Appendix 1

**Project Documentation**

# PROJECT INITIATION DOCUMENT (PID)

## Social Prescribing

| | |
|---|---|
| **Release:** | Final Draft |
| **Date:** | 29/01/2018 |
| **Author:** | Elaine Thomas |
| **Approved by:** | Louise Rudziak<br>20/02/2018 |

**Document History**

| Revision Date | Version | Summary of Changes | Reviewer(s) |
|---|---|---|---|
| 31/01/2018 | 1 | First draft amendments | IB |
| 8/02/2018 | 1 | Amendments following comments from CIT | AB |
| 13/02/2018 | Final draft | Final amendments following comments from SH, LR and PO | ET |
| | | | |

**Consideration by the Corporate Improvement Team**

| Date | Reviewing Officer | Comments for Consideration |
|---|---|---|
| 8/2/18 | Andy Buckley | Proposed minor changes to the project outcomes, the inclusion of a Post Project Evaluation in the timetable, and that the equalities impact be documented. All comments incorporated into final version. |

**Approvals**
This document requires the following approvals:

| Name of person, group or committee |
|---|
| Cabinet 6 March 2018 |
| |
| |
| |
| |

**Distribution**
A final copy of the approved document will be distributed to:

| Name | Job Title |
|---|---|
| Social Prescribing steering group members (TBC) | Na |
| | |
| | |
| | |
| | |

## 1. PURPOSE OF DOCUMENT

This Project Initiation Document (PID) defines the Social Prescribing project. It builds upon the Initial Project Proposal document and sets out the aims of the project, why the project should go ahead, who is involved and their responsibilities. This PID will provide the baseline for the project's management and for an assessment of its overall success.

## 2. PROJECT DESCRIPTION

This proposal seeks to develop a service, initially over a 2 year period, in partnership with the Local Community Networks (LCNs) in Chichester. Rural North Chichester LCN, covering the GP practices to the north of the downs and South Chichester LCN covering the GP practices in the south of the district.

## 3. BACKGROUND

Social Prescribing is defined as the skill of connecting people to services and support in local places. It is a service for GPs and other health professionals to access for patients who present with problems that are essentially nonmedical and require more holistic community based interventions.

It has been estimated that around 20% of patients consult their GP for what is primarily a social problem (Citizens Advice 2015). 70% of all causes of appointments for ill health are impacted by the wider determinants of health eg where we live, our support networks, our housing, the environment we live in etc.

GPs are not in a position to address a patient's wider health issues due to time constraints and lack of knowledge of local services or appropriate community based referral routes. They are often at a loss of how to help their patients.

The growing pressure on GPs and other local services mean that people are increasingly having to wait for support or at worse are falling through the gaps and not getting any support at all. Locally GPs have suggested that this situation will only worsen, hence the need to change the way we provide services.

Social Prescribing type projects have been in place in various guises for many years across the country but this project has emerged following a successful pilot in Adur and Worthing, 'Going Local', which particularly links GPs with community groups and services. The recently published year one evaluation shows that this is an effective approach in connecting people with their community and empowering them to access groups, activities and services and enabling people to make positive changes to their own lives.

Social Prescribing links to the councils corporate plan objective to 'support our communities, particularly those who are vulnerable, to be healthy and active'.

The proposal is for the council to host the service by employing the staff but the project will be developed and driven by a steering group made up of funding partners and other key organisations. This is an opportunity for the

council to lead a new project delivery partnership where we can potentially join up services across the whole system for the benefit of our most vulnerable communities.

If the decision is taken not to progress this work then it is likely that the service will be hosted by one of the Voluntary Sector partners which could lead to increased management and support costs balanced by a reduction in the funding we have available for staff time. Currently GPs are keen for the council to be the employing organisation as they can see the economies of scale by joining with the existing Wellbeing service along with its record of successful service delivery.

## 4. PROJECT OBJECTIVES AND SUCCESS CRITERIA

### 4.1. Outputs

- Capacity to support 600 -700 individuals each year. (based on project outcomes achieved by Worthing and Adur Councils)
- A more appropriate, local route for people to access support in a timely way
- Increased recognition amongst NHS partners of the value and role of Voluntary Sector services
- Cross system support for Voluntary and Community sector groups who deliver services which support people signposted via the social prescribing project.
- More cost effective use of Council and NHS resources.
- The project will be deemed successful when GPs are referring into the service appropriately and see reduced demand from patients who present with non-medical issues. This will indicate that patients are receiving the right services to support their needs.

