Appendix 1

Link Back Project Proposal (Early Intervention) – 2018/2019

❖ Introduction

The Link Back Service which was commissioned in May 2015 to support hospital discharge at the Royal Sussex County Hospital has now completed its third year.

❖ Service Aims

The service was commissioned to:

i. To build stronger links between acute based health and social care staff and the Community and Voluntary Sector (CVS);
ii. To improve the referral pathway to services and activities in the CVS for people recently discharged from the Royal Sussex County Hospital;
iii. To assist in reducing the number of re-admissions of people recently discharged from the Royal Sussex County Hospital;
iv. To assist in reducing outpatient appointments of people recently discharged from the Royal Sussex County Hospital;
v. To assist in reducing A&E attendances of people recently discharged from the Royal Sussex County Hospital;
vi. To reconnect older people following discharge from RSCH with their communities - enabling access to appropriate services and activities provided by the Community and Voluntary Sector (CVS) and others, where relevant.

❖ Current Staffing

2 x FTE Community Link Specialists (additional staff member as of April 2018)
Anticipating recruitment of small team of volunteers to enhance the service we are able to provide and improve patient outcomes.

❖ Outputs 2017/18

Referrals into the service	**273**
Support planning visits	**125**
Telephone support	**38**
Number of service users supported	**163**

❖ Identified gap in service provision – Early intervention

Since May 2015 the Link Back Service has been focussed on optimising the longer term health and wellbeing of patients following a hospital admission. Managing tasks such as shopping, prescriptions and making follow up appointments can be overwhelming for patients during this period of recovery which without appropriate support can lead to anxiety, ill health and increased chance of readmission. In the

worst case scenario patients could be left without adequate food or drink to sustain them.

Over the last three years we have worked closely with the Red Cross Home and Settle team who provided the urgent support for vulnerable older patients being discharged home with little or no care in place and/or with no supportive family networks. These patients would then be referred on to Link Back for support with longer term needs with respect to support and social isolation.

The Red Cross Home and Settle Service was decommissioned as of June 29th this year. This leaves a significant gap in the support of vulnerable patients on discharge from hospital and increased risk of avoidable readmission.
The current Link Back Service does not have capacity to respond to short- term or urgent support needs following discharge.

- **Developing a specialist knowledge of grant options and assistance available to home owners in order to maintain independent living.**

An additional FTE staff member with a focus on early identification of needs with respect to their home environment will enable a more responsive service by;

- Avoiding delayed transfers of care from hospital due to the provision of required adaptations and equipment
- provision of short term practical support for patients on discharge from hospital
- identifying areas of need and facilitating access to the resources required to optimize recovery and ongoing health and wellbeing
- ensure are patients are able to remain safe and well in their own homes at a vulnerable time in their recovery
- identifying essential repairs and accessing appropriate works to reduce the risk of further accidents or injury
- identifying dementia friendly adaptations and equipment that will facilitate a patient living independently for longer
  maximising take up of the Disabled Facilities Grant to support patients post discharge.
- providing emotional and practical support in order to build confidence and resilience

- **Growth and development of a team of (early intervention) volunteers**

An additional FTE staff member will enable the development of a small pool of *early intervention* volunteers who are able to provide the practical support necessary to support patient health and wellbeing during the initial recuperation stage post discharge. This service is currently not possible, due to constraints with available time for our current Link Back staff team.

The volunteer role will enable scope to:

- Enable an earlier intervention offering practical support such as essential shopping, collecting prescriptions, co-ordinating health appointments, meal preparation light laundry or decluttering.
- Offer 1-1 support to assist assessed clients to achieve their goals such attending a social group the first time or helping to set up a service such as home help or meal delivery.
- Provide short term emotional support and social company to reduce anxiety and build confidence.
- Support the client to reconnect to their local community by accompanying them to social support services or peer support activities as appropriate. Provide protected time to analyse data, identify gaps to enable the ability to tailor the service to meet outcomes in a more efficient manner, based on statistical evidence. This would aim to analyse re-admission data, to seek methods of avoiding the incidence of this, where it can be prevented.

