Voluntary sector proposals

Annex to the People and Communities Board's report *A new relationship with people and communities*

February 2017

Preface

In September 2016, the People and Communities Board (PCB) was commissioned to recommend a limited set of high impact actions that would help to add speed and scale to the delivery of Chapter 2 of the NHS Five Year Forward View.

During this work, we asked a number of voluntary sector organisations to share their ideas for high impact actions. We received around 40 suggestions from 26 organisations.

These have been used to develop the framework set out in the report A new relationship with people and communities: Actions for delivering Chapter 2 of the Five Year Forward View.

We were not asking for funding bids, and this was not a fair and open call to the whole sector. However, a number of the proposals outlined approaches or interventions developed in the VCSE sector, which have been tested and evaluated and which might have the potential for wider adoption. We felt it would be worth highlighting these to NHS England as case study examples representing a much wider spread of innovative programmes that lie within the VCSE sector but which are not easily surfaced for national attention.

Our full report suggests that NHS England should establish a national mechanism which *can* issue fair, open and transparent calls for submissions of innovative, tested programmes, to be considered for funding so that they can spread more widely and demonstrate their full value.

Along with this subset of case studies, we also enclose a table outlining the full set of proposals received. Some of these have already been taken up as suggested actions or offers within the PCB's report.

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Introduction

The People and Communities Board started the process of developing the high impact actions by asking a targeted group of voluntary sector organisations for 'proposals on a page'; ideas for potential high impact actions.

We received around 40 of these proposals, which included specific programmes for single conditions (some of which could be adapted for other conditions, or for any conditions, broader proposals for new approaches, and offers of training and hosting events).

We were not asking for funding bids, and this was not a fair and open call to the whole sector. However, a number of the proposals outlined approaches or interventions developed in the VCSE, which have been tested and evaluated, and which might have the potential for wider adoption. We felt it would be worth highlighting these to NHS England as case study examples representing a much wider spread of innovative programmes that lie within the VCSE but which are not easily surfaced for national attention.

This was not an open process for people to submit their proposals to be compared.

Our full report suggests that NHS England should establish a national mechanism which can issue fair, open and transparent calls for submissions of innovative, tested programmes, to be considered for funding so that they can spread more widely and demonstrate their full value.

The case studies selected have in common that they:

- Have been tested in a small number of local areas or healthcare settings
- Have had some evaluation
- Appear to fit within the categories of intervention that have been studied and evidenced for development in the new models of care (such as education for self management)

By collecting these examples here, the People and Communities Board is not making comment on their value in comparison to the full set of proposals: this piece of work has not, by necessity as well as design, been one of in depth analysis and evaluation. This list is chosen to illustrate the richness of innovation and interventions that could be called forth from the VCSE sector. Costing implications included cannot be directly compared, and are indicative only.

Arthritis Research UK: ESCAPE-Pain

Intervention

ESCAPE (Enabling self-management and coping with arthritic pain through exercise) is a six-week programme of integrated exercise and self-management delivered in a group setting by a physiotherapist.

The programme aims to increase self-management of both hip and knee pain, helping people to avoid surgery, and stay active. As well as participating in a tailored exercise routine, patients learn about the causes of pain and self-management techniques.

Justification

In the UK, 8.75 million people have sought treatment for osteoarthritis. It causes pain and functional limitations which impact on quality of life and the ability to live independently. Osteoarthritis is the most common reason for knee replacements: in 2013 there were over 91,000 primary knew replacements in England, Wales and Northern Ireland.

Outcomes

Participants who completed ESCAPE had less pain, better physical functioning, were less depressed and had better beliefs about how they could use exercise to control their pain compared with people who remained under usual primary care.

Improvements were similar regardless of whether participants received the programme individually or in groups, but group rehabilitation was not only much cheaper but more popular because people enjoyed interacting with each other. Improvements were still evident up to 2½ years later without any additional input.

Value

ESCAPE was cheaper and more cost-effective than usual care, with savings arising primarily due to delivering treatment in small groups rather than individually. The cost per patient per session through ESCAPE has been calculated at £114.99, which is almost half of the calculated outpatient physiotherapy cost per patient of £228.92. The annual saving from implementing ESCAPE was £6,152 for a population of 230,000, or £2,675 per 100,000 population.

