Social Prescribing Extended Pilot
Interim Monitoring Report

March 2017

Executive Summary

Social prescribing is one of the key recommendations for improving health and care.

This is the interim report for the extended social prescribing pilot in Brighton and Hove (April 2016-March 2018). The pilot involves Impetus' Community Navigation Service working with GPs and primary care, and Possability People's Link Back Service working with secondary care to support hospital discharges. Community Works is supporting the development of the pilot.

Connections are being built and strengthened between social prescribers in the City.

A robust, joint approach to evaluation is being developed. The outcomes measured by each organisation have been aligned with the Better Care outcomes. Client feedback shows improved wellbeing, resilience, and independence as well as increased choice and reduced isolation. The key metrics have been identified. 308 people have been supported and 729 onward referrals to groups, services and activities made.

Four costed case studies demonstrate the impact of social prescribing and also show cost per person indicative savings of between £1,663 - £6,205 and 13 - 103 hours of time savings across the health and social care systems.

Learning and reflections include

1. The people Link Back and Community Navigation work with have different needs.
2. There is an increase in the number of people with complex needs.
3. A flexible support offer is needed as needs emerge over time.
4. Continuity is key in order to build trust and support the person.
5. Both organisations are adopting a mix of paid staff and volunteers.
6. Continued funding of VCS services is needed so they can be signposted to.
7. Communication difficulties between services hamper the support offered.
8. Specialist research would be needed to fully evidence time and cost benefits

Introduction

What is Social Prescribing?

"Social prescribing is a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector. " (Friedli & Watson, 2004)

In Brighton and Hove however, Social Prescribing extends into secondary care.

Another definition suggests…

"Social prescribing provides a pathway to refer clients to non-clinical services, linking clients to support from within the community to promote their wellbeing, to encourage social inclusion, to promote self-care where appropriate and to build resilience within the community and for the individual" (Social Prescribing in Bristol Working Group, 2012)

Research into social prescribing reports benefits in three key areas:

- Improving mental health outcomes
- Improving community well-being
- Reducing social exclusion

In Brighton and Hove, patients are referred to a social prescriber (a Community Navigator in Primary Care or a LinkBack Specialist upon hospital discharge) who initiates an holistic guided conversation to assess the person's situation, needs and wishes. Once a clear picture of the person's life has been established, the social prescriber discusses a range of options for the patient to choose from and then facilitates referrals to the appropriate services, groups and activities. Facilitated referral goes beyond simple signposting and describes a number of activities which might include; researching detailed information such as location, opening times, criteria, travel information and contact person of a group, filling in forms, discussing a patients needs with a service, making appointments for a patient etc.

Why Social Prescribing?

Simon Stevens, Chief Executive of NHS England, requested a report from the People and Communities Board. This report 'A new relationship with people and communities - Actions for delivering Chapter 2 of the NHS Five Year Forward View' was published in February 2017.

It identifies a series of 'high impact actions' for accelerating the adoption of person- and community-centred approaches to health and care. Action four is making social-prescribing systematic and equitable. This extended pilot is developing and scaling up social prescribing activities in primary care and at BSUHT and is addressing all the detailed recommendations in the report.

Similarly, the General Practice Development Programme, building on the learning from Making Time in General Practice and the General Practice Forward View (GP Forward View) identified 10 high impact actions. Action eight is Social Prescribing – to use referral and signposting to non-medical services in the community that increase wellbeing and independence.

Generally, social prescribing is one of the key recommendations for improving health and care. In 2008, Sir Michael Marmot, championed the well-recognised understanding that 20% of an individual's health outcomes result from clinical treatment, with the remaining 80% determined by wider factors such as lifestyle choices, the physical environment and social networks. (Place-Based Health Commission Report 2016)

Social prescribing has indicated:

- There is a time saving for GPs and other health professionals enabling them to work with more medically appropriate people
- GPs, clinicians and healthcare professionals are satisfied that their patients' social needs can be taken care of in a 'safe' and holistic manner
- Patients' wellbeing has increased through having appropriate non-medical help and support
- There is a key role played in helping to reduce social isolation

Extended Pilot Overview

At the Better Care Board on 21st April 2016 it was agreed to fund a holistic social prescribing pilot in Brighton and Hove from August 2016 to March 2018. The CCG had recently been commended in the Fairness Commission final report for committing to social prescribing.

The providers are **Impetus' Community Navigation Service** that provides social prescribing in conjunction with GPs and primary care, and **Possability People's Link Back Service** that provides social prescribing in conjunction with secondary care to support hospital discharges to home or community rehabilitation beds.

The client groups within Community Navigation and Link Back tend to differ. Link Back clients are aged 75+ and likely to present with more complex issues that need addressing before referrals from social activities become meaningful. Community Navigation works with a broader age range to prevent longer term and more complex issues developing.

Community Works is working with these two existing social prescribing providers to develop and deliver an effective and integrated social prescribing pilot model for the City.

Purpose of the extended pilot

Each organisation was commissioned separately and works with differing client groups, so the purpose of the extended pilot differed between the organisations.

LinkBack was commissioned to continue delivering their service and further developing their good practice.

Community Navigation was commissioned to carry out all the necessary development work needed to expand the service citywide. This included developing new systems to accommodate a home visit service, shifting the divide between staff and volunteer roles, recruiting a new Coordinator and a new team of volunteers and re-writing the bespoke Navigator training and manual. The next phase of the service involves expanding across the city using a flexible, cluster based model.

Key benefits of Community Navigation and Link Back

- Saves GPs and hospital clinicians time enabling them to work with more medically appropriate people
- Prevents loneliness and isolation
- Prevents worsening mental health
- Promotes and improves wellbeing
- Provides access to the right services at the right time
- Promotes resilience and independence

“I have met so many people and they are all so kind.”

