PROMOTING INDEPENDENT LIVING TASK GROUP – 15 JULY 2015

The next meeting of the Promoting Independent Living Task Group will be held at 5.30pm on Wednesday 15 July 2015 in Committee Room 1 at the Town Hall, Rugby.

Councillor Ms Edwards
Chairman

A G E N D A

PART 1 – PUBLIC BUSINESS

1. Minutes – to approve the minutes of the meeting held on 4 June 2015.

2. Apologies – to receive apologies for absence from the meeting.

3. Declarations of Interest

To receive declarations of:

(a) non-pecuniary interests as defined by the Council’s Code of Conduct for Councillors;

(b) pecuniary interests as defined by the Council’s Code of Conduct for Councillors; and

(c) notice under Section 106 Local Government Finance Act 1992 – non-payment of Community Charge or Council Tax.

Note: Members are reminded that they should declare the existence and nature of their interests at the commencement of the meeting (or as soon as the interest becomes apparent). If that interest is a pecuniary interest the Member must withdraw from the room unless one of the exceptions applies.

Membership of Warwickshire County Council or any Parish Council is classed as a non-pecuniary interest under the Code of Conduct. A Member does not need to declare this interest unless the Member chooses to speak on a matter relating to their membership. If the Member does not wish to speak on the matter, the Member may still vote on the matter without making a declaration.
4. Access to transport in the rural area – Andrew Stokes, Warwickshire County Council

5. Rugby Social Prescribing Project – Alison Orr, Warwickshire CAVA

6. Corporate Strategy – Head of Business Transformation

7. Work programme and planning for next meeting – review of evidence attached

PART 2 – EXEMPT INFORMATION

There is no business involving exempt information.

Membership of the Task Group:

Councillors H Avis, Ms Edwards, Mrs Garcia, Mrs New and Mrs Roodhouse

If you have any general queries with regard to this agenda please contact Veronika Beckova, Democratic and Scrutiny Services Officer (01788 533522 or e-mail veronika.beckova@rugby.gov.uk). Any specific queries concerning reports should be directed to the listed contact officer. If you wish to attend the meeting and have any special requirements for access please contact the Democratic and Scrutiny Services Officer named above.
Promoting Independent Living Task Group Review

15 July 2015

Briefing Paper

1. **Introduction**

   It was agreed at the first meeting of the task group that the review would focus specifically on older people, defined around their need for support to live independently in their own home, without having to move into residential care. The one page strategy is included with the agenda papers for reference.

2. **Purpose of the meeting**

   At this meeting the task group will take evidence about:

   - access to transport in the rural area (Andy Stokes, Warwickshire County Council’s transport department)
   - Rugby Social Prescribing Project (Alison Orr, WCAVA)
   - the refresh of the council’s corporate strategy (Doug Jones, Head of Business Transformation)

**Access to transport in the rural area**

At the last meeting members of the sheltered housing warden service identified poor access to transport in the rural area as a significant barrier to older people living independently in their own homes. The task group heard that bus services can be very irregular and at unsuitable times, and a particular example was given in Wolston where the operator had changed the bus route so that it no longer stops at Bennett Court (sheltered housing scheme) and residents have to walk some distance to the nearest bus stop. Availability of transport to get to hospital appointments was also highlighted as an issue, with even volunteer drivers being quite expensive and those suffering from dementia being excluded from the criteria to be met for access to ambulance transport.

Although this is not a central aspect of the task group’s work, members felt they should follow up on the issues raised and have therefore invited a representative from Warwickshire County Council’s transport team to explain their role in relation to bus services and community transport and discuss what – if any – potential there would be to address some of the gaps and inadequacies in the public transport available to older people in the rural areas of the borough.

**Rugby Social Prescribing Project**

The Rugby Social Prescribing Project is being led by Warwickshire CAVA in partnership with Coventry and Rugby Clinical Commissioning Group and is a pilot project running from two local GP surgeries from October 2014. GPs prescribe social involvement to their patients and the Social Prescribing Project team engage with the patients to get them involved in local groups and activities. A mid-term evaluation report is included with the agenda papers for reference.
The task group is particularly interested to explore how this project is promoting independent living amongst older people, and what potential there is for the project to support this agenda.

Members may also wish to consider specifically how the council might be able to contribute to the success of this project. The following areas could be explored:

- The council’s role in relation to the community facility on the upper floor of the Market Quarter Medical Practice, which is intended to actively link with the social prescription project. The council allocated the lease for this facility, has arrangements in place to monitor and evaluate the services offered there and is working with the Benn Partnership Centre (which holds the management contract for the facility) to provide its own sports and arts activities at the venue on a pilot basis.
- Opportunities that frontline services within the council may have to signpost customers to the project.
- The council’s role as a service provider to whom patients may be referred.

**Corporate Strategy**

The council’s corporate strategy is due to be refreshed shortly. Potentially this presents an opportunity to include health and wellbeing as a more prominent corporate priority and perhaps even to embed it, alongside ‘clean, green and safe’, as part of the council’s vision.

The Head of Business Transformation has been invited to attend the meeting to talk briefly the process to be followed in revising the corporate strategy, and what evidence the task group would need to present in order to make a robust and credible case for including promoting independent living as a more prominent corporate priority.

### 3. Future work

**Review of evidence and areas for further work**

To help members determine what further work is needed to achieve the aims of the review set out in the one page strategy, the scrutiny officer has prepared the attached ‘review of evidence’ paper in discussion with the senior officers and the task group chairman. The paper aims to summarise the key findings from the task group’s evidence gathering work to date and suggests some emerging conclusions and recommendations.

The paper demonstrates that the task group has effectively achieved the first of its three objectives, “to establish what the council does already and plans to do to support the objective of promoting independent living, and develop an understanding of the council’s contribution within the wider context”.

There is still work to be done to “identify any gaps that the council could reasonably fill, either on its own or by working with partners” and, based on this, “develop a strategic corporate approach to promoting independent living, with clarity about the outcomes the council aims to achieve and the relative priority to be given to this aim at the borough level”.
To this end, further work might include:

- Exploring the council’s links with the voluntary sector and the current and potential use of SLAs and voluntary sector grants to support the promotion of independent living.
- Talking to key voluntary sector partners (e.g., Age UK Warwickshire and Rugby CORE) about their current work to promote independent living and to seek their insights into any gaps in provision that could be addressed by better partnership working by this council and other statutory and voluntary sector agencies.
- Identifying key actions that could be brought together in a corporate strategy for promoting independent living, to maximise the council’s potential to have an impact on this agenda.

Two further areas the evidence-gathering has highlighted, which could be looked at in more detail, are:

- using the tools available to the council as a planning and housing authority to deliver housing that meets the needs of an ageing population (though the main route for this is through the local plan process, so this would be subject to the timescales for the development of the new local plan); and
- the concept of older people’s villages and how this might be transferred and developed in the council’s own sheltered housing facilities.

However, before further policy development work is undertaken in these areas, it may be advisable to first establish ‘promoting independent living’ as a potential corporate priority, supported by the Executive.

Next meeting, 10 September 2015

It is suggested that the meeting on 10 September could take evidence from key voluntary sector partners, as detailed above, and from the council’s community development team on council’s links with the voluntary sector and potential to use these to support independent living amongst older people.

Members will need to be clear about the focus of inquiry for these discussions and are asked to make suggestions of key questions to be addressed.

Visit to Albert Square and Control Room

The task group agreed at the last meeting to arrange a visit to the Control Room in Rounds Gardens and the sheltered housing scheme at Albert Square.

It is suggested that the best time to visit Albert Square would be on a Tuesday or Thursday afternoon, when there is likely to be an activity taking place. It is hoped that a date can be identified in the next few weeks (up to Thursday 13 August). It is suggested that the visit commences at Albert Square around 3pm, followed by a visit to the Control Room.

Members are asked to bring their diaries to the meeting so that a suitable date can be agreed for the visit.

Debbie Dawson, Scrutiny Officer, July 2015
Rugby Social Prescribing Project
ConnectWELL

Harnessing community capacity to improve health and wellbeing

Mid-term Evaluation Report

Author: Angela Baines
May 2015
Foreword

As the original innovators of this groundbreaking pilot project we are both delighted to share this independent mid-term evaluation with all that have an interest in improving health and social care within Coventry and Warwickshire.

The Coventry and Rugby Clinical Commissioning Group’s vision and investment in ConnectWELL is an embodiment of the need and desire to bring about a cultural shift in the way in which all resources available within our communities can be brought to bear to help improve the health and wellbeing of our population.

The project is the first of its kind in Warwickshire and represents a step-change in the relationship between our health sector and the voluntary and community sector. We invite all who wish to align resources to enable and assist individuals to access support to manage their own health better and reduce unnecessary demand on frontline health and social care services to consider the report and its recommendations.

We commend this report to you and actively invite dialogue with all partners on how a Social Prescribing approach can be firmly embedded within the health and social care economy of Coventry and Warwickshire.

Paul Tolley
Chief Executive Officer
Warwickshire Community and Voluntary Action

Dr Jill O’Hagan
Clinical Lead for Partnerships, Rugby Locality,
Coventry & Rugby Clinical Commissioning Group
retired General Practitioner
ConnectWELL’s Overview of the Mid-Term Evaluation Report

Roundberry Projects has produced a mid-term evaluation report, with a final report due to be completed in September 2015, a month after the pilot ends. Caution must be applied when reviewing this report, as data covers the period from project start-up to 31st March 2015 and figures are continuously changing.

Key Findings
The Rugby Social Prescribing Project is the first project of this kind in Warwickshire, assisting people in addressing underlying societal causes or managing compounding factors of ill-health by unlocking and aligning the many resources and community assets that exist within the Rugby borough’s communities. The pilot scheme has been funded by the Coventry & Rugby Clinical Commissioning Group, and is being delivered by Warwickshire Community and Voluntary Action (WCAVA). GPs and practice staff recognise how this Social Prescribing Pilot links with achieving targets such as those set by the Care Act.

Key points to note with this pilot compared to others:
- it relies on specially trained volunteers to signpost and support patients to community services, rather than paid staff
  - 6 trained volunteer advisors, now known as “Navigators”, manage and maintain access points
  - 6 volunteers are trained as “Health Buddies” to support and assist individuals on a one-to-one basis over a 6 week period
- funding was given for a short period – 1 year
- working with 1 or 2 practices a sample was projected of 100 patients, of any age over 18

The Rugby Social Prescribing Project has been launched promptly and those clients who have engaged so far are reporting satisfaction (often glowing satisfaction) with their experience and positive outcomes. As of the end of March 2015, 92 signposts had been made to the 39 patients that had been referred to the service. It is still very early in the pilot to be able to accurately assess client outcomes (as the first clients were referred to the project in November 2014). The number of referrals to the project so far is small; however, GPs and practice staff believe that this is because the concept needs time to become embedded. Project partners are aware of this and are taking steps to address it (including adapting to work with 4 practices in the Rugby borough, widening eligibility, increasing awareness of the service in practices, and engaging the public with the name ConnectWELL).

The WCAVA project team have shown that they are responsive to the needs of medical practices in delivering the project and a robust partnership between the project team and medical practices team is emerging. For both sides this is a new relationship, lessons are being learnt and new ways of working emerging.

Good project management and reporting structures have been put in place. To date, 707 Voluntary and Community Sector organisations and activities in and around Rugby have been identified, logged and recorded and are available as a resource when signposting clients.
Whilst it is always difficult to tell how long volunteers may stay, generally WCAVA experiences a low turnover because of its commitment to treating volunteers well. The volunteers are delighted to have been nominated and shortlisted as finalists for the Team of the Year at the 2015 Pride of Rugby Awards.