Evidence also found significant reductions in healthcare utilisation, with the programme producing wider savings due to a reduction in demand for interventions such as X-rays, MRI scans or specialist consultations and referrals. Costs for these have not been included as there are significant variables between individuals.

Contact

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The Stroke Association: My Stroke Guide

Intervention

My Stroke Guide (MSG) is an online, NHS Information Standard accredited self-management resource to support stroke survivors' recovery. It has been developed in co-production with stroke survivors and carers and has been rigorously tested to ensure its design is accessible.

MSG features 30 'Essential Guides', short films featuring stroke survivors and health professionals, practical tips, links to other websites and apps, animated films for people with aphasia, information on goal setting, peer support and interactive games. The social forum area of the guide has meant that stroke survivors can interact directly, provide and receive peer support and create new networks with people who can share their experience. A Carers social network forum has also been developed to facilitate carer peer support.

Justification

MSG has the potential to support a large portion of the 100,000 – 120,000 people who have a stroke every year as well as the estimated 1.2 million stroke survivors across the UK. We know many stroke survivors do not receive the support they need with 45% reporting they feel abandoned and 47% saying they were not contacted by a health professional after leaving hospital (Stroke Association 2016 Stroke Survey of 1,424 people in England).

Coordinators can assist stroke survivors who require one to one support to access MSG through direct health coaching and a wider range of stroke survivors through a number of mechanisms including reaching out to provide information about MSG to hospitals, GP surgeries and community rehabilitation and Early Supported Discharge teams.

Value

Dedicated MSG coordinators to support those with the highest need would help ensure maximum benefit. It is estimated that one coordinator could support up to 200 stroke survivors who require 1 to 1 support to access MSG per year, through direct health coaching. They would be able to support 500 additional people who do not require this level of support, through a number of mechanisms including reaching out to provide information about MSG in hospitals, GP surgeries and community rehabilitation teams.

The cost would be £30,068 including on-costs (for London based staff £34,027) for 1 MSG Health Coach.

Contact

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Diabetes UK: Living with Diabetes Day events

Intervention

Diabetes UK has worked in 93 areas to deliver 'Living with Diabetes days' as part of the local menu of learning options working with healthcare systems and the local diabetes community. The days offer the opportunity to meet and learn from others in an informal environment. Events were targeted in areas of high deprivation.

'Living with Diabetes Days' provide an important way of signposting the value of self-management education, increasing the uptake of evidence-based structured education.

Justification

Evidence shows that structured education to help people manage their diabetes improves health outcomes and reduces the onset of serious complications. Across the 93 events delivered to date, 10,913 people have been reached. They reported an increase in knowledge from 55%.

Evaluation using patient reported outcomes showed that those attending improved their understanding of diabetes, felt motivated to manage their conditions better, discovered what healthcare they are entitled to, and felt more aware of what local services were available to them.

Value

Costs of the days include the time of local organisers, volunteers and clinicians, venue, and catering. To deliver nationally with a team of 6 staff costs approximately £1 million, including venues, information/resources, lunches, clinical support, travel and expenses, but local costs vary.

Contact

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Alzheimer's Society: Side by Side programme

Intervention

Alzheimer's Society's Side by Side service has a real focus on empowering people with dementia. Trained volunteers will closely support people living with dementia to identify their own personal talents, strengths and capabilities and what they can bring to their peers and the wider community. They will encourage people with dementia to get out and about, be active, retain old activities and take up new interests where possible. The service will provide support to access universal services such as public transport, retailers and leisure facilities and empower people with dementia to develop their own solutions to meet their identified needs. Where appropriate, Side by Side will look to link people with dementia into existing group activities in their community and identifying barriers that block their ability to participate in their communities.

The service provides more ongoing support than the often time-limited home from hospital and reablement services, which can leave people with dementia at a cliff-edge and at risk of readmission. It provides a vital link between people affected by dementia and the Dementia Friendly Communities programme.

Outcomes

Recent NCVO evaluation showed that Side by Side volunteers open up more ways for people with dementia and their carers to access support. Carers report a positive impact, and that they find themselves more able to cope with their caring role, with greater peace of mind knowing their loved one is supported. The evaluation found that the service provides good value for money, with lower costs than community support services.

