Community Connector Report

March 2016 – February 2017

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1.0 Executive Summary

- The One Ilfracombe Community Connector role was first commissioned in January 2015.
- The aim of the Community Connector is to link Ilfracombe residents quicker and more accurately to the services, activities or agencies that can improve their overall health and wellbeing as well as ensuring that Ilfracombe residents don't 'slip through the net' and reach a crisis point which has significant impact upon front line services.
- The Community Connector deals with the following main issues; social isolation, mental health issues, healthy lifestyle, help to stay living at home and money debts and benefits.
- In 2016/17 the Community Connector role was funded by Devon and Somerset Fire and Rescue Service, Northern Devon Healthcare Trust, NEW Devon CCG and Devon County Council.
- During 2016/17 the Community Connector has seen 205 clients with a total of 281 issues.
- 58% of the referrals received in 2016/17 have been from front line agencies and statutory services. This is a vast increase compared with the 2015/2016 period.
- The Community Connector has carried out analysis of each client's issues to identify the gaps in service and ensure they receive the best individual outcomes.
- **The yearly savings attributed to the Community Connector in 2016/17 is £44,043.77. This is an increase of £12,661.50 on the 2015/16 savings. (see Cost Benefit Analysis – Appendix A)**

2.0 What is the Community Connector Role?

The Community Connector role is a social prescribing service that links people to local groups, services and activities to help reduce social isolation and provide engagement to the local community. The role supports co-ordination between different services as well as providing social, emotional and practical support to Ilfracombe residents. This is a role that tackles the need for preventative community care provision within Ilfracombe and provides a bridge between primary care, statutory services and the voluntary and community sectors. The role provides a central point in which local agencies can access information for their clients or directly refer clients to help with their health and wellbeing needs. The role also promotes self-empowerment by working to enable clients to improve their own situation with a level of support bespoke to them.

2.1 What is Social Prescribing?

'Social prescribing was described by the Centre Forum Mental Health Commission (2014: 6) as 'a mechanism for linking patients with non-medical sources of support within the community. These might include opportunities for arts and creativity, physical activity, new skills, volunteering, mutual aid, befriending and self-help, as well as support with benefits, employment, housing, debt, legal advice or parenting problems'. Centre Forum found that social prescribing was usually delivered through primary care and although a range of referral models and options existed, appropriate community structures (e.g. third sector agencies) needed to be in place to support referral.

Ten key outcomes have emerged from the evidence gathered by University College London;-

- Increases in self-esteem and confidence, sense of control and empowerment
- Improvements in psychological or mental wellbeing, and positive mood
- Reduction in symptoms of anxiety and/or depression, and negative mood improvements in physical health and a healthier lifestyle
- Reduction in number of visits to a GP, referring health professional, and primary or secondary care services
- GPs provided with a range of options to complement medical care using a more holistic approach
- Increases in sociability, communication skills and making social connections
- Reduction in social isolation and loneliness, support for hard-to-reach people
- Improvements in motivation and meaning in life, provided hope and optimism about the future
- Acquisition of learning, new interests and skills including artistic skills

UCL Social Prescribing review 2015

2.2 Why is the Community Connector needed? (Locally and nationally)

The decline in tourism in Ilfracombe in the 1970's and the general decline in Coastal towns during the 80's and 90's has adversely impacted upon social cohesion, population health, access to education and employment opportunities. In addition, local government and health and emergency services have faced severe cuts in budgets, and will continue to do so.

Demographic and social changes such as the local ageing population and increasing numbers of people with long-term health issues mean that more people are going to need help and support. This is where the Community Connector has become a vital resource in the last two years. Many of the consultations that One Ilfracombe and other organisations in the town have undertaken over the last few years made reference to the fact that there

were services in Ilfracombe but most people had no idea what they were or how to access them. The need for a role to be a 'centre point' to direct people to the right services was increasingly apparent. To date, the role has seen over 450 people, many with more than one issue. The role has also been integral in highlighting gaps in services in Ilfracombe which often lead to people not accessing the service they needed due to the geographical constraints of our town.

Over the last year, the health and social care services have come under increasing pressure to reduce the amount they are spending per person in North Devon which will have an impact on those receiving services.

Local health and social care services are also under severe financial pressure, and health and social care services are likely to be £557 million in deficit in 2020/21 if nothing changes. North Devon Healthcare trust is trying to achieve clinically and financially sustainable care services through their 'Sustainability and Transformation Plans' published in November 2016.

2.3 'Sustainability and Transformation plans' in North Devon

'Over the last year, health and social care organisations across Devon have come together to develop a plan that will ensure the people of Devon will experience safe, sustainable, integrated, local support by 2021. Devon's Sustainability & Transformation Plan describes a major programme of transformational change and improvement across wider Devon starting from 2016/2017.

They have identified seven high priority areas: Prevention; integrated care model; primary care; mental health; acute hospital and specialist services, children and young people, and productivity.

The Community Connector role directly meets the prevention and integrated care model priority areas of this plan.

<u>Prevention</u>

The STP's will be looking at the following priorities within the theme of prevention and early intervention. These include –

- Smoking cessation,
- Alcohol misuse
- Healthy eating
- Moving more
- Accident prevention (falls and fractures)
- Social connectedness and combatting loneliness
- Mental health gap and access outcomes

- Addressing wider determinants of health – social, economic, environmental and cultural factors

The Community Connector role tackles all of the issues through the clients seen (many of which issues are far more apparent in Ilfracombe than other Devon towns.) The Community Connector aims to enable people to access the services and activities that they need in a fast and holistic way, ensuring that people do not slip through the net and early interventions are made.

