Social prescribing in Brighton & Hove

Interim evaluation & service update

April – September 2017

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Headlines

The Community Navigation service has made significant progress during this last six months. Since our previous report 'Social Prescribing extended pilot evaluation' April to December 2016, the numbers of people supported, sessions provided, onward referrals and volunteer hours have all increased significantly per month. This results from increasing demand and a citywide expansion, building on the strong infrastructure of the core service which has been developing since 2014.

Percentage increases are significantly over and above the level of additional investment, demonstrating the increased value from scaling up the service.

Headline comparison between extended pilot evaluation and this report

	Apr-Dec 16 pilot evaluation (n)	*(Av per month)*	*Apr-Sep 17 interim evaluation (n)*	*(Av per month)*	*% increase per month (av)*
Patients seen	204	34	284	47	40%
Sessions	665	73	948	158	120%
Onward referrals	532	61	765	127	110%
Complex cases	36	4	51	8.5	110%
Additional support needs	42	4.75	85	14	200%

Outputs

- 284 people supported
- 184 new referrals in period
- 948 sessions (plus 50 emails and 42 letters, which are written to patients to give any further information as a case is being closed, if they cannot be reached by telephone, or if this is their preferred method of contact)
- 3.3 sessions per person on average
- 5.2 average hours of support time given (not including travel)
- 765 onward referrals to groups, activities and services
- 1,089 volunteer hours given (supporting patients, attending meetings, training, supervision)
- 13 weeks average case length
- 64% of patients aged over 55
- 18% of cases were complex
- 30% of patients presented with at least one additional support need, e.g. mobility needs, learning disabilities. This is an increase of 9% in the past year

The below table shows how many new referrals (of the total 184) were made by each category of professional. The 2 'Unknown' are from incomplete referral forms.

Referring professionals	*No. referrals made*	*% of total referrals*
Doctor	151	82%
Nurse	15	8%
Other clinical staff	2	1%
Non-clinical staff	4	2%
Care Coach	4	2%
Impetus Service	5	3%
Self re-referral	1	0.5%
Unknown	2	1%

Outcomes

- 83% of people said that Community Navigation had been useful/very useful to them
- 92% of patients thought the Navigator listened to them and understood their needs
- Distance travelled monitoring showed an average increase of 1-2 points on a 5 point scale (1 point increase is regarded nationally as good progress)

Key Learning

- CN represents significant value for money by utilising volunteer support within its delivery model
- Successfully establishing the core service has provided a strong, robust base for scaling up with minimal additional investment
- Future decisions about funding and setting targets for SP needs to take into consideration the following
    1. Rapidly changing health and social care landscape.
    2. Increasing numbers and length of complex cases being referred.
    3. The overall growing rate of referrals.
    4. The need to sustain the increasing workload resulting from the citywide expansion (see next steps)

Next steps

Next steps include; operating citywide, a discussion of barriers to providing an effective citywide service, criteria for complex cases and further opportunities.

National context

Community Navigation or social prescribing (SP) continues to grow with hundreds of schemes now identified across the UK. The inclusion of SP in the NHS Five Year Forward View as one of ten high impact actions to help reduce pressure on primary care has helped put the spotlight on SP as an effective way of helping to address health inequalities. The Kings Fund dedicated a sell-out conference to social prescribing in May 2017 and the national SP network goes from strength to strength with **regional networks growing in number and members.** The London Mayor has recently cited **social prescribing as a key initiative going forward** across the City. Both the recent Department of Health VCSE fund and Healthy Lives Social Impact Bond funding have generated significant interest across the country in developing and expanding social prescribing schemes.

An evidence review published in June 2017 was broadly supportive of **the potential of SP to reduce demand on primary and secondary care** and the evidence of cost savings were encouraging.

A recently published national guide 'Making Sense of Social Prescribing' produced by the UK Social Prescribing Network and the University of Westminster cites Brighton and Hove Community Navigation as one of its example services.

Most social prescribing schemes of a similar size do not involve volunteer Navigators. The Brighton and Hove model represents good practice in volunteering as well good value for money. We estimate that at least £50k per year is saved in service costs by involving volunteer Navigators. Current research being undertaken by the Kings Fund is looking specifically at this area and the learning from our model.

