Care Plus Group

General Evaluation of the Health & Wellbeing Collaboratives 2014

Contents

Executive summary

- The Collaborative Portfolio of programmes have been in operation in North East Lincolnshire since 2007. In this time they have risen to the health and social care challenges that have been put before them.
- The programmes are set up to deliver the 5-ways to wellbeing and have a strong focus on prevention and early diagnosis of a range of topics.
- The Programmes rely heavily on volunteers and in 2014 there were 80 ACTIVE volunteers who provided 6790 hours of volunteering to support the programmes. An active volunteer is someone who has worked on the programme in the previous 6 months. The value of the time provided by volunteers in 2014 is calculated at £84,529 (using minimum wage and costs).
- The programmes are set up using an adaptation of a rigorous process originally designed in the USA but which now bears no resemblance other than the rigor applied to demonstrating impact.
- North East Lincolnshire has an ageing population destined to suffer ill health for longer unless there are changes in lifestyle and unhealthy behaviours.
- Loneliness and isolation materially affect the health of older people and as the population ages this could become a serious issue impacting on demand for services. 6838 of over 75s are estimated to be living alone in 2010 but by 2030 this is predicted to increase to 10,292 which is a significant rise.
- The older people's health and wellbeing programme attempts to address loneliness and isolation in a variety of ways. Some delivered in partnership with other agencies, being targeted to the individual and others by developing a network of support via social clubs. In 2014 there were 19 volunteer led and delivered social clubs in the NE Lincolnshire area with 12,362 attendances within them. The clubs provide activities such as Tai Chi, outings, New Age Kurling and whatever the participants identify of interest.
- The specific health risks of older people during seasons such as how to survive winter cold and summer heat are promoted within specific campaigns delivered by the older people's health and wellbeing programme.
- The Early Presentation of Cancer symptoms programme focuses on the signs and symptoms of the main tumours affecting the local area. These are bowel, prostate, gynaecological, lung, throat and upper gastrointestinal. In 2014 the teams made 10,971 contacts with the public to raise awareness using events and both national and locally designed materials.
- Since 2011 the team has trained 420 Cancer champions to offer more detailed support to people in the community. The cancer champion initiative has been successfully funded by MacMillan for the period 2012 – 2014.
- Cancer Screening rates for cervical cancer are in excess of the national target of 80% at 83.5%. This is a significant rise from 79.8% in 2006 before the start of the programme. This achievement is in part due to the activities of the 'Inside Counts' initiative targeting 25 – 34 year old women and which was designed and is delivered by the programme team.
- Bowel cancer screening rates are close to the national target of 60% at 59.9% and the achievement of 55% plus has been consistent since the commencement of the programme in 2007.

Executive summary *Continued*

- The skin health collaborative has been operating since 2009 with a small number of volunteers but despite this has had 1,101 contacts with the public for brief intervention conversations. There is scope to further address the results of the Moffatt et al (2009) report with a small additional resource.
- During 2014 the team set up a small group to raise awareness of dementia signs and symptoms and where to get help if you need it. During the second half of 2014 the dementia team made 281 contacts for brief advice conversations. The team was set up with a modest investment of £2,631 from the Releasing Community Capacity programme and to date they have provided 203 volunteer hours which equates to £2,527.
- The Collaborative programmes have been proven to be effective and cost effective and clearly fit with local strategic intention and direction. They are well placed to support the communities to help meet the challenges of reduced budgets and decommissioned services. They are unique in their reach, scope and approach and this has built in spread and sustainability opportunities. They are seen as experts in Community Engagement in North East Lincolnshire, and are sought out as mentors by services and communities.
- The approach is unique and no other area in the UK has the same focus on topics and the collaborative approach which brings all sectors together to tackle common issues.
- The Collaborative programmes struggle to expand as the capacity to manage volunteers and be innovative is limited to a historical staffing establishment. With modest investments in the team a lot more can be achieved and sustained.
- There are a number of recommendations to help with the spread and sustainability of the programme.

1. Seek additional resource to have a specific focus on the recruitment, induction and training of volunteers and to set up a volunteer support programme.
2. Additional long term condition topics are added to the portfolio.
3. Suggest to the Clinical Commissioning Group that the skin health report (Moffatt et al 2009) is revisited to identify potential prescribing savings.
4. Raise awareness of the skin health and the dementia awareness programmes by way of a systematic information programme for professionals.
5. The older people's programme needs to ensure its place in discussions relating to older people's service developments such as having a key role in the Good Neighbours programme, for example.

Introduction

Health is defined by the World Health Organisation (WHO) as ***'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'***[1]

Whilst the definition has not changed since 1948 many international health systems have modified the definition over time to suit their own priorities and circumstances.

The UK Government defines health and wellbeing in a broader way,
'a positive physical, social and mental state; it is not just the absence of pain, discomfort and incapacity. It requires that basic needs are met, that individuals have a sense of purpose, that they feel able to achieve important personal goals and participate in society. It is enhanced by conditions that include supportive personal relationships, strong and inclusive communities, good health, financial and personal security, rewarding employment, and a healthy and attractive environment.' [2]

More recently the UK NHS and Public Health England have pointed to the New Economics Foundation's: Five Ways to Wellbeing as a simple way of defining the dimensions needed to improve health and wellbeing in the population. [3] The Five Ways to Wellbeing model devised by the New Economics Foundation are a set of evidence-based actions which promote people's wellbeing. They are: Connect, Be Active, Take Notice, Keep Learning and Give. These activities are simple things individuals can do in their everyday lives and the Health and wellbeing Collaboratives [4] all contribute to these aims and the results are shown below.

[1]Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

The Definition has not been amended since 1948.

[2]Our health and wellbeing today – HM Government (2010)
[3] http://www.neweconomics.org/projects/entry/five-ways-to-well-being
[4] The IHI (USA) Breakthrough series and adapted for communities and the UK in 2000

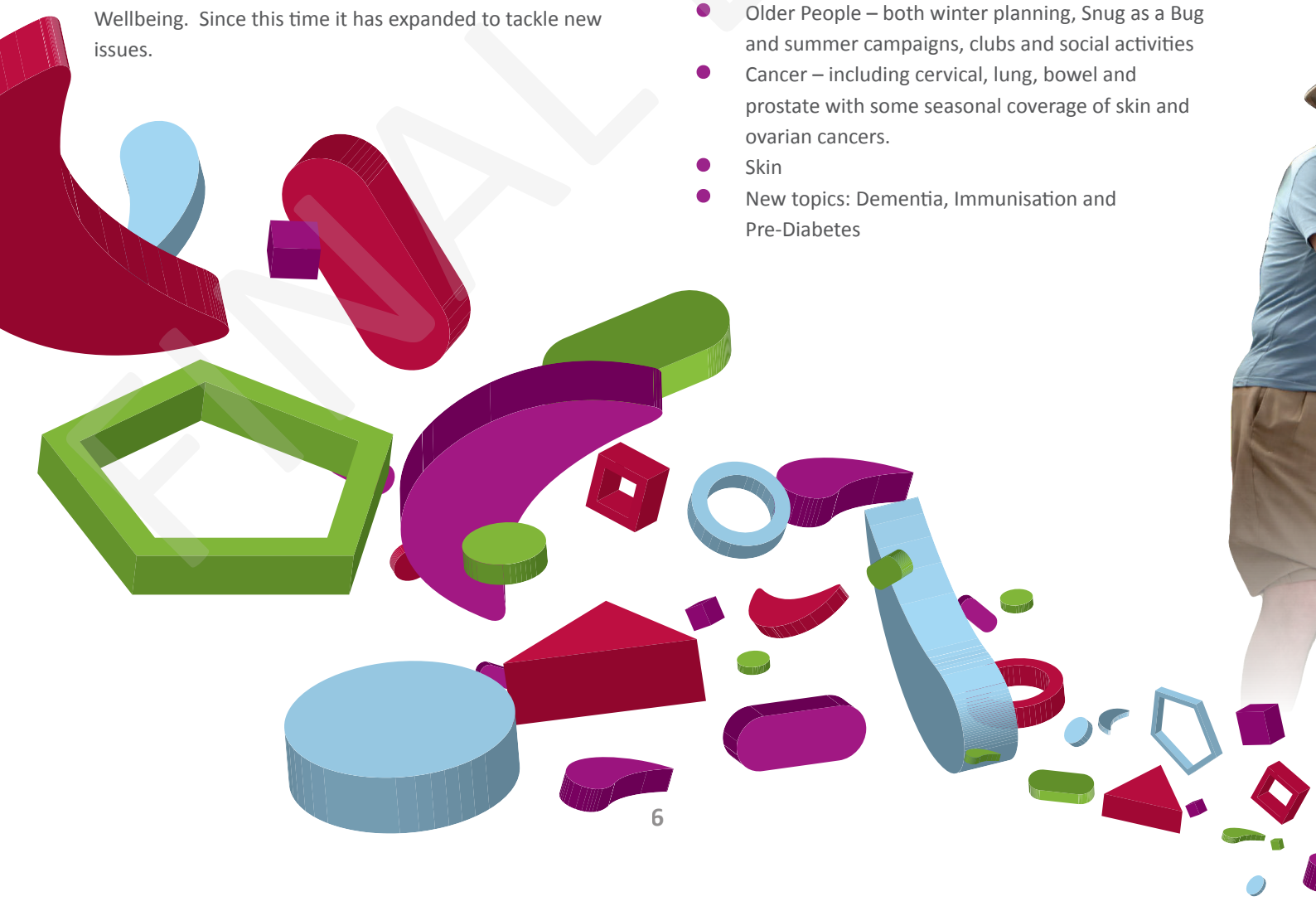
The scope of the impact of the Health and Wellbeing Collaboratives

North East Lincolnshire has a family of collaborative programmes operating across the area. The approach originates from a 2002 Department of Health programme called the 'Healthy Communities Collaborative'. It uses a blend of community led behaviour change, community involvement and community action methodologies. Community teams comprised of at least half local people are supported by a range of professionals who contribute their service expertise and support.

