Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 9 March 2022

Subject: Future Delivery of Social Prescribing

Report of: Director of Public Health

Summary

This report provides an overview of delivery of social prescribing in Manchester. It outlines how the Be Well service works, giving examples of good practice in the delivery of social prescribing (including information on how the service works with primary care to support patients), and highlighting case studies of the benefits of the service for Manchester residents. The report also summarises the findings of the recently completed independent evaluation of Manchester's Prevention Programme, and other social prescribing initiatives currently being developed and delivered within Manchester and Greater Manchester. The next steps in developing and delivering Manchester's social prescribing and wellbeing support provision within the context of the Population Health Covid-19 Recovery Plan and Manchester's Wellbeing Model are outlined.

Recommendations

The committee is asked to consider the report and note the next steps for developing health and wellbeing support for individuals and communities through the 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
Creating the conditions for people to live healthier lifestyles (e.g., through enabling active travel, sustainable healthy food sources, reduced smoking) will impact not only on population health but also on the wider environment (e.g., reduced traffic congestion, improved air quality, support for local economy).

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	Healthy and resilient residents and communities will be able to thrive in employment and opportunities which will support the local economy, including the voluntary and community sector.
A highly skilled city: world class and home-grown talent sustaining the city's economic success	Healthy and resilient residents and communities will be able to thrive in employment and opportunities which will support the local economy.
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	Supporting individuals' health and wellbeing, creating the conditions in communities to support good health, and reducing avoidable health inequalities, will increase the potential of our communities.
A liveable and low carbon city: a destination of choice to live, visit, work	A healthy population living in a zero-carbon environment is essential for the city's future economic success and resilience.
A connected city: world class infrastructure and connectivity to drive growth	Improving health and wellbeing of Manchester residents and connecting them to opportunities will enable to thrive in employment and opportunities which will support the local economy.

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Background documents (available for public inspection):

None

1.0 Introduction

1.1 Wellbeing is about people's experience, and whether they are struggling or thriving. It encompasses the environmental factors that affect us, and the experiences we have throughout our lives. The impact on health of the conditions in which we are born, grow, live, work and age (the 'social determinants' - housing, education, work, money etc.) is well documented in the 2010 Marmot Review, and Health Equity in England: The Marmot Review 10 Years On (2020). Wellbeing also recognises other aspects of our lives: how we feel about ourselves and our strengths and capabilities as individuals; our relationships with others; and our sense of purpose and control over our lives. Being healthy is more than not being ill, it is also being physically and mentally well, so that we can achieve what we want in our life.

1.2 Inequalities in health, wealth and experiences persist in our city despite Manchester's strong economic growth and significant transformation over the past two decades. Sections of Manchester's population still experience poorer health outcomes than their peers in other parts of the country and many develop preventable health conditions a decade earlier than in other parts of the UK. Like health, wellbeing is influenced by our environment and living conditions, having meaningful and satisfying work, having enough money, and having good relationships and support networks, among other things. Wellbeing is also affected by our physical and mental health, and whether we have the support we need to manage and live with health conditions.

1.3 The avoidable disparities in health outcomes seen between different groups of people have been brought into sharp focus by the COVID-19 pandemic. Over the course of the past 20 months, clear evidence has emerged of the disproportionate impact of the COVID-19 virus on particular groups in the population, who have been shown to be more likely to contract the virus and have a higher risk of mortality involving COVID-19. The full impact that the pandemic will have on the social determinants of health is yet to be seen, but it is already evident that some communities have been more adversely impacted than others. Similarly, individuals' wellbeing has been affected immediately (e.g., income or employment losses and illness) and through less tangible social and psychological impacts (e.g., loneliness, anxiety and loss of sense of purpose), and these effects are more pronounced in particular groups in the population.

1.4 This report will give an overview of how wellbeing support, including social prescribing, is currently delivered in Manchester through the Be Well service. It will update Health Scrutiny Committee members on other developments in social prescribing over the past 2 years (e.g. the Primary Care Network social prescribing link worker scheme, and Greater Manchester developments). The report will also summarise key findings on Be Well impact and outcomes from the recently completed independent evaluation of the Prevention Programme. Finally, it will outline the next steps in the development of health improvement and wellbeing support (Manchester's Wellbeing Model) within the context of the Population Health Covid-19 Recovery Plan and Manchester's Marmot Inequalities Action Plan (Building Back Fairer in Manchester).