Value

The service provides good value for money, with costs lower than those for community support services. The Carmarthenshire pilot yielded a unit cost of £879 per client in 2015-16. This helps prevent hospital admissions which cost an estimated £400 a day.

Contact

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Macmillan Cancer Support: Electronic Holistic Needs Assessment

Intervention

The Electronic Holistic Needs Assessment (EHNA) is a web-based tool allowing the person with cancer to indicate their holistic concerns. These concerns are then used by the health or care professional to prioritise a discussion and co-create a care and support plan.

EHNA aims to address people's needs as well as identifying capacity for them to retain control and independence by self-managing aspects of their care and support. Whilst it's not expected to resolve every concern, it facilitates appropriate signposting to resources and services. The resulting plan can then be shared with the person, and the wider support team.

Models of delivery vary, with most organisations delivering the intervention at key transition points on the cancer pathway. It is mostly used in acute care, but has also been used in social care settings.

The EHNA can be delivered in any setting by registered and non-registered support personnel, including trained volunteers. Most delivery is done within organisations, but the person can use their own tablet, smartphone or PC at home to complete before a support discussion occurs and the care and support plan is created or reviewed. The approach is not about employing new staff, but looking at how current roles can use the tool to better support people.

EHNA could potentially be used across other conditions, and has been piloted for diabetes.

Outcomes

EHNA has a range of benefits. For individuals, it enables greater engagement in the care and support planning discussion with their health or care professional, so that their concerns are better addressed. For professionals and support personnel, a clear indication of individual's needs and priorities allows them to tailor discussions to meet specific concerns. It can also be (and have been) used in local service development and commissioning.

Value

Recent analysis found that delivery of the EHNA and care plan costs £13.70 per individual assessment. Delivery is through current roles, and has largely been carried out by CNSs,

with lower band support workers doing this in some areas. The contract with their current supplier covers the use of the EHNA primarily for patients living with cancer, and so reflects this number of patients. Hosting costs on this basis are currently £60,000 per annum. It would cost around £7000 to rebrand the tool for other conditions/make it non-specific.

Discussions have been held with NHS Digital about the prospect of them hosting the database, and they may have capacity in the near future.

Contact

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Age UK: Integrated Care Programme

Intervention

Age UK works with health, social care and the local voluntary sector in an area to provide an integrated solution and seamless experience of care for older people with clusters of long term conditions at high risk of repeated addition to hospital.

I*ntegrated Care Programme:* The individual older person designs their own care management plan, with support from a care co-ordinator.

Risk stratified person-centred discharge: Based on this model, Age UK are developing a new risk stratification tool incorporating long term conditions and the Electronic Frailty Index, which should lead to more efficient use of scare resources. The tool ensures a proactive, person-centred discharge, with continued practical support at home preventing care breakdown and readmission.

Digitally supported personalised action plan: Designed to ensure Age UK Independence Co-ordinators have high quality, guided conversations with older people. This should prevent double entry, save time and maximised quality, including ensuring co-production of the plan with the older person. It can be shared easily with older people, their families, and the multi-disciplinary team and integrated into primary care records.

Benefits of the approaches set out above include improved wellbeing using the Warwick Edinburgh Mental Wellbeing Scale, reduced lengths of stay in hospital and fewer hospital readmissions.

Value

The cost of scaling up the model in one STP area – Kent and Medway – over 2-3 years costs £2.5-3 million. This would benefit between 18-20,000 people. Rolling out to start up model in remaining STP footprints, targeting a minimum of 1,000 people per area would cost an estimated £500,000- £550,000 per site. This would need £413,000 NHS England match funding and £137,000 CCG/STP match funding. The cost of building and testing a new risk stratification tool to tackle delayed transfers of care in Cornwall and North Tyneside, benefiting 200 people initially, is £250,000.

Contact

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NCB: Expert Parent Programme

Intervention

The Expert Parent Programme (EPP) is an evaluated peer-led programme of support for parents of children with complex needs to enable management of their conditions and effective use of the various systems they encounter. The programme includes a workshop delivered by parent trainers to parents, complemented by online resources.

The programme consists of:

- A workshop for parents and carers of disabled children and young people, delivered by parents. This peer-to-peer support is the fundamental tenet of the programme;
- A network of CDC approved parent trainers;
- Comprehensive online information and links to existing information;
- Interactive e-learning resources.