The Community Navigation service was established in August 2014 as a method of 'social prescribing'. It helps GP patients with long-term conditions and other vulnerabilities e.g. low to moderate depression, bereavement, social isolation or financial difficulties. Referrals are received via GP surgeries and Care Coaches. The service is commissioned by Local Government and Health agencies and run by the Brighton charity Impetus.

Over half the people referred are aged 55+ and many are experiencing social isolation and anxieties about their medical conditions or wellbeing. Community Navigation enables people to access non-medical services, groups and activities to meet their wider health and wellbeing needs.

Community Navigators are trained staff and volunteers. They work with a person to look at their social and emotional support needs and help them access local services by facilitating referrals. In addition, they provide tailored support to suit the person's situation and needs. A person's relationship with their Navigator is empowering and short-term. Navigators do not create dependence but rather encourage and enable people to take up the services they need.

Community Navigation works by…

1. Meeting a person one-to-one in a confidential space to assess the patient's needs using a 'guided conversation'. This initial assessment incorporates a range of questions designed to gain a clear overview of the person's life and give them the opportunity to tell their story. This usually takes about an hour.
2. Offering a range of options that can meet the person's needs, as identified by them during the assessment.
3. Facilitating referrals by finding up to date, relevant information about the right services and making any arrangements as necessary, e.g. making appointments on the patient's behalf, filling in forms, liaising with agency staff.
4. Following up after an agreed amount of time.
5. Completing a record of referrals made and outcomes.

Link Back was established in March 2015 and is a free service for older people in Brighton and Hove following a stay or outpatient appointment at the Royal Sussex County hospital (RSCH), Craven Vale and Knoll House. The service links people to the community, voluntary and private sector services that can enhance their independence and day to day lives on their return home. The service benefits from direct access to other Possability People services, for example, The Disability Advice Centre, Advocacy, Shopmobility, The Continuing Independence Service (providing PAs),Citywide Connect services and It's Local Actually.

- Provides specialist local knowledge to enable speedy referral to local services.
- Provides information and advice needed to reduce loneliness and social isolation.
- Enhances local connections which improve health and wellbeing.
- Supports health and lifestyle change.
- Improves self-esteem, confidence and independence.
- Connects people to their neighbourhood.

Service Aims

The service was commissioned to:

1. Build stronger links between acute based health and social care staff and the Community and Voluntary Sector (CVS);
2. Improve the referral pathway to services and activities in the CVS for people recently discharged from the Royal Sussex County Hospital;
3. Assist in reducing the number of re-admissions of people recently discharged from the Royal Sussex County Hospital;
4. Assist in reducing outpatient appointments of people recently discharged from the Royal Sussex County Hospital;
5. Assist in reducing A&E attendances of people recently discharged from the Royal Sussex County Hospital;
6. Reconnect older people following discharge from RSCH with their communities - enabling access to appropriate services and activities provided by the Community and Voluntary Sector (CVS) and others, where relevant.

Building Connections between Providers

The pilot has brought together key organisations to form a **social prescribing network** which has begun to map the services offered and client groups they work with. (Appendix 1 shows a summary of the mapping.) Issues around capacity, expectations, referrals and gaps have begun to be explored. It has emerged that although there are a number of organisations offering some form of social prescribing, there is little or no duplication as all are working with different client groups. Citywide Connect led by Possability People also contributes to the development of cross-sector partnership building through its locality Hub Events.

Organisations involved include:

Age UK B&H
Brighton and Hove Libraries
East Sussex Fire and Rescue
Healthy Living Pharmacy
Impetus
Macmillan Horizons
Martlets
Possability People
Sussex Interpreting Service

A **social prescribing flow chart** of the connections between Link Back and Community Navigation – the two providers funded through this pilot – shows how the services work towards the same aims whilst working with differing models and client groups. This will be expanded to include other providers in the second year of the pilot.

Flowchart of Community Navigator and Link Back Services **February 2017**

Service Aims

- To link patients with sources of social, practical and emotional support that can help improve their health and well-being and quality of life
- To provide a bridge between Primary (CN) or Acute (LB) Care and sources of health and well-being support offered by the voluntary and community sector and others
- Promotes self management through patient centred methods and an empowering approach involving making decisions about support accessed (Community Navigation)
- Enables patients to identify needs, set goals and access services; engaging with carers, family members, neighbours as needed (Link Back)

Community Navigation Referrals from: GPs, Nurses etc.in a Primary Care setting. Whole person assessments form basis of Care Coach referral.

Client group: Patients identified as having non-clinical needs and long-term conditions and other vulnerabilities, e.g. low to moderate depression, bereavement, social isolation or financial difficulties.

63% were female and 57% were aged over 55.

Link Back Referrals from: Hospital Discharge teams for patients in an acute setting: Home First, Hospital Rapid Discharge team and Community Short Term Service Rehab teams.

Client Group: Patients age 55+ being discharged from the Royal Sussex County Hospital needing support to aid their discharge home and maximise their ongoing independence, health and wellbeing.

58% female and 31% were aged 86+ and 36% aged 76-85

Referrals accepted if the person has unmet social, practical or emotional needs and if the complexity of need is within the scope of the service.

Community Navigation – 1-2 sessions in surgery or in their home for an hour each, plus several telephone follow ups and facilitated referral work over a 2-6 month period.

Link Back – Support planning visit at home following hospital discharge plus 2 telephone reviews and follow up over a 4 month period

Person is enabled to access appropriate services and activities to meet non-medical needs and to reconnect with their community.

Community Navigation – The top referral types include; social groups, mental health services, exercise, adult learning and support with benefits & finance. 74% said they felt better for seeing the Navigator, and 87% said they had all the information they need to address their issue.

Link Back – 36% of service users requested 1-1 befriending, re-ablement and practical support and 16% sought social activities. 94% achieved 1 or more goals.

