Manchester Health and Wellbeing Board
Report for Information

Report to: Manchester Health and Wellbeing Board – 18 March 2020

Subject: Manchester's Approach to Prevention and Wellbeing Services – an update focused on social prescribing

Report of: Director of Population Health

Summary

This report provides an overview of current social prescribing provision in Manchester within the context of the Prevention Programme, and outlines the high level plans for the future development of prevention and wellbeing services in the city, through the 2021 Wellbeing Model.

The report provides information on:

- The national and local strategic context for social prescribing
- Information on how social prescribing is being delivered in Manchester
- Plans for further developing prevention and wellbeing provision through the Wellbeing 2021 model

Representatives from Big Life who deliver social prescribing services in Manchester will attend the meeting and deliver a presentation that includes video case studies of residents who have used the service. The development of the model has been considered and supported by the Manchester Health Scrutiny Committee on 4 February 2020.

Recommendations

The Board is asked to:

(1) Note the contents of the report
(2) Endorse the approach to developing prevention and wellbeing support provision through the 2021 Wellbeing Model

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Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	The Prevention Programme works across the life course (from youngest to oldest) to: 1) Support residents in strengthening the social determinants of health -
Improving people's mental health and wellbeing	
Bringing people into employment and	

ensuring good work for all Enabling people to keep well and live independently as they grow older Turning round the lives of troubled families as part of the Confident and Achieving Manchester programme One health and care system – right care, right place, right time Self-care	employment, finance, housing and social connectedness 2) Support the adoption of healthy lifestyle choices - physical activity, nutrition, smoking cessation and emotional wellbeing 3) Improve the quality of life, health outcomes and life expectancy of people with long-term conditions - identifying long-term conditions early, proactively managing long-term conditions 4) Optimise the health of people with long term conditions - enhancing standards of clinical care, supporting the mental health and social needs of people with these conditions 5) Use asset-based, personalised and holistic approaches to enable self-care.

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Background documents (available for public inspection):

None.

Introduction

1.0 Development of Manchester's five year Prevention Programme began in 2016. The aim of the programme is to enable Manchester's Local Care Organisation (MLCO) to take a community-centred and asset-based approach to delivering care, and promote health and wellbeing for residents of the city, working through the MLCO's 12 Neighbourhood Teams. This will enable more people to have the knowledge, skills and confidence to manage their own health and care, and reduce demand on health and care services, whilst promoting community resilience and improving health outcomes.

1.1 The development of a coherent citywide social prescribing model is one of the core components of the Prevention Programme. This aims to give people who access health and care services, a link to social and non-medical support within the community to address the social determinants of health.

1.2 The purpose of this report is to provide the Board with an overview of the current progress in establishing and delivering citywide social prescribing provision. It also outlines the future plans for development of social prescribing within wider prevention and wellbeing approaches from 2021 onwards.

Background

2.1 Strategic context

2.1.1 In recent years there has been an increasing focus on the role of communities in promoting health, and the opportunities for developing prevention and wellbeing support through community-based, integrated, primary care-led approaches; including social prescribing as a 'high impact action' to increase capacity within primary care[1].

2.1.2 The current NHS Long Term Plan (2019) includes a commitment to building an infrastructure for social prescribing within primary care, supported by resources for Primary Care Networks (PCNs) to develop social prescribing link worker roles within their multi-disciplinary teams.

2.1.3 The Greater Manchester Population Health Plan (2017) also sets out a vision for a health and care system that is based on person and community-centred approaches, supported by a strategy for Person and Community Centred Approaches (PCCA) which includes a focus on social prescribing as an integrated part of localities' health and care systems.

2.1.4 Manchester's Population Health Plan (2017) sets out a ten year plan for reducing health inequalities and improving health outcomes for the city's residents, including a priority of supporting people, households, and communities to be socially connected and make changes that matter to them to improve their health and wellbeing. This is reflected in and supports the objectives of the MHCC and MLCO Operational Plans.

[1] NHS Five Year Forward View (2014), NHS General Practice Forward View (2016)

2.1.5 A programme of Person and Community Centred Approaches (PCCA) has been established to support delivery of the Our Healthier Manchester Locality Plan across the health and care system, overseen by the Manchester PCCA Programme Collaborative, which brings together leaders from across the system to facilitate cross-working and identify and act on opportunities to progress these approaches. The PCCA programme includes the Prevention Programme work streams of social prescribing and community-centred approaches.