The workshop consists of a 'four hour off the shelf' package that can be delivered over an entire 4 hour session or as short 'one off' activities as part of a support group meeting, coffee morning or conference workshop.

The workshop covers:

- Module 1: Person centred approaches; parent carers' unique knowledge of their child
- Module 2: Understanding the health system; who's who and how do they help; outcomes in detail; needs vs rights
- Module 3: How to work effectively with and get the most out of the health system; how to give feedback or complain; effective partnerships

Expansion of this programme would be through training local parents to deliver the workshop to local groups of parents, creating a sustainable network of trainers, and maximising long-term impact.

Justification

Disabled children and young people, and those with complex needs often experience uncoordinated care, and poorer health outcomes than their peers. The EPP helps their parent carers to have solution-focused conversations with health professionals, and to articulate the impact of care of their child's outcomes. This helps ensure effective, appropriate care based on choice and control.

EPP was developed as a pan-disability programme, and different versions have been created to address particular NHS priorities and system pinch-points, for example for parents of children and young people with learning disabilities and challenging behaviour and/or autism, or those accessing or waiting for CAHMS.

Outcomes

The programme was established in 2012, and an evaluation found that following the programme, 92% of parents asked agreed that the training had helped them to understand how their use of language and terminology when talking about their child can help professionals get a clearer understanding of their child and how best to meet their needs.

Value

The capacity building nature of the programme ensures that beyond an initial investment, a sustainable network of trainers will be able to work locally to deliver the programme, adapted to suit local needs and services. To deliver across all STP footprints, it is estimated that the EPP would cost £350,000.

Contact

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Youth Access: Youth Information, Advice and Counselling Services

Intervention

The Youth Information, Advice and Counselling Services (YIACS) model is an integrated health and wellbeing model for young people delivering a range of early intervention, prevention and crisis interventions in community based (primarily voluntary and community sector) settings.

Originally developed in the 1960s, the YIACS model has a number of core features:

- Dedicated services for young people up to age 25 (typically 13-25 or, increasingly, 11-25)
- Someone to talk to in a young person-friendly setting (informal, non-judgemental, confidential, safe)
- Holistic support on a range of issues that are frequently inter-related:
    1. social welfare issues, e.g. benefits, housing, debt, employment
    2. mental and emotional health issues, e.g. depression, low self-esteem, self-harm, family problems and stress
    3. wider personal and health issues, e.g. relationships, sexual health, drugs and alcohol, healthy eating
    4. practical issues, e.g. careers, money management, independent living skills
- A range of complementary interventions, including one to one interventions, delivered through multi-disciplinary teams of advisers, therapists and youth workers
- Open access – for all young people, with no arbitrary age or clinical thresholds
- Flexible access routes – including through self-referral and 'drop-in' sessions
- Voluntary participation – young people can self-refer and make an active choice to use the available services; support is offered independently from parents/carers, and is not time-limited.
- Independent from government
- Free at the point of delivery

Youth Access members utilise a range of approaches to implementing YIACS in local areas.

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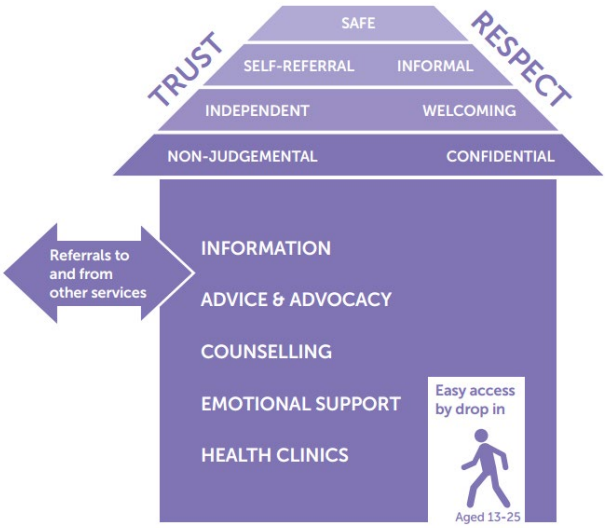

Justification

The Department of Health reaffirmed its commitment to the recommendations of the Children and Young People's Mental Health and Wellbeing Taskforce's 'Future In Mind' report, which included local investment in YIACS.

