

Social Prescribing in Secondary Care Pilot Service

Evaluation Report

July 2018



Acknowledgements

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We would also like to thank Healthy London Partnership for commissioning this report, and their staff and those of Homerton University Hospital for their input over the course of the pilot.

About Family Action

Family Action is a charity committed to building stronger families and brighter lives by delivering innovative and effective services and support that reaches out to many of the UK's most vulnerable people. We seek to empower people and communities to address their issues and challenges through practical, financial and emotional help. We are experienced at running Social Prescribing services and related service models, such as our WellFamily service in both primary and secondary care.

For further information about our services, please see www.family-action.org.uk/what-we-do

About Healthy London Partnership

Healthy London Partnership formed in 2015. Our aim is to make London the healthiest global city by working with partners to improve Londoners' health and wellbeing so everyone can live healthier lives.

Our partners are many and include London's NHS in London (Clinical Commissioning Groups, Health Education England, NHS England, NHS Digital, NHS Improvement, trusts and providers), the Greater London Authority, the Mayor of London, Public Health England and London Councils.

All our work is founded on common goals set out in Better Health for London, NHS Five Year Forward View and the Devolution Agreement.

About Apteligen

Apteligen provides specialist research and consultancy services to the public sector with a focus on how information can be translated and applied in ways to inform improved management and decision making. We help public sector organisations gather, analyse and interpret information in ways to help them solve a wide variety of problems.



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Executive Summary

Social Prescribing is defined by NHS England as “helping patients to improve their health, wellbeing and social welfare by connecting them to community services which might be run by the council or a local charity.”

Family Action piloted a Social Prescribing in Secondary Care Service, commissioned by Healthy London Partnership, from December 2017 until the end of June 2018 at the Homerton University Hospital in Hackney. The service received referrals from secondary care staff, primary care staff, self-referrals, and other voluntary sector organisations.

The service provided non-clinical support via up to eight one to one sessions, with Link Workers facilitating social prescriptions to community organisations and providing practical and emotional support with issues such as finances, housing and carers support. Social Prescriptions were most commonly made to Outwards, Health Coaches, Single Homeless Project, Hackney Advice Service and the Wellbeing Network. Figure 1 compares referrals received with length of support and referrals to other organisations.



Figure 1: Referrals received by the service and the number that became active clients, average length of time service users engaged with a Link Worker and referrals made by the service to other organisations

Though the short duration of the pilot meant not all outcomes from the Theory of Change were expected to be achieved, the service model aims to:

- offer a wide range of non-medical short and long term support to alleviate and/or reduce returns to secondary care through improved wellbeing and physical health of service users
- support inpatients to transition out of hospital by providing emotional support in the transition time between hospital and home, with the hope of smooth transitions leading to reduced readmissions
- reduce discharge delays where these were related to support outside of hospital
- offer support to family members of patients who are too unwell to liaise with the Link Worker directly so that no one falls through the gaps
- reduce demand pressure faced by hospital staff
- improve integration with primary care

Service User Outcomes

- A variety of outcomes were achieved on the service’s Outcomes Framework, indicating that the service was able to have a wide impact on factors affecting the lives of service users
- The most common outcomes achieved relate to: being involved in decisions around support, forming positive new friendships, being supported to manage finances and

receiving support around physical health

- On the Well-being Star 'feeling positive' was the biggest improvement, with 'looking after yourself' and 'money' common improvements too

Wellbeing Value

- A total of £22,965.48 per annum of value was generated for 14 service users as a result of the support provided through the service
- If average Wellbeing Value is calculated for the six service users who achieved an outcome that could be costed, this equates to £3,827.58 per person per annum. This compares favourably against a £1,038 unit cost for service users who became active cases.

Healthcare System Outcomes

- The Social Prescribing in Secondary Care service was well received by secondary care staff, and interviewees felt that the service has helped to improve integration between primary and secondary care and community organisations
- However, referral levels were lower than anticipated. This seems to be the result of:
 - the length of time required to embed a service within secondary care pathways
 - the service not being available on the hospital system for secondary care staff to confidently and easily refer, as well as receive feedback on a patient's progress
- Interviewees highlighted the importance of continued commitment from senior secondary care staff in order to ensure that the support the service can offer is clear to their staff teams and remains at the front of their minds when referring in a high pressured environment
- Impact on resource demand in primary and secondary care was not able to be commented on due to a lack of NHS data to analyse, though the Theory of Change shows this could be expected to occur

Future Considerations

- Consider the time needed for implementation of service in a complex environment, and for recruitment of Link Workers and Volunteer Befrienders
- Consider Link Workers operating from a permanent base within the hospital to further integrate the culture in secondary care with that of the voluntary sector
- Ensure data sharing agreements are in place at implementation so the service is able to measure impact on the healthcare system, and secondary care staff feel more confident to share data required at referral stage
- Further investigation into disengagement would be helpful as additional options, such as home visits, may be required to reduce barriers to using the service

The pilot service only ran for six months, with a short implementation period and some ongoing referral issues. Despite this, there are early indications that positive outcomes have been achieved for service users, the service is likely to lead to outcomes that have a higher value than the cost of delivery, and it can improve the integration of secondary care with primary care and community organisations. This suggests Social Prescribing in Secondary Care is a model that could have even greater benefits in future given additional implementation and service delivery time.

Introduction

Family Action

Family Action transforms lives by providing practical, emotional and financial support to those who are experiencing poverty, disadvantage and social isolation. Reaching out to those in need, we strengthen families and communities, build skills and resilience and improve the life chances of everyone we work with. Family Action's values are central to us. We are a can-do organisation, we strive for excellence, we maintain a clear people focus and we have mutual respect for everyone.

Our services are innovative and we take a holistic, strengths-based approach to working with families. We seek to empower everyone we work with, adding significant value to the lives of service users, to those who commission services and to those who create policy and influence change for the future.

Family Action has considerable experience delivering Social Prescribing in Hackney. We run a primary care Social Prescribing service in Hackney, as well as both a primary and secondary care WellFamily Service. The WellFamily service model was identified in an earlier national Social Prescribing report as a service model offering some similar features that learning could be taken from in relation to the Social Prescribing model.¹

What is Social Prescribing?

NHS England describes Social Prescribing as "helping patients to improve their health, wellbeing and social welfare by connecting them to community services which might be run by the council or a local charity."² Community services could range from art classes to walking clubs or support groups. Social Prescribing enables health care professionals to refer people to a range of non-clinical support, often via a Link Worker who coordinates what is available in the community for a social prescription. It is intended to help people to have more control over their lives, avoiding them becoming trapped in a 'revolving door' of services. It may also lead to resource savings and shifts for health and social care through reduced inappropriate use of and improved integration of services.

Social Prescribing is particularly suitable for people who:

- are lonely or isolated
- have long-term conditions
- use the NHS the most
- have mental health needs
- struggle to engage with services
- have wider social issues e.g. debt, housing problems, employability issues, relationship problems
- are carers

¹ SDC and Scottish Government (2007) *Developing Social Prescribing and Community Referrals for Mental Health in Scotland*. Available from: www.artshandresources.org.uk/wp-content/uploads/2017/01/2007-CDS-Developing-social-prescribing-and-community-referrals-in-Scotland.pdf

² NHS England (2018) www.england.nhs.uk/contact-us/privacy-policy/how-we-use-your-information/public-and-partners/social-prescribing/

The Social Prescribing in Secondary Care Pilot Service

Family Action's Social Prescribing in Secondary Care Service (the service) was commissioned by Healthy London Partnership and works with Homerton University Hospital in Hackney, London. The service started in December 2017 and ran until the end of June 2018.

The service's original focus was to support with winter pressures during 2017/18, though the learning from the pilot will also inform future planning of similar Social Prescribing in Secondary Care Services through the development of a How to Guide Guide.

Social Prescribing is not as commonplace in secondary care as it is in primary care. Therefore, the aim of this evaluation was to contribute to a growing body of knowledge about the best way to utilise this model in secondary care. This service was run in an area that already has a well embedded Social Prescribing service in primary care. As this was run by Family Action, some elements of service implementation time and costs could be reduced and shared, and Family Action were also well aware of common challenges, voluntary sector services available in the area to prescribe to, and useful ways to embed a voluntary care service within the healthcare system. The findings of this report should be considered in this context.

Owing to the timescales of the pilot, impact data is limited and therefore this report focuses more on process evaluation. However, there are early indicative findings about the effectiveness of the service in terms of its intended outcomes and integration into the care pathway. The full evaluation methodology can be found in Appendix 1.

External Context

The London Mayor, Sadiq Khan, is supportive of Social Prescribing, including as a key objective in the draft Health Inequalities Strategy that it "becomes a routine part of community support across London."³

Social Prescribing models also support the aims of the NHS Five Year Forward View (2014)⁴ to support people more holistically, linking health with social care and other support needs, and ensuring that there is a focus on prevention and early intervention.

The Five Year Forward View, General Practice Forward View (2016)⁵ and draft Health Inequalities Strategy all recognise the important role that the voluntary sector and a community based approach can play in supporting wellbeing and reducing pressure on health services. The Social Prescribing model is particularly relevant to this, as not only does it link patients to community

³ Greater London Authority (2017) Better Health for All Londoners: Draft Health Inequalities Strategy. p.87
Available from:

www.london.gov.uk/sites/default/files/draft_health_inequalities_strategy_2017.pdf

⁴ National Health Service England (2014) *Five Year Forward View*. Available from: www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

⁵ National Health Service England (2016) *General Practice Forward View*. Available from: www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

activities, but the provision of the service by a voluntary sector organisation also enables the use of existing community relationships to strengthen engagement with the service by service users.

Theory of Change

A report on a Social Prescribing service in Brighton and Hove, working in both primary and secondary care, states that 20% of an individual's health outcomes result from clinical treatment, and the remaining 80% comes from determinants such as social networks, physical environments and lifestyle choices.⁶ A Health Education England study on Social Prescribing concluded that in order to best integrate an individual's health and care needs, services must move away from episodic care to a more holistic approach.⁷

With this in mind, Social Prescribing services generally aim to increase individuals' uptake of community activities and other sources of support, the attendance at which may in turn:

- improve physical fitness,
- improve independence and self-management of long term conditions,
- reduce social isolation,
- reduce anxiety and depression and
- improve general wellbeing

These sources of support 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, parenting problems, debt or legal advice.

The specific aims of Family Action's Social Prescribing in Secondary Care Service, in addition to those stated above, were to:

- offer a wide range of non-medical short and long term support to alleviate and/or reduce returns to secondary care
- support inpatients to transition out of hospital through the use of emotional support in the transition time between hospital and home, with the hope of smooth transitions leading to reduced readmissions
- reduce discharge delays where these were related to support available outside of hospital
- offer support to family members of patients who are too unwell to liaise with the Link Worker directly so that no one falls through the gaps
- reduce demand pressure faced by hospital staff
- improve integration with primary care

If the individual outcomes above are achieved, it can be expected that people are less likely to attend A&E or be readmitted to secondary care on an emergency basis. It is also hoped they will require fewer GP appointments, or know when it is more appropriate to seek primary rather than

⁶ Community Works et al. (2017) *Social Prescribing Extended Pilot Interim Monitoring Report*. Available from: www.bh-imperius.org/wp-content/uploads/2017/11/Social-Prescribing-Extended-Pilot-Monitoring-March-2017-Final.pdf

⁷ Health Education England. (2016) *Social Prescribing at a Glance, North West England: A Scoping Report of Activity for the North West*. NHS, UK. Available from: www.hee.nhs.uk/sites/default/files/documents/Social%20Prescribing%20at%20a%20glance.pdf

secondary care support. A Social Prescribing service in Brighton found that the service ensured that people could access the right support at the right time⁸, preventing escalation of needs to the point where primary or secondary care is required. This would also reduce the number of bed days required by a patient before discharge, as not only would the level of need, and therefore the treatment time required be reduced, the correct support available to the patient within the community is expected to reduce discharge delays. Offering support to families where a patient is too ill to speak to a Link Worker, and referring them to social care and community care where appropriate also ensures that re-attendance at secondary care does not occur because the family as a whole felt unsupported to meet the patient's needs.

In Bristol, a Social Prescribing service achieved similar outcomes for individuals as those above, as well as reductions in attendance at GP surgeries.⁹ A Social Prescribing service in Rotherham running for four years found that there were reduced attendances at Accident & Emergency (A&E) departments, outpatient appointments and inpatient admissions for 80% of those who used the Social Prescribing Service four months after doing so.¹⁰ In Blackpool, the High Intensity User Service for frequent 999 callers (though not a pure Social Prescribing model) saw A&E attendance reduced by 93% and admissions reduced by 82% for the 100 callers selected for the pilot over 15 months.¹¹

The reduced demand for secondary care services, and delays in relation to this, as a result of a Secondary Care Social Prescribing Service would also be expected to reduce resultant stress on staff, having the potential to improve morale and reduce sickness. Being able to ensure patients are getting the right support for their needs, rather than seeing them frequently return to secondary care would also boost morale. Social Prescribing is also an opportunity to improve the engagement of secondary care staff with what other services there are available to support them and their patients. Connecting secondary care staff who refer in to the service to community provision for their patients, as well as with primary care staff who would normally receive discharge summaries but may not be able to prevent readmission to secondary care through clinical means, enables improved integration of primary and secondary care, as well as integration with community support and social care. The use of community activities to improve self-management of long-term conditions would also be expected to reduce demand for GP consultations, the shortage of which can lead to people seeking secondary care in the first place.

Figure 2 demonstrates the inputs, activities, outputs, outcomes and final goal expected for Family Action's Social Prescribing in Secondary Care Service. Not all outcomes were expected to be seen during the pilot due to the short timescale the service was delivered for. The pilot tested the processes and systems needed for Social Prescribing in Secondary Care to achieve initial short term outcomes. The service used an Outcomes Framework and Triangle Consulting's Well-being Star to monitor outcomes throughout service delivery. Appendix 1 contains further details.

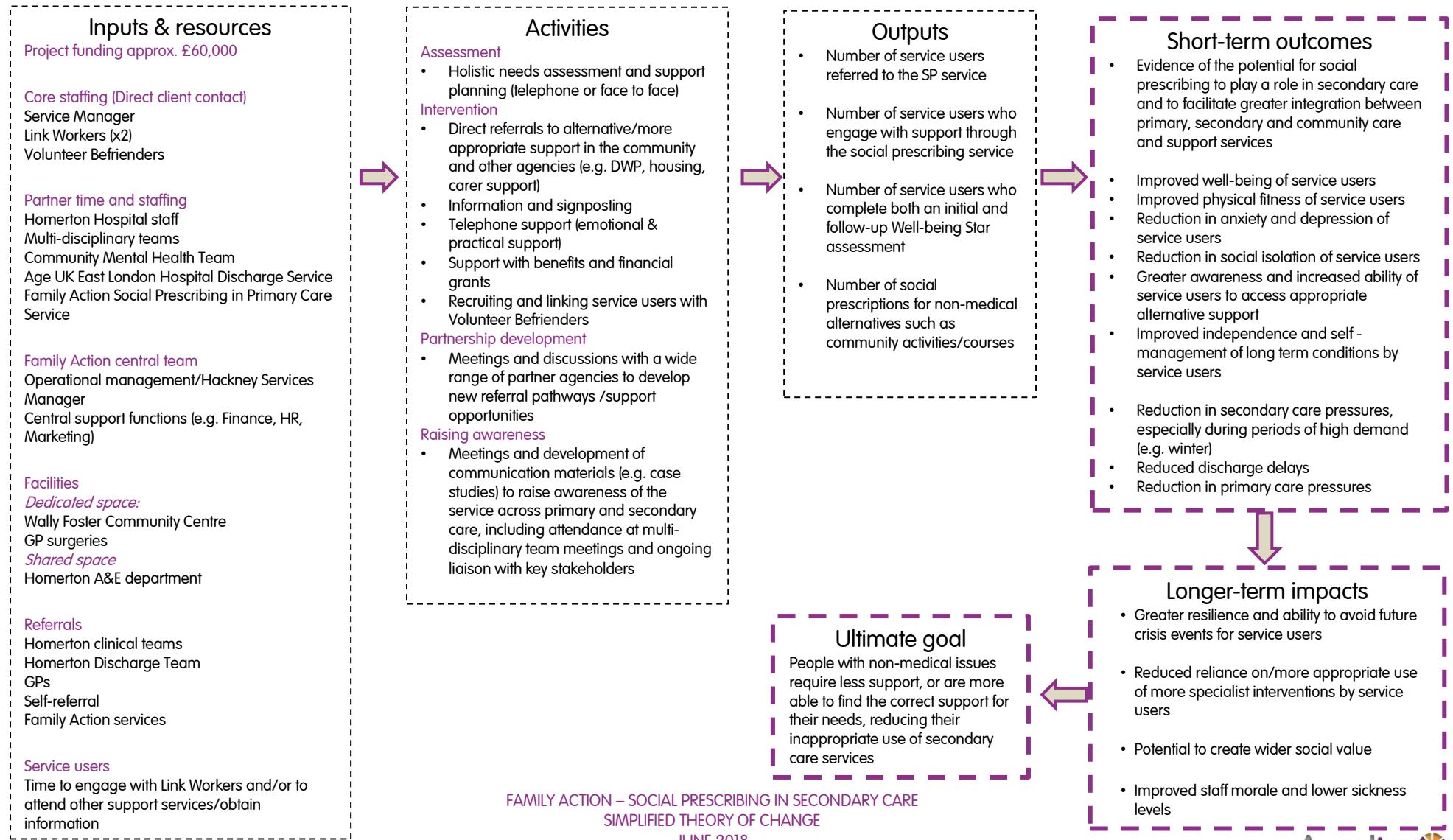
⁸ Community Works et al. (2017) *Social Prescribing Extended Pilot Interim Monitoring Report*. Available from: www.bh-impetus.org/wp-content/uploads/2017/11/Social-Prescribing-Extended-Pilot-Monitoring-March-2017-Final.pdf

⁹ Kimberlee, R. (2013) *Developing a social prescribing approach for Bristol. Project Report*. Bristol Health & Wellbeing Board, UK. Available from: <http://eprints.uwe.ac.uk/23221>

¹⁰ Dayson, C. and Bashir, N. (2014) *The social and economic impact of the Rotherham Social Prescribing Pilot: Main Evaluation Report*. Available from: www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham.pdf

¹¹ Johnston, M. and Monteith, R. (2015) *Commissioning for Value: Reducing the number of high intensity users of unscheduled services*. Available from: www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2016/11/casebook-blackpool-tackling-frequent-callers.pdf

Figure 2: Theory of Change Family Action Social Prescribing in Secondary Care Service



Service Delivery

Figure 3 demonstrates the service delivery pathway. Once referred to the service, an allocated Link Worker contacted the patient and carried out a holistic assessment within four working days. This could be within the hospital, in a GP practice or at a convenient office location nearby. The service provided non-clinical support via up to eight one to one sessions. This is consistent with what has been offered successfully in Family Action's Social Prescribing in Primary Care Service model (and other Social Prescribing services in general). Sessions were delivered in person or over the telephone as required.