2.2 The health of Manchester's population

2.2.1 The health of people living in Manchester remains among the worst in England, with a high number of preventable deaths and significantly lower than average life expectancy at birth. The risk behaviours that lead to poor health outcomes (obesity, physical inactivity, smoking, alcohol misuse) are highly prevalent in Manchester. Health inequalities in the city linked to deprivation are estimated to give rise to at least £300-320m in economic losses and £53m in costs to the NHS per year[2]. Surveys indicate low mental wellbeing in the population, associated with employment status, poor general health and a higher prevalence of diagnosed medical conditions[3]. Preventable long term conditions result in high levels of primary care use and expenditure on unplanned care and are projected to rise with the ageing population.

2.2.2 The recently published Marmot Review – 10 Years On (University of London Institute of Health Equity, 2020) provides a stark assessment of the fact that the last decade in England has been marked by deteriorating health and widening health inequalities. The review finds that improvements in health have stalled, and links this to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources – the social determinants of health. The social gradient – the impact of deprivation on life expectancy and healthy life expectancy – has become steeper, with inequalities more pronounced between and within regions of England. The report makes recommendations for national action to address health inequalities and the social determinants of health, including prevention and early intervention; these would strengthen the local work currently underway as outlined in this report.

2.3 Manchester's Prevention Programme

2.3.1 The Prevention Programme aims to make a significant mid to long-term impact on the health of Manchester's population, by reducing the occurrence of the mental and physical long-term conditions that lead to poor health outcomes and quality of life, and impact on the capacity and costs of the health and care system. This can be achieved by supporting changes to lifestyles and behaviours and, more significantly, by addressing the social determinants of health and intervening in the early years of life. This can only be achieved by

[2] Based on losses estimated for England in the Marmot Review (2010) and extrapolated to the Manchester population

[3] North West Mental Wellbeing Survey for 2012/13

working more effectively with the groups, organisations and services best placed to have an impact on these areas.

2.3.2 The Prevention Programme has three delivery work streams:

- Neighbourhood Health and Wellbeing Development, which aims to enable the leadership teams of the 12 MLCO Neighbourhoods to develop and implement neighbourhood plans that (i) make the most of local assets to target local needs and (ii) are co-produced with local community groups and residents. This is supported by 12 Health Development Coordinators.
- Community Links for Health, which aims to embed a coherent citywide social prescribing model to enable community-based health and care practitioners (initially focusing on primary care) to quickly and easily introduce patients to a social prescribing hub where social prescribing link workers and health coaches work with referred individuals to understand their strengths and goals and support them to connect to sources of community-based support to address social determinants and improve health
- Community Capacity Building, which aims to support neighbourhoods and voluntary and community sector groups and organisations to develop approaches that will support the prevention programme objectives and strengthen communities to support health and wellbeing.

3. Prevention and wellbeing services – social prescribing

3.1 Background

3.1.1 Social prescribing is a means of enabling health and social care services to refer people to a range of local, non-clinical support, often provided by voluntary and community sector organisations. The approach is commonly targeted to primary care settings, in response to the capacity issues arising from the proportion of time GPs spend dealing with non-medical issues such as housing, unemployment and debt. It seeks to address people's needs in a holistic way, by taking into account social determinants that influence health, and supporting individuals to take greater control of their own health and wellbeing. Targeting these approaches at the groups who are most at risk as a result of health behaviours or social circumstances will reduce the inequalities in health between the most and least deprived areas.

3.1.2 Social prescribing services in the UK have developed independently and organically over recent years, however most are based on a similar model, which has three core components: a single point of contact for referrals, a social prescribing workforce providing support to individuals, and connection to a range of local community-based activities, groups and sources of support

3.1.3 Established social prescribing services across the country have reported a range of outcomes for individuals, communities and local health and care systems, including:

- improvements in individuals' physical and/or mental health and wellbeing, social connections, ability to manage their own health; and other positive benefits such as reduced isolation/loneliness
- increases in access to a range of community-based sources of support, stronger connections between health and care services and communities/VCSE sector, and improved opportunities for asset-based community development to support health and wellbeing
- reductions in use of primary, acute and secondary healthcare services and savings in health and care system costs

3.2 Social prescribing in Manchester

3.2.1 The Prevention Programme is a 5 year programme, which was originally intended to become operational in 2016/17, and include a single citywide social prescribing service. However due to different funding sources and timescales, there has by necessity been a phased approach to establishing the Prevention Programme, including the social prescribing infrastructure for the city. Early implementation began in north Manchester, initially Greater Manchester Mental Health Foundation Trust provided the Be Well – North social prescribing service (beginning in December 2017) and the Big Life Company provided the Be Well – Central and South social prescribing service (beginning in November 2018). Following a recent tender process, the Big Life Company will now provide a citywide service.

