

Manchester City Council Report for Information

Report to: Health Scrutiny Committee – 4 February 2020

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

Report of: Director of Population Health
Consultant in Public Health Medicine

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;
- A summary of the model for social prescribing, and information on how this is being delivered in Manchester; and
- Plans for further developing prevention and wellbeing support services.

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.

Recommendations

The Health Scrutiny Committee is asked to:

1. Note the contents of the report; and
2. Comment on the initial proposals for developing prevention and wellbeing support services through the 2021 Wellbeing Model.

Wards Affected: All

Environmental Impact Assessment - the impact of the issues addressed in this report on achieving the zero-carbon target for the city

More residents walking and cycling and using public transport will support the achievement of zero carbon target and also have very positive benefits for their health and wellbeing
--

Manchester Strategy outcomes	Summary of how this report aligns to the OMS
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	
A highly skilled city: world class and home grown talent sustaining the city's economic success	Employment, and working conditions, are one of the social determinants of health. A third of people of working age have a long-term health condition (LTC) or disability. In many cases this will affect their ability to work, as well as affecting a range of other everyday activities. Social prescribing can support people with health conditions to stay in work or return to employment. It has been estimated that health inequalities in Manchester give rise to at least £300-320m in economic losses and £53m in costs to the NHS per year.
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	Person and community-centred prevention and wellbeing support addresses the social determinants of health, improves physical and mental wellbeing, reduces isolation and connects people to promote community resilience and reduce health inequalities.
A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

Contact Officers:

Name: David Regan
Position: Director of Population Health, Nursing and Safeguarding
Telephone: 0161 234 5595
Email: d.regan@manchester.gov.uk

Name: Dr Cordelle Mbeledogu
Position: Consultant in Public Health Medicine
Telephone: 07903 272 337
E-mail: c.mbeledogu@manchester.gov.uk

Name: Lydia Fleuty
Position: Programme Lead, Population Health and Wellbeing Team
Telephone: 0161 219 6931
E-mail: l.fleuty@manchester.gov.uk

Background documents (available for public inspection): None

1.0 Introduction

- 1.1 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 Neighbourhoods. Delivery of the programme will enable more people to have the knowledge, skills and confidence to manage their own health and care. This will reduce demand on health and care services, whilst promoting community resilience and improving health outcomes.
- 1.2 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.
- 1.3 The purpose of this report is to provide the Committee 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 prevention and wellbeing approaches from 2021 onwards.

2.0 Background

2.1 Strategic context

- 2.1.1 In recent years there has been an increasing focus on the role of individuals and communities in promoting health, and the opportunities for developing prevention and wellbeing support through community-based, integrated, primary care-led approaches. The NHS Five Year Forward View (2014) emphasised a focus on prevention and patient and community engagement and empowerment, to maintain improvements in healthy life expectancy, reduce the burden of preventable diseases, and avoid further increases in health inequalities. The subsequent NHS General Practice Forward View (2016) proposed social prescribing, using practice-based 'navigators' to support patients to access external services and activities, as one of its ten 'high impact actions' to increase capacity within primary care.
- 2.1.2 The current NHS Long Term Plan (2019) sets out a framework for increasing personalised care for physical and mental health by 2023/24, including 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. This has been supported by guidance from NHS England on 'Social prescribing and community-based support' (2019), for PCNs and others leading local implementation of social prescribing.
- 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. Central to this is developing the way health and care services

support people's wider health and wellbeing, focusing on the whole person, their life and circumstances and not just treating people for a particular illness. The Greater Manchester Health and Social Care Partnership's strategy for Person and Community Centred Approaches (PCCA) includes a focus on social prescribing, aiming to support the ten Greater Manchester localities to develop and embed social prescribing as an integrated part of their health and care system.

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, reflecting the ambitions of the Our Manchester Strategy (2016-2025) for the development of the city, and supporting the strategic aims of the 'Our Healthier Manchester' Locality Plan (2016-2021). One of the five priorities for the plan is supporting people, households, and communities to be socially connected and make changes that matter to them to improve their health and wellbeing. The Population Health Plan supports the objectives of the Manchester Health and Care Commissioning (MHCC) Operational Plan for preventing and tackling health inequalities and transforming community-based care, and the Manchester Local Care Organisation objectives of promoting healthy living and building on vibrant communities.

