjoyed every second of my workout. Besides loosing one stone, I feel better, can walk upstairs with both legs, angina is much improved. Meeting people and making new friends, my depression has lifted, great support when Mam gives me a bad night. The staff were a great support, understanding and helpful. I am very pleased I joined and have enough confidence now to try any activity’²⁵

²¹ Christine Baker focus groups 2008

²² Information on The Outcome Star to be included in the appendices

²³ Christine Baker Focus Groups 2007 & 2008

²⁴ Communities for health executive summary Iain Kitt 2009

²⁵ 68 year old woman

The text above is from a letter written to staff at the Lemington Centre recently. Certificates are awarded after the 12 month re- assessment has been completed. Staff reported that at the very beginning this participant took three attempts before attending for her first assessment as she was so anxious about coming out.

These self reported outcomes show that this beneficiary has improved her health and wellbeing:

- Lost one stone in weight
- Walking improved
- Angina symptoms improved
- Mood lifted
- Feels more able to try other activities
- Feels connected and has made friendships
- Is more able to cope with her caring responsibilities

‘I now have a much better outlook on life. My mood has lifted and I am able to cope when I get low without relying on medication.....I am taking responsibility for my own health which makes it even more rewarding.’

Communities for Health and Joining the Dots

'All PCTs and local authorities should have joint systems for reaching vulnerable patients at highest risk, who may be de-motivated and not in meaningful contact with services. These systems should be of sufficient scale to make a difference'.....²⁶

When further funding was granted to extend the pilot, the project was merged to provide a service covering the west of Newcastle with common referral criteria. The merged criteria were aligned with the bigger and more strategic pilot project of 'Joining the Dots' (JTD). The vision of JTD was to create a bridge (and join the dots) between Acute care, Intermediate care and third sector provision, in an attempt to prevent the 'revolving door' syndrome. It was expected that Communities for Health would provide a model of delivery for JTD.

The merged referral criteria are:

- 50years upwards
- suffering from low mood and/or social isolation
- with any long term condition

*'....People with LTCs account for a significant and growing proportion of health and social care resources.....almost £7 in every £10 spent'*²⁷

The scheme hit a roadblock when funds earmarked by the Department of Health but held by New Deal for Communities for this undertaking were sent back to the city council by and effectively became 'lost' for over 6 months. Fortunately this money has been recovered but this episode did put the project on hold for most part of 2009.

Other relevant developments were that HealthWORKS Newcastle was now responsible for the management of the physical activity team at The Lemington Centre²⁸ and a Health trainer was now based at this centre and involved in the C4H project.

²⁶ Systematically addressing health inequalities DOH (June 2008)

²⁷ Improving the health and well-being of people with long term conditions (DoH) (Jan 2010)

²⁸ HealthWORKS Newcastle works in partnership with the The Lemington Community Association Board

Management of Communities for Health and the relationship with Joining the Dots

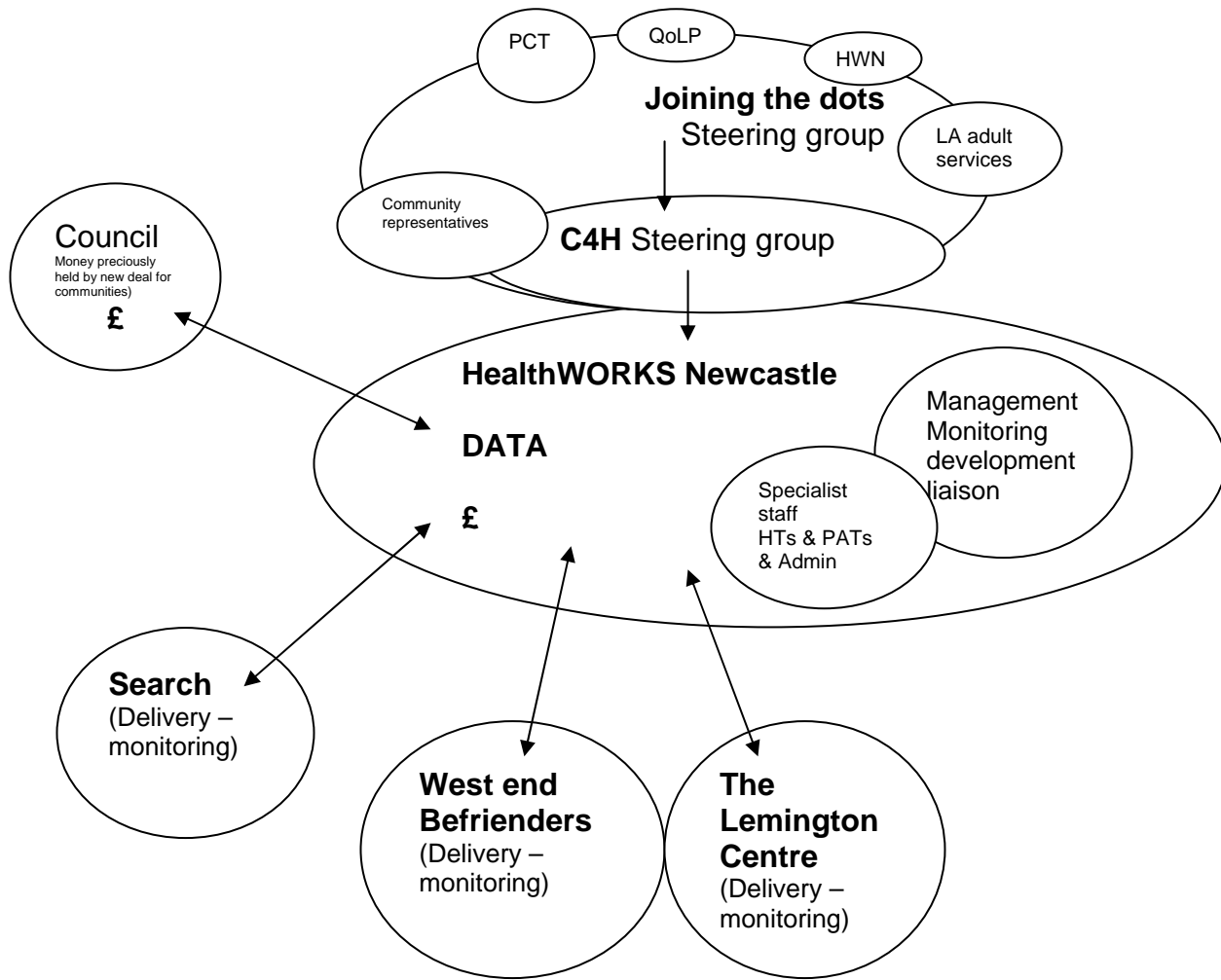


Figure 4: Diagram showing the management structure of C4H in relation to JTD

Level of Need

Given that the combined population for the inner and outer west of Newcastle totals **87,827²⁹** how many people fit the criteria for the C4H project in the west of Newcastle?

Referral criteria 1: Over 50 years of age

27% of the population are over 45 years (no data found for over 50's) of age equals **23,713** people.

Referral criteria 2: suffering low mood

46% of the population between the ages of 16 – 74 were estimated to have a mental health problem³⁰. This would give us a figure of **10,908** people who might fit this criterion.

'Mental health and well-being has a significant influence in all spheres – achievement, life style, physical health, resilience and recovery, employment, relationships, and civic participation and engagement. Mental Health Services within the NHS, and the Local Authority and the third sector, have vital roles to play in promoting positive mental health and well-being and ensuring effective partnership working and fully integrated commissioning and service provision'³¹

Referral criteria 3: Having one or more long term medical condition

22.7% of the west of Newcastle self report long term limiting illness. Of the over 45's this would give us an estimate of **5,383** people.

Referral criteria 4: social isolation/ hard to reach

While the Search Users Survey indicates that 49% of their participants felt socially isolated now (or in the past), the recently published Marmot Review reports that in the most deprived areas 19% have severe social isolation and 26% suffer from some isolation. Given that the areas of the C4H project lie in some of the most deprived areas³² these figures can be used as a guide.

Population Description	number	19% severe social isolation	26% some isolation
Whole population	87 827	16 687	22 835
Of the Over 45s	23 713	4 506	6165
Over 45's with low mood	10 908	2 073	2 836
Over 45's with LTC	5383	1022	1400
Over 45's with low mood plus LTC's	2 476	470	643

'Communities facing multiple deprivation often have high levels of stress, isolation and depression'³³

²⁹ All demographic data taken from Newcastle JSNA 2009

³⁰ Draft mental Health profile for Newcastle

³¹ The Marmot Review 2010

³² Index of multiple deprivation NCC ward data

³³ The Marmot Review 2010

These figures can only be used as an approximate guide as they are averaged across the whole population. It is generally known that the older population have a higher percentage of LTCs and of social isolation often due to poor mobility, ill health and bereavement. It is likely that the figures would be on a sliding scale from the younger members of the community having a much lower percentage of social isolation and the very elderly having a considerably higher level of social isolation.

However it is useful to have some figures to compare the data collected from the project. Most of those referred to C4H have met all the criteria outlined above. The range calculated above as meeting all of the criteria were from 470 – 643 people.

