Executive Summary
The evaluation of the Social Prescribing Service in GP Practices in Brighton & Hove

1.1. Background and aims

The Community Navigation Service (CNS) was established in August 2014 as a new social prescribing service for primary care (GP Practices) in Brighton and Hove. The service is run by Brighton & Hove Impetus, a community and voluntary sector organisation delivering a range of services aimed at improving the health and wellbeing of people in Brighton and Hove. The explicit aim of the CNS was to aid patients to see 'the right person, at the right time, in the right place' and to reduce the proportion of GP appointments for patients with non-medical needs.

The CNS was set up as a pilot project, with four rounds of funding with differing arrangements and amounts, and with a staggered roll-out across all GP practices in Brighton & Hove over four years.

A process evaluation of the pilot was conducted by Solutions Public Health and the public health team, Brighton & Hove City Council between April and September 2018. The aims of the evaluation were to consider the development and performance of the service since its inception in August 2014 until April 2018; specifically:

This evaluation of the Community Navigation Service (CNS) aims to assess whether the service is being run in an efficient and effective way, where there might be challenges and barriers to effectiveness and recommends what next steps might be taken to address those issues.

1.2. Methods

The evaluation used information from:

- A review of Impetus documents, including previous evaluations, service plans, internal senior team meeting notes and documents about operational changes to the service.
- Analysis of the data collected by Impetus, including client demographics, number and reason for referrals, contact between the CNS and clients, and outcome of referrals.

The following primary data were collected as part of the evaluation:

- Semi-structured telephone interviews with key staff and stakeholders involved in the Social Prescribing initiative, including primary care staff (5 GPs, 2 Practice Nurses and one nurse trainer), Impetus staff (the Community Navigation Manager, Volunteer Coordinator, and two volunteers), staff from three community and voluntary sector organisations that receive referrals and the CCG Commissioner.
- An online Survey for primary care staff regarding frequency of referral into the CNS and reasons for not referring, how well informed they feel about the service, and views on whether the service is working well and bringing benefits to patients or GP practices; completed by 25 GPs, 19 Practice Nurses, three Practice Managers and two receptionists.

1.3. Key findings

The overall feedback received about the CNS is that primary care referrers, CNS staff and volunteers and onward referral agencies consider it to be worthwhile and helpful to those referred into it. There is clearly a role for a service that connects people who have been identified in primary care with a need for non-medical support, to onward referral agencies which may help prevent a further decline in health and wellbeing, maximises the use of resources available in the community and help support appropriate use of primary care clinician time.

Results from Impetus's own outcomes based evaluations show that overall there were improvements to patients' health and wellbeing as a result of Community Navigation with 93% saying they had all the information they needed to address their issue, 84% experiencing improvement in their wellbeing, 49% were able to access services, group or activities after seeing the CN and 62% being able to take the next step within 3-6 months. In the 2017 evaluation, 'distance travelled' monitoring showed an average increase of 1-2 points on a 5 point scale (1 point increase is regarded nationally as good progress). On average 5.2 hours of support were given over (averagely) 13 weeks to clients.

Overall social prescribing is well received by the client and for those who know about the CNS, is considered beneficial to both patients and GP Practices. GPs find the service valuable as an alternative option for those clients they feel unable to help and as a source of information about local services. It is difficult to analyse the full impact on GP workload as referrals by GPs are not recorded on clinical systems.

This evaluation of the CNS recognises the contextual challenges and barriers to the development and effectiveness of the current service and recommends what next steps might be taken to address those issues. Seven overarching themes emerge from the data and documents collected and reviewed. These are:

1.3.1 Effectiveness of the current community navigation service model

The CNS model has evolved over the time through an iterative process of learning and reflection. Two particular components of the model reviewed here are the location of the Community Navigators (CNs) and the use of volunteers to deliver support to clients.

Location of CNs: CNs were initially based in GP Practices, the model was revised and CNs were then based in a central office with the option of conducting client visits at home, at the base or in practices. The evaluation identified various advantages to a practice based model such as improved relationship with primary care staff; a simplified referral process; improved patient engagement; increased knowledge of navigators regarding local needs; lower travel times for navigators and reduced need for home visits. Disadvantages include volunteer preferences leading to inequity; lack of private space in practices; reduced flexibility as navigators can only see clients available during the times they are based in that practice; reduced flexibility to match skills of volunteers with clients' needs; issues with volunteer management and support; and reduced ability to see clients in their own homes if required.