Having taken part in the Department of Health programme to tackle falls amongst older people, North East Lincolnshire applied for Neighbourhood Renewal Funding in 2007 to develop the approach and spread to additional localities. A successful application led to the approach being adopted for Cancer and Older People's Wellbeing. Since this time it has expanded to tackle new issues.

This report looks at the work done by the teams from January to December 2014. It focuses on the headline data collected by the Health and Wellbeing Collaborative Team and covers:

- Older People – both winter planning, Snug as a Bug and summer campaigns, clubs and social activities
- Cancer – including cervical, lung, bowel and prostate with some seasonal coverage of skin and ovarian cancers.
- Skin
- New topics: Dementia, Immunisation and Pre-Diabetes



Summary
Overall data: *Volunteers*

*Volunteers are sometimes defined as **'Someone who gives time, effort and talent to a need or cause without profiting monetarily'**. Within the Collaboratives there are 84 volunteers.*

Pre-Diabetes	8
Early Presentation of Cancer	37
Skin	6
Older People	33
Dementia (these volunteers are members of other Collaboratives)	10
Total	**94**

Within the Collaboratives the volunteers are called 'team members' and are treated in exactly the same way as paid members of staff with shared events, shared tasks, shared training and the opportunity to co-produce the programme by adding their insight and plans into the design and delivery. This greater level of responsibility is one of the reasons why some of the volunteers/ team members have been members since 2007 and are responsible for the ever changing programme of events and resources that support the programmes.

The Value of Volunteers

The Cancer and Older People Collaboratives currently have the most volunteers, each with around one third of the overall total. Both benefit from the longest running initiatives. Older people also gains from the clear benefit to many of the volunteers who are older people themselves, in addition to having plenty of issues to tackle.

Early Presentation and diagnosis of cancer is a national and local priority and continues to be a popular issue to tackle. Given the steady number of volunteers over the year, retention clearly has not been a problem.

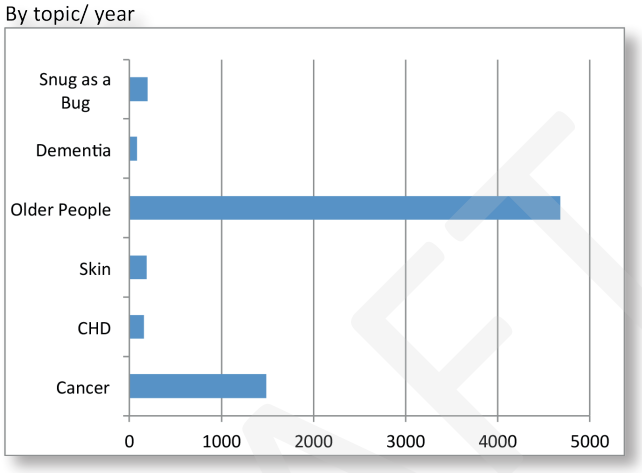
Volunteers supplement paid workers and without them certain interventions and events would not be possible as staff capacity is limited. Measuring the economic value of the work of volunteers is useful in return on investment calculations and performing a Volunteer Investment and Value Audit (VIVA). There are different bases for calculating economic value such as:

- Using minimum or living wage rates as a basis (£6.50/£7.85)
- Using national gross average, full time, hourly rates of pay (£13.90)
- Using local rates of pay – available from ASHE tables. (Lowest Durham £11.91).
- VIVA – uses a comparable local wage for that sort of activity. E.g. Administration tasks may realise £7.00 per hour or engagement activities £8 per hour.

The volunteers worked a significant number of hours: a total of 6,790. An indicative value of this in monetary terms can be given by multiplying the number of hours by the minimum wage of £12.45 (inclusive of national insurance payments): this equates to £84,529 for the year if this activity was to be delivered by paid workers.

Volunteer hours

By topic/ year



Looking at the number of hours by topic sees a correlation with the number of volunteers, with the exception of Older People which is higher than expected. This would appear to be as a result of a significant number of regular activities being run each month.

Being part of a collaborative means that volunteers are all trained in the same way. Training is a combination of different skills designed to help the volunteer understand the issue in hand, unpick it using a set of principles, come up with ideas, test these ideas using PDSA[5] approaches and to build sustainable interventions.

The change principles include, not exclusively...

- Understand the need
- Build on and Develop networks
- Focus energy on a common goal

This approach requires the volunteers to map what is already in existence before they set up new initiatives. They also perform some social marketing approaches such as segmenting and targeting audiences, developing insight into those audiences to identify barriers and motivators to change and use creative approaches to the development of resources and appropriate methods of dissemination of messages. This approach means that the teams can be more effective in their approaches and don't waste time and resources.

[5]Plan Do Study Act – Deming (1956)

The Older People's Health and Wellbeing Programme

The Need

North East Lincolnshire has an ageing population that is growing older more quickly than the national average. People are living for longer, but they are also living for longer in poor health.

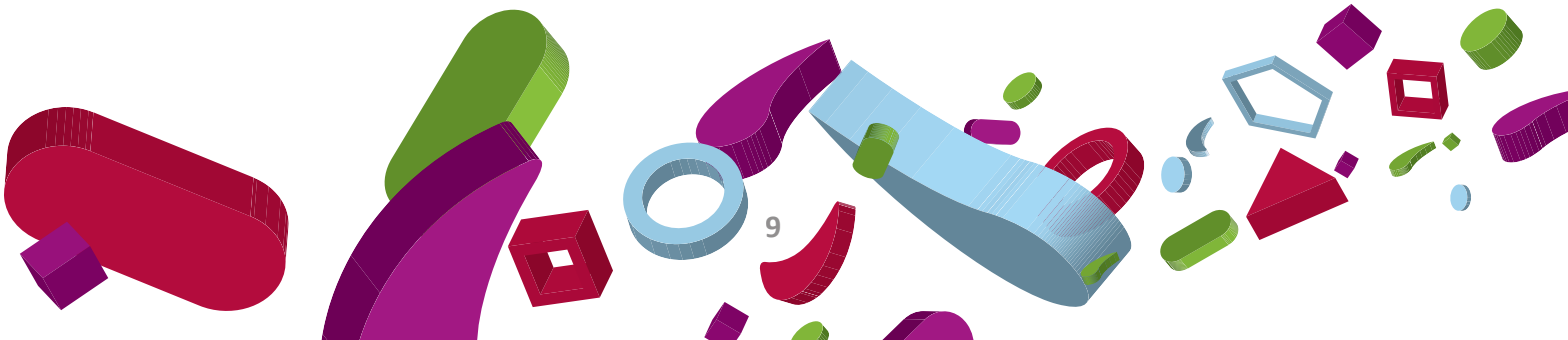
- According to the 2011 census there were 159,616 residents in North East Lincolnshire Local Authority, of which 56400 are over 50, and 28,287 (17.7%) of these were aged 65+ years.
- The ratio of older to younger people reaches 31% in 2014.
- Almost 11,000 people aged over 65 live alone within North East Lincs, over 7500 women, and over 3500 men. This is predicted to increase to over 12000 by 2020. Around half of over 75s live alone.
- In North East Lincolnshire, over 21 people aged over 65 die each week, with death due to frailty increasing by 5% each year.
- 17,000 people over 65 have a long-term limiting illness.
- Ward residents aged 65+ years as a percentage of the total ward population ranged from 27.0% (Haverstoe) to 11.2% (Sidney Sussex)
- And almost 2500 are diagnosed as living with dementia.

Significant numbers of people are isolated and/ or in ill-health, placing pressure on social care, primary and secondary health services.

Nationally, the picture is similar with an increase in the number of people needing care into later life. The fastest increase will be in the 'oldest old' group – those aged 85 and over. Currently this group is just under 1.5million people. By 2035 this group is expected to reach 3.5 million people. Much of the care for this group is provided by adult children who may be older or also work. The picture for carers is that adult children caring for parents will care for longer. The total number of informal carers has remained constant over the last two decades however, the total number of hours of informal care has increased substantially, by 2.4 billion hours 1995 and 2010. This indicates that more and more informal carers are taking on more hours of care. Apply to this the increase in demand, reductions in social care budgets and benefits changes the need for carers to also do paid work indicates that in the future there will be a shortfall of available caregivers. This has been predicted to reach a shortfall of 160,000 caregivers nationally by 2035 (IPPR).

Loneliness and isolation are factors which materially affect the health and wellbeing of older people in the community. Those people with better health and wellbeing, social connections and activities such as those in the Five Ways to Wellbeing are likely to need less care and therefore fare better.

The Older People's Health and Wellbeing Collaborative provides all older people in North East Lincolnshire with the opportunity to access health and social activities as well as to volunteer and contribute to making life better for older people in the area.



Topic specific data: *Older people*

Mid-year estimates given in 2010 show that there would likely be 28,100 people aged 65 and over in North East Lincolnshire. 6,838 of those aged 75 and over were predicted to be living alone in 2010, projected to be 10,292 by 2030. [6]Some of the most vulnerable older people in North East Lincolnshire communities can become depressed and oppressed with their situation. The Older People's Health and Wellbeing programme works to prevent this with activities such as social clubs, lunch clubs, New Age Kurling and tea dances. Part of the attempt to reduce isolation is to co-produce sustainable social clubs run by volunteers for the benefit of local older people.