**4.2. Outcomes –** NB: the steering group are still taking advice from WSCC Public Health on the evaluation and therefore the measurable outcomes listed below are subject to change. Further evaluation measures are being planned to enable longer term monitoring of outcomes.

**The Customer / Community:**

- People who find it difficult to access services will have a support mechanism to help them to become more resilient and build confidence in being able to support themselves.
- Monitoring of onward referrals will identify gaps in service / capacity within Voluntary Sector services.
- Case studies will demonstrate how individuals become more independent leading to reduced dependency on Council, GP and hospital services.

**People (CDC staff):**

CDC will host the service employing the staff (4FTEs) who will cover the district. They will develop strong links with relevant service areas in the council where support for clients is required. This cross cutting approach will

enable service areas to improve their understanding of client needs and the wider issues that impact in their ability to access our services.

**Service Performance:**
By providing this level of support for individuals we will be able to ensure that our most vulnerable and potentially resource intensive customers are supported with the right services at the right time.

**Financial:**
CDC part funding of £57,000 a year for two years is match funded by partners.

**Environment:**
None

**4.3. Outcome Measures**

A 10% reduction in repeat GP visits by those patients who engage with the service following a GP referral, measured in the 12 month period following the completion of the intervention with a Community Referrer

Measured using the 5 Ways to Wellbeing assessment tool at the start and end of the intervention with a Community Referrer, where at least 50% of clients demonstrate;

- an increase in self-esteem and confidence,
- Improvements in mental wellbeing, and positive mood
- Increases in sociability, communication skills and making social connections
- Acquisition of learning, new interests and skills

Clients will complete the '5 ways to wellbeing assessment tool which records their capacity to 1) 'Connect' with their community and others, 2) 'Be physically active' 3) 'Take notice' of their surroundings and appreciate their environment, 4) 'Keep learning' and acquiring new skills, 5) 'Give', eg time, resources, skills. This tool is completed at the start of the intervention and repeated at the end. The Community Referrer will work with the individual where relevant to improve each area of the 5 ways.

A robust evaluation process will be put in place at the start of the project. Initially recording client demographic data, referral sources, reasons and the onward journey for support etc to ensure the service is reaching the right people and identifying any gaps or support that may be needed for local services.

Case studies will demonstrate the client journey across the time they spend with the Community Referrer and other services. This approach will enable us to demonstrate the effectiveness of the service and the impact that contact with new community groups can have on individuals.

The number of further visits to the GP and acute hospital admissions will be monitored from GP records over time. Based on evidence from other areas it is expected that we will see a reduction in both.

This is a Public Health evidence based evaluation tool used by other Social Prescribing projects in the county which will therefore enable statistically comparable outcomes to be made.

**4.4. Dis-benefits**

There is some concern within Voluntary Sector partners that the increase in referrals made by the Community Referrers to Voluntary and Community sector groups could cause problems if they do not have capacity to accommodate the additional demand. To mitigate this as part of the service evaluation we will closely monitor onward referral routes and identify any gaps or demand issues promptly. We are working with the Communities Team to determine the potential for supporting such groups with accessing the Council's grant process and working with West Sussex County Council to ensure their grants and commissioning programmes are able to support these local groups. Colleagues from Voluntary and Community sector groups will be invited to sit on the project steering group to ensure their views and concerns are taken into account.

**4.5. Out of Scope**

To ensure the service does not get overwhelmed, self-referrals and referrals from other sources initially will not be accepted. It is also important that we work with GPs and practice staff to ensure that appropriate referrals are made.

## 5. PROJECT CONSTRAINTS

The constraints to this project are associated with the amount of funding we are able to secure. Currently funding for 4FTE staff has been identified but if the project is successful the referrals will need to be closely monitored to ensure the service does not become overwhelmed or additional funding secured to expand the service.