'Our approach to prevention of ill health and encouraging independence and wellbeing is based on our identification of areas of significant local need and the potential to make both a health and financial impact across a large area. These priorities are better delivered together rather than in individual organisations as we will not realise more cost and outcome benefits'. Wider Devon Sustainability and Transformation plan 2016.

Integrated care models

The STP's will also be looking at a community centred approach to health and wellbeing as this helps to build community capacity and resilience which in turn helps to provide support and reduce social isolation and loneliness and can contribute to reducing health inequalities for individuals and communities. The NHS are hoping that by creating interactions between statutory services and local voluntary and community groups they will be able to reduce demand on health and care services and lead to wider social outcome improvements.

The Community Connector role already works between the statutory, voluntary and community groups in Ilfracombe to ensure that the person has all the support they need to improve their situation and is demonstrating a reduction in demand.

2.4 NHS Five Year Forward view

The NHS 'Five Year Forward View' took a strong focus upon preventative treatments in public health, stating 'That's why we will lead where possible, or advocate when appropriate, a range of new approaches to improving health and wellbeing' (NHS, 2014: 10). Whilst most local authorities have responsibility for a range of broad-based public health programmes, the NHS has a distinct role in secondary prevention. This review demonstrates that social prescribing is able to encompass new approaches to secondary prevention by which people become engaged with responsibility for their own health and wellbeing, and pursue a healthier lifestyle.

'GPs and practice staff may not be ideally placed to refer to community resources due to the additional time needed to consult with patients and to keep abreast of the diversity services

and providers.' Thomson, Camic & Chatterjee (2015) 'Collaboratives of care' NESTA (2013: 13)

2.5 GP Forward View

'One of the 10 high impact actions to release capacity identified in the recently published GP Forward View was Social prescribing -

- Practice based navigators
- External navigators

'Support for more integration across the wider health and care system'. Social support Voluntary sector organisations can also play an important role in supporting the work of general practice. For example, local models of social prescribing can enable GPs to access practical, community-based support for their patients, including access to advice on employment, housing and debt. Some areas have developed call-off services for specific groups such as carers.'

2.6 UCL Social Prescribing review 2015

'To reduce future health costs a stronger focus on collaborative commissioning of services and interventions is needed which will involve the strategic promotion of mental wellbeing, mental capital, creativity and resilience as outcomes. It is important to make connections with a far wider range of stakeholders than previous traditional health models have encompassed, and where partners might include community services, such as business, culture, education and leisure sectors, in addition to local third sector and voluntary agencies. It is also vital to look for other sources of provision within the community to provide non-medical interventions which have the possibility of being linked to IAPT Steps 1 and 2 and a range of other mainstream health intervention programmes. Through identifying local provision, community resources can be expanded and developed to address many social, health and wellbeing issues. Museums and galleries, for example, as community resources are well-placed to promote health and wellbeing activities in non-traditional audiences (Camic & Chatterjee, 2013) as are other cultural, arts, environmental, exercise and socially-oriented programmes.

2.7 Making time in GP Practice – NHS Alliance 2016

Social Prescribing involves linking people to activities in the community which they might benefit from, connecting them to non-medical sources of support. The evidence to support it is mixed. Many small scale studies of social prescribing schemes describe the benefits of a range of interventions for people experiencing a range of common mental health problems, long term physical health problems and social deprivation. Advocates suggest that at its best, social prescribing can:

• Support people to overcome chronic illness and unhealthy lifestyles

• Enable people to learn new skills

• Support people to become less grant dependent and to find work

• Provide the tools to create an enterprising community

• Deliver better social and clinical outcomes for people with LTCs and their carers

• Allow more cost efficient and effective use of NHS and social care resources

• Provide a wider, more diverse and responsive local provider base.

"Around a fifth of GPs' time is spent dealing with patients' social problems including debt, social isolation, housing, work, relationships and unemployment - yet 50% of GPs have no contact whatsoever with local social care providers. So we need to empower general practice by breaking down the barriers with other sectors, whether social care, community care or mental health providers, so that social prescribing becomes as normal a part of your job as medical prescribing is today." Jeremy Hunt, June 19 2015

Social prescribing is an area that appears to offer potential, albeit one in which practices and CCGs need to find what type of social prescribing is most beneficial. It is an area in which training and experimentation seems to be worthwhile.

2.8 Changes in Adult Social care to North Devon – Devon County Council

New Government spending targets means that a further £110m of savings are likely to be needed to be made by Devon County Council over the next 4 years with £35m of this in the coming year 2016/17.

Adult Social care services have increased the levels for eligibility for its social care packages as one means of making savings. This means that a large number of people who may have been entitled to care packages before might not meet the criteria required. This means that services such as the Community Connector are being relied upon to find suggestions and offer advice to people who cannot access social care services and support.

3.0 The Community Connector role 2016 – 2017 in numbers

3.1 Who has the Community Connector seen over the last year?

Sex	Total	Percentage	Comparison with 2015 - 16	
Males	63	30%	86	49%
Females	142	70%	89	51%
Total	205	100%	175	100%

Ages	Total	Percentage	Comparison with 2015 - 16	
Under 55	83	40%	96	55%
Over 55	122	60%	79	45%
Total	205	100%	175	100%

The Community Connector has seen 205 clients with a total of 281 issues in the last year. This compares with 175 clients the previous year with 245 issues.
60% of the clients who came to see The Community Connector in the last year were over 55 years of age. Last year, the majority of people who accessed the service were under 55.