Several barriers to referrals and patient engagement are explored within the Evaluation report, with positive suggestions made to optimise referral rates.

**Steps Forward for the Team**
1) Liaise with participating practices to obtain commitment on the provision of data collection to provide evidence on clients’ outcomes.
2) Ensure that there is a ConnectWELL champion at all of the practices, not just at some practices.
3) Navigators and Health Buddies to encourage clients to tell the person who referred them about the benefits of support from Rugby SPP/ ConnectWELL as this will encourage more referrals.
4) Project staff to continue to work with individual practices to agree specific feedback mechanisms on patients/clients for each practice.
5) Incorporate referrals from nurses and other practice staff in addition to GPs.
6) ConnectWELL staff to attend practices’ Unplanned Attendances meetings to identify clients who may benefit from the pilot.
7) Ensure that the client database enables Navigators to know who is responsible for which follow up actions.
8) Consider extending the number of contacts (ie. length of support) Navigators and Health Buddies can offer support to clients.

**Wider Recommendations**
1) An extension of the pilot for another 12 months to properly gauge outcomes for clients and also to be able to assess this pilot against others.
2) The project board to urgently consider extending the pilot to all practices in Rugby before the end of the pilot. The selective nature has held back marketing of the service for fear of having to say no to prospective clients. This would require additional funding support, due to staff’s workload capacity.
3) Look at the impacts of rolling referrals out to nurses at the Beech Tree practice (from April 2015) and also consider extending to physiotherapists, occupational therapists etc.

**Further Enquiries**
The Working Group, which has direct oversight of the Pilot, meets quarterly.

If there is a desire from outside of the Working Group to be involved with the Future Development of Social Prescribing please contact gemma@wcava.org.uk to register your interest.
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Appendix 1: Interviewees

Appendix 2: Organisations to which clients have been referred

Appendix 3: Case studies
Executive Summary

“Sometimes you hate yourself so much you want to die. And you are two lovely people and have helped me start to believe in myself again. There’s nothing else like this out there – I have found.”

*Health Buddy client questionnaire response, May 2015*

The Rugby Social Prescribing Project is unusual in that the support for patients is being delivered by volunteers specially trained for the role by Rugby WCAVA. Volunteers have generally had very positive interactions with clients. This is a new way of delivering services for the medical community where new relationships have to be forged.

To date 39 patients of the 100 forecast over the year have been referred to the scheme. Those who have engaged (65.5%) have generally found it to be beneficial. It appears that Health Buddy clients interviewed for this evaluation gained the most benefit and anticipate needing to see their GPs less in the future. All clients feel that it would help to have a longer period of interaction with the scheme.

The number of referrals so far is lower than expected at this mid-term point. Reasons for this are explored such as the need for social prescribing to become embedded amongst GPs and also the experiences of running the pilot in just a small number of practices in the borough instead of all. Another factor is that the type of patient considered for referral initially (those with lower level support needs) was quite restrictive. Eligibility has been widened. The project partners have been reviewing the number of referrals and have already put in place some measures to increase numbers. Further recommendations are made as a result of this evaluation.

To measure outcomes in a clinically robust way Health Buddy clients are being asked to undertake the Warwick Edinburgh Mental Wellbeing Scale assessments at intervals. No data is being collected on other common SPP measures, such as incidences of GP appointments pre and post interaction, and weaknesses in evidence collection need to be addressed before the final evaluation.

The overwhelming message from partners is that the length of the pilot project needs to be extended to allow social prescribing to become embedded and because outcomes in these cases are not immediately evident. As one respondent from a medical practice put it: “You can’t judge a project on Year 1 alone, you need longer because you don’t get a Return on Investment that quickly”.

Rugby SPP/ConnectWELL Mid-term Evaluation
1 About this evaluation

Roundberry Projects was appointed in December 2014 to carry out a two stage evaluation process for the Rugby Social Prescribing project.

The client’s Evaluation Specification was to examine:

- The client journey and outcomes using the Warwick Edinburgh Mental Wellbeing Scale
- The project set up and processes
- Partnership working
- Impact on participating Voluntary and Community Sector and other agencies
- Barriers and gaps in services
- True costs of involvement in the project – WCAVA, Volunteer Hours, GPs’ and Practice Manager Time and resources.
- Recommendations for future Social Prescribing Projects

Data is to be provided by the Project Team.

Methodology

In completing this report use has been made of the extensive project files kept by the WCAVA Social Prescribing Project team (SPP) and qualitative and quantitative data collected supplemented with qualitative interviews with staff, project partners and a sample of project clients. The quantitative data covers the period from project start up to mid-April although qualitative data was gathered until early May 2015.

A qualitative evaluation approach has been dominant in this evaluation because of a lack of readily available quantitative data.

A final project evaluation report will be completed in September 2015.
2. Introduction to the Rugby Social Prescribing Project

The Rugby Social Prescribing Project (Rugby SPP) is the first project of this kind in Warwickshire. It is a pilot scheme which has been funded by the Coventry & Rugby Clinical Commissioning Group. The pilot is being delivered by Warwickshire Community And Voluntary Action (WCAVA) on behalf of the Clinical Commissioning Group.

The pilot is receiving £54,525 for a period of 12 months running from August 2014 to August 2015.

2.1 What is Social Prescribing and Social Referral?

The concept of social prescribing has emerged over a number of years and can be briefly explained as:

“Social Prescribing is at root about using community based services, alongside traditional health services to help improve health and well being. There is a growing understanding of the need for health services to provide a ‘more than medicine’ approach, which focuses on the individual, their aspirations, needs, and assets, and their context within a community.”

A variety of models have been seen in the pilot projects around the UK and a useful overview is given by Friedli et al for the NHS North West Care Services Improvement Partnership. Some have focussed on delivering benefit for the older people, others such as the Rotherham pilot take a wider approach for patients across all GP practices in the borough. The holistic approach of the Bromley by Bow Centre in London appears to be an exemplar.

The common theme is to prescribe a non-medicalised activity for the patient, as Friedli states:

“These might include opportunities for arts and creativity, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help, as well as support with, for example, employment, benefits, housing, debt, legal advice, or parenting problems. Social prescribing is usually delivered via primary care – for example, through ‘exercise on prescription’ or ‘prescription for learning’, although there is a range of different models and referral options.”

Most schemes appear to have relied on referrals from GPs however different pathways have been taken from here, either to dedicated paid staff to work with the patient to find community services to meet their needs, or via trained volunteers carrying out a similar signposting role. In the some cases funding was also provided to Voluntary Sector

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1 Lindsay Manning, NHS England, Speech to Rotherham Social Prescribing Summit, February 2015
2 Friedli et al (2009) Social prescribing for mental health – a guide to commissioning and delivery
5 Friedli et al (2009) Social prescribing for mental health – a guide to commissioning and delivery
organisations to deliver the activities patients were referred to.

2.2 Context and Project Need

National level
The budgetary pressures on the NHS are well known. Lindsay Manning points out that “Simon Stevens, [NHS Chief Executive] has identified a “more than medicine” approach as one of the key ways in which the NHS needs to change, moving from “a ‘factory’ model of care and repair” to one that focuses on much wider individual and community engagement\(^6\). This is evidenced by the personalisation agenda for instance seen in the Care Act 2014.

Social prescribing is one way of meeting the challenges facing the NHS which have been identified in the Five Year Forward View. Challenges include the impact of unhealthy lifestyles, the fact that 70% of the NHS budget is spent on Long Term Conditions (LTCs), and the new technologies which mean that people are living longer but also that care can be delivered in different ways.

These approaches may be seen to be part of the concept of integrated care. This has been defined by the UK National Collaboration for Integrated Care and Support (NCICS) as being:

“The support built around the needs of the individual, their carers and family and that gets the most out of every penny spent. The NCICS view is that if the illness is prevented, the condition properly managed, the fall avoided, that not only is that better care for the individual but it also means less pressure on the system (NCICS, 2013). Person-centred coordinated care and support is promoted as being key to improving outcomes for individuals who use health and social care services (NCICS, 2013)\(^7\).”

Local level
The Rugby Locality sits within the Coventry and Rugby Clinical Commissioning Group. There are 12 practices in Rugby all aiming to deliver the Coventry & Warwickshire CCGs’ joint 5 year strategy.

Alongside this are the Warwickshire Health & Wellbeing Board and Joint Strategic Needs Assessment which bring together health and social care to provide a more joined up care to individuals. Flowing from this is the Warwickshire Health & Wellbeing Strategy 2014-18 and the evidence reviews commissioned to guide the strategy. The principle of social prescribing could be seen to align with the three areas of evidence gathered which were: “Integration and Working Together”, “Promoting Independence” and “Community Resilience”.

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\(^6\) Lindsay Manning, NHS England, Speech to Rotherham Social Prescribing Summit, February 2015

This evidence led to the following relevant areas of focus within the main priorities being set for the Strategy 2014-18:

- Enable people to effectively manage and maintain their physical and mental health and wellbeing (Priority 1 – Promoting independence for all)
- Take an asset based approach to working which values communities and the range of assets they possess; (Priority 2 – Community resilience)

This last area of focus also mentions the role of volunteers and community champions to be supported to work with their community.

The conclusions of two of these evidence reviews bear repeating to set the context and need for this pilot project:

“Conclusion – Integration in Warwickshire
Many organisations have a role to play to ensure successfully integrated services. It is imperative to consider the needs of the individual and ensure they are at the heart of services working together. Desired outcomes from successful integration of service delivery in Warwickshire should include, person centred coordinated care using a case management approach, co-production, improved outcomes for individuals, reduced pressure on the system by preventing illness, managing conditions effectively, appropriate use of primary care, appropriate discharge and reablement (NICS, 2013). All of these outcomes should be underpinned by best practice, support from the community and voluntary sector, national evidence and work towards achieving a positive impact against the priorities in the JSNA.”

“Conclusion - Resilience
Public health interventions that employ community engagement approaches can be effective across a range of outcomes and beneficiaries. This includes in enhancing health behaviours, health consequences, self-efficacy, social support, skills and future employment.”

WCAVA’s Expression of Interest to the Coventry & Rugby Clinical Development Group to fund this pilot project highlighted the current level of pressure on services in Rugby because of the recent significant growth in population which is set to increase further with more major development, for instance at the Rugby Mast site. Data from the Warwickshire Observatory shows that Rugby had the largest population growth in the county between 2012-3 accounting for 80% of the county’s population growth. This was mainly due to immigration. The current population is 101,373. Looking ahead to 2037 Rugby is also expected to see the largest increase in population in the county 18.9% compared to a 13.9% county average. This population growth can be expected to put increased pressure on public and voluntary services.

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8 Warwickshire Health And Wellbeing Strategy 2014 – 2018, Warwickshire Health and Wellbeing Board
11 https://warksobservatory.wordpress.com/2014/07/03/warwickshires-population-now-at-548729-people/
12 https://warksobservatory.wordpress.com/2014/05/30/warwickshires-population-projected-to-increase-to-623900-people-by-2037/
Rugby SPP/ConnectWELL Mid-term Evaluation
Another external factor affecting this pilot should be noted. Since the project launch two of the 12 practices in Rugby have ceased operation and the responsibility for care of those patients passed jointly to Market Quarter and Beech Tree Medical Practices but operating out of separate premises. Both practices are involved in this pilot scheme.