Local Context

In Brighton and Hove, we see people with increasing job insecurity, often on zero-hour contracts and people experiencing social isolation due to acquired disabilities and temporary housing. The cost of housing is already high in Brighton and Hove and more recently, rising inflation and increasing food prices are putting pressure on living costs.

The introduction of Universal Credit and the large numbers of claimants being refused Personal Independence Payments and Employment Support Allowance is also impacting the service and this is expected to increase as the citywide expansion proceeds.

Social isolation, low mood and stress are common reasons for referral to Community Navigation. When 'unpicked' in session these presenting problems are often underpinned by the reasons noted above.

The service is seeing an increasing number of complex cases (see below.)

Complexity of Cases

18% of Community Navigation cases were identified as complex, compared with 4% in 2014*. The number of complex cases per month has more than doubled since the extended pilot evaluation Apr-Dec 2016

Statutory services are stretched or tightening their eligibility criteria due to funding cuts. People who previously would have access to a key worker, social worker or CPN are being referred to Community Navigation instead, which adds pressure to our service and increases the complexity of cases.

We know there is a need in the city for long term, person centred support for people with complex health and wellbeing needs.

Our Navigators regularly report people experiencing a reduction of services, particularly in adult social care, care coaching/coordination, mental health, housing and welfare advocacy. The increase in complexity of our cases also indicates other gaps in services in Brighton and Hove. We are collecting evidence on this, which will form part of future reporting.

This group of 'complex' patients often do not meet elevated current criteria for accessing statutory services; mental health, adult social care, housing support, welfare & debt advice. Our work to date indicates that when we work more intensively with patients for longer, they become better informed, more activated and eventually able to access appropriate community services to support them longer term.

Whilst we need to increase our capacity to address the growing number of complex cases currently being referred, our social prescribing model (guided conversation to assess needs and facilitated referral to access services and groups) **will remain the same. We will not be inviting more complex cases, but rather working more intensively and for longer with those currently referred.** This will help to address the health inequality faced by a group of patients that;

a) Meet our current criteria
b) Fall below the threshold for statutory services but clearly need extra motivational support to take next steps in improving their wellbeing.

See 'next steps' for more information on our current development plan.

**We define a complex case as lasting more than six sessions and three or more months, and/or involving multiple presenting issues and needs that result in the need for more motivational support and guidance to effectively access services.*

*Complex cases need more time and support, taking an average of **9.5 support hours**, which is nearly double the overall service average.*

The Community Navigation model

CN Coordinators conduct a pre-visit questionnaire by telephone that assesses eligibility, as well as safety for staff and volunteers of visiting the person at home. They also facilitate triage and onward referral if required. They carry out an initial assessment in a person's home in the form of a 'guided conversation' which ascertains background and non-medical needs to identify goals and services. They hand over some follow up work to the volunteer CNs, e.g. research, onward referrals, form filling, attending groups and appointments, whilst overseeing each case to ensure the person's needs are being met.

Once the person has accessed the right services and groups, the Coordinator advises the volunteer to close the case. A follow up call takes place 3-6 months later to check the person still has access to services.

Volunteer Community Navigators are mainly based at the B&H Impetus office, although where GP practices have room space available, make regular referrals and where there is a volunteer available in that area, a 'Lead CN' is located within the surgery to ensure flexibility of the delivery model. At present, there are still 4 Lead CNs, and these arrangements continue to work well.

Service Update

There have been significant developments in the Brighton and Hove Community Navigation (CN) service since April 2017. As requested by the Brighton and Hove CCG, the service commissioner, we began the process of scaling up the service to work citywide and are now accepting referrals from 30 GP surgeries across all six clusters in Brighton & Hove. We expect the service to be available to all 36 GP surgeries (except Brighton Homeless Healthcare) by December, providing appropriate funding continues for this expanded service.

To scale up citywide, we recognised our 'one Navigator per surgery' model was not sustainable for every surgery in the city and further developed our home visit model. Visiting people at home allows us to provide a consistent and responsive citywide service and is also favoured by patients.

