# PLEASE NOTE VENUE AND TIME

# ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM AGENDA

HARTLEPOOL
BOROUGH COUNCIL

**Tuesday 14th November 2006**

**at 9.00am**

**in Community Room, Central Library,
York Road, Hartlepool**

MEMBERS: ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM:

Councillors Barker, Akers-Belcher, Brash, Fleet, Griffin, Lauderdale, Lilley, Rayner, Wistow, Worthy and Young.

Resident Representatives: Mary Green, Jean Kennedy and Joan Norman

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **MINUTES**

   3.1 The minutes of the meeting held on 19th September 2006 *(attached)*
   3.2 The minutes of the meeting held on 26th October 2006 (*to follow)*

4. **RESPONSES FROM THE COUNCIL, THE EXECUTIVE OR COMMITTEES OF THE COUNCIL TO FINAL REPORTS OF THIS FORUM**

   No items.

5. **CONSIDERATION OF REQUEST FOR SCRUTINY REVIEWS REFERRED VIA SCRUTINY CO-ORDINATING COMMITTEE**

   No items.

# PLEASE NOTE VENUE AND TIME

6. **CONSIDERATION OF PROGRESS REPORTS / BUDGET AND POLICY FRAMEWORK DOCUMENTS**

6.1 Adult and Community Services Department: Budget and Policy Framework Initial Consultation Proposals 2007/08 – *Scrutiny Support Officer*

7. **ITEMS FOR DISCUSSION**

7.1 **Scrutiny Investigation into Social Prescribing:-**

(a) Covering Report – Evidence from Bradford PCT – *Scrutiny Support Officer*

(b) Evidence from Hartlepool PCT – Presentation by Peter Price

8. **ANY OTHER ITEMS WHICH THE CHAIRMAN CONSIDERS ARE URGENT**

**ITEMS FOR INFORMATION**

**i) Date of Next Meeting Tuesday 19th December 2006 commencing at 10.00am in the Community Room, Central Library, York Road, Hartlepool.**

# ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM

## MINUTES

19th September 2006

**Present:**

Councillor: Gerald Wistow (In the Chair)

Councillors: Councillors Jonathan Brash, Mary Fleet, John Lauderdale, Geoff Lilley and Gladys Worthy.

In accordance with Paragraph 4.2(ii) of the Council's Procedure Rules Councillor Rob Cook attended as a substitute for Councillor Sheila Griffin.

Resident Representatives:
Mary Green

Also Present:
Councillor Steve Wallace, Chair of Hartlepool PCT
Chris Willis, Hartlepool PCT
Carmel Morrs, Hartlepool PCT
Peter Price, Hartlepool PCT
Karen Gater, Hartlepool PCT

Officers: Paul Walker, Chief Executive
Tony Brown, Chief Solicitor
Ewan Wier, Adult and Community Services Department
Charlotte Burnham, Scrutiny Manager
Sajda Banaras, Scrutiny Support Officer
Angela Hunter, Principal Democratic Services Officer

## 41. Apologies for Absence

Apologies for absence were received from Councillors Caroline Barker, Stephen Belcher and Sheila Griffin.

## 42. Declarations of interest by Members

Councillors Jonathan Brash, Mary Fleet and Steve Wallace declared personal and non-prejudicial interests in minute 47.

## 43. Minutes of the meeting held on 6th September 2006

Due to the unavailability of the minutes, consideration was deferred until the next meeting.

## 44. Responses from the Council, the Executive or Committees of the Council to Final Reports of this Forum

None.

## 45. Consideration of request for scrutiny reviews referred via Scrutiny Co-ordinating Committee

None.

## 46. Consideration of progress reports/budget and policy framework documents

None.

## 47. Hartlepool PCT – Future Board and Management Arrangements *(Scrutiny Support Officer)*

The Chairman of the PCT presented a report which summarised the challenges faced by new PCT Boards in meeting the demanding criteria set out by the Department of Health.

A discussion followed in which it was questioned under which legislation was the local authority being consulted and was this statutory consultation. The Chair of the PCT responded that this was not statutory consultation, as it would have had to be undertaken over a 13-week period, and this consultation had to be completed by the end of September. The Acting Chief Executive of the PCT added that as the consultation was not directly about a change in service provision, it was not liable to be undertaken on a statutory basis. The Chief Solicitor indicated that whether consultation was done on a statutory basis or not, an essential element was to allow sufficient time for consultees to respond adequately and fully having regard to the nature of the issues involved. He added that failure to comply with this could invalidate the process and leave any decision taken without proper consultation open to challenge.

The Chairman of the Adult and Community Services and Health Scrutiny Forum confirmed that in line with the advice received from leading Counsel the Forum would undertake this investigation within the Health Scrutiny Guidance as a Statutory Consultation. Whilst the PCT did not accept legal

advice received by the Council, the Chairman of HPCT was invited to make his presentation on the basis that it did not compromise the Forum or the PCTs respective legal positions. In light of the timescales involved the Chairman also confirmed that a three week consultation period is insufficient to allow the Scrutiny process to be followed through and respond to the October deadline for HPCT.

The Chairman of the PCT recommenced with his presentation and indicated that the main challenges being faced by the PCT were:

- Management Cost Savings
- Joint/Shared Management
- Budget Deficit
- Fitness for Purpose Assessment
- Joint Working and Locality Focus

The report indicated that after considerable efforts, Hartlepool PCT's Senior Management Team could not find a way to maintain a separate management structure dedicated solely to the Hartlepool PCT Board, that achieved the necessary 15% savings, satisfied the Fit for Purpose criteria and enabled delivery of the financial recovery plan. However, the following two options were suggested by the Senior Management Team as possible ways forward:

- Option 1 – one management team servicing four PCT Boards
- Option 2 – two management teams, one servicing Hartlepool and North Tees PCT, the other Middlesbrough and Redcar & Cleveland.

The Acting Chief Executive informed Members that the PCT had tried to address how this whole process can be used to strengthen partnership arrangement with the local authority. She added that by 2008, most NHS Trusts should received Foundation Trust Status. Attached by way of appendix was a diagram that showed the four boards across the Teeswide area and how they may be managed by Teeswide Sub-Committees, a Remuneration & Terms of Service Committee and a Joint Strategic Planning and Commissioning Committee.

Also attached by way of appendix was a diagram showing the proposed Tees Management Arrangements. This included separate Directorates for both North and South of Tees Chief Executive's as well as Teeswide Directorates and Functions. The Acting Chief Executive indicated that the proposed structure should help to look and plan ahead as well as ensuring patients receive the best care with a choice of providers and locations. As far as Public Health was concerned, it was suggested that there needed to be improvements made with regard to joint working with the local authority and that links with the community needed to be strengthened.

A discussion followed in which the following issues were raised:

**Would the role of the PCT Board including allocating spending?** The Chair of the PCT indicated that decisions would be taken by the Board but that

and that the majority of the Board were non-executives. A decision was being awaited from the Appointments Commission with regard to the candidates interviewed for a place on the Board.

**Would the Joint Strategic Planning & Commissioning Committee be an accountable body?** The Acting Chief Executive confirmed that the Committee would be from across the four boards and the Teeswide Director would need to operate within a framework. The Terms of Reference for this Committee would have to be approved by the Hartlepool Board. It was added that the majority of expenditure that would be overseen by this Committee was that of GPs.

**Would individual PCTs delegate their spending responsibility to that body with the decisions made by the Committee?** Karen Gater responded that Hartlepool PCT would retain a board and it would have a statutory duty to balance the books. PCTs cannot subsidise each other and they must ensure their books were balanced. The Chair added that all PCTs would have to agree before any proposals could be approved. That was his 'bottom line'. The Chief Executive indicated that the Terms of Reference of the Committee had not been formed yet, but they would not act contradictory to the Board.

**Did Option 2 not have the same disadvantages as Option 1 but in a more diffuse manner?** The Chair of the PCT indicated that this should not happen if the proposals were implemented correctly. He added that Hartlepool and Stockton would pair up naturally as they operated under the same ethos, as do Middlesbrough and Redcar.

**Would the partnership of Hartlepool and Stockton not rely on a similar agreement being made between Middlesbrough and Redcar?** The Chair of the PCT responded that this may be the case. However, Middlesbrough and Redcar see themselves as working together in a natural way also.

**What did the 'Fitness for Purpose' assessment mean to the people of Hartlepool?** The Chair of the PCT indicated that this assessment should mean that the people of Hartlepool have access to a health service with a choice of provider. Information would be provided to patients to enable them to make an informed choice. In order for this to work efficiently, there must be robust contracts in place. The Director of Finance added that the whole system needed to have more rigorous monitoring in place as it was so complex. Increasingly individuals were choosing to go elsewhere for treatment.

The Director of Public Health added that the proposals should lead to getting maximum health gain for the allocated budget, including prevention. The whole package of the commissioning process was important to ensure investment was made in the right areas.

**How was primary care being taken forward?** The Acting Chief Executive informed Members that the financial position over the next 18 months was not good. However, primary care was seen as an area for development and was

in the Vision for Care for Hartlepool.

**There was concern that the majority of the job cuts would occur at operational level?** The Chair of the PCT indicated that any job cuts would be shared across both Hartlepool and Stockton sites. However, he added that the proposal was to reduce the layers of management within the structure and achieve cost savings at that level rather than at the service delivery level.

**Would patients be referred to a particular hospital dependent on the cost of their treatment?** The Chair of the PCT advised that there was a national tariff in place for all treatment. The Director of Finance added that all patients would be able to attend to Hartlepool Hospital unless they required specialist treatment that could be provided elsewhere. Patients could also choose to be treated elsewhere, provided the treatment was provided at the national tariff. The Chair of the PCT informed Members that the people of Hartlepool had a loyalty to their local hospital and that this relationship should be maintained.

**Concern was expressed that patients were being told to use Hartlepool maternity services as North Tees was closed adding extra pressure, who would decide this course of action?** The Chair of the PCT indicated that this should be a question for the hospital and their management. However, the Acting Chief Executive added that in reality, patients were moved to another hospital to help deal with any pressures.

**Hartlepool and Stockton appeared to be in conflict with regard to the Darzi review, how would a single management team deal with this?** The Chair of the PCT indicated that the Boards would reflect the views of the non-executive members and if a majority was not in attendance, executive members would abstain from voting as had happened in the vote about PCT reconfiguration. If the Boards did have conflicting views, officers, including the Chief Executive would need to deal with this. However, he would expect the Chief Executive to pursue the decisions made by the non executive majority. The Acting Chief Executive added that the organisations involved would need to find a way of working together.

**What if the management team had to make a public statement and the Boards had different views?** The Chair of the PCT advised that he felt that the Chairman of the PCT should be the public face as officers could be pulled in two directions. The Chief Executive indicated that any major decisions would be taken by the Joint PCT Committees that will be formed.

**There was some concern that serving 2 boards would be twice as hard as serving 1, although there appeared to be no alternative to this option?** The Chair of the PCT advised that there did not appear to be a perfect plan to be implemented, but this was the least worse of the options given and did have some benefits.

The representatives from the PCT were thanked for their informative presentations and for answering Members questions.

**Decision**

In line with advice obtained from leading Counsel in relation to health service reforms, the Adult and Community Services and Health Scrutiny Forum has conducted this investigation as a statutory investigation as outlined in Health Scrutiny Guidance. This preserves the Forum's right to refer the issue to the Secretary of State. However, in the spirit of partnership working the Forum agreed to interpret this responsibility as flexibly as possible and Members agreed to hold a further joint meeting with Members of Scrutiny Co-ordinating Committee on 29 September 2006 to expedite the issue in line with the PCT's timetable.

GERALD WISTOW

CHAIRMAN

# ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM

## MINUTES

26 October 2006

**Present:**

Councillor: Gerald Wistow (In the Chair)

Councillors: Jonathan Brash, Mary Fleet, Sheila Griffin and Geoff Lilley

Resident Representative:
Evelyn Leck

Also Present:
Paul Hyde, Independent Consultant
Julian Penton, New Deal for Communities
Dr Brash – GP
Keith Bayley – HVDA

Officers: Alan Dobby – Assistant Director of Adult and Community Services
Cath Adams – Principal Review Manager
Sajda Banaras, Scrutiny Support Officer
Denise Wimpenny, Principal Democratic Services Officer

## 48. Apologies for Absence

None

## 49. Declarations of interest by Members

The Chair requested that declarations of interest be recorded in accordance with those made at previous meetings.

## 50. National Perspective/Social Prescribing *(Scrutiny Support Officer)*

The Scrutiny Support Officer presented a report outlining the National perspective in relation to Social Prescribing.

The report provided an extract from the 'our health, our care, our say' white

paper which set out the Government's vision to provide people with good quality social care and NHS services in the community where they lived.

**Decision**

that the extract from the white paper, be noted.

## 51. Evidence from HVDA and Paul Hyde Author of Report Commissioned by Hartlepool Partnership and HVDA in relation to Developing Social Prescribing in Hartlepool

*(Scrutiny Support Officer)*

As part of the Forum's on-going inquiry into Social Prescribing, the Forum received evidence from Paul Hyde, the Author of the report commissioned by Hartlepool Partnership and HVDA into 'Developing Social Prescribing in Hartlepool. Paul Hyde presented the report to Members which provided background information relating to social prescribing. Members were introduced to social prescribing as a concept and informed of how it could complement or be used as an alternative to traditional medical responses to health issues.

Members were advised that it was estimated that up to 75% of people who attended GP surgeries had psychosocial problems. Whilst it was appreciated that GP's were extremely knowledgeable in relation to social conditions they had limited resources to address certain patient needs. GP's in Hartlepool had heavy workloads and a short time period allocated for each consultation.

It was pointed out that there were certain patients whose frequent appearance made the Doctor's heart sink. In light of this, the Forum were advised that Social Prescribing models could assist GP's in tackling a patient's psychosocial problem(s) by developing a relationship between the GP practice and the Community and Voluntary Sector (CVS). By doing so, the CVS were able to offer the patient a holistic assessment of all their medical and non-medical issues and seek to address the root cause of the problem rather than the effect.