2.3 The Rugby project

The stated aims of this pilot project were to assist people in addressing underlying societal causes or manage compounding factors of ill-health by unlocking and aligning the many resources and community assets that exist within the Rugby borough’s communities. The project aimed to work with patients who had experienced a recent change in their circumstances, for instance bereavement or a diagnosis of a chronic condition such as Diabetes. Patients with high risk or acute mental health conditions were outside the scope of the project.

Initially the project aimed to work with 1 or 2 GP surgeries to create a pathway model which would build on the social prescribing and social referring models piloted elsewhere, such as in Bromley by Bow and Norfolk. The target was to work with 100 patients.

Key points to note with this pilot compared to others:

- It relies on trained volunteers to signpost and support patients to community services, rather than paid staff
  - 6 trained volunteer advisors, now known as “Navigators”, would “manage and maintain access points
  - 6 volunteers would be trained as “Health Buddies” to support and assist individuals on a one-to-one basis over a 6 week period
- Funding was given for a short period – 1 year
- Working with 1 or 2 surgeries a smaller sample was projected of 100 patients. In comparison, in Rotherham all surgeries were included but the budget was far larger.

Four main outcomes were planned for this pilot project:

1) All participating volunteers will gain learning and development opportunities, increased self-confidence and the satisfaction that they are actively contributing to their local community and to individuals’ health.

2) GP surgeries will note a tangible reduction in prescribing levels and/or the frequency of patients’ presentation at GP surgeries by those accessing the project compared with those who are not.

3) Participating patients will gain an increased awareness of the social activities, support groups and community projects in their local area which can assist them to become more active and address issues which contribute towards their health.

4) Participating GP surgeries will gain an in-depth understanding and appreciation of the wealth of additional support available within local communities and volunteer resource. It is expected that the map will be shared across Public Health and Well-being Board structures.
3. The client journey and outcomes

3.1 The client journey
The Social Prescribing Project (SPP) team within Rugby CAVA have worked with the participating surgeries to establish a clear pathway for handling referrals which is set out in Diagram 1 below.

Until this mid-term point in the project, patients have been mainly referred to the project by GPs (although at one practice, Brookside, nurses have also been able to refer) and it has been planned that the GP decides whether the patient needs intensive support (i.e. a Health Buddy) or information and signposting (i.e. a Navigator). In practice the project team or the patient can choose to change the route if necessary.

Diagram 1 – The Rugby Social Prescribing Pathway

Referrals to the Rugby SPP are now being taken from 4 surgeries in the Rugby borough. Three are in the town centre and one in a village around 7 miles from the town centre.
The surgeries involved account for around 24,000 people from a population of just over 101,000 across the borough.

As at 31st March 2015 there had been 39 referrals to the project, of these:
- 29 were Navigator Referrals
- 10 were Health Buddy Referrals.

The service is open to anyone over the ages of 18. Patients/clients have been aged from 25 – 91 years and volunteers have noted more clients in the younger age ranges than they had anticipated. Age data does not appear to have been given to the project team for all clients. Data has been given for 11 of the 39 referrals and the range is shown below.

Data on the gender of clients does not appear to have been recorded specifically, however it can be deduced from 30 of the 39 anonymised client records. From the data available slightly more females than males have been referred to the project.
3.1.1 Navigator Referrals

The chart below shows the interaction of the 29 referrals with the project so far.

The chart demonstrates that there is a high incidence of clients having been referred by their GP/health professional but not engaging with the project 7/29 (24.1%).
Whilst the number of those missing appointments is smaller, this may also be a sign of reluctance to engage with the project: 3/29 (10.3%). If the two figures are added together this accounts for over a third of referrals 10/29 (34.5%).

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<td>Did not respond</td>
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For those who have engaged with the Navigator service they have usually had one face to face meeting to discuss their needs and interests and to be given signposting information. The Navigators have followed this up on up to 3 occasions by phone, email or post to seek feedback from the client and where necessary to encourage them to follow up on the signposting or to suggest alternative services. Not all follow up contacts elicit a response.

Until March 2015 the Navigators were able to provide the signposting information but not to contact the service provider and make the arrangements for the client to attend. It has been recognised that this is a weakness as many clients lack confidence and Navigators now do make arrangements for clients to attend activities. It is though too soon to see the impacts of this change.

3.1.2 Health Buddy Referrals
As of 31st March there had been 10 referrals for Health Buddies. The chart below shows how clients have interacted with this service.
Of the 10 clients, half (5) have engaged with the project and worked with, or are about to work with, an allocated Health Buddy. Data is also available to show Health Buddy client engagement by referring medical practice.

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The client notes indicate that those who are working with the project have multiple issues with which they require assistance. These may be related to finance/access to benefits as well as medical conditions.

Of the 5 people not wishing to use the Health Buddy service 2 have accepted signposting advice instead. The remaining three would not respond to telephone calls or letters to date.

Chart 5

3.1.3 To what services have clients been referred?
In running this pilot WCAVA has been able to refresh and update its database of organisations and services available in Rugby borough. 707 voluntary and community sector organisations and activities in and around Rugby have been identified, logged and recorded.
and are available as a resource for navigators to signpost clients. Health Buddies and the Wellness Co-ordinator also use the same resource in assisting their clients.

Information provided by WCAVA indicates that Navigators and Health Buddies have made 92 signposts to approximately 80 different activities.

Of these 79 signposts have been made by the Navigators to 69 different activities. A list is included in the Appendices to this report. The following are organisations/activities which have been signposted to on more than one occasion:

<table>
<thead>
<tr>
<th>Age UK</th>
<th>Community Transport</th>
<th>CAB</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIND</td>
<td>Rugby BC Housing</td>
<td>WCAVA Volunteering</td>
</tr>
<tr>
<td>Art Group</td>
<td>Percival Guildhouse</td>
<td>OASIS</td>
</tr>
</tbody>
</table>

### 3.2 Outcomes

It is still very early in the pilot to be able to accurately assess client outcomes as the first clients were referred to the project in November 2014.

The outcomes for Health Buddy clients are being assessed using the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS); it is not being used for the Navigator clients as they have a much shorter contact period with the project. This measurement scale has been developed for the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. It is a 14 item scale with 5 response categories, summed to provide a single score ranging from 14-70. The items are all worded positively and cover both feeling and functioning aspects of mental wellbeing. Assessments are carried out by the Wellness Co-ordinator.

At this point in the evaluation process only 2 Health Buddy clients have agreed to take part in the WEMWBS assessment. No clients have completed all 3 assessments necessary to complete the monitoring. One client has completed the baseline and second wave assessment 4 weeks later, the second has only completed the baseline assessment.

<table>
<thead>
<tr>
<th>Client</th>
<th>Baseline</th>
<th>2nd wave (+4 wks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MQ009</td>
<td>24</td>
<td>31</td>
</tr>
</tbody>
</table>

Warwick University data states that in the general population the average Mean score is around 51\(^{13}\). The increase in score here would indicate an improvement in well-being at this point, changes in responses indicate an increased interest in others and new things and

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\(^{13}\) Full information can be found at: [http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/](http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/)

optimism. A qualitative interview carried out with the client for this evaluation confirms this and that they “do not really see [my] GP anymore”.

No process appears to be in place to record the impact of interactions on Navigator clients, for instance the incidence of GPs appointments for the clients before and after the intervention or extending the WEMWBS assessments to Navigator clients.

No data appears to be collected to record the impact on Health Buddy clients’ interactions with GPs and other health professionals.

### 3.3 Qualitative feedback
As part of the evaluation, a questionnaire has been developed for both Navigator and Health Buddy clients. Five questionnaires have been completed in time for this evaluation of which 2 were by Health Buddy clients and 3 by Navigator clients.

Of the five responses 1, from a Navigator client was negative because he felt that he needed financial support to do the signposted activities and without this could not use the service’s support.

The other 4 were positive about the support. The 2 positive Navigator clients noted how useful it was to know what help was available. They appeared to be individuals who would be motivated to use these services when needed.

The most positive feedback was from the 2 Health Buddy clients, one saying “it’s helped loads”. The other client stated:

> “Sometimes you hate yourself so much you want to die. And you are two lovely people and have helped me start to believe in myself again. There’s nothing else like this out there – I have found.”

All five respondents expressed a concern that the project should be able to help people over a longer period, one Navigator client saying “it came to an abrupt halt”. This highlights the need to ensure continuity of provision and support both at project planning and at a direct support level.

Both Health Buddy clients expressed the view that the support had or would mean they would need to see their GP less in the longer term.

The project staff have also kept records on qualitative feedback which indicate good news for clients.

One GP has reported that “overnight the Social Prescribing Project changed the life of one of my patients”. Patients have been assisted to:

- receive benefits they were not previously aware of
- funding for driving lessons for a carer
- receive specialist counselling
- take part in art and Tai Chi classes
4. Project set up and processes

4.1 Project set up
There have been several social prescribing or social referral projects around the UK in recent years. Key features of this pilot are:

- It relies on trained volunteers to signpost and support patients to community services, rather than paid staff as Navigators and Health Buddies
- Navigators manage and maintain access points so that patients within surgeries can be actively supported to identify and access relevant and appropriate services available in their locality to help them take ownership of and address the underlying social causal factors that are affecting their health and wellbeing through 1 meeting with the client and 3 follow up contacts (phone call, email)
- Clients with a Health Buddy have 6 sessions to support and assist individuals on a one-to-one basis over a 6 week period to engage with the appropriate local community based support identified to address the underlying factors affecting their health
- This pilot was based on the principle at the outset that clients would be “just dipping over” into needing support so these arrangements could help catch clients before symptoms deteriorated
- Initially patients/clients were given the contact details for the SPP and asked to make contact
- Funding was given for a shorter period – 1 year
- A relatively small amount of funding was allocated - £54,525.
- The plan was to work with 100 patients from 1 or 2 surgeries in the Rugby borough.

Given the short timescale (the Expression of Interest was submitted in March 2014) it was important to get the project up and running as quickly as possible. The project team is very proud of having achieved this within 7 weeks, for instance commenting on their achievements so far as being “phenomenal”.

4.2 Project structure
The project funding allowed for a Full Time Equivalent post to manage and implement the project with interactions with patients/clients to be mainly by trained volunteers.

To make best use of resources the FTE post was divided into specific part-time roles with a Project Manager overseeing a Wellness Co-ordinator, Project Administrator and Volunteer Team Leader. The structure is set out in Diagram 2.

The Project Manager and Volunteer Team Leader roles were allocated to existing Rugby WCAVA staff. New recruits were appointed for the Wellness Co-ordinator and Project Administrator roles.

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15 Paul Tolley, Expression of Interest to Coventry & Rugby Clinical Development Group – Social Prescribing Pilot- Harnessing community capacity to improve health, WCAVA
16 Ibid
Diagram 2 – The project team

The project team is overseen by a Project Board which met monthly initially, then quarterly, comprising:

- CCG Communications Team
- Age UK Warwickshire
- Clinical Lead for Partnerships – Rugby Locality, Coventry & Rugby CCG
- SPP Project Manager
- Rugby Locality Manager, NHS Coventry & Rugby CCG

WCAVA worked with the CCG to make the 12 Rugby borough GP practices aware of the project and encourage them to be involved in the pilot. Of the 12 practices, 5 practices have chosen to engage with the pilot and attend quarterly meetings for GPs and Practice Staff.

The pilot was rolled out to 3 practices with staggered starting dates. These were planned to be each one month apart. This approach has enabled volunteers to be trained and become familiarised with the role and the practices. The SPP service was first launched at the Market Quarter practice on 31st October 2014, followed on 24th November at the Brookside Surgery in Stretton on Dunsmore. The service was launched at the third practice on 2nd February 2015. Due to the low referral rate a 4th surgery, the Clifton Road Surgery, started making referrals on 19th March 2015.

