Wolverhampton City
Clinical Commissioning Group

PROJECT DOCUMENTATION

BUSINESS CASE

Project: Social Prescribing Link Workers

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Business Case

3 Purpose

This business case describes a model of delivering Social Prescribing across Wolverhampton, to enable patients in finding appropriate support for their individualised needs.

Social Prescribing is described as:

***"Social Prescribing** is about linking people up to social or physical activities in their community with a wide range of benefits" (North Tyneside)*

*"**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. (Age Concern, Yorkshire and Humber)*

Referrals would be made into the service by:-

- GPs
- Practice nurses
- Community nursing teams
- Social workers
- West Midlands Ambulance Service
- A&E

Referral Criteria

The referral criteria for Social Prescribing can be very broad as often it is a need that is identified from an understanding of the individuals situation or by something that the patients says or behaviours they display. Whilst social isolation is more prevalent in older adults who live alone, it is not exclusively this group of patients who would benefit from social prescribing. Therefore it is recommended to keep the referral criteria broad at this time with scheduled reviews (quarterly) once the project has commenced to manage demand and capacity. The service would

- Patients who frequently access NHS services
- Patients who are lonely
- Patients who show mild symptoms of anxiety and/or depression
- Patients with long term conditions that could benefit from individualised support
- Where a medical solution or intervention is unlikely to be successful or satisfactory

A similar project has been running in Dudley (Integrated Plus) for the past 12 months and whilst slow to start is now beginning to demonstrate positive results. Not least, feedback is showing a significant reduction in the demand on Primary Care.

Based loosely on the Dudley model, the proposed service will consist of 3 Link Workers, one based in each of the three localities in Wolverhampton. A Project Manager will co-

ordinate the service and it will be supported by Admin. The service will provide the following support to the patient:

- Initial one-one assessment of individualised need
  Upon referral the Link Workers will arrange to meet with the patient to determine their situation and their needs.

- Well Being assessment using approved tool (i.e. Well Being Star)
  During the initial assessment a Well Being Assessment will be undertaken using an approved tool. The level and areas of support required will be determined and base lined against the score that the tool generates

- Development and agreement of a management plan
  The Link Workers will agree with the patient a plan of action to improve their wellbeing and reduce social isolation. Further contact will be scheduled at regular points in time and will likely be telephone contact.

- Appropriate Signposting/Referral
  Depending upon the outcome of the initial assessment the patient will be signposted or referred to appropriate service. This may be for education and lifestyle advice (i.e. Healthy Lifestyles) or to community or voluntary sector services such as exercise classes, book clubs, smoking cessation, lunch clubs, improved self-management of their condition etc. depending upon the need and preference of the patient.

- Regular contact and monitoring of patient
  The Link worker will maintain contact and support with the patient as agreed in the management plan and assess any further or differing needs.

- Updated Well Being Assessment and data analysis
  At the end of the agreed period of support a further Well Being Assessment will be undertaken and the results recorded. The outcome of this will determine whether indeed the support has made an impact. Data analysis will also be undertaken to determine any reduction in the patient accessing services i.e. GP appointments, A&E attendances, emergency admissions etc.

The Project Manager and Link workers will work closely with GP practices within their locality to build relationships and promote the service. They will be an integral part of the Community Neighbourhood Teams (CNTs) attending the monthly MDT meetings and being based with the teams when they are co-located. They will also work with staff in A&E and at West Midlands Ambulance to raise awareness of referral criteria and pathways. Being employed by Wolverhampton Voluntary Sector Council (WVSC), they will continually update and maintain their knowledge of organisations that can offer support to patients.

During the process where a more medical need is identified by the Link Worker, they will be enabled to refer back to the CNT or to the patients GP.

The effectiveness of the project will be monitored in a number of ways:-

- The evaluation of the well-being tool will demonstrate where an improvement in a patients' well-being has been made.
- Patients activity both in Primary and Secondary Care will be monitored prior to and following the intervention.
- Feedback from service users
- Feedback from health professionals

4 Reasons

Often a need is identified, particularly in Primary Care but GPs do not have the time to undertake the in depth discussions with patients about their lower level social needs and just deal with the immediate medical need. This Social Prescribing model enables sufficient time to be allocated to the patient for them to discuss their likes, dislikes, needs and challenges.

Reduced resources and growing demand across both Health and Social Care means that there is a need to shift the focus from managing symptoms to prevention and resolving underlying causes. Whilst it is difficult to attribute a reduction in activity to this low level intervention, evidence shows that by improving peoples wellbeing and reducing social isolation, patients general health improves and they access fewer health services.

In view of the Better Care Fund Programme the development of Social Prescribing takes another step towards holistic management of individuals, providing that lower level intervention to support the proactive and rapid response approach across all of the works streams (Adult Community, Dementia, Mental Health) and also demonstrates the desire to work more closely with voluntary sector organisations.

There is growing evidence (*Self Care - A Real Choice, DH, January 2005*) to show that supporting self-care leads to:

- Improved health and quality of life
- Increased patient satisfaction
- Significant impact on the use of services, with fewer primary care consultations, reduction in visits to outpatients and A&E, and decrease in use of hospital resources

5 Options

Option 1 – Do Nothing

Option 2 – Deploy Social Prescribing model working with the Voluntary Sector Council to deliver the model as a 12 month pilot

This model is a familiar model across the country. Neighbouring Dudley has also adopted this approach. Here the Voluntary Sector Council employ Link Workers for their 5 localities who then work closely with GPs and Multi-Disciplinary teams to provide support, advice and guidance to people referred into the service. Utilising the Voluntary Sector Council reduces influence from if the Link Workers were from specific voluntary organisations. The service is supported by a Project Manager and an Admin officer. Feedback is that by having Project management support the Link Workers have more capacity to deliver the front line service.