Referrals were received for anyone in secondary care or who was discharged from hospital within the last three months (six weeks for parents of discharged children), provided that they were not:

- experiencing a mental health crisis
- actively suicidal e.g. have a plan in place
- severely harming themselves
- individuals with complex needs who require specialist support
- at risk of hospital admission owing to the high/complex level of need

Figure 4 demonstrates the timelines involved in the delivery of the service. This timeline does not include actions undertaken to implement the service before delivery began. This can take up to three months; however, this time scale was substantially shortened for this pilot as existing office space and relationships with hospital staff from Family Action's Social Prescribing in Primary Care could be used. Please see the How to Guide for Social Prescribing in Secondary Care for more detail on these implementation activities.

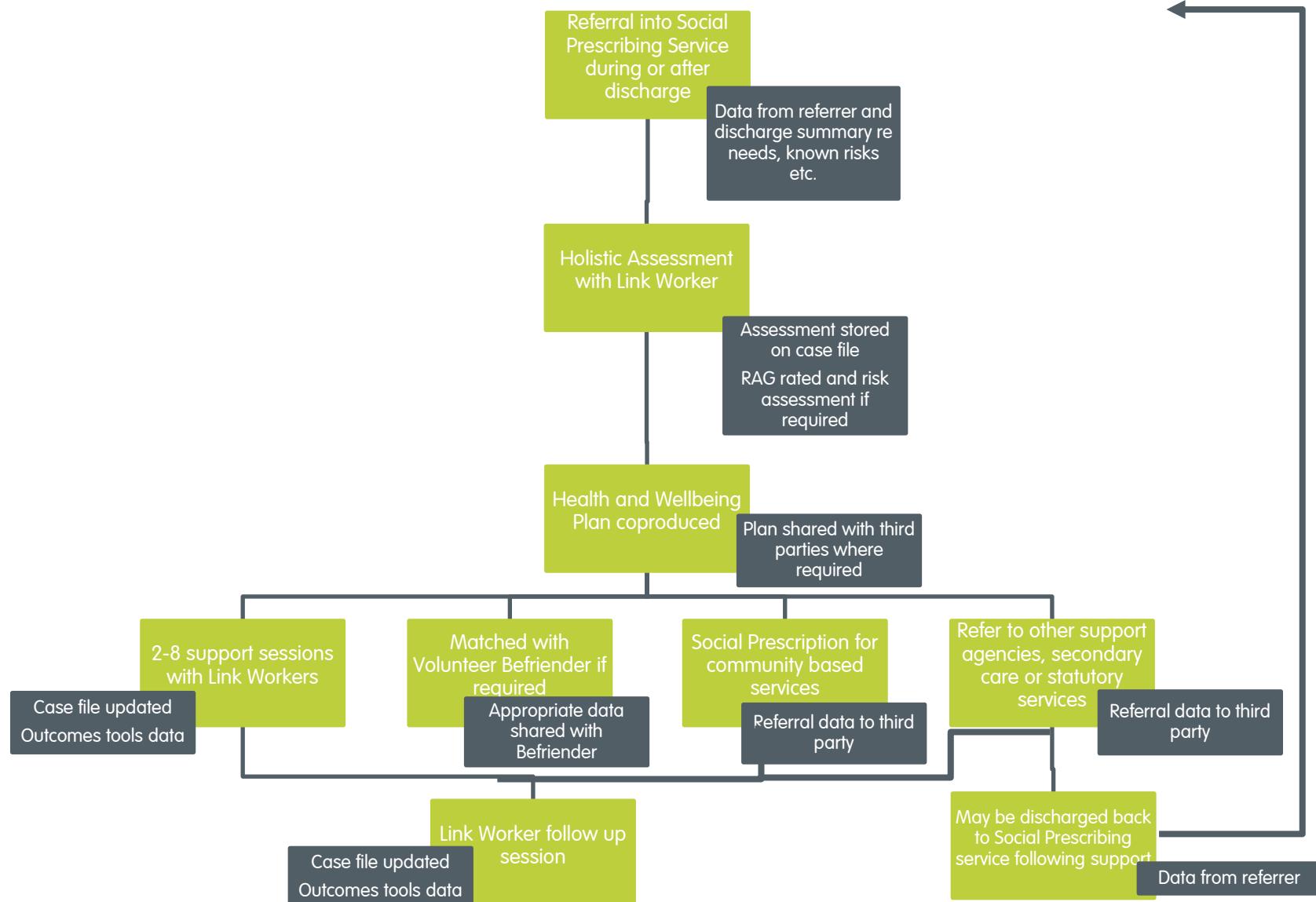


Figure 3: Social Prescribing in Secondary Care Service delivery pathway

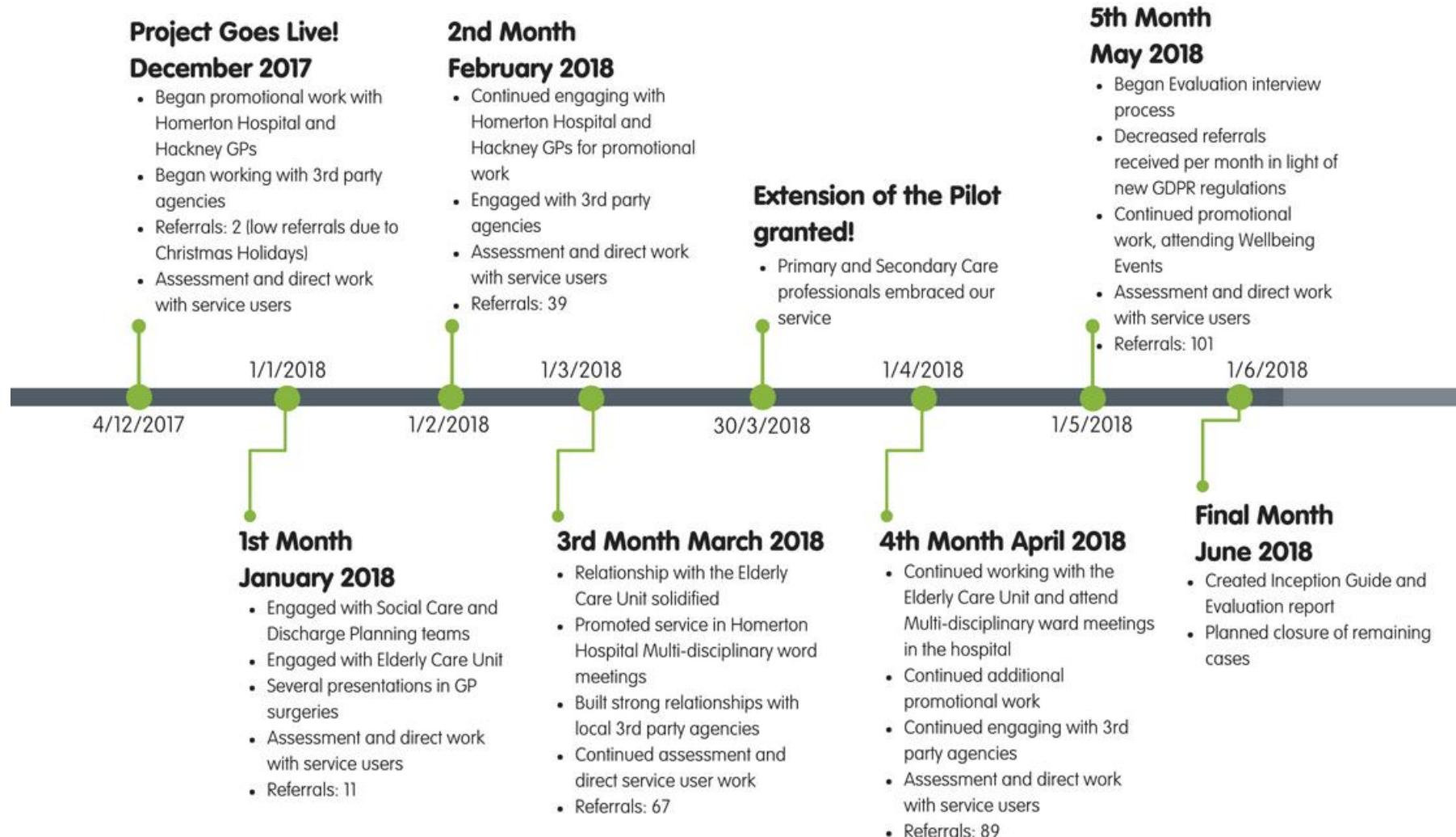


Figure 4: Service delivery timeline

Safeguarding

The expected complex needs required comprehensive risk assessment and safeguarding processes. As part of the assessment process, Link Workers asked the safeguarding questions:

- Has the client been a victim of violence?
- Has the client been a perpetrator of violence?
- Has the client been a victim of any other harmful practices or violence?

If the answers to these questions, and any others from the assessment lead to a case being RAG (red, amber, green) rated amber or red, this required a full risk assessment to be carried out. Risk assessments included what the risks were, who was at risk, and any action taken in order to manage the risk(s). Risk assessments were submitted to the Service Manager for approval, and added to the case file. These were reviewed quarterly, as well as at any time there was a change in risk. With red cases, relevant social services were contacted to make sure they are involved. Concerns were also shared with any third party organisation that was known to be involved with the service user. Staff were able to contact a senior member of Family Action staff on call 24 hours a day, seven days a week if required.

In terms of RAG rating, the service followed these guidelines:

- GREEN: where there were no identified safeguarding concerns (all cases were considered green at point of referral before an assessment was carried out)
- AMBER: where there were some concerns about a case and it needs to be monitored very closely in case of a need to escalate
- RED: where a case already had social services involved and there was significant concern e.g. a referral had been made to children's social care for a Section 47 enquiry, which had resulted in a Child Protection Plan or a safeguarding alert has been made for an adult suffering from abuse

The service did not have any serious case issues, demonstrating that the safeguarding processes in place appear to function efficiently. Lori's amber rated case study demonstrates how risk may be involved in the cases we worked with and how it was managed.

Case Study: Service User

(names have been changed to protect anonymity)

Lori is 91 years old and was admitted to the Elderly Care Unit (ECU) alongside her husband following a fall. Whilst they were both in the ECU her husband sadly died. When Lori was discharged home, her daughter Mary was worried that Lori could not manage alone in her home even though she has carers, including her nephew Stephen, who is her primary carer. Lori was housebound and Mary was also feeling overwhelmed, especially as she was concerned that Lori did not always allow carers to wash her. Family Action was concerned that there was a risk that, despite Lori having mental capacity, Mary would make decisions for her without her consent. Family Action mainly provided support over the telephone to Mary to manage her anxiety and met with Stephen on a one to one basis. Stephen was referred to Hackney Carers Centre and Lori was assigned a floating support worker to help her complete benefits and parking pass applications to enable others to take Lori out of the house. Mary now feels that things are 'slowly coming together.'

Staffing

The service was run by a Hackney Services Manager and a Social Prescribing Service Project Manager, both of whom are well qualified and have several years in management and frontline experience. The Hackney Services Manager oversaw the operational and strategic management of the service, whilst the Social Prescribing Service Project Manager was responsible for the delivery and direct line management of the Link Workers and Volunteer Befrienders. The Hackney Services Manager has qualifications in Social Care and Systemic Family Therapy. She has also developed service models and established relationships with CCGs, GP Confederations, and services across the system. The Social Prescribing Service Project Manager is an experienced counsellor with supervisory responsibility and extensive knowledge about services across City and Hackney CCG. She is also knowledgeable about the issues commonly affecting Social Prescribing service users.

The two Link Workers had a therapeutic, social care or health qualification/background, with experience working holistically to offer support on practical and emotional issues. They also had a sophisticated understanding of Social Prescribing and coordinated the menu of support for each service user. The Link Workers facilitated quality partner and joint working between care staff and a wide range of voluntary and community groups, as well as local government. Each service user had access to an individual Link Worker attached to their case, and a Volunteer Befriender where required. Link Workers delivered services to patients at the hospital, or a local community centre for those who were able to visit it. Link Workers had a strong presence at Homerton University Hospital but their office was not based there due to lack of space. Where appropriate, Link Workers worked with clinical leads to agree on activities in the Social Prescription.

Volunteer Befrienders

Family Action has a long and established history of volunteering; our beginnings were shaped and determined by volunteers. All volunteers are provided with a written role description, outlining the purpose, tasks and main expectations of their role. They receive training via e-learning and face-to-face sessions on safeguarding, confidentiality and data protection.

The Volunteer Befrienders provided support with engagement and added value to the capacity and quality of service. Volunteers were matched to a service user with consideration of language (where possible) and other specific requirements such as gender and/or availability. Each Link Worker was able to support six volunteers. For the pilot project, as a result of limited implementation time and the length of time required for safe recruitment, volunteers were shared with the Family Action's Social Prescribing in Primary Care Service. For this reason, the number of volunteers supporting the Social Prescribing in Secondary Care Pilot Service cannot be stated. The Social Prescribing in Primary Care Service has a range of volunteers from diverse backgrounds, 80% of whom are female and 20% male. Most of the volunteers have experience in working in social care, are training to be counsellors/psychotherapists or have another related qualification.

Service User Profile and Service Outputs

Referrals received by the service

Up to 25th May 2018 the service had received 102 referrals, 53 of whom went on to become active clients for whom a support plan was coproduced with (Figure 5). The lower number of active cases

compared to referrals is owing to inappropriate referrals and a high level of disengagement by those who had been referred – of the 67 cases where a case closure type was recorded, 55% were closed because of no engagement (Figure 6). However, once patients started to use the service, only 9% disengaged. In a small proportion of cases, no engagement or disengagement was a result of the patient passing away. In some cases, the service user may have disengaged because they were not able to communicate directly with the service owing to their medical needs. In these cases, we offered support to family members instead to support them. Work with family members was not entered onto the case management system as an active case.

There was a rise in referrals until March 2018, suggesting that as staff involved in secondary care became more familiar with the service's purpose, they increased their referrals. This took approximately two months. The peak in active clients matching this also suggests that these referrals were appropriate and that service users wished to engage. The particular peak in referrals in March may also be related to a period of severe cold weather at the end of February and beginning of March, which is likely to have led to an increase in hospital admissions, especially among the elderly. This would have placed extra pressure on secondary care staff, but referrals may not have been appropriate or service users not willing to engage, as the number of active clients does not peak to match this. The decrease in referrals and active clients immediately before May 2018 may be the result of the new General Data Protection Regulation (GDPR), which caused some concerns with secondary care staff about data they were able to share for referrals.