4.3 The referral process

The referral process lies at the heart of the project.

The project staff have worked with practice staff to develop a 1 page referral form for GPs to use which can be accessed from their IT system and which automatically populates with the required information. The GP needs simply to insert the patient name and, if they choose, can add more information in a comments box.

Initially, at Market Quarter the first practice to take part, there were 2 separate forms for the GP to choose between allocating a Navigator (Information only) or Health Buddy (Up to 6 weeks low level support). Feedback led to this being changed to a single referral form for GPs to use and this has been supplied to all subsequent practices rolling out the pilot.
However, at the April Volunteers team meeting it was reported that some referrals were being received simply on pieces of paper with the patient’s name and phone number. There was no information on the type of support needed or the name of the GP referring. This was also problematic because with Beech Tree and Market Quarter practices sharing a building it was therefore difficult to ascertain which practice the patient belongs to.

In two of the three original practices only GPs have been making referrals. The other practice has enabled nurses to make referrals believing they also have a good understanding of a patient’s circumstances and needs during consultations. There is interest in the scheme from physiotherapists but this has not yet been taken further.

### 4.4 Project administration and monitoring

The Social Prescribing Project is being managed by the Rugby WCAVA which has considerable experience in delivering projects. The project team have therefore been able to use WCAVA’s in-house expertise and structures to set up the project management processes for this project. There is extensive project reporting and recording via:

- Weekly staff team meetings
- Monthly reports to the CCG
- Monthly milestone reports
- Monthly project reporting forms giving Red/ Amber/ Green status
- Initially monthly Project Board meetings
- Quarterly GPs’ meetings
- Monthly reports to each practice regarding referrals

As the nature of the project involves team members working with clients who may be vulnerable a system has been established to provide both a listening ear and also to safeguard team members when they have one-to-one meetings with clients. Project staff are striving to keep data on the project’s outcomes through:

- Recording Navigators’ and Health Buddies’ interactions with clients on a spreadsheet. This is also the method for recording the services to which referrals have been made.
- Case studies, aiming for first 10 clients then 1 in 10
- Undertaking WEMWBS with Health Buddy clients

The decision to have several part-time roles appears to work well. In practice all staff members have worked more than their paid for hours on the project. The flexible working structure enables staff to meet volunteers or clients at times that are outside standard working hours.

A future development group is currently being established to consider how the pilot may be developed along with potential funding streams.
4.5 Scope of the project
The Expression of Interest to the Clinical Development Group for funding envisaged running the pilot in one or two practices. The “type” of patient to be referred was not tightly defined in the EOI. However it was clear that this was to be an “enabling” person-centred service which would “guide, signpost and support” patients/clients on to other voluntary and community services to bring about improvements in their health and well-being.

It is clear that the project team is disappointed in the number of referrals coming forward so far (39 to April 2015). Due to referrals happening more slowly, and at a lower rate than expected the pilot has now been expanded to take in 4 practices.

Feedback from project staff and GP/practice staff indicates that a lack of clarity over the type of patient to be referred to the project has been one factor in the lower than expected uptake to date.

Project staff reported that at the outset GPs suggested they had very many patients they could refer to the project. There was considerable concern about the project team being overloaded at the beginning. At the GP meeting on 7th October 2014: “It was agreed by those in attendance that for the pilot, the type of NHS patients suitable for this service were those who wanted access to support to help themselves, and who were not currently in need of specialist or high level mental health intervention/support.” This concern appears to have been shared by GPs and project staff alike.

As the rate of referral has been slower than anticipated the profile of patients has changed. Project staff have fed back that whilst at first they were expecting clients who had experienced a significant change in circumstances such as bereavement, redundancy or diagnosis with a long term condition, this has not been the case and clients now appear to have a wider range of reasons for being referred to the scheme and more complex needs. This includes people who have been living with long term conditions for some time and who may be accessing health services other than GPs alone.

4.6 Marketing the project to patients
There have been two distinct audiences for the project’s marketing communications – potential clients and the GPs or health professionals who will be making the referrals.

A range of patient-facing marketing materials and activities has been produced to support the project. These included leaflets, posters and banners to raise awareness amongst patients when visiting surgeries. The leaflets have also been given to GPs to hand to patients on referral. Initially these were all branded Rugby’s Social Prescribing Project but since February these have all be replaced with new materials branded ConnectWELL – Rugby’s Social Prescribing Project.

In addition project staff and volunteers have organised or attended awareness raising events – for instance with an Awareness Week at Rugby Health & Wellbeing Centre.

The project team and medical staff have reported feeling constrained in their publicity efforts because the project is limited to a few surgeries. They mentioned being concerned
about raising people’s expectation unnecessarily if those people might then not be eligible to take part. This has held back attempts to gain local media coverage and increase background awareness of the project, as well as the concept of social prescribing and its potential benefits.

Navigators and project staff have reported more recently that clients are coming to them without a referral with leaflets that they’ve picked up in the surgery. This demonstrates that the marketing approach is working. Navigators and staff do ask these clients to discuss a referral with their GP first and then come back.

Feedback from participating GPs’ practices indicates that there is some reluctance on the part of patients/clients to engage with the project. In part this was thought to be due to the original name for the project – Rugby Social Prescribing Project. This led some patients to believe that it was linked to social services and social workers which was off-putting. The new name of ConnectWELL introduced in March 2015 is considered by staff and partners to be more appropriate. It is too soon to determine with any accuracy whether the change of name has brought about an increase in uptake by those referred.

4.7 GP and practice staff project structures
The practices taking part in the pilot have been self-selecting arising from the interest of one or more practice leaders in social prescribing. At this mid-term point the practices taking part in the pilot are:

- Market Quarter Medical Practice, Rugby Health & Wellbeing Centre, 6500 patients
- Brookside Surgery, Stretton on Dunsmore, 4000 patients
- Beech Tree Medical Practice, Rugby Health & Wellbeing Centre, 4000 patients
- Clifton Road Surgery, Clifton Rd, Rugby (started 19th March 2015), 9000 patients.

Communication has generally been between the project staff and the practice manager and a GP project champion within each practice. All practice GPs have been briefed about the project and how to refer patients through clinical meetings. Referral forms have been included in GPs computer files for prescribing options. GPs have also been given flyers to hand to patients when they make a social prescription.

Quarterly project staff and GPs meetings are held to discuss project delivery. Project staff have also attended practice clinical meetings to promote the project.

Feedback from project staff indicates that GPs practices have been asked to record data on project clients such as the number of GP visits before and after contact with the project, but have not acted upon these requests. GPs and practice staff interviewed in the course of this evaluation have indicated that such analysis would be possible.

4.8 Volunteer recruitment and management
A distinguishing feature of this pilot is the use of volunteers to provide the signposting and support to patients/clients. The Volunteer Team Leader role has been allocated 10 hours
per week to cover recruitment, staffing rotas, team supervision and taking up references and DBS checks.

There has been comprehensive training for volunteers which has been self-evaluated and well received. Team members (including volunteers) participate in an initial training session as a large group, and then have inductions for individuals / smaller groups about their specific role. Additionally each volunteer is provided with a folder of policies and procedures.

Volunteer management is based on the working practices of the WCAVA. Volunteer team meetings are held every two months and there are one to one “supervisions” every two months offering volunteers the chance to off-load any concerns. Out of pocket and travel expenses are paid from the project budget. Project volunteers have also been given the opportunity to have further training – for instance in mentoring to extend their skills and visiting the local MIND centre, Age UK centre, a course on dementia awareness, MECC (Making Every Contact Count). Exit interviews are carried out.

Volunteers have been recruited through both specific events and advertising for the SPP and as a result of general approaches to the WCAVA volunteer office. The combining of the SPP volunteer team leader role with that of the WCAVA volunteer support officer seems to have helped to get the volunteers organised quickly and led to an efficient recruitment process. Ideal skills for volunteers to these roles are the ability to listen, resilience and computer literacy.

At the mid-term evaluation point 18 volunteers had been recruited and 8 are currently active/in training. Two further volunteers have reduced their commitment to be “on call” should they be needed. A brief picture of the volunteers:

Table 4

<table>
<thead>
<tr>
<th>Gender</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>11</td>
</tr>
<tr>
<td>Male</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 5

<table>
<thead>
<tr>
<th>Stage of life (where known by evaluator)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Students/ seeking work experience &lt;25</td>
<td>2</td>
</tr>
<tr>
<td>Working age 25+</td>
<td>4</td>
</tr>
<tr>
<td>Retired</td>
<td>3</td>
</tr>
</tbody>
</table>

The fact that 4 of the Navigator volunteers have left and others have reduced their commitment may be seen as a disadvantage of using volunteers because it is often perceived that they might not have the same level of commitment as paid staff therefore the reasons need to be considered. The flow of the referral rate and its impact in terms of providing a vibrant volunteering opportunity also needs to be considered.
Table 6

<table>
<thead>
<tr>
<th>Reasons for leaving/reducing volunteer role</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boredom due to lack of referrals</td>
<td>1</td>
</tr>
<tr>
<td>Health/family reasons</td>
<td>7</td>
</tr>
<tr>
<td>Found paid employment</td>
<td>1</td>
</tr>
<tr>
<td>SPP “not their thing”</td>
<td>1</td>
</tr>
</tbody>
</table>

The active current volunteers appear to be very committed to the project and two of those who have left have expressed an interest in returning to the project in the future. No more Health Buddy volunteers are being recruited until the referral rate increases.

Whilst it is always difficult to tell how long volunteers may stay, generally WCAVA experiences a low turnover because of a commitment to treating volunteers well.

The volunteers are delighted to have been nominated and shortlisted as finalists for the Team of the Year at the 2015 Pride of Rugby awards.
5. Partnership Working

The pivotal partnership in this project is between the project delivery team, made up of WCAVA staff and volunteers, and the partners and staff of the 4 participating medical practices. The partnership between the project staff and volunteers with the voluntary and community sector (VCS) organisations delivering activities and statutory agencies is no less important but appears to be far less of a determining factor in the project’s success.

As set out in Chapter 3 the number of patients/clients referred to the social prescribing project is lower than expected at this point. From the quarterly GP meeting attended by the evaluator it is obvious that both the project staff and medical practice staff are supportive of the project but different drivers and attitudes exist. These meetings appear to benefit from frank, honest but constructive discussions between the main partners. Reference was made at the meeting to being in the storming phase of group development\(^\text{17}\).

5.1 WCAVA project staff & volunteers views on partnership working

Rugby WCAVA see themselves as champions of the local voluntary and community sector and as such have been enthused by the potential of social prescribing and referral projects to bring about improvements in people’s health and wellbeing.

Staff are clearly frustrated at the lower than expected number of patients being referred to the pilot project. They recognise that the VCS has different ways of working to the primary care sector, “it’s so foreign to GPs to work in this way”, but they feel that they have “bent over backwards” and “cleared the decks” to meet the surgeries’ needs. They have responded to requests for more publicity materials etc but referrals are still low. This is balanced by staff being aware that “possibly this is because it’s [social prescribing] so new to everyone and we haven’t had time to build up relationships”. The team feels that the use of volunteers to signpost and buddy clients may have been an off-putting factor for medical staff who are used to working with statutory organisations.

There is some frustration amongst project staff that no agreement has been able to be reached with the medical practices regarding feedback on patients to provide more data on the pilot’s impact. Staff are fully aware of the need for good data to inform funding decisions.

To try to encourage more referrals staff have suggested attending practices’ unplanned admissions meetings or shadowing GPs for a few hours to see whether patients who could be referred are not being referred. Other suggestions include asking surgeries to come up with a list each of 10 regular attender patients who may benefit from the scheme.

