HEALTH AND PARTNERSHIPS SCRUTINY COMMITTEE
12 SEPTEMBER 2018

ITEM NO. .....**6**.....

BETTER CARE FUND: SOCIAL PRESCRIBING TESTBED OUTCOME

SUMMARY REPORT

Purpose of the Report

1. To brief the Committee on the outcome of the social prescribing testbed carried out under Better Care Fund and the next steps.

Summary

2. The testbed ran as planned from 1 May 2017 to 30 April 2018. More than 100 people were referred in during the programme. Lessons learned are being taken forward into a longer term scheme of wellbeing facilitators based in GP surgeries.

Recommendation

3. It is recommended that the Committee notes :-

   (a) the outcomes and the value of the lessons learned; and

   (b) the next steps being taken.

Suzanne Joyner
Director of Children and Adults Services

Background Papers

No background papers were used in the preparation of this report.

Pat Simpson, Project Manager – Better Care Fund
Extension 6082

S17 Crime and Disorder	No impact
Health and Well Being	Better Care Fund projects support Darlington Health and Wellbeing Plans
Carbon Impact	No impact
Diversity	No impact
Wards Affected	All
Groups Affected	Older adults
Budget and Policy Framework	None
Key Decision	no
Urgent Decision	no
One Darlington: Perfectly Placed	Health and Wellbeing Strategy is part of One Darlington, Perfectly Placed
Efficiency	None
Impact on Looked After Children and Care Leavers	None

MAIN REPORT

Information and Analysis

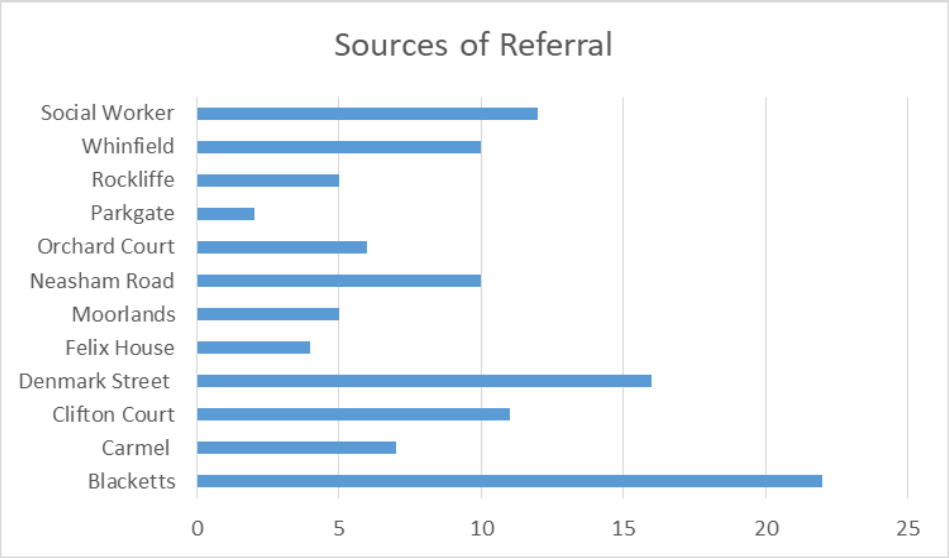
4. Around 130 people were referred to the Ways to Wellbeing testbed during its operation.

5. There was considerable variation in the numbers of referrals by different GP practices, possibly as a result of better understanding of the scheme by practice staff, or more proactive navigation.

6. Three-month reviews indicate good levels of sustained achievement of outcomes.

7. Investment in the testbed was £93,000. The post-testbed review does not indicate the testbed model as currently configured is cost effective.