3.2.3 The citywide social prescribing model for Manchester includes:

- A single point of access ('social prescribing hub') for primary care practitioners (GPs and others) and other health and care workers to refer patients to, by EMIS, phone or secure email
- Initial strength-based assessment of referred individuals' non-medical needs to establish whether they require support from the service; if no support is required the service can provide signposting to appropriate sources of other support
- Allocation to a named key worker (community link worker or health coach) providing support at varying levels of intensity depending on the individual's needs, which may include social determinants (e.g. employment, housing, money), health behaviours (e.g. weight management, alcohol use), and supporting people to connect with local groups and networks or other specialist services.
- Intensive work-related health support for people who are employed and need support to stay in work whilst managing a health condition, or who are unemployed and need support to return to or move closer to employment, delivered through specialist partners operating as part of the Be Well service.
- Individuals can remain connected to the service for a follow-up period, in case they require further support to help them sustain the progress made during their initial involvement with the service

3.2.4 The social prescribing model for Manchester is based on a set of principles that embody the 'Our Manchester' approach, these are:

- Person-centred: listening to what people need and want and involving them in decisions and plans about their support
- Asset-based: building on people's strengths and supporting them to be in control of the things that matter to them and help them stay healthy
- Collaborative: developing empowering supportive relationships and connections with and between individuals, communities and health and care services

3.2.5 To date, Be Well services have received over 10,700 referrals for support (mainly from primary care services) and supported over 7,800 individuals to address social and health issues and connect with sources of community support. The vast majority of primary care practices (97%) are now actively referring their patients to Be Well. Feedback from service users indicates that over 80% of individuals who have received support say that it has improved their physical and mental health and wellbeing.

4. Future developments – prevention and wellbeing services

4.1 Be Well service

4.1.1 As outlined above, social prescribing services in Manchester are already receiving referrals and providing support for high numbers of patients, particularly given the relatively short time they have been in operation. As one of Manchester's Transformation Fund New Models of Care, there is an ambitious plan for the scale and reach of the Prevention Programme over its first five years of operation. To achieve this, commissioners and providers are working closely together to further increase the number of referrals to social prescribing services, and the uptake of support by referred patients. An action plan for this has been developed, which includes:

- Development and maintenance of relationships with primary care and Integrated Neighbourhood Teams;
- Extending referral pathways for social prescribing to other services, including Health Visiting and the VCSE "host" organisations for Be Well;
- Strengthening the approach to initial engagement with patients, including resources for referrers;
- Using multiple methods for establishing contact with referred individuals;
- Communications to clarify differences between social prescribing and other 1-1 support services (e.g. care navigation)

4.1.2 Initial operational delivery of social prescribing services indicates that individuals referred to the Be Well services are more complex than was anticipated in the modelling carried out during the development of the Prevention Programme. This impacts on service capacity and caseloads for Be Well, as more time is required to work with more complex patients who require higher intensity support. It is also being reported by Be Well providers that there are often limited options in terms of other non-medical holistic 1-1 support for patients who are too complex for Be Well services. Commissioners will continue to monitor these issues to inform future developments.

4.2 Prevention Programme

4.2.1 An evaluation of the Prevention Programme will run for the duration of the programme; an independent organisation (SQW) has been commissioned to carry this out. The evaluation is based on a 'theory of change' approach and will consider a range of outputs, outcomes and impacts for the programme and its component parts, for individuals, communities and the wider health and care system. The evaluation is due to report in March 2021, with SQW providing interim updates to the Prevention Programme Steering Group to inform ongoing programme development.

4.2.2 The voluntary community and social enterprise (VCSE) sector is an integral component in the successful delivery of social prescribing provision, which is contingent on being able to connect individuals to local groups and sources of support in order to achieve sustainable change and improved health and wellbeing outcomes. A time-limited piece of work has just begun to model the impact on the VCSE, to support a robust approach to building capacity to support social prescribing in the longer term.