A vital part of this expansion involved increasing the capacity of our CN Coordinator role, allowing us to recruit an additional member of staff.

Our (2 x FTE) Coordinators not only train, support and line manage our volunteer Community Navigators (CNs), but also carry out initial assessments, home visits, and hold their own caseloads.

Service Outputs

Data shown is for 6 months, April – September 2017

Patient Outcomes

***83% of people supported said that Community Navigation had been useful/very useful to them**

****92% of patients referred thought the Navigator listened to them and understood their needs**

'Distance travelled' monitoring

When we first meet a person, we carry out a 'guided conversation' with six open questions designed to find out about a person's life. Once we have listened and understood their needs, we ask them to give scores on a five-point scale, with one being the worst and five the best. These are recorded on a 'Wellbeing Web' and the same scoring process is carried out again at the end of the case to show how their scores have changed.

3-6 months after a case is closed, we carry out a follow up call to see how the person is doing. During this call we also ask whether they felt the Navigator understood and listened to them.

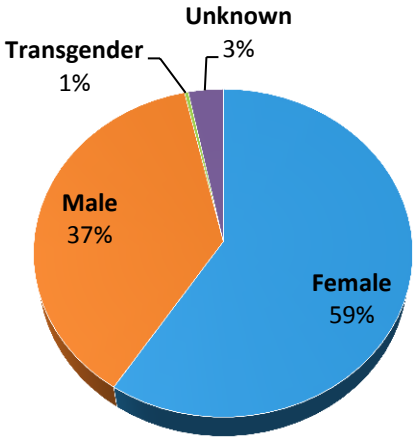
In our guided conversation, we ask:	**Outcomes:**
Q1 - How satisfied are you with how much you socialise with others (e.g. family and friends)?	Reduced risk of, or actual isolation
Q2 - What activities do you do or local facilities do you use regularly (e.g. clubs, groups, community centres)?	Reduced risk of, or actual isolation
Q3 - How well informed are you about services and activities available to you (e.g. advice, support, clubs)?	Improved independence
Q4 - Do you get access to the services you need (e.g. advice, learning, counselling)?	Improved independence
Q5 - How are you able to deal with the issue(s) at the moment? / If the issue(s) came up again, would you be able to deal with it on your own?	Improved resilience
Q6 - How would you describe your wellbeing in relation to the issue(s)?	Improved wellbeing
*When case is closed: How useful has the Community Navigation service been to you?	Person centred care & support
**In 3-6 month follow up: Do you feel the Navigator understood and listened to you?	Person centred care & support

For question 3, there is an average increase of two points.
For all other questions, there is an average increase of one point.

Our outcomes framework uses the same principles as other distance travelled monitoring tools nationally. The national Social Prescribing Network regards success, based on a similar tool, to be an average increase of one scoring place for each outcome on the five-point scale.