Members were advised that Social Prescribing recognised that a perfect solution for some patients may be a type of social prescription which could include a medical prescription. However, it could also encompass one or more the following social prescriptions:-

- Exercise on Referral Scheme such as the Hartlepool Exercise for Life Programme
- Referrals to specialist groups ie Hartlepool Mind for a holistic assessment

- Any other community or voluntary groups the GP may be aware of

However, given the number of community and voluntary sector groups, it was highlighted that there were many in Hartlepool who offered valuable opportunities for patients and could meet many social needs. However, a referral scheme for each would place undue pressure on GP practices as CVS groups could not provide their own referral scheme.

The following suggestions were pointed out on how the system may operate:-

- GP to refer appropriate patients for a holistic assessment to an experienced assessor with comprehensive and up to date information

- Patients supported to take up a 'social prescription' to either:-

  - lose weight
  - tackle stress
  - to work as a volunteer in the community to meet with others with similar issues

The importance of health staff and GP's trusting the system was highlighted together with a need for effective monitoring and evaluation methods.

Discussion ensued in which the following issues were raised:-

**A recent Neighbourhood Services meeting had considered Private Sector Landlords and a summary of wider housing issues. A Member queried whether family/social issues were taken into consideration as part of the holistic assessment?** The Consultant advised that a one hour holistic assessment may be appropriate to identify patient needs. This was far more time than a GP could offer and would take into account all issues, for instance, the patient may complain of depression and weight gain as being symptoms. However, further discussions throughout the assessment may identify the root cause of the symptom as being debt/financial concerns. Members were advised that the success of such schemes was dependent upon what was requested by the patient and what support was provided. The need for an holistic assessment was central to the whole scheme as had been identified through evaluations nationally.

**Weight gain was a problem for many people. Were there any statistics available in relation to success rates of weight loss programmes?** The Consultant stated that the report indicated a 90% success rate for the uptake of holistic assessments. However, this did not take into account patients who thereafter failed to attend the programmes.

**Do you perceive social prescribing as a replacement for drug therapy, if so, was there a problem asking GP's not to prescribe drugs?** Members were advised that whilst social prescribing was not a replacement for drugs, many people attending the surgery left without a prescription and, in addition, many patients were prescribed drugs and failed to take them.

**For those people who did not visit their GP regularly, how would they obtain information about Social Prescribing Schemes?** Members were advised that all CVS groups actively promoted their groups and access issues should be considered in the report.

The Consultant was thanked for an informative presentation and his attendance at the meeting.

**Decision**

that the contents of the presentation and report, be noted.

## 52. Introduction of New Deal in the Community Social Prescribing Project and Written Submission from Hartlepool Mind in relation to Social Prescribing in Hartlepool *(Presentation from Programme Manager for Community Development and Inclusion)*

As part of the Forum's on-going inquiry into Social Prescribing, Hartlepool Mind had been invited to provide a written submission to the Forum. As representatives of Mind were unable to attend the meeting, given the close partnership working between the Community and Voluntary Sector, the report attached as Appendix B was presented by a representative from the New Deal for Communities (NDC). Members were requested to ask any appropriate questions to contribute to the evidence based final report.

The Chair welcomed the New Deal for Communities (NDC) Programme Manager, for Community Development and Inclusion. Following on from the previous presentation, Members were advised that research had highlighted the link between psychosocial problems and loneliness. The absence of social connection had profound implications on how people operated in society. With regard to volunteering, longevity and morbidity, there was factual information which confirmed that volunteers and people with meaningful occupations were healthier and lived longer. Hartlepool Mind recognised the emotional as well as physical needs of individuals. Psychosocial factors formed the basis of the holistic assessment which would be offered by Hartlepool Mind.

The Programme Manager advised that part of the social prescribing model was that New Deal for Communities (NDC) funding support was a pilot scheme in collaboration with Dr Brash's GP surgery. It was anticipated that the benefits of such social prescribing schemes would also assist in reducing the practice's drugs bill. The holistic assessment would use existing knowledge and support and encouragement would be provided from Hartlepool Mind's skilful interview techniques. An example was provided for the Forum which demonstrated the success of adopting an holistic assessment approach as skilled service navigators referred patients to

appropriate schemes based on the outcome of the assessment. The Forum was advised that a Steering Group had been established and would continue to develop the project.

The Chair advised that Hartlepool Mind and Social Prescribing Schemes referred to above had received good coverage nationally and were recognised as contributing to the evidence base about the effectiveness of the approach well founded in practice. The Programme Manager was thanked for his informative presentation and his attendance.

**Decision**

that the information given, be noted.

## 53. Social Prescribing *(Presentation by Dr Brash)*

The Chair welcomed Dr Brash who was in attendance at the meeting to outline a GP's perspective in relation to Social Prescribing.

Dr Brash provided advice on how patients may be referred. At present, GP's were expected to advise patients on average within a ten minute consultation. Dr Brash supported the idea of holistic assessments and a service navigator role to assist GP's/patients in identifying an appropriate scheme. He pointed out that the following issues would need to be carefully considered:-

- how and when this could be rolled out across the town
- confidentiality aspect and sharing sensitive information. The patient must be aware of the issues
- the length of time to operate the scheme as this could not be provided indefinitely

Dr Brash provided examples of how social prescribing had worked in practice. It was pointed out that approximately 30 to 40% of drug prescriptions were not taken up and quite often patients would discontinue medication without informing their GP. In conclusion, Dr Brash stated that he looked forward to working in partnership to take the scheme forward.

Discussion ensued in which the following issues were raised:-

**How many partners would be involved?** The Programme Manager responded that as many bodies as possible would be involved in the process. It was intended to involve previous patients who had achieved a positive outcome to attend as helpers/volunteers. Studies had indicated that basic needs being met made a real difference to peoples well being. There was a limited budget available to facilitate this.

**Could this budget be used to support a social prescribing initiative around further education?** The Programme Manager advised that the

budget could not be utilised to pay course fees, however, this was worth considering as a future possibility.

**From a Doctor's perspective, what feedback was required to ensure you are satisfied that social prescribing was effective.** In response, Dr Brash reported that there would need to be a formal method of measuring success possibly via patient feedback.

**Was there capacity in the NDC area to cope with referrals? From a local authority perspective, they would need to be happy that this was a worthy system to expand?** The Programme Manager reported that the Director of Adult and Community Services had been involved in discussions of the Project Management Group. The group would be happy if in 6 months time good relationships had developed with GP surgeries and would welcome the possibility of over-prescribing.

**Decision**

that the information given, be noted to assist the Forum in completing the Social Prescribing Scrutiny investigation.

## 54. Evidence from HVDA and Author of Report Commissioned by Hartlepool Partnership and HVDA in relation to Developing Social Prescribing in Hartlepool

*(Scrutiny Support Officer)*

The Chair welcomed the Manager of HVDA who was in attendance at the meeting to provide a summary of the jointly commissioned report by Hartlepool Partnership and HVDA, details of which were outlined in Appendix A to the report. The key issues outlined in the report were as follows:-

- Background – Social Prescribing
- The National Picture
- National Best Practice
- Current Provision in Hartlepool
- Information on the local voluntary sector provision from previous research in Hartlepool
- How a social prescribing scheme could benefit GP's
- Key Findings
- Potential models for social prescribing in Hartlepool
- Exploration of Option 3
- Barriers to developing social prescribing in Hartlepool
- Development pathway
- Interviews and information drawn from

The Manager stated that HVDA were the single contact for approximately 750 community and voluntary groups. The main aim of the group was to ensure that all voluntary agencies were aware of where and who to refer people.

Further work was needed on how the work could be better organised.

Following discussion in relation to improving community engagement and community centres not being utilised to their full capacity, it was suggested that these issues be considered within the Forum's report.

In conclusion, the Chair thanked the representatives for their attendance which had provided an excellent start to a piece of work and had highlighted areas for consideration. The presentations had provided the Forum with a better understanding of the more holistic approach and emotional and social needs. It was pointed out that it was the Forum's responsibility to establish the links in carrying out this inquiry and to ensure sufficient publicity and attention was given. It was suggested that it may be beneficial to talk to Dr Brash again and the Hartlepool Mail.

**Decision**

that the information given, be noted and discussions be used to assist the Forum in completing the Social Prescribing Scrutiny investigation.

## 55. Consultation on Community Care Eligibility Criteria

*(Director of Adult and Community Services)*

Members views were sought, as part of the consultation process, on the following proposed changes in relation to:-

(a) the proposal to change the eligibility criteria and re-invest some of the savings in support to community based services for all

(b) what sort of community based services the Forum would like to see developed

In January 2006 Cabinet had agreed to consult on raising the Fair Access to Care Services eligibility criteria to "substantial needs". The authority currently provided statutory Social Care services such as home care or day care to those people whose needs were moderate, critical or substantial. Those people with lower level needs were given advice and information on other help which may be available to them in the community. These were services like Age Concern, Hartlepool Carers, Shopmobility and social groups.

Council's were expected to review their access criteria in each year's budget cycle. In doing so, it was proposed to change the eligibility criteria for those with moderate care needs. This would mean that those with moderate needs would be given advice and information like those with lower level needs. The proposed changes would assist the authority to free up resources to develop preventative community service open to all and to better support those people in need of high levels of statutory care.

Details of the consultation process were outlined in the report. Members discussed the relevance of social prescribing and the community care

eligibility criteria and the timescale for completion of the review. With regard to the timescale, Members were advised that Cabinet planned to consider the consultation feedback and reach a decision on the threshold criteria in January.. It was suggested that the matter be reconsidered in January taking into account evidence from the social prescribing review.

Following discussion the following issues were raised:-

**How many people fell within the critical needs criteria and how many would be moved from the moderate to low criteria?** The Assistant Director of Adult and Community Services advised that there were currently approximately 3,000 people who received support. Several hundred people would be reassessed in the coming year as having moderate needs and their statutory care services may be removed.

**A Member expressed disappointment that the home help services had been removed. Was any assistance provided for household tasks?** The Assistant Director of Adult and Community Services reported that people with severe needs received assistance with bathing, toileting, prompting medication and help with domestic tasks as a lesser priority.

**A Member requested a breakdown of the various bands and queried how much funding would be released by not meeting the needs of those people?** Members were advised that the exact figures were not available but the three bands contained roughly equal numbers. It was intended to utilise the funds for community based services and social inclusion schemes.

Members expressed concern that if the current service was removed this may have a negative effect and that further information be obtained before reaching a conclusion.

Further information was requested in relation to the savings identified as well as how the money would be re-invested. It was suggested that other local authorities be consulted to determine if this type of review had been carried out and, if so, with what results with a view to sharing information prior to recommendations being made.

It was pointed out that the Scrutiny Co-ordinating Committee were currently looking at funding for voluntary sector organisations which should be taken into consideration.

It was acknowledged that answers may be not available to all of the questions raised. It was suggested that the information be provided for consideration at the December meeting. In addition, it was recommended that Cabinet be informed of the issues raised.

**Decision**

(i) that further information be provided on how much funding would be released as a result of the proposal.

(**i**) that further information be provided on how the money would be re-invested.

(**ii**) that information from other local authorities be provided.

(iv) that since the Forum's work programme did not permit a full enquiry to be conducted, it should seek to summarise the evidence available to it in December and advise the Cabinet what information and considerations should be taken into account in reaching a final decision.

## 56. Minutes of the meeting held on 6 September 2006

Confirmed subject to the following amendment:-
Minute 31, Page 3, Paragraph 4, final sentence to be amended to read:-

"He added that the Centre for Excellence for paediatrics and gynaecology would be an extra service and that the hospital was to become a major centre for elective surgery and medical emergencies."

## 57. Minutes of the meeting held on 19 September 2006

Deferred for consideration at the next meeting.

## 58. Responses from the Council, the Executive or Committees of the Council to final reports of this forum

None

## 59. Consideration of progress reports/budget and policy framework documents

None

## 60. Any Other Business – Proposed PCT Management Arrangements

The Scrutiny Support Officer advised that Cabinet were happy to accept the Forum's interim report in relation to the PCT's proposed management arrangements.

Feedback was requested in relation to a response from the PCT to which the Scrutiny Support Officer advised that no acknowledgement had been received to date. It was suggested that a response be followed up with the PCT to determine whether to write to the Secretary of State.

It was reported that the Chief Executive and Chairman of the Health Authority had been invited to attend a Members Seminar scheduled for 6 November. It was considered that it would be more appropriate for them to attend a public meeting of Council or Scrutiny.
Following discussion, the Forum suggested that the meeting be reconsidered and the issue be further discussed at the Council meeting that evening.

**Decision**

(i) that a response from the PCT be followed up.

(ii) the invitation to the Members' Seminar be reconsidered and the issue be further discussed at the Council meeting that evening.

GERALD WISTOW

CHAIRMAN

# ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM

14 November 2006

HARTLEPOOL BOROUGH COUNCIL

**Report of:** Scrutiny Support Officer

**Subject:** ADULT AND COMMUNITY SERVICES DEPARTMENT: BUDGET AND POLICY FRAMEWORK INITIAL CONSULTATION PROPOSALS 2007/08

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## 1. PURPOSE OF REPORT

1.1 To provide the opportunity for the Adult and Community Services and Health Scrutiny Forum to consider the Adult and Community Services departmental pressures and priorities, grant terminations and proposed savings as part of the Budget and Policy Framework initial consultation proposals for 2007/08.

## 2. BACKGROUND INFORMATION

2.1 At a meeting of the Scrutiny Co-ordinating Committee held on 27 October 2006, consideration was given to the Executive's Initial Budget and Policy Framework consultation proposals for 2007/08.

2.2 At this meeting it was agreed that the initial consultation proposals be considered on a departmental basis by the appropriate Scrutiny Forum. Any comments / observations would then be fed back to the additional meeting of the SCC to be held on 17 November 2006 to enable a formal response to be presented to the Cabinet on 4 December 2006.

2.3 As such attached as **Appendices A to D** are the Adult and Community Services departmental pressures and priorities, grant terminations and proposed savings as part of the Budget and Policy Framework initial consultation proposals for 2007/08.