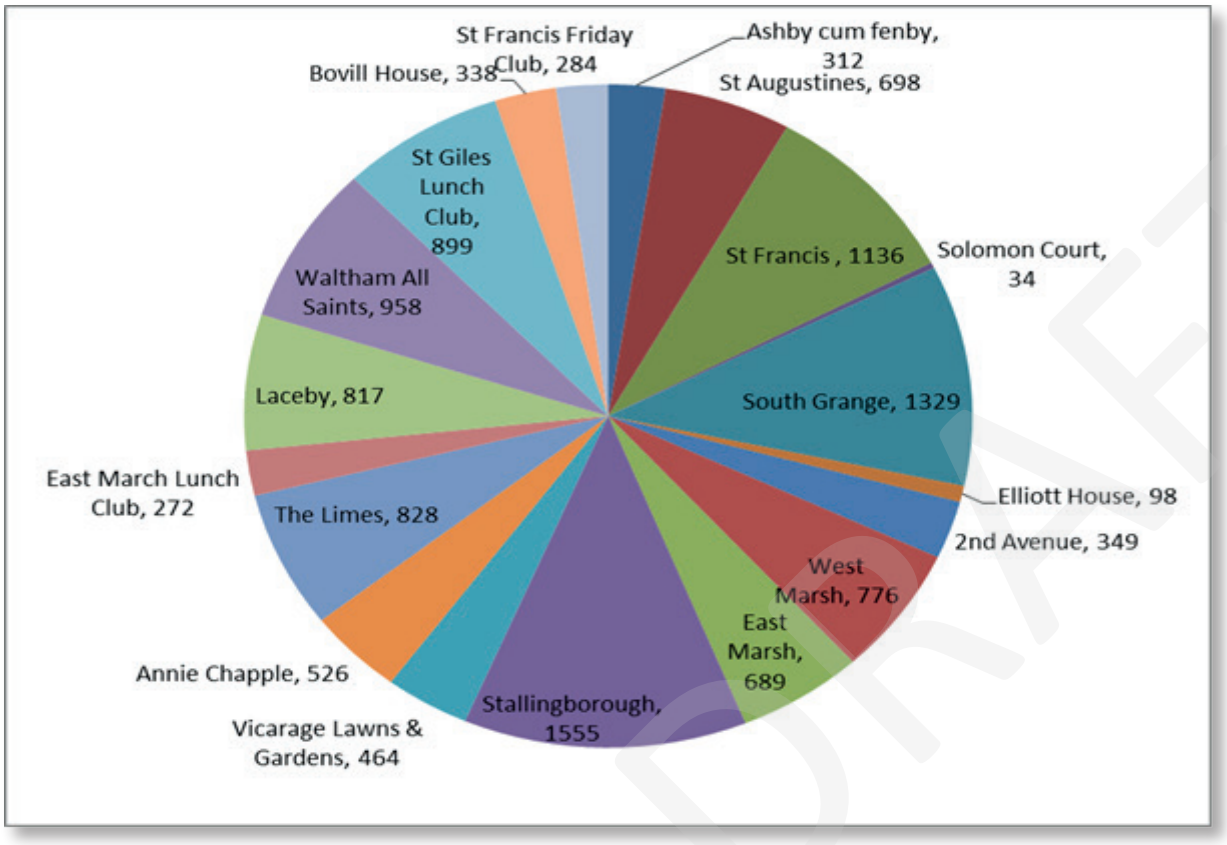
[6]THE HEALTH AND WELL BEING NEEDS OF PEOPLE IN NORTH EAST LINCOLNSHIRE *Joint Strategic Needs Assessment, 2011*

Older People's Social Clubs attendances

There are several interesting points about attendance at older people's social clubs. Firstly, there are a considerable number of clubs; 19 in the collaborative areas. Most seem to have a lot a variation in attendance levels from one month to another. This is attributed to the differing needs of older people and their varying responsibilities. In some areas the clubs close during school holidays or grandparents may have to look after children during the school holidays. Older people can also have lots of other health or social appointments to keep.

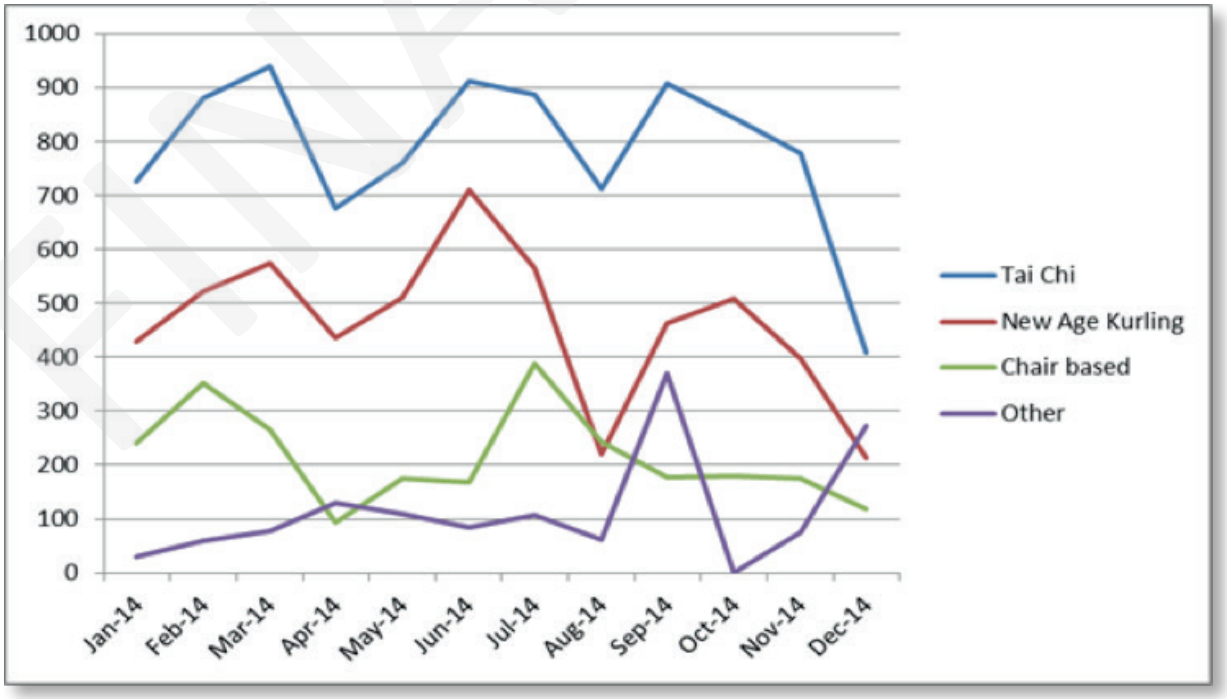
The pie-chart below gives a clearer picture of the level of attendance in each club. Whilst some clubs are clearly busier than other, most get significant numbers of people attending over the year. Overall, there were a total of 12,362 attendances at social clubs over 2014.

Total number of 2014 attendances per club



- Solomon Court has now closed due to lack of numbers, however new clubs have now been opened with the time banking imitative

Older People's Activities



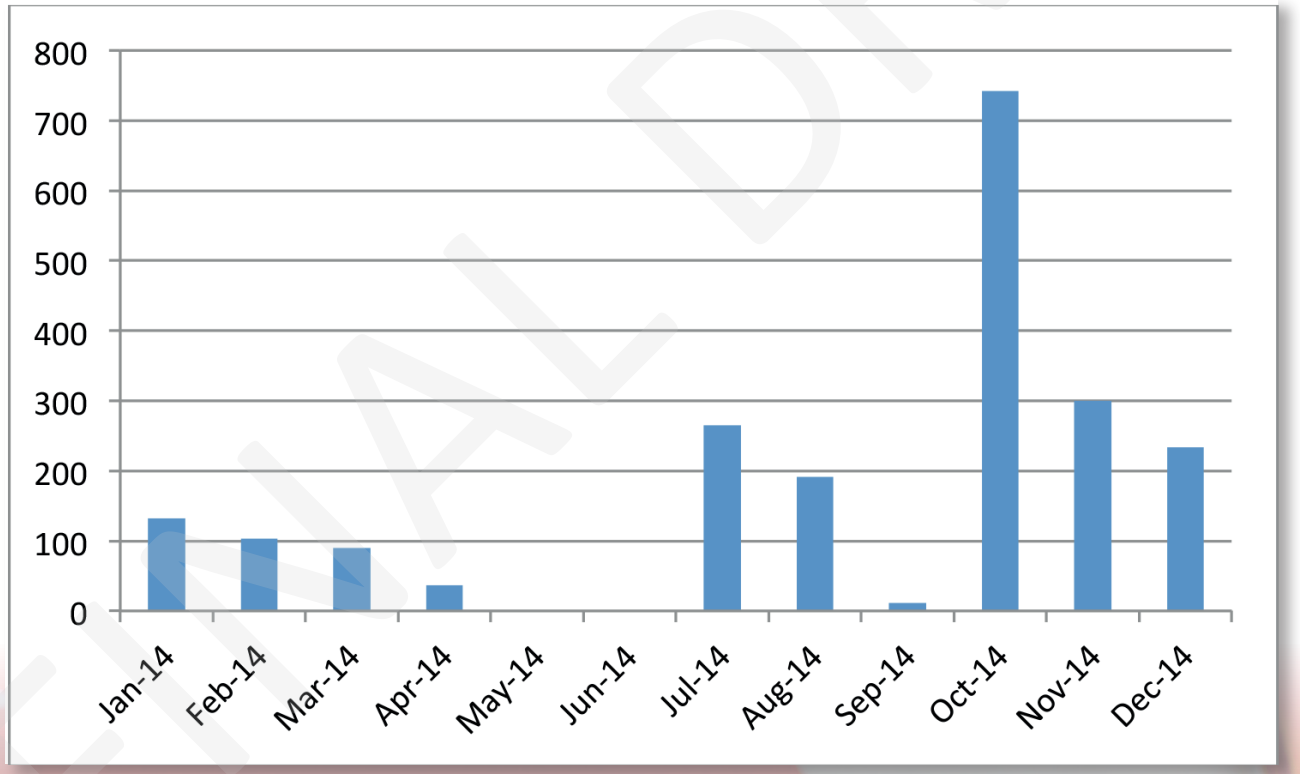
People over 65 can be more at risk of falls. One of the factors for reducing falls is to improve balance and leg strength and the evidence for this is clear that the best method of doing this is Tai Chi .[7] New Age Kurling was introduced in the collaborative in 2009 and has become very popular with the members of the social club who now have a 'Kurling Cup' and a league where they travel to other areas to compete with other older people. People with disabilities can participate in New Age Kurling so it is accessible and popular. Chair based exercise is also suitable for less mobile older people and helps them retain hand-eye co-ordination and flexibility.