Breakdown of referrals



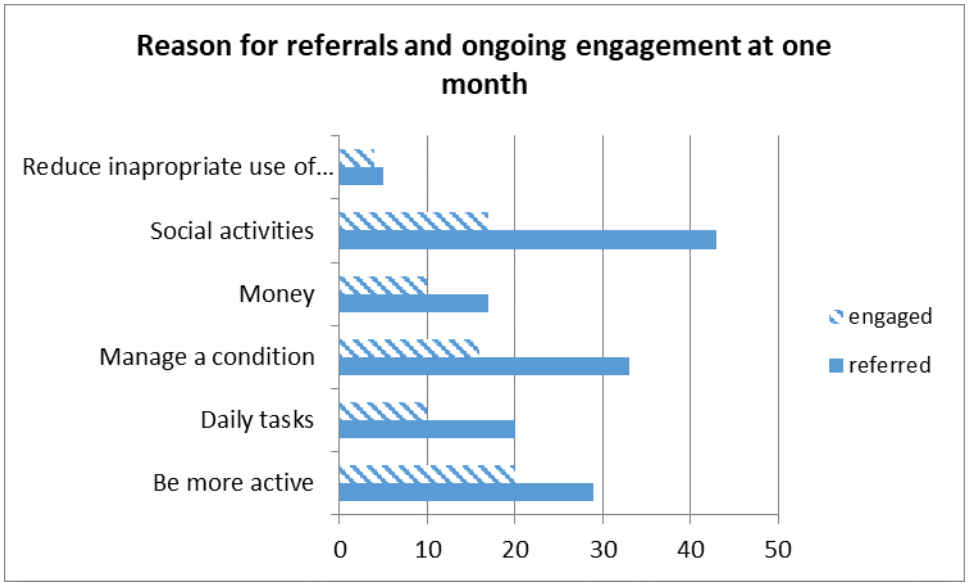
8. Just over a third of all referrals are male, but the age spread is wider than anticipated; guidance was given that referrals below 65 years would be accepted in the interests of prevention, but the age range is wider than BCF intentions.

9. The very great majority of referrals are white British.

Impact

10. By the end of the testbed, all those who had been supported for three months or more report the outcomes being sustained.

11. The following chart shows the rate of fall-away after referral. The plain bars are the number referred for each reason, and the striped bars are the number who wished to remain engaged in support after one month.



Summary of support provided

12. Most referrals are to Age UK and DAD. There is a variety of groups with which referred people have been connected and a handful of locality based informal interest groups but for the most part referrals have been to fairly mainstream large organisations.

Background

13. The testbed was set up from May 2017 with these key objectives:

    (a) To maximize identified Individual's overall quality of life by supporting, signposting and connecting them with community groups and activity provision in their local area and to meet the identified needs that are unable to be met by community provision as currently commissioned. The Service will achieve this by:-

(i) Increasing the referrals made by GPs and other health and social care professionals to local community activity provision, targeting those communities identified as having greatest need and leading to more individuals accessing local community activity and activities in areas of greatest need;

(ii) Increase the number of individuals accessing local community activity provision;

(iii) Improve the social support available for individuals by supporting, signposting and connecting individuals to community groups, activity, activities and provision in the local area;

(iv) Reduce social isolation and improve community connectedness to contribute to overall improvements in the health and wellbeing of individuals and communities; and

(v) Reduce demand on crisis or acute health and social care services.

14. The introduction of the service was marketed by presentations to GP Practices, social work teams and the preparation of posters for display in Practices and social care locations. A system for recording referrals and the goals set with people was designed and put in place using an existing computer system at the Local Authority, and training for wellbeing navigators was provided.

15. After three months an informal 'where are we now' review was carried out, with input from the navigators, referrers and commissioners. A formal six month review was then carried out, which included refreshed guidance for navigators and a requirement to increase the referral rate, as it was clear that insufficient referrals were being made.

Final position

Performance

16. At the end of the testbed there have been 128 referrals. An investment of £93,000, equates to an unsustainable cost per referral. Avoided cost would be derived from the number of clients reporting fewer visits to the GP but only four were reported.

17. Referrals increased month on month but only to a level between 15 and 20 per month. Similar services elsewhere achieve around 50 per month.

Referrals

18. There is a noticeable variation in the numbers of referrals from different practices.

Lessons learned

19. Behaviour change takes time – the persistent changes reported at three months support this.

20. Presenting issues are not always the issue to be supported; the skill of the care co-ordinator is in identifying the underlying issues.

21. It is important to specify what change is expected for the person through their Wellbeing Plan.

22. Other schemes which have been in place for several years operate a “single organisation” approach rather than a consortium approach: one employer, one way of working etc.

23. There appears to be unmet demand for befriending and volunteer driving, which would bear testing. The current befriending service through Age UK has a very tight eligibility criteria dictated by the funder which can make matching a client with a befriender difficult, causing delay. The funding for this scheme was due to end in December 2017 but has in fact been renewed.