Issues	Total	Percentage	Comparison with 2015 - 16	
Social Isolation	72	27%	43	18%
Housing	21	7.5%	15	6%
Mental Health	5	2%	18	7%
Help to stay living at home	43	15%	28	11%
General advice	12	4%	29	12%
Health & Wellbeing	34	12%	31	13%
Home Safety Check	13	5%	n/a	0%
Education/Courses	10	3.5%	25	10%
Employment Help	9	3%	1	0.5%
Carer support	3	1%	8	3%
Transport	5	2%	3	1.5%
Dementia support	5	2%	9	4%
Benefits/Debt/Money	49	17.5%	35	14%
Totals	281	100%	245	100%

The issue that the majority of clients presented with was social isolation. This was also the top issue last year, but there has been a large increase in the number of people presenting with this issue. This may be due to the service being better known in the community or

because services are now identifying people that are socially isolated and understanding the value of referring them to the Community Connector Service.

Referrals	Total	Percentage	Comparison with 2015 - 16	
Self-Referral	86	42%	107	61%
Mental Health	6	3%	4	4%
GP	46	22%	29	17%
CD/CD+	20	10%	10	6%
RISE	15	7%	0	0
Tyrell/Barnstaple Hospital/CCG	10	5%	4	1%
Other	22	11%	21	11%
Total	205	100%	175	100%

3.2 How do the numbers compare to last years?

In the last year, the numbers of self-referrals have reduced but the number of referrals from front line staff including GP's and social care services has risen. This is most likely to be in response to the cutting of statutory services and the raising of the eligibility criteria for certain services. People who no longer meet criteria are being referred to services such as the Community Connector for help in other ways, such as voluntary groups and community services.

Result	Total	Percentage	Comparison with 2015 - 16	
Successful	201	72%	177	72%
Not successful	56	20%	23	9%
On-going	21	7%	45	18%
Unknown	3	1%	2	1%
Total	281	100%	242	100%

The Community Connector role has a very high success rate of 72% for the last year. Success is measured as the client being referred to the correct service and achieving the necessary outcome. Client cases that have been deemed unsuccessful include circumstances where the person wasn't eligible for a certain service, a group or activity was unavailable or the client decided to not to engage with the service.

3.3 Themes

This section looks at the main issues that clients have approached the Community Connector with during 2016/17.

3.3.1 Social Isolation

Social Isolation continues to be a problem within Ilfracombe, with the effects leading to both mental and physical health issues. The Community Connector has seen 72 people in the last year who are classed as isolated and signposted them to relevant groups and activities to help them make friends and engage with the community more. This is still the largest group of referrals to the Community Connector.

"Loneliness and social isolation are harmful to our health: research shows that lacking social connections is as damaging to our health as smoking 15 cigarettes a day (Holt-Lunstad, 2010). Social networks and friendships not only have an impact on reducing the risk of mortality or developing certain diseases, but they also help individuals to recover when they do fall ill (Marmot, 2010)"

Example Case Study – The client was worried about her mother as she doesn't go out much and relies on her for everything. The client wanted to know of groups that she could take her mother to, so that she could make new friends and get out of her home and have some interests as she thinks her mum is deteriorating in health as she just stays indoors watching TV. The client was signposted to the coffee mornings around the town, the Games Galore group, Pensioners Club and various art and craft groups. The client took her mother to one of the coffee morning groups and her mother has started to make new friends. She also went to Bingo with her daughter and aims to join the Games Galore Group as her confidence and renewed interest in life grows.

3.3.2 Housing

The Community Connector has seen 21 people in the last year with issues relating to their housing needs. This has included advising people how to go about applying for new housing, how to get help with issues such as damp, poor heating and general issues with landlords. Also covered were services that could help the homeless.

Example case study – The client was homeless and sofa surfing as he couldn't afford his rent. He wanted advice on how to get help to get accommodation. He also has an 8 year old daughter. The Connector notified the client of the process that he needed to follow to register for housing with NDC and what could be done to help him in his situation in terms of benefits and obtaining furniture and white goods. He was really grateful and registered with NDC housing. The client has since been housed and is getting his life back on track. He is very happy for the support given by all the services.

3.3.3 Benefits, Debt and Money

Due to a large number of Ilfracombe residents claiming benefits (ill health related benefits are claimed by 690 Ilfracombe residents – January 2017 DWP data) benefits, debt and money advice continues to be a large focus for the Community Connector. The role sign posts people to agencies and services which can help with debt management and budgeting as well as carrying out benefit checks to make sure residents are getting the right support.

"One in four people will experience a mental health problem during their life (Goldberg and Huxley, 1992). It is difficult to disentangle the inter-relationship between debt and mental health, but the links are clear. Being in debt can negatively affect a person's mental health, while living with a mental health problem increases the likelihood of falling into debt."

Example Case Study – The client has been ill and in hospital frequently. She has been signed off sick. She wanted to know more about Personal Independence Payments (PIP) as she felt that she may not be well enough to go back to work for some time. The Community Connector explained about PIP and referred her to Encompass so they could help her with the application process. The client had an appointment with Encompass and received the help she needed. She was subsequently successful in her claim and was very pleased.

3.3.4 Mental Health

The Connector has seen a large number of clients who are currently living with a type of mental health issue. The advice and support needed varies from finding out about groups and services to helping them form new friendships, interests and support in the community. Clients were signposted to the correct statutory services (counselling or GP services) or to a more holistic approach such as meditation or mindfulness, as well as to local recreational groups of interest.

