Improving Health Together

A Business Case for Social Prescribing Across South Tees

August 2015

Final Report - Executive Summary

'A pathway enabling primary care services to refer patients and carers with social, emotional or practical needs to a range of local services, often provided by the voluntary and community sector (VCS) to improve wellbeing and support resilience and self-help'

The South Tees Social Prescribing Project Board - 2015

Author: **Lesley Spaven**
Social Prescribing Project Leader

1. EXECUTIVE SUMMARY

1.1. This document provides a summary of the full business case for the introduction of a new social prescribing service in South Tees in the context that those involved in planning, developing and delivering services are facing the difficult task in trying to create a sustainable health and social care system in the face of one of the most challenging financial and organisational environments the NHS and local authorities have ever experienced.

1.2. South Tees faces many of these challenges with significant health inequalities, increasing demand for health and social care services and a decrease in funding, all of which indicate a need for a radical shift in how services are commissioned and delivered.

1.3. The ageing population and increasing prevalence of chronic diseases requires a strong re-orientation away from the current emphasis on acute and episodic care towards prevention and self-care.[1]

1.4. In recent years, Middlesbrough Voluntary Development Agency (MVDA) has been leading discussions with key partners around the potential to develop a local social prescribing service culminating in the development of an options appraisal and business case which supports a phased introduction of a South Tees social prescribing service.

1.5. The proposal fits with a large number of key national, regional and local drivers for change including addressing health inequalities, reducing the pressures on: primary and secondary care services, adult social care services and the use of the NHS for non-medical problems.

1.6. There is mounting evidence that shows how social circumstances can have a significant impact on health and wellbeing and how people often turn to primary care providers for a medical solution to what is clearly a social issue. This can include for example mental health problems brought on by debt or family issues, poor lifestyle choices and self-care as well as loneliness and isolation.

1.7. There are a number of key national, regional and local strategies, policies and evidence that support an increase in the use of the voluntary and community sector and community assets, specifically the introduction of social prescribing, to contribute to the systems change that is required to address these growing issues.

1.8. The use of the voluntary and community sector to support people with non-medical needs to help improve their health and wellbeing is gaining momentum and 'social prescribing' is being widely introduced across the UK as a mechanism for relieving some of the pressures on the health and social care system and to improve health outcomes for the population.

[1] Transforming our health care system – The Kings Fund, April 2015

1.9. Evidence shows that social prescribing can have a big impact on reducing attendances at GP practices and A&E departments, missed outpatient appointments, admissions and re-admissions to hospital[2] as well as significant returns on investment as demonstrated in Rotherham who are reporting an expected net return of £3.38 for every £1 invested in social prescribing, Sefton reporting £6.95 for every £1 invested and a staggering £9 for every £1 invested in Swindon[3].

1.10. When evaluating the social and economic impact of the Rotherham Social Prescribing Pilot the key successes demonstrated the following outcomes for those patients who used the service:

- 21% reduction in inpatient admissions
- 20% reduction in A&E attendances
- 21% reduction in outpatient appointments
- 83% experienced positive change in at least one outcome area
- £350,000 in additional welfare benefits generated

1.11. It was also established that in addition to direct health related benefits, the public sector also experienced broader outcomes as a result of the Social Prescribing Pilot.

1.12. For example, patients accessing the service were generally more satisfied with the support they received and felt better supported to manage their condition. There was also emerging evidence that non-health services, in particular social and residential care, benefited from similar reductions in resource utilisation and service delivery costs. However, detailed analysis of social care data would be needed to properly quantify the extent of the reductions.[4]

1.13. This business case is the culmination of several years' partnership working to design a service most suited to the needs of the local people and local services in South Tees. It is supported by a detailed research and evidence base on the benefits of social prescribing and the challenges facing health and social care services.

1.14. The proposal for a social prescribing service for South Tees initially suggests working with a select number of GP practices (11 expressions of interest so far) in year one extending to all 46 GP practices by year three.

1.15. The service will enable GPs and primary care staff including community nurses to refer patients with non-medical needs via a single referral route into a social prescribing hub. A lead organisation will be appointed to manage and oversee the delivery of the service.

[2] The Business Case for People Powered Health April 2013 – NESTA & Innovation Unit
[3] Social Prescribing Action Learning Set | Report Building Health Partnerships Practice Development Network Swindon 14th March 2014 – Institute for voluntary Action Research
[4] The social impact of the Rotherham social prescribing pilot: main evaluation – Sheffield Hallam University, September 2014

1.16. The service will initially focus on those patients suffering from long-term health conditions (LTCs), those with mild to moderate mental health conditions and carers.