Data

Number of referrals for Communities for health

year	inner west HT	outer west PAT	totals
2008	68	111	179
2009	73	81	154
2010	4	8	12
	145	200	345

Participants involved in Search activities.

617 different individuals took part in groups or activities in 2008. The advice service was accessed over 1, 200 times although we do not have data on the individuals who benefited from the service.

Judith Green (commissioned to carry out the user survey) estimates that 20% of all participants of search's activities could qualify for the C4H criteria. This would amount to 123 individuals in 2008. It is not clear how many new participants are involved in the activities each year and how many are regular participants.

Participants involved in WEB activities

The money that is paid to WEB pays for one sessional worker for 12 – 15 hours per week. From June 2008 there have been 15 new participants for C4H. 4 volunteers have been supported. Two group sessions are delivered with around 18 individuals in each group. This support is intensive and is mostly on a one to one basis.³⁴

³⁴ Notes made from meeting with Rachel Parsons 3rd February 2010

Demographics

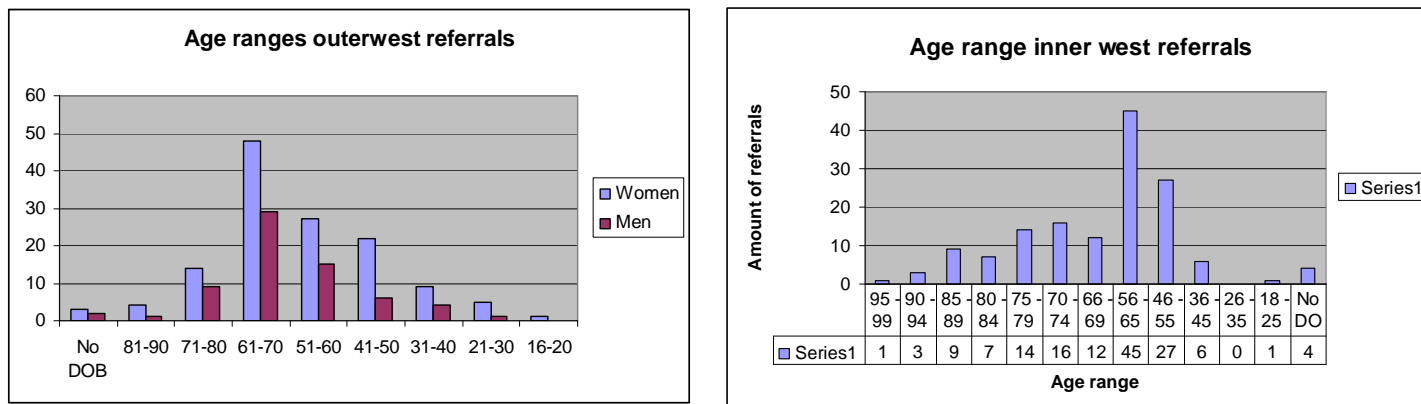


Figure 5: Graphs showing age range³⁵

HealthWORKS Newcastle referrals³⁶: 74% were over 56 years old and 14% were between 80 – 100 years old (the initial referral criteria were for participants over 65years old).

Outer West referrals: 76% were over 50, but only 2.5% were over 80 years old. Moreover it was found that 24% of the outer west referrals were **under 50 years of age** (due to the initial referral criteria starting from 25 years old), demonstrating a need for services of this type in the under 50's.

For Search and WEB the majority of the participants were 70 – 85years old.

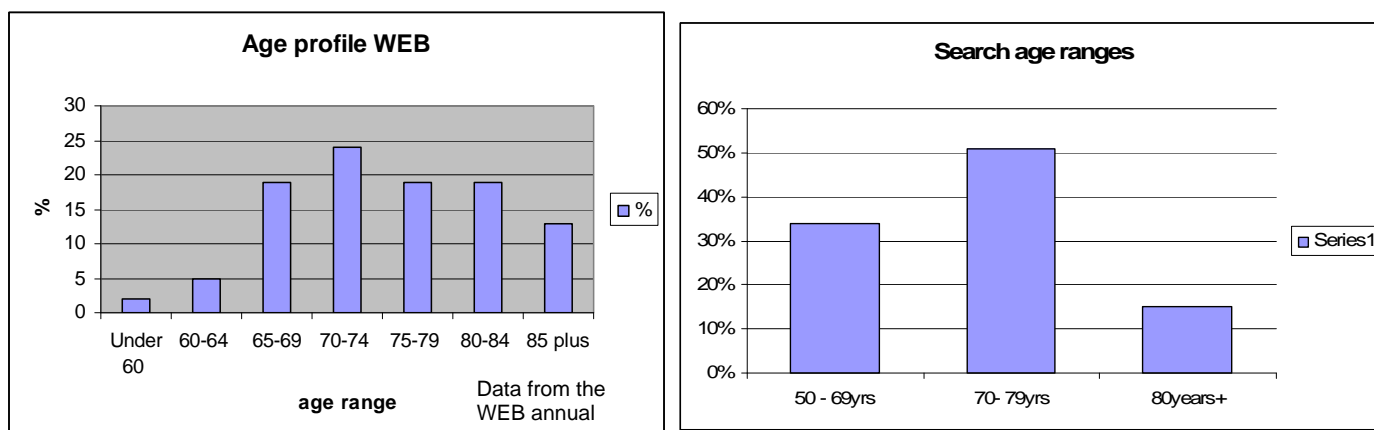


Figure 6: Graph showing age range³⁷

Gender

As is usual in these types of interventions (POPPs executive summary) participation by women far out ways that of men.

³⁵ Data source monitoring by HealthWORKS Newcastle

³⁶ During the pilot HealthWORKS Newcastle referrals refer to inner west only

³⁷ Data source; user survey Search 2008 and WEB 2007

	% male	% female
Inner west referrals	37*	63
Search	13	87
WEB	16	84
Outer west referrals	34*	66

Table 1: Referrals by gender³⁸

However this can be expected as there are generally more women living longer; more women are living alone and suffering isolation, and more women are prone to suffer from poor mental health.

Factors identified by the Institute of Public Policy Research as shaping wellbeing in older people include:

- **Poverty** - financial security (through advice and targeting those wards who have high areas of deprivation)
- **Physical / mental health** - ill health / lack of mobility
- **Marital status** - divorce or separation
- **Living alone** - 80 per cent of those classifying themselves as 'often lonely' live alone. Women over 75 are almost twice as likely to be living alone as men.
- **Social isolation** - Community participation - family life, an active social life and support from partners, friends, family and religion is important in promoting well being and a sense of value. Transport and access to important social networks
- **Gender** - women are more prone to some mental health problems than men particularly depression
- **Ethnicity³⁹**

From the figures in the chart above it can be noted that there are 50% more males participating when they have been directly referred by a GP.

³⁸ **Source:** Monitoring data from inner and outer west referral numbers plus Search and WEB user surveys

³⁹ source Newcastle city council JSNA 2009

Geographical area:

The geographical data shows the outer west having the widest geographical spread of referrals. The most commonly referred from areas being; Lemington; Throckley; Chapel House; and West Denton and Westerhope. The inner west showed less spread with the majority being referred from NE4 which covers the Benwell and Elswick areas.

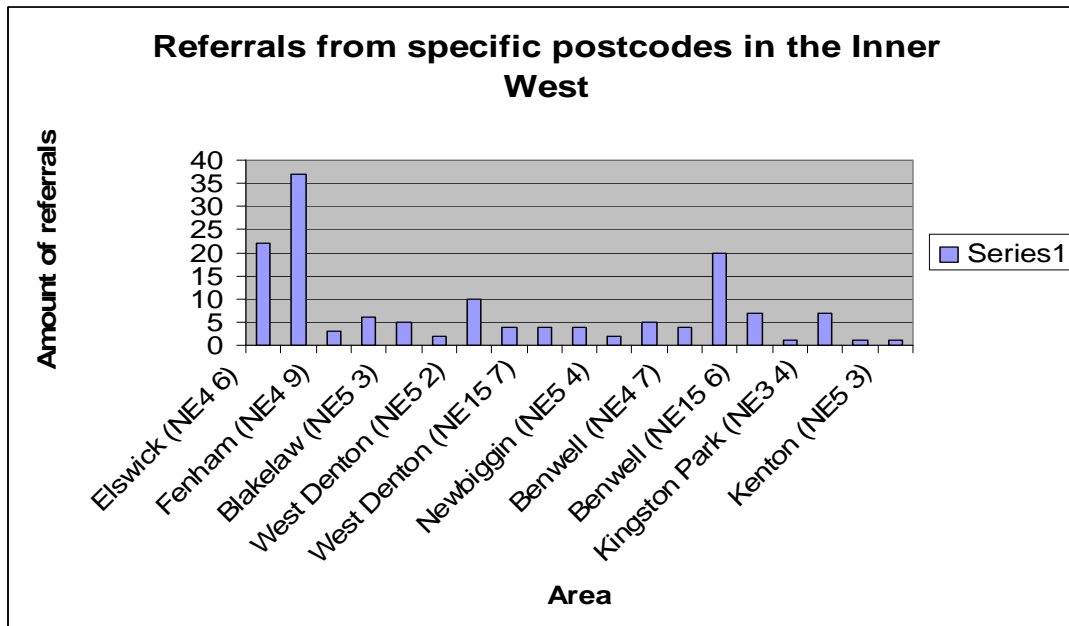


Figure 7: Graph showing geographical data HealthWORKS Newcastle inner west

There is a considerable overlap of the areas the GPs have referred from between the inner and outer west. It also demonstrates that patients are willing to travel to engage in a service they value. However this must be treated with caution as choice and local services are important and the lack of access to transport can be a barrier