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. This is 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 work streams on:

- Person-centred care: workforce development, access to information and person-centred records
- Social Prescribing: Be Well services, connectivity and support for Primary Care Networks
- Community-centred approaches: Neighbourhood Health & Wellbeing Development and the Our Manchester Population Health Targeted Fund
- Integrated Personal Budgets: Personal Health Budgets, Personal Budgets (Social Care)

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. Manchester currently has the third lowest life expectancy at birth for men and the second lowest life expectancy at birth for women. The largest contributors to the gap in life expectancy between Manchester and England are circulatory diseases, cancers and respiratory diseases; these are also among the high spend areas for healthcare. All the lifestyle behaviours that lead to these poor health outcomes are highly prevalent in Manchester; adults in the city have higher rates of obesity and alcohol misuse, and smoke more than the average levels for England. There is also considerable variation within Manchester, with some wards and areas and particular groups in the population, showing considerably

higher levels of ill health and deprivation than others. It has been estimated that health inequalities in Manchester give rise to at least £300-320m in economic losses and £53m in costs to the NHS per year (based on losses estimated for England in the Marmot Review and extrapolated to the Manchester population). These estimates will be greater if the relative deprivation and existing levels of inequality are taken in to account.

2.2.2 The North West Mental Wellbeing Survey for 2012/13 shows that low mental wellbeing among people living in Manchester is associated with employment status, poor general health and a higher prevalence of diagnosed medical conditions. Long term conditions are responsible for a large proportion of GP consultations, result in high expenditure on unplanned care and are projected to rise with the ageing population.

2.3 Manchester's Prevention Programme

2.3.1 Identifying people with mental and physical long-term conditions as early as possible, and ensuring that they receive optimal treatment will improve the quality of life for this population and limit the costs of these conditions to the system. In the mid to long-term, however, the greatest impact will be seen by preventing these conditions from occurring in the first place. 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 working more effectively with the groups, organisations and services best placed to have an impact on these areas.

2.3.2 Manchester's Prevention Programme sits within the PCCA Programme outlined above, and aims to embed community-centred and asset-based approaches within the MLCO's neighbourhood teams, with five key objectives:

- Supporting residents to strengthen the social determinants of health.
- Supporting the adoption of healthy lifestyle behaviours across the life course.
- Early identification and proactive management of long-term conditions.
- Optimising the health of people with long-term conditions through good quality clinical care, and supporting patients' mental health and social needs.
- Using asset-based, personalised and holistic approaches to enable self-care.

2.3.3 The Prevention Programme has three delivery workstreams:

- 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.

3.0 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. This is estimated to be 20% of consultation time, and increasing; 60% of GPs surveyed recently said that social prescribing would help reduce their workload. Social prescribing seeks to address people's needs in a holistic way, taking into account the social, economic and environmental factors that influence their health, and aims to support 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 from primary care and other health and care services.
- Workers (often called social prescribing or community link workers) who provide strength-based, person-centred, 1-1 support to individuals at varying levels of intensity for a limited period of time.
- Supported 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 funded through North Manchester CCG Investment Reserve, from 2017/18. Following a competitive Tender process Greater Manchester Mental Health Foundation Trust were awarded the contract for the north Manchester social prescribing service, which became operational in December 2017 as the Be Well – North service. Implementation in the remainder of the city funded through Greater Manchester Transformation Fund and MHCC Population Health and Wellbeing Directorate, followed from 2018/19. After a competitive Tender process the Big Life Company were awarded the contract for the central and south Manchester social prescribing service, which became operational in November 2018 as the Be Well – Central & South service.

3.2.2 Both Be Well services are commissioned to provide the same social prescribing model, although as a result of being provided by different organisations, there are some different approaches to operational delivery by each current lead provider. Additionally, commissioners at the time decided to include a specialist stop smoking service within the current Be Well – North service; this is not included within the Be Well – Central & South service.