[7]*Easterbrook et al, Health Development Agency (2000)*

In 2014 due to capacity and sustainability issues a Health and Wellbeing exercise co-ordinators programme was developed using funding from the change champions programme, six new exercise co-ordinators have been trained.

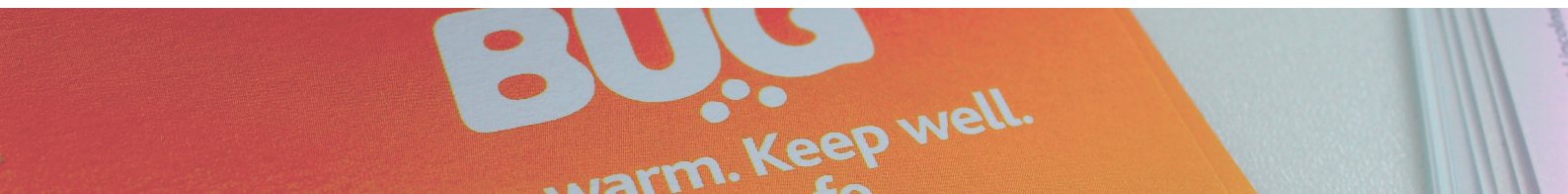
The most popular activities for older people were those that involved being on your feet; Tai Chi and New Age Kurling. Both took a dip in popularity in August and December for the summer and Christmas holidays. The category 'Other' had a spike in activity in August and December which was due to seasonal specific activities such as Summer Fayres, Christmas celebrations and shopping trips.

Snug as a Bug *Contacts*



Snug as a Bug Contacts

Snug as a bug is an initiative to encourage people to keep warm in winter. It therefore has an understandable spike in activity in the run-up to the cold season. However, Snug As A Bug was adapted this year to also include keeping cool in summer, thus explaining the summer activity.



The Snug as a Bug programme is seasonal and starts in December and finishes in March. However, snug as bug was adapted this year to also include keeping cool in summer, thus explaining the summer activity.

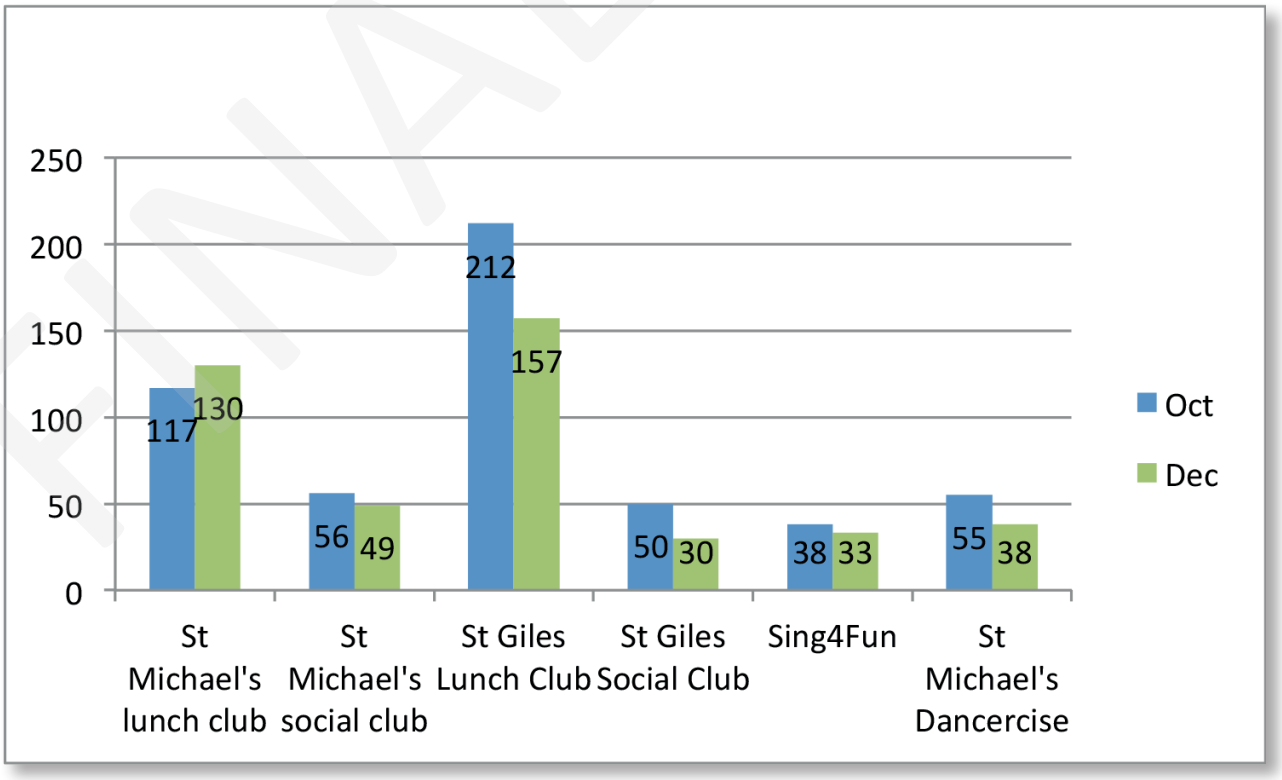
This is the seventh year of this very successful campaign which is well supported by our team of volunteers who have in this year put in over 162 hours of their own time to make the campaign work.

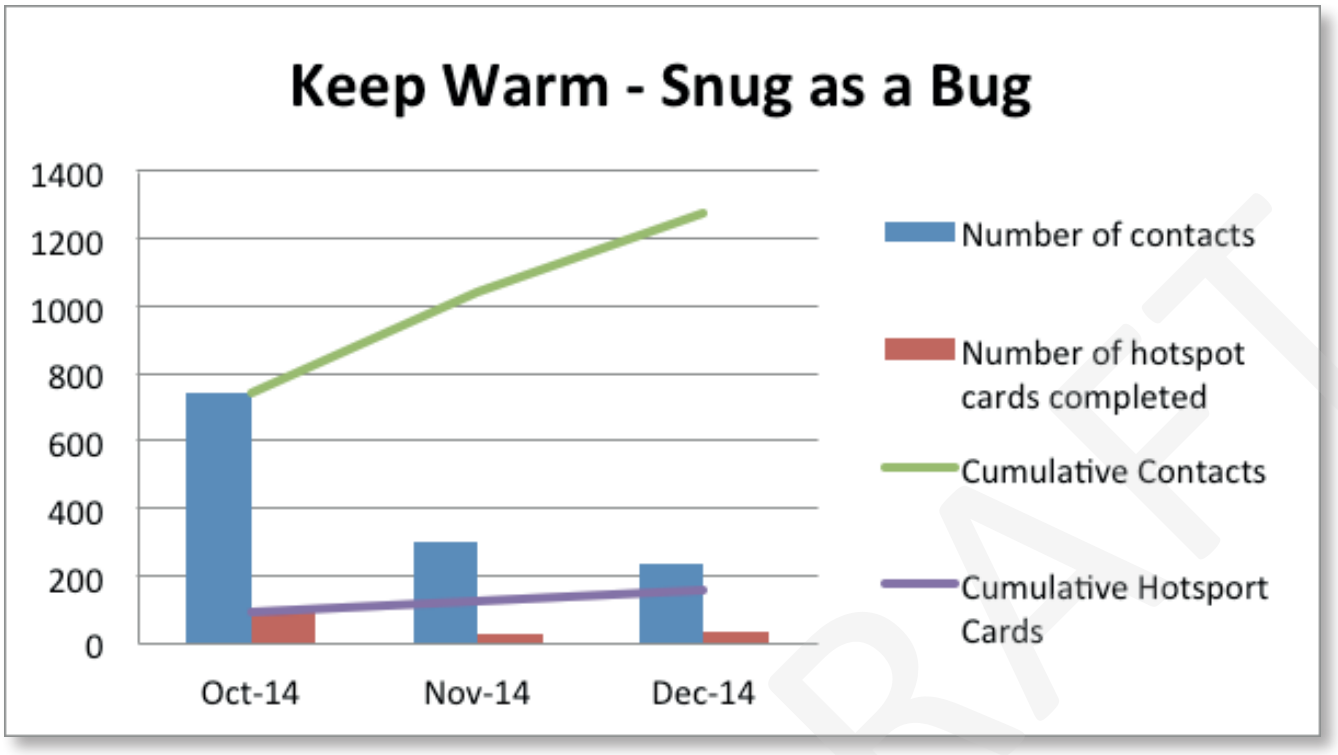
Within the Snug as a Bug sessions clients are encouraged and supported to ask for a benefits check and to complete a hotspot card. The graph below shows a clear link between the number of contacts increasing in line with the number of hotspot cards being completed. Snug as a Bug events are very important to local partners as they help to support older people with fuel poverty, benefits and home insulation. The partner agencies would have difficulty accessing these vulnerable clients without the Collaboratives.