Working with the Voluntary Sector Council optimises the knowledge of community and voluntary services that are available to support patients' wellbeing as the Council has a wealth of information and established links with voluntary sector organisations.

6 Benefits Expected

There are many benefits to be realised from adopting a Social Prescribing model.

Benefits for the patient include:-

- Improved fitness
- Improved mobility
- Reduced social isolation and loneliness
- Lower levels of anxiety and depression
- Improved well being
- Learning new skills
- Developing friendships and networks
- Awareness of available services
- Medicines intake is regulated or reduced

Benefits for Primary Care:-

- Allocated time for patients who are identified as needing additional, non-medical support
- Improved well-being of the practice population
- Patients require less GP time as their needs are being managed
- Less demand on surgery time (phone calls, appointments)

Benefits to the CCG:-

- Improved health and well-being of the population of Wolverhampton
- Increased working with community and voluntary sector organisations
- Reduced secondary care activity (A&E attendances and Emergency admissions), therefore potential QIPP savings

Benefits to the Community and Voluntary Sector

- Increased knowledge of voluntary and community organisations
- Closer working with other agencies i.e. Health and Social Care

7 Risks

A research project is about to be launched in the City using Health Navigator's Proactive Health Coaching. This is a very similar model to the one proposed here but as a research project is only focussing on a small number of patients using a Random Controlled Trial. There will be 100 patients in the Intervention Group and 50 patients in the Control Group (no intervention). In order not to skew the results of this research it will be essential to ensure that members of the Control Group do not receive any intervention from the CCG Social Prescribing model.

As experienced with other projects it is extremely difficult to attribute a reduction in activity and subsequent savings to one specific project when so many other factors are in play. This is even more difficult when looking at low level, non-medical intervention; therefore it will be difficult to evidence that savings are solely attributable to this model.

The modelling for the service has been done purely based on capacity of 3 Link Workers not on demand for the service as this is as yet unknown. Should the service be successful it may generate more referrals than the team can manage resulting in waiting lists for patients to be seen.

8 Cost

Option 1 – no cost

Option 2 – cost of WVSC delivering model as a 12 month pilot

Service Element	**Cost year 1**
Project Manager @ 30K + 16% on – costs 0.5WTE	17,400
Community Development Officers @ 25K x 3 + 16% on costs	87,000
Administration @17K + 16% on costs 0.5WTE	9,860
Staff Training	1,500
Desk space at community location (assuming employment and management by accountable body) 2000 x 3	6,000
Staff Travel @ 45p x200 pm x 4	4,320
Central and management costs: Management, reception, payroll, rent, Insurance, IT maintenance, utilities,	

payroll, reception, photocopying, finance . HR etc.. @15% of hosted staff salary costs and 10% outreach.	8,178 8,700
Marketing/publicity	500
Telephone @ £35 x 3 x 12	1,260
Laptop/ipad x 3 PC x 1	2,952 646
Totals	**£148,316**

9 Timescales

If the proposal is successful, upon receipt of approval recruitment will commence. Please see timeline below

Table 1

				Timescales (weeks) from approval					
	wk 2	wk 4	wk 6	wk 8	wk 10	wk 12	wk 14	wk 16	wk 18
Development of Job Desciption/Service specification									
recruitment of Link Wokers									
Notice Period									
Communicaitons									
Service Commencement									

10 Investment Appraisal

Whilst it is difficult to demonstrate the impact from this specific project, other areas report that a reduction of demand on Primary Care is a key impact, in both telephone calls from the patient to the practice and in GP consulting time for patients who currently present high demand due to underlying social factors.

It is anticipated that each Link worker would hold a patient on their caseload for approximately 3-6 months. The contact time for each patient would be variable but as an estimate we would model an initial 1 hour meeting with fortnightly telephone calls (approx. 20 mins) thereafter.

Taking into account travel time, for each average 7.5 hour day the Link Worker could undertake 3 New referrals (I hour face – face meetings) and up to 6 follow up (20 minute calls), with an hour for admin each day.

Based on a rolling programme of patient discharge/drop out and new referrals each Link Worker could hold a caseload of approximately 442 patients per annum - Total for 3 Link Workers 1326 patients.

This proposal is very much for a qualitative project which will reduce demand on Primary Care releasing capacity to more appropriate interventions, reducing social isolation and improving the wellbeing of patients referred to the service. This in turn, however, may have an impact on secondary care activity and the table below depicts scenarios through estimating a reduction of 1 A&E attendance and 1 emergency admission for a percentage of the patient cohort. (Assuming A&E attendance of £81 and emergency admission of £2,000).

Table 2

	No. of patients	A&E	Emergency Admission	Total
Reduction of Activity for 10% cohort	132	10692	264000	274692
Reduction of Activity for 30% cohort	398	32238	796000	828238
Reduction of Activity for 50% cohort	663	53703	1326000	1379703
Reduction of Activity 100% cohort	1326	107406	2652000	2759406

11 Equality – Appraisal

12 Quality Impact Analysis (QIA)

13 Privacy Impact Assessment (PIA)