Outcomes

YIACS evidence the impact of their youth counselling services through the use of nationally recognised and validated clinical outcome tools, including SDQ, YP CORE, CORE-10, GAD-7, PHQ-9 and HONOSCA. Although direct comparisons with statutory CAMHS services are not currently possible, it appears likely that YIACS may achieve results that are at least as good at a lower cost with clients who often have similar levels of need. YIACS' relative efficiency is partly the result of their greater accessibility (including shorter waiting lists), strong relationships with clients (enabling them to keep young people engaged with the service), and lower delivery costs. 70% of young people report improvements in their mental or physical health after getting advice in a YIACS. 64% report improvements in stress (64%) and 34% improvements to their health in general.

Value

Therapeutic intervention in YIACS costs £60 head. Although direct comparisons with statutory CAMHS services are not currently possible, it appears likely that YIACS may achieve results that are at least as good at a lower cost with clients who often have similar levels of need.

YIACS' relative efficiency is partly the result of their greater accessibility (including shorter waiting lists), strong relationships with clients (enabling them to keep young people engaged with the service), and lower delivery costs.

Contact

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Overview of full list of VCSE proposals received

	Organisation or individual	Overview	Proposed scale	Cost	Proposals included in report
1	Age UK (Richmond Group)	Builds on Age UK's developing Integrated Care Programme (ICP) and seeks to accelerate its scale, reach and effectiveness	Validation in one current site, with subsequent roll out to all STPs	£2.5-3m for scale up of current programme in one site; £550K per site thereafter	
2	Alex Fox	The NHS commissions for wellbeing - Outlines case and refers to VCSE Review recommendations	Nationally	Policy related	Yes
3	Alex Fox	The VCSE becomes a design partner in local care and health systems - Outlines case and refers to VCSE Review recommendations	Nationally	Policy related	Yes
4	Alzheimer's Society	Broad recommendation to implement the 'Side by Side' volunteering programme for Dementia patients at a greater scale	Not specified	£870 per client per annum	
5	Arthritis Research UK (Richmond Group)	Broad recommendation to deliver the ESCAPE programme (enabling self-management and coping with arthritic pain through exercise) at scale	Evaluation calculated the cost per patient per session at £114.99 compared to cost of outpatient physiotherapy of £228.92. The annual saving was £2,675 per	Not specified	

			100,000 population.		
6	British Heart Foundation (Richmond Group)	Broad recommendation to implement the BHF programme for access to home based intravenous diuretics service to support heart failure patients, enabling them to manage their symptoms in the comfort of their own home or community setting.	Not specified	Not specified	
7	British Red Cross	A 3-site development across England to provide the Red Cross at Home Service	3 sites proposed; scale of which not specified	Not specified	
8	Carers UK, Carers Trust, NHS England, ADASS	Broad proposal for systematic adoption of the Memorandum of Understanding for Carers	National rollout suggested	Example provided: £55K set up cost for one CCG/LA	Yes
9	Community Network	Proposal for 'Talking Communities', a telecoms enabled peer support, to be co-produced across all Sustainability Transformation Plan (STP) areas.	Via all STPs	Not specified	
10	Design and Learning Centre for Clinical and Social Innovation	A proposal for spreading the use of the Swedish *Esther* model working with people with complex needs/long term conditions.	Nationally	*£2M per year for 5 years*	
11	Diabetes UK (Richmond Group)	Broad recommendation to implement Diabetes UK programme 'Living with Diabetes days' at scale	Not specified	Not specified	
12	Friends, Families and Travellers	Outlines case and possible approaches for building on Inclusion Health agenda	Not specified	Not specified	Yes
13	Jane Cooper Neville	Broad proposal to implement the Stanford University self-management interventions (e.g. Chronic Disease Self Management Course) at scale	Not specified	Not specified	