Also, at the 74 venues to promote Snug as a Bug that took place this year, from flu clinics to social clubs conversations took place with older people about winter planning and the importance of stocking up, and staying in when the weather conditions are severe and handed out 1700 winter planning cards. The 2015 Autumn new campaign will in addition include, 'How to understand your Gas bill' initiative which helps older people assess whether they are on the best tariff and how to switch suppliers if they aren't.

Partnership working with Timebanking

Time banking has become popular over the last 10 years and has only just started to work in North East Lincolnshire. A worker from Foresight attended the Releasing Community Capacity Change Champions Programme and developed a time banking idea as a result. At the end of 2014 the Older people's Team and the time banking group got together to develop some time banking opportunities to benefit older people. Volunteers cleaned the church to get free room hire for meetings. This relationship has enabled the older people's team to support the setting up of three lunch clubs and the process of developing a more sustainable approach for the lunch club concept.





The Snug as a Bug Campaign uses two approaches:

1 Flu clinics or a stand at an event, a volunteer engages an older person with a free gift such as a torch and then has a conversation about the correct room temperature for their home. They discuss and complete Hot spot cards together which has been proven to be the most effective way to have them completed. Traditional approaches to the completion of hot spot cards were to include them in bags of freebies but very few were ever returned.

2 Hold an event at a club where older people attend, have some fun quizzes around keep warm, keep well and keep safe.

The Keep Well, Keep Cool and Keep Safe Campaign

The Keep Well, Keep Cool, Keep Safe was initiated as a pilot spin off from Snug as a Bug, using a social marketing approach. The pilot started in July and ended in August 2014. It will restart in May 2015 and continue into August.

This was a pilot campaign last year around how a heat wave can have an adverse effect on older people.

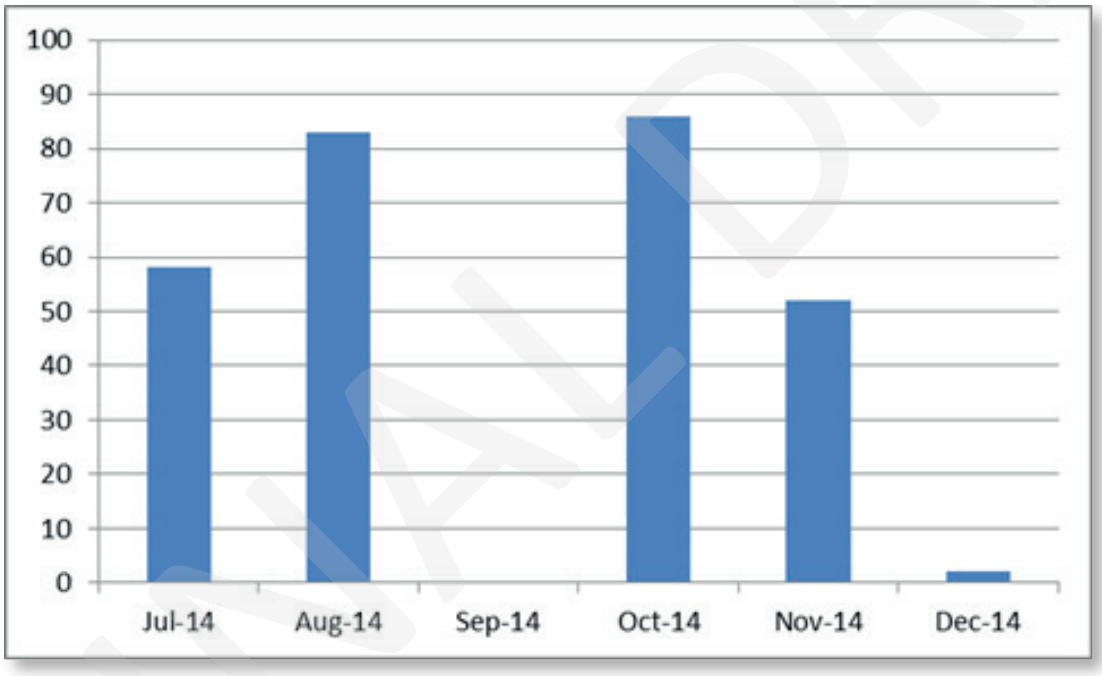
The approach used is for volunteers to attend a social or a lunch clubs have fun quizzes and giving away free fans and bookmarks promoting Keep Well, Keep Cool and Keep Safe.

The Dementia Awareness Programme

During 2014 a small group of volunteers from the Cancer and Older People's Collaboratives engaged in the Releasing Community Capacity (RCC) Change Champions Programme. They were successful in bidding for some funding to develop a dementia awareness programme in the community.

They are a small group of volunteers who have developed some materials to promote dementia awareness. They have had Dementia Friends training and support from the Dementia alliance and the Alzheimer's society whose leaflets they use in their outreach work.

During the second half of 2014, the team started Dementia awareness activities, providing information and a signposting service to relevant local services, which support the needs of those individuals with Dementia and to their family/carers.



A total of 281 contacts were made. Like other intiaitives, the number of contact were down in December due to Christmas activities.

During the team's first 9 months they have,

- Received funding from the RCC of £2631.50
- 10 active team members and have formed a dementia awareness steering group
- 9 of the volunteers have trained as Dementia Friends
- held 3 steering groups
- held 6 awareness events
- had 132 discussions on dementia which they record
- Given 203 volunteer hours between them which equates to £2527.35 nearly matching the investment in them.
- Signposted to other services.

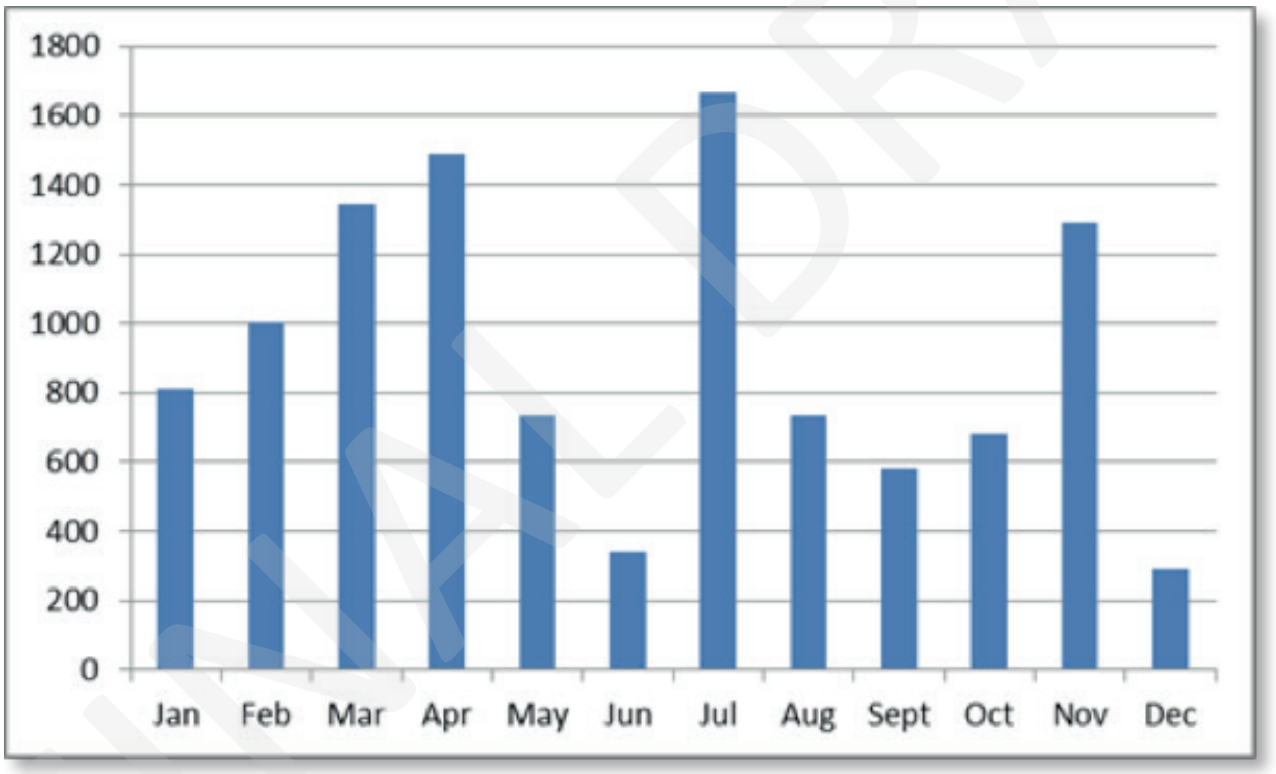
Cancer

Almost 900 people in North East Lincolnshire are diagnosed with cancer each year and just over 450 die of the disease, accounting for 29% of all deaths in the area.