## 6. PROJECT ASSUMPTIONS

The key assumptions made are that GPs will engage with the service and refer appropriate patients for support. The LCNs which include GPs from all practices have identified Social Prescribing as a key priority and there is a workshop planned during March 2018 specifically to provide training for GPs on how to refer. We will put in place a Memorandum of Understanding (MOU) signed by all key partners to ensure there is shared commitment and responsibility to the project.

It is important to find the right people and skill set for the Community Referrer roles eg, good relationship forming skills with clinicians, individuals and community groups. The right values for working with people, able to set boundaries and should be inherently social. Having the right people in post will make it easier for both clinicians and individuals to engage with the service.

There are some minor assumptions that are currently being worked through with the steering group. The name of the project, job titles for the staff, terminology between partners eg use of the term patient, client, person etc. It is important to agree shared terminology and language with new partners.

## 7. PROJECT COSTS

| 4 full time equivalent Community Referrers | | | |
|---|---|---|---|
| **Item** | **Year 1** | **Year 2** | **Total Cost (£)** |
| Salary incl. on costs<br>Yr 1 current grade 4 SP 24<br>Yr2 current grade 4 SP 25<br>Subject to job profiling and Hay review | 116,308 | 120,136 | 236,444 |
| Travel / expenses incl mobile phones | 4000 | 4000 | 8000 |
| Printing costs –referral cards etc | 1000 | 1000 | 2,000 |
| IT –laptops | 2,000 | 500 | 2,500 |
| Client miscellaneous | 1,500 | 2,000 | 3,500 |
| Training and Development | 2,000 | 2,000 | 4,000 |
| **Total** | **126,808** | **129,636** | **256,444** |

**Funding secured**

| **Funding source** | **Yr1** | **Yr2** | **Total** |
|---|---|---|---|
| Chichester District Council | 57,000 | 57,000 | 114,000 |
| South Chichester GPs | 30,000 | 30,000 | 60,000 |
| Rural North Chichester GPs | 13,000 | 13,000 | 26,000 |
| Clarion housing | 10,000 | 10,000 | 20,000 |
| A2 Dominion | 5,000 | 0 | 5000 |
| Midhurst League of Friends | 16,000 | 16,000 | 32,000 |

| | | | |
|---|---|---|---|
| One off contribution from West Sussex County Council Chichester Partnerships and Communities Team | 2000 | 0 | 2,000 |
| **Total** | **133,000** | **126,000** | **259,000** |

**In kind support –** via a MOU

| | |
|---|---|
| Chichester District Council | Recruitment and management of staff within the Wellbeing Team. Support from HR and Finance. |
| GP leads via Rural North Chichester and South Chichester Local Community Networks | Office space at surgeries<br>Day to day support from a named person<br>Admin support for recording in patient records<br>Clinical supervision for staff |
| West Sussex County Council Partnerships and Communities Team manager | Support for and access to Voluntary Sector groups |
| West Sussex County Council Public Health research unit | Evaluation criteria and process |
| Coastal West Sussex Clinical Commissioning Group LCN Development Managers | Website, online referral processes, support with evaluation |

### 7.2. On-going Costs Following Project Completion

The project will be piloted initially for the two year period 2018/19 – 2019/2020. A new countywide Social Prescribing Steering group made up of West Sussex County Council and Coastal West Sussex Clinical Commissioning Group along with a range of partners are looking at a more equitable countywide approach to funding this work in the future. It will also be the responsibility of the project steering group to ensure the work is properly evaluated in order to demonstrate effectiveness. It is anticipated that this work will prove its worth enough to be considered a valuable part of the system for future funding to be identified.

## 8. OPTIONS SUMMARY

**Option 1:** CDC hosts the service. Staff are employed by the council and are managed as part of the existing Wellbeing team.

The GPs are supportive of this as the preferred delivery option. The Wellbeing team is well established, has processes in place that a new service can align with. It is known and trusted by GPs as a service they understand that will

support the client / patient and has a history of delivering positive outcomes. The service has an identifiable brand that the social prescribing project can adopt. Currently it is anticipated that the service could be called 'Wellbeing Plus' to illustrate the additional scope of the new project. The Wellbeing Advisors currently work with clients to improve their lifestyles with a view to reducing the likelihood of them developing heart disease, cancer and type 2 Diabetes. The new Community Referrers will be able to cross refer and work with clients but on wider issues therefore providing a well rounded service where clients are supported from one place.