4.2.3 MHCC has recently agreed to establish a Social Prescribing Development Fund to create and sustain a local infrastructure of community assets and provision that addresses health and social needs identified by Manchester's social prescribing service. The fund will specifically be used to address the needs, preferences and demands which local people present to the Be Well service, in order to recognise the increased demand on VCSE services as a result of social prescribing, and is intended to supplement but not replace core funding for the sector. It will also provide an opportunity for addressing gaps in community provision in particular neighbourhoods, using data and intelligence gathered by the Be Well service.

4.3 Primary Care Networks (PCNs) – social prescribing link workers

4.3.1 In the 2019 Long Term Plan, NHS England committed to building the infrastructure for social prescribing in primary care by providing additional resource to PCNs to recruit social prescribing link workers as part of their multi-disciplinary teams. The majority of Manchester PCNs are working with the Big Life Company to recruit link workers aligned to current Be Well provision.

4.4 2021 Wellbeing Model

4.4.1 The Prevention Programme is a 5 year programme to establish the infrastructure needed to embed person and community-centred ways of working within the MLCO's developing Integrated Neighbourhood Teams and other associated services. Outcomes and impact of prevention initiatives and approaches on population health take time to be seen although benefits for individuals can be achieved sooner. The modelling for the development of the Prevention Programme indicated that benefits to our communities and to the health and care system would start to emerge from 3-5 years of the

programme becoming operational. The programme became fully operational towards the end of 2018/19, and Integrated Neighbourhood Teams became fully operational in 2019.

4.4.2 The Prevention Programme is based on good quality evidence of the approaches that will yield good outcomes for the health and wellbeing of Manchester's population, and continuous reflection and learning are central to the delivery of the programme. This allows the programme to be developed to continue the trajectory for improving population health outcomes across the health and care system that has been established, and to do so in a sustainable and long-term way.

4.4.3 The 2021 Wellbeing Model (see Appendix 1) sets out the next stage of development of prevention and wellbeing approaches for Manchester, building on the successes of the Prevention Programme, and learning from the delivery of that programme to date. It is a framework for services and approaches to improving the wellbeing of Manchester's residents, based on the level of support people need to look after their own health and wellbeing. Included within the model, is a focus on integrating approaches to prevention and wellbeing service provision, particularly those that address behavioural risk factors e.g. weight management, smoking, physical activity. These will be delivered within a comprehensive model that supports individuals at all levels of need, underpinned by a focus on the social determinants that influence individuals' health behaviours.

4.4.4 There are 5 levels of support within the model, depending on the circumstances and needs of individuals, with the majority of people only needing lower levels of support and a smaller number of individuals with more complex needs requiring more intensive support. The model aims to provide a framework for system-wide approaches in a range of settings, including:

- Good quality health and wellbeing information in accessible formats giving self-care advice that individuals can follow for themselves.
- Community-centred approaches to health and wellbeing at a neighbourhood level and within communities of interest
- Social prescribing approaches to connect people to community support and support the health and care system to develop these approaches
- Person-centred wellbeing support providing holistic and integrated responses to a range of risk behaviours
- More intensive support for people with complex needs, co-ordinated across a range of health, social care and other services

4.4.5 Development of the 2021 Wellbeing Model is currently in its early stages, however a number of design and delivery principles have been established. These will underpin the future development of the model and its component parts. The model is intended to:

- Be strength-based, person-centred, holistic and integrated
- Provide continuity and a long-term approach to prevention and wellbeing provision that is sustainable and creates social value

- Focus on communities and the people who live in them – to develop capacity and assets, to enable involvement, participation, and co-production; and to ensure services are neighbourhood-based (where appropriate) and accessible to all
- Take a 'whole family' approach across the whole life course, recognising that individuals live within systems, responding to the transitions between life stages, and considering the impact of changing populations
- Give parity to mental and physical health and wellbeing, and address the causal factors that can compromise both of these and impact on lifestyle behaviours (e.g. social circumstances, childhood experiences)

4.4.6 Further development of the model over the coming year will include

- Mapping current provision and population health and support needs and identifying how these can be developed within the Wellbeing Model framework
- Stakeholder, resident, service user and community engagement plans to support co-production of a model that reflects the strengths, needs and views of the population
- Finance strategy and business case development to secure necessary support to implement the model to continue delivery of the Population Health Plan objectives towards 2027

5. Recommendations

5.1 The Board is asked to:

(1) Note the contents of the report
(2) Endorse the approach to developing prevention and wellbeing support provision through the 2021 Wellbeing Model

Appendix 1 – 2021 Wellbeing Model