The one year survival trends for all cancers combined for both males and females are improving, but are consistently marginally below the England average.[8] The Early Presentation of Cancer Symptoms Collaborative Programme seeks to increase survival rates. It covers several tumours:

Bowel cancer (including bowel cancer screening), Prostate cancer, Gynaecological cancers (including cervical screening), Lung cancer, Throat Cancer and Upper Gastro-Intestinal Cancer. There's also some seasonal emphasis on, skin cancer and breast cancer awareness.

Early Presentation of Cancer Symptoms Activity



Over 2014, the teams made a total of 10,971 contacts with people about signs and symptoms of cancer. The chart shows some variation in activity. The peaks in activity in March, April and November coincided with national campaigns. The dip in June, was a result of an office move and December's was a result of Christmas activities. Locally it is the practice for grandparents to delay their summer holidays until children go back to school in September so they are available less in the period of the summer holidays and into October.

The cancer volunteers have been trained in the collaborative approach and use the social marketing techniques to identify target groups and to understand the best places to access them and the best way to shape the messages. Most tumours have an age relationship and some tumours are gender specific so the teams have to be specific about these issues.

[8]Health and Wellbeing Board Cancer Profile - NYCRIS 2012

Whilst they use the national materials such as the Be Clear on Cancer materials they also develop some of their own collateral to use in the community.

During the contacts identified above the community teams will have conversations using a semi – structured approach. The conversations are brief advice conversations and they involve a two-way discussion, sometimes with the use of a leaflet and can involve signposting to another service.

Cancer Champions

The Cancer Champion training course is delivered by the Collaborative team and funded by Macmillan: Cancer Support. It covers the topic of having brief advice conversations alongside signs and symptoms and raising awareness issues.

As part of the Collaborative team's efforts to sustain cancer awareness they have been successful in gaining four years of funding from MacMillan Cancer support to deliver the Cancer Champion training.

To date 420 cancer champions have been trained in North East Lincolnshire who now spread the word about the importance of early detection of cancer. There is a clear demand for the continuation of this training, which has also become a useful tool for recruiting volunteers into the Cancer Collaborative.

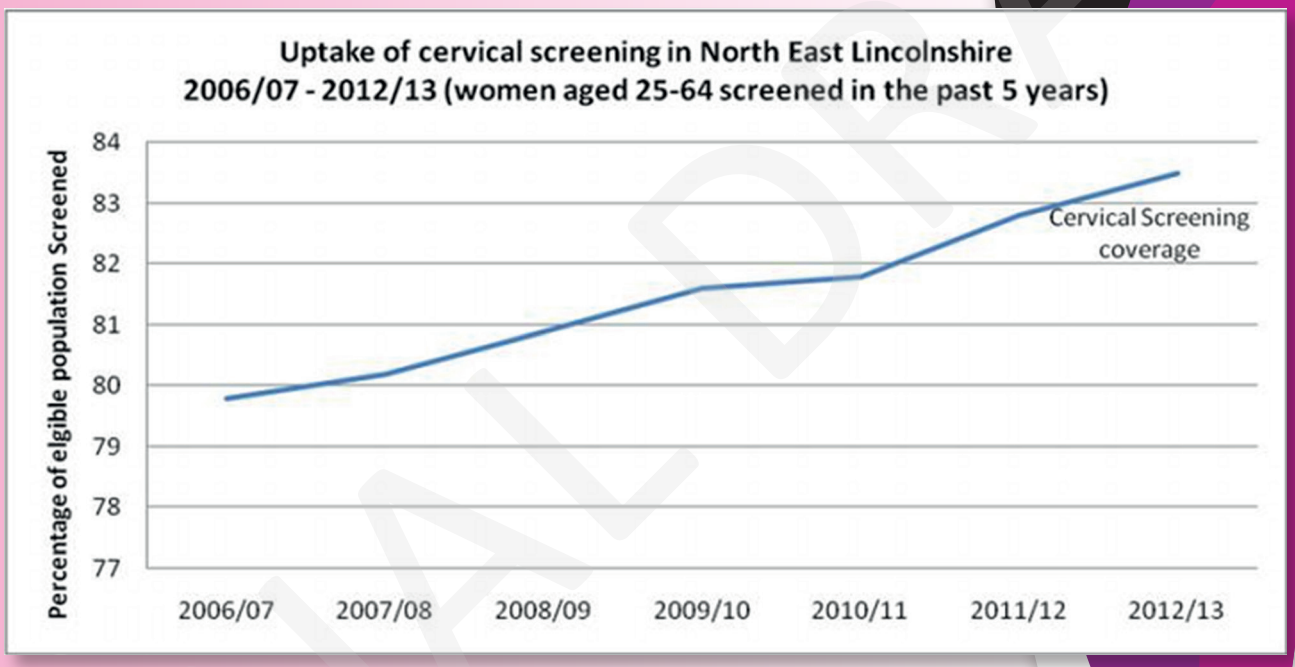
The Cancer Champion training covers,

- Facts about cancer
- Knowledge on each tumour
- Barriers
- Resources
- Reassure people that it is okay to talk about cancer
- Promote the approach that the GP wants you to go to him if symptoms persist. 'If something is different for you – go to the GP!'
- The role of the Cancer Champion
- Risk factors
- Techniques
- Useful contacts

Supporting Cancer Screening

An important part of the Early Presentation of Cancer Symptoms Collaborative is to increase the number of people taking up screening. The data that is available for 2014 shows NE Lincolnshire exceeding the 80% target for cervical cancer screening uptake and very nearly reaching the 60% target for Bowel Cancer screening. Breast screening is promoted periodically as required.

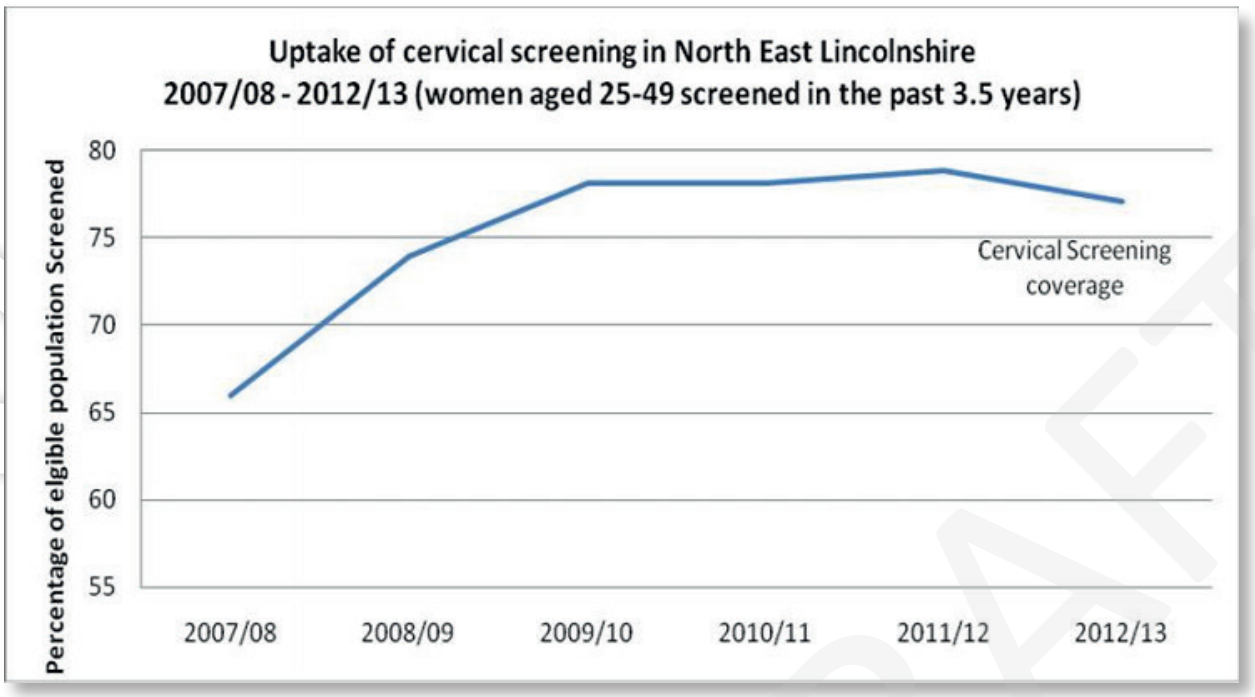
Graph 1 - Source NCIN



Local analysis of screening data, indicated that women in the younger age band had a lower uptake of cervical screening. The community teams concentrated efforts on that age group with the locally developed 'Inside Counts' initiative.

Graph 2 shows that uptake of cervical screening has increased significantly in North East Lincolnshire across younger ages. Since 2007/08, the rate for ages (25 – 49) has risen from 66 percent to 77.1 percent in 2013. This compares to a figure of 71.5 percent nationally in 2013. The dip from 2012 similarly reflects a national trend in declining cervical screening uptake. (Source Health & Social Care Information Centre).

Graph 2 - Source NCIN



Bowel Cancer Screening Measurements

The bowel screening campaign commenced fully in North East Lincolnshire in June 2008. The community teams developed promotional material to support raising awareness of the importance of bowel screening, with an initial focus on the Immingham community. This has now been extended to all of North East Lincolnshire. Table 2 below highlights the annual uptake of NHS Bowel Cancer Screening across all ages 2008 – 2013.