**Option 2: The project is hosted by a Voluntary Sector provider**
The service could be hosted by one of the Voluntary Sector partners. The concern is that Voluntary Sector partners would require additional funding to resource the capacity required to do this thereby increasing the cost of the project. The in kind support in the form of employment and management costs that the council is able to provide reduces the cost of the project significantly. The resource on the ground would potentially be much less if these were included in the budget.

Furthermore, the existing links with the Wellbeing team are key to the successful delivery of this project. It seems logical to bring the two services together as one.

**Option 3: GPs host the service**
GPs are unable to be the employing organisations because the group is made up of 4 separate businesses and currently one practice cannot be responsible for staff working in others. The hope is that as LCNs become more established they will become an employing body for these kind of projects so may be an option for the future. GPs are also supportive of the service being closely aligned with the Wellbeing team.

**Option 4: Do nothing**
This project allows the council to be involved in an exciting new partnership with NHS colleagues at relatively low cost. The service provided can make a real difference to the lives of some of our most vulnerable residents by building on the success of the Wellbeing Service to provide a more rounded approach to the support we can provide. Although initially it may increase demand on services it is an approach that will potentially ease pressure on CDC services in the long term eg housing, revenues and benefits by tacking issues with residents who need a high level of support to access our services before they reach crisis point.

## 9. PROJECT APPROACH

The preferred model is option 1 where the 4FTE Community Referrers are employed by the council as part of the existing Wellbeing team.

2FTE Community Referrers will be shared across 4 GP practices in the north of the district Midhurst, Petworth and Loxwood. In addition the service will be available at Pulborough surgery as many Chichester residents living close to the Horsham border are registered there. We are working with Horsham

District Council to establish a working relationship and to a secure a financial contribution.

In the GP practices to the South of the district 2FTE Community Referrers will be shared across 6 practices. Parklands, Cathedral Medical, Tangmere, Southbourne, Selsey and Wittering. Patients from the other smaller city centre surgeries will also be able to access to service.

The Community Referrers will receive referrals directly from GPs and practice staff for those patients who have frequent appointments with a GP but have little medically wrong with them. GPs have long lists of suitable patients who would benefit from this type of intervention.

The Community Referrer will contact the patient within 2 weeks and arrange to meet with them. The initial conversation will be exploratory to establish the patient's needs and what they potentially want to achieve by engaging with the service. Any immediate onward referrals will be made at this stage. Further appointments will be made to continue working with the patient to ensure they receive as much support as they need. The Community Referrers will also be able to spend time introducing the patients to community groups or classes to help build confidence going forward. .

## 10. PROJECT PLAN

| Task No. | Task / milestone | Completion Date | Responsible Owner | Dependency |
|---|---|---|---|---|
| **Stage 1** | | | | |
| | Agree funding with partners | January 2018 | ET with partners | Agreed |
| | Agree service model in the Rural North area | December 2017 | ET with partners | Agreed |
| | Agree service model in South Chichester area | January 2018 | ET with partners | Agreed |
| | Form steering groups for each area | February 2018 | ET with partners | Agreement from partners |
| | Secure approval for hosting arrangements for the service | March 2018 | ET | Cabinet report and PID approval from Members |
| **Stage 2** | | | | |
| | Develop agreed outcomes and evaluation processes | January 2018 | ET with steering group | Will be based on experience from other projects, countywide alignment and agreement with partners |
| | Agree and sign a Memorandum of Understanding with key partners | March 2018 | ET with steering group | Agreement from partners |