2.4 To assist Members of this Scrutiny Forum in the consideration of the Adult and Community Services departmental initial proposals, arrangements have been made for the Director of Adult and Community Services to be in

attendance and an invitation to this meeting has also been extended to the relevant Portfolio Holder (attendance subject to availability).

## 3. RECOMMENDATIONS

3.1 It is recommended that the Adult and Community Services and Health Scrutiny Forum:-

(a) considers the Adult and Community Services departmental pressures and priorities, grant terminations and proposed savings as part of the Budget and Policy Framework initial consultation proposals for 2007/08; and

(b) formulates any comments and observations to be presented by the Chair of this Scrutiny Forum to the additional meeting of the Scrutiny Co-ordinating Committee to be held on 17 November 2006 to enable a formal response to be presented to the Cabinet on 4 December 2006.

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**Contact Officer:-** Sajda Banaras – Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
Tel: 01429 523 647
Email: sajda.banaras@hartlepool.gov.uk

## BACKGROUND PAPERS

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

**APPENDIX A**

**SCHEDULE OF GRANT REGIMES TERMINATING DURING 2006/2007**

| Grant Title | Does Council need to consider mainstreaming the grant? Please state Yes/No and provide brief justification. | Value of Grant in 2006/2007 £'000 | Value of 2006/2007 Grant spent of staff costs (include NI and Pension) £'000 | Number of staff funded from Grant FTE's | Number of staff on fixed term contract FTE's | Estimated cost of making staff redundant £'000 | Funding available to fund redundancy costs £'000 |
|---|---|---|---|---|---|---|---|
| Preserved Rights Grant | Yes - grant tapers faster than costs taper total grant £376K | 40 | | | | | |
| Total Grant Regimes Terminating | | 40 | | | | | |

**APPENDIX B**

# SCHEDULE OF BUDGET PRESSURES 2007/2008

| Budget Heading | Description of Budget Pressure | Risk Impact of Not Funding Pressure | Value Budget Pressure<br><br>**2007/2008**<br>**£'000** | Value of additional Budget Pressure in 2008/2009 (only complete this column if value shown in 2007/2008 column is part year pressure)<br>**£'000** |
|---|---|---|---|---|
| Learning Disability Inspection | Resources to fund recommendations of statutory LD inspection eg<br>Direct Payments (see above costings)<br>Day Services modernisation capital costs of new base and potential double running costs to develop new service – cost yet to be clarified<br>Carers support/Flexible Respite options approx 150 k<br>Appropriate Advocacy service 80k per annum | Red<br>Reputation (will affect star rating and CPA) &<br>Failure to achieve national VP objectives | 230k min per annum. Potential for 100k double running costs for approx 18/24 months<br>(Also one off capital cost) | |
| Physical Disability/Sensory Loss | Approx 100 people waiting for statutory assessment re disability needs, demand for assessment and subsequent service have increased dramatically since 2002. Lack of assessment and services fails in Statutory responsibility and could leave council liable | Red<br>Life and limb risk to those left without equipment. | 148 | |

**APPENDIX B**

# SCHEDULE OF BUDGET PRESSURES 2007/2008

| Budget Heading | Description of Budget Pressure | Risk Impact of Not Funding Pressure | Value Budget Pressure<br><br>**2007/2008**<br>**£'000** | Value of additional Budget Pressure in 2008/2009 (only complete this column if value shown in 2007/2008 column is part year pressure)<br>**£'000** |
|---|---|---|---|---|
| Learning Disability Purchasing | to DDA claims and possible litigation if person is hurt whilst waiting for service. Additional OT expertise and purchasing budget to reduce specific waiting lists (currently up top 8 weeks) and meet statutory requirements around completion of assessments/additional resources necessary for outcome of assessments. Identification of 5 cases of transition from Children's Services. | Red<br>Inability to meet statutory obligations to maintain services to existing service users'? | 140 | |
| Direct Payments | Providing Direct Payments is a Statutory Requirement and to enable people to safely use the DP a Direct Payments Support Service is required, if DP users are unsupported will leave Council open to claims | Red<br>Reputation &<br>Failure to improve | 100 | |

**APPENDIX B**

# SCHEDULE OF BUDGET PRESSURES 2007/2008

| Budget Heading | Description of Budget Pressure | Risk Impact of Not Funding Pressure | Value Budget Pressure<br><br>**2007/2008**<br>**£'000** | Value of additional Budget Pressure in 2008/2009 (only complete this column if value shown in 2007/2008 column is part year pressure)<br>**£'000** |
|---|---|---|---|---|
| | of negligence re &S/Employment issues. The take up of DP is a KPi ( currently a failing one for Hpool) and was seen as essential in the recent LD inspection . | | | |
| Supporting People Programme | Strengthening team to deliver a more effective Supporting People programme in accordance with the grant conditions and Government's/Audit Commission's expectations, This will enable the housing related support needs of vulnerable people to be more effectively addressed. It responds to the needs identified in the Supporting People Inspection, which was published in February 2006. It will also help to ensure that | Red – relates to important housing related support for vulnerable people – accommodation and "floating support" | 100 | |

**APPENDIX B**

# SCHEDULE OF BUDGET PRESSURES 2007/2008

| Budget Heading | Description of Budget Pressure | Risk Impact of Not Funding Pressure | Value Budget Pressure<br><br>**2007/2008**<br>**£'000** | Value of additional Budget Pressure in 2008/2009 (only complete this column if value shown in 2007/2008 column is part year pressure)<br>**£'000** |
|---|---|---|---|---|
| | services are appropriate to meet the expectations of future inspections. | | | |
| Libraries | People's Network' PC's – all libraries – gives public access to internet. Insufficient budget for NIS managed service charges for existing PCs. Would have to withdraw public access. | Red<br>Reputation (forms part of BVPI 220) & failure to maintain current level of service. | 25 | |
| | | Total Budget Pressures | 743 | |

**APPENDIX C**

# SCHEDULE OF RED BUDGET PRIORITIES 2007/2008
# TOP LEVEL PRIORITIES

| Budget Heading | Description of Budget Priorities | Risk Impact of Not Funding Priorities | Priorities Value Budget Priorities **2007/2008 £'000** | Value of additional Budget Priorities in 2008/2009 **£'000** |
|---|---|---|---|---|
| Older People | Two connected care navigators for implementation of Connected Care Pilot. Significant development of neighbourhood-based partnership working, in pursuit of preventative policies, and reducing health inequalities. Very high profile nationally! | Red<br>Reputation & Failure to improve | 50 | |
| Maritime Festival 11017 | 2008 Maritime Festival; increased cost of delivering high quality service as a precursor to tall ships visit, spread over 2 years. | Red<br>Reputation & Failure to maintain standard of festival | 10 | |
| | | Total of Top Priorities | 60 | |

# SCHEDULE OF RED BUDGET PRIORITIES 2007/2008
# SECOND LEVEL PRIORITIES

| Budget Heading | Description of Budget Priorities | Risk Impact of Not Funding Priorities | Priorities Value Budget Priorities<br><br>**2007/2008 £'000** | Value of additional Budget Priorities in 2008/2009<br><br>**£'000** |
|---|---|---|---|---|
| County Sports Partnership | 25% match funding to obtain grant for funding of important new post. Ie Opportunity to gain additional strategic grant. Will develop a local sports network and facilitate greater access to healthy physical activity. | Red<br>Failure to improve and loss of external funding | 8 | |
| | | Total of Second Priorities | 8 | |

**PROPOSED SAVING AT 3%, 4% AND 5%**

**ADULT AND COMMUNITY SERVICES**

| Budget Heading | Description of Efficiency/Saving | Efficiency/Saving | Risk - Red, Amber, Green | Risk Assessment of implementing efficiency/saving | Impact of efficiency/saving on staffing levels | Value of efficiency/ saving £'000's | Description of one off cost of achieving efficiency/saving | One off cost of achieving efficiency/saving £'000 |
|---|---|---|---|---|---|---|---|---|
| Older Peoples Agency - Respite Services | Implementation of FACS and removal of moderate - reduce Substantial/ Critical level to 6 weeks | S | R | Politically sensitive. Sound project planning necessary for implementation. Likely significant increase in emergency assessments and placements or use of in-house homecare | None | 135 | None | |
| Management | Planning function - reduction in current capacity | S | R | Medium - reduces capacity in the longer term. Inability to achieve national objectives. | 2 Fte | 88 | Potential Redundancy costs | Tbd |
| Homecare | Reduction from three geographical areas to two reconfiguring management/supervision of service | E | R | Manageble impact. Reduces management capacity for 7 day service. Future developments around Telecare may be impacted | 3 Fte | 72 | Potential Redundancy costs | Tbd |
| Havelock | Deletion of Day Opportunity Clerk post | S | R | High ER/VR or redeployment | 1 Fte (continue to invest in Modern Apprentice and administrative role | 20 | Potential Redundancy costs | Tbd |
| Homecare | Reduction in home care service - 200 hours | S | R | Loss of flexibility in supporting discharge arrangements, placement management. Research on In Control & Direct Payments confirms LA' still have necessity to require flexible, responsive services as support and to be used as emergency support. Impact on | 10 - 20hr Contracts | 95 | Potential Redundancy costs ( natural wastage/vacancies) | Tbd |
| Community Centres | Planned closure of former Bridge Youth Centre and upgrading of neighbouring Burbank Community House to accommodate users | E | R | This proposal reduces the risk of considerable expenditure on a Victorian property - risk of new building being used to capacity in future years. Politically sensitive. | None | 36 | Capital improvement estimated £110K reqd to improve Burbank Community House.Demolition of Bridge costs TBD | Tbd |
| Warren Road | Deletion of Day Opportunity Clerk post | S | R | High ER/VR or redeployment | 1 Fte (continue to invest in Modern Apprentice and administrative role | 20 | Potential Redundancy costs | Tbd |
| Transport | Reprovision of service to achieve quality and flexibility (savings between 3-15%) | E | A | High - Tender and/or potential impact on staff in HBC fleet | Impact on fleet staff Responsibility on Service staff to co-ordinate transport | 75 | | |
| Sport & Recreation | Closure of Eldon Grove Community Sports Centre | S | A | Services relocated into Brierton Community Sports College and other Community Service property. The risk relates to the successful devt of the management SLA with Brierton Sports College to enable 1st April 07 commencement. Potentially politically sensit | Potential for staff redundancies however these are expected to be absorbed into recurring vacancies within other Sports Centre premises. | 30 | May include change requirements to Eldon Grove should other Service depts seek to relocate office based activity into vacated premises - ultimately leading to alternative premises savings elsewhere. Also potential for staff retention in short term unt | None |

**PROPOSED SAVING AT 3%, 4% AND 5%**

**ADULT AND COMMUNITY SERVICES**

| Budget Heading | Description of Efficiency/Saving | Efficiency/Saving | Risk - Red, Amber, Green | Risk Assessment of implementing efficiency/saving | Impact of efficiency/saving on staffing levels | Value of efficiency/ saving £'000's | Description of one off cost of achieving efficiency/saving | One off cost of achieving efficiency/saving £'000 |
|---|---|---|---|---|---|---|---|---|
| Sport & Recreation | Change of Vending service provision from internal to contracted out within Sports Centres | E | A | Savings targets may not be realised dependent upon turnover and contract. | None expected - may involve hours reduction or p/t redundancy if cannot be absorbed within service | 17 | Potential redundancy if cannot be absorbed | tbd |
| Culture , Heritage & Grants | Freeze Community Pool | S | A | No specific risk, however Community Sector are currently undergoing a funding crisis in certain areas leading to increased pressure on the Fund. Politically sensitive. | None within HBC | 12 | None | None |
| Community Centres | Reduction of service cost by reduction of maintenance and premises costs | S | A | Risk of service premises rapidly deteriorating - particularly as this cost saving excludes Bridge and Burbank which are affected elsewhere | None | 20 | None | None |
| Culture , Heritage & Grants | Close Art Gallery and TIC on Sundays and Bank Holidays | S | A | Negative impact on visitor perception and the Tourism regeneration economy. Reduced visitor figures re BV PI targets. Potential sensitivity owing to Tall Ships bid. | None directly - however salary enhancements affected and contract hours recycled elsewhere in service. Loss of enhancements protected for 18 months | 8 | None | None |
| Staff Development | Reduce course fees and training expenditure | S | G | Front line staff will not be able to maintain skills and knowledge, and risk failure to meet minimum statutory standards. | None | 12 | None | |
| Sport & Recreation | Increased income potential over service as a whole, over inflation | S | G | Risk of non achievement through lower than anticipated user levels | None | 10 | None | None |
| Parks & Countryside | Closure of Ward Jackson and Burn Valley toilets | S | G | Reduces the contract sum payable to Neighbourhood Services but meets the recent WC Strategy recommendations as proposed by Neighbourhood Services. Ward J Park will have café Toilets during café opening hours and Burn Valley toilets are currently close | No impact in Adult & Community Services - potential impact on Neighbourhood Services Strategy (WC) | 8 | None | None |
| Library Services | Review of Delivered services leading to greater efficiency in the provision of Mobile Library / Bookbus / Home Delivery Service | E | G | The review is expected to deliver a more efficient routing and delivery of service and will reduce the number of vehicles required due to the changing nature of the service | 1 Fte Reduction in one driver - however current cover is restricted to short term contracts in anticipation of the changes. | 50 | None | None |
| Library Services | In service reductions of budget across various headings to increase efficiency - out with the Vehicle delivered services | E | G | Less flexibility in ability to respond to service changes and developments. | None | 15 | None | None |
| Lansdowne Road | Sale of Existing property (not used for service) | S | G | Low | None | 5 | None | |
| Culture, Heritage & Grants | Revised opening / staffing hours at the Hartlepool maritime Experience - lower hours in winter | S | G | Partnership with HMS Trincomalee requires joint agreement, aim is to reduce winter hours when quiet periods identified , potential for some longer hours in summer. | None - move staff to annualised hours and less reliance on the casual / temp staff pool | 7 | None | None |