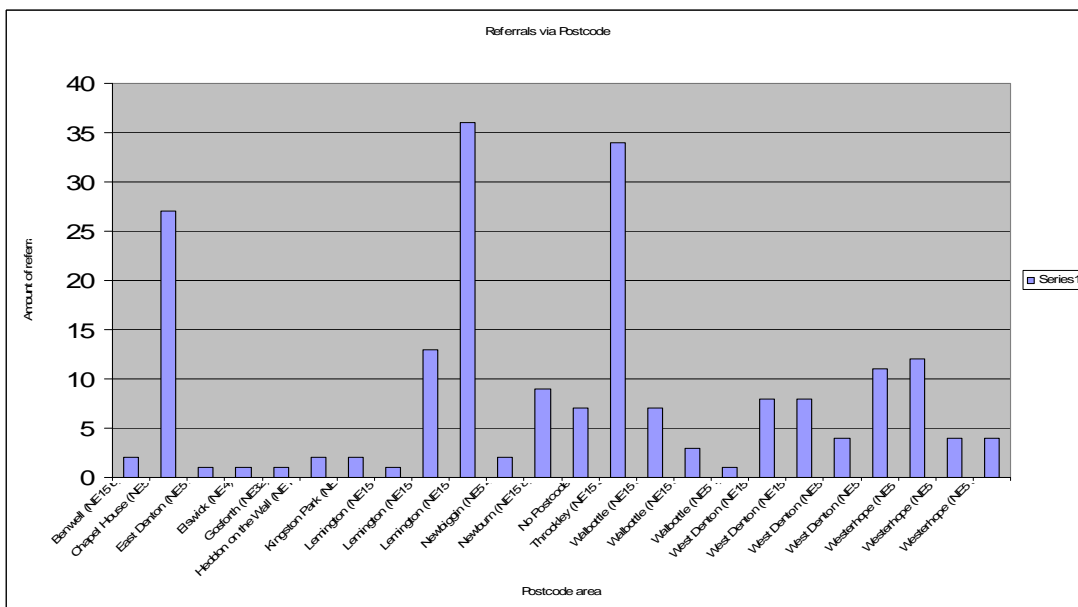


Figure 8: Graph showing geographical data HealthWORKS Newcastle outer west

Search

“About half of all participants lived in the areas of Benwell and Elswick, where Search is based. A total of 83% lived in the inner west, and a further 14% from other parts of West Newcastle.”

WEB

Referrals are only taken from the inner west of the city.

Disability

“The North East has the highest proportion of people with disabilities in England. There is a clear link between physical disability and poor mental health, regardless of which presented first, although services are usually configured to deal with these separately. In Newcastle 9.5% of the working age population are on incapacity benefit with much higher levels in some disadvantaged neighbourhoods. Mental illness accounts for 46% of these.”⁴⁰

It is quite hard to make meaningful comparative data in this area as the Local Authority figures combine long term limiting illness and physical disability. However the figures for those registered or considering themselves to be disabled are outlined in the table below

HWN referrals	% registered or consider themselves Disabled
Inner west referrals	23%
Outer west referrals	19%

Table 2: Referrals by disability

Long term illness

Having a long term medical condition has been part of the participation criteria for the outer west from the outset. Participants had to have one of the following: Ischemic heart disease, diabetes or obesity (many of them had multiple LTCs)

Although the inner west criteria did not stipulate long term medical conditions most of those referred had multiple LTCs, probably due to the greater age of the **participants** although there is much research on the relationship between LTCs and mental health.

*‘People with diabetes have 2 - 3 times the rate of depression than the general population’⁴¹
‘Co-morbid depression is associated with increased health care costs, and increased health care utilisation’⁴²*

Now the two projects are combined the referral criteria stipulate one or more LTC so that 100% of the referrals have one or more Long Term condition. Search’s User Survey indicated that 74% of their participants had one or more LTC and WEBs User Survey showed that most of their participants had multiple LTCs. With 22% citing mobility problems; 4% blindness or partial sight and 4% hearing impaired and 27% Diabetes.

⁴⁰ Draft Mental Health Profile Newcastle March 2008)

⁴¹ Consensus Development Conference: Diabetes Care 2004

⁴² Egede 2002

Ethnicity

In the outer west the vast majority of those referred are white British (97.5%) and 2.5% are Asian. This is a higher percentage of BME referrals in comparison to the population statistics. The outer west ward statistics for white British are as follows; Lemington 98.3% Newburn 98.9% Westerhope 98.6% and Denton 98.3%.⁴³ However there have been no mixed, Chinese or black African or Caribbean people referred.

The inner west referrals show a different pattern with only 2% of the BME community being referred to the Health Trainers, despite the fact that the BME percentage of the population is much higher than in the outer west (white British in Benwell & Scotswood 95.8%; Fenham 92%; Elswick 80% and Wingrove 72.1%.) There is a much lower referral rate of the BME community via the GPs.

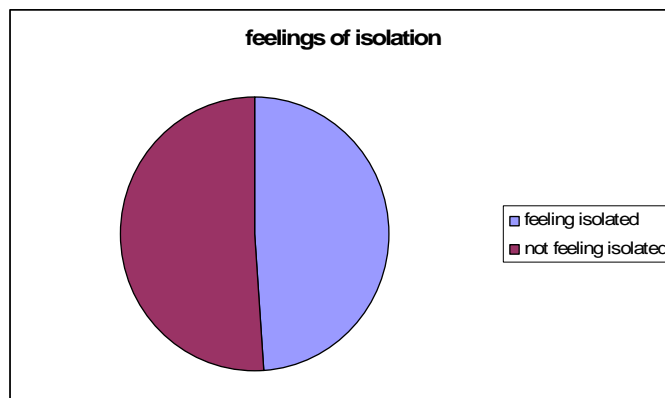
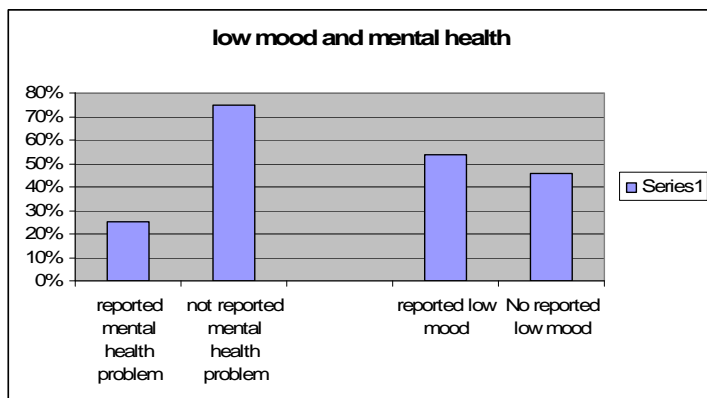
According to Search's user profile very few of their users come from the BME community, in contrast WEB's BME participants account for 78% of their referrals and 100% of their Communities for Health referrals.

Low mood and social isolation

'Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. Social networks have a larger impact on the risk of mortality than on the risk of developing disease, that is, it is not so much that social networks stop you from getting ill, but that they help you to recover when you do get ill'.⁴⁴

All patients referred via the GPs have been suffering from low mood and or social isolation. Several of the participant's suffer from both. The referral stipulates 'low mood' the reality is that many are referred with depression and at least 3 have been suicidal. Several are referred with phobias (Agoraphobia) anxiety conditions, self harm and eating disorders. Many have suffered abuse as children or as adults or particularly difficult bereavements. Social isolation can be a product of the low mood or a cause of the low mood. Even amongst Search's participants (which could be assumed a lower level of need than those referred)

- 54% reported that they suffered from "low mood" now or in the past
- 49% reported being "socially isolated" now or in the past.
- 25% reported having a mental health problem⁴⁵.



⁴³ Ward data source; Newcastle JSNA 2009

⁴⁴ The Marmot Review 2010

⁴⁵ It is likely that the latter figure in particular is an under-estimate, as the proportion of "no answers" was higher for this question.

Figure 9: Graph showing wellbeing information from Search User Survey

These figures are high and suggest that Search is providing a much needed service. It is also indicative of the high levels of poor mental health prevalent in Newcastle. One of the reasons for these high figures could be that:

- The majority of participants (57%) lived alone. In all, 19% lived in sheltered housing and a further 6% in care homes or supported housing.
- Many of the participants had multiple long-term conditions. For example, 8% of those suffering from an illness or disability had **six or more specific** long-term conditions.

*'Understanding of the relationship between social and community capital and health is growing. Communities facing multiple deprivation often have high levels of stress, isolation and depression. Social networks and participation can improve mental health inequalities.'*⁴⁶

- 41% of participants had experienced a fall, and 44% were afraid of falling, which is significant as this is a major cause of incapacity, hospitalisation and loss of independence for older people, and falls prevention is thus a key concern of health policy.⁴⁷
- 41% of Search's participants also indicated that they did no physical activity. It would have been very interesting to know whether these were the same people who have fallen as research (Dawn Skelton et al) shows a casual link to inactivity and falls.