"Having a mental health problem increases your chance of feeling lonely and feeling lonely can have a negative impact on your mental health."

Example Case Study - The client suffered from mental health issues and her doctor thought she should join some activities in Ilfracombe such as yoga etc. to help her relax. The client didn't know where to go, or how to find out about any therapy groups so she came to the Connector to find out what was available. The client was signposted to the Heart Centre, Little Birds, Yoga, Pilates, Tai Chi and mindfulness groups. The client regularly attends the Link Centre and has also joined a yoga class in Ilfracombe which she enjoys. She feels that her mental health is improving and she is getting better at controlling her anxiety.

3.3.5 Help to stay living at home

The Community Connector aims to enable people to live independently for longer in their own homes. This could be by signposting them to home help services for domestic support, preparing meals or other domestic tasks or advising them about personal alarms and other equipment to make life easier at home. Other advice and signposting provided included statutory services which could offer support such as Care Direct.

"Older people prefer to stay in their own homes and communities until it is impossible for them to do so, rather than move into residential care. Most older people enjoy being in their own home surroundings and view residential care with suspicion."
Social care institute for Excellence – Commissioning home care for older people June 2014

Example case study – The client had difficulty carrying out simple domestic tasks at home, due to his health. This made him stressed and anxious resulting in a lack of appetite and poor eating habits which was affecting his health. The Community Connector signposted the client to various home help services. The client has booked 2 hours every week with one of the services and is much happier now he has some support at home. He increases the hours of support when he can afford it. This has helped him to reduce his stress and he is maintaining a better diet which in turn is improving his health.

3.3.6 Health and Wellbeing

The Community Connector has seen 34 clients with health and wellbeing issues in 2016/17. These issues include alcohol related issues, smoking cessation requests and help finding the right exercise classes.

Example case study – The **c**lient is worried about her husband who drinks too much and wanted to know if there were any services which he could access to get some help. (Not the doctors as he wouldn't go there.) The client was signposted to RISE who were able to offer support and advice and as such, the clients' husband has been able to cut down on his drinking. This has had a positive impact on the family as well as the husband's physical and mental health.

***A full list of Case Studies is available as Appendix D attached to this report**

3.4 Additional Training for the Community Connector 2016 - 2017

During the last year, the Community Connector has undertaken additional training to widen the scope of her knowledge;

- ASSIST Suicide Prevention training with Devon County Council
- Virtual Dementia Tour with Training 2 Care
- Training with Devon County Council Care Direct Plus
- Training with Devon County Council Community Enabling and Social Care reablement teams.

4.0 Working with One Ilfracombe Partners

4.1 Working with Devon and Somerset Fire and Rescue Service

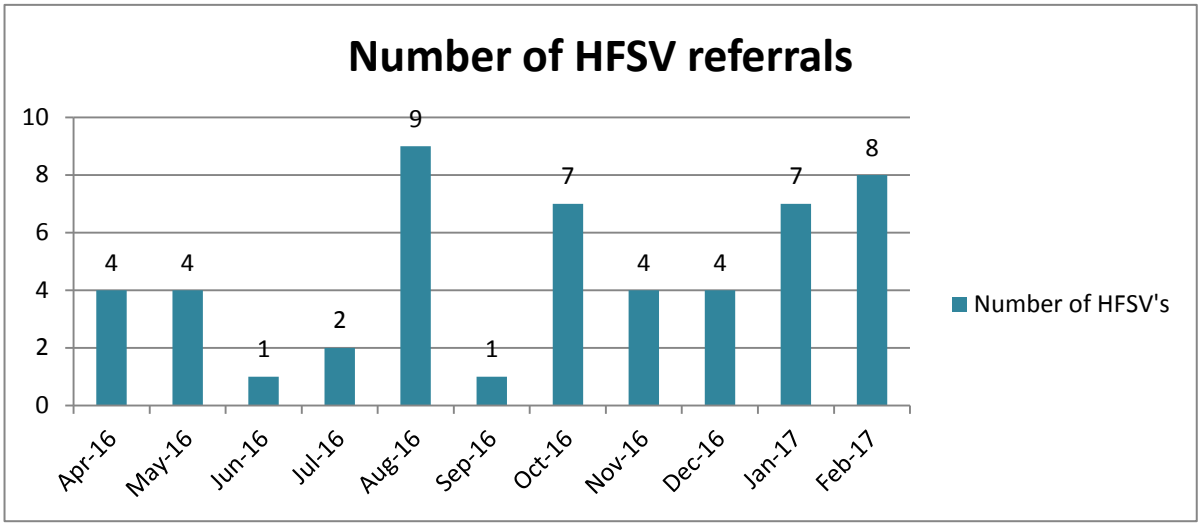
*"Devon & Somerset Fire & Rescue Service provides **free** Home Fire Safety Visit's to our identified vulnerable members of the community.*

*Our Technicians will carry out a home visit, give **free** advice, guidance and equipment relating to Fire Safety in the home that is bespoke to the individual and their home, they will also cover escape plans and what to do in the event of a fire.*

*A Home Fire Safety Visit should take no longer than 45 minutes and is **free** to the occupant"*

By carrying out a quality Home Fire Safety Visit, the likelihood of a fire is reduced by at least 55% (in some cases as high as 90%) - Societal saving **£146 per visit** - Devon and Somerset Fire and Rescue Service 2016.