The use of volunteers: Volunteers bring a wide range of skills and experience to the role adding and maximising value of the volunteer's expertise is different than when doing so with paid positions.

The skills, experience, availability and confidence of the volunteers have to some extent influenced the service design along with availability of space in practices. Average volunteer length of service is around eight months with each volunteer working one session a week. It should be recognised that a volunteer model has resource implications in time, energy (and funds)for recruiting and training new CNs, whilst at the same time the use of volunteers does increase capacity. Additionally, the natural flux of volunteers impacts on the service capacity at any one time and so there is a continual balance between promoting the service and managing demand.

Cost: A total of 1311 clients were referred into the service; of these 1186 were seen by the CNS, with 1078 receiving an onward referral; a total of 2692 onward referrals were made. The total funding provided to the CNS during its period of operation was £423,192 therefore the cost per client who received some contact/support from the CNS was £356.82. This figure includes all the contacts, interventions and background office support work for the clients over the period of their case being active. Over the period covered by this research, the average number of contacts per client was 3, over an average of between a 1 to 3 month period. This figure does not include any reflections of the social return on investment of using volunteers and supporting the work of community and voluntary sector organisations with the onward referrals nor any estimate of the long term prevention.

1.3.2 Complexity of cases

Impetus staff members are clear that the increasing volume of "complex" cases seen by the CNS takes up an increasing amount of CN time, impacting on the overall volume of clients that can be supported. This is reflected in an increase in proportion of complex clients recorded in the Impetus database (from 3.7% of cases in 2016 to 14.4% in 2017). Complex cases required more interactions - on average 3.3 significant interactions and 3.6 short interactions, compared to 1.5 significant and 1.4 short interactions for non-complex cases. There are clear referral criteria and everyone who comes into the services meets these. It is the case that the complexity is not always clear at the point of referral or the start of any interaction, so if it becomes clear that the client falls outside of the criteria, appropriate ongoing referrals are made and the case closed. The CNs have noticed increasing complexity within the criteria range.

1.3.3 Engaging with GP practices

The level of engagement across GP practices varied depending on how long the practice had been using the service, and this contributes to the different referral rates across practices. Some GPs felt they were given 'enough', and others 'not enough', information about the service to confidently refer patients or to know whether the service is of value. Practice nurses currently report little knowledge of the service. Increased engagement and training could increase referrals and potentially reach a different cohort of clients. The lack of a long-term service level agreement and uncertainty about long-term funding is likely to have impeded the development of an overarching strategy to support the CNS engagement initiatives with GP practices. However in the future better engagement is required with GP practices to ensure the service reaches the target numbers of clients, is universally available across the city.

1.3.4 Capacity, efficiency and demand generation

GP practice referral rates varied between practices from 4.1 clients referred to 0.1 clients referred per month; practices have been referring an average of 1.3 clients a month. 63.3% of respondents to the primary care survey reported that they felt the service was of benefit to their practice, however at current referral rates there is limited positive impact on GP time. It is also likely that there are patients who meet the referral criteria who are not benefitting. At the time of the evaluation, summer 2018, the CNS is receiving a level of referrals described as 'near to capacity' within the context of its resources and funding as many of the cases are highly complex.

1.3.5 Options available to increase case capacity include; increasing the number of paid staff ; locating more CNs in GP practices; reducing the number of home visits; reviewing the type of clients supported (ie supporting fewer complex cases), and reviewing the service 'package' offered to reduce the number of interactions required before an onward referral whilst maintaining a person-centred approach. Funding, planning and management

As this project was set up as a pilot, the funding and management agreements developed overtime and were not clear cut which impacted on the development the service for the city. With limited published evidence and few best practice examples from elsewhere, the service grew in size and scope iteratively in response to the local context and issues faced. As it was a pilot there was no service level agreement. The impacts of this included; limits to long-term planning, and differing expectations regarding the model and data collection methods. Changes were made to the model and running of the service as it developed over the time, without sufficient scrutiny of the process. This has made comparisons over time difficult.

1.3.6 Monitoring and evaluation

The monitoring database used by Impetus is a useful tool for tracking referrals and contact with clients. However, the data varied in quality and completeness. This may be connected to the structure and design of the database and database review processes. There needs to be a comprehensive system that can validate data quality as it is entered, review data quality and completeness before a case is closed, and prompt a regular data audit to follow-up data entry errors.