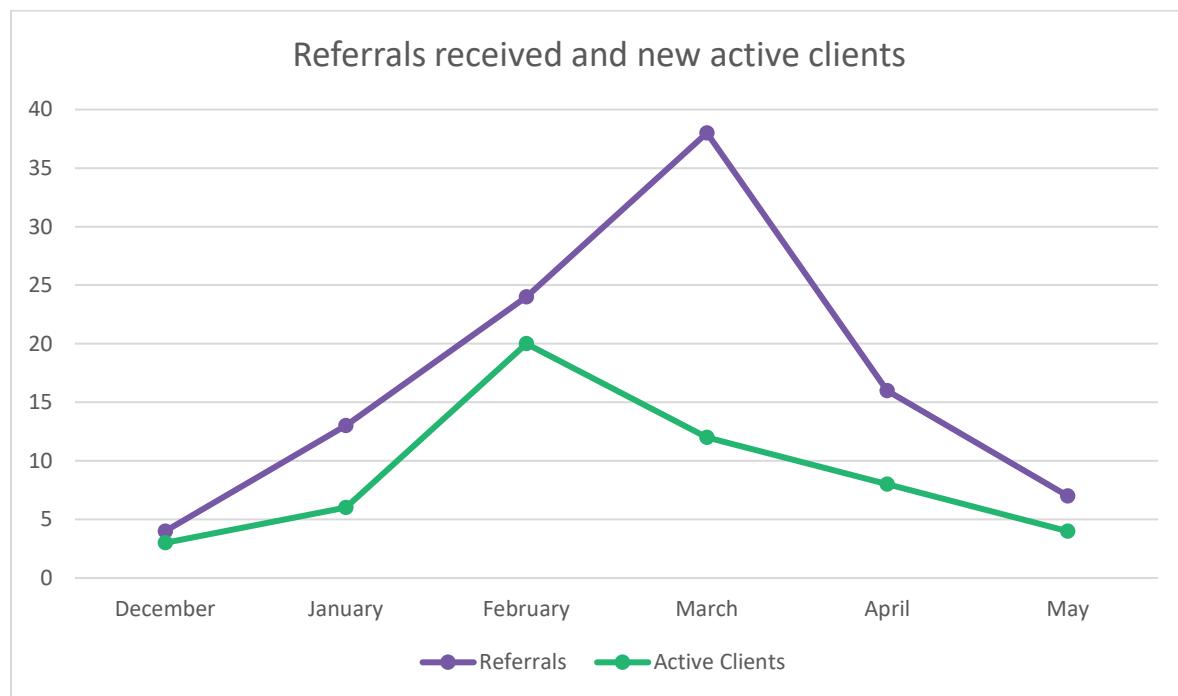


Figure 5: Referrals received and new active clients December 2017 to May 2018

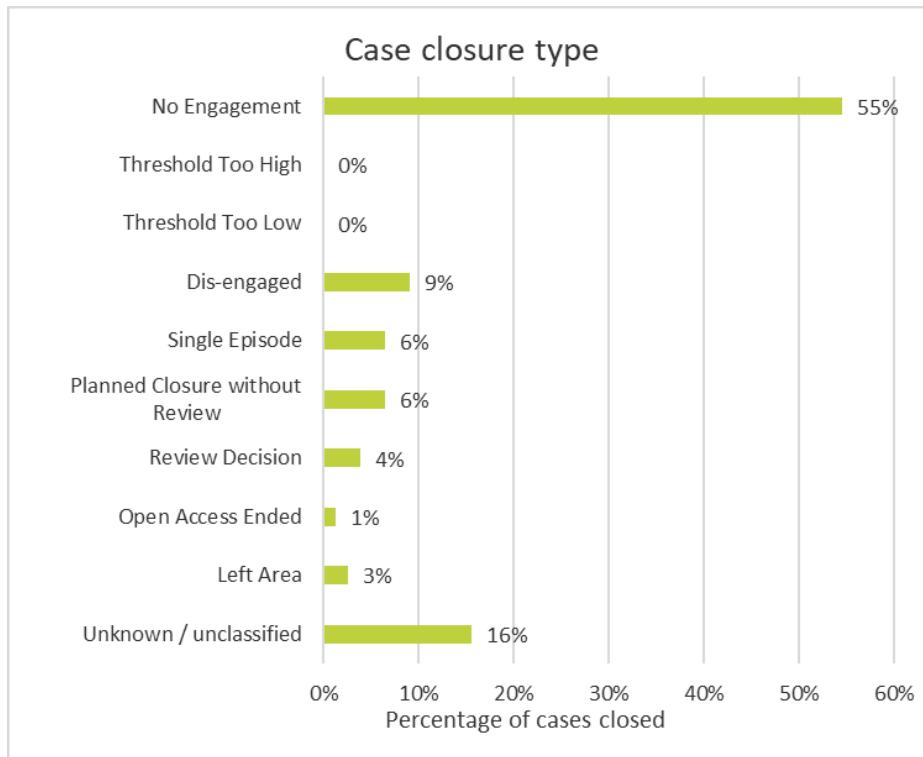


Figure 6: Case closure type

Demographics of service users

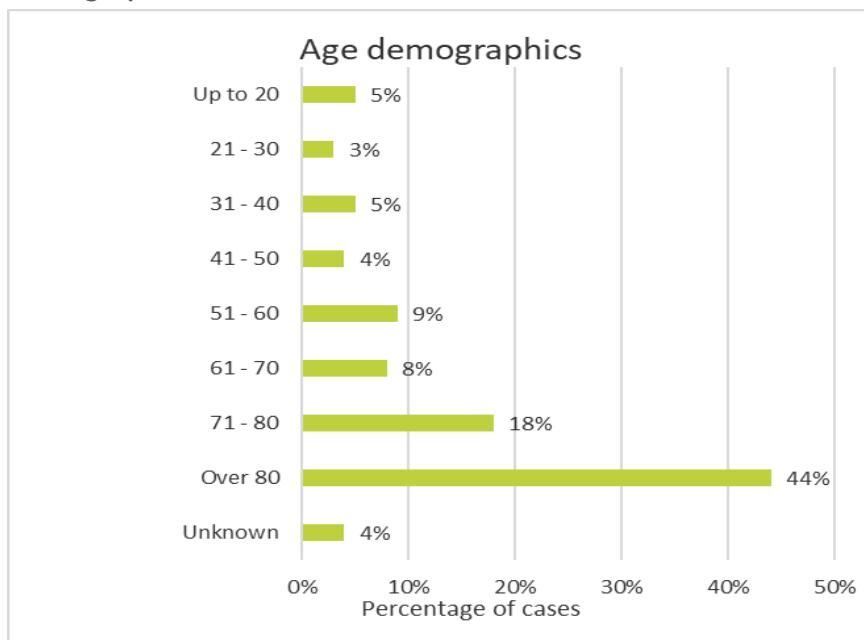


Figure 7: Age profile of service users

The service was most commonly supporting those aged over 80 (Figure 7), though a broad range of age groups accessed the service. The service also supported a nearly even amount of men and women (Figure 8, the remainder were unrecorded). This is unusual in comparison to other Family Action wellbeing support services, indicating that the service may have met unmet need from male service users. This would need to be examined in relation to the age and gender of those

accessing Homerton University Hospital to know if this data reflects that the service ensured equality of access for all.

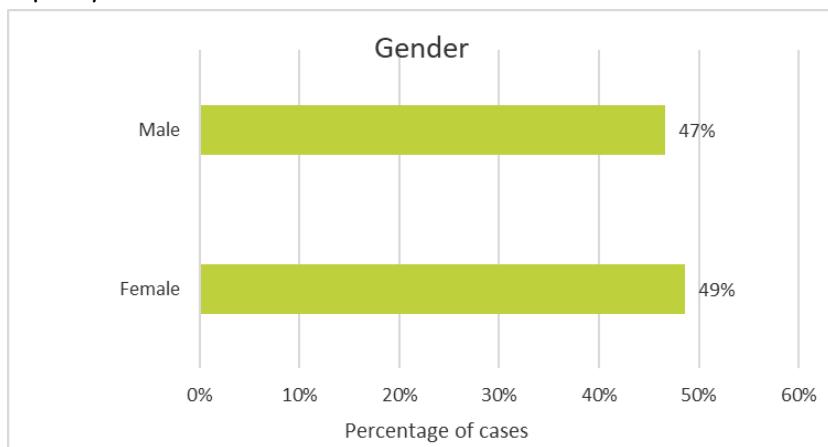


Figure 8: Gender profile of service users

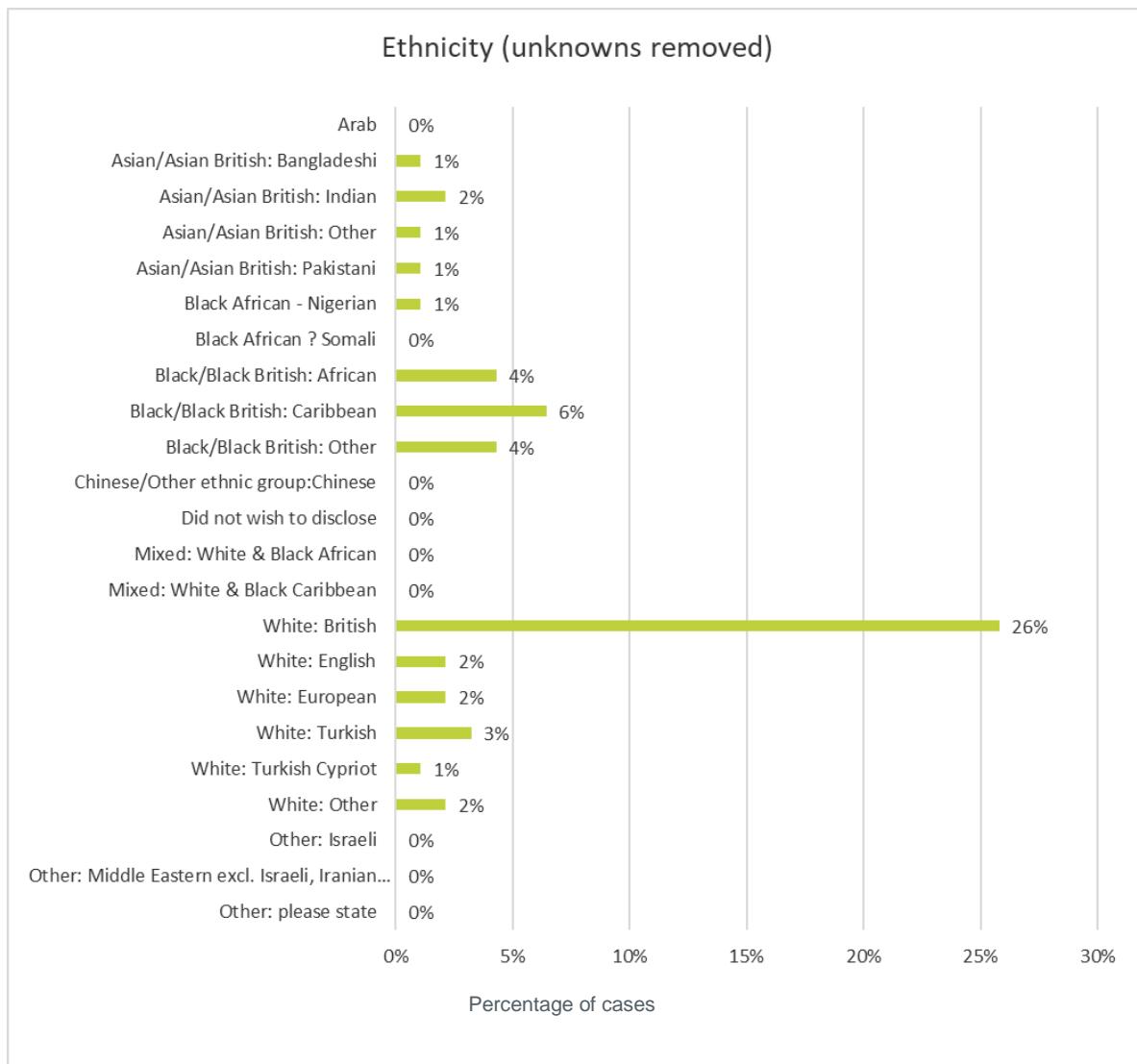


Figure 9: Ethnicity profile of service users

Of those service users where ethnicity was recorded, the majority were White British (Figure 9). This reflects that the largest ethnic group in Hackney according to 2011 census data is White British (Table 1). However, the statistics for other ethnic groups were lower than might be expected given the 2011 census data. This might suggest that more work would need to be done to ensure that everyone could access the service equally, however it is impossible to be certain if this occurred due to ethnicity not being recorded in all cases. Key learning from service delivery is that language barriers may mean a service user is less likely to self-refer, and when referred by a healthcare professional is reliant on their carers/other translators to understand the purpose of the service and help them choose whether to engage. There may be cultural barriers involved in understanding the purpose of the service in relation to medical models, which are understood. Fewer referrals may also be received from healthcare professionals if language and cultural barriers mean they have not been made aware by carers or the service user of the other issues that the service user faces.

Table 1: Ethnic Groups in Hackney – 2011 Census Data¹²

Ethnic Group	Percentage of Hackney Population
White	54.7
British	36.2
Other white	16.2
Irish	2.1
Gypsy or Irish Traveller	0.2
Black/Black British	23.1
African	11.4
Caribbean	7.8
Other	3.9
Asian/Asian British	10.5
Indian	3.1
Other	2.7
Bangladeshi	2.5
Chinese	1.4
Pakistani	0.8
Mixed	6.4
Other	2.0
White and Black Caribbean	2.0
White and Asian	1.2
White and Black African	1.2
Other	5.3
Any other ethnic group	4.6
Arab	0.7

¹² Office for National Statistics (2011) Census data UK Available from: www.ons.gov.uk/census/2011census

Needs at referral

The experience of this pilot has highlighted the complex profile of many people who present to A&E with underlying social issues, which was expected from the Theory of Change. Many cases involved some combination of social isolation, issues with benefits and housing, low level mental health problems, such as anxiety or stress, low confidence, and a history of little or no engagement with (or access to) appropriate care and support (interview data and Figure 10). Anecdotally, people are also more likely to have reached a crisis when they present to secondary care, meaning that support is likely to be needed over an extended period of time, and staged in a way that helps people to rebuild their confidence and willingness to engage with support. While this may not be the sole responsibility of the Social Prescribing Service (for example, service users will be referred to other support services in the community that provide longer term support), it does reinforce the need to be clear about what Social Prescribing can offer – and for whom – within the context of a complex service user profile and high levels of need.

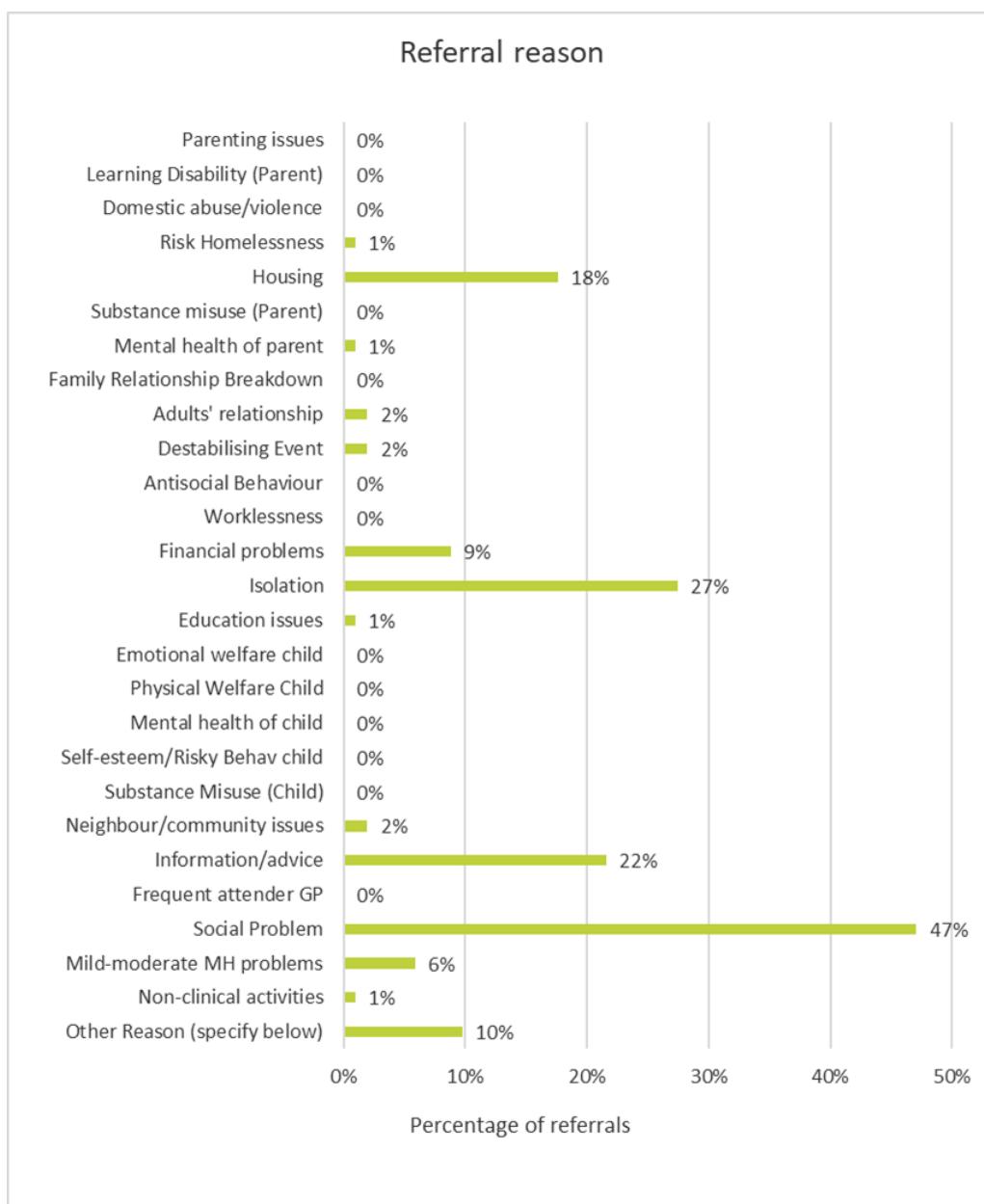


Figure 10: Reasons for referral to the Social Prescribing in Secondary Care Pilot Service

Social Prescriptions

The service produced a total of 550 referrals (social prescriptions) to other organisations from December 2017 to May 2018 (Figure 11). The top ten organisations most commonly referred to for the Social Prescribing in Secondary Care Pilot Service and Family Action's Primary Care Social Prescribing Service are detailed in Table 2, and the full list of organisations is in Appendix 2. It can be seen that the organisations most commonly referred on to by the Social Prescribing in Secondary Care Pilot Service match the support needs most commonly required at referral.