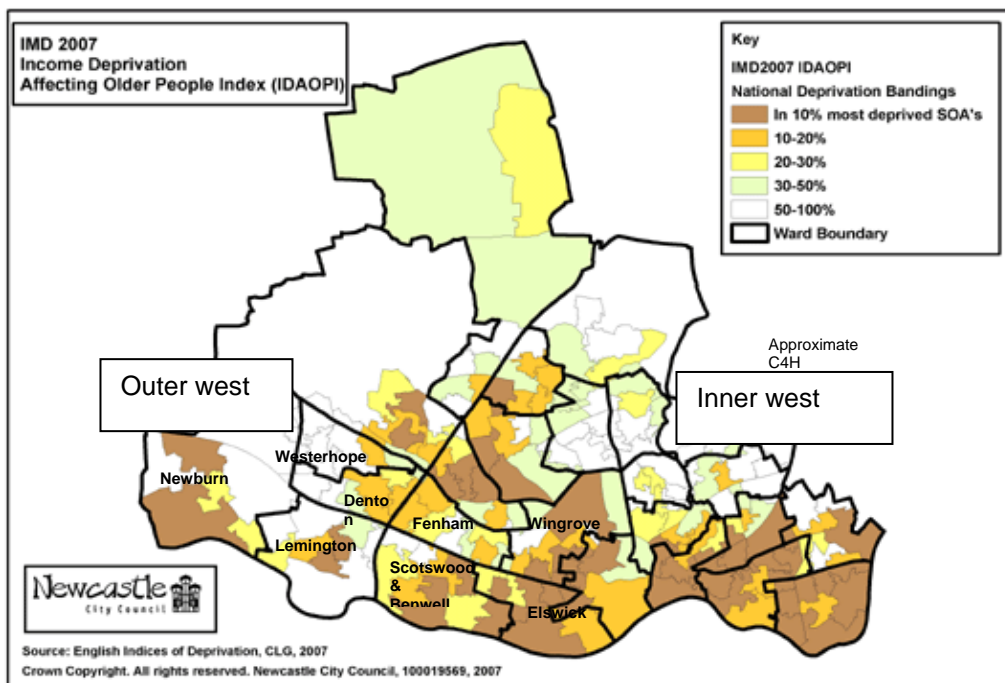


Figure 10: Map showing information regarding older people and poverty in the participating wards

⁴⁶ The Marmot review 2010

⁴⁷ Search user survey 2008

Costs

The following shows the break down of costs per year. These show the total costs for running the scheme at The Lemington Centre, The Search Project, West End befrienders, Health Trainer input and administration costs.

Year	Cost	Running total
2008	£118, 110	£118,110
2009	£120, 000	£238 110
2010	£150, 000 budget	£388,110

Table 3: Running costs for C4H

The cost per person equates to **£244** per person per year for the high level support and drops to **£70** person per year for the lower level support i.e. community activities which can be seen as having a preventative function.

For the higher level of intervention the individual is seen for an assessment which can take up to one and a half hours, or be done over several sessions, plus formal reviews at 3, 6 and 12 months as well as numerous opportunistic informal reviews. A report is sent to the GP after every assessment or review detailing the patient's progress. The individual gets three months of activities completely free, after which they pay a stepped charge. After 15 months of participation they would be paying full costs for any activity that incurred a charge e.g. gym, aromatherapy etc with the full costs of a gym session being £2.50 and £5.00 for an aromatherapy session. Looking at a market comparison these full prices are significantly lower than average.

As a comparison, the cost of prescribing Diabetes medication was £581.2 million for the period Oct 2007 – Sept 2008 and there are 2.1 million people diagnosed with diabetes² equating to **£277** per person per year.⁴⁸ (N.B. this is not the whole cost of treating diabetes per person as no account has been made for visits to health professionals/blood tests or any complications that may need to be treated)

Programme development

There are some areas that could yet be developed with in this model as **Putting People First** also suggests;

*'Binding together local Government, primary care, community based health provision, public health, social care and the wider issues of housing, employment, benefits advice and education/training. This will not require structural changes, but organisations coming together to re-design local systems around the needs of citizens.'*⁴⁹

Some of the areas have already been linked up in the process of this project such as primary care, community based health provision and benefits advice; if increased funding were forthcoming it is entirely feasible that the Communities for Health

⁴⁸ statistics from the NHS information Centre

⁴⁹ Putting people first, Adult Transformation

programme could introduce further elements such as linking up with social care and housing. This would also mean a closer working relationship and inclusion into the referral pathway with Intermediate Care Teams and further development of a link-worker role.⁵⁰ Some elements of this role are already being served by the Physical Activity and Health Trainer staff involved in the Communities for Health delivery.

There are more third sector organisations that should be involved and supported by this programme because of their locality, and the quality of the service they are currently providing. An example would be the well respected 'Time For You' project at St Margaret's Church in Scotswood, providing complimentary therapies, a listening service and a healthy eating café.

This pilot project has demonstrated effective partnership working with several organisations and has gained the trust of GP practices. The scheme can support social care services to keep people active in the community, increase their social networks and local support systems whilst facilitating individuals to better manage their health and wellbeing. It is clear that by funding the more intensive support systems for the hard to reach and vulnerable within our communities, the wider benefits have been the preventative work with many more adults.

*'To make this happen the sector needs a shared vision. The direction is clear: to make personalisation, including a strategic shift towards **early intervention and prevention**, the cornerstone of public services'.*⁵¹

This model of working is proven to be cost effective and increases satisfaction for individuals with the services provided.

*'emerging evidence from the Partnership for Older People Projects (POPPs) which indicates that earlier interventions before people reach high levels of need may be more cost-effective for the health and social care system and provide better outcomes for individuals. This is also reflected in the Office for Disability Issues report 'Better outcomes, lower costs' into housing adaptations'.*⁵²

Can this pilot be used as a model to assist adult transformation in the city of Newcastle? According to the Department of Health;

'Programme characteristics (to be scaled up) will include being:

- **evidence based-** concentrate on interventions where research findings and professional consensus are strongest
- **outcomes orientated-** with measurements locally relevant and locally owned
- **systematically applied-** not depending on exceptional circumstances and exceptional champions
- **scaled up appropriately** – industrial scale – processes require different thinking to small 'bench experiments'
- **appropriately resourced** – refocus on core budgets and services rather than short bursts of project funding; and

⁵⁰ Also discussed in Jeanette Robson's report Occupational Therapy interface and Joining the dots

⁵¹ Transforming Social Care LAC (DH) (2008)1

⁵² Transforming Social Care LAC (DH) (2008)1

- **persistent** – *continue for the long haul, capitalising on, but not dependent on, fads, fashion and policy priorities.*⁵³

Is it evidence based? -the project is directly comparable to POPPs and other parts of the project have a very strong evidence base (e.g. physical activity)

*‘Several longitudinal studies have shown that social networks and social participation appear to act as a protective factor against dementia or cognitive decline over the age of 65 and social networks are consistently and positively associated with reduced morbidity and mortality. There is strong evidence that social relationships can also reduce the risk of depression Social isolation impacts on health: social networks and social participation act as protective factors against dementia or cognitive decline over the age’*⁵⁴

Is it outcomes orientated? – The outcomes have been measured by focus groups and user surveys and have been overwhelmingly positive. The use of the Outcome star is about to be piloted in order to try to better measure qualitative outcomes.

Is it systematically applied? – In order to achieve equity of service all GP practices would need to have access to the service plus the development of an intermediate care team referral pathway. This would be part of the roll out of the project.

Is it scaled up? - The pilot has developed from a small scale project with a six month time frame to a project covering the West of Newcastle for three years. The model has shown to be robust and could be rolled out city wide, given adequate resources.

Appropriately resourced – It has been demonstrated how cost effective this type of intervention is through POPPs. In order to develop further it would require considerably more resources to involve other third sector organisations, develop appropriate administration systems and engage fully with GP practices and Intermediate Care Teams city wide.

Persistent – The third sector organisations directly involved in this project have been in existence for many years and their services will continue in one form or another even if this pilot failed to become mainstreamed.

The PCTs, Local Authorities and third sector organisations should support and welcome the Communities for Health model of working. It is a model that is effective, increases choice and participant’s satisfaction with services and fits well with the Putting People First agenda for transforming Adult Services.

If this scheme is supported and developed city wide it could have a huge benefit for individuals and their families that will demonstrate good cost savings and reduce acute hospital admissions and outpatient appointments.

⁵³ Systematically Addressing Health Inequalities DOH (June 2008)

⁵⁴ The Marmot Review 2010

Conclusions

‘Communities for Health’ has worked directly with **426** individuals to date.⁵⁵

However, staff have noticed that having the C4H programme in place has perhaps benefited others not specifically referred in to this programme. For example at The Lemington Centre it has been noted that as referrals for Communities for Health were received the numbers of Referrals for Exercise also increased. (In 2007- pre C4H -113 referrals were received while 181 were received in 2009)⁵⁶.