3.2.3 The citywide social prescribing model delivered by both Be Well services is as follows:

- A single point of access ('social prescribing hub' – one for each Be Well service) 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) depending on initial assessment of needs and goals, who then provides ongoing 1-1 support for the duration of the individual's involvement in the service. Support can be at varying levels of intensity depending on the individual's needs, and may include work on 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.

- Both Be Well services also offer 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.
- Depending on the intensity of initial support received, 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 and underpin the way that social prescribing should be delivered locally, 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 Manchester's social prescribing infrastructure is still in a relatively early stage of development, having only been established for 2 years in the north of the city, and 1 year in central and south localities. Nevertheless, in that time the 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. As noted previously, a key initial priority for both services has been engagement with primary care services, as a result the vast majority of primary care practices (97%) are now actively referring their patients to the Be Well services. Feedback from service users indicates that over 80% of individuals who have received support from the Be Well services say that it has improved their physical and mental health and wellbeing.

4.0 Future developments – prevention and wellbeing services

4.1 Be Well services

4.1.1 The current contract with GMMH for provision of the Be Well – North service expires in March 2020, and a Tender exercise has recently been completed to select the future provider for the service. The outcome of this process is due to be formally announced at the end of January 2020. The new service will retain the name Be Well – North and will deliver the social prescribing model outlined in section 3.2.3 of this paper. Specialist smoking cessation support will not be included in the Be Well – North service under the new contract; a separate Tender exercise is currently underway to identify a provider for a citywide Tobacco Addiction Treatment service.

4.1.2 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)

4.1.3 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 independent evaluation of the Prevention Programme has been commissioned, to run for the duration of the programme. Following a tender process through the Manchester City Council Data Sciences Framework, SQW were appointed to carry out the evaluation. 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. There are anecdotal reports from VCSE groups and Be Well services that the increased referrals resulting from social prescribing may be impacting on capacity within some parts of the VCSE sector. In order to

develop a robust and systematic approach to building capacity in the VCSE to support social prescribing, a proposal is in development for a time-limited piece of work to model the impact of social prescribing on the VCSE, to be carried out in the remainder of the financial year 2019/20.

- 4.2.3 This piece of work will inform a responsive and focussed approach to building and maintaining capacity in the VCSE for social prescribing, through a social prescribing development fund. The proposed approach will form an integral part of Manchester's social prescribing scheme that directly supports the needs and goals of service users and allows outcomes of the fund to be tracked.

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 putting 1000 new social prescribing link workers in place by 2020/21, and setting a target for 900,000 people to be referred to social prescribing by 2023/24. The social prescribing link workers will become an integral part of the multi-disciplinary teams which are part of PCNs, and form one of five additional roles in the five year framework for GP contract reform, with 100% reimbursement for the salary costs of the link workers.
- 4.3.2 The decision on how this funding will be used locally lies with each of the 14 PCNs in Manchester, however it is hoped that it will be used in a way that aligns with the existing social prescribing provision in the city. The final position for Manchester's PCNs is still emerging, however it appears at time of writing that around two thirds of PCNS are in advanced discussions to partner with Be Well to recruit link workers aligned to current provision. MHCC commissioners across population health and primary care are working together to support this as appropriate.