The One Ilfracombe Community Connector promotes Devon and Somerset Fire and Rescue Service Home Fire Safety Visits (HFSV's) through engagement with the local community. The role has proved effective in creating further awareness on the services and activities that are available in Ilfracombe. The Connector now includes DSFRS Home Fire Safety Visits as part of her basic role which will ensure that the visits are promoted to hard to reach, vulnerable members of our community. The Connector is set up as a partner and referrals are monitored through the partnership register.



51 referrals have been made by the Community for HFSV's since April 2016.

This shows a societal saving of £7,446.00 over 11 months.

All previous clients are being contacted in batches to see if they would be happy to have these visits.

The Community Connector has attended 'Making Every Contact Count' training which was organised by DSFRS in conjunction with the NHS.

The Community Connector role is being promoted to the Devon and Somerset Fire Advocates and fire fighters as a signposting service to help them connect the people they visit to other services they might need. This forms part of the overall 'Making Every Contact Count' initiative which is a government scheme being championed by the NHS.

Making Every Contact Count (MECC) is an approach to behaviour change that utilises the millions of day-to-day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations.

For staff MECC means having the competence and confidence to deliver healthy lifestyle messages, to encourage people to change their behaviour and to direct them to local services that can support them.

Case Study example for Home Fire Safety Visit

The client is in her mid 80's and lives alone. She was interested in a home safety visit as she only had one smoke alarm which is very old and she didn't know if it was in the right place. She also had difficulty testing the alarm as she couldn't reach it, so she wasn't sure if it was still working or not.
The Home Safety Officer replaced the old smoke alarm as it was very old and the battery was dead and fitted another alarm nearer to her bedroom , so she would be able to hear it if it went off when she was sleeping (she wouldn't hear the one just outside the kitchen if she was in bed). She also gave the client a pointy stick so that she could reach the alarm and test it. Advice was also given about her plugs which she didn't realise she was overloading and the Home Safety Officer advised on where she should leave her keys overnight so that she could get out safely in the event of a fire.
The client was very pleased with the information and help that she received and feels a lot safer in her home now.

4.2 Working with Devon County Council – Development of the Community Connector Role

The Community Connector role was funded by adult social care at Devon County Council up until June 2016. One of the main outcomes initially proposed for the role was to enable people to stay in their own homes for as long as possible and to remain independent for longer. This has been achieved with a large number of people that the Connector has seen, by connecting them with groups and activities to reduce the effects of social isolation amongst older people. The Connector has also been able to signpost clients to affordable home help which has meant that they have not needed to apply for care packages with Devon County Council and can remain in their own homes longer.

Further work

One Ilfracombe was approached by Martin Barnard and Simon Kitchen from Devon County Council in July to look at ways to integrate the Community Connector role in a better way into Devon County Council Adult and Social Care Services.

The discussions looked at the way in which the Connector Role was working and how it could act as a front door into health and social care services in Ilfracombe in the future (and the possibility of rolling out similar schemes across Devon).

Possible scenarios for new way of working

- Additional training for CC with DCC Care Direct
- Care Direct referring directly to CC
- Role becoming the front door to health and social care services
- Helping with personalised budgets
- Formation of peer support groups
- Expansion of current CC follow up activity for clients
- Seed funding arrangement – possibility of allowing CC access to this funding for activities
- Increasing links with Voluntary sector

To date, the Community Connector has been working closer with Care Direct and Care Direct plus, with these teams referring directly into the role. Meetings have been held between the Community Connector and these teams to enable better understanding and communication between the services.

The Community Connector has also met with the DCC Community Enabling and Social Care Re-ablement teams to share information so that they are able to refer clients on to the Community Connector once their support package is completed.

The Community Connector had access to seed funding from Devon County Council to support Care Direct/Care Direct plus clients up to £60.00 to help with transport, activity groups, counselling – anything to help them with the issues they are facing. This seed funding was only available for Care Direct referrals and finished in March 2016.

4.3 Combe Coastal GP Surgery referrals

'GPs and practice staff may not be ideally placed to refer to community resources due to the additional time needed to consult with patients and to keep abreast of the diversity services and providers.' Thomson, Camic & Chatterjee (2015)

The number of direct referrals from Combe coastal GP surgery has increased from 29 client referrals in the first year of the Community Connector service to 46 this year. This has been due to increased engagement with the GP service including two Community Connector presentations to highlight the benefits of the service for patients.

The Community Connector is also based at the Combe Coastal GP surgery one morning a week. This service is becoming more widely known both by staff and patients at the surgery which has increased the number of referrals and people accessing the service. This is changing in March 2016 with the use of appointment cards.

A general move towards social prescribing has also become apparent at the surgery as two General Practitioners have contacted One Ilfracombe to try and find ways to increase the links between themselves and the Community Connector.

4.4 Frontline service referrals (split into organisations)

Organisation	Number of referrals	Description of referrals
NDHT	10	North Devon District Hospital, Tyrrell Hospital Ilfracombe and Occupational Therapists
DPT – Mental Health	6	Referrals from The Gables and Ocean View Ward
RISE	15	Rise Recovery Drug and Alcohol Services
DCC – Care Direct and Care Direct Plus	20	People who need to access social care packages
GP's	46	Referrals from The Combe Coastal GP surgery
Other	22	Referrals from The Infant School, Age Concern, NDVS, Police and See Hear Group

5.0 Cost Benefit Analysis

The Cost Benefit analysis (attached to this report as Appendix A) for the Community Connector role was undertaken in line with the NEW Economics Foundation (NEF) process for cost benefit analysis.