The aromatherapy was provided for the benefit of the C4H project and there have been 674 visits by these participants in 2009, and a further 246 visits have been made by Exercise on Referral members. The Lemington Centre has 1,009 current members who are all beneficiaries of the improved service. Similarly at Search it can be estimated that 120 of their members will fulfil the projects criteria but over 600 older people are also beneficiaries of their service and at West End Befrienders over 82 people are helped by the project. In total, with the upstream participation this is over 1, 700 people. Consider then the wider benefit to their families, friends and the community as a whole.

This data only gives one half of the picture as it quantitative data only. The omissions are how many of the referred patients have achieved their goals? This data is available but in such a form that it would take months to sift and quantify which is beyond current resources. The one area that can be reported upon is depression and anxiety and these scores show improvement.⁵⁷ It is hoped that the Outcome Star previously mentioned may fill this gap and provide quantitative data for the following areas; mental wellbeing; relationships; social networks; physical health; pain; activities of daily living; finances; and confidence to exercise.

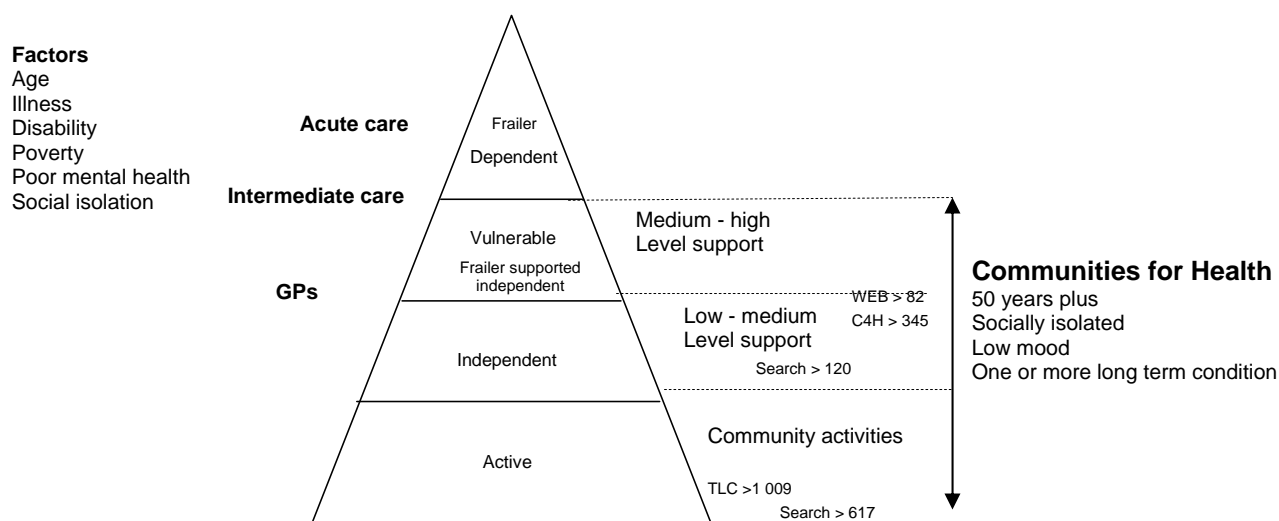


Figure 11: Diagram showing the hierarchy of need

⁵⁵ Source HealthWORKS Newcastle monitoring 2010

⁵⁶ HealthWORKS Newcastle monitoring 2010

⁵⁷ Independent evaluation by Iain Kitt 2009

The merging of the Communities for Health project into the Joining the Dots programme is timely as it fits well into the transformation of Adult Social Care and the Putting People First agenda.

A quote from the **Putting People First** paper shows how well placed the project is to move the transformation agenda forward in a model that has been tested at community level:

‘Ultimately, every locality should seek to have a single community based support system focussed on the health and wellbeing of the local population.’

The Communities for Health project has demonstrated

- positive outcomes for both the health and well being of a sector of the community that is difficult to engage
- effective partnership working with several organisations including GP practices
- a mechanism to keep people active in the community, increase their social networks and local support systems whilst facilitating individuals to better manage their health and wellbeing

Funding

‘Increased funding for longer-term projects and follow-up funding for successful pilots is needed. Increased availability of long-term and sustainable funding in ill-health prevention across the social gradient’⁵⁸

Without further funding the project will end as it would be impossible for the third sector organisations currently involved to bear the cost. If funding could be guaranteed over a period of time staff would feel confident in developing the service. Delays have already happened because of uncertainty regarding funding and staff are aware that they are offering a service to vulnerable individuals that could be taken away. This could also have a detrimental effect on the good relationships that have been built with local GPs.

Without increased funding the project cannot be developed or be rolled out city wide.

The question is, who should be approached for continued funding and how? For example the commissioners could be approached on a single issue basis e.g. the project is targeted at older people, OR that it is helping to manage long term conditions, OR that it is incorporating physical activity. This may be an easier way for commissioners to ‘understand’ the project but it would deny the holistic approach and system change model that is being worked towards.

‘Many initiatives remain as pilots and cannot secure the necessary routine or mainstream funding to continue, even when they are shown to work. In addition to increasing the amount spent on ill health prevention, government funding at local and national levels needs to shift from short-term projects to longer-term interventions that are evidence-based and designed with robust evaluations. Many of the ill health prevention interventions and programmes are

⁵⁸ Marmot Review 2010

funded over short periods of one to three years, yet it often takes a number of years to witness the effects from these interventions. Failing to provide longer-term funding for small scale projects that are found to be also effective leads to a loss of knowledge and skills.⁵⁹

PCTs, Local Authorities and third sector organisations should recognise the potential of the Communities for Health model of working. It is a model that is effective, increases choice and participant's satisfaction with services and fits well with the Putting People First agenda for transforming Adult Services.

*“Thank you for all your help.
You have all been so
supportive. I feel completely
different even before I’ve
gone for counselling”¹*

⁵⁹ The Marmot Review 2010

References

The national evaluation of partnerships for older people projects POPPS (DoH)
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111240

Summary NHS operating framework 2010/11
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107

Systematically addressing health inequalities (DoH) June 2008
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086570

Improving the health and wellbeing of people with long term conditions (DoH) Jan 2010
www.dh.gov.uk

Joint strategic Needs assessment Newcastle upon Tyne 2009 (LA)
www.newcastlejsna.org.uk

Draft mental health profile Newcastle 2008
www.newcastlejsna.org.uk

Lets get moving – commissioning guidance (DoH) October 2009
www.dh.gov.uk/en/PublicHealth/HealthImprovement/PhysicalActivity/DH_099438

The Marmot Review(DoH) February 2010
www.ucl.ac.uk/ghcg/marmotreview/FairSocietyHealthyLives

NHS information Centre
www.ic.nhs.uk

Joining the Dots Discussion Paper 2009 Prof Chris Drinkwater
S: Current Major projects/Joining the Dots

Joining The Dots – Occupational Therapy interface Jeanette Robson 2009
S: Current Major projects/Joining the Dots

Report on work with communities for Health Dr Gerard Reissmann January 2010
S; Current major projects/communities for health/delivery &roll out/ draft report/ appendices

Transforming Social Care LAC (DH) (2008)1
www.dh.gov.uk

Independent evaluation by Iain Kitt 2009
S; current major projects/communities for health/evaluation

Putting PeopleFirst (DoH) 2007
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081118

Everyone's tomorrow 2007
www.newcastle.gov.uk

Appendices



COMMUNITY HEALTH TRAINERS

In Choosing Health (DoH 2004) Health Trainers were identified as a means of providing advice, motivation and practical support to individuals in their local communities.

“in keeping with a shift in public health approach from ‘advice from on high to support from next door’, health trainers will be drawn from local communities, understanding the day-to-day concerns and experiences of the people they are supporting on health. They will be accredited by the NHS to have skills appropriate to make they changes they want, in touch with the realities of the lives of the people they work with and with a shared stake in improving the health of the communities they live in, health trainers will be approachable, understanding and supportive.”

Choosing Health also set out six specific areas of health inequality to be tackled:

- Smoking
- Diet and Obesity
- Physical Inactivity
- Alcohol Abuse
- Sexual Health
- Mental Health

What is a Health Trainer?

- A key tool in addressing health inequalities
- Health Trainers reach out to people who are in circumstances that put them at greater risk of poor health.
- Drawn from the local community or knowledgeable about the community in which they will serve
- Either paid or unpaid within the NHS or part of a third party partner organisation
- Be trained in a variety of settings, determined according to local requirements, including classroom-based learning and on the job training
- Accredited nationally
- Either identify, or have referred to them, appropriate ‘clients’ drawn from hard to reach disadvantaged groups. Clients can self refer too.
- Work with those clients 1:1 to assess their lifestyle and wellbeing and identify any areas they wish to work on

- Work with the client to set goals, agree an action plan and provide individual support where necessary focussing on behaviour change
- Monitor and review their client's progress and revise the plan where necessary to meet the clients goals
- In most cases Health Trainers work from locally based services which offer outreach support from a wide range of community venues.