1.17. The target group has been identified through a balance of listening to the needs of local primary care staff, and reviewing the evidence base showing which conditions social prescribing has been most effective with. It is estimated that LTCs consume around 70% of health and social care resource expenditure[5] nationally.

1.18. In addition to the primary referral criteria the service will also focus on patients who are frequent attendees at GP practices, are failing to manage or at risk of developing a LTC or are disengaged or at risk of becoming disengaged from their GP practice.

1.19. This will help to address key local issues around the increasing demand for, and dependency on primary and social care services by supporting people with LTCs, encouraging better self management and prevention as well as addressing health inequalities.

1.20. A select number of voluntary and community organisations from key service areas and based on an understanding of patient service needs will be funded to employ Link Workers who will be attached to GP practices.

1.21. The most successful social prescribing services are built on the foundation of Link Workers who provide the support, motivation and encouragement to patients to build confidence and take control and responsibility for their own health and wellbeing.

1.22. Link Workers will undertake a holistic needs assessment and action planning with patients to identify non-medical interventions. They will provide ongoing support to enable patients to access appropriate interventions from within the voluntary and community sector leading to longer term sustainability of improved health and wellbeing and less dependency on statutory health and social care services.

1.23. The service will adopt a community asset approach by drawing on the vast and diverse range of additional voluntary and community based services across South Tees which currently stands at over 1,000 organisations. These services will mainly be provided through existing contracts or grants.

1.24. However, it is recognised that the introduction of social prescribing will increase demand for services and therefore the flexibility and ability to create additional capacity within the voluntary and community sector has to be taken into account.

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[5] http://www.england.nhs.uk/house-of-care/

1.25. Additional funding will be made available to Link Worker employing organisations to address any capacity issues brought about by extra demands for services via pump priming in year one or spot purchasing to ensure there are no delays in patients accessing the services to support their needs.

1.26. Funding may also be made available to other voluntary and community organisations in the form of spot purchasing or small subsidies where there is evidence of increased demand or to support the establishment of new groups where there are gaps in provision.

1.27. There are two options proposed in the business case based on an escalating number of GP practices, patient referrals and Link Workers. It is suggested that year one will be viewed as a pilot year and therefore the proposals for year one are the same for both options.

1.28. Year one will include 11 GP practices and it is estimated that the service could handle 572 referrals during this first year of operation via four Link Workers. By year three this could potentially increase to approximately 2,400 and 12 Link Workers for option one or 7,200 with option two and 24 Link Workers, covering all 46 GP practices.

1.29. There is significant advantage in scaling up the number of patients worked with, as many of the costs are fixed for the project which makes the service far more cost effective. Working at scale also has an advantage in making the monitoring and outcomes more robust.

1.30. It is proposed that the cost of the service is met from the main public sector commissioning bodies across South Tees: Middlesbrough Council, NHS South Tees Clinical Commissioning Group and Redcar & Cleveland Council.

1.31. The expected outcomes for patients receiving the service include:

- Better self-care particularly in relation to LTCs leading to less reliance on primary and social care services
- Increased interaction with the local community leading to reduction in loneliness and isolation
- Increase in self-reported wellbeing
- Ability to live independently for longer in their own home
- Reduction in health inequalities

1.32. The key benefits to health and social care services include predicted savings relating to:

- More cost effective use of health and social care resources
- Less reliance and dependency on statutory services
- More appropriate use of clinicians time
- Reduction in the number of GP appointments, attendances at A&E, missed outpatient appointments and admissions / re-admissions to hospital
- A single referral route for GPs and Primary Care Professionals
- Ability to respond effectively to non-medical needs
- Link Workers attached to GP practice
- Extra support for GPs to address patients social issues

1.33. In developing this business case much learning has been taken from across the UK and in particular Newcastle 'Ways to Wellness' and Rotherham, providing confidence in the predicted outcomes and return on investment when balanced against the overall investment cost of introducing social prescribing.

1.34. A number of risks associated with implementing a social prescribing service have been identified and these have been addressed through a risk register to help mitigate risk. When the business case is approved further work will be undertaken on the issues relating to the sharing of information and data, systems to facilitate this and patient consent to ensure robust systems and processes are in place.

1.35. Social prescribing depends on the quality of partnership working between health, social care and the voluntary and community sector. Partnership working between these sectors has been the foundation for the development of this business case and will be taken forward into any future governance arrangements.

1.36. Independent research and evaluation of the social prescribing service will be commissioned to establish if the specific aims, objectives and outcomes are being achieved.