Evaluation

Developing a robust evaluation approach

Community Works, Impetus and Possability People have developed a common approach to evaluating social prescribing. The outcomes measured by each organisation have been aligned with the Better Care prevention and personalisation outcomes.

This evaluation begins to jointly report against these outcomes using indicators developed by Community Navigation and Link Back.

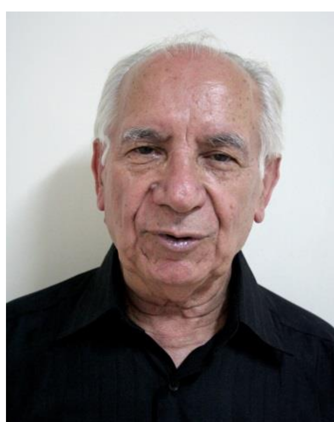
The two services operate at different scales, work with different client groups and therefore use different tools and indicators, so it is not appropriate to directly compare their data. However, both sets of indicators are aligned with the Better Care outcomes, as shown in the table below.

The key metrics have been identified and are also summarised below under service outputs.

Four costed case studies have been developed to demonstrate the impact of social prescribing.

This approach to evaluation has been informed and agreed by both the Keeping People Well group and the Social Prescribing network. It includes learning from social prescribing evaluations from elsewhere in the country.

Evaluations for both Impetus and Possability People are attached in Appendices 2 and 3.



"It has made a difference to how I feel and I realise there is a lot of support out there."

Service Outcomes

Better Care Prevention / Personalisation Outcome	CN and LB Outcome	Community Navigator (CN) Indicator	Link Back (LB) Indicator
I am enabled to remain independent for as long as possible	Improved independence	Access to timely and appropriate information, knowledge of available choices, ability to access services and activities *'Did the patients have all the information they needed to address their issue?'* *'Did patients have increased access to the support they needed?'* **64% suggested they now have better access to the services they need**	Access to timely and appropriate information, knowledge of available choices, ability to access services and activities *'Did the clients have all the information they needed to address their issue?'* *'Did clients have increased access to the support they needed?'* **35 % increase in those agreeing with this statement: 'I have the support I need to stay as well as I can' -** (NB This also reflects people's feelings about their care packages and was therefore beyond the outcomes that Link Back is able to influence)
I am supported to have social connections and feel happy	Reduced risk of, or actual, isolation	Improved satisfaction with social life, increased social activity *'Whether patients spent more time with others as a result of Navigation'* *'Whether patients accessed more local activities as a result of Navigation'* **74% suggested they are more satisfied with the amount of time they spent with others** **42% increased the amount of local activities they do, e.g. clubs and groups in their neighbourhood within 3-6 months of seeing a Navigator**	Improved satisfaction with social life, increased social activity *'Whether clients spent more time with others as a result of Link Back'* *'Whether clients accessed more local activities as a result of Link Back'* **87.5% increase in those agreeing with the statement: 'I am able to take part in the activities I enjoy in my community'**

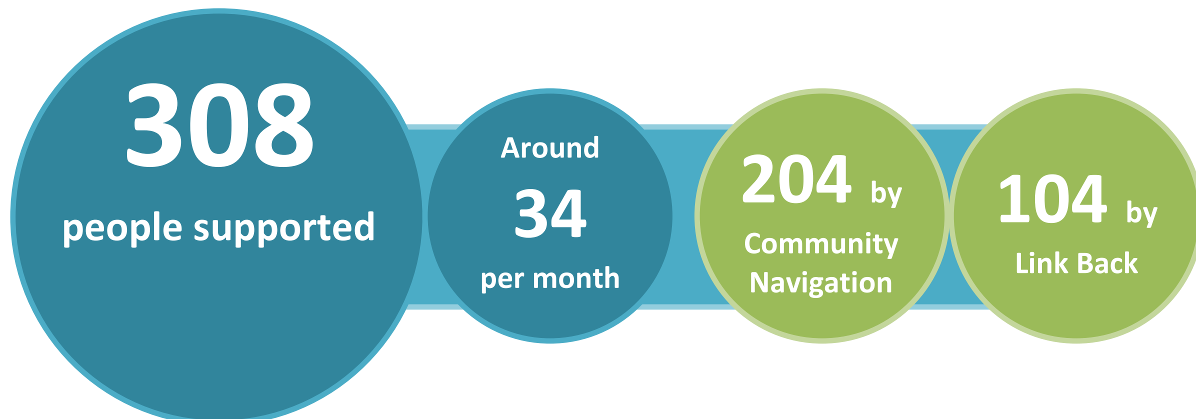
Better Care Prevention / Personalisation Outcome	CN and LB Outcome	Community Navigator (CN) Indicator	Link Back (LB) Indicator
I am enabled to stay well and maintain a good quality of life for as long as possible I feel that my quality of life is enhanced by the care and support I receive	Improved wellbeing	Enhanced quality of life, perceived improvement in wellbeing *'How much better did patients feel for seeing the Community Navigator?'* **74% of patients rate their wellbeing good to excellent after seeing a Navigator**	Enhanced quality of life, perceived improvement in wellbeing *'How much better did clients feel for seeing the Community Link Specialist?'* Link Back is developing a question around this and will have more data to share in future.
I am able to access a range of community support to help me maintain my resilience and wellbeing	Improved resilience	Improved ability to cope with their situation, ability to take the next step identified *'Whether patients feel more able to cope'* *'Percentage of patients who take up services'* **84% of patients increased their resilience and now feel more able to deal with their issue(s)**	Feeling positive: hope, learning to cope and feeling confident *'Whether clients feel more able to cope'* *'Percentage of clients who take up services'* **53% increase in those agreeing with the statement: 'I am coping in my daily life'**
The service I've received is tailored around my specific needs I receive the best possible person-centred care and support	Empowerment and choice	Sense of control, ability to make positive decisions. *'Patient score of how useful the Navigation process was to them'* **97% of patients thought the Navigator listened to them and understood of their needs** **94% rated the Community Navigation good to excellent**	Satisfaction with the service *'Client level of satisfaction of how useful the Link Back service was to them'* **81% agreed with the statement: 'Are you satisfied with the service you received from Link Back' - and 19% were unsure (often due to memory issues)**