**PROPOSED SAVING AT 3%, 4% AND 5%**

**ADULT AND COMMUNITY SERVICES**

| Budget Heading | Description of Efficiency/Saving | Efficiency/Saving | Risk - Red, Amber, Green | Risk Assessment of implementing efficiency/saving | Impact of efficiency/saving on staffing levels | Value of efficiency/ saving £'000's | Description of one off cost of achieving efficiency/saving | One off cost of achieving efficiency/saving £'000 |
|---|---|---|---|---|---|---|---|---|
| Culture , Heritage & Grants | Increase level of Hire fees for Commercial hire of Theatre & Halls | S | G | Possible loss of bookings due to charge increases | Increases the differential between current community / subsidised hire rates and that of the Commercial hire. | 5 | None | None |
| Culture , Heritage & Grants | Reduction in projects fund | S | G | Current demand on this support fund and changes to service provision in related premises is achievable with limited impact | None | 8 | None | None |
| Day Services | Reconfiguration of Mental Health day opportunities | E | G | Low - review underway | Tbd | 51 | Tbd | Tbd |
| **TOTAL 3%** | | | | | | **797** | | |
| Support Services | Reduce support for complaints, adult protection, public information, and monitoring of services | S | R | Additional pressure on front line staff, fall in quality of provision to vulnerable adults; and loss of reputation/performance ratings | 2 Ftes | 60 | Potential Redundancy costs | Tbd |
| Multi Link Team | Non filling of current vacancies | E | R | Reduces managerial/supervisory capacity in challenging operational area. Impact on delayed discharges may incur reimbursement fines. | 2 Fte | 45 | Potential Redundancy costs | Tbd |
| Older Peoples Agency - Day Services | Closure of St Cuthbert's Day Centre | S | R | Politically sensitive. Possibility of increased home care need for some users and would still need to find alternative service if meeting eligibility criteria. | None | 62 | | |
| Assessment & Care Management | Reduction from three geographical areas to two reconfiguring management/supervision of service | E | R | Reduces managerial/supervisory capacity in challenging operational area. Doesn't fit with locality working but reduces accommodation problems! Potential incrase in stress related issues. | 3 Fte | 104 | Potential Redundancy costs | Tbd |
| **TOTAL 4%** | | | | | | **1,068** | | |
| Community Pool | Further reduction in value of Community Pool | S | R | Greater direct impact on Community Groups in receipt of funding. Some voluntary organisations may cease to exist. | Redundancies inevitable in Voluntary Sector | 65 | None | None |
| Havelock/ Warren Road | Removal of kitchen facility from day services & replacement of food with cook/chill provision | E | R | High - political impact, staffing and potential redundancies ER/VR or redeployment | 4.5 Fte | 86 | Potential Redundancy costs | Tbd |
| Havelock | Reprovision of existing service to independent sector - set up as voluntary or service user led service | E | R | High - political impact, staffing and potential redundancies ER/VR or redeployment | Potential redundancies on TUPE issues. | 113 | Tupe, ER/VR. Start up costs for new service | Tbd |
| **TOTAL 5%** | | | | | | **1,332** | | |

# ADULT AND COMMUNITY SERVICES AND HEALTH SCRUTINY FORUM REPORT

**14 November 2006**

HARTLEPOOL BOROUGH COUNCIL

**Report of:** Scrutiny Support Officer

**Subject:** Covering Report – Evidence from Bradford PCT

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## 1. PURPOSE OF REPORT

1.1 To provide Members with a copy of Bradford PCT's Evaluation Report and supporting documentation in relation to their Social Prescribing Project known as; C.H.A.T. (Community Health Advice Team).

## 2. BACKGROUND INFORMATION

2.1 As the Members w ill be aware, part of the role of this Scrutiny Forum in conducting an in-depth investigation is to seek views from all relevant stakeholders in relation to the issue under investigation. It is by gathering evidence from a variety of sources that the Forum is able to build up a knowledge base to assist it in taking the inquiry forward.

2.2 It is to this end that the representatives of Bradford PCT have been invited to today's meeting to outline for Forum Members how Social Prescribing is being developed in Bradford. Following an initial presentation in relation to the project (see attached information in **Appendices A to D**) Members are requested to ask any questions felt appropriate to gather sufficient evidence to assist in its production of a final report.

## 3. RECOMMENDATIONS

3.1 That Members note the content of the attached papers and invite representatives from Bradford PCT to make their submission.

**Contact Officer:-** Sajda Banaras – Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
Tel: 01429 523 647
Email: Sajda.banaras@hartlepool.gov.uk

Bradford NHS
South & West
Primary Care Trust

**C.H.A.T**
Community Health Advice Team (C.H.A.T) is the name we are using for the Bradford South and West PCT Social Prescribing project.

**What is Social Prescribing?**
It is a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector.

**Aim of project:**
To give primary health care workers a resource to enable them to broaden their service provision to patients with psychosocial needs.

**Objectives:**
- To enable primary care staff to link patients to appropriate support in the community
- To co-ordinate, facilitate, and support links between primary care and the voluntary and community sector, increasing their capacity to work together
- To support patients to access appropriate voluntary and community sector services and provide follow up support

**Why use Social Prescribing?**
- 70% of the population visit their GP within a year
- Over 75% of patients presenting to primary care have at least one psychosocial problem
- Primary care workers have limited treatment options for non-medical needs
- Social networks and support enhance people's physical and psychological health
- It offers the opportunity and manageable structure to work in partnership with the voluntary sector
- It recognises, and responds to, the wider social and economic determinants of health
- It can improve patients' quality of life and well being, while reducing the workload and stress of primary care workers

**When to use Social Prescribing?**
- When you have extended consultations with patients who have limited emotional support
- When you have long consultations with patients with complex social issues
- When you have regular visits from patients who are socially isolated
- When you spend time locating support services

**IF YOU HAVE ANY QUERIES PLEASE CONTACT SIMON WHITE at Simon.White@bradford.nhs.uk or 01274 237626**

# CHAT Referral Guidelines

Our new social prescribing service CHAT is a primary care resource that can help you to improve the health and well being of patients with psycho social needs. CHAT can provide short-term support and timely and appropriate access to local voluntary and community groups that can help to address your patients' non-medical needs.

**When to refer**

- If you are having extended consultations with patients who are socially isolated and/or have complex social issues and/or have limited emotional support.

- If you are spending time locating local support services

**Who to refer**

You can refer patients with one or more of the following psychosocial needs: -

- Social Isolation/Loneliness
- Low self-esteem/self confidence
- Stress/Anxiety/difficulties coping
- Relationship difficulties
- Financial difficulties
- Housing
- Immigration
- Education/Training
- Unemployment
- Learning difficulties/Sensory impairment
- Caring for a dependent
- Parenting
- Bereavement
- Weight problems

**A CHAT Referral Form should be completed for all patients referred as the scheme operates on an appointment only basis which can only be made upon receipt of a completed referral form. Completion of the referral form will also enable us to provide you with written feedback on the outcome of the referral.**

***Please put completed forms in a sealed envelope, marked for the attention of CHAT and place in Simon White's pigeon hole.***

Simon White **01274 237626**

# CHAT UPDATE TO END JUNE 06

Total no of referrals: 163

| | Ridge | Royds | Bowling Hall | Total |
|---|---|---|---|---|
| **Male** | 39 | 17 | 2 | 58 |
| **Female** | 61 | 41 | 3 | 105 |
| **Total** | 100 | 58 | 5 | 163 |

Ethnicity:

| | Ridge | Royds | Bowling Hall | Total |
|---|---|---|---|---|
| **White British** | 71 | 39 | 3 | 113 |
| **White Other** | 1 | 2 | 0 | 3 |
| **Asian** | 13 | 2 | 0 | 15 |
| **Black** | 1 | 2 | 0 | 3 |
| **Not Known** | 14 | 13 | 2 | 29 |
| **Total** | 100 | 58 | 5 | 163 |

Age range:

| | Ridge | Royds | Bowling Hall | Total |
|---|---|---|---|---|
| **16-25** | 8 | 20 | 1 | 29 |
| **26-35** | 8 | 9 | 1 | 18 |
| **36-45** | 13 | 9 | 0 | 22 |
| **46-55** | 17 | 7 | 0 | 24 |
| **56-65** | 8 | 4 | 0 | 12 |
| **Over 65** | 32 | 2 | 1 | 35 |
| **Not Known** | 14 | 7 | 2 | 23 |
| **Total** | 100 | 58 | 5 | 163 |

Referral reasons:

| | Ridge | Royds | Bowling Hall | Total |
|---|---|---|---|---|
| **Social isolation** | 47 | 36 | 3 | 86 |
| **Volunteering** | 12 | 3 | 0 | 15 |
| **Disabilities** | 3 | 2 | 0 | 5 |
| **Training** | 16 | 5 | 0 | 21 |
| **Family issues** | 10 | 6 | 0 | 16 |
| **Exercise** | 1 | 1 | 0 | 2 |
| **Feels useless** | 5 | 2 | 0 | 7 |
| **Bereavement** | 3 | 1 | 0 | 4 |
| **Housing issues** | 10 | 8 | 1 | 19 |
| **Total** | 107 | 64 | 4 | 175 |

Who has referred?:

| | Ridge | Royds | Bowling Hall | Total |
|---|---|---|---|---|
| **GPs** | 29 | 32 | 1 | 62 |
| **Nurses** | 46 | 14 | 3 | 63 |
| **Health Visitors** | 2 | 8 | 0 | 10 |
| **Receptionists** | 1 | 0 | 0 | 1 |
| **Self** | 22 | 4 | 1 | 27 |
| **Total** | 100 | 58 | 5 | 163 |

No of different referrers:

| Ridge | Royds | Bowling Hall | Total |
|---|---|---|---|
| 21 | 8 | 3 | 32 |

Bradford South & West Primary Care Trust NHS

leeds metropolitan university

The Centre for Health Promotion Research

# The Evaluation of the CHAT Social Prescribing Scheme in Bradford South & West PCT

November 2005

James Woodall

and

Jane South

Leeds Metropolitan University

# Acknowledgements

The authors would like to thank the following people:

Tracy Higgins, Health Partnerships Co-ordinator and Simon White, Public Health Project Development Worker for their support and assistance throughout this evaluation.

The Practice Managers of the Ridge and Royds for their help in accessing the patients and professionals.

Finally, all the patients and staff who took part in the research.


# Executive Summary

A pilot social prescribing scheme has recently been set up in Bradford South and West Primary Care Trust (PCT). The aims of the scheme, called CHAT (Community Health Advice Team), are to broaden service provision for patients with non-clinical needs and to facilitate links between primary care and the voluntary sector. The evaluation focused on the development of the scheme in the Ridge and Royds medical practices and used a case study design to examine the scheme from the perspectives of service users and health professionals. In addition, some data were gathered from key individuals involved in the first pilot scheme delivered by Healthy Lifestyle Healthy Living Centre at Dr Micallef & Partners, Highfield Health Centre. In total, 18 semi-structured interviews were carried out over a ten week period.

The evaluation suggests that CHAT is a valued scheme within the primary health care setting. There has been a steady flow of referrals in both practices and CHAT is being used by a diverse range of patients in terms of age, gender and social problems. The findings from the qualitative data show that the scheme is acceptable, relevant and appropriate from the perspective of staff and service users. Patients and health care professionals perceive the CHAT scheme to be a successful bridge between primary care and the voluntary sector. In the interviews all patients expressed some form of positive outcome as a result of being on the scheme – reduced isolation, increased confidence, and access to non-stigmatised support were a few examples. Patients perceiving CHAT as an individual, caring service, tailored to their own appropriate needs, was a powerful indicator of its success.

Staff who took part in the evaluation discussed how the CHAT scheme had the potential to reduce workload and improve the quality of patient-professional consultation. The benefits for staff having a 'personalised, caring' service were frequently cited as being one of the strengths of CHAT. CHAT provided access to a source of expert knowledge which was welcomed by staff. The benefits of the scheme to general practice were also highlighted

by this evaluation. Having the scheme as an extension of primary health care adds further to the holistic work happening in these practices.

The current model of the scheme is working well and has been found to be acceptable and relevant. If the scheme was extended and potentially rolled out to other practices in the PCT it would be important that the core elements of the model developed in Bradford South and West were maintained. However, consistent and regular feedback for referrers is currently not being achieved and this is an issue which may need to be considered for future practice.

# Contents

# 1. Introduction

Social prescribing is a mechanism for linking patients in primary care with non medical service support in the community. The approach provides a framework for developing alternative responses to psychosocial need (Friedli and Watson, 2004) and forms part of a wider recognition of the influence of social and cultural factors on health.

Social prescribing helps to address the gap between primary care and voluntary organisations through community development workers. These individuals have detailed knowledge of local services and support groups, ensuring appropriate referrals for patients (Bromley PCT, 2001). Recent discussion from Friedli and Watson (2004) has seen social prescribing having benefits in three key areas:

1) Improving mental health outcomes;
2) Improving community well-being;
3) Reducing social exclusion.

The scheme is particularly applicable for vulnerable and at risk groups, people with mild to moderate depression and anxiety, and those who are frequent attendees at General Practitioner (GP) surgeries.

## Bradford South & West PCT scheme

A pilot social prescribing scheme has recently been set up in Bradford South and West Primary Care Trust (PCT). The aims of the scheme, called CHAT (Community Health Advice Team), are to broaden service provision for patients with non-clinical needs and to facilitate links between primary health care and the community and voluntary sector. The first pilot scheme in the PCT was started in 2004 through Healthy Lifestyle Healthy Living Centre at Dr Micallef and Partners, Highfield Health Centre. This has recently expanded to include Dr Mills and Partners. A second social prescribing pilot was started in 2005 within two general practices, The Ridge (in Great Horton and Wibsey)

and Royds (in Buttershaw). A CHAT worker was appointed to develop and deliver the scheme in both practices.