| | | | | |
|---|---|---|---|---|
| | Undertake recruitment process | April 2018 when hosting arrangements are agreed | ET | Internal HR processes / timescales |
| | Develop working practices for surgeries | March 2018 GP workshop planned | Partners | Partner timescales and cooperation |
| | Agree timetable for launch | April 2018 | ET with steering group | Staff recruitment timescales |
| **Stage 3** | | | | |
| | Staff induction / training | April / May 2018 | ET with partners | Staff recruitment timescales |
| | Deliver briefing sessions to referring practices | April / May 2018 | Partners and new staff | Staff recruitment timescales |
| | Develop relationships with VCS providers and operate a database of services | April / May 2018 | New staff | Staff recruitment timescales |
| **Stage 4** | | | | |
| | Launch and begin receiving referrals | June 2018 | New staff | All of the above |
| | Review monthly with steering group | Ongoing | ET and steering group | No dependencies |
| | Report to LCN boards | Quarterly | ET and steering group | Timetables |
| | Report to Overview and Scrutiny Committee | Annually | ET | Timetables |
| | Report to Chichester in Partnership | To be agreed | ET/ Amy Loaring | Partners interest, agenda space |
| | Report to Cabinet | May 2020 | ET | Timetables |

## 11. PROJECT TEAM

| Partner | Responsibility |
|---|---|
| Elaine Thomas- Wellbeing Manager CDC lead | Securing funding<br>Recruitment of staff<br>Staff line management<br>Project planning and development |
| Amy Loaring – CDC Project and Partnerships Manager | Links with Chichester in Partnership and support to develop Voluntary Sector capacity |
| WSCC Communities Team manager | Securing funding from partners |

| | |
|---|---|
| | Ensuring good relationships are in place with CVS organisations<br>Support to develop Voluntary Sector capacity |
| GP lead for Rural North Chichester Local Community Network (based at Loxwood surgery) | Securing funding<br>Securing office space in surgeries<br>Ensuring all GPs are briefed and are committed to the project<br>Ongoing support for staff |
| GP lead for South Chichester Local Community Network (based at Parklands Surgery) | Securing funding<br>Securing office space in surgeries<br>Ensuring all GPs are briefed and are committed to the project<br>Ongoing support for staff |
| West Sussex Coastal Care (Coastal West Sussex Clinical Commissioning Group) includes leads for Rural North and South Chichester Local Community Networks | Governance / evaluation / referral pathway processes (to be agreed with steering group)<br><br>Ensuring all social prescribing projects across the area are working to similar outcomes and standards and are therefore comparable. |
| Sussex Community NHS Foundation Trust | Support with training, referral processes and ensuring links with other areas of developing LCN work |

## 12. COMMUNICATION

Communication regarding the project including budget monitoring will be via the steering group which will meet monthly to begin with. Each funding partner will communicate and report back to their own organisations. CDC will monitor progress via the Overview and Scrutiny process and Chichester in Partnership.

## 13. RISK LOG

The following risks have been identified together with an assessment of their severity and actions that can be taken to mitigate/reduce the risk. Details of all project risks will be recorded as and when they are identified.

| Risk No | Risk Description | Likelihood<br>Unlikely<br>Possible<br>Probable<br>Certain | Impact<br>Minor<br>Significant<br>Serious<br>Major | Planned Actions to Reduce Risk | Responsible Officer |
|---|---|---|---|---|---|
| 1 | The council having to absorb redundancy costs for staff after the 2 year pilot comes to an | Possible | Serious | Staff will be on fixed term contracts. We will explore the possibility of | Elaine Thomas |

| | | | | | |
|---|---|---|---|---|---|
| | end. | | | employing people on secondment. A MOU will be put in place between key partners to clarify commitment to the project. | |
| 2 | GPs fail to engage and refer patients to the service | Possible | Major | Training and ongoing briefing and communication. GPs will be included in MOU. | Elaine Thomas |
| 3 | The demand for the service exceeds its capacity. | Possible | Minor | Initially we will restrict referring organisations to GPs only. There will be clear referral criteria for referrals.<br><br>Community Referrers will case manage and sign patients off as soon as possible. | Project steering group |
| 4 | Reduced / lack of capacity within the voluntary sector groups to support additional referrals | Possible | significant | Onward referrals will be monitored closely to ensure gaps are identified at an early stage.<br><br>We will work with commissioners and grant funders to identify ways to prioritise relevant service areas. | Project steering group |
| 5 | Increased demand on council services eg Housing, Revenues and Benefits, Communities services | Possible | significant | Liaison and briefings with council staff will take place prior to the project launch. Onward referrals to council services will be monitored to ensure they are appropriate. | Elaine Thomas |