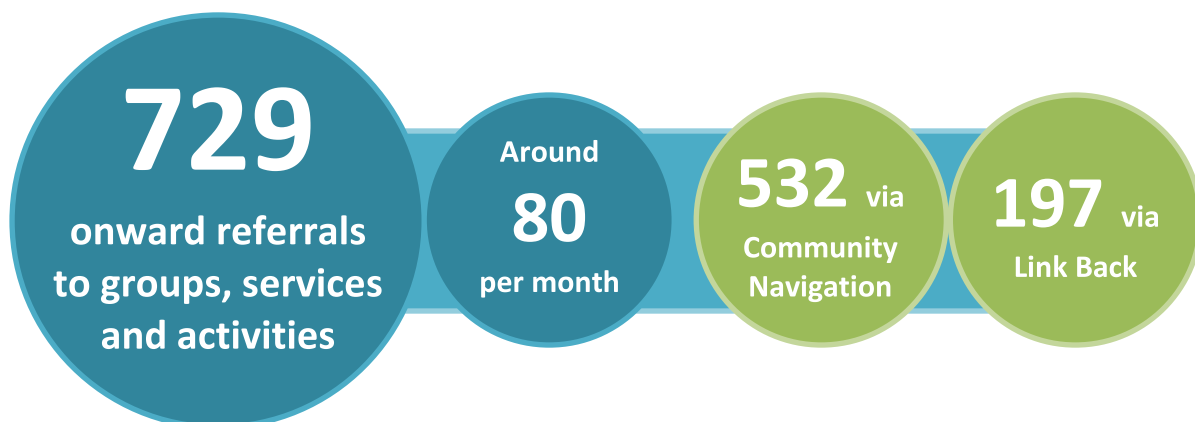
Better Care Prevention / Personalisation Outcome	CN and LB Outcome	Community Navigator (CN) Indicator	Link Back (LB) Indicator
I have access to appropriate information and support to enable me to manage my long term health condition/s I have access to timely and appropriate information when I need it I have access to appropriate advice and support to help me to avoid harm or injury I know what choices are available to me and who to contact when I need help	Improved independence	Access to timely and appropriate information, knowledge of available choices, ability to access services and activities *'Did the patients have all the information they needed to address their issue?'* *'Did patients have increased access to the support they needed?'* **87% of patients suggested they were better informed following Navigation**	Keeping Well: diet and exercise, eating and drinking *Did the clients have all the information they needed to address their issue?'* *'Did clients have increased access to the support they needed?'* Entitlements: disability benefits and allowances *Did clients have increased access to the support they needed?'* **92% increase in those agreeing with the statement: 'I am aware of all the allowances I am entitled to, to support my day to day living'** Daily Living: shopping, going out, transport and care *Did clients have increased access to the support they needed?'* **50% increase agreeing with the statement:** **'I have all the practical support I need'** (NB - This includes increased carer support and practical services. The outcomes reflect gaps in provision around free transport and home help services.)

Service Outputs

The outputs that follow combine the activities of Link Back and Community Navigation during the social prescribing extended pilot. The data shown is for 9 months; April-December 2016. The two organisations operate in different settings and are resourced differently. The charts below show the similarities and differences between the services offered.

NB. Each service was resourced differently, which explains the difference in numbers of people supported and numbers of onward referrals made. Link Back CCG funding is currently £41,917 per annum and is delivered by one member full time member of staff and 0.1 of a full time equivalent volunteer. Community Navigation CCG funding is currently £106,250 per annum to cover around one third of the city. It is delivered by 1.5 full time equivalent staff and 1 full time equivalent volunteer. Data for each service is therefore NOT directly comparable. More detail on resourcing will follow in a full evaluation in May 2017.





Onward referrals to services, groups and activities

Both organisations referred to a wide range of organisations and groups which reflects the tailored service they are offering to meet individual's needs.

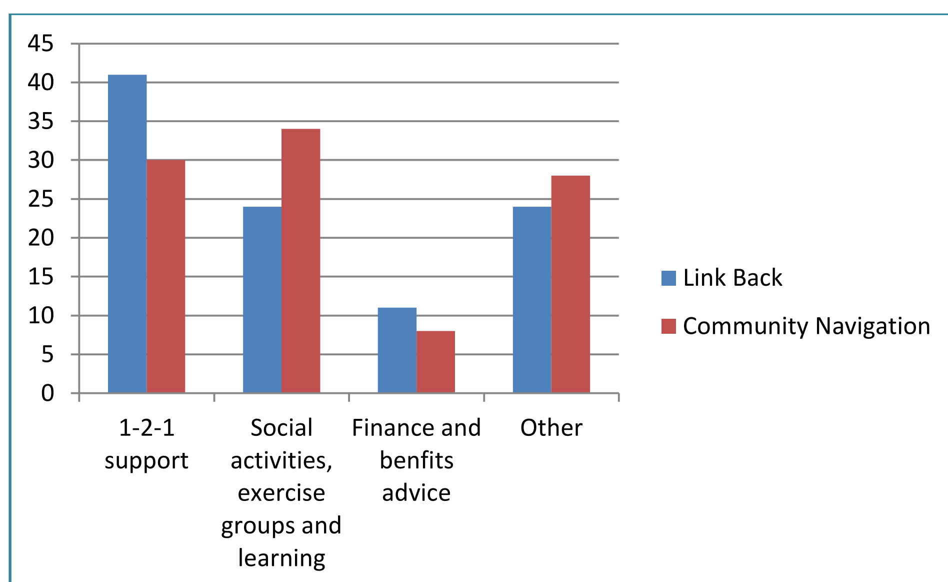
For ease, these have been categorised into four types.