The project team’s impression from visiting practices’ clinical meetings is that not all clinical staff know about or understand the pilot and social prescribing. There is a recognition that the project is in its infancy and the project needs time to bed in. Staff believe the lack of knowledge of the project is exemplified by one patient arriving at a surgery for an

\(^{17}\) A reference to Bruce Tuckman’s Forming, Storming, Norming and Performing theory of group development.

Rugby SPP/ConnectWELL Mid-term Evaluation 26
appointment with the ConnectWELL team in May 2015 and being turned away by the receptionist who did not know of the service.

Both volunteers and project staff are acutely aware of the time pressures facing GPs and the impact this has on partnership working.

Volunteers have felt welcome in surgeries but again are conscious of the time pressures on medical staff. Meanwhile many Navigator slots at surgeries have gone un-used leading to volunteers feeling less motivated. In response the number of sessions at which Navigators are present at one surgery has been reduced to once a month from once a week.

5.2 GPs and practice managers’ views on partnership working

Discussions with representatives of the practices involved show that different processes and cultures are at play in each practice. Individual health professionals will have varying interest in and responses to the concept behind social prescribing. It is therefore difficult to present a completely unified view from the medical teams involved in the pilot but common themes have emerged.

A common view is that the pilot is about addressing those societal issues which affect patients’ health and helping them to change by increasing their confidence and opportunities.

The prevailing view amongst those who have fed into this evaluation is that this pilot is still in its infancy. There was a recognition that it takes time for such schemes to become embedded. For instance, a local GP reported that the development of an ultrasound service from an alternative provider which offered a faster response time than the then current provider had taken 6 months to be properly utilised.

Importantly, some felt strongly that it is unrealistic to expect to be able to see the benefits from a one year pilot because of the time need to change behaviours [a reference to GPs’ prescribing patterns]. One person was of the view that if a Return on Investment had been expected in the first year the project had been set up to fail because a longer period is needed for it to be properly established.

Some GP partners have admitted that not all Registrars within practices may be aware of the pilot, and that perhaps this is because doctors were not involved enough at the beginning. But it also seems that many new services are introduced, some only last a year and disappear when doctors are “just getting used to it”. Therefore some doctors may have the attitude that there are just so many new initiatives and they will wait and see if this one becomes long term. This has to be seen against the context where GPs feel they are in a “crisis” situation of heavy workload and organisational change.

There has been concern amongst some within the medical practices about the role of volunteers in the project. Partly this appears to have been around concerns about patient confidentiality. Partly it appears also to be due to unfamiliarity with the volunteers taking part and lack of opportunity for GPs and volunteers to meet. Initially, this seems to have
led to uncertainty that the volunteers will be able to help patients. But this appears to have been overcome as the project progresses.

There has been frustration for some on the amount and type of feedback about clients back to GPs. One solution suggested to increase the referral rate was for more feedback to GPs about the outcomes for their patients and demonstrating how social prescribing can take the pressure off doctors. It was indicated that GPs wouldn’t mind if the Navigators waited outside their door for a gap between appointments to provide the feedback. However it seems that type of approach would definitely not suit other GPs who would prefer to hear from patients themselves. And the volunteers have indicated that they are wary of approaching doctors directly as they appreciate doctors are busy. Meetings between the Navigator and Health Buddy volunteers and medical staff have been suggested. There appears to be a need for practice-specific feedback mechanisms to be implemented.

Feedback from one practice suggested that the patients themselves were wary of engaging with the project. The social prescribing name had unfortunate associations with social services, and also some patients just couldn’t see how the project could help them. A solution to this may be to have non-clinical member of practice staff to be an advocate for the scheme. For instance it was identified this could sit with one practice’s Carer co-ordinator role.

Other suggestions have come through evaluation feedback. These include attendance of the project team staff or volunteers at practices’ unplanned admissions meetings and for the project staff to write to all carers on practices’ registers to offer the service.

While some suggest that more publicity materials be available, others feel that the best advertising for the project is for patients to come back to their GP and tell them how much social prescribing has helped them. One GP had feedback to the project that their signposting changed the life of her patient.

A repeated view is that the pilot should be rolled out to all 12 practices in Rugby borough to increase the number of referrals and be given longer to build up its reputation. This would also mean the scheme could be advertised more widely through local media and at more community events. This would build patients’ understanding of what social prescribing is about to encourage them to engage when referred and possibly to actively seek referral.

Looking to the longer term there was also questioning about ongoing funding and whether this should come solely from the CCG budget but, for example, additionally from local authority or social care funding.
6. Impact on participating Voluntary and Community Sector and other agencies

It is too early to make a clear assessment of the SPP’s impact on participating VCS and other agencies. This pilot differs from other projects in that no funding goes to these organisations in return for supporting the client.

Because of the way in which clients have been signposted to other services and activities the receiving agency may not be aware of the input of the social prescribing project. Of the four VCS representatives interviewed for this evaluation two were aware of the project. All expressed support for the concept of social prescribing, and this pilot project, and indicated that they were happy to take referrals from any source. Those that were not aware of the pilot stated that others in their organisation may have been aware or that there is just so much going on it’s difficult to follow everything.

Whilst funding is often constrained in this sector, all those consulted expressed a commitment to supporting individuals irrespective of whether they had been referred by the project or via another source.

When asked about their capacity to take on more clients, those consulted believed that their organisations could cope with an increase in caseload/service users although this would have limits. One service pointed out that whilst they had spare capacity in Rugby in other areas of the county there was a waiting list for their services, mainly due to a lack of volunteers in those areas. This reinforced the sense that Rugby benefits from a thriving voluntary sector.
7. True costs of involvement in the social prescribing project

A useful benefit of social prescribing bringing health and wellbeing improvements may be seen to be making cost savings in the NHS and social care.

Data provided for this evaluation\(^\text{18}\) indicates that the cost to the NHS of an appointment at a GP practice (with a doctor or other health professional) is £28. The average cost of an A&E attendance is approximately £114\(^\text{19}\). But these are only headline interactions of patients with the NHS and other factors need to be taken into account.

Unfortunately, no data has been collected to track whether patients/clients’ needs for appointments with GPs or other practice staff e.g. nurses has changed as a result of the pilot. Realistically with some clients it may also be too early to detect a change.

Data has been collected and can be calculated to demonstrate the actual costs of the project to date. Costs below are to 29.4.15 unless indicated. These would include:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteer Travel expenses</td>
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</tr>
<tr>
<td>Volunteer Training Costs</td>
<td>£ 25.00</td>
<td>SH to attend SPP Summit in Rotherham.</td>
</tr>
<tr>
<td>WCAVA project staff wages and on-costs</td>
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<tr>
<td>Staff travel</td>
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<td>Printing &amp; publicity</td>
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<td>Office equipment &amp; stationery</td>
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<td>Meeting &amp; event catering</td>
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<tr>
<td>IT costs</td>
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<td>Rent</td>
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<td><strong>TOTAL</strong></td>
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Costs not charged to the project where figures available:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room hire at surgeries</td>
<td>£ 620.00</td>
<td>Free during pilot. Chargeable thereafter 3 surgeries share 1 room Costs to 17.4.15</td>
</tr>
<tr>
<td>GP &amp; Practice Manager time at 3 x quarterly SPP meetings</td>
<td>£ 1073.50</td>
<td>Based on hourly rates provided by PMgr and GP Locum rate ph and recorded attendances at meetings.</td>
</tr>
</tbody>
</table>

\(^{18}\) Data provided by Dr Lesli Davies from Government sources – any errors in application will be the fault of the report author!

\(^{19}\) Reference Costs 2012-13, Department of Health, November 2013

Rugby SPP/ConnectWELL Mid-term Evaluation
Volunteer time (£3770.00)$^{20}$ Would continue to be free if this model continues

<table>
<thead>
<tr>
<th>Items not included as no figures available:</th>
</tr>
</thead>
<tbody>
<tr>
<td>− Travel costs for medical staff.</td>
</tr>
<tr>
<td>− Training costs for medical staff</td>
</tr>
<tr>
<td>− Fee to UHCW Chaplain Team for 3 days training</td>
</tr>
</tbody>
</table>

For the final project evaluation the partners in the project need to agree an approach to tracking the use of GP/practice appointments before and after intervention for at least a sample of clients. An assessment of the number of prescriptions issued might be another measure.

A full costs benefit analysis is beyond the scope of the project evaluation because of budget but might also include:

− Appointments not used/freed up
− Prescriptions not issued
− Return to work of patients
− Other referrals not issued eg to IAPT
− Costs of training for GPs and practice staff

A study from New Zealand in 2002$^{21}$ suggested that the costs of a suicide attempt in both economic and non-economic factors was NZD$6,350 or NZD$8502 in 2015. If the one recipient who said s/he had considered suicide was prevented from attempting this by the project this will have saved the NHS in the order of £4050. To put the costs so far into context reference can be made to a study by Dr Richard Kimberlee for the Bristol Clinical Commissioning Group:

“By simply looking at the staffing costs/beneficiary supported there is a range of cost effective ratios from: £223.74 to £833 for each beneficiary supported across SP holistic projects. A potential core cost of around £500/beneficiary for mature holistic projects would not be unreasonable to consider for future commissioning of holistic approaches$^{22}$.

$^{20}$ Source: Project Reporting Form May 2015

$^{22}$ Kimberlee, RH. (2013), Developing a Social Prescribing approach for Bristol, for Bristol Clinical Commissioning Group

Rugby SPP/ConnectWELL Mid-term Evaluation
8. Barriers and gaps in services

This evaluation has highlighted a number of barriers and gaps to project delivery. They are detailed below although further commentary will be in the relevant chapters.

8.1 Barriers to referrals

The lower than expected number of referrals is the major issue affecting this pilot project.

a) The pilot only being available in a selected surgeries

This is clearly seen by representatives from the medical practices as a key reason for the lower than expected number of referrals because of the time it takes for a new service to become embedded.

It has also been seen to be a barrier to gaining wider publicity and shared understanding. Project members have not wanted to raise the expectations of people who are not with the participating surgeries. The practices taking part in the pilot have been self-selecting arising from the interest of one or more practice leaders in social prescribing.

b) The pressure on GPs’ time

In the NHS nationally, and within the CCG, there is support for social prescribing approaches. Yet this has to be set against a background of many competing pressures on individuals working in primary care. It appears to be a barrier to GPs’ reflecting on alternative prescribing options such as social prescribing.

c) Communication with and within GPs and surgeries

From the WCAVA project team’s viewpoint this is a major barrier to the project’s success. There are differing views on what type of feedback GPs and practice staff need meaning project staff are unsure how what or how to do to improve communication about the project and in turn how this may encourage doctors to refer more.

d) Concerns about the use of volunteers

This appears to have been a barrier both to some prospective clients and also to medical staff because of concerns about confidentiality and ability to deal effectively with patients. GPs also do not necessarily know the age/gender profile of volunteers; meetings would be useful or short profiles but time constraints and uncertainty over the best way to communicate mean these haven’t happened.

e) Definitions of the type of patient to be referred

There is an acknowledgement from all involved in the project that at the start it was too restrictive in the type of patient to be referred. From WCAVA’s viewpoint they felt it unethical to take on clients to whom they may not be able to offer the necessary level of care. There were also concerns by both WCAVA and medical staff that the project may be
overloaded at the start and have a waiting list. This may have prevented GPs referring at the start.

f) Only GPs making referrals
In two of the three original practices GPs have been making referrals. At the third practice nurses have also been able to make referrals. However in comparing the number of referrals from each of the 3 practices it is difficult to prove that this has made a difference so far.

g) Length of time the pilot has been running and embedding the project
The data available to end of March on the number of referrals indicates that length of time the pilot has been running in a particular practice affects the number of referrals. However it is not the only factor. Qualitative feedback would indicate that patient engagement and willingness to refer may be other barriers as well as whether the when and how often the project volunteers are in the surgery premises.