Figure 11: Referrals received by the service and the number that became active clients, average length of time service users engaged with a Link Worker and referrals made by the service to other organisations

Table 2: Top ten organisations referred on to by Family Action Social Prescribing Services in Hackney

Primary Care Social Prescribing	Secondary Care Social Prescribing
New Age Games	Outward
Wellbeing Network	Health Coaches
One You Estate Based Activities	Single Homeless Project
Health Coaches	Hackney Advice Service
Hackney Volunteer Centre and Step-up	Wellbeing Network
Hackney Advice Service	Core Arts
Family Action WellFamily Plus	Age UK
Core Arts' Core Sport	Community Supporters
Redmond Community Centre	Connect Hackney
IAPT Psychological Services TalkChanges	City and Hackney Carers Centre

It is interesting to note the differences between which organisations were most commonly referred on to as part of social prescriptions in the Primary Care and Secondary Care Social Prescribing services that Family Action ran. Social Prescribing in Primary Care service users are usually physically in a position to attend activities, such as New Age Games. They also commonly have mental health support needs, reflected in the referrals to psychological therapies, Wellbeing Network, and WellFamily Plus. They are also often interested in volunteering. Service users from the Social Prescribing in Secondary Care Pilot Service were more often referred to organisations that support elderly people, had a greater demand for befriending and required more support for carers. This is to be expected given the differing age demographics of the two services.

Service duration

The majority of service users only waited up to five days to become an active client following referral, with the average length of time being 3.6 days (Table 3). This demonstrates the efficiency of the service and the opportunities for the service to work closely with the hospital Discharge Team and Age UK's discharge support, as service users do not face a long wait to receive support at this time. Of those who became active clients, the average length of support was 48 days (approximately seven and a half weeks), with the highest number of service users receiving support for more than 75 days, though there was a fairly even spread between the lengths of service received (Figure 12). Of the 33 service users who did not disengage part way through support, the average length of support offered was nearly seven weeks, with 60-75 days and up to 14 days service duration being most common. This demonstrates the varied complexity of the cases supported, as well as the likely efficiency of Social Prescribing at meeting a wide range of needs and making a difference. Seven weeks is not a long service duration in order to achieve outcomes for people who otherwise may continue to demand secondary care as a result of the non-medical cause of their issues not being tackled earlier. Ketifa's case study gives more detail on what support from the service may have entailed for an individual.

Table 3: Average time from referral until active client (does not add to 100% owing to rounding)

	Number	Percentage
0 - 5 days	45	87%
6 - 10 days	2	4%
11- 15 days	1	2%
16 - 20 days	1	2%
21 - 25 days	0	0%
More than 25 days	3	6%

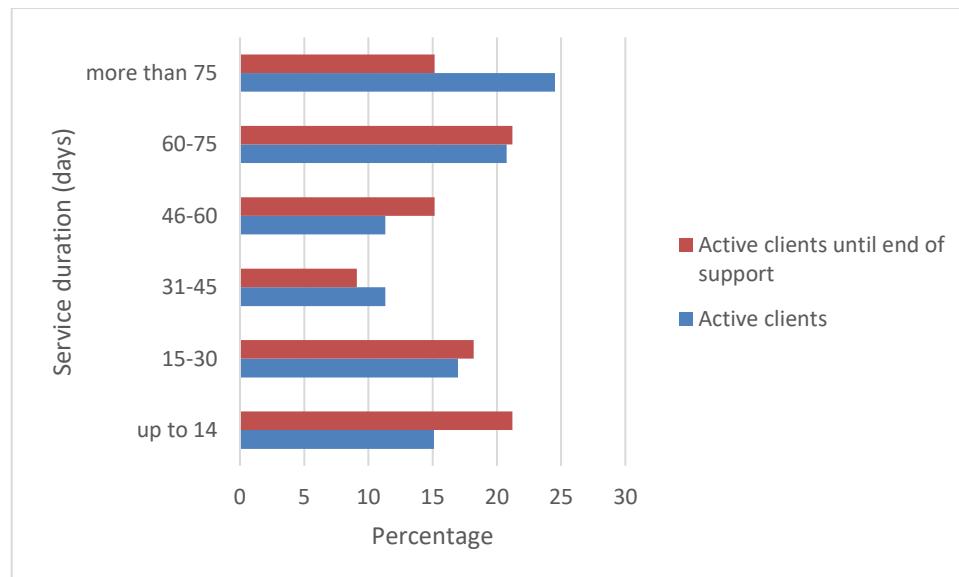


Figure 12: Service duration for all service users who became an active client, compared to service users who became active clients and completed support

Case Study: Service User

(names have been changed to protect anonymity)

Ketifa is in her early 80s and was referred to the service by the Homerton University Hospital Elderly Care Unit with concerns about her social isolation. Ketifa does not speak English and her daughter was worried about how socially isolated Ketifa was. Ketifa used to have a house filled with family and friends who would visit regularly, and she used to love cooking and entertaining them. Unfortunately, this is not the case anymore.

Ketifa was matched with a Link Worker who helped her find a Befriender that spoke the same language, and she was also signposted to the Turkish Cypriot Women's project in Hackney. Ketifa is delighted to have some company and her daughter thinks that her Befriender is a 'really good person'. Ketifa now has something to look forward to every week.

Service User Outcomes

In 35 cases where it was recorded whether goals were met, of these 52% of service users partly or fully met their goals (Figure 13). It is not surprising that many service users did not meet or only partially met their goals given the short timescale over which service delivery ran – if the average length of service delivery is over seven weeks, and longer for those service users who stay engaged, there are likely to be a number of service users who were working towards achieving goals, but had not met them yet when data was extracted for this report. The high level of disengagement will also affect these figures. It can be seen that a large variety of different outcomes were achieved on the Outcomes Framework for the service (Figure 14), indicating that the service was able to have a wide impact on factors affecting the lives of service users. The most common outcomes achieved relate to being involved in decisions around support, forming positive new friendships, being supported to manage finances and receiving support around physical health. This supports the expected outcomes of the Theory of Change around improved wellbeing, reduced social isolation, and increased ability to access alternative support. These outcomes were also commonly seen in case studies (Appendix 4). The service was not able to access NHS data on A&E attendances, GP appointments or number of bed days for the service users we worked with, however the Theory of Change would suggest that this improved wellbeing, reduced social isolation and increased ability to access alternative support could lead to reduced demand across healthcare services.

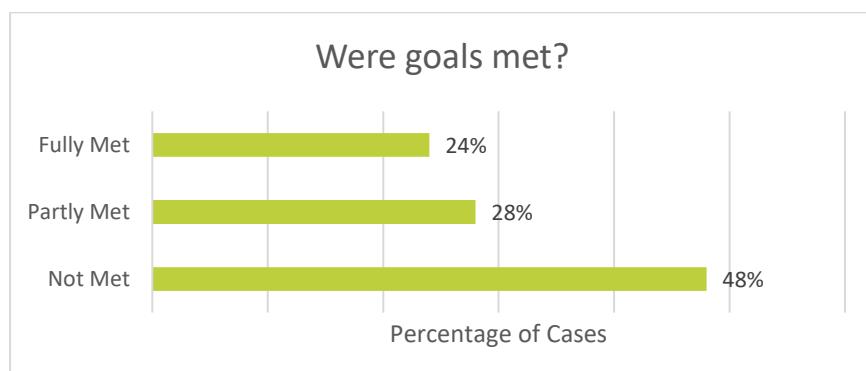


Figure 13: Percentage of goals met by service users where recorded

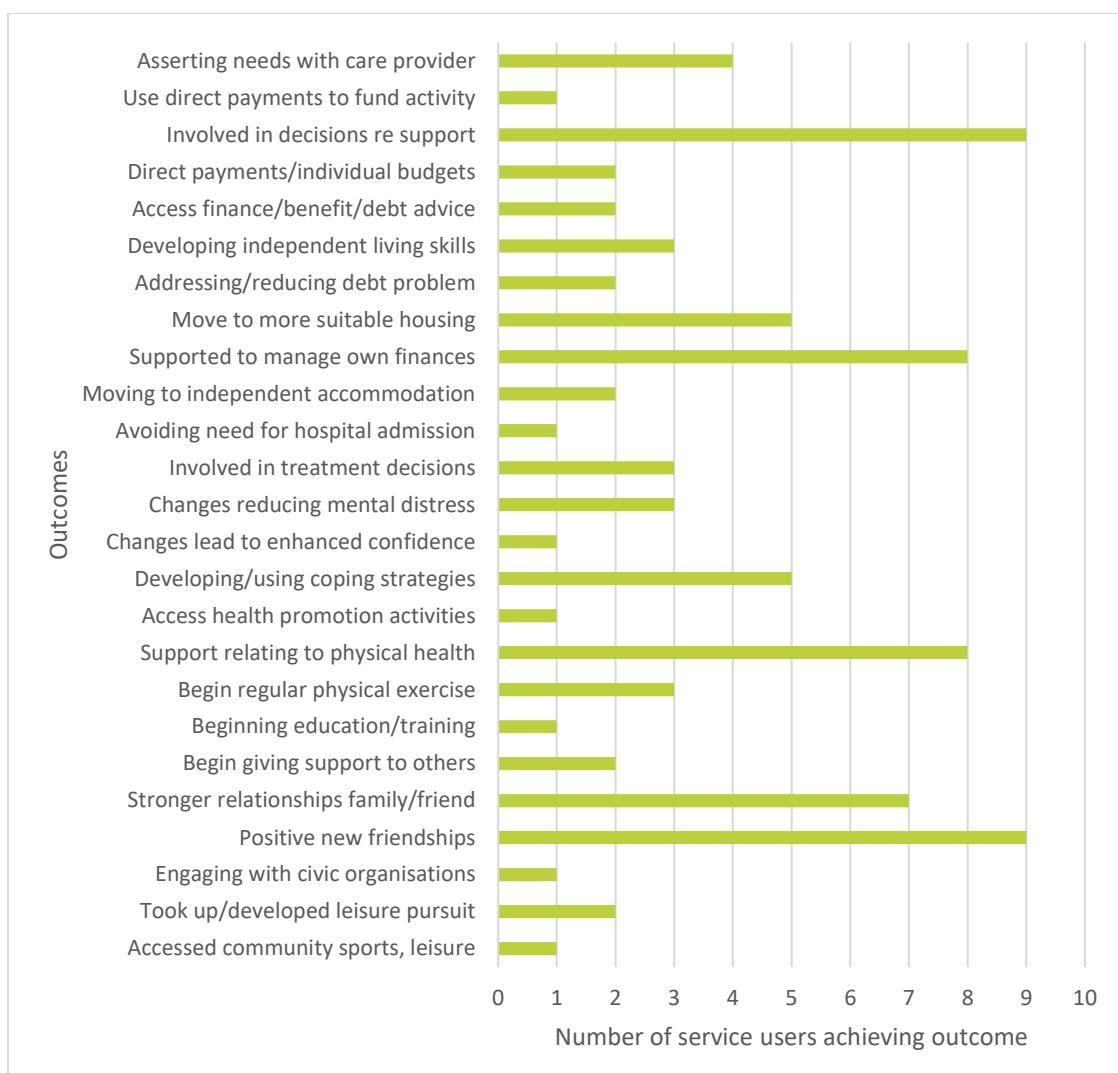


Figure 14: Outcomes achieved on outcomes framework for all referrals

Some of the outcomes achieved on the Outcomes Framework are also evident in the changes to Well-being Star scores, such as improvements around finances and support related to physical health. Where appropriate, the service used the Well-being Star to measure progress for service users. The Well-being Star uses a five-point scale – starting at ‘one’ where people may not have got to grips with their health condition, through to ‘five’, where people are doing everything they can to manage this aspect of their life well. It is arguably more difficult to make an improvement where someone is scoring lower on the scale initially, as more support is required, and this may take a longer period of time for the service than the pilot time period has allowed for. Therefore, only Well-being Star scores where the initial score was less than three (which indicates the point at which people are starting to make positive changes) were analysed (Figure 15). ‘Feeling positive’ was the biggest improvement, with ‘looking after yourself’ and ‘money’ common improvements too. This chart also shows that ‘managing symptoms’ and ‘lifestyle’ have seen noteworthy improvements in scores.

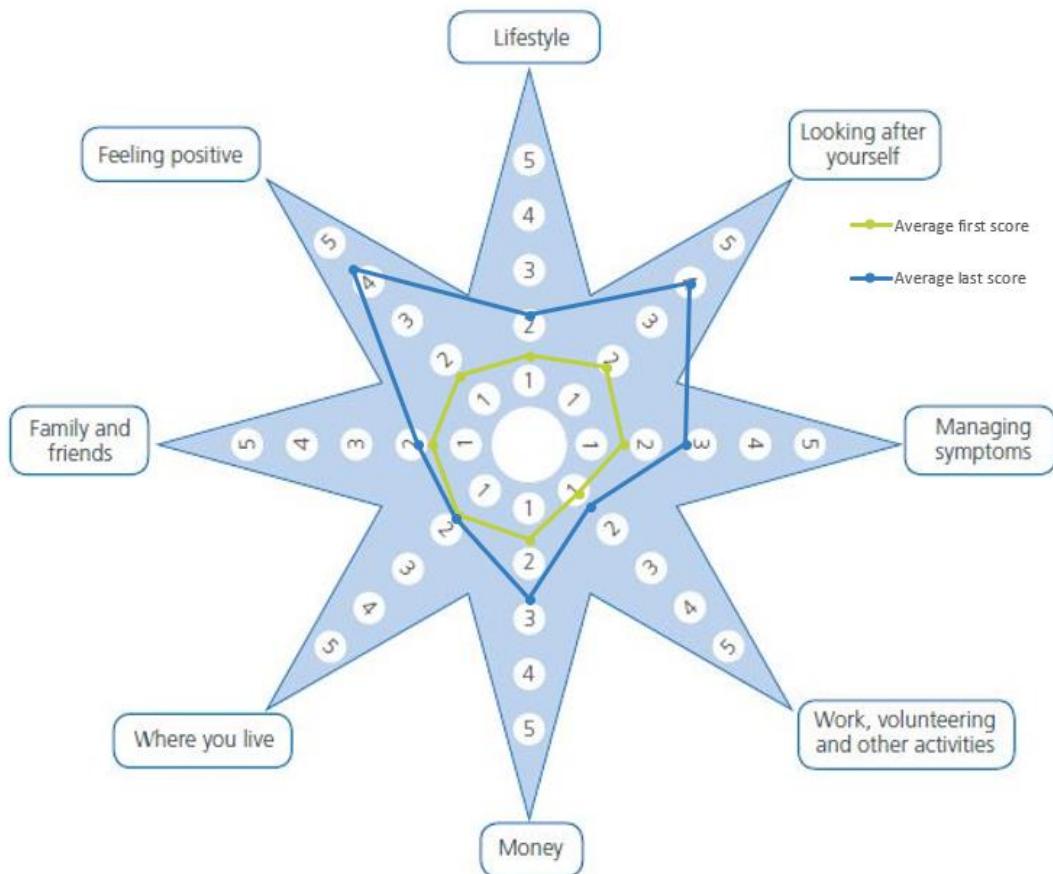


Figure 15: Well-being Star scores where initial score was less than three

Some of the outcomes achieved on the Outcomes Framework seem to be more common than the size of the change in Well-being Star would suggest. For example, the Outcomes Framework has ‘positive new friendships’ and ‘stronger relationships with family’ as common outcomes for service users, whereas this was only a small change within Well-being Star scores for ‘family and friends’. The underlying reasons for this would need to be explored further in any future service delivery, as this may simply relate to the length of time that Well-being Star scores could be collected. A decrease in final scores is also often seen when a service user is anxious about coming to the end of support, though this may be less true of Social Prescribing where service users go on to access other activities and support options.

Overall, the service staff feel that they have supported many people to become more independent, but that more time is needed to consolidate the work done to date and explore how Social Prescribing can work most effectively, and in a more integrated way, across both primary and secondary care.

Joseph’s case study demonstrates how he achieved some of the outcomes seen above with the support of the service.

Case Study: Service User

(names have been changed to protect anonymity)

Joseph is an 82 year old man who lives with his 79 year old wife Veronica. Both Joseph and his wife suffer from various health conditions and disabilities. Veronica has osteoarthritis in her knees, hips and shoulders, meaning that she is unable to carry out daily tasks.