1-2-1 Support Referrals: 36% of Link Back's referrals were to 1-1 support including re-ablement and practical or personal care. This reflects their client group's needs on discharge from hospital. Community Navigator make similar referrals accounting for 30% of their referrals - 7% mental health services, 6% older people's services, 5% for befriending, 4% for advocacy, 4% for counselling, 2% for disability and 2% for carers.

Social activities, exercise groups and learning referrals: 34% of Community Navigator referrals were to social or exercise groups or learning. This was 16% for Link Back along with 8% for lunch club and hot meal based referrals.

Benefits and financial advice referrals: Was 11% for Link Back and 8% for Community Navigators

Other: This includes adult social care, transport, adaptations, fire safety advice, community health, faith based support, advocacy, counselling, mobility, outings, volunteering, disability, carers and general information.



The data below represents a breakdown of onward referrals to groups, services and activities, clearly showing the differences between the two services and their client groups.

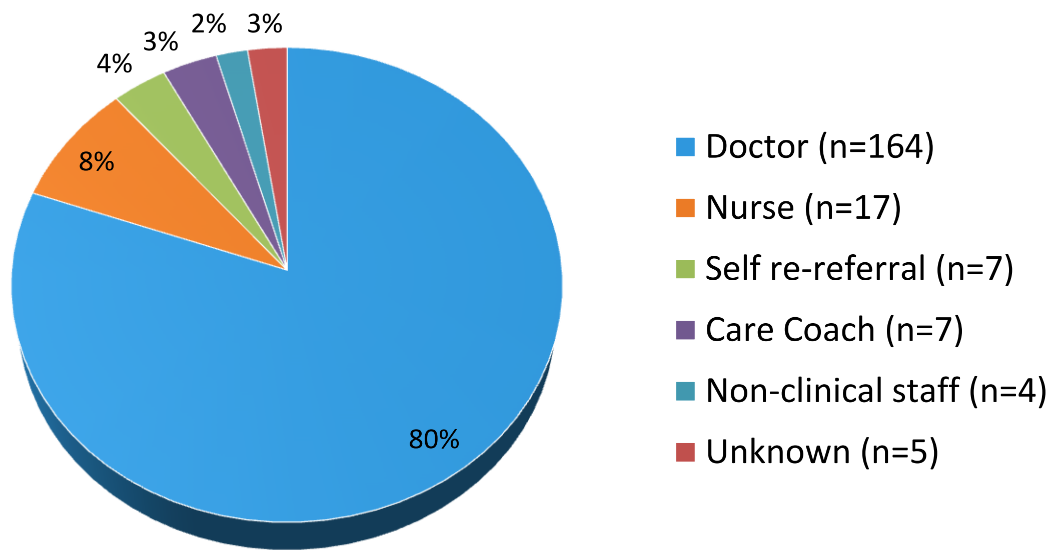
Link Back Onward Referrals

- 36% 1-1 support including befriending, re-ablement, practical and personal care.
- 16% social activities.
- 16% adult social care and adaptations
- 11% disability and benefits advice
- 8% lunch club and hot meal based
- 5% mental health services/counselling
- 8% other services including community transport, fire safety advice, community health and faith based support

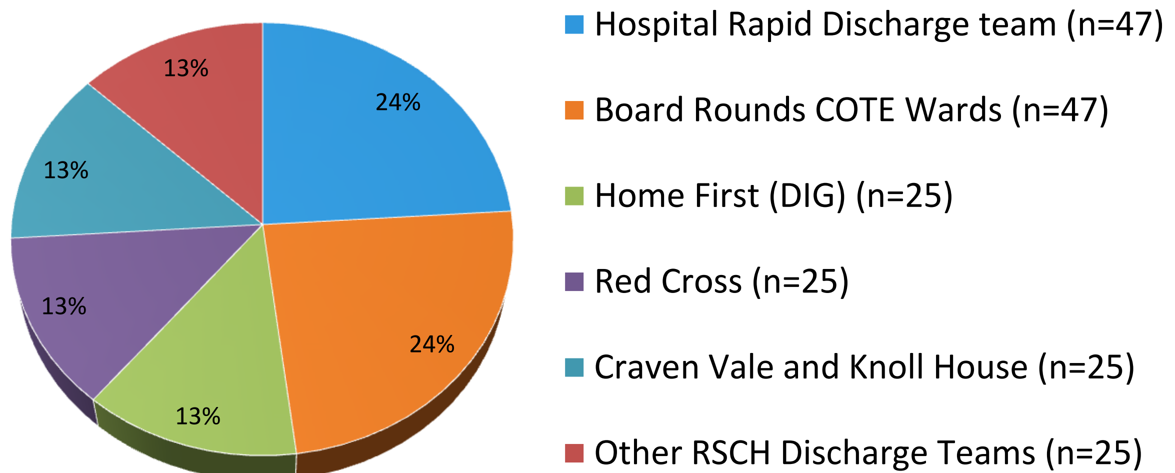
Community Navigation Onward Referrals

- 18% social groups
- 10% exercise
- 8% finance
- 7% mental health services
- 6% learning
- 6% older people's services
- 5% housing
- 5% befriending
- 23% sought other services including advocacy, counselling, mobility, outings, volunteering, disability, carers and general information