The social prescribing scheme in Bradford South and West PCT works by primary health care professionals referring patients with non-clinical needs to CHAT. The CHAT worker meets with the patient to discuss their needs and then identifies an appropriate source of support in the community. The CHAT worker facilitates access to community groups or courses and may accompany the patient on their first visit if required. Any member of the primary health care team, including GPs, nurses, health visitors, district nurses and receptionists, can refer patients to the scheme by completing a simple referral form. Alternatively, patients can self refer by completing the tear off slip included in a leaflet which is available from surgery receptions and local pharmacies. A key benefit of the scheme is that the CHAT worker is able to spend longer with a patient than primary care staff are often able to, offering up to three forty-minute appointments. This provides the patients with the opportunity to discuss any issues that they feel are affecting their health and the possibility of exploring a variety of solutions.

## Evaluation

The Centre for Health Promotion Research, at Leeds Metropolitan University, was commissioned to evaluate the pilot social prescribing scheme (CHAT) in Bradford South and West PCT. The evaluation objectives were:

- To examine the acceptability, relevance and appropriateness of the scheme for participants and primary health care staff;
- To assess the effectiveness of social prescribing in addressing social, emotional or practical needs within a primary care context;
- To identify factors influencing the delivery and utilisation of social prescribing;
- To produce a short evaluation report with the main findings and points of learning from the pilot scheme.

The evaluation focused on the development of the second pilot in the Ridge and Royds practices and used a case study design to examine the scheme from the perspectives of service users and health professionals. In addition, some data were gathered from key individuals involved in the first Healthy Lifestyle Healthy Living Centre pilot scheme.

This report is divided into 7 sections. Section 2 of this report reviews the existing literature related to social prescribing. Section 3 provides the evaluation methodology including the process of data collection and analysis. The findings are reported in sections 4 and 5 which are then discussed in section 6. Finally, section 7 discusses the future of the scheme and identifies issues for consideration.

# 2. Literature Review

## 2.1 A rationale for social prescribing

According to a relatively large Norwegian survey (n=1401), over three-quarters of patients consulting their GP admit to having at least one psychosocial problem (stress, sorrow, loneliness), and over a third reported that psychosocial problems impact on their present health (Gulbrandsen, Hjortdahl and Fugelli, 1997). The pressure on GPs and other primary health care professionals is immense. *Saving lives: our healthier nation* (Department of Health 1999) advocated the promotion of health through drawing on community support structures such as the voluntary sector to help manage psychosocial problems in primary care. However, due to increased work pressures, it can be difficult for general practitioners to access and keep up to date with developments in voluntary agencies (Bromley PCT, 2001). This is reiterated by Graham (1995) who suggests that general practitioners generally underutilise services in the voluntary sector.

The role of the voluntary sector in health service provision should not be understated. It is estimated that the sector has a substantial income of twelve billion pounds per year, with an abundance of volunteers with time to dedicate to individual patients. Furthermore, given the variety of organisations integrated within the sector, there is likely to be one which could provide help for every patient presented to primary care and the NHS (Crombie and Coid, 2000).

## 2.2 The effectiveness of social prescribing

Social prescribing is a relatively new concept and there is limited published literature which addresses its role in primary health care. The effectiveness of such schemes has lacked rigorous evaluation. This has been hampered primarily through inconsistencies in interpreting the term ‘social prescribing’ and through weak methodological design, particularly in respect to qualitative

evaluations (Brown, Friedli and Watson, 2004). There are, however, projects in existence based on similar principles which provide valuable insights into the effectiveness of social prescribing.

A randomised control trial by Grant et al. (2000) compared the outcome of patients assigned to the *Amalthea Project* with those who were assigned only to receive general practitioner contact. Those randomly allocated to *Amalthea* had access to voluntary organisations as well as general practitioner care. All patients in both the control and experimental groups displayed psychosocial problems and were considered eligible by their general practitioner for contact with the voluntary sector.

All patients in the study supplied baseline psychometric data, which was measured at one and four months after randomisation. The study, published in the *British Medical Journal* showed that those assigned to the *Amalthea Project* had significant improvements in anxiety, improved ability to carry out every day activities and improved feelings about general health and quality of life. Although referral to *Amalthea* was more costly than traditional general practitioner care (£153 versus £133), the research would suggest that referral to a service that facilitates contact between the voluntary sector and primary care is more effective than stand alone general practitioner care.

Other schemes such as the Family Welfare Association (FWA) offer a referral facilitation service similar to *Amalthea*. The FWA employs Family Support Coordinators (FSC) to provide generic advice, support and counselling services for individuals and families in a primary care setting. In two and a half years over 1200 referrals were made to this service across five areas. Emotional and minor mental health problems were the most common problems (53%) followed by material problems, such as welfare and housing (41%). An evaluation of the scheme reported that the service was anonymous and therefore less stigmatising than statutory social services. This was particularly pertinent for service users who feared becoming involved in child protection procedures (Clarke et al. 2001).

In the Park practice within Penge and Anerley PCT, primary health care staff are able to refer patients with psychosocial issues to a community development worker, who facilitates access to community based support. This worker provides an important link for patients who would otherwise not have made contact with support organisations. At the end of the pilot phase the service at the practice was evaluated. Based on retrospective interviews with primary care staff and sixteen referrals, the key findings of the evaluation were:

- Positive feedback from patients, notably a reduction in social isolation;
- Patients accessing services of which they would otherwise not be aware;
- Staff observing increases in patients' self-esteem and confidence;
- Problems highlighted by the primary care staff including a lack of knowledge of voluntary and community services. However, staff found referring via the community development worker simple and quick.

(Friedli and Watson, 2004)

The Patient Support Service (PSS) in Doncaster uses a similar approach to that of the Park practice within Penge and Anerley PCT. Referrals to the scheme are made by GPs or practice nurses to the PSS team. These patients are then assessed by the PSS and are referred to community based services within the locality. Semi-structured interviews with patients and staff (n=11 patients, n=9 staff) showed that PSS had successfully utilised the voluntary sector to support patients. It was deemed an important adjunct to traditional approaches of referral in general practice, acting as:

> "a linchpin between the professional role of medicine and the voluntary world of psychosocial support" (Faulkner, 2004 page 46).

*Prescription for learning* is another innovative scheme based on the principles of social prescribing. Launched in Nottingham, GPs, practice nurses, health visitors and mental health nurses refer patients to the scheme with symptoms

such as anxiety, low self-esteem and chronic pain. The aim of the scheme is to provide the patients with increased confidence, thereby reducing dependence on primary care professionals. An evaluation of the *prescription for learning* scheme in Nottingham assessed the health impact on 196 patients. Research by Aylward and James (2002) reported that the scheme had increased participants' self-esteem and their social activity as well as having a positive impact on their physical health.

Similar schemes to social prescribing, such as those developed to offer welfare benefits advice in primary care have been well researched. Sherratt et al. (2000) suggest that Primary Care Trusts appreciate specialist advice workers, as they provide a better service to patients and also save staff time. In Bradford, a welfare advice service was especially successful in addressing the needs of older people and ethnic minorities. Easy access and bilingual South Asian advice workers were critical in the project's effectiveness. The authors concluded by suggesting the service is an excellent strategy by which primary care can address the social, economic and environmental influences on the health of their population (Greasley and Small, 2005). Harding et al. (2002) make the point however that although the intervention is effective, provision of the service is patchy and not fully encouraged by all clinical staff.

## 2.3 Conclusions from the literature

Despite the weakness in the evidence base for social prescribing, there is sufficient research to indicate that it is a useful approach in primary health care, and can benefit patients through providing a holistic package of care (Bromley PCT, 2001). While the evidence base for social prescribing is growing, the process involved in establishing partnerships and implementing schemes in reality may be far more complex.

# 3. Evaluation methodology

A qualitative approach was adopted for the evaluation, based on methods of data generation that are flexible and sensitive to the social context in which they are produced (Mason, 1996). A case study design was used which examined the scheme from the perspectives of service users, primary health care professionals and practice staff, and those involved in developing and delivering the pilots. In addition, monitoring data from the second pilot were analysed.

## 3.1 Methods

Given that an appreciation of factors affecting the health of those who are referred to the social prescribing scheme may be potentially complex, semi-structured interviews were thought to be appropriate and sensitive for gaining the type of information sought. This approach was considered more likely to facilitate respondents to state their feelings regarding the scheme and illuminate the processes involved. Interview schedules for both the patients and health care staff were developed. These schedules were designed through reading literature relating to social prescribing and consultation with the CHAT manager and worker. The patient schedule broadly covered areas around the process of referral, expectations of CHAT, implementation and delivery, relevancy and the outcomes of being part of the scheme. The schedule for health care staff covered areas around the criteria and suitability for referral, perceived outcomes for patients, their awareness of the scheme, issues around communication and what they thought about the future of the scheme within the NHS.

A list of patients and staff that had participated in the CHAT scheme and were interested in taking part in the evaluation was passed to the research team. A purposively selected sample of service users were then taken for interviewing to reflect the diversity of CHAT cases in relation to gender, age, frequency of service use and multiple/complex needs *versus* single/less complex needs.

Health professionals were sampled on the basis of professional role, experience of CHAT and number of previous referrals.

Once the sample had been identified, letters were sent to patients and staff outlining the purpose of the evaluation and some general study information. Approximately 7-10 days after the letters had been sent, the researcher telephoned those in the sample to discuss the evaluation and the possibility of conducting interviews. Individuals who declined to participate in the interview were thanked for their time. Additional interviewees were then re-sampled. From the health professional sample all of those asked for interview accepted. The breakdown of this sample is below in Table 1. Response rates for patients were 43% (out of a total of 23 patients contacted for interview 13 declined or could not be contacted) indicating the difficulty in recruitment from this population (see Table 2). Five of the patients were interviewed over the telephone due to difficulties in organising interviews.

Table 1. Participant breakdown (health professionals)

| Role | Number |
|---|---|
| General Practitioners | 3 |
| Practice Managers | 2 |
| Healthy Living Centre Coordinator | 1 |
| Mental Health Nurse Practitioner | 1 |
| Nurse Practitioner | 1 |

Table 2. Participant breakdown (patient)

| Sex | Age band (years) | Practice |
|---|---|---|
| Male | 16-24 | Royds |
| Male | 16-24 | Royds |
| Male | 25-34 | Royds |
| Male | 65-74 | Royds |
| Female | 16-24 | Royds |
| Male | 35-44 | Ridge |
| Male | 35-44 | Ridge |
| Male | 55-64 | Ridge |
| Female | 75-84 | Ridge |
| Female | 75-84 | Ridge |

## 3.2 Data collection and analysis

The interviews took place over a 10 week period and were conducted either in the general practices, in the patient's own home, or over the telephone when it was not possible to arrange a face to face interview. Each patient interview took between 15-50 minutes to complete and staff interviews took between 20-30 minutes to complete. All interviews were tape recorded after receiving consent from participants. After the interview had formally finished some time was allowed for informal discussion for those who wanted it, this was not recorded.

The interviews were firstly transcribed verbatim and this process proved to be an opportunity to reflect on the data. Once the transcription process was complete, it was necessary for the researcher to 'immerse' within the data (Silverman 2003). This process included the re-reading and listening of the interviews, as well as observing the interview notes and schedule. The data was analysed using the framework approach as outlined by Pope, Ziebland and Mays (2000) and two researchers coded and analysed the emerging themes. Overall, the research was undertaken in a systematic and logical approach to ensure validity and reliability with reference to qualitative traditions. The methods for obtaining the data were deemed accurate, honest and thorough.

## 3.3 Ethical considerations

The evaluation was conducted in accordance to the ethical principles of research and had approval from Bradford South and West Primary Care Trust. All patients attending the CHAT scheme were informed that it was being evaluated. Participation by both patients and staff was voluntary and everyone was asked for their consent to participate in the interviews. Throughout this evaluation the respondents' anonymity was respected.

# 4. Findings - Interviews

This section presents the results of the research carried out with patients at the Ridge and Royds practices as well as staff from Healthy Lifestyle Healthy Living Centre, Dr Micallef and Partners, the Ridge and Royds practices. The results are organised in accordance with themes established from analysis. The section organises the results into various headings and where it is appropriate, illustrated arguments or findings with direct quotations from the participants. The quotations have been left anonymous to protect participants.

## 4.1 Understanding of CHAT

All of the staff interviewed showed a thorough understanding of social prescribing and the CHAT service. They were aware that it was a scheme for linking patients in primary care with non medical service support in the community. One General Practitioner described the scheme as:

> "the opportunity for patients with complex social problems to be able to see someone who very much has a wider range of knowledge about what is available in the voluntary sector, particularly in the local area."

CHAT was recognised as a service for a range of people with various social issues. Staff were keen not to stereotype the patient who would be appropriate for the service, but instead explained that a referral to CHAT could be for patients of numerous ages and social need:

> "Personally I've made twenty-one referrals into it, a lot of older, isolated, people who have just moved into the area and don't know the area, one lady who got bereaved two or three years ago and hasn't quite got over it…a few younger ones, depressed but perhaps just need some advice about benefits or courses in reading or writing or computers."

## 4.2 Expectations of CHAT

The patients who were referred onto the scheme had varying expectations of what CHAT could do for them. The majority of interviewees wanted to feel a

sense of social inclusion and expected CHAT to be the vehicle to provide contact with their community:

> "Contact with other people, just talking really, just contact. When you live on your own it's not funny. If there's someone to talk to you it's much better. You tend to magnify difficulties if you are on your own."

The interviewees wanted to feel as though this scheme would cure their boredom and introduce them to like minded people who hold similar characteristics to themselves:

> Interviewer: …what would you like to achieve from being on this scheme?
> Patient: More friends…like with other disabled people of my age range thirties to forties.

Some individuals wanted an increase in skills through participation on the CHAT scheme. One younger interviewee wanted CHAT to assist him in changing his current lifestyle, as he was feeling down due to his redundancy, exacerbated by his ever increasing lack of mobility. He wanted CHAT to provide him with some extra interest, particularly in assisting him in understanding information technology.

Some people had no prior expectations of the service and simply participated just to experience what it was like. Other interviewees had an elevated expectation and wanted full-time employment, a house or a complete eradication of their social isolation as a result of the scheme. Staff felt that it was important to ensure that the patient's expectation of the service was realistic at an early juncture in the referral pathway, so that the outcomes of participation could match initial expectations:

> "I think it's about the communication process with the patient and making sure that their expectations are right."