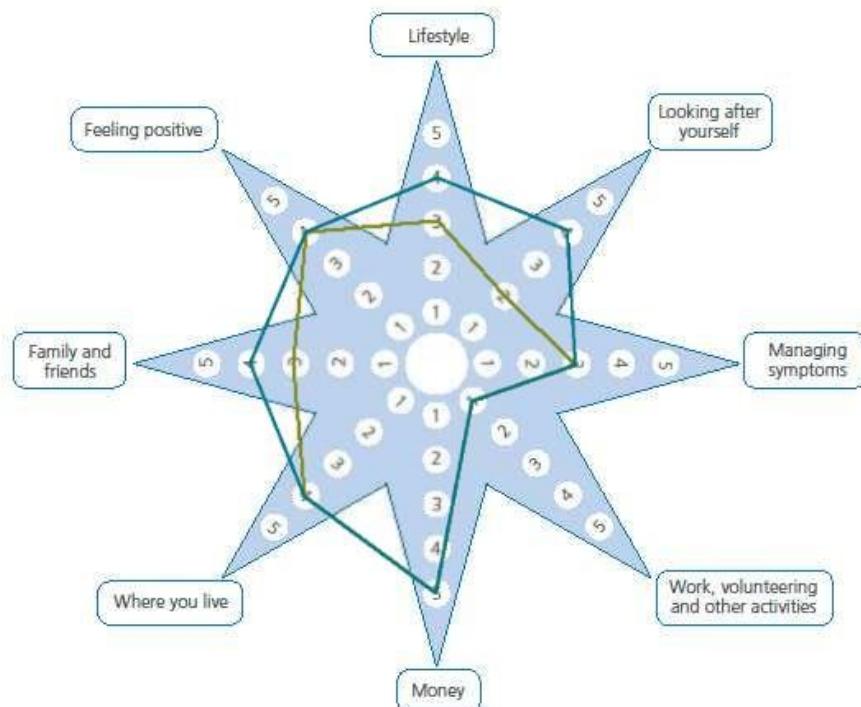
Joseph suffers from many disabilities and other health conditions such as diabetes, high cholesterol, anxiety and a prostate tumour. He visits the hospital for regular appointments and has been admitted on more than one occasion.

With the help of their Link Worker, Joseph and Veronica applied for a taxi-card and have been using this to attend their GP appointments and do regular shopping. Their Link Worker facilitated a referral to Department of Work and Pensions (DWP) home visiting team to help them apply for Attendance Allowance. This was awarded to them with a higher rate than expected, which allowed them to employ a weekly cleaner who irons their clothes and cleans the house. Veronica has started attending coffee mornings and training workshops at the Carers Centre, and Joseph has been matched with a Befriender who visits him regularly, helping them both to feel less socially isolated.

Joseph and Veronica are very grateful for the work of the service, saying that without our help and support they would have been lost.

Well-being Star (@Triangle Consulting):

Green = before service support, Blue = after service support



Wellbeing Value and Unit Costs

Wellbeing Valuation allows organisations to measure the success of a social intervention by how much it increases people's wellbeing. In order to estimate the potential value generated by the service, 14 individual case studies of people who had received some form of support from a Link Worker during the period of the pilot were selected as a sample and entered into the HACT Wellbeing Value Calculator version 4.0¹³. Further details of the methodology can be found in Appendix 1.

Allowing for deadweight (typically considered to be the outcome and its associated value that might have been generated without any intervention), a total of £22,965.48 per annum of wellbeing value was generated from the outcomes for those 14 service users as a result of the support provided through the service. This is equivalent to an average of £1,640.39 per person per annum.

However, it should be noted that eight of the 14 case studies in the sample were at too early a stage for the outcomes involved to have a value calculated for them. If average wellbeing value is calculated only for the six service users who achieved an outcome that could be costed, this equates to £3,827.58 per person per annum.

The outcomes that have a value attached typically relate to support to be more active, support with finances and/or housing, and support to increase social contact. Full details of the calculations can be found in Appendix 3. Full text of the case studies used, like Afua's below, can be found in Appendix 4.

The value generated needs to be put against the estimated unit cost of delivering the service in order to arrive at a net benefit. The service had a budget of £55,000 for implementation and delivery and 52 active clients, leading to a unit cost of £1,038. However, it must also be taken into account that the service ran for only a short time, which bears the same implementation costs as a longer running service. Implementation costs are impossible to separate from delivery costs for this pilot, and therefore it is not possible to estimate what the unit cost may be for an ongoing service where a case worker has a full caseload. In addition to this, the service received a number of referrals for clients that did not engage, which required time to follow up. Direct delivery costs per active client will therefore reduce over time as the service becomes more embedded into Secondary Care systems, leading the majority of referrals to be appropriate and the service well communicated to clients.

It is important to note that there is likely to be some bias in the sample, as the case studies tend to reflect typical 'success stories', rather than being representative of everyone who is referred to the service. However, this initial analysis does give a level of confidence that a Social Prescribing in Secondary Care Service has the potential to generate social value with short-term intervention, despite a complex service user profile.

¹³ HACT (2014) *Measuring the Social Impact of Community Investment: A Guide to using the Wellbeing Valuation Approach*. Available from www.hact.org.uk/value-calculator

Case Study: Service User

Afua is in her late 50s and finds it difficult to do tasks requiring the mobility of her arms, such as washing herself and cooking. She also suffers from diabetes and high blood pressure.

Afua had initially requested support with her Personal Independence Payment (PIP) application, however, after forming a trusting relationship with her Link Worker, she opened up about feeling socially isolated, and disclosed that she was illiterate and would like to learn how to read. Afua's Link Worker referred her to Health Coaches, Read Easy Hackney and New Age Games for chair based activities.

Now, Afua has been offered an assessment to start working with Health Coaches, will start a reading course in September, and is waiting to start her chair-based activities. She was also supported with filling out her PIP application and passed the Employment and Support Allowance medical assessment, meaning that she now receives benefits that she is eligible for.

Afua is excited about her future, and happy that it is looking different from before. She is also looking forward to becoming more involved socially and hopes that by learning how to read this will make her more independent in the community.

The case studies also show that there may be the ability to shift resource within primary, secondary and social care as a result of the Social Prescribing in Secondary Care Service. Savings may be achieved through:

- Reduced A&E attendances
- Reduced GP attendances
- Reduced hospital bed days through efficient discharge processes
- Reduced social care costs, such as the need for paid care, when service users could be supported to manage their long-term conditions and increase income through benefits and grants, which can then be used to support needs.

Two examples of this resource shift, drawn from similar experiences of typical best and worst case scenarios whilst delivering the service, are demonstrated in Tables 4 and 5. Unless stated, all unit costs are taken from the PSSRU Unit Costs of Health and Social Care 2017¹⁴ and do not include London weighting. Although further work would be needed to estimate a total figure for the resource shift, it can be seen just from one instance of each contact alone that there are resource savings alongside a much simpler process of engagement for the service user.

¹⁴ PSSRU, University of Kent (2017) *Unit Costs of Health and Social Care* available from <https://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2017/>

Table 4: Example case with and without Social Prescribing in Secondary Care Support

Example case without Social Prescribing Support	Associated average costs	Example case with Social Prescribing Support	Associated average costs
Terry is 77, has high blood pressure and often suffers from falls. He is not doing any activities that may help him to manage his condition better at home, and feels lonely and isolated from others.		Terry is 77, has high blood pressure and often suffers from falls. He is not doing any activities that may help him to manage his condition better at home, and feels lonely and isolated from others.	
Terry attends A&E following another minor fall. Once he is treated overnight, Terry is sent home. Social care is not informed.	Non elective inpatient stay (short) = £628	Terry attends A&E following another minor fall. Once he is treated overnight, Terry is sent home. Social care is not informed.	Non elective inpatient stay (short) = £628
Terry's management of his condition does not improve and he returns to A&E. This time he needs to be admitted for treatment. His discharge is delayed whilst support from social care is put in place.	Ambulance – see, treat, convey = £246 Non elective inpatient stay (long) = £2953	Terry's management of his condition does not improve and he returns to A&E. This time he needs to be admitted for treatment. When he is nearing discharge, clinical staff refer him to the Social Prescribing in Secondary Care Service.	Ambulance – see, treat, convey = £246 Non elective inpatient stay (short) = £628
Once Terry is discharged, he receives support in his home from social care every week.	Social care support = £169 per week	The service assists with discharge plans, meaning that Terry is discharged more quickly. Once he is discharged he receives support from the Social Prescribing in Secondary Care Service to attend activities that will help him to relax, increase his coordination and muscle strength and meet people. He also receives support from social care once a week.	Social Prescribing in Secondary care service cost per service user ¹⁵ = £1038
However, he is still lonely and frequently attends his GP surgery in order to have someone to talk to. The GP recommends that he undertakes activities that will strengthen his coordination and help him	GP consultation = £37	Terry engages well with the service and sees an improvement in his condition. It is agreed that he no longer needs support from social care.	

relax, but does not have access to a Social Prescribing service to refer Terry to.			
Terry does not access these activities himself as he doesn't know how to do so, and is nervous of this. He continues to access the GP, and when his condition worsens as a result of continued poor self-management, he attends A&E again.	<p>GP consultation = £37</p> <p>Ambulance, see, treat, convey = £246</p> <p>Non elective inpatient stay (long) = £2953</p> <p>Social care support = £169 per week</p>	Terry manages his condition well, and only attends the GP when it is necessary to do so e.g. to do standard reviews.	<p>GP consultation = £37</p>
His social care support is increased, and finally it is decided that it would be best for Terry to live in a residential care home to meet his needs.	Residential care home = £1108 per week cost to LA		

Table 5: Example case with and without Social Prescribing in Secondary Care Support

Example case without Social Prescribing Support	Associated average costs	Example case with Social Prescribing Support	Associated average costs
Jasmina is 39 and has moderate depression and social anxiety. She is not doing any activities that may help her to improve her wellbeing as she finds it difficult to leave her house without support. She does not feel able to attend her GP surgery and discuss the problem.		Jasmina is 39 and has moderate depression and social anxiety. She is not doing any activities that may help her to improve her wellbeing, as she finds it difficult to leave her house without support. She does not feel able to attend her GP surgery and discuss the problem.	
Jasmina has a mental health crisis when she does try to go out and is taken to A&E. She is discharged back to her GP.	A&E attendance ¹⁶ = £138	Jasmina has a mental health crisis when she does try to go out and is taken to A&E. She is referred to the Social Prescribing in Secondary Care Service.	A&E attendance ¹⁷ = £138

¹⁶ Department of Health NHS reference costs 2015/16 available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/577083/Reference_Costs_2015-16.pdf

¹⁷ ibid

Jasmina attends her GP to discuss medication. However, she does not find her medication helpful, and still does not feel able to try other activities. Jasmina does not go back to her GP to talk about her difficulties.	GP consultation = £37 GP prescription costs = £29.20 Citalopram 20mg annual cost ¹⁸ = £30.42	Jasmina is offered a befriender to help her to access community activities. She reports an improvement in her confidence and wellbeing.	Social Prescribing in Secondary Care service cost per serviced user = £1038
Jasmina has another mental health crisis and attends A&E again. She is discharged back to her GP, but does not attend, often attending A&E at crisis point instead. This cycle continues.	A&E attendance ¹⁹ = £138 A&E MH liaison services = £196 per contact MH specialist team = £172 per contact Health care support for outpatients and A&E = £859 a year	Jasmina is also able to visit the GP if it is necessary to do so, rather than allowing the situation to escalate to secondary care.	GP consultation = £37
Jasmina is referred to the Community Mental Health Team for extra support	CMHT = £39 per hour		

¹⁸ Regional Drug and Therapeutic Centre Newcastle, Cost Comparison Charts, April 2018 available from: http://gmmmg.nhs.uk/docs/cost_comparison_charts.pdf

¹⁹ Department of Health NHS reference costs 2015/16 available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/577083/Reference_Costs_2015-16.pdf

Healthcare System Outcomes

Relationships with healthcare staff

Since the introduction of the pilot in December, considerable time and effort was spent raising awareness of the service among hospital teams and building key relationships. These included:

- Staff in A&E
- The Integrated Discharge Team
- Non-clinical navigators
- Community Mental Health Team, and
- Inpatient wards (via multi-disciplinary meetings).

Family Action also drew on existing WellFamily and Primary Care Social Prescribing Service networks to support the service implementation - Family Action has been working within City and Hackney CCG's area for over 20 years and has well-established relationships with 43 GP practices and a credible track record.

All of the stakeholders interviewed highlighted the importance of senior buy-in to the pilot, to encourage and support the introduction of new pathways of care, and to fully utilise the potential value that a Social Prescribing Service can offer in this context.

"The hierarchical nature of secondary care, along with the level of staff changes and turnover, means that there needs to be strong leadership and senior buy-in, along with ownership at all levels." – Commissioner

This buy-in was secured at the outset, with senior secondary care clinicians engaged in the design of the pilot and signing up to the project through a letter of support. However, translating this into new or different ways of working at the level of individual clinicians and clinical teams requires considerable ongoing leadership and support, due to the time and resource pressures of healthcare staff. This includes having someone with sufficient seniority who can champion and influence these new ways of working within their department. There also needs to be an ongoing process of collaboration between those delivering the service and the clinical teams to find the right people to refer, and ensure the referral pathway is as straightforward as possible. The Link Workers did a considerable amount of work towards this, but felt that although they were met with general support there could have been more follow-up action.

Case Study: Link Worker

I have worked with the service throughout the pilot. My mornings were dedicated to meeting at the office, following up emails and planning the day. Around mid-day, during the hospital visiting times, I would visit different wards, as well as meet with key people at the hospital, such as the social work team and discharge planning team. I also attended the multi-disciplinary meetings of each ward at the hospital to help professionals identify suitable referrals, or visited GP practices. My afternoon was dedicated to assessments, phone calls to clients and third parties, admin work, and support sessions.

Forging strong partnerships with NHS staff has been paramount to the positive outcomes of the pilot project. We have achieved this by highlighting how our service could ease pressure on healthcare professionals, finding a way to embed it in the hospital system. Initially, we fostered relationships with key people in the hospital's discharge and social work teams, developing their knowledge about our service in the hope of implementing referrals. As this proved to be largely ineffective, we then obtained consent to work with each ward directly. There we informed staff by delivering a series of presentations about our project while helping them identify suitable patients for referrals. We have built relationships with many local support organisations across a variety of sectors who we can socially prescribe to.

We strategically shaped the service offer to reduce the many barriers we initially encountered in embedding the service with healthcare professionals. We tailored the referral pathway to the needs of busy NHS staff, which proved to be more efficient and fruitful. We also obtained permission to attend the hospital's MDM and MDT meetings to help secondary care staff identify potential patients they could refer, and gained access to GP's discharge lists to recognise suitable service users.

In the future, in order to ease some of the pressure on Link Workers, it would be helpful for promotional and marketing work with hospital staff to precede the date that the pilot goes live, in order to make sure that the hospital is on board with embedding the service and facilitating the activities of Link Workers. Furthermore, receiving permission to include our referral form in the hospital's IT system would facilitate and encourage referrals.

The relationship I have developed with my colleagues has been paramount throughout the entire time of the pilot. Having trusted colleagues with whom to discuss the issues I was encountering was a great source of support. I do not know what I would have done otherwise! Receiving supervision from a knowledgeable practitioner was also important, as it helped to deal with the most difficult cases.

Referral origins

It is encouraging that the majority of referrals were received from health practitioners, rather than self-referrals or GP referrals (Figure 16).

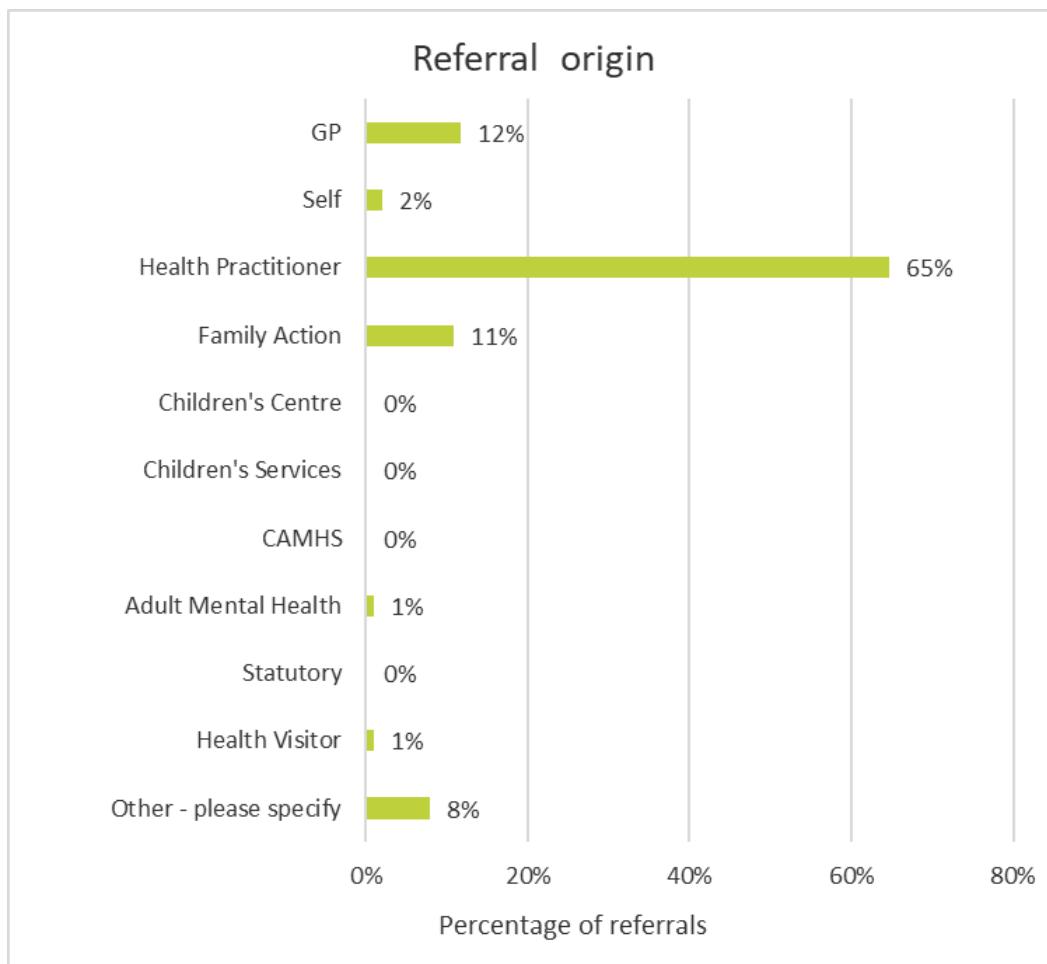


Figure 16: Origin of referrals in to the Social Prescribing in Secondary Care Pilot Service

Health practitioners included Homerton University Hospital’s Discharge Team, Elderly Care Unit (ECU) staff and Social Work team. The most common referral route was via the ECU. It was hoped that more referrals would come from the Discharge team, A&E staff and non-clinical navigators than was actually the case. ‘Other’ referral sources included other voluntary organisations working in the hospital, such as Age UK East London. For this pilot service, referrals from Children’s Centres, children’s services and CAMHS were not expected and no particular secondary care staff teams were targeted to achieve referrals.