The data demonstrates that coverage has consistently remained over 55% but has only achieved the national target of 60% in 2012 when coverage of 61.3% was achieved.

Table 2: NHS Bowel Cancer Screening Uptake – North East Lincolnshire ALL AGES

Available screening data[12]

Year	Bowel Cancer Screening Uptake (%)
2008	55.2%
2009	56.6%
2010	56.9%
2011	55.4%
2012	61.3%
2013	55.4%
2014	59.9%

Pre-Diabetes

The Pre-Diabetes Collaborative project seeks to identify people out in community settings who have no idea that they may be at risk of developing diabetes as a condition over the next ten years.

The project is a one year initiative, funded by North East Lincolnshire Council and the Collaborative element is funded by the Clinical Commissioning Group. This innovative proposal draws on a team of community volunteers who have been trained to undertake risk assessments in the community, who are then followed up where appropriate by a range of offers to suit the individual. The approach used is one that has been successfully used throughout North East Lincolnshire with other programmes, and has indeed received national recognition in the past.

The Collaborative approach to rapidly and significantly enlist local people in providing a participative solution to early recognition, increased awareness and timely intervention is both innovative and nationally significant in that it would be we believe a first in the field of diabetes prevention.

The Objectives of the project were:

- **To identify people in community settings who were likely to develop type 2 diabetes in the next ten years, unless preventative action was taken**
- **To provide a group education session and support group to encourage people to make small lifestyle changes – The group is branded as 'Time to Measure Up' and is facilitated by a Diabetes Nurse Educator. Groups are free of charge, and offer advice, weight measurement and waist measurement on a monthly basis.**
- **To provide a referral mechanism for GPs and Practice Nurses for their pre-diabetes patients to offer them support to make lifestyle changes**
- **To monitor by means of follow up, patients in the target group**
- **To promote the project via media channels**

Measures - 2014

Measure	Outcome
Number of public events attended	60
Number of pre-diabetes risk assessments undertaken (target 1000)	1117
Number of people identified as moderate to high risk who have taken action within 3 months of the risk assessment	362
Case studies collected	3
Number of people signposted to existing behaviour change services*	281
Waist measurement reduction from first assessment, repeated at 3 month, 6 month, 9 month and 12 month intervals	3 month: Average waist loss of 4.3". (Note 6 and 9 month follow ups not achieved, due to class duration only being 4 sessions and capacity issues for diabetes nurse educator)
Attendances at pre-diabetes 'Time to Measure Up' training	81 people attended for an average of 3.89 sessions on a monthly basis (programme length intended to be 4 sessions)
Number of people indicating their wish to self- manage* *Offers ranged from GP referral, to health trainer service, to walking groups, tai chi groups. Note: all those that consented to follow up were automatically referred to their GP.	281

Waist and Weight Measurement

Note: Only individuals with a start weight and a 3 month and a 6 month weight measurement included in the analysis

Weight Measurement	No. people	Total weight loss	Average weight loss
At 3 months	30	-131 lbs	-4.37 lbs
At 6 months	16	-137 lbs	-8.56 lbs

Waist Measurement	No. people	Total inches lost	Average inches lost
At 3 months	30	-50.5 inches	-1.68
At 6 months	16	-39 inches	-.2.44 inches

Future direction

The future of the project is dependent on further funding being secured.
Due to slippage, the project is due to conclude on 31st March 2016.

The Skin Health Collaborative

There are eight million people living with a skin disease in the UK. Some are manageable; others are severe enough to kill. The Skin Health Collaborative promotes awareness of skin health within the community. They raise awareness of various skin health issues, including how to look after yourself and your skin to prevent leg/foot ulcers, pressure sores and other problematic wounds.

The Skin Health Collaborative originated from an initial study which was held between 23 November to 7th December 2009 and which focused on current skills around leg ulcer care in the community. The study involved staff from 13 different clinical disciplines,

- District Nursing Service
- Practice Nurses (limited availability)
- Macmillan and hospice nursing services
- Lymphoedema Service
- Intermediate Care
- Community Response Teams
- Rehabilitation Services
- Prosthetics and Orthotic services
- Nursing homes
- Residential Homes (random sample)
- Social Service Day Centres
- Learning disability services (random sample)
- Mental Health Teams

It was identified that variations in the treatment of leg ulcers and skin lesions, mostly in elderly people was costing the local system more than necessary. An audit of knowledge and skills of frontline practitioners in the identification and care of people was performed and the results shared at the skin health board.

In the report 427 people were identified as having a leg wound of which 35% had them for >6months, 17% 1 to 5 years and 4% having them for >5years. A leg ulcer is difficult to treat and can be distressing for the patients and those caring for them.

The results were collated and presented in a report "A study to investigate the problem of skin integrity in North East Lincolnshire Care Trust Plus, Professor Christine Moffatt CBE, et al, Centre for Research & Implementation of Clinical Practice (CRICP) and Care Plus Group (2010)".

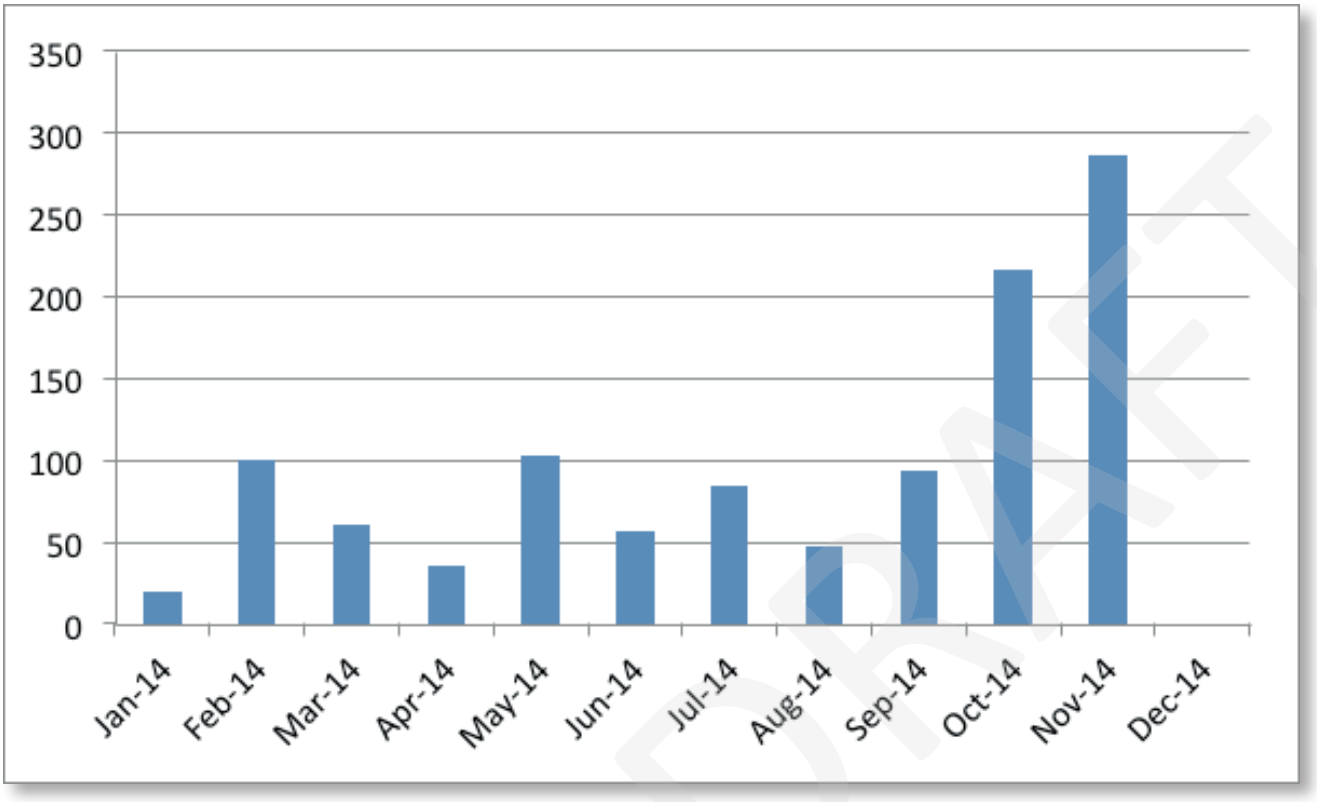
The report identified a number of issues for improvement in North East Lincolnshire which have been addressed by clinical staff. The report also estimated that the total cost of treating wounds in North East Lincolnshire was in the region of £3.2 million per year with the majority of the cost (80%) being in professionals time.

Volunteers who were involved in the research identified issues that could be addressed by volunteers in the community as a way of,

- Promoting the issue of protecting your skin, particularly if you are elderly as skin becomes frailer and thinner as we age.
- Encouraging people with skin lesions to seek help from the appropriate services.

To reduce the number of leg ulcers in the community the Skin collaborative team developed the Speak out for Skin campaign which promoted hydration both internally (fluids) and externally (moisturisation). The campaign continues to date.

Skin Health Contacts



During 2014 the Skin Health Collaborative made a total of 1,101 contacts. This total is most likely lower than other collaborative because it operates with the least number of volunteers. There is evidence that the impact of the volunteer work has resulted in increased referral into the specialist tissue viability team. There have been six referrals this year.