24. There is clearly a need for a regular, but fairly casual befriending service – people willing to help people out with taking them to appointments, shopping locations etc; a ‘PA’ style service. This would still incur the cost of PNC checks and it would be worth testing the value of the “Good Friends” service in this role.

Conclusions

25. The lessons learned from this testbed have been taken into account in the specification for a Wellbeing Facilitator service delivered through Primary Care and managed through Primary Healthcare Darlington. The service is planned for implementation from October by Primary Healthcare Darlington and has Better Care Fund investment of £180,000 investment with a full set of quantitative measures and indicators.

26. This will have a ‘single organisation’ model, and benefit from pulling referrals from patient lists via the frailty index rather than hoping for referrers to identify potential beneficiaries. It will still be able to take referrals from Social Care.

27. The specific group of people target will be:

    (a) Patients identified and clinically judged as having moderate frailty using the eFrailty Index tool, through discussion with the GP and wider practice team and registered with a GP practice within NHS Darlington CCG.

    (b) Patients who are identified on an ad-hoc basis by the GP who thinks the Wellbeing Facilitator can have a positive impact.

    (c) Patients who have recently been discharged from hospital following an unplanned hospital admission whereby the GP/relevant professional feels a

referral to the facilitator would be of benefit with a view to preventing further unplanned admissions or social deterioration.

(d) People who have been discharged from intermediate care and reablement services, should be considered by the referring services for any ongoing support from the wellbeing facilitator in discussion with both the patient and the patients GP.

28. The Wellbeing Facilitators service has these objectives:

(a) Actively promote a culture of personalisation;

(b) Actively promote health and wellbeing by making every contact count;

(c) Provide personalised support to an identified cohort of frail patients to enable them to proactively manage their own health and wellbeing that demonstrates the impact that this has on patients;

(d) Maximise the use of appropriate services and community assets and evidence the impact that this has had on patients;

(e) Increase the effective delivery of the Wellbeing Plan including an action plan which identifies how support/outcomes will be achieved;

(f) Enhance the individual's ability to live independently and reduce their reliance on urgent, emergency and out of hours care services; and

(g) Engage with all practices to ensure that the role of the wellbeing facilitator is embedded in the proactive support for the moderately frail patients registered in each practice.

29. Wellbeing Facilitators will:

(a) Comprise of a Team and a Team Leader role who carry an appropriate case load to cover the identified cohort as detailed above;

(b) Be based within general practice and provide a service Monday to Friday between 9:00am and 5:00pm;

(c) Develop and maintain a detailed knowledge and working relationships with local community and voluntary sector services to enable supported sign-posting of people with identified need utilising resources such as www.livingwell.darlington.gov.uk directory of resources;

(d) Develop relationships and links with other organisations such as Local Authority Adult Social Care Teams and County Durham and Darlington NHS Foundation Trust to reduce duplication and increase efficiencies across services;

(e) Allow the patient to develop their plan to address their physical, emotional, mental and social needs of the patient through defined outcomes and goals;

(f) Raise with the GP or other appropriate professional if a further clinical review is identified during discussions with the patient;

(g) Work with patients, carers and MDT members to encourage effective help-seeking behaviours and to reduce unnecessary hospital admissions and A&E attendances;

(h) Act as a point of contact and communication between GP, patients and carers and other agencies;

(i) Work with commissioners, integrated locality teams and other agencies to support and further develop the Wellbeing Facilitator role;

(j) Support each patient on the caseload for an average of twelve weeks thereby encouraging the patient to proactively manage their own health, and wellbeing and include a minimum of three direct patient contacts;

(k) Review the plan after 12 weeks and the patient should complete a feedback questionnaire; and

(l) Consult with the Team Leader and named GP if an extension to the twelve week period of support is needed.

30. Wellbeing Facilitation is key to new ways of working across health and social care. In Darlington pilots and initiatives are being tried and tested as Primary Care develops a hub approach in general practice. The GP Federation, Primary Healthcare Darlington, will play a key role in these developments and it is anticipated that wellbeing facilitators will engage in the pilots involving primary care approaches and that the Federation will play a pro-active role in engaging with all practices/relevant stakeholders to support relationship building and embedding the care co-ordination role with GPs, practice nurses and other practice staff.