Progress and Outcomes

- Nearly 90% of Primary Care Trusts have a Health Trainer Service
- More than 3100 Health Trainers (City and Guilds Level 3) and Health Trainer Champions (RSPH Level 2) are either trained or in training
- 60,000 clients have been seen by Health Trainers
- Nearly half of Health Trainers are drawn from the 20% most deprived communities in the country
- Two thirds of clients fall within one or more deprivation indicators
- More than two thirds of clients have achieved a goal within their Personal Health Plans (PHPs)
- There has been considerable enthusiasm for the concept among third party organisations (e.g. Offender Health, British Army, Royal Mail, Football Foundation and the National Pharmacy Association)

Qualifications:

City & Guilds Certificate for Health Trainers at Level 3 is the national qualification for Health Trainers and forms the basis of the training and development needed for their role. The Level 3 Certificate for Health Trainers comprises four mandatory units which cover the following national occupational standards (competences) which describe what a Health Trainer needs to be able to know and do, when they are fully developed in their post:

HT1 Making relationships with communities

HT2 Communicate with individuals about promoting their health and wellbeing

HT3 Enable individuals to change their behaviour to improve their own health and wellbeing

HT4 Manage and organise your own time and activities

The four units must be completed in order to achieve the full certificate. No previous qualifications are required. Individuals employed as Health Trainers might take a number of months to achieve the competences - this will depend on the knowledge, understanding and skills they have before they take up the post. The Certificate for Health Trainers is within the national Qualifications and Credit Framework (QCF).

More information about the qualification can be found at www.cityandguilds.com and the National Occupational Standards (NOS) (or competences) for Health Trainers can be found at

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_100720.pdf

There is currently a variety of training providers offering both Health Trainer and Health Trainer Champion training, that lead on to the qualifications described above (HealthWORKS being one of them). A range of e-learning resources are also being developed. Training is usually organised in partnership with the local Health Trainer service and delivered to meet local needs.

Quarter 1 2010 C4H report

Compiled By Rachel Silcock

This report shows the monitoring figures from Inner and Outer West for the Communities for Health (C4H) project in Quarter 1, April 1st 2010 – June 30th 2010 excluding figures from SEARCH.⁶⁰

The new Outcome star has recently been piloted this quarter on some of the C4H clients that have been referred. There is a review meeting scheduled for the end of July and feedback will be discussed in the next quarterly report.

From the inner West there has been 14 referrals to the Communities for Health project in Quarter 1 2010. See figure 1:

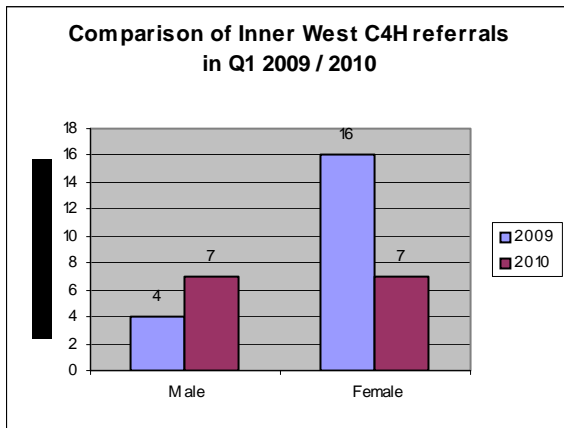


Fig 1. Comparison of Inner West C4H referrals in Q1 2009 / 2010

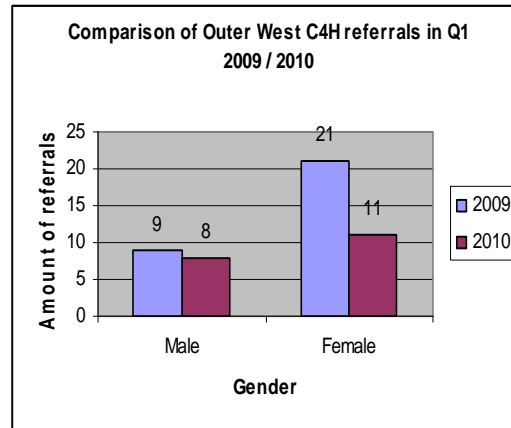


Fig 2. Comparison of Outer West C4H referrals in Q1 2009 / 2010

The Outer West figures can be seen in Figure 2.

For the comparative quarters in the Inner West we are receiving referrals from the following surgeries as can be seen in figure 3 & 4 below:

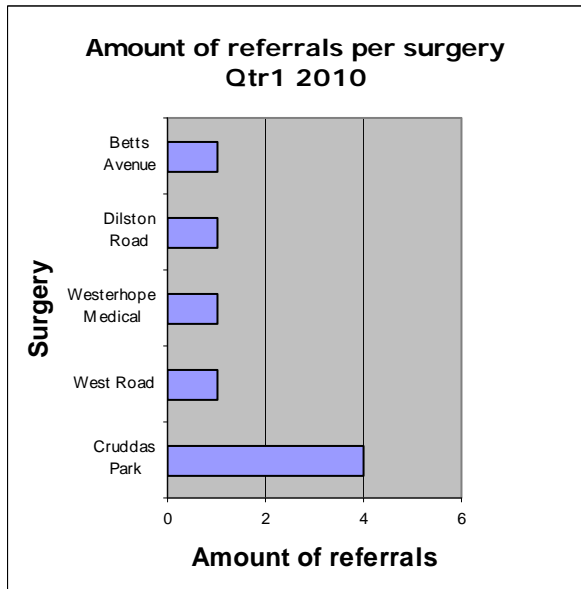


Fig 3. Referrals per surgery in the Inner West Qtr 1 2010

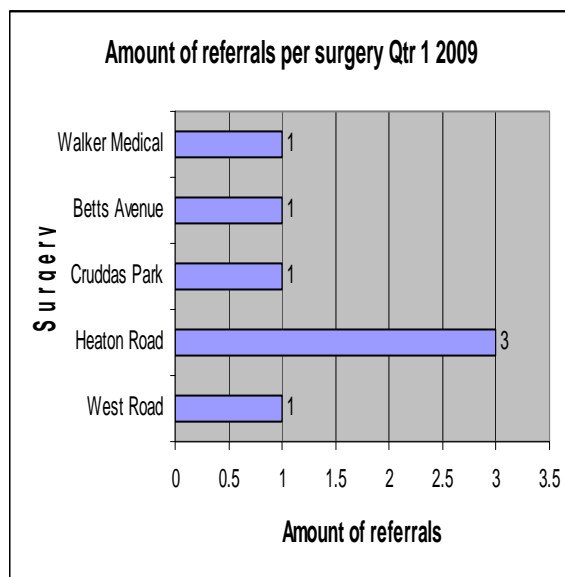


Fig 4. Referrals per surgery in the Inner West Qtr 1 2009

⁶⁰ These are available as a separate appendices

Six of the referrals from the Inner West C4H project in 2010 were referred from sources other than the GP's, in comparison to the same quarter last year there were 13 referrals from other sources. This would include Health Trainers or other Health professionals.

In 2010 qtr 1 we have had no referrals from Heaton Road Surgery who were our biggest referrers in qtr 1 2009. On our criteria we have Holmside as one of our main surgeries for the Inner West but as can be seen in Quarter 1 from both 2009 & 2010 we have had no referrals from Holmside to the Inner West C4H project. After looking across all the data from April 2009 Holmside have only made one referral into the Inner West C4H project. However, there have been 6 referrals to the Outer West C4H project from Holmside Surgery, 3 of which were in the first quarter of 2010. The same issue is apparent with Grainger Medical group, as they also have no referrals to the C4H Inner West project in the two comparative quarters and again have only made 2 referrals to the C4H inner West project since April 2009. Cruddas Park has been the most productive with referring into the project and this could be attributed to Elaine Glendenning (HWN Health Trainer) being present at the Surgery every Monday for the Diabetes clinic.

Outer West monitoring shows that the referrals have been coming in from a variety of surgeries, mainly Throckley, Parkway and Holmside (As mentioned earlier this is one of the surgeries on the Inner West criteria list) The most noticeable difference is the reduction in referrals from Newburn Surgery compared to the same quarter last year.