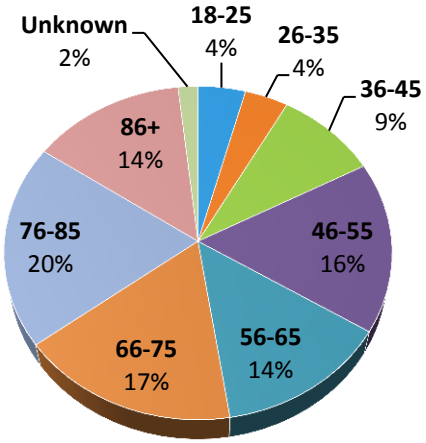
Patient Demographics

Gender of people referred

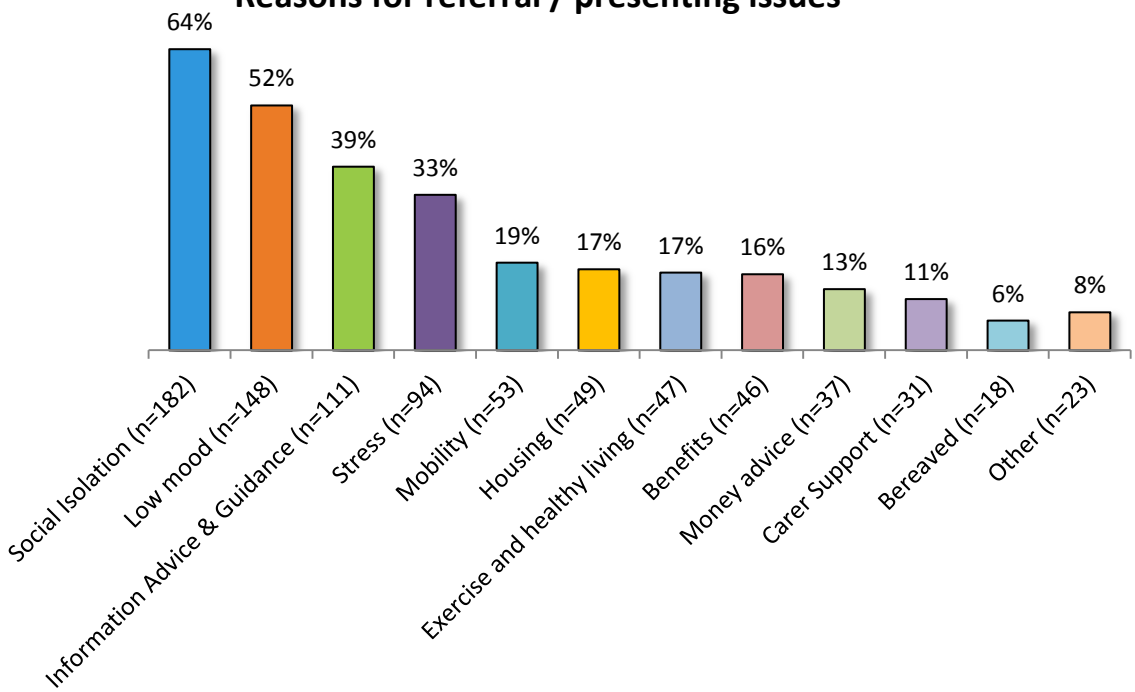


The 3% 'Unknown' are from incomplete referral forms.

Age range of people referred



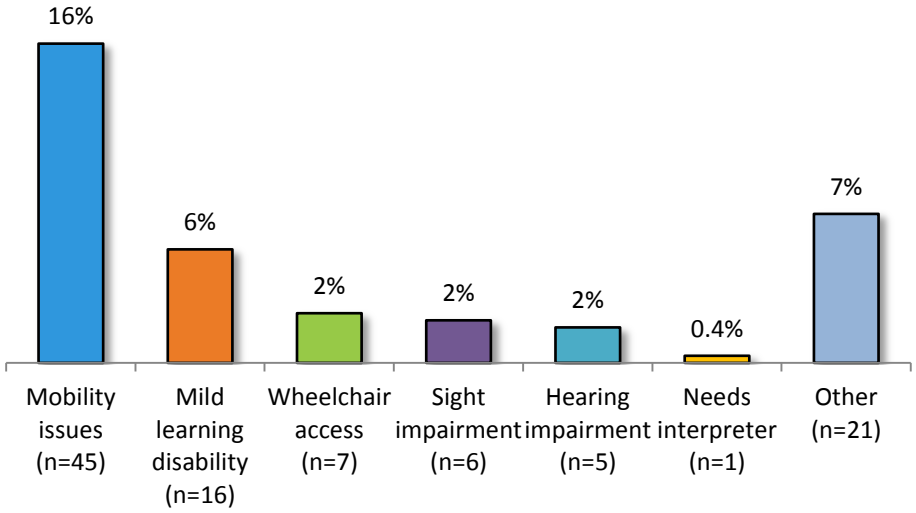
Reasons for referral / presenting issues



'Other' referral reasons were: Adult Learning, Confidence, Dementia, Employment, Form Filling, and Volunteering.

This chart shows the number and percentage of patients who presented with each issue. The total is more than 100% as patients have multiple presenting issues.