Table 9

<table>
<thead>
<tr>
<th>Practice</th>
<th>Market Quarter</th>
<th>Brookside (rural)</th>
<th>Beech Tree</th>
<th>Clifton Rd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start Month</td>
<td>October</td>
<td>November</td>
<td>February</td>
<td>March</td>
</tr>
<tr>
<td>No Patients</td>
<td>6500</td>
<td>4000</td>
<td>4000</td>
<td>9000</td>
</tr>
<tr>
<td>No Referrals</td>
<td>23</td>
<td>10</td>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>

8.2 Barriers to clients engaging

a) The social misnomer
Feedback from practice staff indicates that some patients are linking social prescribing to social workers and therefore do not want to get involved. The volunteer Navigators have also reported that once clients realise they are not “official” and linked to statutory agencies they are more open.

The new ConnectWELL name should improve this situation.

b) Confidence & motivation
There is a high rate of those having been referred not wishing to work with the Navigators and Health Buddies. All patients are contacted on at least 3 occasions by the volunteer team to try to encourage them to take part.

The types of diagnoses that referred clients appear to have would indicate that often clients are suffering from a lack of confidence and or anxiety related conditions and do not feel capable of engaging with the scheme. Another factor may be that some clients are leading chaotic lives and do not see the potential benefit that may accrue.

c) Transport
At the outset with one rural surgery and 2 town centre surgeries transport was seen as being a potential barrier. Whilst it does not appear to have stopped clients from the rural
surgery engaging with the project itself, transport has been cited by clients from across the area as a problem.

The availability of public transport in the Rugby area may be very different to other large metropolitan and urban areas where pilots have taken place.

The cost of transport is another key factor that has been noted and meant that some clients are unable to take part in activities they have been signposted to.

d) Volunteer presence and visibility in surgeries
This factor has generally only been touched on in qualitative feedback. Initially volunteer Navigators were allocated to be in participating surgeries at designated times.

<table>
<thead>
<tr>
<th>Practice</th>
<th>Times</th>
<th>Hours available/wk</th>
<th>No of referrals</th>
<th>Start month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Quarter</td>
<td>Thursday pm &amp; Friday morning surgeries (shared premises with BT)</td>
<td>4</td>
<td>23</td>
<td>Oct</td>
</tr>
<tr>
<td>Brookside</td>
<td>Tuesday lunchtimes 12-2 (surgery closed 1-2pm )</td>
<td>2 (1)</td>
<td>10</td>
<td>Nov</td>
</tr>
<tr>
<td>Beech Tree</td>
<td>Thursday pm &amp; Friday morning surgeries (shared premises with MQ)</td>
<td>4</td>
<td>5</td>
<td>Feb</td>
</tr>
<tr>
<td>Clifton Rd</td>
<td>No room to offer so patients go to the shared MQ &amp; BT sessions</td>
<td>4 (by appointment)</td>
<td>1</td>
<td>March</td>
</tr>
</tbody>
</table>

It may be concluded from the data shown in the table above that the availability of Navigators during surgery times increases referrals.

e) Lack of information about clients
The volunteer navigators also reported in April\textsuperscript{23} that they were often receiving referrals on a plain piece of paper, sometimes just a name and phone number. This may have put clients off as Volunteers had to make contact without knowing which GP had made the referral and had no indication of what the client’s needs may be. It also hinders accurate monitoring for evaluation purposes.

8.4 Gaps
A number of gaps in the project’s operation have emerged since the pilot was launched.

\textsuperscript{23} Project volunteers meeting 20\textsuperscript{th} April 2015.
Rugby SPP/ConnectWELL Mid-term Evaluation
a) **Length of contact time with clients**

Feedback from both Navigator and Health buddy clients shows that they would appreciate support over a longer period of time. In particular the 6 session limit for Health Buddy clients is problematic as they are presenting with complex needs and these sessions can quickly be used up in just the first visit to the range of support services needed e.g. Drug & Alcohol Team (DAT), Rape Or Sexual Abuse Support (ROSA) and Citizens Advice Bureau (CAB).

The length or number of times Navigators can contact prospective clients may be too short for some, but not all as people need to build up their confidence or for the timing to be right. One client who only engaged on the third attempt said: “I wasn’t ready before”.

Volunteers report there being a fine line between pester clients and building their confidence.

b) **Collection of credible data for monitoring and evaluation**

This is a major gap in the ability to provide quantitative data to support the pilot’s findings. There appears to be no assessment of the improvement in Navigator clients’ health and wellbeing beyond qualitative feedback. So far there are not enough clients undertaking the WEMWBS to provide meaningful evidence. Quantitative data from Medical Practices would be beneficial to aid the end of pilot evaluation.

c) **Looking at the reasons for non-engagement as well as low referrals**

While the overall number of referrals is lower than expected, it would be helpful for more consideration to be given to the numbers of those not engaging and how these clients may be encouraged to take part.

d) **Rural/urban differences**

At the outset one issue of interest to both practices and the project team was whether there would be a difference in uptake between the rural and urban patients. It is too early to say definitively although it may be that uptake is lower.

e) **A SPP champion in each practice**

These do not appear to be in place in all practices and may help communication between the project team and all practice personnel.
9. Conclusions and recommendations

Conclusions

The Rugby Social Prescribing project has been launched promptly and those clients who have engaged so far are reporting satisfaction (often glowing satisfaction) with their experience and positive outcomes.

The numbers of referrals to the project so far is small, however. GPs and practice staff believe that this is because the concept needs time to become embedded. As one GP put it “this will snowball, it just needs more time.” If the referral trend continues at this level the pilot will have 82 clients in total rather than the 100 forecast. Project partners are aware of, and are taking steps to address, this problem but it must be an urgent priority.

GPs and practice staff see the linkages between social prescribing and achieving targets such as those set by the Care Act.

Looking at other pilots and studies such as that by the RAISE Network\(^ \text{24} \) an extension of the pilot for another 12 months is essential to properly gauge outcomes for clients and also to be able to assess this pilot against others.

The RAISE Network cites a study by researchers at the London School of Economics (Knapp et al (2012) which used a cost–benefit approach and decision-modelling techniques to examine potential costs and economic consequences. They conclude that there could be sizeable savings to the public purse when investing in community capital-building initiatives at relatively low cost\(^ \text{25} \).

It would therefore appear to be a wise investment for the CCG to extend funding for this pilot scheme for another year. Beyond that the linkages to other social outcomes and sourcing of funding should be considered.

The WCAVA project team have shown that they are responsive to the needs of medical practices in delivering the project and a robust partnership between the project team and medical practices team is emerging. For both sides this is a new relationship, lessons are being learnt and new ways of working emerging.

Good project management and reporting structures have been put in place. However the difficulties in agreeing what client data can be collected and how it will be analysed in order to judge the outcomes for clients is a risk to the extension of the project and beyond the pilot that needs to be addressed urgently.


\(^ {25} \text{Knapp, Martin and Bauer, Annette and Perkins, Margaret and Snell, Tom (2012) Building community capital in social care: is there an economic case? Community development journal, online ISSN 0010-3802} \)
## Progress towards project outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Evidence shown of progress Red/Amar/Grren</th>
</tr>
</thead>
<tbody>
<tr>
<td>All participating volunteers will gain learning and development opportunities, increased self-confidence and the satisfaction that they are actively contributing to their local community and to individuals’ health.</td>
<td>Good feedback in training and supervisions.</td>
</tr>
<tr>
<td>GP surgeries will note a tangible reduction in prescribing levels and/or the frequency of patients’ presentation at GP surgeries by those accessing the project compared with those who are not</td>
<td>No data being collected to evidence</td>
</tr>
<tr>
<td>Participating patients will gain an increased awareness of the social activities, support groups and community projects in their local area which can assist them to become more active and address issues which contribute towards their health.</td>
<td>Evidenced among those engaging of awareness and by qualitative feedback of improvements</td>
</tr>
<tr>
<td>Participating GP surgeries will gain an in-depth understanding and appreciation of the wealth of additional support available within local communities and volunteer resource. We expect our map to be shared across Public Health and Wellbeing Board structures.</td>
<td>Some evidence of a closer working relationship between voluntary and statutory sector.</td>
</tr>
</tbody>
</table>
Recommendations

1) The pilot be extended for a further 12 months to allow social prescribing to become more embedded and more data to be available.

2) Commitment to be obtained from practices participating in the pilot and the project team on data collection to provide evidence on clients’ outcomes.

3) Each practice to appoint a ConnectWELL champion.

4) Navigators and Health Buddies to encourage clients to tell their doctors about the benefits of support from Rugby SPP/ConnectWELL as this will encourage more referrals.

5) The project board to urgently consider extending the pilot to all practices in Rugby before the end of the pilot. The selective nature has held back marketing of the service for fear of having to say no to prospective clients. Volunteers have capacity to take on more clients, although there may be impacts on the project staff workload.

6) Project staff to continue to work with individual practices to agree specific feedback mechanisms on patients/clients for each practice. This may include opportunities for GPs to get to know Health Buddies/Navigators better.

7) Look at the impacts of rolling referrals out to nurses at the Beech Tree practice (from April 2015) and also consider extending to physiotherapists, occupational therapists etc.

8) ConnectWELL staff to attend practices’ Unplanned Attendances meetings to identify clients who may benefit from the pilot.

9) Monitor the number of those not engaging and compare this to other pilots.

10) Review the client database to ensure volunteers/staff are clear about who is responsible for which follow up actions.