Impetus developed a tool - the Wellbeing Web - to track patient outcomes and measure changes in client wellbeing. It is based on the validated Outcomes Star and felt was appropriate and useful for clients. Standardised question sets and tools, such as the Warwick and Edinburgh Mental Wellbeing (WEMWB) tool, were considered, but felt inappropriate by the provider as it disrupted the guided conversation with clients and included questions that were not seen as person centred, felt inappropriate or could potentially be upsetting to clients. It should be noted the 'Shorter' well used, validated WEMWB tool is not generally considered to include potentially upsetting questions. However, the CN team developed a bespoke tool after discovering there was no validated tool available that could adequately record the client outcomes agreed with the commissioner. The shorter WEMWB is not an adequate tool on its own, so the Wellbeing Web was developed to provide a single person centred distance travelled monitoring tool that could meet the client outcome reporting requirements agreed. Consistency and validity is a problem when using an un-validated bespoke tool as the results cannot readily be compared with other social prescribing programmes, nor can data easily be fed into calculations of social return on investment.

Follow-up data is collected at any point between three to six months after the case is closed, as with other programmes it is difficult to ascertain cause and effect however with sufficient numbers, trends in wellbeing should be able to be monitored and could be attributed to the engagement with the CNS or access to services resulting from CNS referrals.

Specific information is not collected on the outcome of onward referrals. Clients provide this verbally and it is recorded in the case notes and used to inform decisions about next steps and case closure. However it is not possible to report on service uptake details of the onward referrals. This information would be useful to assess whether the referrals being made by the CNS are relevant to client's needs, whether the client acts on the referral, and whether the onward referral services have the capacity to absorb the referred clients.. However, it is recognised that there may be data protection issues that might hinder this process.

1.3.7 Working with onward referral agencies and gaps in services

The two onward referral agencies interviewed were very positive about the CNS and had both presented their service offer to the CNS volunteers meetings. The proportion of people coming via the CNS to these services was relatively small compared to the total numbers of people they support. Although the services did comment they had few CNS referrals they recognised the potential benefits of the CNS. Staff interviewed at the onward referral organisations typically receive more information about a client when they are referred by CNs than when they walk in off the street and therefore will have more insight in to the client's needs.

There is a lack of clarity in primary care regarding the threshold for referral into Adult Social Care (ASC) compared to the CNS, and the boundaries between those services are not always clear. Further clarification needs to be done in primary care to raise awareness of the boundaries and referral criteria of these services.

The services that CNs found relatively easy to refer-to were drop-in services offering peer support for example, as these had very few barriers to entry. CNS staff members are a useful source of information regarding gaps or lack of capacity in community and voluntary sector services. A system should be established to gather and report this information back to the commissioner and/or Steering Group.

Areas that CNs identified as being either unavailable or oversubscribed included:

- Housing advice and support - with long waiting times, advice needed on damp, overcrowding and landlord issues
- Services for people from Black and Minority Ethnic Communities
- Stroke Services
- Social Isolation support
- Emotional abuse support
- Free counselling
- Recovery College (uses education to support adults recovering from mental health challenges) was mentioned as a service which was very useful, but over-subscribed
- Smaller community groups and clubs which may already be at capacity.

1.4. Recommendations

1. The CCG and provider to agree a detailed Service Agreement Plan with clear overall aims and objectives, governance, performance indicators, funding arrangements and data collection system. A monitoring and evaluation framework to be agreed in line with the national evaluation framework (expected early 2019); Commissioner and provider to agree amendments to the model including outcome measures, the balance of paid and volunteer CNs, client eligibility criteria with a complex case definition, and the package of CCG support to the provider, to facilitate implementation.
2. Provider and commissioner to develop a Primary Care Engagement Plan which outlines a rolling package of engagement with GP Practices and to explore the feasibility of locating more CNs in GP Practices.
3. Commissioner and provider to scope expanding the range of organisations and job roles which can refer patients/clients to the CNS.
4. Establish robust data collection and management systems including quality assurance processes, collection of data on onward referral outcomes and client wellbeing in line with National Quality Assurance Guidance due 2019.
5. The commissioner to develop and agree a method for measuring programme impact on GPs and other clinicians' workload.
6. The commissioner to review links between CNS and other social prescribing services in the city, to ensure duplication is minimised and cross referral pathways effective.