Referral process and case management system

Whilst meetings about the service were generally well received by secondary care staff (including the use of individual case studies to help demonstrate the value that the service can offer), referral numbers remained below the level expected when the pilot was introduced. Interviews suggested that this may be the result of the service not being linked in with the hospital system, meaning that it took longer for secondary care staff to submit a referral, and may have ultimately discouraged them given that they work in a time pressured setting. Secondary care staff need access to a simple system of referral that is consistent across teams and provides suitable feedback on service user pathways and outcomes to show the value of the service. In Family Action’s Primary Care Social Prescribing Service, the Link Workers have access to the GP’s system, ensuring referrals and appointments are quickly made, and information and updates included on EMIS are available to Link Workers from the point of referral. A shared case management system also enables

healthcare staff to receive feedback about the support a patient has received. This feedback to healthcare staff enables them to see the value of the service. In the absence of a shared system, regular feedback to secondary care staff via case studies has been beneficial at demonstrating the value of the service. From interviews, it was found that secondary care staff valued this feedback, and would have welcomed a short monthly report with a summary of the needs that were identified by Family Action, the support that has been prescribed, and whether the service user has engaged with that support.

Continuity of care and referral information

Secondary care staff are often working with very little holistic information about a person's medical and social history, and need to make decisions about appropriate care (including ongoing care and support) under pressure. Time that would be needed to fully explore both the presenting problem(s) and any non-medical or social issues underlying these is limited. The nature of staffing within secondary care also means that there is limited continuity of care, unlike in primary care where a person may have multiple contacts with one (or a small number of) clinical staff. This has implications for the appropriateness of referrals, as for secondary care staff, the service may seem appropriate from their limited information on the patient, but there may actually be more complex underlying needs. The size of the clinical team in emergency care, and the multitude of roles, possible pathways, and referral options at the point of care, presented a key challenge for the service and reinforced the need to differentiate this service and provide greater clarity for secondary care staff. Time is therefore required to introduce, embed and integrate the service within the secondary care setting – commissioners will need to factor this in to the length of service delivery contracts, as it has taken the six months of the pilot for the service to start becoming embedded within referral processes.

Healthcare and community sector integration

The experience of the pilot has highlighted that two very different cultures have needed to work together i.e. community and voluntary organisations and clinical acute care. The service needs to consider how the benefits of the service are best communicated to secondary care staff and can continue to be embedded in existing clinical pathways.

Very clear referral criteria, included within hospital systems early on in service delivery may help build confidence and understanding among secondary care staff about who to refer to the service, and differentiate the service from the other referral options secondary care staff have available to them.

"Everyone has been engaged and enthusiastic about the pilot, and its role in prevention – however, the service needs to carve out its niche and the added value it offers." – Integrated Discharge Team

Personalised care and management of long-term conditions are supported by the Social Prescribing model, and this needs to be highlighted to clinical staff in order to maximise the impact of the service and ensure it is linked in to the correct clinical pathways. Secondary care staff may also need support to initiate conversations about the service with their patients where they are not used to discussing social issues with them.

The service can add particular value by being able to consider a variety of needs, however it can also mean that referrals are inappropriate if a person's needs are more complex than can be

catered for. Interviewees felt there was value in the breadth of support that this service could provide, so this should not be narrowed, rather continued promotion of the service's offer and outcomes to secondary care staff is required. In June, service staff saw that continued attendance in person at secondary care staff team meetings was starting to have a beneficial impact on referral figures, with appropriate referrals received more automatically from different teams rather than requiring Link Worker follow up. This indicates that the service was beginning to become embedded in the secondary care system, which would be expected to see improved outcomes for the health system and service users as people are more likely to be referred at the 'right time'. This also indicated that continued promotion would have an impact. Further testing and feedback by secondary care staff on processes to refer to the service and ability of the service to meet expected needs would be beneficial in order to strengthen integrated pathways and ensure they work for different teams. Having enough time in the implementation period to build relationships with key staff and develop strong referral pathways was also discussed within the interviews.

Case Study: Two senior clinical staff members at Homerton University Hospital

The Social Prescribing in Secondary Care Pilot Service at Homerton Hospital has been a good opportunity for us to test whether this type of support can be properly embedded and integrated into an emergency care setting. Since the pilot started in December, we have spent lots of time raising awareness among the clinical team, and finding ways to support our clinical staff to easily identify and refer people who present to A&E with additional, non-medical support needs.

Everyone has been really supportive of the pilot. However, we have a team of nearly 300 working in the department, with regular turnover of staff and the use of locums on a regular basis. This creates a key challenge for us and means that introducing a new service like this will take time to fully embed in our existing work practices and pathways of care. We are also under increasing pressure around what needs to be undertaken by the clinical staff, in addition to the direct patient care they provide, within the four hour target period.

To this end, we have been trying to form strong links with our non-clinical navigators, who can meet with patients and provide a bridge across to the Family Action service and primary care. The non-clinical navigators are each responsible for a geographical area – including the GP practices in that area – within the borough. Likewise, we have also been trying to form strong links with our Frequent Attenders List Manager, who also has a background in emergency care nursing, to access those who attend A&E frequently.

A key difference between secondary care and primary care – where Social Prescribing has a longer history of success – is the fact that primary care staff often already have a relationship with their patients and can offer greater continuity of care. This means that these underlying non-medical needs, which are often complex, can be identified more easily in many cases.

Case Study: Two senior clinical staff members at Homerton University Hospital continued

Looking forward, we will continue to share case studies of people who have been supported by Family Action with our clinical staff – these have been really valuable already. We would like to ensure that individual clinicians get some feedback about the patients they refer too, even if it is just a couple of lines to explain what the outcome and benefits of that referral was, perhaps in the form of a short monthly summary. This would help to build a greater understanding at the point of care about the unique value that this service offers over and above the many other referral options. Along with ongoing training and education, we can continue to work towards making the referral process as smooth as possible and to increase uptake of Social Prescribing in this setting.

Location

The Link Workers had a strong presence in Homerton University Hospital, however there is the possibility that being integrated with secondary care by being permanently based in the hospital would enable Link Workers to provide more direct feedback to secondary care staff about referrals and support provided, improving the quality and number of referrals received. The interviews also discussed that providing Link Workers with a dedicated space on-site would enable them to more easily and efficiently assess each person's needs and develop a comprehensive plan of support. This would help to secure greater engagement with service users and increase the number of appropriate referrals by providing immediate feedback to hospital staff.

"I've not met any resistance from anyone in relation to the pilot, but now it's time to move forward and build on what we've learnt about how social prescribing can work in this setting." – Non-clinical navigator

Future Considerations

Recruitment

Two experienced Link Workers were successfully recruited in time to begin service delivery. However, safe recruitment processes can take up to three months, and this needs to be considered for the implementation period set for any new pilot. Strong local contacts within the health, social care and voluntary sector helped with attracting suitable candidates – without these links recruitment processes may not be successful and will need time to be repeated. Attracting the right people with the required skill set and qualifications is crucial for this type of service, as it relies heavily on the integration of secondary care, primary care and voluntary organisations – a Link Worker needs to be skilled at interacting with a variety of different roles, as well as delivering the service.

The ability to share Volunteer Befrienders with Family Action's Primary Care Social Prescribing Service was also beneficial, but should this type of service not already exist for a provider, time will also need to be factored into the implementation process to recruit volunteers safely.

Implementation time

It takes time to set up and embed a pilot in a complex environment such as a high-pressured

secondary care setting in order to achieve a good level of appropriate referrals. The learning from this service is that even where key professionals in secondary care support the service, and the service provider has good existing links with clinical staff, systems and referral pathways have to be agreed and established before the service begins delivery. Implementation time is required for this to happen in a way that suits various clinical needs.

Data sharing and feedback loops

A lack of agreed protocols and data sharing agreements limited referral numbers in this service, made worse by the GDPR changes. Secondary care staff were not sure what data they could share, leading to incomplete referral information, which may have affected the speed at which the service could start to deliver outcomes. The ability to refer in to the service using the hospital's system would not just save time, as mentioned previously, but would also reduce secondary care staff's anxiety about whether they are allowed to share the data required to send a referral to the service. The interviews conducted for this evaluation suggest that a clearer line of accountability within the hospital would be needed in order for staff to feel confident referring to the service given data protection and risk. By ensuring the service is an option for referral on the hospital system, staff can be reassured that the referral is going through the hospital's agreed governance processes. The ability of Link Workers to feed back to secondary care staff about the service user's outcomes would also be improved through a shared system, as secondary care staff would not need to rely on the manual creation and sharing of summary reports by Link Workers.

Access to NHS data is also required in order to be able to measure some of the outcomes in the Theory of Change, such as whether an individual has decreased their use of secondary care resources. Access to secondary care staff to investigate the effect of the service on their morale would also be required to test the Theory of Change. This data was not available for this evaluation.

Data protection policies are an important consideration, and a confidentiality and consent policy and procedure that is agreed with key secondary care staff during service implementation would be beneficial. This requires time to set up due to complex systems and processes.

Disengagement and barriers to accessing the service

The high level of disengagement is possibly the result of the service supporting a high number of elderly service users who are receiving end of life care, or who passed away during service delivery. There were also a high number of service users referred to the service who had communication difficulties and this raised the issue of whether they had consented to receive the service, or whether their carer did not want to admit that they needed help, and thus they disengaged. The use of carers as interpreters where there were language barriers was an issue regarding the service user's consent and capacity to undertake a comprehensive assessment, as there were some concerns from Link Workers that this assessment and engagement with the service was then dependent on the carer's interpretation and willingness to engage. It may be that a carer felt the service user did not need the service/misunderstood the service offer and therefore would not facilitate engagement, despite a service user's needs being a good match for the service in the opinion of the referrer and the Link Worker.

Disengagement for service users where these issues were not present needs to be explored further – this may have been a result of inappropriate referrals where secondary care staff did not understand the referral criteria, or referrals being appropriate according to the current criteria, but

patients not being clear on what the service offered them and how it was different from other support available. The way in which the service was delivered appears successful based on the early outcomes achieved by those who do engage with the service, however, additional options such as home visits may be required in order to reduce the number of people who disengage. Provision (in terms of staff time) for this would need to be considered if, on further investigation into disengagement, this did seem to have potential benefit.

Conclusion

The experience of the pilot has highlighted the very different challenges of introducing a Social Prescribing service in secondary care than are faced within other clinical settings, such as primary care or in a community care setting. It has also highlighted clear benefits of the service for this cohort of service users. There is clear movement towards integration of primary and secondary care with community support, with a complementary but different service offer seeing referrals made to different types of organisations than are seen in primary care.

The Social Prescribing in Secondary Care Service provides an opportunity to introduce a greater focus on non-medical or social issues within a busy secondary care setting, which, quite rightly, is focused on the clinical presentation. However, this is likely to take longer to embed than the time that was available for this pilot, in part because of the number of staff who need to be aware of the service and to understand the potential value for individual patients.

The early indications are that Social Prescribing in secondary care does achieve outcomes for service users, and that these could lead to savings for health and social care, as well as wider social value. Service users appear to be feeling more positive about themselves, and more able to cope, look after themselves and manage their symptoms. Ability to manage finance also shows early signs of improvement.

The Social Prescribing pilot has, overall, been well received as an opportunity to test this type of service model as a way of supporting better use of resources in acute care, as well as providing more appropriate care and support for a wide range of people within (and beyond) the hospital setting. There was also universal support for the principles underpinning the service from secondary care staff, and confidence in Family Action as a credible and high quality provider of this type of care and support.

However, there was also a strong recognition of the potential differences between the secondary care setting and primary care (where Social Prescribing has started to become more established), such as the different profile of people who present at hospital, the different staffing arrangements, and the different physical environment of an A&E department or hospital ward. There is also an issue around continuity of care, which is more likely to happen in primary care compared with an emergency care setting. In order for the service to offer the most value, further work needs to be done to differentiate this service from the other referral options available, with a clear and simple referral pathway that senior secondary care staff support and promote across a number of different clinical teams.

Despite the referral and systems challenges, all of the people interviewed felt that there was an immediate and urgent need to find new ways of reducing unnecessary pressure on secondary

care in Hackney (especially during the winter months), while at the same time helping people to access more appropriate types of support that would prevent future issues arising. A Social Prescribing service was considered to be one of those ways, as despite the short implementation period and delivery length of the pilot, and the issues discussed, early indications of the outcomes that may be achieved from such a service are very encouraging and a Wellbeing Value suggestive of being much greater than the cost of delivery can already be assigned.

Appendices

Appendix 1: Evaluation Methodology

Apteligen have analysed all data used within this report and independently verified the findings and conclusions presented to ensure they are consistent with the data captured by the service and their interviews.

Family Action's management information, collected on all cases referred into the service, as well as outcomes data collected during service delivery has been used to form the quantitative data relied upon in this evaluation report. This data covers from service start in December 2017 to the 25th May 2018.

To measure impact, the service has an outcomes framework that is used to note outcomes achieved at case closure. This framework has eight domains covering:

- Community participation
- Social networks
- Employment
- Education and training
- Physical health
- Mental wellbeing
- Independent living
- Personalisation and choice

Quantitative Outcomes Data

Triangle Consulting's Well-being Star²⁰ is also used at each support session to measure progress by the service user. The Well-being Star is based on an understanding of the changes people go through when learning to live well with a long-term health condition. The journey of change informs the scoring on eight areas that patients, GPs, nurses and specialist health professionals have identified as key to enabling people to do as much as they can to minimise the effect of their health condition.

Qualitative outcomes data

To collect qualitative data, Apteligen undertook seven semi-structured interviews with key stakeholders involved in the design, delivery and/or oversight of the service. The sample included the two Link Workers providing the service; two senior clinical staff working in secondary care; the Head of the Integrated Discharge Service; a non-clinical navigator working in A&E; and a representative from Healthy London Partnership who commissioned the pilot. Invitations for interview were also sent to representatives from two of Family Action's key partner organisations, City and Hackney CCG and the Improving Emergency Care Project Manager at Homerton University Hospital. Unfortunately, Apteligen was unable to make contact with these stakeholders during the time available.

²⁰ Copyright Triangle Consulting. Available from: www.outcomesstar.org.uk/using-the-star/see-the-stars/well-being-star/

The interviews explored each person's involvement with the pilot to date, their views on any particular successes and/or challenges faced, evidence of early impact, and things that should be considered if scaling up a service like this in a secondary care setting in the future.

Wellbeing Value

Wellbeing Valuation is becoming widely recognised as a reliable and valid approach to social impact measurement. It is endorsed by the UK Government in its guide to policy evaluation²¹, and is being used increasingly by government departments and non-governmental bodies throughout the UK. Wellbeing Valuation allows organisations to measure the success of a social intervention by how much it increases people's wellbeing, typically derived from the following domains:

1. Building safer, stronger communities
2. Promoting independence
3. Improving health
4. Creating opportunities to learn new skills and/or gain employment, and
5. Making better use of assets within communities.

In order to estimate the potential social impact generated by the service, Apteligen reviewed 14 individual case studies of people who had received some form of support from a Link Worker during the period of the pilot. These case studies were compiled by members of the Family Action team. The case studies included both men and women, across a wide range of ages (25 to 91 years old).