11) Consider extending the number of contacts (i.e. length of support) through which Navigators and Health Buddies can offer support to clients.
Appendices

Appendix 1 Interviewees

Interviews
Alison Orr
Gemma Smith
Cathryn Ravenhall
Carol Kavanagh
Dr Jill O’Hagan  CCG/ Market Quarter Practice
Dr Lesli Davies – Clifton Road Surgery
Cheryl Herbert – Beech Tree Practice
Madeleine Clark – Brookside Surgery
Chris Hill Age UK Warwickshire
Volunteer Navigators
Percival Guildhouse
ROSA
Rugby MIND
Health Buddy and Navigator clients

Meetings attended
ConnectWELL, volunteers meeting
ConnectWELL, quarterly GPs’ meeting
## Appendix 2
Organisations to which clients have been referred

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age UK</td>
<td>Daycentre for Older People and Support for their Carers</td>
</tr>
<tr>
<td>Age UK</td>
<td>Befriending Services</td>
</tr>
<tr>
<td>Age UK Warwickshire</td>
<td>Rugby Forget-Me-Not Friends</td>
</tr>
<tr>
<td>Alcoholics Anonymous</td>
<td>Substance Misuse</td>
</tr>
<tr>
<td>Benn Partnership Centre</td>
<td>Advice &amp; Information Services</td>
</tr>
<tr>
<td>Bilton WI</td>
<td>Social Activities</td>
</tr>
<tr>
<td>Bradby Club</td>
<td>Employment</td>
</tr>
<tr>
<td>Cafe De France</td>
<td>Carers Resource Centre</td>
</tr>
<tr>
<td>Carers Resources Centre Rugby (CRC)</td>
<td>Carers Services</td>
</tr>
<tr>
<td>CAVA / WCAVA</td>
<td>Volunteering</td>
</tr>
<tr>
<td>Citizens Advice Bureau</td>
<td>Advice &amp; Information Services</td>
</tr>
<tr>
<td>Claremont Centre</td>
<td>Volunteering</td>
</tr>
<tr>
<td>Claremont Centre</td>
<td>Befriending</td>
</tr>
<tr>
<td>Clifton on Dunsmore Local History Group</td>
<td>Heritage &amp; Architecture</td>
</tr>
<tr>
<td>Come Dancing at the Benn Hall</td>
<td>&quot;Proper&quot; Dancing</td>
</tr>
<tr>
<td>Community Transport</td>
<td>Help with transport</td>
</tr>
<tr>
<td>Coventry and Warwickshire MIND</td>
<td>Rugby Wellbeing Hub</td>
</tr>
<tr>
<td>Coventry and Warwickshire MIND</td>
<td>Rugby Wellbeing Hub</td>
</tr>
<tr>
<td>Coventry and Warwickshire MIND</td>
<td>Dementia Befriending Service</td>
</tr>
<tr>
<td>Do It - Be More</td>
<td>Find what is happening near you</td>
</tr>
<tr>
<td>ESH Works</td>
<td>Substance Misuse Support</td>
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<tr>
<td>Friends of the elderly</td>
<td>Phoning Friends</td>
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<td>Hope 4</td>
<td>Winter Shelter</td>
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<tr>
<td>Hope 4</td>
<td>Hope 4 Centre</td>
</tr>
<tr>
<td>Hope 4</td>
<td>Hope 4 U</td>
</tr>
<tr>
<td>Hope4 Ltd</td>
<td>Housing/Homelessness</td>
</tr>
<tr>
<td>Inner Peace Yoga</td>
<td>Health &amp; Wellbeing</td>
</tr>
<tr>
<td>Job Centre Plus</td>
<td>Volunteering</td>
</tr>
<tr>
<td>Kailish Yoga Centre</td>
<td>Health &amp; Wellbeing</td>
</tr>
<tr>
<td>Mediation and Community Support (MACS)</td>
<td>Mediation and Community Support</td>
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<tr>
<td>MIND</td>
<td>Mental Health</td>
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<tr>
<td>Organization</td>
<td>Service/Activity</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Mind (Rugby Mind)</td>
<td>Befriending volunteers</td>
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<tr>
<td>Mixed Level Hatha Yoga</td>
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<tr>
<td>Mixed Level Hatha Yoga Classes</td>
<td></td>
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<tr>
<td>Oasis</td>
<td>Counselling/ resource centre</td>
</tr>
<tr>
<td>Orbit Care And Repair - Rugby</td>
<td></td>
</tr>
<tr>
<td>Orbit Independent Living</td>
<td></td>
</tr>
<tr>
<td>Overslade Community Association</td>
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</tr>
<tr>
<td>R.E.S.T.</td>
<td>Relaxation Eases Stress and Tension</td>
</tr>
<tr>
<td>Relate (Rugby &amp; North East Warwickshire)</td>
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</tr>
<tr>
<td>ROSA</td>
<td>Independent Sexual Violence Advisor Service</td>
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<tr>
<td>ROSA-rape or sexual abuse</td>
<td>drop in and counselling</td>
</tr>
<tr>
<td>Rugby and District Art Society</td>
<td>Brownsover</td>
</tr>
<tr>
<td>Rugby Borough Council</td>
<td></td>
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<tr>
<td>Rugby Borough Council</td>
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<tr>
<td>Rugby Carers Support</td>
<td></td>
</tr>
<tr>
<td>Rugby Citizens Advice Bureau</td>
<td></td>
</tr>
<tr>
<td>Rugby Autism Network</td>
<td></td>
</tr>
<tr>
<td>Rugby Food Bank</td>
<td></td>
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<tr>
<td>Rugby Jolly Joggers</td>
<td>Rugby</td>
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<td>Rugby Jolly Joggers</td>
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<tr>
<td>Rugby Library</td>
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<td>Rugby Mind</td>
<td>Wellbeing Hub</td>
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<tr>
<td>Rugby Ramblers</td>
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<td>Rugby Ramblers</td>
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<td>Yoga</td>
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<td>Rugby Wellbeing Hub</td>
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<td>Ryton on Dunsmore Village Events</td>
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<tr>
<td>Stretton on Dunsmore Walks</td>
<td></td>
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<tr>
<td>Stroke Association</td>
<td></td>
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<tr>
<td>The best of Rugby - Brownsover Art</td>
<td>Art</td>
</tr>
<tr>
<td>The Bradby Club</td>
<td>Work Club</td>
</tr>
<tr>
<td>The Percival Guildhouse</td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>Service(s)</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>The Silver Line</td>
<td>Helpline for older people</td>
</tr>
<tr>
<td>Top Hill</td>
<td>Housing</td>
</tr>
<tr>
<td>Volunteer Centre Rugby</td>
<td>Volunteering</td>
</tr>
<tr>
<td>Warwickshire Association for the Blind</td>
<td>Warwickshire Association for the Blind</td>
</tr>
<tr>
<td>Warwickshire Age UK</td>
<td>Support for 50+</td>
</tr>
<tr>
<td>Wruail Housing Trust</td>
<td>Arts &amp; Media</td>
</tr>
<tr>
<td>Warwickshire County Council (WCC)</td>
<td>Advice &amp; Information Services</td>
</tr>
<tr>
<td>Warwickshire Voluntary Transport</td>
<td>Community Services/Facilities</td>
</tr>
<tr>
<td>Warwickshire Welfare Rights Advice Service</td>
<td>Warwickshire Welfare Rights Advice Service</td>
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<tr>
<td>Warwickshire Welfare Rights Advice Service</td>
<td>Warwickshire Welfare Rights Advice Service</td>
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<tr>
<td>Welfare Reform Resources</td>
<td>email group</td>
</tr>
<tr>
<td>Yoga</td>
<td>Rugby</td>
</tr>
<tr>
<td>Yoga</td>
<td>Health &amp; Wellbeing</td>
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<td>Health &amp; Wellbeing</td>
</tr>
<tr>
<td>Young Minds</td>
<td>Mental Health</td>
</tr>
<tr>
<td>The Psoriasis Association (Northampton) and PAPAA (Hertfordshire)</td>
<td>Health &amp; Wellbeing</td>
</tr>
<tr>
<td>Northamptonshire Carers</td>
<td>Carers Services</td>
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<tr>
<td>Daventry Citizen’s Advice Bureau</td>
<td>Advice &amp; Information Services</td>
</tr>
<tr>
<td>Reach</td>
<td>Counselling &amp; Therapy Services</td>
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<tr>
<td>Coventry Heritage Detectors Society</td>
<td>Heritage &amp; Architecture</td>
</tr>
</tbody>
</table>
Appendix 3 Case Studies

Case study A

Background
The client visited with wife & daughter regarding help for both himself & wife. The client currently earns but may not be able to do so in the future & this was of concern. His wife is also his carer as he has medical issues.

The Challenge
Although they were in touch with other organisations re: financial support, they wanted financial help with driving lessons which obviously is a specialist area. Also, they live on the boundary with Northants.

Meeting the Challenge
To identify who/where would support driving lessons, suggested they speak to the organisation currently helping in the financial support.

The Outcome
Client has obtained funding from a carer’s organisation to help her driving lessons.
Case study B

Background
X came to see us about financial help. He had a stroke a number of years ago but had not, up to now, thought about benefits etc.

The Challenge
After discussion, a package of information was put together for X concerning benefits advice and details of the stroke association who could also assist him in these matters.

Meeting the Challenge
Following this initial information, X had got in touch with the stroke association who were helping him complete relevant documents to claim benefits.

The Outcome
X now receives various benefits such as housing benefit.

Visit our website: www.wcava.org.uk
Sample Questionnaire Response – Health Buddy client (verbatim)

Female, 40s
1. How did you hear about ConnectWELL/Social Prescribing?
   You did! You phoned me. Doctor hadn’t told me she had referred me.

2. How has ConnectWELL helped you?
   To believe that I can be quiet normal again, build my confidence and support me to re-engage with society.

3. Has the help offered been what you expected? If not what did you expect?
   No, everything has been what I expected, once I knew what to expect. In fact, you (Wellness Coordinator and Health Buddy) have been more supported that I expected.

4. Do you think anything about ConnectWELL could be done better or differently so that it could help you more?
   Longer. Depending on the individual. I am just starting to feel and try different things. I wish I had tried one thing and stuck with it rather than trying lots I’m not settled in one place and stay. Now I have tried stuff I need more sessions to settle somewhere.

5. How easy has it been to use the service? Eg transport, timing location
   Very. I find everyone really helpful. I have my own transport, timing everyone’s been flexible. Can’t be easy behind the scenes but the service has been really helpful to me.

6. Would you recommend ConnectWELL to others? Why?
   Yes. Why? Because I think your fab! (ConnectWELL). Sometimes you hate yourself so much you want to die. And you are two lovely people and have helped me start to believe in myself again. They’s nothing else like this out there – I have found.

7. Do you think you will need to see your GP less often because of the help you received?
   Don’t really she her any more. Long term? Settled and confident then yes.
Promoting Independent Living Review

Review of Evidence

What have we learnt so far and what further work needs to be done?

1. Introduction

This paper aims to summarise the key findings and issues arising from the task group’s evidence gathering to date and suggests some emerging conclusions and recommendations about the potential opportunities and gaps to be addressed.

The aims of the review, as set out in the one page strategy, are to:

1. Establish what the council does already and plans to do to support the objective of promoting independent living, and develop an understanding of the council’s contribution within the wider context.
2. Identify any gaps that the council could reasonably fill, either on its own or by working with partners.
3. Develop a strategic corporate approach to promoting independent living, with clarity about the outcomes the council aims to achieve and the relative priority to be given to this aim at the borough level.

2. Overview

Promoting independent living is not a statutory priority for the council, but Rugby Borough Council has a stated corporate priority to “support independent and healthy living”. However, there is no clear corporate agreement about the council’s role in promoting independent living and the actions within the Corporate Change and Improvement Plan relating to this priority are fairly disparate.

The council is the strategic planning authority and strategic housing authority for the borough and, as such, has a key contribution to make in promoting independent living for the growing population of older people. The council has statutory responsibilities in relation to the Disabled Facilities Grant, which is used to fund home adaptations. At the county level, promoting independent living is a key priority within the Warwickshire Health and Wellbeing Strategy 2014-18, to which this council is a contributor.

The council has a decision to make as to whether promoting independent living should be more consciously pursued as a corporate priority, through a cross-cutting approach, or whether council services should simply continue to engage in activities that support independent living as a legacy of existing work. Although the council has a community leadership role in relation to health, it is recognised that it will benefit less financially from investment in this preventative work than other statutory partners.

While there is a good deal of work being carried out at the county level and by other statutory partners on supporting older people to live independently in their own homes for
longer, this task group is, for the first time, exploring the issue from a borough council perspective. The task group is looking uniquely at the contribution the council can make by adopting a more intentional corporate approach, drawing together all of the different opportunities within the council’s services to positively influence this agenda.

3. Why is this important to Rugby Borough Council now?

The task group has begun to identify some clear current imperatives for the council to adopt a more strategic and intentional approach to promoting independent living.

- **Demographics**

Demographic data provides a strong case for prioritising activities to promote independent living, with clear projections of an ageing population who are likely to experience multiple ill health issues.

Population projections demonstrate that Rugby is set to have an increasing number of residents aged 65 and over and a particularly significant rise in the population aged 90 years and over.