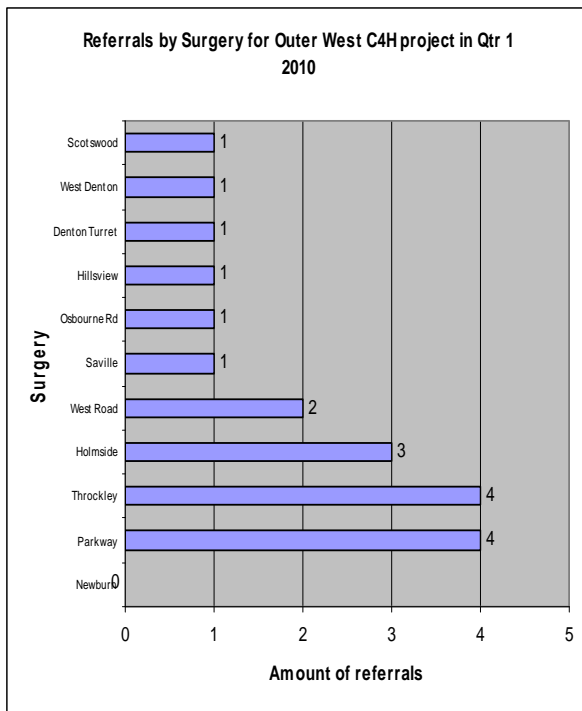


Fig 5. Referrals per surgery in the Outer West in Qtr 1 2010

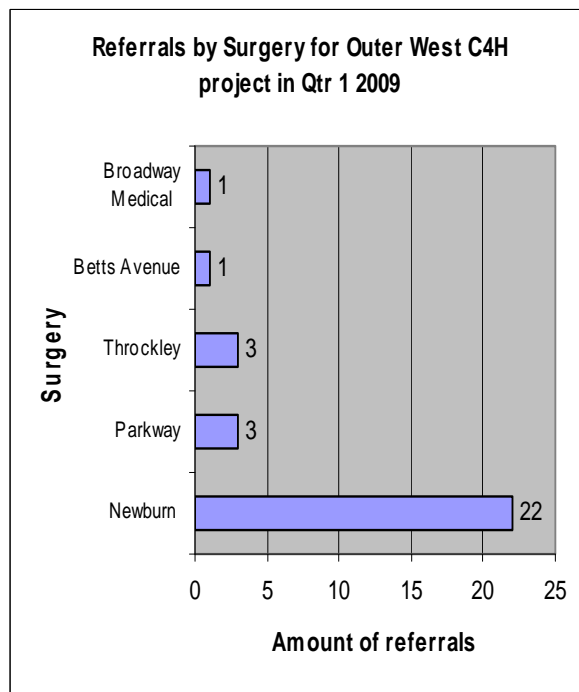


Fig 6. Referrals per surgery in the Outer West in Qtr 1 2009

Newburn referred 22 people into the C4H project in Q1 2009 and they referred none in Q1 2010. Throckley and Parkway have stayed consistent and the small increase in referrals from other surgeries shows that the project is becoming recognised by surgeries across the city that may have not been initially targeted.

Figure 7 & 8 below show the individual GP's that have referred into the C4H Outer West project across Q1 2009 and Q1 2010.

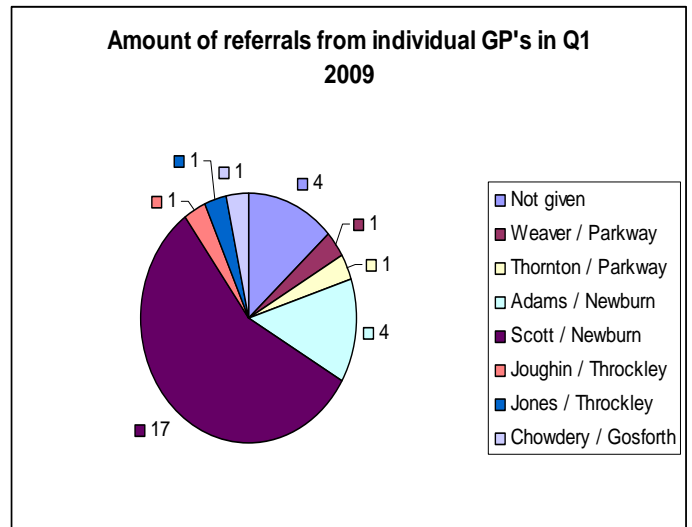
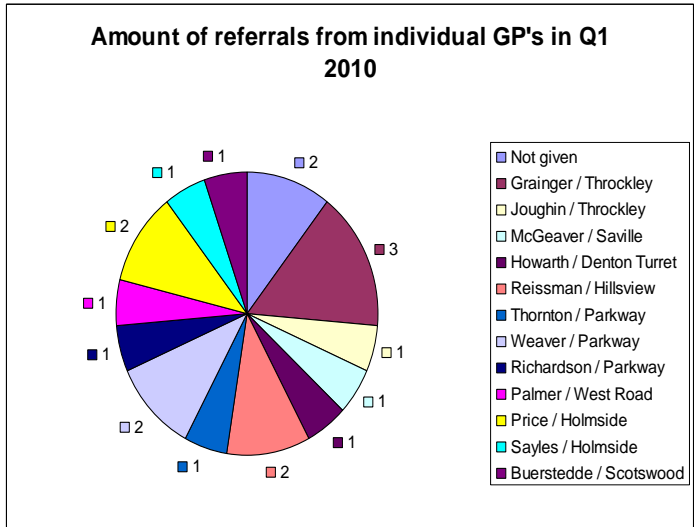


Fig 7. Referrals from individual GP's in the Outer West Qtr 1 2010

Fig 8. Referrals from individual GP's in the Outer West Qtr 1 2009

We have no data for individual GP's in the Inner West.

As seen in figure 9 there has been an increase in referrals from the NE4 (Newcastle West & Fenham) postcode area but there has been a drop off in every other postcode, noticeably from NE1 (Newcastle City Centre) and NE6 (Byker, Heaton and Walker).

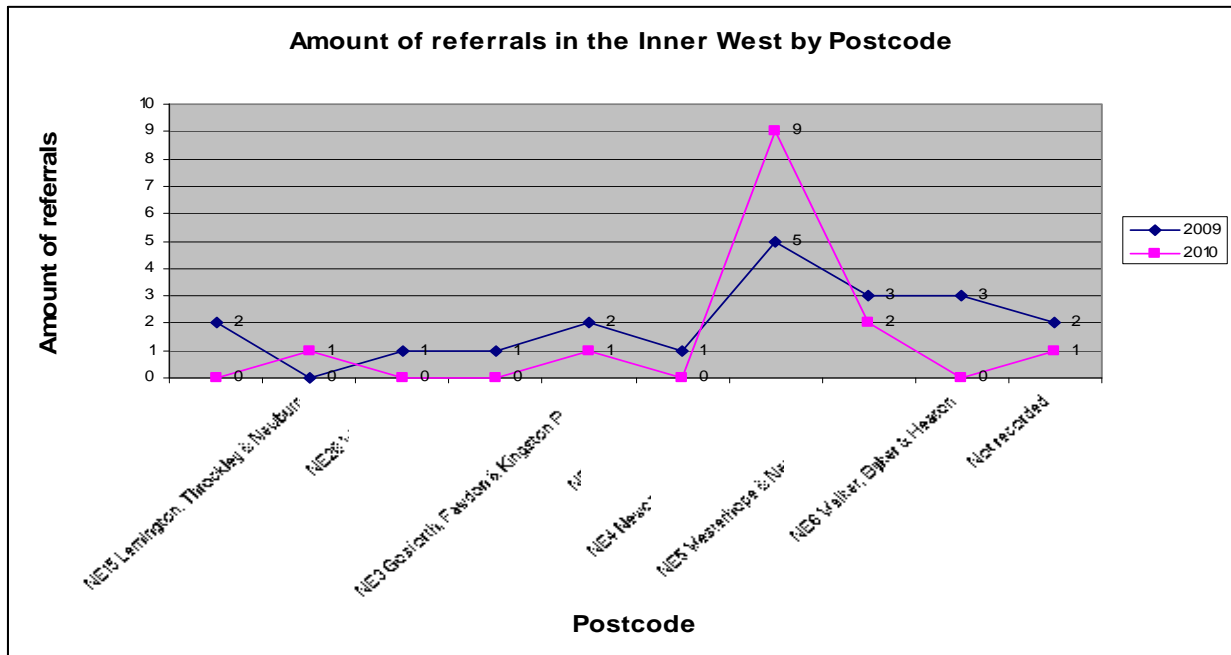


Fig 9. Referrals from the Inner West Q1 2009 & 2010 by Postcode

Figure 10 shows a significant drop in referrals from Lemington and Throckley, but an increase in referrals from West Denton.

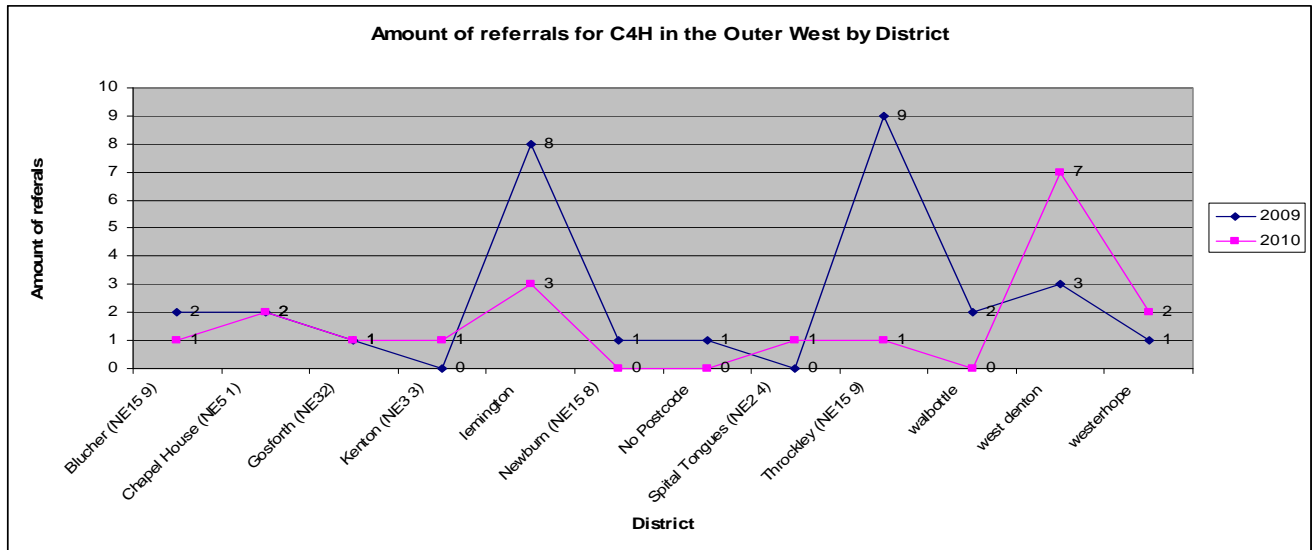


Fig 10. Referrals from the Outer West Q1 2009 & 2010 by District

As expected with reduction in referrals, gym attendance for C4H clients has also decreased in comparison to the same quarter last year. Although there was a slight rise in May 2010, June and April have been considerably less than quarter 1 2009.