Case Study - Mrs AC

This case study illustrates the importance of specialist knowledge of what assistance is available to home owners in order to access appropriate adaptations and support in order to reduce the risk of accident and injury.

Mrs AC who is a home owner and self-funding was referred to the Link Back Service in November 2017.

She was referred for support to access social activities and home help.

During the support planning visit Mrs AC revealed that she was very anxious about falling again in the shower due to having to climb into the bath. She said she was waiting for a bath lift so that she could bathe more safely.

Her Community Link Specialist (CLS) offered to follow this up with Access Point and was informed a bath lift had been ordered by Responsive Services.

In February 2018 during Mrs AC's 2 month review she informed her CLS that she was still waiting for the bath lift.

Her CLS enquired via Access Point about using a DFG grant to speed the process up but was informed that as the order was in process this was not advisable.

In April 2018 her CLS made contact with her Care Manager who explained that the original bath lift order had been cancelled by Responsive Services due to it being a 'long term need' and she had therefore gone on a waiting list. The lift was ordered

again by the Care Co-ordinator at the end of April and was due to arrive the following week.

Mrs AC had waited for 5 months to get a bath lift in place. Specialist knowledge of the DFG and options available to Mrs AC could have reduced this waiting time and in turn the considerable risk and anxiety she experienced.

- **Improving lives: saving time & money**

Below we offer two new case studies which look in detail at patient outcomes and the potential cost savings. We recognise that these are difficult to attribute due to the complex nature of the support environment that exists around any individual at any given time.

However, based on four previous case studies and the two detailed below we estimate an average cost saving of **£8,876.00** per patient supported through the programme.

It's worth noting that this does not account for the amount of clinician time saved in not having to intervene as a result of the support given.

Case study 1 - Post discharge Social Prescribing – Link Back Service

Description of social prescribing activity (100 words)
Mrs S who is 84 years old was referred to Link Back by the Stoma Nurse on Level 8 at RSCH. She had recently been fitted with Stoma was struggling to manage some of the additional challenges having a stoma had made to her life with respect to daily tasks such as shopping and cleaning. She was not aware of the services available to her or activities locally. The Social Prescribing activity included; - Referral for Attendance Allowance for financial support - Referral to Befriending - Referral to Vision Loss team for home assessment - Referral to LifeLines for Health Link support and information on activities
What difference or impact did social prescribing support make? E.g. accessed a new activity, confidence increased, felt less isolated, developed a plan (100 words) **Attendance Allowance:** This allowed her to get the support she needed with shopping and cleaning thus reducing her anxiety about continuing to live independently. **Befriending:** Additional social company at home reduced her anxiety about being isolated at times when she did not feel up to going out due to her stoma. **Health Link:** Knowing that she could access support when needed getting to health appointments greatly reduced her anxiety about managing her condition longer term.

Vision Loss: Equipment provided by the ROVI team gave her more confidence undertaking day to day tasks such as moving around the flat and reading paperwork.

What services do you estimate have been needed less because of social prescribing? (100 words)

Reduced hospital admissions: Prior to this referral Mrs S had had numerous hospital admissions relating to poor management of her medical condition. Eight months after this intervention her stoma nurse reported that she had had no further hospital admissions.
Reduced anxiety and improved confidence: Mrs S felt more supported to manage independently at home avoiding unnecessary calls to the paramedics.

Reduced risk of missed health appointments

What type of cost savings might this be?

Proxy Measure	**Item Cost**	**Source**	**Estimated no of items**	**Estimated Annual Saving**
Hospital stay - average cost per episode	£1863	CCG	5 per year	£9315
Cost of loneliness	£960	Centre for Economics and Business Research	1 per year	£960
Cost of mental health services	£803	Sainsbury Centre for Mental Health	1 per year	£803
Cost of emergency call out	£223	PSSRU	5 per year	£1,56
Total				**£12234**

Comment from the client (100 words)
I was so relieved to have been awarded the Attendance Allowance as I can afford to pay for the support I need such as practical help and taxis for shopping. Likewise, magnifying lamp and white stick are a huge help. The support has changed my outlook completely. I now feel able to call people such as my doctor and explain what I need whereas before I never had the confidence.