There was a big push of activity in October and November saw 502 contacts during these months: 46% of the overall total. This was a result of activities in locations with a high footfall, such as a Older Peoples advice day at Memorial Hall and Asdas. Earlier in the year there was a focus on smaller sheltered dwellings where the contact numbers are lower, but nevertheless valuable with more in-depth conversations. The volunteers have also delivered presentations to small groups at coffee mornings.

Immunisations

A historical service ASGARD was decommissioned in 2014 leaving the role of immunisation Outreach worker available for the Collaborative team to take on.

The role had a focus on engaging with disengaged members of the population who regularly attended at A&E and had drugs and alcohol addiction problems. Within this role the worker would offer home visits to young families to encourage them to take up childhood immunisations. NHS England, commissioners were keen to keep on the element of home visits and this part of the service and the staff member came to the Collaborative team where there was a better fit.

The Immunisation Outreach Worker commenced in post on 21st October 2014, thus leading to some activity in the final quarter of the year. The focus of this work is reaching those who do not attend their GP appointments and are being contacted on an outreach basis at home. Due to the time lag in the recruitment – immunisation process, the figures in the above table can look unusual in some months. However, looking at the overall totals, a good up take rate can be seen.

	Oct	Nov	Dec	Total
Immunisations Number of Clients Referred	18	13	8	39
Number of clients offered an appointment	18	13	8	39
Number of clients successfully contacted	15	12	20	47
Number of clients referred to other services	1	0	2	3
Number of clients immunisations achieved	8	8	14	30

Conclusion

The Collaborative approach has proven to be effective and clearly fits with the strategic direction of the CCG and the Health and Wellbeing Strategy.

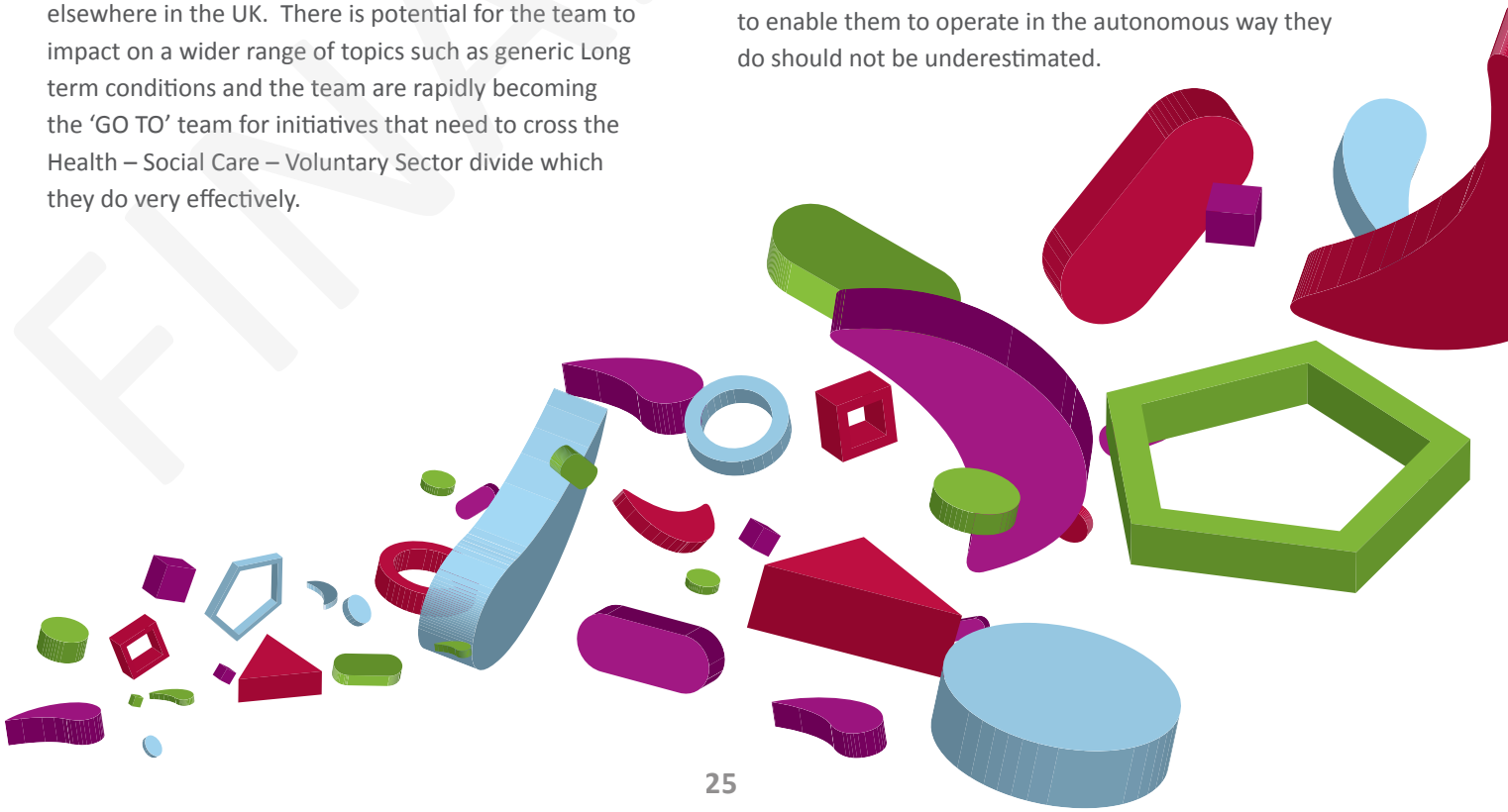
The Healthy Lives Healthy Futures Review conducted by North Lincolnshire and North East Lincolnshire CCGs, is focused on people taking responsibility for their own health and keeping well into old age so the Collaboratives are well placed to demonstrate how this can work in practice and offer an outlet for informal volunteering which meets the needs of those people who do not wish to enter into more formal volunteering structures.

2014 has proved an active year for the Health and Wellbeing Collaborative Team. Existing programmes have continued with the help of a steady number of volunteers and an ongoing schedule of regular activities. In addition new topics have been embraced and work commenced. The Collaborative approach is going from strength to strength.

However, this approach of holding a portfolio of Collaboratives in one area is unusual and unknown elsewhere in the UK. There is potential for the team to impact on a wider range of topics such as generic Long term conditions and the team are rapidly becoming the 'GO TO' team for initiatives that need to cross the Health – Social Care – Voluntary Sector divide which they do very effectively.

In the current economic climate the approach the Collaboratives use of raising awareness of health risk; increasing knowledge of signs and symptoms of disease to promote earlier presentation; and, signposting to appropriate support, sometimes provided by the community and in the community are all essential to get the best use of services and reduce unnecessary demand on stretched services. The local health and social care economy will no longer be able to meet the needs of an ageing population in isolation and the Collaboratives hold a unique position and provide a vital alternative to traditional service provision.

There is a healthy reliance on the role of the volunteers in the teams. The term 'Volunteer' conjures up many pictures but it needs to be spelt out that the Volunteer team members in the Collaborative Programmes are taking on extensive and responsible roles within the programmes which would be hard to replicate within formal volunteering structures. The amount of resource that the volunteers need in terms of support to enable them to operate in the autonomous way they do should not be underestimated.



Recommendations

- The Collaborative Team has capacity issues coupled with tensions about which new topics to take on and which ones to lose. The volunteer team members are deeply immersed in topics of interest to them. This is what makes the programme successful and makes shifting to other topics difficult. There is an ongoing need to recruit and induct new volunteers into the programmes which is time consuming and labour intensive and needs to be done on an ongoing basis to maintain activity.

- **Recommendation One: Permanent additional capacity is sought for to have a specific focus on the recruitment, induction and training of new volunteers for the programme and to set up a volunteer support programme structure. A Volunteer Co-ordinator post is required to fulfil this function.**

- There is an opportunity to streamline some of the activities within the programmes to meet the wider needs of the issue of ongoing long term conditions. Long term conditions are defined as conditions which cannot be cured but can be managed over time by medication and interventions. Long term conditions include cancer, cardiovascular disease, dementia, diabetes, hypertension, chronic kidney disease, atrial fibrillation and mental health. Many of the risk factors, target groups, behaviours and lifestyle issues that apply to cancer and cardiovascular disease are the same for diabetes and hypertension and contribute to atrial fibrillation and kidney disease so there is scope to introduce these other topics within the Collaborative portfolio.

- **Recommendation Two: The additional topics are added to the portfolio in the form of an awareness raising programme in the first instance.**

- There is a lot of potential to still be realised from the skin health and the dementia awareness programmes. With additional resources to measure the impact to date in more detail a clearly targeted communications and marketing programme could be undertaken. A closer focus on the skin health programme in partnership with the clinical nurse specialists, could identify whether the recommendations of the early Moffatt report were implemented and quantify the financial impact of the changes. If they haven't been implemented then the CCG needs to address this as a matter of urgency as implementing the learning could reduce the prescribing budget for wound care significantly.

- **Recommendation Three: A suggestion is made to the CCG that the Moffatt Report is revisited to see if there is potential for further changes in the wound care protocol in primary care. Recommendation Four: The skin health collaborative and the dementia collaborative are given support to raise awareness of their roles in the community. This need not cost much but could be initially raising awareness with other professionals that they are in place and working on these topics.**

- There is significant local interest in the target group for the Older People's health and wellbeing programme (over 50s). This can lead to confusion about who does what and also lead to duplication of provision.

- **Recommendation Four: That regular meeting are held between the different agencies to ensure that this confusion is minimised as much as possible. This can be achieved by maintaining a place on the Good Neighbours Board and extending an invitation to join to others working locally.**

Health & Wellbeing Collaboratives

collaboratives

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