By following the NEF guidance and using their comprehensive CBA report titled 'Community Connector break even model' a CBA has been undertaken on the work of the One Ilfracombe Community Connector for the first 10 months. This has been based on the number of referrals and outcomes that have been made during the first four months. It is strongly recommended that when looking at the CBA of the Community Connector the reader should be mindful of the NEF report as this gives full details on the process and how the attributions have been calculated.

The full cost benefit analysis has attributed **£44,043.77** of cost savings to the Community Connector role.

Taking into account the costs of employing a community connector for 26.25 hours a week

Cost Savings	£44,043.77
Employment costs p.a	£12,799.68
Savings	£31,244.09

These cost savings are seen by agencies including Devon and Somerset Fire and Rescue Service, Mental Health Services (DPT), Northern Devon Healthcare Trust, Devon County Council and many others.

Please see attached NEF report for further details (Appendix B – pages 53 – 68).
Although CBA and attribution to the Community Connector role can be subjective, by following the NEF guidance (that is endorsed by DCLG) the figures within this report are as accurate as possible using the NEF calculation that attributes 15% of the value to the One Ilfracombe Community Connector process.

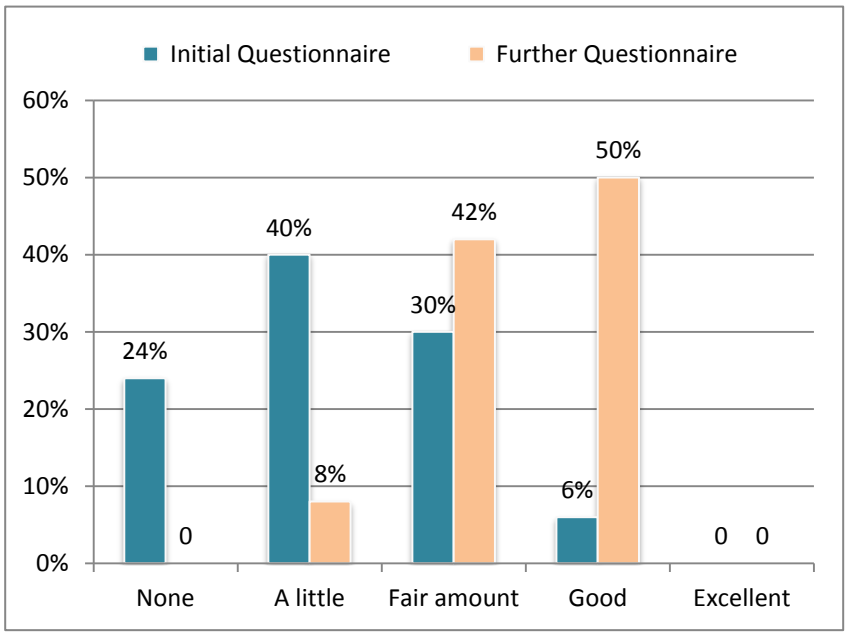
6.0 Client knowledge

6.1 – Questionnaire results

Each client who has engaged with the Community Connector was asked a series of questions during their first appointment to give us an idea of their current knowledge of local services and activities and their confidence in using them. The results were used to map how much information they learnt through their engagement with the Community Connector and how their confidence, social activity and connections to the community changed over this period.

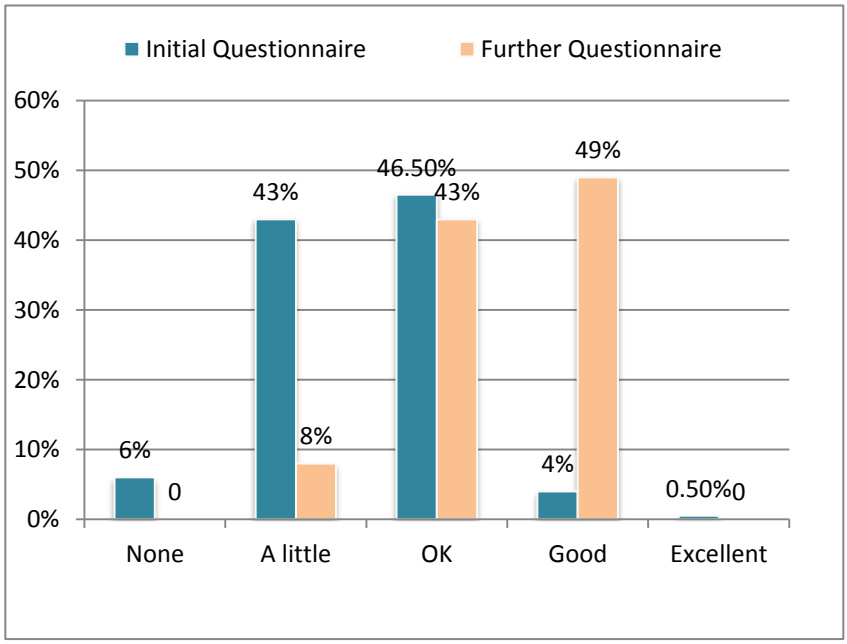
How would you rate your knowledge of local services?

During the initial appointment only 6% of people interviewed said their knowledge of local services was good. When asked at further appointments 50% said their knowledge was good.