Using the information contained in each case study, Apteligen populated the HACT Wellbeing Value Calculator version 4.0²² to determine the potential wellbeing value created across the sample as a result of the service's support. Apteligen adopted the following rules when identifying outcomes to include within the value calculator:

1. Outcomes that could be clearly and almost entirely attributed to the support provided by the Link Worker (including referral to other agencies). Note that the calculator makes an adjustment for deadweight (what would have happened anyway)
2. A maximum of one outcome per person, given the short timeframes involved, in order to avoid 'over claiming'
3. Outcomes were included where there was evidence of the person's previous status (for example, the case study says that the person had little or no social contact before receiving support and was now attending a social or community group regularly)
4. Recording of outcomes 'blind' to the financial values themselves, to avoid any bias or tendency to record outcomes with higher values
5. No outcomes were recorded as achieved if the case description indicated that changes were still underway (for example, a referral for alternative support had been made but the person was yet to be assessed or demonstrate the required level of engagement).

Apteligen also followed the rules for each individual outcome as defined in the value calculator where relevant.

²¹ HM Treasury (2018) *The Green Book*. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/685903/The_Green_Book.pdf
²² HACT (2014) *Measuring the Social Impact of Community Investment: A Guide to using the Wellbeing Valuation Approach*. Available from www.hact.org.uk/value-calculator

Appendix 2: Organisations referred on to as part of Social Prescriptions

Housing Issues:

1. Single Homeless Project
2. One Support
3. Family Mosaic
4. Shelter
5. Green House

Social Isolation & befriending Service:

1. Community Supporters
2. Befriending Matters
3. Compassionate Neighbours
4. Outward

Benefit Issues:

1. Department of Work and Pensions Visiting Team
2. Hackney Advice Service
3. Age UK East London
4. City & Hackney Carers Centre

Activity & Exercise:

1. One You
2. New Age Games
3. Health Coaches

Anxiety & Emotional Support Services:

1. Mind
2. City & Hackney Wellbeing Network
3. WellFamily Plus
4. A&E WellFamily
5. IAPT

Advocacy

1. Choice in Hackney

Education & Learning:

1. Hackney Learning Trust
2. Read Easy Hackney

Other organisations/ agencies:

1. Hackney People First
2. Connect Hackney
3. Triangle Stroke Project
4. Dogs Trust
5. Derman

Appendix 3: Wellbeing value calculations

Case Study	Outcome Achieved	Case level calculation before deadweight	Case level taking into account deadweight
1	Frequent mild exercise	4319.22	3498.569
2	No outcomes yet that can be valued in HACT tool	0	0
3	No outcomes yet that can be valued in HACT tool	0	0
4	No outcomes yet that can be valued in HACT tool	0	0
5	Able to pay for housing	6120.61	4957.698
6	Talks to neighbours regularly	6819.84	5524.072
7	No outcomes yet that can be valued in HACT tool	0	0
8	Member of social group	2959.385	2397.102
9	Housing service for people in temporary accommodation (no dependent children)	192	192
10	No outcomes yet that can be valued in HACT tool	0	0
11	Afford to keep house well-decorated	7896.348	6396.042
12	No outcomes yet that can be valued in HACT tool	0	0
13	No outcomes yet that can be valued in HACT tool	0	0
14	No outcomes yet that can be valued in HACT tool	0	0
TOTAL		£28,307.41	£22,965.48

Appendix 4 – Case study files

<p>Client's profile and history:</p> <p>Client: D.C.</p> <p>Age: 26</p> <p>Gender: Female</p> <p>Ethnic category: Black African/Nigerian</p> <p>Rag rating: Red</p>
<p>Reason for referral/Background Information:</p> <ul style="list-style-type: none">• D.C.'s main issue regards her housing situation; she has been living in temporary accommodation for the past eight years, together with her eight-year-old daughter. The accommodation is not suitable to host them both, and this is affecting the mental health and wellbeing of mother and daughter• The father of the child has never fulfilled paternal duties. He currently lives in Nigeria, where he was deported to four years ago. D.C. has attempted to connect with him through Facebook without success• D.C.'s mother and stepsister are supportive of D.C.'s daughter, but D.C. has a strained relationship with her family, having left home aged 16. Her father sexually abused her at age 16, and her mother reports that she finds it difficult to love D.C. because of her poor behaviour in the past• D.C. has been referred to WellFamily A&E after attending Homerton University Hospital because she took an overdose following drinking. She is not currently suicidal but says she will try to commit suicide if her housing situation is not improved by the end of the year• D.C. is currently working part-time but is signed off sick due to mental health issues. She recently has had an assessment at Vivian Cohen House for psychotherapy. D.C. mentioned she stopped taking antidepressants and uses alcohol and cannabis to relax (not when her daughter is home). She suspects that her diagnosis is Emotionally Unstable Personality Disorder
<p>Goals identified by client and support worker:</p> <ul style="list-style-type: none">• D.C. is working with two Family Action services: A&E WellFamily and Social Prescribing in Secondary Care• A&E WellFamily provides her with emotional support• She would like for Social Prescribing in Secondary Care to support her with her housing situation and, after she feels more settled, with helping her find a way to be more involved in the community• Explore support that may be required for D.C. to better understand the needs of her daughter and be aware of any symptoms of poor mental wellbeing in her daughter. Ensure D.C.'s daughter is well supported and safe• Explore the effect of alcohol on D.C.'s mood and behaviour and what support might be required – D.C. does not believe her alcohol use to be problematic
<p>Number of sessions with well-being coordinator: 3</p>
<p>Actions/activities referred to:</p> <ul style="list-style-type: none">• Referral sent to Single Homeless Project (SHP)• Social Services involved concerning her daughter. Link Worker spoke with D.C.'s daughter's school and Children's Social Care to check if there was any risk of neglect owing to D.C.'s mental health and drinking issues – they reported no concerns• Link Worker explored a referral to Young Hackney for D.C.'s daughter so she can access activities and have a support worker to talk to should she have any worries about her mum• Link Worker explored a referral to parenting course for mum so that she could understand the needs of her daughter more

Outcomes:

- D.C. is currently on the list for a 2-bedroom property, but she wants to bid for a one bedroom because she thinks she can get that one faster. Unfortunately, this is not possible, and Link Worker worked with her to help her understand this
- SHP begun working with D.C. and performed a home visit to assess the condition of her home. SHP provided her with the contact of a solicitor who could help her further, but D.C. did not follow up

Feedback/quotes from client and or GP

Unfortunately D.C. disengaged from the service. Children's Social Care and D.C.'s daughter's school were aware of the concerns and monitoring this.

Client's Profile:

Client: BS

Age: 52

Gender: Male

Ethnic Category: Turkish

Rag Rating: Green

Background Information:

- BS has been referred to us by the Homerton University Hospital discharge planning team
- He has issues with alcohol misuse and due to that his hands are shaking
- He is also suffering with diabetes, high cholesterol, chronic pain and social isolation
- He has been living on his own and has no link with his ex-partner and children
- He spends all day at home doing nothing except sometimes watching television

Reason for referral:

- BS needs to be supported to register with a local GP as he has been registered at a GP on Edgware Road, where he was living before
- He is socially isolated and needs to get engaged with local community
- He needs help with his benefit and rent arrears

Actions/ Interventions made by Link Worker:

- Discussed changing his GP and register with a local GP but he decided to stay with the GP at Edgware Road as he known them for years and he is very comfortable with them
- Explored local activities with him and provided him information about New Age Games activities and he said he will contact them directly and start attending some activities
- Discussed with him to refer him to recovery service. He said he is already going to a recovery service in Westminster
- He has rent arrears of £4,000 and he has received many letters to pay his arrears but he ignored these letters and got a notice to pay the arrears. Link Worker contacted the Barnet Housing Rental team and applied housing benefit for him, which he has been awarded. Due to benefit cap and not being on ESA support group, he needs to pay the remaining shortfall, which is about £2,500. Link Worker has referred him to Derman to provide him further support as Link Worker and BS find it difficult to communicate properly as they do not speak the same language
- Link Worker has also helped him to write a mandatory reconsideration letter for Personal Independence Payment (PIP), and he is waiting to hear back from them

Number of sessions with Link Worker: 10

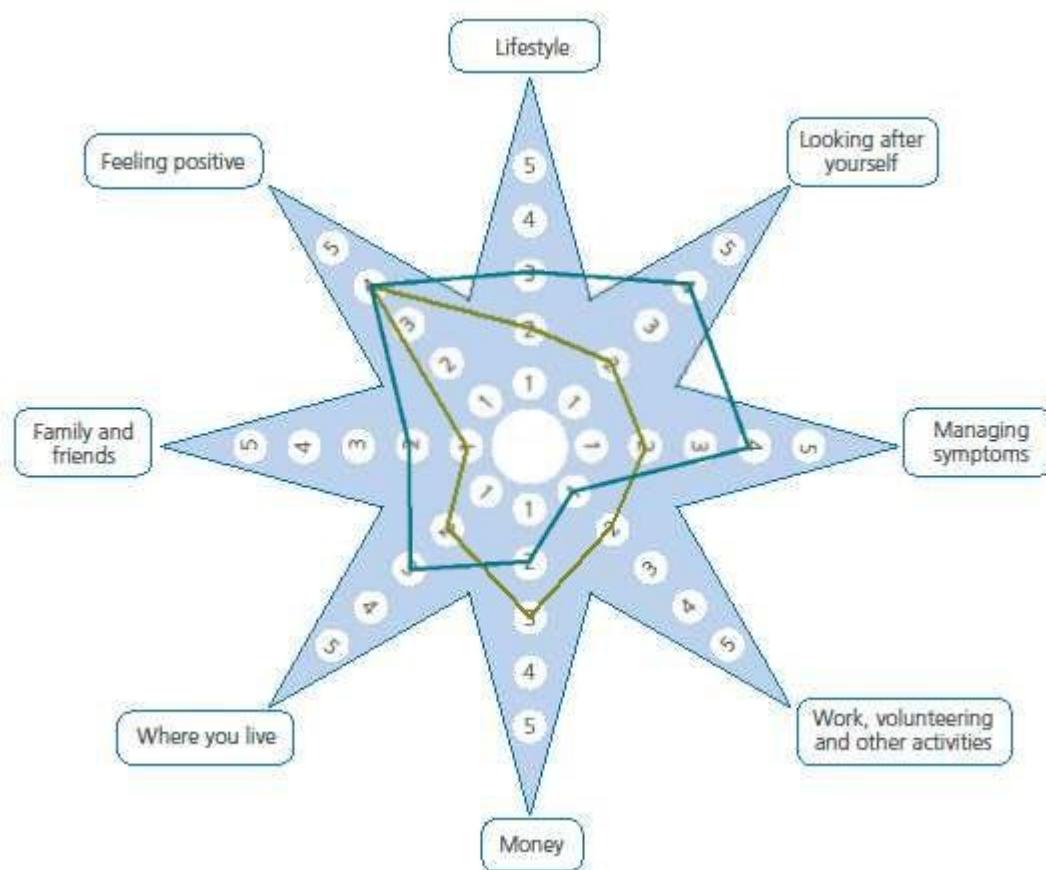
Outcomes:

- Housing and Council Tax benefit has awarded with 6 months backdated
- Referred him to New Age Games activities and will start attending soon
- Asked for review for his ESA so he can be put on to support group which will help him with his rent arrears
- Derman have agreed to help him with his benefit which will be easier for him in terms of communication

Feedback from client:

BS is very happy and grateful for Link Worker's help and support with his benefit issues and gave a thank you card for that.

Well-being Star (@Triangle Consulting):
Green = before service support, Blue = after service support



Client's profile and history:

Client: S.W.

Age: 61

Gender: Male

Ethnic category: White: British

Rag rating: Green

Reason for referral/Background Information:

- S.W. worked with A&E Well Family Service and his sessions came to an end, however as he is a complex case and has had a hospital admission, he was referred to our service
- Main areas of support regarding social isolation
- Linking S.W. to longer-term support services
- Provide some emotional support
- S.W. was diagnosed with schizophrenia and has an ongoing paranoid delusion about his phone

Goals identified by client and support worker:

- S.W. wishes to join a drawing course
- S.W. wishes to link up with his support worker from One Support
- S.W. wishes to be supported with Personal Independence Payment (PIP) form
- S.W. wishes to explore other ways to tackle social isolation

Number of sessions with well-being coordinator: 8**Actions/activities referred to:**

- Followed up his PIP application and provided the necessary missing details to Department for Work and Pensions (DWP)
- Link Worker supported S.W. to link up with his floating support worker, and we organised joint meetings to identify support needs together
- Discussed referral to Community Supporters for befriending services
- Discussed his interest in the arts and patient stated he has been attending Core Arts, a programme that tackles mental health issues through art activities and workshops
- Link worker supported S.W. emotionally during the entire duration of the sessions, particularly spoke about how not being in a romantic relationship for many years has affected him and makes him very sad

Outcomes:

- S.W. was awarded PIP
- He continues attending Core Arts, a community mental health art programme. He has shown some interesting pictures to the Link Worker and is definitely very committed to his art
- S.W. has been assessed by Community Supports for a Befriender

Feedback/quotes from client and or GP

Client was happy about the kind of support received, although he wishes he could have had more sessions.

Client's profile and history:

Client: W.N.

Age: 25

Gender: Female

Ethnic category: Asian / British

Rag rating: Amber

Reason for referral/Background Information:

- W.N. self-referred by calling Family Action Head Office stating that she needs support with her benefits
- W.N. would like to be referred to floating support services
- W.N. argues that she finds it very difficult to thrive at college because of her ADHD
- W.N.'s teacher is worried about her
- W.N. has received a letter from Department of Work and Pensions (DWP) prompting her to apply for Personal Independence Payment (PIP) instead of a Disability Living Allowance (DLA)

Goals identified by client and support worker:

- W.N. wishes to be supported with applying to PIP
- W.N. wishes to receive medication for the ADHD
- W.N. wishes to receive psychotherapy for her condition
- W.N. wishes for Link Worker to liaise with her college teacher

Number of sessions with well-being coordinator: 3**Actions/activities referred to:**

- Application to PIP over the phone
- Referral to Improving Access to Psychological Therapies (IAPT), Homerton University Hospital
- Referral to WellFamily Plus – Young Service (to receive emotional support while she waits to start with IAPT)
- Referral to Outward, floating support service

Outcomes:

- W.N. was assigned a floating support worker, who will carry out an assessment soon
- W.N. began working with WellFamily Plus service
- W.N. was accepted by IAPT, and she will be offered an assessment
- W.N. received PIP questionnaires to fill out, session booked to work on these with Link Worker
- Link Worker liaised with her teacher and explained to her the support that is now in place for her

Feedback/quotes from client and or GP

Client was very grateful of support provided by Link Worker, and happy that she has been linked with relevant organisations for long-term support.

Client's Profile:

Client: GC

Age: 72

Gender: Male

Ethnic category: White British

Rag Rating: Amber

Background Information:

- GC is a registered sex offender and has been in to A&E at Homerton University Hospital with low mood/anxiety and suicidal thought
- He has been living in a one bedroom flat, rented privately but he has been issued an eviction notice for December 2017
- By looking at his situation, property owner gave him three months extension and sent him another eviction notice, which is effective from 19th April 2018
- He has been on the local authority-housing list since 2011 but until now, no good luck with it.
- He has dogs and was very concerned about not being able to keep them if he moved into a hostel or sheltered accommodation

Reason for referral:

- GC would like some urgent help regarding his housing issue as he is at risk of homelessness
- He would like some emotional support to reduce his anxiety and depression

Actions/ Interventions made by Link Worker:

- Made an urgent referral to Single Homeless Project (SHP) Floating Support Service to deal with his housing issues
- Suggested service user visit GP to gain letter about health issues in support of housing application
- Referred him to A&E WellFamily Service for counselling to support him with his anxiety and depression
- Gave him information about New Age Games Activities

Number of sessions with Link Worker: 3**Outcomes:**

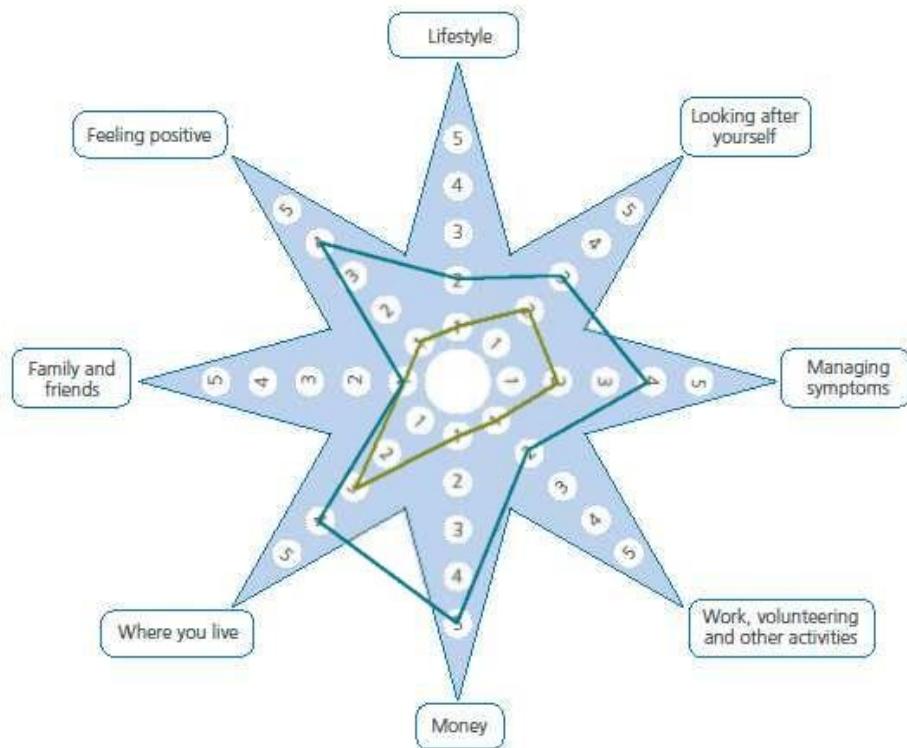
- He has been placed in temporary accommodation with his dogs
- He has been attending sessions with A&E Well Family for his emotional support
- Waiting to start some activities
- He looked well and reported feeling positive and hopeful

Feedback from client:

GC has been very grateful of support provided by the Link Worker.