Case study 2 - Post discharge Social Prescribing – Link Back Service

Description of social prescribing activity (100 words)

Mrs W who is 91 years old was referred to the Link Back Service by the Ward Staff on Level 8a at RSCH. She had been admitted following a fall and a pattern of calling to emergency services due to panic attacks.
Mrs W's priority was support with personal care in the mornings and adaptations in her bathroom to enable her to use the shower.
A referral was made to Access Point for an Adult Social Care assessment and OT assessment in the bathroom.
We also discussed social groups that she could access locally once she was more mobile

What difference or impact did social prescribing support make? E.g. accessed a new activity, confidence increased, felt less isolated, developed a plan (100 words)

Being listened to and having her concerns taken seriously made a huge difference to Mrs W's state of mind. The care package in the mornings reduced her anxiety levels about coping alone and improved her confidence and outlook. Adaptations in the bathroom reduced her falls risk and made her bathroom accessible.
The additional care improved her sense of wellbeing enabling her to consider her other needs such as increasing her activity and social interaction.

What services do you estimate have been needed less because of social prescribing? (100 words)

Reduced use of Paramedics and Emergency Services
Reduced hospital admission due to reduced falls risk
Reduced GP calls and home visits

What type of cost savings might this be?

Proxy Measure	**Item Cost**	**Source**	**Estimated no of items**	**Estimated Annual Saving**
Cost of GP visit	£45	PSSRU	3 per year	£135
Cost of prescription	£42	PSSRU	3 per year	£126
Hospital stay - average cost per episode	£1863	CCG	1 per year	£1863
Cost of loneliness	£960	Centre for Economics and Business Research	1 per year	£960
Cost of mental health services	£803	Sainsbury Centre for Mental Health	1 per year	£803
Cost of falls	£5000	B&H Connected	1 per year	£5000
Cost of emergency call out	£223	PSSRU	5 per year	£1165

Total				**£10052**

Comment from the client (100 words)
Thankyou Gwyn. You did me a wonderful turn. I realise now I was having a breakdown. I had kept myself busy decorating after my partner died. After that finished I started falling apart. No-one was listening to me, so I was calling the doctor and the paramedics as I didn't know who else to call. And then you came after hospital and it all changed. The carers are wonderful and I have more energy as the doctor changed my medication. I no longer need to use the three-wheeled walker! I now feel more positive and getting out more.

❖ EARLY INTERVENTION CLS

We will recruit one FTE to the post, to be managed by our Link Back Service Manager. The post will be managed and supported in line with Possability People's policies and procedures, and the role description will be focussed on providing the early intervention support and expertise in raising awareness of and supporting applications to the DFG fund.

We will establish a monitoring framework for this activity which will track not only the impact of our interventions on the individuals we support but also monitor outcomes such as number of successful/unsuccessful DFG applications.

❖ SERVICE PROPOSAL

It is challenging to predict the demand for the early intervention support and DFG applications without current experience or access to existing data. We have estimated the following figures cautiously and allowed some development time in year one (2018/19) to establish knowledge of the service and volunteer base. The full capacity of the project would be achieved in year 2 with a full complement of volunteers.

We have, also, estimated that the role will spend 10 hours per week attending essential meetings, development work and continually raising awareness amongst existing and an ever-changing clinician team at the hospital to ensure the level of referrals that we would expect. In addition we have included in the costing 7 hrs administrative support weekly to support the co-ordination and delivery of the service.

Current Service

	Av No. Referrals per Month	Per Year	Av No. Support Plans per Month	Per Year	Av No. signpost/Telephone Support per Month	Per Year
Proposed 2018/19	35	420	19	228	15	180

Proposed Early Interventions

	Av No. Early Interventions /DFG per Month	Per Year	Based on No of Early Intervention Volunteers
Proposed 2018/19	12	144	3-5

- **Proposed Budget**

Staff Costs £30010 (based on 1x FTE at point 22, one day per week bank staff rate and all associated on costs)

Staff and Volunteer travel £1040 (based on 2x annual savers at £540 each)

Office costs and overheads £1210

Management fee £5700 (Possability People management fee and line management for worker/support for volunteer).

Total Funding Requested £37960