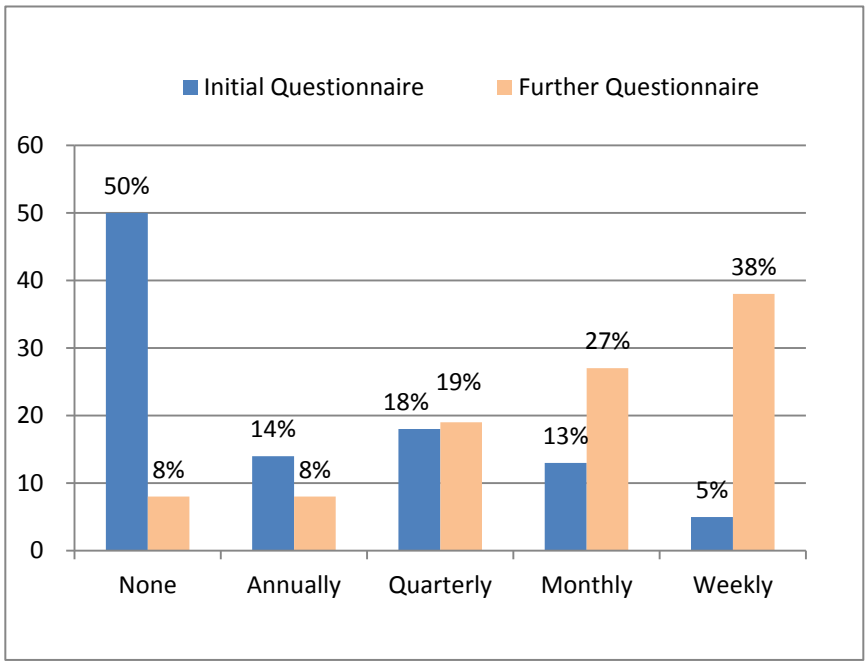
Do you feel confident in accessing and using local services?

During the initial appointment only 4% of people said they were confident in accessing and using local services. At a further appointment 49% said they felt confident.



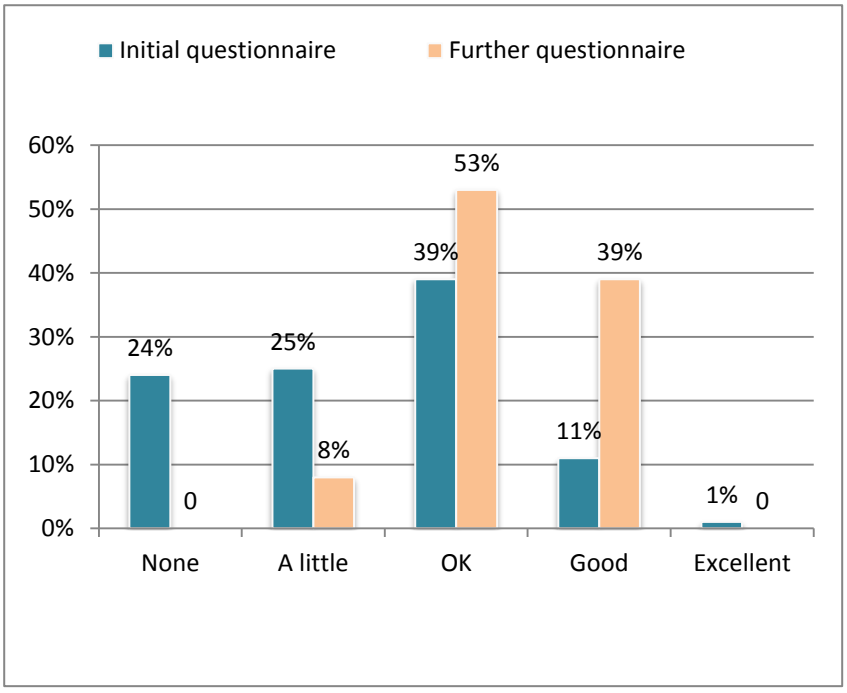
How often do you take part in Social Activities?

During the initial appointment only 5% of respondents took part weekly in social activity – when asked again at a further meeting, this number had increased to 38% .



How connected do you feel to your local community?

During the initial appointment 24% of people didn't feel connected to their community.
At further appointment this dramatically dropped and no one felt disconnected from the community anymore.



6.2 Quotes from clients 2016

(*full list of quotes is available as Appendix C)

- 'This is a really great service, I don't know anything that's available here and being able to come to one person to find out everything is great.' Client 3
- 'This service is a great idea.' Client 4
- 'Thanks for your help; I had no idea about the service you told me about. It will make a big difference.' Client 5
- Thank you for your help, it really made a difference.' Client 9
- 'This is a great service; I never knew all these groups existed.' Client 12
- Thank you so much for your help. I didn't know about the services that can help me'. Client 17
- 'Thank you for all your help, I have now got a ground floor property which is a great relief as my health is deteriorating so much I was becoming housebound in my previous place.' Client 18
- 'This is such a great service, it's been very helpful. 'Client 19
- 'Thank goodness there is some free support available, as I find it so hard to give up smoking on my own, even with the patches.' Client 32
- Since the death of my husband I have found things hard. It's good that Ilfracombe has a service that can give people the info they need as it is hard to find things out on your own sometimes.' Client 35
- 'This is a really good idea, it's great that the community has something in place that everyone can access and benefit from. 'Client 36
- ' I was confident using local services, but now I have lost confidence, having the knowledge about the services and how they work/helps makes a real difference to me being able to use them.' Client 41

Testimonial from Agency

"The whole team have found Miriam to be an invaluable connection in providing the vulnerable people in our community the help they so desperately need. In an economically challenging climate the services that Miriam so effectively sources can make a real difference to someone's daily life."

Community Health and Social Care Team – Tyrell Hospital

6.3 Conclusion from feedback.

All the feedback that we have received over the last year, both from clients and referral agencies has been positive. This is being reflected in that referrals from agencies have doubled from the same period last year (47 referrals from agencies in 2015 – 2016 compared with 97 referrals 2016 – 2017).