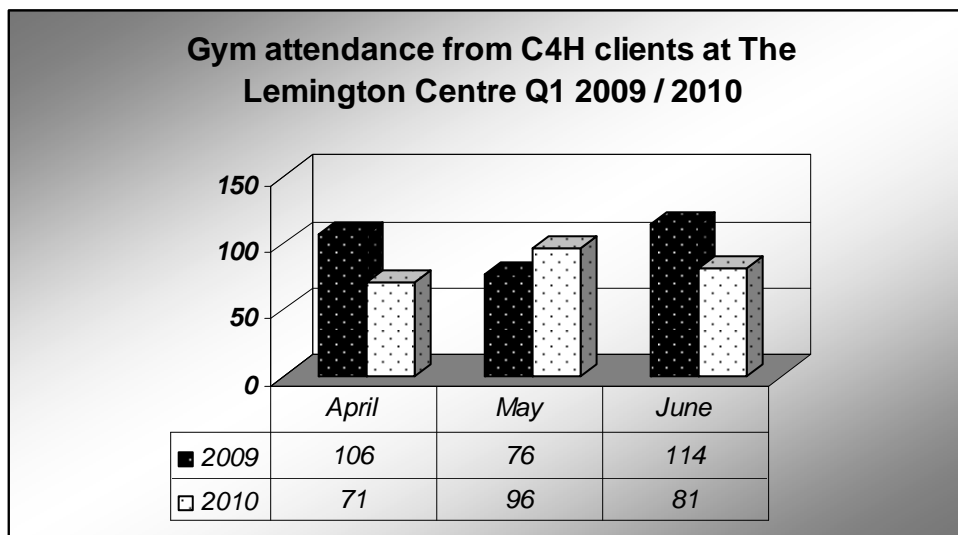


Fig 11. Gym attendance at The Lemington Centre for C4H clients in comparative quarters

None of the referrals for the Inner West and only one of the referrals for the Outer West were from an ethnic background other than White British in this quarter.

The figures from West End Befrienders (WEB) for quarter 1 2010 with there main aim being to support individuals from Minority Ethnic communities.

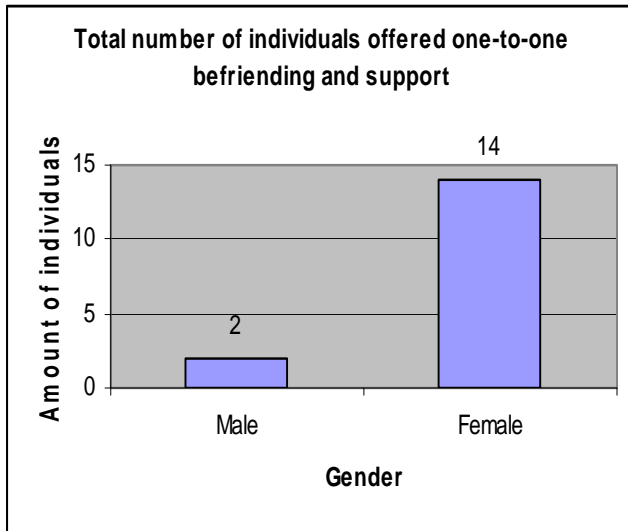


Fig 12. Total number of individuals offered one-to-one befriending and support from WEB

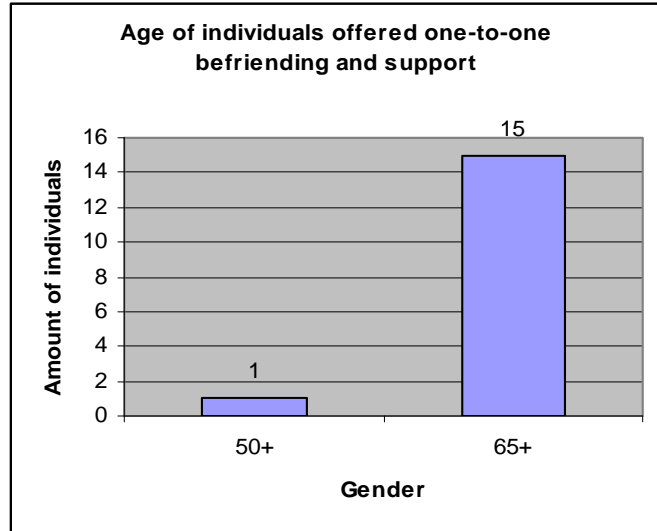


Fig 13. Age of individuals offered one-to-one befriending and support from WEB

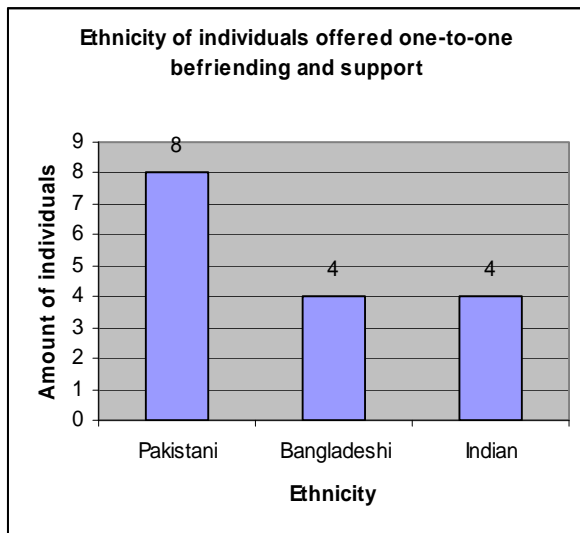


Fig 14. Ethnicity of individuals offered one-to-one befriending and support from WEB

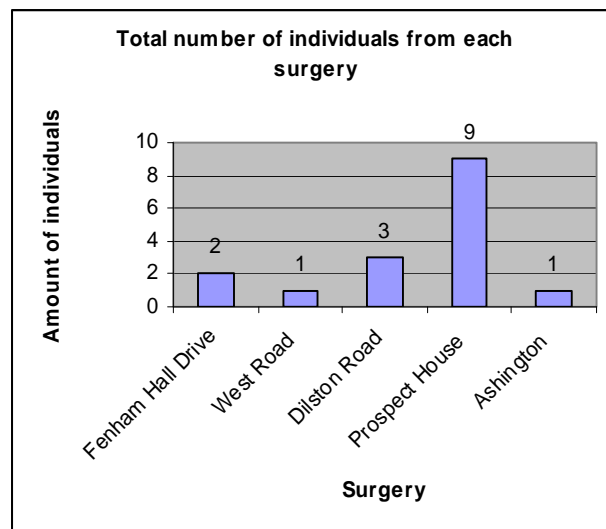


Fig 15. Total number of individuals from each surgery who take part in one-to-one befriending and support from WEB

The figures above are for the period April 09 – Jun 2010. The West End Befrienders (WEB) continue to work with all their previous service users and in Qtr 1 2010 have had one new service user, a Pakistani lady from the NE4 district currently registered with a GP in Ashington who is being offered one-to-one befriending and support and is attending the group sessions. There have also been 3 new Bengali ladies who have joined the group sessions in the last quarter and WEB has taken on another female volunteer who works one-to-one with service users. WEB have provided 3-4 days out for the service users in the last quarter and 10-12 people attended with 2-3 volunteers supporting each time.

Overall there have been 159 referrals to the Inner West and 229 referrals to the Outer West for the Communities for Health project since it started in 2008.

year	inner west HT	outer west PAT	totals
2008	68	111	179
2009	73	81	154
2010	18	37	55
	159	229	388

Fig 16. C4H referrals since 2008

In conclusion there has been a significant drop in the referrals in Qtr 1 2010 for the C4H project in both the Inner and Outer West compared to the same quarter last year. Linz has recently added Betts Avenue as an extra surgery on the criteria for the Inner West and with the small but constant trickle from other surgeries that have not been specifically targeted then we can hopefully increase or sustain the amount of referrals in the next quarter.

ⁱ Department of Health. *Communities for Health: Unlocking the energy within communities to improve health*. October 2009

ⁱⁱ Iain Kitt. *Communities for Health Project: evaluation report*. May 2009

ⁱⁱⁱ Personal Social Services Research Unit. *The National Evaluation of the Partnerships for Older People Pilots*. 2009. (www.pssru.ac.uk)

^{iv} Female with cognitive damage due to repeated cardiac events, very low mood