Additional support needs



30% (n=85) of patients supported had at least one additional support need. Averaged per month this shows a significant increase; 200% since the extended pilot evaluation report Apr-Dec 2016.

(The total in the chart is more than 30% / n=85 as some patients had multiple additional support needs.)

'Other' support needs were: Alcohol issues, Autism Spectrum Disorder, ADHD, agoraphobia, BPD, can't read, chronic disease (colitis), COPD, depression, fibromyalgia, fibrosing alveolitis (breathlessness), fractured neck, short of breath, housebound, Kleinfelter's syndrome, OCD, personality disorder, psychosis in remission, referral to breast clinic.

Next steps

Operating citywide

During this expansion phase, the Community Navigation service has been gradually increasing the number of surgeries it can take referrals from and intends to be available citywide by the end of the calendar year.

The *expanding* service has adequate funds to cover all costs associated with managing the service, employing 2 x FTE Coordinators and supporting 10 x Volunteer CNs.

This provides a capacity to work **with up to 725 cases annually**.

The average number of referrals since the service began in 2014 has been 2 per month per surgery

To be a fully *expanded* citywide service accepting referrals at this same rate would require an additional 0.5 FTE Coordinator and 2 x volunteer Navigators. This would increase the capacity to **865 cases per year**.

Barriers to providing an effective citywide service

If the funding level remains at current levels, the CN service could work with a maximum of 725 cases per year (1.7 referrals per month per surgery). We are expecting an increase in referrals from the surgeries we have recently started working with (this is the usual pattern) so **at this funding level we would need to devise a fair way of offering a reduced service** (e.g. operating waiting lists, limiting referral numbers per surgery, not working with particular surgeries/clusters).

Further opportunities to address complex cases

The CN service is seeking additional funding streams to expand, adding capacity to offer complex case work and specialist/equalities Community Navigation.

Whilst we need to increase our capacity to address the growing number of complex cases currently being referred, our social prescribing model (guided conversation to assess needs and facilitated referral to access services and groups) **will remain the same. We will not be inviting more complex cases, but rather working more intensively and for longer with those currently referred.** This will help to address the health inequality faced by a group of patients that;

a) Meet our current criteria

b) Fall below the threshold for statutory services but clearly need extra motivational support to take next steps in improving their wellbeing.

We need to ensure referrers understand we will *not* be doing the work of care coaches/ coordinators or social workers and cannot attend MDTs. The only difference is that we support this group of patients more often and for longer, with an increased emphasis on the motivational

interviewing methods we use to identify and reach goals. The average contact time with a Navigator is 5 hours over 3 months. We know that some patients need around 10-15 hours contact time over one year before they are 'activated' enough to take next steps.

The models of and criteria for accessing social prescribing, social work and care coaching/coordination are all fundamentally different. These roles do share similarities though. Each of these types of service provides a one-to-one worker who builds rapport with the patient and acts as a single point of contact to share information, motivate, nurture and open doors to appropriate services and groups. Where patients have a need for one-to-one support but do not meet the criteria for social work or care coaching/coordination, Community Navigators are able to step in and ensure they do not fall through the gaps.

We recognise that some patients need more time than others to begin making positive changes in their lives. With the patients we see, this is nearly always related to mental ill health and it would further increase their health inequality if we were to leave this group of patients without the adequate longer term support they need to increase their motivation to improve wellbeing and access appropriate services.

We also recognise that this steps beyond prevention work. **Whilst we are not a crisis service and we do not see patients that were eligible for Proactive Care, we *are* seeing patients who have long term health conditions and this also needs to be recognised and understood.**

That said, **we are aware of the need to closely observe the growing complexity of our cases.** If complex cases continue to rise to the point where our social prescribing model cannot meet the needs of patients being referred, we may need to alter our criteria. It is likely this would create a gap in services for a middle tier of patients with longer term health conditions that require one-to-one support but who do not meet the criteria for any appropriate and available service.

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Impetus is an award-winning Brighton charity helping people who feel lonely or socially isolated because of age, disability or poor mental or physical health. Our team of staff and volunteers help people make connections in their community to improve health and wellbeing. We offer a range of community support including befriending, advocacy and social prescribing.