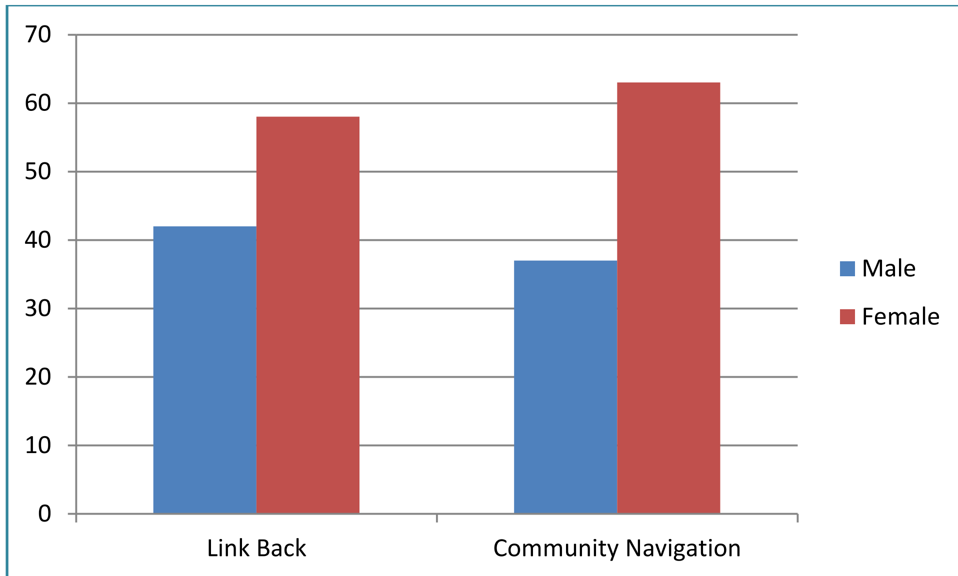
Community Navigation Referring professionals



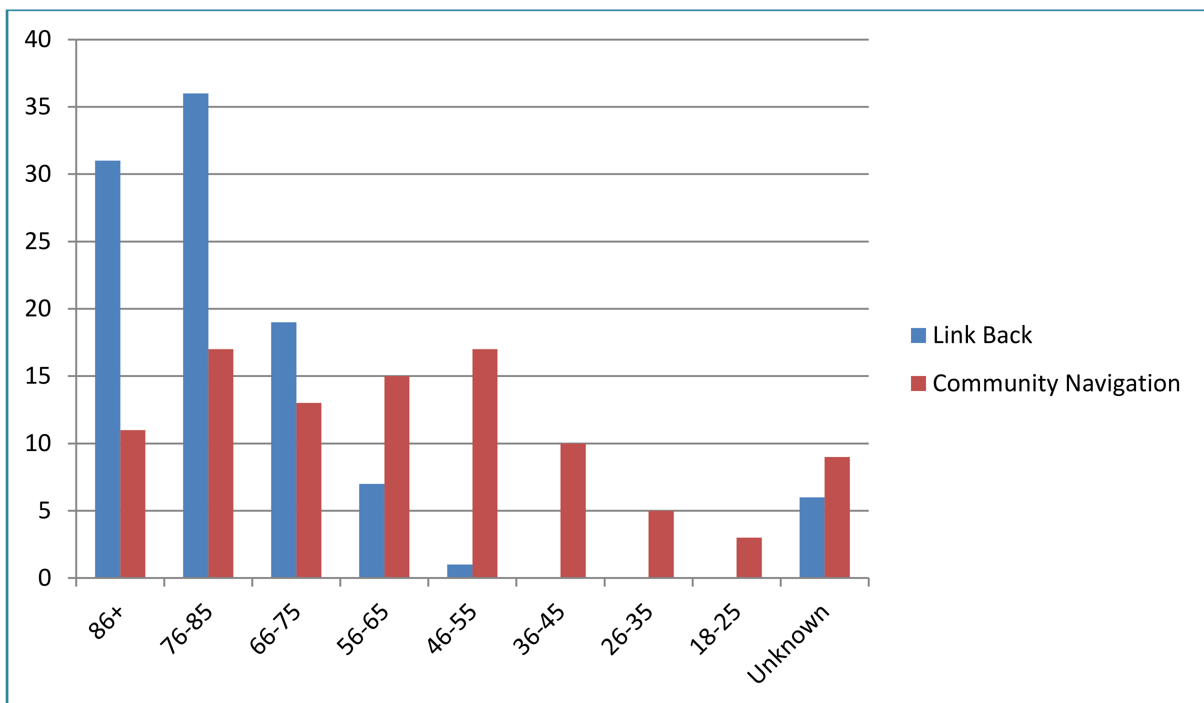
Link Back Referrers



Both organisations received around 60% of referrals for women and 40% for men



Age profile of patients supported



Link Back supports older people, mainly aged over 75. Community Navigation supports a wider age range, mainly over 35.

Case Studies

These case studies are illustrative of the impact of social prescribing. They include a cost benefit analysis, estimated by noting commonly used services by patients in similar circumstances. The cost savings in Health and Social Care result from services not accessed because of social prescribing support. These indicative figures have been calculated using Unit Costs of Health & Social Care 2016, PSSRU and sense checked with the Proactive Care Voluntary Sector Links Working Group which includes a GP and Adult Social Care Manager. These are conservative estimates and other costs may be saved as timely prevention helps avoid crises in the long term. The four case studies below present a range of situations.

Time and Cost Savings

Situation	Estimated cost saving per case study per annum	Estimated time savings across Health & Social Care systems
Overcoming low mood and stress – building confidence	£2,009	13.5hrs
Reducing risk of falls and resolving financial difficulties	£6,205	14hrs
Overcoming social isolation and anxiety	£1,663	13hrs
Supporting people to live well with a learning disability, vision loss and bereavement	£4,166	106hrs

The costs do not reflect the improvement in quality of life for the people receiving social prescribing or the resilience they will have developed. The case studies give a flavour of the difference social prescribing can make to someone's life.

The time savings are estimates based on the number of hours of primary, secondary care or adult social care time that was saved as a result of developing more resilience and independence as well as accessing a range of other services and groups in the community instead.

Cost and time savings will be explored in more detail in the full evaluation in May 2017.