14	Lincolnshire Carers First	Broad recommendations to scale up current carer initiatives a)Thinking Family; and b) Making Every Contact Count	Not specified	Not specified	
15	Macmillan Proposal A (Richmond Group)	Broad recommendation to deliver the Macmillan Values Based Standard (VBS) - a methodology that improves staff and patient experience - at scale	Not specified	Not specified	
16	Macmillan Proposal B (Richmond Group)	Broad recommendation to make the Electronic Holistic Needs Assessment (EHNA) available across all long term conditions	All people with LTCs	Not specified	
17	Macmillan Proposal C (Richmond Group)	Broad recommendation for roll out of Macmillan's Specialist Care at Home model throughout England	National roll out	Not specified	
18	Marion Lynch / NHS England Thames Valley Area Team	High-level proposal to develop a generic narrative capability consultation model	Not specified	£50K	
19	NAVCA (supported by a submission from Bev Taylor of NHSE)	Scale up of The Single Point of Contact (SPOC) Model of Social Prescribing as seen in the Rotherham and elsewhere	Embed the current social prescribing pilots into the main stream commissioning cycle	Costings from pilots indicates that the cost of social prescribing once established is £1,171 per patient substantively engaged	Yes

20	NCB	Widespread roll out of the peer-led Expert Parent Programme which supports parent carers of disabled children	Via STP footprints	£350K to deliver across all STPs
21	NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC)	Broad proposal for changing the NHS terminology routinely used, to patient accessible language	Nationally by NHSE	Not specified
22	Oxford Academic Health Science Network	Leading Together Programme: a new leadership development course co-created and co-delivered by patients, carers, professionals and the public. It supports the development of new ways of working and embeds coproduction at a strategic level in the NHS	Ready for national spread, being rolled out across South of England	£1000/person
23	Race Equality Foundation A	Scaled-up deployment of the evidence-based Strengthening Families, Strengthening Communities parent programme	Via all CCGs	£223m nationwide
24	Race Equality Foundation B	Scaling-up a peer educator approach to see a significant increase in the number of black and minority ethnic people on the Organ Donor Register	10 UK cities by Sept 2017	£250K per 100 peer educators
25	Race Equality Foundation C	Implement the Principles of High Quality Interpreting and Translation Services as an Information Standard - an 18-month support programme for commissioners to assist with better commissioning of interpreting services in primary care	National support programme for all CCGs1	£97K
26	Regional Voices A	Building on previous Regional Voices pilot work, refine a model to support third sector and statutory sector partners to collaboratively use data and intelligence to help address health inequalities facing disadvantaged	Four Vanguards	£30-50K

		communities			
27	Regional Voices B	Regional Voices will to deliver training module for commissioners and VCSE providers	One pilot site initially	£20K	
28	Regional Voices C/D	Regional voices to deliver local workshops to support rapid rollout of learning and good practice from Realising the Value	All STPs	£430K	Partly
29	Regional Voices E	Regional Voices working with HEE and skills councils will enable the design and deliver local VCSE workforce planning and CPD training to Engaging Communities to grow the provider market fit for delivering STPs	National	£925K	
30	Regional Voices F	Regional Voices will support local VCSE partnerships to develop and deliver a citizen-led social movement for health	Via all STPs	£6.87m	
31	Regional Voices G	Develop local VCSE Partnerships in order to effectively influence STPs on behalf of local citizens and communities	Via all STPs	£4.15m	
32	Regional Voices H	Regional Voices to run a programme to support roll out of learning from the PHE/NHSE work on Community Centred Approaches to Health and Wellbeing	Via all STPs	£592K	
33	NCPC	Broad recommendations to continue and improve roll out, and implementation of EOLC strategies: The Ambitions framework for local action (2015) and The government's National Commitment on end of life care (2016)	National roll out	Not specified	Partly

34	Stroke Association (Richmond Group)	My Stroke Guide (MSG) is an online, NHS Information Standard accredited self-management resource developed for stroke survivors to support their recovery	Nationally (60K stroke survivors)	£2.5m	
35	Volunteering Matters & Cabinet Office	Series of ~10 local experiential workshops targeted at joint participation by local Health & Social Care Commissioners & local VCSE providers geared towards encouraging joint bids that utilise social action	Series of 10 local workshops	~£30,000	
36	Year of Care Partnership	Proposed that personalised care and support planning (CSP) becomes the normal approach to routine care for all people living with LTCs (and disabilities) on GP registers. Programme would be delivered via Central YOCP team and regional hubs.	Nationally via STPs	Not specified in initial proposal but costings are available on further request	Yes
37	Youth Access	Recommendation that all young people aged 11 to 25 to have access to a Youth Information Advice and Counselling Service (YIACS) in every local area.	All CYP aged 11-25 in each local area	Not specified	