## 4.3 Process and delivery of service

### *Referral*

The patients who were interviewed were referred to the scheme by numerous health care professionals, ranging from GPs and practice nurses to

receptionists. Commonly, referrals were made to CHAT during routine health checks:

> Interviewer: Could you tell me how you first heard about this CHAT scheme?
> Patient: It was from the nurse from the XX medical practice…I go for a diabetic check about once every three months.

The process of referral was seen as being straightforward, flexible and user-friendly for all staff. However, on numerous occasions staff would sometimes forget that the service was available to them:

> "You have lots of different guidelines and it's just remembering it."

> "Because it's a new service it's remembering that it exists on top of everything else. So sometimes I may think about it after the event, so really I have to get used to it."

Having a single point of contact for staff was perceived as a benefit for the delivery of CHAT, referring patients to a single person reassured clinicians that the referral would be dealt with appropriately. This also gave the delivery of the service a personalised edge, whereas in other schemes some staff felt as though they were referring people "into a hole".

Staff reported that referring patients was particularly effective, as no paper work left the practice and having designated points where the CHAT worker collects and drops off patient information was felt to be particularly beneficial. The speed of processing referrals particularly impressed patients. Many were surprised to have contact with the CHAT worker so soon after the initial referral was submitted.

### *Informing patients*

Informing patients of the service was a crucial element of the referral process. Most staff reported making a conscious effort to ensure that patients had a full understanding of the scheme before progressing with the referral. However, staff felt that there were limitations to providing written materials to some patients, especially those who were illiterate or had learning difficulties:

> "I try to make sure people have had the literature or have had a chat with me about what it is involved before I refer them so that they are likely to go and want to do it…

> we have got a significant amount of patients that aren't literate so giving people written material doesn't always work."

Patients reported that the amount of information received at this point within the referral pathway was insufficient. While the leaflet provided was useful, additional information from the healthcare professional would have been helpful:

> "I was in the dark…. My doctor explained a bit about it, I'm not sure if she knew a lot about it."

However, one GP argues the point:

> "It's like if you refer someone to surgery you have a consultation with a surgeon who goes into it in detail. So I don't think they have to have that detailed knowledge up front."

### *The initial assessment*

Most of the initial CHAT contact was arranged within the respective practices with home bound visits for patients who found coming into the practice problematic. Most of the patients valued the initial assessment carried out by the CHAT worker and found the assessment thorough and beneficial. The non-clinical aspect of the referral was appreciated and patients felt more at ease with talking to a non-medical worker. One suggested that when she spoke to the doctor she was continually apprehensive. This was reiterated by one practice manager:

> "I think also it's a bit more informal *[CHAT initial assessment]* it's not a clinical situation it's informal and people are more relaxed and probably open up a bit more than they would sat in a clinical room with a clinical person. It makes it easier for the patient and it can be taken at the patient's pace, looking at really what their needs are and supporting them through that process."

### *An individual 'caring' service*

The importance of the CHAT worker was frequently cited as a fundamental aspect for the service delivery and its success within the practices, one GP suggested:

> "It's a lot about personnel and who's doing it."

Another health professional thought:

> "The skill of that person is the key to this whole scheme."

The benefits of the CHAT worker being approachable, flexible, sympathetic and empathetic were highlighted as skills which would help in eliciting information from patients. From a clinician perspective, staff felt comfortable with referring patients as they had high levels of trust and confidence in the CHAT worker's enthusiasm and ability to find appropriate voluntary sector services.

Patients generally appreciated the offer to be accompanied to the initial session by the CHAT worker. The older patients interviewed suggested that having a friendly face to accompany them helped build their confidence:

> "I will need a lot more confidence, but if you know that someone is going along with you then that's different."

Interestingly, the younger patients suggested that the offer of accompaniment was rarely taken up. This is shown in the two quotes below:

> "Well he asked me if he wanted to go with me, I said no I'd be alright."

> "I said that I was alright to go on my own. He was willing to come with me though."

## 4.4 Has CHAT delivered appropriate voluntary sector services?

There were mixed perceptions to whether CHAT had delivered appropriate voluntary sector services relevant to the patient's individual needs. For some, the scheme had provided them with an opportunity to meet new people as well as developing new skills. One health care professional explained how the CHAT scheme had referred one of her patients to a benefits advisor and as a result it had increased her monthly entitlement.

One interviewee felt that although on one hand the CHAT scheme had provided him with activities to fill his time, the computer course which he attended was inappropriate and his expectations had not been met:

> "We were in a room like this with a few other people, it was quite uncomfortable actually… when I did the computer course there was no detail of the computer. I mean when I went there it was really basic, really basic like writing a letter and things… I want to get into the art of it, the downloads the fixing of it and the software… it was too basic and no good for me at all."

There were a number of reasons why some patients had not accessed voluntary sector services. Some of these issues were outside of the scheme's control such as literacy or travel issues. The following quote illustrates this further:

> "He gave me many options, but I have a problem in getting around. I have a car but I have problems getting around and I have problems sticking to times. He suggested one or two little things but I can't guarantee what I might feel like."

## 4.5 Communication and Feedback

Most staff perceived that the communication links that were in place within the scheme were working well. Having formal contact through practice meetings, telephone conversations and e-mail were all important to ensure that staff were informed of a patient's progress. However the more informal modes of communication were also deemed important:

> "I might bump into her in the corridor or something and it's that informal, soft, cosy, cuddly stuff, it's difficult to quantify but it's so important"

Some staff, however, thought that the communication links within the referral pathway were not functioning efficiently. Vital information about the outcome of a referral was not being communicated back to the original referrer. Formalised procedures such as letters to clinicians were not being fully completed, and this was felt to be an area which would need to improve if the service were to continue:

> "Maybe one place where it's not functioning completely as we would like is that we're not getting a letter back about people at the moment so it's about me often having a conversation with the patient, so if things are falling through or someone has not taken up on it then I may not be aware of that…at the end of the day the bits of paper going back and forth do really have to happen."

All patients spoke of having positive relations with the CHAT worker however, many patients would have preferred additional opportunities for communication, for example additional telephone calls or meetings. This was mainly expressed when the patient felt the service provided by CHAT was inappropriate.

## 4.6 Outcomes: benefits for staff

Some staff felt frustrated and confined by the medical model in which they were working with patients, and therefore saw CHAT as an alternative avenue for working with patients with psychosocial needs. One GP highlighted the issue:

> "I don't see traditional medicine as the be all and end all, you have to look at the person as a whole. There's no point fixing them up physically and ignoring the housing benefit or the fact they can't read and write, and if I can't fix it I want to be able to point them into the right direction."

Having an additional resource for working with patients was seen as being highly beneficial. One interviewee felt as though CHAT was an opportunity to physically "do" something for patients:

> "It's having that extra something you can do for patients. Patients expect you to be able to do something and sometimes there isn't anything you can do, and patients may go away feeling spited. It's a really useful service that you can offer."

Some staff discussed anecdotally that as a result of the scheme their workload had decreased. This was partly due to the amount of consultations being reduced, especially from notoriously high consulters. This was reiterated by two practice managers:

> "Clinicians are very busy and the social problems are the last thing they can deal with in a consultation. If there are other things that are medical then that is where their focus is going to be concentrated…it's really useful to have someone there now with a different route, that relieves the burden on the clinicians. They know the patients are still being cared for through the CHAT process."

> "So for us it's appointment time saved for clinicians. It's knowing that patients are being supported and helped in other ways that we can't actually deliver from the practice."

Other interviewees felt that it may be too early or too difficult to quantify whether the CHAT scheme really has had an impact on the workload of health professionals. GPs anecdotally reported that the content of consultations may have altered as the social issues for patients were now being dealt with by CHAT, leaving GPs to deal primarily with medical issues. It was also felt that CHAT was serving a relevant purpose even if it wasn't affecting a clinician's workload:

> "I think it's too early to say, and I think if you're seeing someone for depression, then you're going to be seeing them anyway once a month for their medication and a mood check, so I wouldn't say it's going to reduce the amount of time I see them, but it may well. I'm not having to spend as long with them because there is someone else dealing with the social areas."

Some staff saw CHAT as a scheme which had the ability to break down barriers between medical and non-medical staff. It was suggested that the scheme had integrated and built professional relations between GPs, nursing staff, health visitors and district nurses as anyone could refer patients into the scheme.

## 4.7 Outcomes: benefits for patients

The members of staff who were interviewed perceived that the main outcomes for the patients that they had referred, would be increased confidence levels and a chance to take up appropriate opportunities:

> "Well I see people growing in confidence and a real sense of that they are actually achieving something by taking up the opportunities that have been put their way."

This was reiterated by one patient:

> "I feel more confident in myself…I didn't know the options that were available to me, he just pointed me in the right direction."

The patients felt that the benefits were that CHAT seemed to be a personalised service which cared for their specific condition. This is illustrated by an elderly lady who lives alone:

> "I would just recommend it to other people. I think the more people that are involved the better. Yes I think it's a very good idea, particularly for people who live alone."

Patients found it particularly difficult to express what benefits the CHAT scheme had provided for them. They felt that their participation in the scheme was too much in its infancy to comment on any long term benefits. However, some interviewees suggested that it had provided relevant qualifications and in some instances alleviated depressive symptoms. Most of the other interviewees had confidence that CHAT would deliver longer term benefits, but this would take time and continued participation.

Most of the patients identified some short term benefits of being involved in the scheme. These benefits were mainly around social inclusion, support and feeling 'part of something', or about companionship and meeting new people. Other interviewees discussed how participation on the scheme had 'opened their eyes' to services in the local area:

> "I didn't realise there was all these things that were going on around me especially where I live…it's nice to know that there are things like that available."

For some patients, just attending the initial assessment had delivered benefits. The opportunity for patients to be listened to in-depth for a period of time was a new experience, and they valued the opportunity to share their problems in a friendly and non-confrontational environment:

"I had a chat with xx…he was really really nice, easy to talk to… it's an outsider to talk to and it's often easier to talk to a stranger than people you know."

## 4.8 The future

All staff interviewees hoped the CHAT scheme would continue as a service within Bradford South and West PCT. Staff perceived it as a positive scheme which could only benefit their patients:

"I'd say it's something that has really worked in our practice and it would be a real shame if it stops."

Health professionals were keen to stress that schemes such as CHAT take time to develop within practices. It was felt that CHAT was beginning to get recognition as a credible resource for staff and as a result, referrals into the scheme were on the increase. Some staff wanted the scheme to be extended to other surgeries in the area to incorporate more patients into the scheme:

"I did a workshop promoting CHAT. People were coming to us not realising that it was locality based, they actually thought it was across Bradford. They were quite upset that there wasn't one in their area because they thought the concept of it was fantastic."

Staff envisaged that social prescribing was “the way forward” and would have a positive impact nationally, especially in particularly deprived areas. It was emphasised that if it is to be truly successful social prescribing should be thought of in broad terms, and not simply a scheme for the elderly or socially isolated.

The patients interviewed also had positive comments to make about CHAT and the work the scheme had done for them:

> “I’m glad it’s in the local area. I’ve never known anything like this. If it wasn’t around I think a lot of people would lose out, and also we gain because we get something from the courses.”
>
> “I would say it’s a good thing to keep on going because if I had carried on the way I was, on the dole, I wouldn’t have got to where I wanted to be without the help of the CHAT worker.”

# 5. Findings – Monitoring data

This section presents the results from monitoring data collected from participants referred onto the CHAT scheme. This data is taken between January and September 2005, at the second two pilot practices (Ridge and Royds).

## 5.1 Frequency of referrals

There were 81 referrals to the CHAT scheme between January 25th and September 13th 2005. Almost a third of these referrals were referred in May and June (n=26, 32%, see Figures 1 and 2). It can be noted from Figure 2 that despite the Ridge being a much larger practice than Royds, there is in fact little difference in referral rates.

Figure 1. Frequency of CHAT referrals (Jan-Sept 2005)

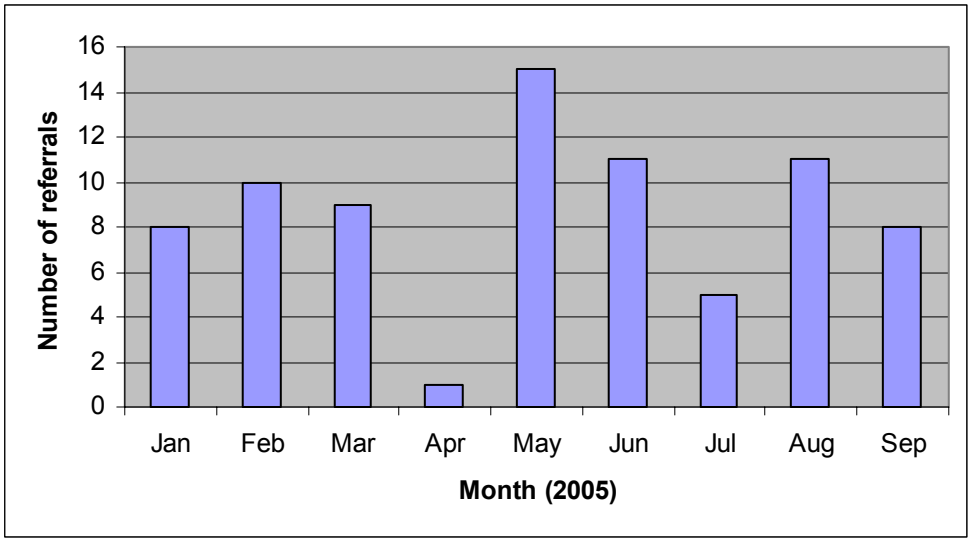
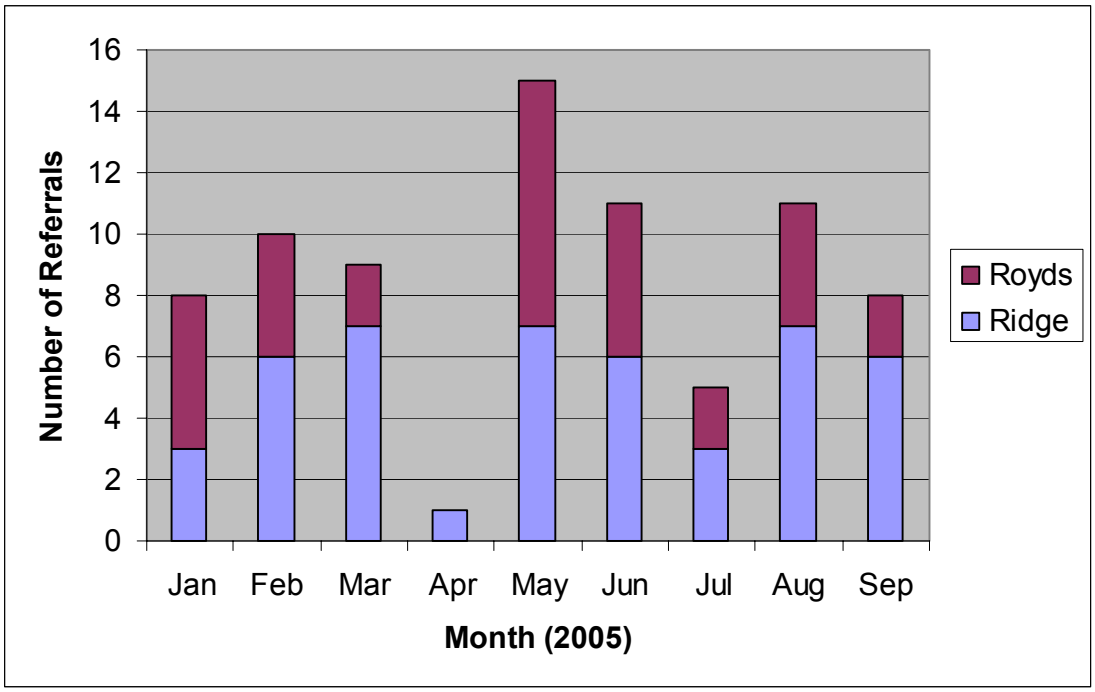