1.37. The ability to measure wellbeing is important as it will enable commissioners and service providers to understand the impact the service has had on people's lives. Of equal importance is the ability to accurately measure the service costs verses cost savings, as compared to standard NHS and social care interventions, as this will ultimately impact on the ability to commission the service long-term.

1.38. To demonstrate success linked to the service a 'social prescribing outcomes framework' (SPOF) has been developed. A number of measures and indicators have been identified as part of the SPOF linked to referral criteria, impact on patients and services and reflecting the national Adult Social Care, NHS and Public Health Outcomes Frameworks. Further work will be undertaken in partnership with commissioners on rationalising the SPOF and testing out its robustness to effectively evidence key outcomes and to identify key sources and mechanisms for capturing data.

1.39. The nationally recognised 'Wellbeing Star' which is widely used by other social prescribing services will be adopted as part of the SPOF to measure individual patient outcomes. It was designed for people living with a LTC, to support and measure their progress in living as well as they can, but also provides a useful mechanism for supporting general wellbeing.

1.40. To provide an added layer of challenge and scrutiny it is proposed that a Management Board be established to provide oversight of the service. The multi-agency Management Board will receive regular reports on performance, quality assurance and service improvement and outcomes provided by the lead organisation.

1.41. This will be used as a basis to meet the reporting requirements of the key commissioners of a South Tees social prescribing service. An added benefit of the Management Board will be to share good practice as the service develops, and to address any issues in a timely manner as they arise.

1.42. It is important that any service introduced has a recognised brand that will help to embed the service both with referring organisations and patients. Further work will be undertaken to develop a brand for social prescribing that actively involves and engages service users.

1.43. The proposal is to have the service operational by April 2016 or as soon after this date to allow sufficient time for further work on the SPOF, engagement of GP practices, procurement and recruitment processes all of which is subject to business case approval and finance.

2. Conclusion

2.1. General practice and primary care services face challenging times, with rising costs, growing needs, and organisational changes. Broadening from a clinical model of primary care to one that combines the clinical and non-clinical not only has the potential to improve community health and well-being, but makes economic sense; it allows GPs and primary care staff to tap into the existing local resources provided by the voluntary and community sector.

2.2. Combining clinical and non-clinical interventions in a way that can benefit patients offers an exciting way forward for primary health and social care which could reduce the pressures on these services. CCGs and local authorities have much to gain from working in partnership with the voluntary and community sector[6].

2.3. Embedded in local communities and a trusted source of information, GPs and primary care staff are in a key position to encourage their patients to use non-medical services to promote and maintain health and wellbeing. The challenge for busy GPs and primary care staff is how to enable patients to access activities given that they vary from place to place and over time.

[6] J. White (2012) - Health together: how community resources can enhance clinical practice British Journal of General Practice – Google Scholar

2.4. Knowing what is available, having assurance regarding quality, and having the time to explore options with patients requires local knowledge, time and capacity which clinicians simply do not have.

2.5. Social prescribing provides an opportunity to support health and social care services to not only help relieve some of the pressures relating to demand but also improve health and well-being outcomes for patients.

2.6. There are a number of considerations that should be taken into account when determining the feasibility of introducing a social prescribing service including the potential resource implications of increased referrals to voluntary and community organisations. There has to be sufficient supply and range of services that supports the needs of patients.

2.7. The voluntary and community sector has the ability and expertise to support commissioners and policy makers to improve the health of their community and reduce health inequalities, both through provision of services and commissioning support.

2.8. There needs to be a robust and effective review and evaluation process that provides evidence of improved outcomes as well as a mechanism for ensuring the quality of the services that are being provided in order to build the confidence of GPs and encourage their use of social prescribing.

2.9. Any model of social prescribing needs to harness the 'network' of opportunities that other voluntary and community organisations provide in terms of reaching the whole community to support early intervention and prevention.

2.10. Continuing to medicalise society's problems is unsustainable. Social prescribing has been shown to improve health and wellbeing and reduce costs and is an option that should be fully embraced.

2.11. Social prescribing is not a new concept and has been operating successfully in many parts of the UK for several years. All the evidence points to the economic and social benefits of introducing a social prescribing service which could be replicated across South Tees.

Contact

Lesley Spaven
Social Prescribing Project Leader

Email: lesley.spaven@mvdauk.org.uk
Tel: 01642 803603

Middlesbrough Voluntary Development Agency (MVDA)
St Mary's Centre
82-90 Corporation Road
Middlesbrough
TS1 2RW

www.mvda.info

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