Overcoming low mood and stress – building confidence

Martin, aged 41 was visiting the GP on a weekly basis and was referred to a Community Navigator with low mood, stress and employment issues after organisational changes at work resulted in increased pressure and high anxiety. He received 4 sessions over a 10-week period and was referred on to agencies offering employment and finance advice, As You Are (Counselling), Sussex Recovery College courses, groups at Mind in Brighton and Hove, Depression Alliance and Anxiety Forum. Over the weeks, Martin became more and more confident as he was encouraged to try new activities and focus on solutions. His depression gradually lifted over the weeks. He is now taking up a new career in the fitness industry.

Martin became more solution focussed and resilient. He took up new courses and activities that enabled him to recover from depression. This led to him retraining and making the changes he needed in his career. He has the mental and emotional resources he needs to handle low moods and anxieties should they arise again. He is also much happier and more fulfilled.

"Getting the right help is such a minefield and when you're depressed, you need someone else to back you up and fight your corner. A lot of stress was taken away from me and my wife, as someone was acting on our behalf finding services and resources. Once I started to see the Community Navigator, I didn't have to keep asking my GP questions about other services as I knew that was all taken care of. There was a ripple effect throughout my whole family; my wife and child were better supported and cared for and my parents felt relieved. She's helped me more than I can tell you. I wouldn't have got this far without her."

Better Care Prevention and Personalisation Outcomes contributed to

- ✓ I am enabled to remain independent for as long as possible
- ✓ I am supported to have social connections and feel happy
- ✓ I am enabled to stay well and maintain a good quality of life for as long as possible
- ✓ I am able to access a range of community support to help me maintain my resilience and wellbeing
- ✓ I have access to appropriate information and support to enable me to manage my long-term health condition/s
- ✓ I have access to appropriate advice and support to help me to avoid harm or injury
- ✓ I receive the best possible person-centred care and support

£2,009 estimate of services needed less per year because of social prescribing

- 20 less GP visits a year and 6 less prescriptions - £906
- Mental health care assessment - £300
- Avoidance of treatment for anxiety and depression- £803

Lessons learnt

- The person-centred approach was of central importance. Listening to the patient's needs and taking a non-judgmental, non-directive approach assisted in finding his own solutions, which meant he was better empowered and enabled to achieve his own goals.
- The amount of time given to patient was also key. There were 4 x one hour appointments and approximately 4 hours further time in research and facilitating referrals.

Reducing risk of falls and resolving financial difficulties

Mr. S, aged 68 was worried about housing and benefits issues having recently moved accommodation.

Link Back visited him in hospital which help to reduce Mr. S's anxiety levels. This also reassured his discharge coordinator and enabled a safe discharge home.

He was referred to Possability People's advocacy service to support him with his arrears claim. A successful appeal stopped him from being evicted and avoided input from housing services. This aided his recovery as it significantly reduced his anxiety and fears about losing his home.

He was also referred to Age UK B&H for help applying for attendance allowance as his initial claim had been rejected. This enabled him to get the practical care support he needs and avoided adult social care input.

A further referral to Care Link Plus for telecare equipment helped reduce his falls risk due to an earlier stroke. His Care Link pendant has increased his confidence to continue living independently as he feels assured he can get help in an emergency. Speedy help is known to reduce the medical intervention needed and hospital length of stay after a fall.

'All round it has been a very positive experience. Sue (advocacy volunteer) did a very good job getting assurance from the housing association that I didn't owe them any money which is a relief.

And Tommy from Age UK was really thorough in applying for Attendance Allowance which they have now granted. I also have my alarm pendant so feeling much more confident. You have done an excellent job. I'm coping very well now!'

Better Care Prevention and Personalisation Outcomes contributed to

- ✓ I am enabled to remain independent for as long as possible
- ✓ I am enabled to stay well and maintain a good quality of life for as long as possible
- ✓ I am able to access a range of community support to help me maintain my resilience and wellbeing
- ✓ I have access to appropriate advice and support to help me to avoid harm or injury
- ✓ I receive the best possible person-centred care and support

£6,205 estimate of services needed less per year because of social prescribing

- 6 less GP visits a year and 6 less prescriptions - £402
- Avoidance of treatment for anxiety and depression- £803
- Avoidance of fall and associated costs - £5000

Lessons learnt

- Visiting Mr S in hospital, before he was discharged, helped build confidence about going home.
- Timely intervention prevented an escalation of issues which often affects recuperation and recovery times.
- The Community and Voluntary Sector has a significant impact around supporting recovery in a tailored and swift manner.

Overcoming social isolation and anxiety

Delia is 61 and was referred to a Navigator with social isolation. She was suffering with agoraphobia, was avoiding going out and speaking to people and was becoming increasingly distressed and isolated.

Over a 5-month period, the Navigator saw Delia for 2 face to face sessions and 5 telephone sessions, as well as accompanying her to a Recovery College open day on one occasion (owing to her distress in going to new places alone). Added to this was approximately 6 hours further time in research and facilitating referrals.

Having identified that Delia has a thirst for knowledge and a variety of interests she used to engage with, the Navigator recommended Recovery College courses and U3A. Delia was also referred to Hop50+ day centre and a local knitting group.

Over several months, Delia began to make steady progress. She is now able to go out during the day unaccompanied if she chooses to and is living a more fulfilling life.

'The Navigator was interested in every aspect of my life. She really helped me get to grips with the agoraphobia that was developing. She helped me do things that I couldn't have done on my own. On the way to meet her at the college open day, I had a panic attack on the bus. Normally, I would turn back and go home, but I knew she would be there, so I felt able to carry on. That was the last time I had a panic attack. I knew I could do it after that.

Before I met her, I was having trouble getting out and even when I did, I would look down at the pavement to avoid making eye contact with people. I even walked the dog at night, just so I didn't have to interact.'