Figure 2. Frequency of CHAT referrals (Jan-Sept 2005)




## 5.2 Referral patterns

Females (66%) were referred to the service more commonly than males (30%, 4% not recorded). The age of patients ranged from 16-89 years, however the 16-24 age category use the service more predominantly than other age categories (n=15, see Figure 3). Figure 4 illustrates that the majority of referrals from the Royds practice are under the age of 54 years. The Ridge practice however has a much higher referral pattern from those aged 55 years and over, particularly for the 75-84 year age category.

Figure 3. CHAT referrals by age band

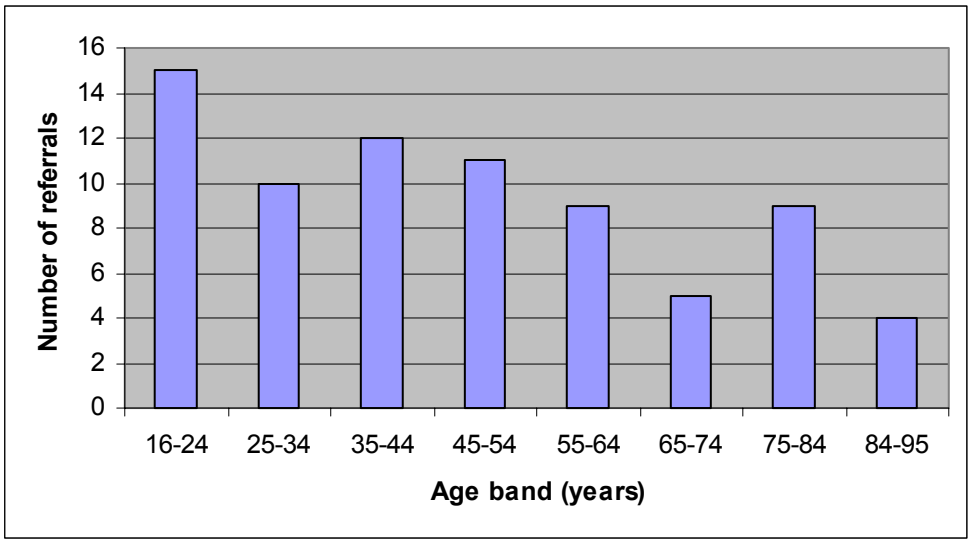
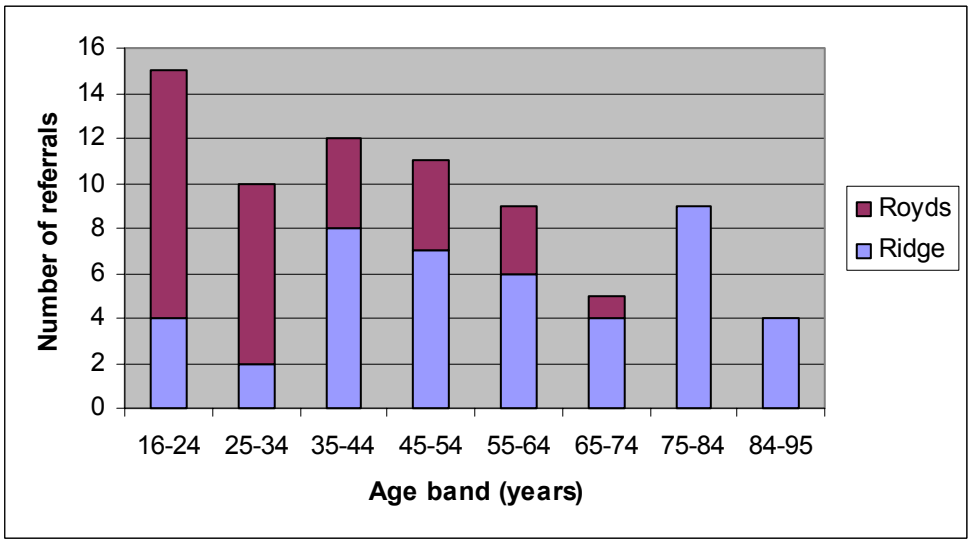


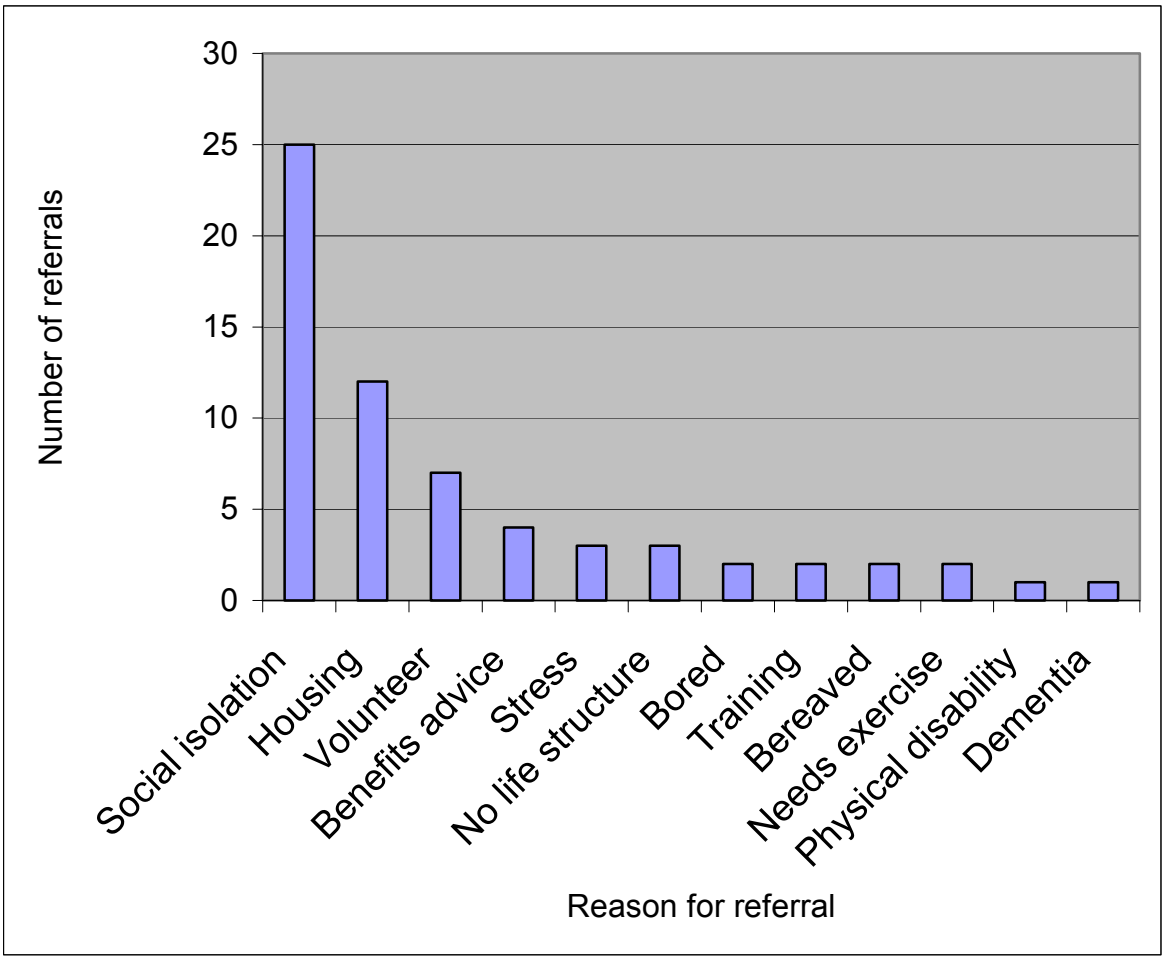

Figure 4. CHAT referrals by age band and practice




## 5.3 Reason for referral

Patients were referred to the service for a range of psychosocial issues, these were categorised by the CHAT worker. Social isolation dominated the reason for referral (n=25, 39%) with housing issues being another key issue (n=12, 18.8%). Figure 5 highlights this more fully.

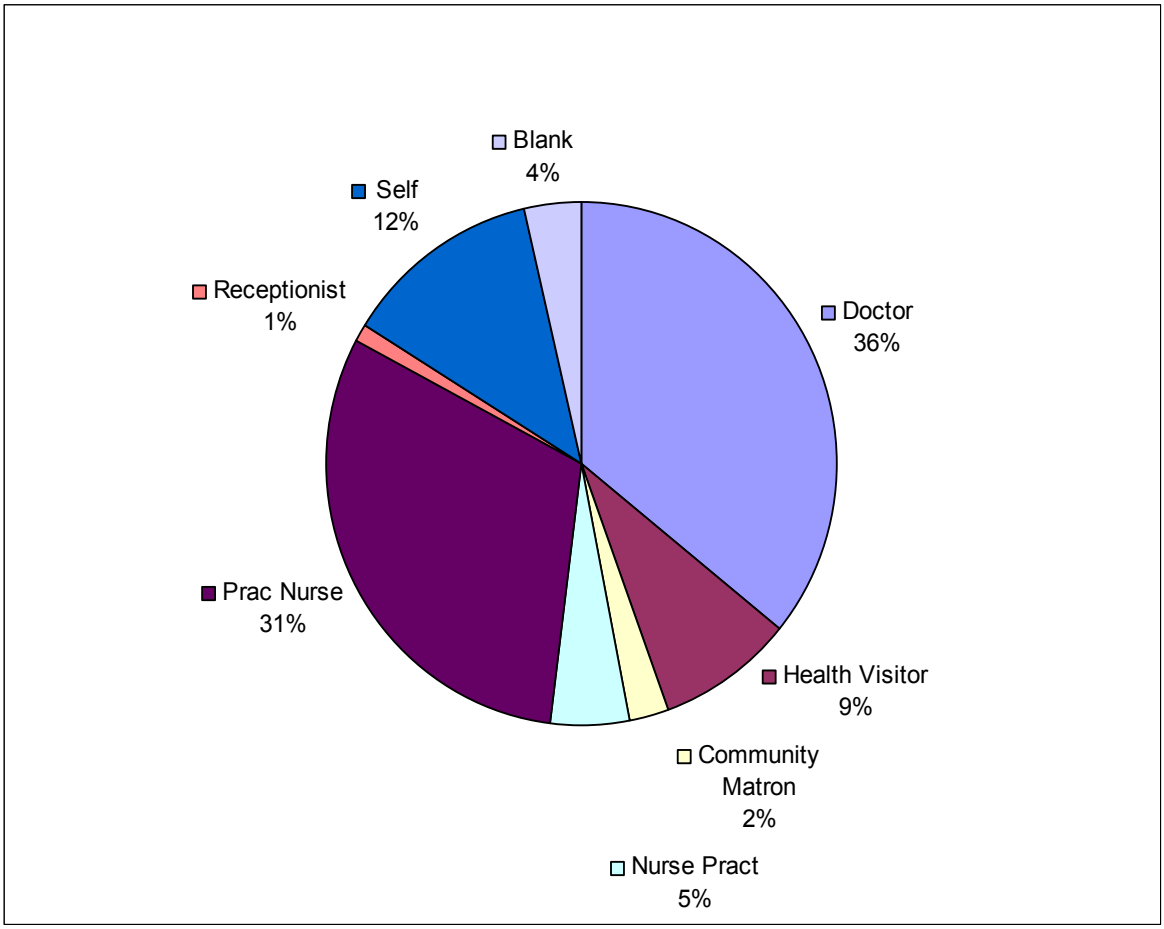
Figure 5. Reason for referral




## 5.4 Source of referral

Referrals to the CHAT scheme have come from several sources. Within this 8 month period the referrals were made most frequently by GPs (n=29, 36%) and Practice Nurses (n=25, 31%). Health Visitors and Nurse Practitioners collectively referred 11 patients (14%). There were 10 self referrals to the project (12%), and only 1 referral (1%) by the reception team (see Figure 6).