4.4 2021 Wellbeing Model

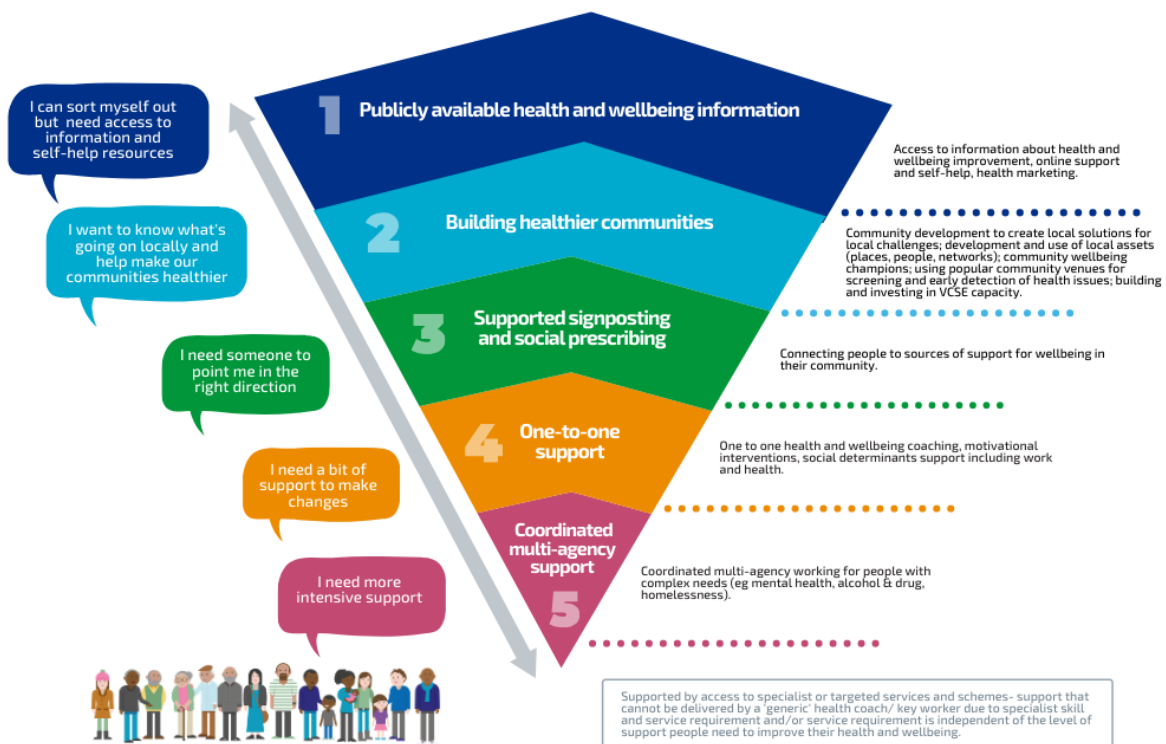
- 4.4.1 As noted earlier, the Prevention Programme was conceived as a 5 year model to establish the infrastructure needed to embed person and community-centred ways of working within the MLCO's developing Integrated Neighbourhood Teams and other associated services. Outcomes and impact of prevention 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.
- 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 Figure 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.

Manchester's wellbeing model for 2021

Wellbeing - the state of being comfortable, healthy or happy (Oxford Dictionary)



4.4.4 There are 5 levels of support within the model, depending on the circumstances and needs of individuals.

- i) The majority of the population require only very basic support (first level), which can be achieved by providing good quality health and wellbeing information in accessible formats that give clear advice that individuals can follow for themselves.
- ii) The second level of the model outlines the community-centred approaches to prevention and wellbeing support at a neighbourhood level and within

communities of interest. This will help to develop environments and networks that support good health and wellbeing across the city.

- iii) The third level builds on the current social prescribing and wellbeing support provision.
- iv) The fourth level will establish a more integrated approach that can support individuals in a person-centred way depending on their circumstances, goals and level of need. It will also connect them into their community for ongoing support.
- v) The fifth level of the model recognises that there is a smaller number of individuals in more complex circumstances and/or with more complex support needs. They are likely to require more intensive support to be co-ordinated across a range of health, social care and other services, building on approaches to this that are being established in parts of the system (e.g. care navigation).

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 The next 12-18 months will see continued development of different aspects of the model, which will be implemented later in 2021. Developments will include:

- Population mapping – currently underway working with partners across the health and care system, to understand and describe the health and support needs of individuals at each level, the differences in needs between each level of the model, and how this maps to the current health and care system.
- Engagement with senior stakeholders including Elected Members will agree outline proposals for the model to integrate approaches to prevention and wellbeing across population health, primary care, social care and community health services.
- Development and delivery of stakeholder, resident, service user and community engagement plans to ensure development of the model is done in partnership and reflects the strengths, needs and views of the population

- Development of more detailed cohort modelling using business and population health intelligence to inform finance strategy and business case planning.

5.0 Recommendations

5.1 The Health Scrutiny Committee is asked to:

1. Note the contents of the report; and
2. Comment on the initial proposals for developing prevention and wellbeing support services through the 2021 Wellbeing Model.