Better Care Prevention and Personalisation Outcomes contributed to

- ✓ I am enabled to remain independent for as long as possible
- ✓ I am supported to have social connections and feel happy
- ✓ I am enabled to stay well and maintain a good quality of life for as long as possible
- ✓ I am able to access a range of community support to help me maintain my resilience and wellbeing
- ✓ I have access to appropriate information and support to enable me to manage my long-term health condition/s
- ✓ I have access to appropriate advice and support to help me to avoid harm or injury
- ✓ I receive the best possible person-centred care and support

£1,663 estimate of services needed less per year because of social prescribing

- 6 less GP visits a year and 6 less prescriptions - £402
- Mental health care assessment - £300
- Social Care assessment - £158
- Avoidance of treatment for anxiety and depression- £803

Lessons learnt

- The tailored approach was effective, especially in accompanying her to a college open day. Ordinarily, the Navigation service does not have the capacity to do this, but we recognise it is needed at times. The CN service may want to look at developing a 'buddying' service in future.
- The amount of time given to patient was also key.

'I still prefer to be on my own, but now I'm confident that I can go out if I choose to and I am doing so much more with my life."

Support to live well with learning disability, vision loss & bereavement

The Link Back Service provided support to a 58 year old woman, Mrs C, following a short hospital admission and the death of her husband who was also her carer.

Mrs C has vision loss due to macular degeneration and learning disability. Adult Social Care support worker Angela Kinsey-Bowden was providing post bereavement support and help to manage her financial affairs and health treatment following the death of her husband.

Mrs C was referred to the Link Back Service by the Red Cross who were concerned about her being socially isolated and needing practical support.

During our initial assessment Mrs C did not identify any goals as she was still grieving and did not feel ready to consider longer term needs. She was consumed by dealing with practicalities and adjusting to living alone. She had no interest in the social and practical support the service could offer.

However, a step by step approach has enabled Mrs C to engage with a befriending service for 1-1 support and attend a Christmas day lunch. She has also agreed to volunteer support to access her health appointments in place of her support worker. Liaison with the Red Cross potentially avoided a call out by the paramedics or adult social care duty team during an anxiety attack relating to her loss of vision.

Mrs C has developed more confidence to engage with services outside of adult social care and is able to access a broader support network.

Better Care Prevention and Personalisation Outcomes contributed to

- ✓ I am enabled to remain independent for as long as possible
- ✓ I am supported to have social connections and feel happy
- ✓ I am enabled to stay well and maintain a good quality of life for as long as possible
- ✓ I am able to access a range of community support to help me maintain my resilience and wellbeing
- ✓ I have access to appropriate information and support to enable me to manage my long-term health condition/s
- ✓ I have access to appropriate advice and support to help me to avoid harm or injury

£4,166 estimate of services needed less per year because of social prescribing

- Reduction in social care £20 x 2 h x 52 weeks = £2080
- Avoidance of ambulance to A and E and hospital admission - £2086

Lessons learnt

- A step by step approach in supporting patients on their individual journeys is key
- Offering timely and trusted support to engage with the services are important interventions to support people to live independently.
- Liaising with support workers enables trust to be built and joined up support to be offered.

'Mrs C is looking forward to her befriender starting and pleased about LifeLines support to attend the eye hospital…. thank you to Gwyn for all her assistance, flexibility, and the ability to obtain support quite quickly- not easy these days when so many services are very busy.' Angela Kinsey-Foden, Community Support Worker, Adult Social Care

Learning and Reflections

These are the joint learning and reflections from delivering the Link Back and Community Navigation services.

1. The **people Link Back and Community Navigation work with have different needs**. Community Navigation facilitate referrals mainly to activities offering emotional and social support. Link Back also supports service users emotional and social needs however this is usually at a later stage once practical post-discharge support is in place, such as care packages, shopping, and accessing money.

2. There is a percentage **increase in the number of people with complex needs** being referred to both services. The timing of this increase coincided with a reduction of funding in adult social care, though further reasoning needs to be explored.

3. **A flexible support offer is needed**. People need differing amounts of support for different lengths of time. Some may need support attending activities and others may simply need information. Both organisations recognise that **needs emerge over time.** It takes time to engage, build trust and for the person's situation to stabilise. Then with a step by step approach further needs can be identified.

4. **Continuity is key** to build trust and support the person. This reduces the number of onward referrals to agencies and is especially important when people have memory issues. Assessments are shared where possible. Straight forward referrals are taken over the phone by Link Back and Community Navigators have a simple form in EMIS/SystmOne. Care is taken not to duplicate or introduce people unnecessarily.

5. Both organisations are adopting a **mix of paid staff and volunteers.**. This reflects learning and developments nationally in established services. It helps ensure that there is adequate resourcing to supervise and support volunteers. Volunteers tend to have a background in supporting people and they bring skills and experience to the role, as well as enabling the services to be more cost effective when compared with paid staff.

6. There is a need **to continue to fund Voluntary and Community Sector services so that they can be signposted to**. Both organisations reported a reduction in the capacity of the Sector to respond to needs and that waiting lists are longer. Community Navigation has seen a reduction in the options for support available to people and Link Back has found the process can be slow for clients to get support through Access Point, particularly for non-urgent needs requirements such as home adaptations.

7. **Communication difficulties** between services hamper the support offered for both Link Back and Community Navigation. Problems arise particularly around access to medical and care records, such Care First. In addition, the need for a common tool for recording service involvement post discharge from hospital that is accessible to patients, family and other providers has been identified by Link Back and the Home First team and is undergoing further discussion.

8. **Specialist research, such as a matched cohort study, would be needed to fully evidence time and cost benefits** of social prescribing in Brighton and Hove. However, both services use well-recognised, robust mechanisms for monitoring patient outcomes and a further evaluation approach is being developed by the University of Westminster that we will learn from when available.

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