Figure 6. Source of CHAT referral



# 6. Discussion of the findings

The evaluation indicates that CHAT is a valued scheme within the primary health care setting. There has been a steady flow of referrals in both practices and CHAT is being used by a diverse range of patients in terms of age, gender and presenting problem. The findings from the qualitative data show that the scheme is acceptable, relevant and appropriate from the perspective of staff and service users. Patients and health care professionals perceive the CHAT scheme to be a successful bridge between primary care and the voluntary sector. Both patients and staff interviewed seem reassured by its presence within the respective practices and this reiterates similar work by Faulkner (2004).

In the interviews all patients expressed some form of positive outcome as a result of being on the scheme, including reduced isolation, increased confidence, and access to non-stigmatised support. This supports other research which suggests that social prescribing is a viable way of dealing with psychosocial problems (Grant et al., 2000). Like other research (Friedli and Watson, 2004), this evaluation highlighted that as a result of CHAT, patients had been accessing services in the community of which they would otherwise not be aware. Interestingly, those patients who were unsuccessful in locating or attending voluntary sector services still felt positive benefits from having time to talk through issues with the CHAT worker. Being listened to, respected and understood were important for patients and improved their outlook and esteem. Patients perceiving CHAT as an individual, caring service, tailored to their own appropriate needs is a powerful indicator of its success.

The frequency with which health care professionals have to deal with patients that present psychosocial problems in general practice has been reported elsewhere (Gulbrandsen, Hjortdahl and Fugelli, 1997). Staff in this research have discussed how social prescribing, and in this instance the CHAT scheme, has the potential to reduce workload and improve the quality of

patient-professional consultation. The benefits for staff having a 'personalised, caring' service were frequently cited as being one of the strengths of CHAT. Having a CHAT worker who is highly visible in general practice not only reassures patients but also reassures staff. Several health professionals commented that they did not have the scope within their role to keep abreast of what was available in the voluntary or community sector. This is reiterated by others (Bromley PCT, 2001). CHAT provided access to a source of expert knowledge which was welcomed. The benefits of the scheme to general practice have also been highlighted from this evaluation. Having the scheme as an extension of primary health care adds further to the holistic work happening in these practices.

The interviews highlighted some perceived barriers which affected the efficiency of the service. In most cases these were issues that CHAT could not deal with directly i.e. literacy, travel issues etc. Other barriers require only minor changes to current practice. Patients participating on the CHAT scheme, for example, had relatively little knowledge about what to expect from the service. A similar barrier was found by Faulkner (2004). Although an explanation was given from the referrer and leaflets were given to patients, this was insufficient for some and inappropriate for those who were illiterate.

The CHAT scheme, as a mechanism for linking patients with social support, seems in general to be working effectively. Referral runs smoothly and there is a quick response. Records indicate that the 'did not attend rate' is low, which is a positive indicator that systems are working well. There are, however, aspects of the process which could be improved if the scheme is to be rolled out more widely (see Box 1). The weakest area currently is the feedback mechanism of the scheme. Consistent and regular feedback for referrers is important for a number of reasons. Firstly, if health care professionals are receiving regular feedback on the progress of patients then they are being reassured that CHAT is working towards helping the patient. Secondly, regular feedback will aid the identification of patients whose referral to the voluntary sector has collapsed. Thirdly, feedback keeps the CHAT service constantly in the mind of staff. Finally, appropriate feedback raises

staff awareness and knowledge of other agencies; this subsequently strengthens the link between primary health care and the voluntary and community sector.

Box 1. Areas of good practice and issues for consideration

Current areas of good practice

1) No documents leave the practice, all referrals are dealt with internally.
2) Contact with patient is quick and efficient, usually within 2-7 days.
3) The initial assessment is lengthy and thorough and provides an opportunity for the patient to be listened to.
4) Patients are provided with a range of services within easy access to their local area.
5) The offer of accompaniment is received positively by patients, especially those who lack self-esteem and confidence.

Issues for consideration

1) There needs to be an increase in referrals to the scheme. Encouraging self referrals and utilising other staff sources may increase numbers.
2) More thorough and rigorous collection of routine monitoring data.
3) Feedback needs to be provided more consistently to original referrers. This will increase the scheme's profile in general practice.

This evaluation reflects similar findings from other studies, in that social prescribing is an effective mechanism for dealing with patients with psychosocial need. Social prescribing has the ability to play an important part in general practice through contributing to a holistic approach to health care. Whilst this research has evaluated the scheme in Bradford South & West PCT, it would be valuable to evaluate social prescribing on a wider scale.

# 7. Future development: issues for consideration

The CHAT scheme is a successful mechanism for dealing with patients with psychosocial needs in primary care. The flexibility of the scheme and the personalised service which it provides has been highlighted in this evaluation. However, the following section provides some issues for consideration for the scheme, and highlights ways in which the scheme may be taken forward.

## 7.1 Building on the model

The current model of the scheme is working well and has been found to be acceptable and relevant. The key elements of the model are listed in Box 2. If the scheme was extended and potentially rolled out to other practices in the PCT then it would be important that the core elements of the model developed in Bradford South and West were maintained.

Box 2. The CHAT model

- Based in general practices.
- Part of the Primary Health Care Team.
- A visible service with a person known to the primary health care professionals in the practice.
- Referral from any member of the multi-disciplinary team or self referral
- Smooth referral process and patients seen quickly within a week to two weeks.
- Skilled CHAT practitioner with good knowledge of the local community and voluntary sector and experience of supporting people.
- Time spent with patients giving them an opportunity to explore solutions.
- Ability to accompany patient on first visit to overcome barriers to access.

If the CHAT scheme is to expand it is apparent that extra resources will be needed to cope with the demand. Recruiting the right type of individual is essential and appropriate training must be provided. This training should

include developing interpersonal skills and knowledge of community and voluntary based services available in the area. There are also issues around the management of the scheme, and the integration of it into mainstream primary health care.

## 7.2 Increasing referrals

Increasing the number of referrals onto the scheme is important for the continuation of the service. Although referral rates are steady there has not been the anticipated rise as the service has bedded in. Achieving more referrals could be gained in numerous ways but may include:

- Monthly e-mails to health care professionals, reminding them of the CHAT scheme and the benefits which it can provide;
- Making the CHAT scheme a regular agenda item during smaller inter disciplinary team meetings;
- Increasing the number of self referrals;
- Increasing the number of referrals from non-GP or Practice Nurses; Receptionists seem to be an underused source which could contribute to the referral numbers.

## 7.3 Information for patients

One area for consideration identified through the study is the need for additional information for patients from the primary health care professional at the time of referral. Consideration needs to be given to the most appropriate way of doing this, given a leaflet is already available. The patient's expectations of the service should be discussed at an early phase of the referral. This is to ensure patients are fully aware of what the service can provide.

## 7.4 Feedback systems

A clear message from the research is around the importance of feedback to health care professionals. Feedback systems need to become an integral part

of the CHAT scheme and can help remind practitioners of the role of CHAT as well as raise awareness of sources of support in the community.

## 7.5 Future research

Longer term follow up of patients using CHAT would provide evidence as to whether CHAT has reduced the workload of health care professionals. Possible methods may include using pre and post CHAT appointment data collected through the practices (see Appendix 2 for early findings). Further evaluation into the effectiveness of other social prescribing schemes would also add to the current lack of robust research evidence.

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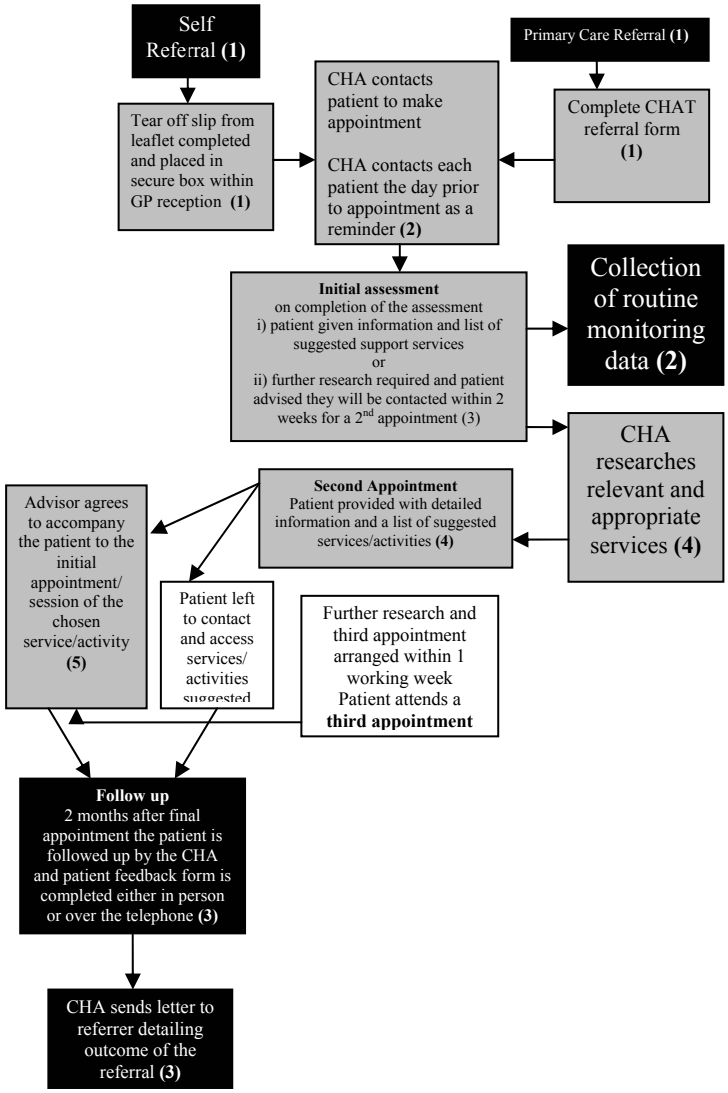
# 9. Appendix

## Appendix 1. The Patient's Referral Pathway

*Adapted from Rushworh, S. (2005) Highfield Health Centre, Healthy Lifestyle Social Prescribing Report.*




Current areas of good practice (Grey box)

1) No documents leave the practice, all referrals are dealt with internally.
2) Contact with patient is quick and efficient, usually within 2-7 days.
3) The initial assessment is lengthy, thorough and provides an opportunity for the patient to be listened to.
4) Patients are provided with a range of services within easy access to their local area.
5) The offer of accompaniment is received positively by patients, especially those who lack self-esteem and confidence.

Issues for consideration (Black box)

1) There needs to be an increase in referrals to the scheme. Encouraging self referrals and utilising other staff sources may increase numbers.
2) More thorough and rigorous collection of routine monitoring data.
3) Feedback needs to be provided more consistently to original referrers. This will increase the schemes profile in general practice.

## Appendix 2. Aggregated pre and post appointment data.

Aggregated pre and post appointment data was collected on patients in the second pilot practices. This data was gathered from the Practice Managers at both the Ridge and Royds practices.

*Royds Healthy Living Centre*

Pre CHAT the average number of face to face appointments with health professionals for all patients within the practice was 0.75 per month (between January and July 2005). For the same period the average number of face to face appointments for CHAT patients was 1.4 appointments. In July and September 2005 during the CHAT scheme the number of face to face appointments for CHAT patients dropped to 1.05 appointments per month, although it should be noted that the overall number of appointments dropped to 0.68 per month.

*The Ridge Practice*

Pre CHAT the average number of face to face appointments with health professionals for all patients within the practice was 1.05 per month (between January and July 2005). For the same period the average number of face to face appointments for CHAT patients was 6.7 appointments. In July and September 2005 during the CHAT scheme the number of face to face appointments for CHAT patients dropped to 3.5 appointments per month. Before the CHAT scheme 14 patients used the service ‘excessively’, whilst during the scheme this was reduced to only 8 patients.

## Appendix 3. Patient Case Studies

*Taken from Rushworh, S. (2005) Highfield Health Centre, Healthy Lifestyle Social Prescribing Report.*

*Case Study Number 1*

Lady – born 1910 lived alone

Mrs A was referred into the CHAT scheme by a District Nurse from the Health Centre.

The reason for the referral was: 'socially isolated, unkempt, daughter main carer but lives 2 buses away, referred to social services for home care'

We were asked to contact daughter first to obtain access to Mrs A for the assessment. A CHAT worker visited Mrs A while her daughter was present and it became evident that the daughter was struggling with the situation. She broke down during the assessment with her mother and told the CHAT worker that she could not cope with the travelling backwards and forwards to her mothers and the responsibility of caring for her.

Mrs A was born in 1910 and was adamant that the only way out of her home would be 'in a box'. She did not want anyone but her daughter caring for her and was declining help from support services who would take some of the burden from the daughter. The district nurse was allowed in the home, but that was becoming more difficult.

The CHAT worker noticed that all around the home were crosses and religious pictures; perhaps through the church someone would be able to support the daughter and Mrs A. After the assessment the worker contacted the local church about Mrs A, to see if they knew her. It transpired that they had known her a long time ago but had not had contact with her for quite a while. The Vicar made arrangements through the daughter to visit Mrs A, with a church visitor. They were warmly received and the lady from the church

arranged to make regular visits to Mrs A and support her where she possibly could.

Three months after this assessment we received an email from the Vicar informing us that Mrs A had passed away. This is a transcript of that email:

'…. I am taking the funeral service for her tomorrow afternoon. There are lots of very positive things about the way in which it all happened. Your intervention was incredibly important – something that enabled her to link up again with us and with others. ……... I was able to have some lovely conversations with her that helped to heal things. She was 'ready to go' – and died in peace with family with her.'

*Case Study Number 2*

Lady – born 1919 – recently widowed

This referral came from a GP in the Practice and the reason for the referral was 'lost husband, socializing, isolated'.

An arrangement was made for a CHAT assessment and the CHAT worker who did the assessment felt that day care would be really good support for Mrs C.

The CHAT worker made arrangements to visit two day centres with Mrs C to give her the opportunity to compare the two and see which she would be most happy to attend. After visiting both of these organisations it was arranged for Mrs C to attend one of the day centres on a Wednesday.

At the two month follow up feedback, Mrs C was still attending the Day Centre and had also increased her visits to twice a week. She was extremely happy and looking forward to continuing in the future.