Well-being Star (@Triangle Consulting)

Green = before service support, Blue = after service support



Client's profile and history:

Client: K.C.

Age: 58

Gender: Male

Ethnic category: British

Rag rating: Green

Reason for referral/Background Information:

- K.C. was referred by Age UK for concerns with regard to his benefits
- His wife had recently died, and the patient may need some emotional support and a link to bereavement services
- Client currently lives in a two bedroom property with his son
- The lease of the apartment was under his wife's name, so he needs help changing that and applying to relevant Housing Benefits

Goals identified by client and support worker:

- K.C. wishes to apply for Housing Benefit
- K.C. wishes to apply to Employment and Support Allowance (ESA)
- K.C. wishes to be helped in regards of wife's Housing Benefit and council tax overpayment
- K.C. wishes to obtain a package of care. Wife used to be his carer. Referral to Hackney Carers Centre discussed and agreed
- Referral to Single Homeless Project (SHP) discussed and agreed
- Link Worker will explore referral to WellFamily for emotional support

Number of sessions with well-being coordinator: 3**Actions/activities referred to:**

- Online application to Housing Benefits
- Offered emotional support / bereavement once practical needs have been addressed
- Referral to SHP – floating support services
- Change of circumstances to Department of Work and Pensions (DWP) plus certificate of wife's death was sent
- Self-referral to Access Team for a care assessment

Outcomes:

- K.C. was assigned a floating support worker, who has been able to visit him in his home and work towards the change of name in his tenancy
- Discretionary Succession Application has been worked on
- Council Tax has been sorted – K.C. was awarded council tax benefit
- K.C. has applied to ESA over the phone supported by Link Worker

Feedback/quotes from client and or GP

Client is very grateful for support provided by Link Worker during this difficult time, since he relied heavily on the help of his wife and she died unexpectedly. The support provided helped him become more independent and able to live a fulfilling life despite his loss.

Client's Profile:

Client: GF

Age: 59

Gender: Female

Ethnic Category: Black British /Caribbean

Rag rating: Green

Background Information:

- GF is a 59 years old woman, self-referred to A&E Social Prescribing Service, who has multiple health conditions and recently being discharged from Homerton University Hospital. She lives with her husband and has a small care package in place
- She has been house bound and waiting for knee replacements in both legs
- She has a carer coming in twice a day to help her with washing and dressing in the morning and during lunch
- Previously she was working as a floating support worker but due to her illnesses she left the job
- She has been struggling financially as she has no income and her husband is working on a zero hour contract

Reason for referral:

- GF needs help with her benefits
- Need to get engaged with local community activities

Actions/ Interventions made by Link Worker:

- Link Worker referred GF to Department of Work and Pensions (DWP) Visiting Team to help her with applying for Employment and Support Allowance (ESA) and Personal Independence Payment (PIP). DWP Visiting Team contacted her and gave her a home visit on the 30th May when they will visit her and deal with her ESA and PIP claim
- GF told Link Worker she has been struggling financially and needs some urgent help. Link Worker has sent her a food bank voucher which she found very useful
- Link Worker explored local activities with her and provided her information about New Age Games activities and she said she will contact them soon as she gets a bit better and more mobile
- Referred her to City and Hackney Wellbeing Network for her emotional support

Number of sessions with Link Worker: 5**Outcomes:**

- GF is waiting for DWP visit to deal with her ESA and PIP
- Referred her to New Age Games activities and will start attending when she feels better
- Waiting to hear from Wellbeing Network

Feedback from client:

GF is very happy and grateful for the Link Worker's help and support so far.

Client's profile and history:

Client: L.J.

Age: 91

Gender: Female

Ethnic category: British

Rag Rating: Amber

Reason for referral/Background Information:

- L.J. was admitted to the Elderly Care Unit (ECU) unit with her husband following a fall
- While they were in the hospital, her husband died
- L.J. was discharged to her home, with the support of her daughter and nephew
- L.J. was referred to our service because her daughter feels the patient cannot manage alone in her home although she has carers going in. Her daughter was concerned about the mental capacity of LJ to make decisions
- Nephew is currently being the main carer, and would like to be registered as this
- Daughter feels overwhelmed and in need of support
- Daughter is concerned that mother does not get enough washing, because she does not allow the carers to wash her if she does not feel like it
- Daughter is preoccupied about scheduling a hospital follow-up. She is organising a car to attend the visit

Goals identified by client and support worker:

- Referral to Floating Support Service, so they can help with income maximisation and visit patient in her home since she is housebound
- Income Maximisation / Benefit Check
- Referral for blue badge parking pass

Number of sessions with well-being coordinator:

Support was provided mainly over the phone. Many phone conversations, and one 1-2-1 support session with nephew.

Actions/activities referred to:

- Referred to Single Homeless Project (SHP) for income maximisation and blue badge parking pass
- Met with nephew for a session and we agreed to send a referral to Hackney Carers Centre. His need to supervise LJ because of risk of falling was discussed
- Supported Next of Kin emotionally over the phone and helped her manage her anxiety about her mother's situation

Outcomes:

- L.J. was assigned a floating support worker, who begun working towards benefit applications in her home, as well as the blue badge parking pass application
- Hackney Carers Centre has scheduled an assessment with the nephew
- Daughter feels a bit relieved and less anxious about the situation. This has also reduced the risk of LJ's daughter making decisions for her despite LJ having capacity

Feedback/quotes from client and or GP

L.J.'s daughter feels that finally, things are 'slowly coming together' and she appreciates the help from the service during this incredibly difficult time.

Client's profile and history:

Client: B.O.

Age: 38

Gender: Female

Ethnic category: Black: British African

Rag Rating: Green

Reason for referral/Background Information:

- B.O. has been ill since last year; she had quite a number of surgeries and struggles to get on with daily life
- B.O. had a kidney transplant but it did not work
- B.O. is feeling quite anxious and depressed
- B.O. would like support thinking about how her medical disability has affected day-to-day life and making sense of things
- B.O. lives on dialysis and this totally changed her whole life

Goals identified by client and support worker:

- B.O. wishes to begin psychotherapy to think about her life situation
- B.O. would like to explore in the future ways to become more involved in her community

Number of sessions with well-being coordinator: 3 (supported over the phone)**Actions/activities referred to:**

- Referred to Improved Access to Psychological Therapies (IAPT)

Outcomes:

- B.O. was accepted by IAPT, and she was offered an initial assessment

Feedback/quotes from client and or GP

B.O. was incredibly happy about beginning psychotherapy, and she is very grateful for the help she received by Family Action. In the future, after her therapy is settled, she would like to explore activities in the community to become more socially involved and lead a more fulfilling life.

Client's profile and history:

Client: M.D.

Age: 67

Gender: Female

Ethnic category: White Italian

Rag rating: Green

Reason for referral/Background Information:

- M.D. underwent a hip replacement operation in December 2017, which left her with limited mobility (she relies on crutches to walk) and in a lot of pain
- M.D. states she needs to undergo the same operation in the other leg soon, and this causes her a great deal of anxiety
- M.D. is struggling with financial difficulties, concerning large gas and electricity bills due to winter's cold weather
- M.D. is also struggling with frigid temperature as she does not have appropriate winter clothing
- M.D. complains of bad sleep due to the poor nature of her mattress

Goals identified by client and support worker:

- To get some emotional support dealing with anxiety and pain in regards of her operation
- To apply for charity grants to buy an orthopaedic mattress, winter clothing and a reclining chair
- To receive help in setting up payment plans for overdue gas and electricity bills

Number of sessions with well-being coordinator: 3**Actions/activities referred to:**

- Contacted British Gas to set up a payment plan
- Contacted Shine organisation to ask for support with winter gas and electric bills
- Identified suitable orthopaedic mattress for purchase
- Identified suitable reclining chair for purchase
- Sent an application to Hackney Parochial Charity to apply for grant for winter clothes, mattress and reclining chair

Outcomes:

- M.D. is less anxious about her bills situation
- M.D. was awarded a charity grant from Hackney Parochial Charity for £895.43
- M.D. is hopeful that the money from her charity grant will allow her to purchase a new mattress and improve her quality of sleep and the pain she feels in her body because of her operation
- M.D. and Link Worker phoned British Gas and agreed on a payment plan

Feedback/quotes from client and or GP

Client states that she is very fond of Family Action services. She previously engaged with WellFamily. She is happy about the changes she foresees happening in her life.

Client's profile and history:

Client: C.M.

Age: 57

Gender: Female

Ethnic category: Black British: African

Rag Rating: Green

Reason for referral/Background Information:

- C.M. was referred by her GP because she needed help with her PIP application
- C.M. suffers from a variety of health conditions, among which diabetes and high blood pressure
- C.M. finds it hard to complete daily tasks such as washing herself, cooking, and anything that requires mobility of her arms
- C.M. is also currently attending a mobility clinic, since she tends to lose her balance a lot and this leads to falls
- Initially, C.M. only wanted to be supported with her benefit application, but as she gained trust in the link worker and felt more comfortable opening up, C.M. was able to speak about other areas of her life where she needed support, for example the fact that she is socially isolated and would like to do more with her time
- C.M. disclosed to the Link Worker that she is illiterate, and that she would like to learn how to read

Goals identified by client and support worker:

- To help with PIP and ESA
- To become more socially involved in her community
- To learn how to lead a healthier lifestyle
- To learn how to read
- To find some physical activities to do in the community

Number of sessions with well-being coordinator: 4

Actions/activities referred to:

- Contacted PIP and applied over the phone
- Referred to New Age Games for chair-based activities
- Referred to Health Coaches
- Referred to Read Easy Hackney

Outcomes:

- C.M. received the PIP assessment form and together we filled it out
- C.M. passed ESA medical assessment, and was awarded the benefit
- C.M. has been accepted from Health Coaches, and was offered an assessment to start working with them
- C.M. has been placed on the list for Read Easy Hackney, and will start their reading course in September
- C.M. is waiting to start chair based activities in the community three times a week
- C.M. keeps attending her balance classes

Feedback/quotes from client and or GP

C.M. was very happy that the Link Worker helped her with PIP and ESA, because she would have not known what to do otherwise. She is also happy that her future looks different, and that she will be able to become more involved socially and to learn how to read which will make her more independent in the community.

Client's Profile:

Client: DJ

Age: 82

Gender: Male

Ethnic Category: White British

Rag rating: Green

Background Information:

- DJ is living with his 79 year old wife VJ
- DJ has been suffering with various disabilities including diabetes, high cholesterol, anxiety/ depression, low mood, chronic pain, social isolation and prostate tumour and had hernia operation recently
- He goes to hospitals for regular appointments and had a few recent admissions to hospital
- His wife VJ also has various health issues, such as diabetes, high blood pressure, osteoarthritis in knees, hips and shoulders and due to that, she is unable to manage her daily tasks

Reason for referral:

- DJ & VJ need help with cleaning their flat and ironing their clothes as they are having difficulties to manage due to their illnesses, also finding it difficult to hire a private cleaner due to not having enough money
- Both need help with their benefits check as they are not sure what benefits they are on and if they are eligible for any other benefits
- Both need help with Dial-a-ride and Taxi card application, which they will use for their journey to doctor appointments and shopping
- They need help with moving to a flat/ house with a lift, as they are living on a second floor without a lift, which makes it very hard for them to use the stairs without physical assistance
- VJ needs carer's assessment as she has been looking after her husband for many years and now she is finding it difficult to manage both herself and her husband
- DJ & VJ are socially isolated and need help with combat Social Isolation

Actions/ Interventions made by Link Worker:

- Helped them both with applying for Dial-a-ride and Taxicard
- Referred them to DWP home visiting team to help them to apply for Attendance Allowance
- Helped them to register with the rehousing list
- Referred VJ to the Hackney Carers Centre for an assessment.
- Referred them to Computer Classes
- Referred DJ to 'Community Supporters' to match him with a Befriender to take him out on a regular basis

Number of sessions with Link Worker: 6**Outcomes:**

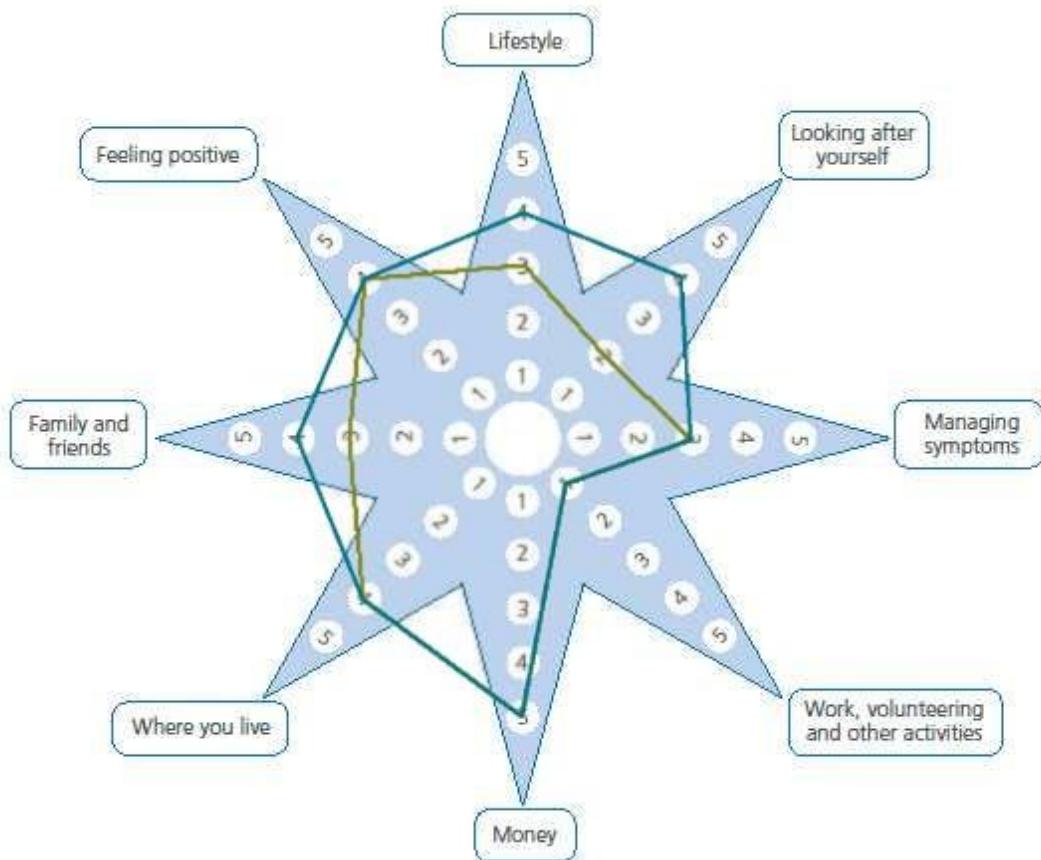
- Dial-a-Ride and Taxicard has been successfully awarded to both and they have been using them for their GP appointments and regular shopping
- Attendance Allowance has been awarded with the higher rate. With this money, they were able to employ a cleaner privately to come weekly, clean the house, and iron their clothes. Referred VJ to Wellbeing Network
- They have been offered for viewing a new house and hopefully they will move to a new house soon
- VJ has been assessed and started attending coffee mornings and training workshops at the Carers Centre
- DJ has been matched with a Befriender who is visiting him regularly

Feedback from client:

Mr & Mrs DJ contacted me recently and thanked me for the work the Link Worker has done for them and said that without our help and support they would have been lost.

Well-being Star (@Triangle Consulting):

Green = before service support, Blue = after service support



Client's profile and history:

Client: H.M.

Age: 83

Gender: Female

Ethnic category: Turkish

Rag rating: Green

Reason for referral/Background Information:

- H.M. was referred to the service by Homerton University Hospital Elderly Care Unit for concerns regarding her social isolation
- Link Worker supported this client over the phone, by speaking with her next of kin, since H.M. is housebound and does not speak English
- Next of Kin explained that her mother feels very lonely. She used to have a full house all the time, with nephews and nieces going over to see her, and a lot of friends and family. She used to take great joy into cooking and entertaining, and now this is no longer so

Goals identified by client and support worker:

- To find a Turkish Speaking Befriender
- To find a Turkish Women organisation in Hackney

Number of sessions with well-being coordinator: 5 (support provided over the phone)

Actions/activities referred to:

- Signposted to Turkish Cypriot Women's Project in Hackney
- Referred to Compassionate Neighbours for befriending services

Outcomes:

- Compassionate Neighbours was able to find a Turkish speaking befriended for the client, who goes to her house to visit her weekly

Feedback/quotes from client and or GP

Next of kin states that the Befriender 'is a really good person' and that her mother is delighted to have some company and something to look forward to every week.