Many clients have been quoted as saying that this is an invaluable service and have returned to see the Community Connector with other issues. Word of mouth has also had a great effect in a community such as Ilfracombe, as clients have recommended friends and family to the service.

People feel better equipped to deal with issues when they have some support from this role, as each client will receive bespoke help and support depending on their need.

7.0 Gaps in services identified

Part of the Community Connector role is to identify where there are gaps in service provision/groups and bring this to the Living Well Team.

A gap highlighted was the lack of smoking cessation services in Ilfracombe, even though the recently published Combe Coastal Health Needs assessment evidenced the still high rates of smoking in Ilfracombe Central ward (31.2%). The One Ilfracombe Team approached Solutions for Health who had recently taken over the stop smoking contract for Devon and supported them in finding a suitable venue for their mobile stop smoking service once a week.

Gap	Gap filled?	Notes
Befriender service for people under 60 years of age	Yes	The Heart Centre in Combe Martin are now offering befriending services for the under 60's in Ilfracombe.
Free art and social groups for people with mental health issues	Yes OI are working with Drink Wise Age Well and a local counsellor to try and start an art therapy course The Heart Centre offer Free art workshops in Combe Martin and are in the process of bringing these activities to Ilfracombe in May 2017	Course hopefully to start in April/May 2017
Gardening Help	Yes	Home help services can offer light gardening support and list of gardeners recommended
Home Help – people who need very low cost help with domestic chores (Subsidised/vol support)	No	Currently people are being signposted to paid for affordable help at £10/£12 per hour
Home from hospital service	Yes, commissioning agreed with Northern Devon Healthcare Trust	Proposal sent from One Ilfracombe to NDHT regarding Home from hospital service
Specialised fitness classes for the elderly	Yes	A dance group for the over 50's has recently started up and been hugely popular (there is a waiting list)
Healthy eating classes	Yes	One Small step are now offering some services in Ilfracombe.
Stop Smoking provision	Yes	Solutions for health were contacted by One Ilfracombe and are now visiting Ilfracombe once a week with their mobile smoking cessation clinic

8.0 Funding and the future for the One Ilfracombe Community Connector

In 2013, an agreement was made between Devon County Council, NEW Devon Clinical Commissioning Group and Northern Devon Healthcare Trust to jointly fund the new Community Connector role through One Ilfracombe. Each of the partners contributed different amounts with Devon County Council contributing the majority of the funding.

- Funding from Devon County Council ceased in June 2016.
- Funding from NEW Devon Clinical Commissioning group ceased at the end of December 2016.
- Funding from Northern Devon Healthcare trust will finish at the end of March 2017.
- Devon and Somerset Fire and Rescue Service have part funded the Community Connector role in 2016 and have committed to further part funding for 2017.

To date, we haven't secured funding from any health agencies for the 2017/2018 period. This has been due to large changes in the organisations (including introduction of the STP and changes to Adult Social care for DCC).

Negotiations are currently ongoing with the health and social care providers and this evaluation will form a large part of the evidence needed to secure funding.

8.1 The Future of the role

The demand for the Community Connector role has increased year on year since the role was introduced. The number of people who are no longer eligible for certain services is increasing and front line staff trying to help them, are having to look in different directions for support. One Ilfracombe are hearing from people time and time again that the Community Connector service is vital for people who are at risk of slipping through the net. The value of the role lies in the fact that it is very local, with up to date information and supports people all the way through their journey. This model is being emulated by various other agencies, as people become more aware of the value of working this way.

One Ilfracombe hope to increase the capacity of the Community Connector by changing the role into a Community Connection team which will include another member of staff. This will allow the gaps in service provision and activities which are highlighted by the Community Connector to be addressed and capacity to be increased. The team will also be

able to help set up groups and promote the need for services that are currently not available in Ilfracombe. They will also support existing groups that can be referred to, for example the befriending services already in Ilfracombe. This vision is dependent on future funding.

8.2 Expansion of the Community Connector Role – Home from hospital service

We are also looking at a Home from Hospital service, in conjunction with Northern Devon Healthcare Trust. The aim of this service will be to ensure that vulnerable people leaving hospital can have a visit from a volunteer on the day that they arrive home. This volunteer will make sure they have basic foods, a meal for that day, ensure that any family members are called and offer a bit of support. They will not be carrying out any personal care or domestic duties but are just there to support the person for the initial period when they are discharged from hospital.

9. Conclusion

The Community Connector role service has seen a significant increase in referrals during the 2016/2017 period. This is due to word of mouth within our community, as well as effective promotion of the role to both residents and organisations who work within Ilfracombe. The numbers of clients referring themselves has decreased whereas the numbers being referred from other agencies has increased. This is showing us that agencies and organisations who work within Ilfracombe understand the benefits of a social prescribing service and the value of the advice and support that the Community Connector role can give.

Budget cuts are consistently being made to statutory services that operate within Ilfracombe due to the current national economic situation – this in turn is placing more emphasis on the voluntary sector and community services. The Community Connector role provides an essential link between these groups which is evident in the types of referral that are presenting.

Client questionnaires show that knowledge and confidence increases dramatically from point of contact with the Community Connector to the conclusion of their issue. A large number of clients have visited the Community Connector on a more than one occasion with different issues which shows confidence in the service.

The cost savings demonstrated in the Cost Benefit Analysis far outweigh the cost of employing a Community Connector. The cost savings benefit a wide variety of organisations, not just those who are currently funding the Community Connector.