In 2012 people aged 65 to 90+ made up 18.1% of the total population of the borough, compared with 16.9% at a national level. By 2037 this is predicted to rise to 26.5% of the borough population, compared with 24% nationally. This equates to 31,800 people in the borough, compared with 18,200 people in 2012 – an increase which also reflects the projected population growth in the borough overall.

The number of people with dementia is predicted to rise by 24.3% (1,610 people) in Rugby by 2020. The number of residents with limited activity is also set to increase, with the most significant increase amongst older people.

- **New health and social care infrastructure**

Nationally, policy is shifting towards service integration and a focus on prevention and there is an opportunity for lower tier authorities to contribute to this agenda.

The Better Care Fund is reallocating funding (£36 million in Warwickshire) from acute health services into a joint fund for integrated services with adult social care. The focus is on preventing the need to access urgent care. Whilst housing authorities do not have any statutory responsibility in relation to the Better Care Fund, there is local recognition of the contribution housing is able to make and the council’s Head of Housing and Property is a member of the Warwickshire Cares Better Together Board (which is overseeing the administration of the Better Care Fund in the county). This has a number of work streams in place on the following themes:

- community capacity
- integrated care
- care at home
- accommodation with care
- long-term conditions
The Disabled Facilities Grant (for which lower tier authorities have statutory responsibility) is now received as part of the Better Care Fund at the county level, though it has been passported to the five districts for two years.

Rugby has played a leading role in the development of the Warwickshire Home Improvement Agency. This initiative anticipated the national drive towards greater service integration and demonstrates the potential for all of the councils in Warwickshire to integrate their services for the benefit of local people. The HIA has resulted in significant reductions in the time taken to complete adaptations, with the number of customers dropping out of the process falling from 35% to just 5%.

The Warwickshire Health and Wellbeing Strategy 2014-18 builds a strong case for making ‘promoting independence for all’ a key priority. One aspect of this is “enabling older people to be able to remain in their own home and to live healthy active lives for as long as possible” and the strategy articulates a number of aims within this area of focus. These relate to:

- preventative interventions for older people (to reduce unnecessary hospital admissions for people with long-term conditions)
- reablement of older people
- the ‘right range’ of housing for older people with the right support
- supporting people to live at home longer through provision of advice, adaptations and extra-care housing
- integrated services for frail older people
- addressing loneliness and isolation
- support for carers

The Strategy has a further priority around integration and working together, and this also includes a focus on supporting people to “remain healthy and independent, in their homes for longer”.

- **Corporate strategy and new portfolio**

The council’s corporate strategy is due to be refreshed shortly. Potentially this presents an opportunity to include health and wellbeing as a more prominent corporate priority and perhaps even to embed it, alongside ‘clean, green and safe’, as part of the council’s vision.

A new Cabinet portfolio was created in May 2015 covering health, community safety and equality, potentially significantly strengthening the council’s strategic leadership around health. There may be an opportunity for the task group to support the new portfolio holder in shaping their role and identifying their priorities.

**4. What is the council doing already?**

**4.1 Housing**

There are almost 600 tenants aged over 60 living in the council’s general needs accommodation, as well as around 1609 tenants living in sheltered accommodation.
The housing team is involved in the Warwickshire-wide Better Care Fund initiative detailed above, as well as work on home improvement at a county level. The council’s housing team also undertakes a significant number of adaptations in its own properties.

The council owns and manages 1374 sheltered housing units and provides a traditional warden service in its sheltered schemes. The wardens support tenants in living independently and maintain regular face-to-face contact with tenants through weekly or twice-weekly visits, and through a comprehensive programme of social activities provided at the community rooms in the urban sheltered schemes.

The Control Centre provides a year-round Lifeline service to 1763 council customers and 548 private customers, raising income for the council’s general fund of over £70k in the last financial year. Lifelines and other assistive technology are monitored 24 hours a day.

Warwickshire County Council has withdrawn its contract with RBC to provide wider assistive technology to 119 customers eligible for care, as the contract was retendered as part of a wider package including rehabilitation services. The council is discussing possible next steps with other districts and boroughs.

The council is currently working with Coventry and Rugby CCG to pilot the use of ‘Toughbooks’ – mobile, durable computers that are used to enable residents to be assessed by a qualified medical professional based in a remote centre. It is anticipated that the use of such technology will reduce unnecessary hospital visits and ambulance calls in the longer-term.

4.2 Sports and recreation

The Queen’s Diamond Jubilee Centre had 1047 gym members aged over 60 at March 2015, and they made approximately 5000 visits (10% increase since March 2014). There are 120 members signed up to the Healthwise GP Referrals Scheme (46% of whom are over 60).

The Centre is running and trialling various activities aimed specifically at older people – for example a dementia class, a chair-based exercise class and bowls. There is a dedicated community sport manager employed by GLL whose role is to identify gaps in leisure provision and promote the importance of exercise.

4.3 Planning

The council exercises its planning responsibilities within the parameters of the National Planning Policy Framework and national planning practice guidance.

A reference to ‘independent living’ has recently been added to the national planning practice guidance and there is a specific requirement for local planning authorities to identify, break down and consider the housing needs of older people and the type of accommodation required. Plan makers will now need to consider the size, location and quality of dwellings needed in the future for older people in order to allow them to live independently and safely in their own home for as long as possible. This was a very recent addition to the guidance when planning officers reported to the task group and the council will be considering how to reflect this in the revised Local Plan.
In local planning policy, financial viability evidence must always be balanced against evidence of housing needs. The National Planning Policy Framework specifically states that the local planning authority must boost the supply of housing and therefore that local policies should not over-burden developments so as to prevent them from coming forward.

5. What are the gaps and opportunities?

Through its evidence-gathering to date, the task group has identified a number of current opportunities and gaps in support for older people to live independently that could be explored further or be worked up as review recommendations. These are detailed below.

5.1 Opportunities

Housing

Warwickshire County Council (WCC) is now starting to develop extra care housing in the borough. This involves residents having their ‘own front door’, but with care provided on site. In response to this, Rugby Borough Council needs to ensure its own sheltered housing stock remains attractive compared with extra care housing. Consideration might be given to remodelling sheltered housing schemes as older persons’ villages.

WCC is also remodelling its Housing-Related Support Services (formerly ‘Supporting People’). It has been suggested that this provides an opportunity to develop a remodelled warden service to private tenants and owners. This would require additional resource and capacity, and it would be important to develop an attractive service that people would be prepared to pay for.

Sport

The council’s sports and recreation team’s current focus is mainly leisure provision for young people. Councillors could take a decision to shift the focus of the team more towards older people.

There is a lack of external funding currently available to support leisure activity for older people and a need for a stronger evidence-base to understand and demonstrate the needs of harder to reach communities – including older people – to engage more regularly in physical activity. The council could argue for a research stream in the next Warwickshire Joint Strategic Needs Assessment to address this.

Tenants in sheltered housing could benefit from walks and chair-based exercise classes. There are clear opportunities for connections to be made between the work of the sports and recreation and housing teams.

Planning

The Coventry and Warwickshire Strategic Housing Market Assessment identified that over the next 20 years there will be a big increase in the elderly population in the borough and also identified the projected needs for specialist housing as a result of growing health needs.
A housing supplementary planning document supports the Core Strategy. A similar supplementary policy could be developed for independent living, or detail about independent living could be added to the existing housing SPD. This could set out aspirations for the types or levels of provision required, whilst recognising that this should be subject to viability.

Members expressed a clear view that independent living should be considered at an early stage in the development of the new local plan. The task group may have an opportunity to feed into the local plan process (initial consultation currently expected September 2015, adoption in December 2016).

**Access to care**

The process of obtaining professional carer support can often be complex and lengthy and it can be difficult to provide evidence of need to meet tight criteria. The task group heard about situations that wardens had encountered where residents needed assistance to reach bathroom facilities in their home, but wardens were unable to assist. Sometimes there was a considerable delay in accessing necessary support from carers. Wardens also highlighted a lack of flexibility in the system to enable residents to access end of life care in their own home for an indeterminate period of time.

Such experiences support the case for development of older people’s villages, where a range of facilities are brought together on one site. The introduction of personal care budgets may also assist in addressing the issue of timely access to care support.

Wardens also identified a need for more routine use of multidisciplinary meetings to ensure all agencies are working together effectively to support those recovering from a hospital stay. It was noted that this falls within the remit of the D2A (discharge to assess) work stream of the Better Together programme, which is working to improve hospital discharge arrangements for elderly patients.

**5.2 Gaps in provision**

**Transport**

In the rural area, access to transport is a significant issue. Bus services can be very irregular or at inconvenient times, and bus stops are sometimes too far to walk to. There are also difficulties in travelling to hospital appointments at UHCW and accessing ambulance transport. The task group is meeting with representatives from Warwickshire County Council’s transport team to better understand the current provision and opportunities to address the concerns about access to transport.

**Food**

More provision of hot meals for sheltered housing residents could help prevent people from needing to go into residential care. There is also the potential to run cookery classes at the urban sheltered schemes as the facilities are available and this could help people to remain independent for longer.
Leisure activities

Stratford District Council have produced an ‘Active Hi-5’ information booklet on activities for adults. This could potentially be replicated in Rugby to improve awareness of and promote involvement in a range of leisure activities, to help people remain active for longer.
PROMOTING INDEPENDENT LIVING TASK GROUP REVIEW

ONE PAGE STRATEGY

What is the broad topic area?
Provision for older people who may need support to live independently. This includes physical provision as well as activities and services to promote social wellbeing and quality of life.

What is the specific topic area?
To develop a strategic corporate approach to promoting independent living in Rugby Borough, in support of the Warwickshire Health and Wellbeing Strategy.

The review will do the following:

1. Establish what the council does already and plans to do to support the objective of promoting independent living, and develop an understanding of the council’s contribution within the wider context.
2. Identify any gaps that the council could reasonably fill, either on its own or by working with partners.
3. Develop a strategic corporate approach to promoting independent living, with clarity about the outcomes the council aims to achieve and the relative priority to be given to this aim at the borough level.

What is the ambition of the review?
That the review will establish members’ community leadership role in relation to health, act as a catalyst to stronger partnership working to support independent living and encourage inventive and innovative solutions.

How well do we perform at the moment?
District and borough councils have a pivotal strategic role in preventing the need for more expensive care and acute admissions, as well as providing services that help improve health and wellbeing.

The council’s corporate strategy contains an objective of “improved health and wellbeing for all age groups and communities.” One of the council’s corporate priorities in pursuit of this is to support independent and healthy living.

The Government’s Better Care Fund is driving an agenda of service integration and pooled budgets and the council is part of the Joint Commissioning Board that is developing a Warwickshire-wide approach in relation to the Fund. The council has also played a strategic role in the county-wide Home Improvement Agency project.

The council is engaged in a range of activities and initiatives to support independent living and promote good quality of life amongst older residents and those with disabilities. The council is also able to influence this agenda, for example through its housing, planning and sports and leisure provisions. However, there is no clear corporate agreement about this council’s role, nor is there a common approach and shared understanding with other statutory, private and voluntary sector partners about respective contributions.

Who shall we consult about the current service and about how we can improve it?
The review may include direct consultation with sheltered housing residents and Telecare users, as well as with local representative groups. The consultation activity will be determined once the task group has received initial briefings.

What other help do we need?
Internal officer support from Housing, Sports and Recreation, Planning and Customer Services. Learning from national good practice.
How long should it take?
Complete by the end of the 2015 calendar year.

What will be the outcome?
An agreed corporate strategic approach to promoting independent living.