2.0 Background

2.1 Social prescribing development and delivery - Be Well

2.1.1 Manchester's Prevention Programme (2017-2021) established a framework and citywide infrastructure for person and community-centred approaches to prevention and health and wellbeing improvement. The aim of the programme was to prevent the development of long-term physical and mental health conditions by supporting people to change the behaviours that can increase the risk of poor health, and by addressing the social determinants of health. Delivery included establishing a new social prescribing and health coaching service for the city - Be Well.

2.1.2 The first Be Well service was established in north Manchester in late 2017, with the Be Well service for central and south Manchester being established in autumn 2018. Big Life Group (a voluntary, community and social enterprise provider) has run the central and south Be Well service since it began, and in April 2020 took over running the north Manchester service. Be Well is now delivered as a single citywide service. Big Life Group works in partnership with a range of other organisations which are sub-contracted to deliver elements of the service – Pathways Community Interest Company (CIC), Northwards Housing/Yes, One Manchester, Southways Housing, Wythenshawe Community Housing Group, and Citizens Advice Manchester.

2.1.3 Be Well provides a single point of contact for organisations to refer anyone they feel will benefit from additional support to improve their physical and mental health and wellbeing, connect to other community support, and address 'social determinants' needs (such as work, housing, money and family issues). The term 'social prescribing' describes the process whereby a GP (General Practitioner) or other health professional identifies that someone needs a 'social prescription' (as opposed to a referral to another part of the healthcare system, or a prescription for medication), and makes a referral to a 'social prescribing service' (e.g. Be Well) to fulfil this. The role of the social prescribing service is then to work with the individual to decide which interventions will best meet their needs.

2.1.4 Be Well was initially established to support primary care services, where practitioners (e.g. GPs and other primary care workers) work under significant time and capacity pressures, and often do not have time to understand the range of options available for community-based 'social support' or work with individuals to identify the most appropriate options for them. However, as the service has become more embedded within neighbourhoods, links have been made with a wider range of neighbourhood, health and care services, who also work with individuals who can benefit from the support Be Well offers. During the initial months of the Covid-19 pandemic, Be Well worked closely with a range of neighbourhood organisations to provide humanitarian and practical support to communities and individuals. Those links endure, and provide an opportunity for expanding the support offered by Be Well as we move into recovery from Covid-19

2.1.5 When someone is referred to Be Well, they are contacted by a worker for a discussion about their strengths, worries, goals and motivation. This approach to assessment and support planning puts the person at the centre of the support they receive from the service, allows them to explore what will help them most, and encourages them to take control of what happens next.

Good practice example: initial assessment and support

Referrals are made to the Be Well hub and allocated to a health coach who contacts the person who has been referred to make an initial appointment, usually within 2 weeks of referral.

This appointment takes a person-centred approach and focuses holistically on the person's current strengths, needs, goals and who else they may have involved in their support. Usually this initial appointment would be completed over the phone but face to face appointments are available if people prefer (these can take place in a range of community venues).

At the end of this appointment, individuals who need ongoing support from the service work with the Be Well coach to make a plan for what they hope to achieve by accessing support, and they are allocated to a coach within the part of the service that is most appropriate to help them achieve their goals.

2.1.6 Around 30% of people who are referred to Be Well have needs and goals that can be met through 'lower intensity' support. This means that individuals have fewer or less complex needs, which may only require a one-off session of support (signposting) or a small number of support sessions (social prescribing) to identify and make the changes they want and need. This support can include giving information and advice about different options that are available, exploring the most suitable activities and groups for each individual, and building people's confidence to connect to community groups and networks (sometimes by supporting them to attend community groups and activities).

Good practice example: supported signposting and social prescribing

Sometimes on having the initial assessment call with a person it becomes apparent that they can engage in services without the additional support of a coach and their need is for information about what activities and groups are available. In these cases, the Be Well coach provides the person with this information during the initial assessment call with the service (signposting). This is followed up by an email or letter to confirm the options agreed, so that the person can link with these independently. Health coaches also benefit from a peer network within Be Well, where they can quickly find out from colleagues about other options that are available e.g., if the person asks for information about an area that the coach is unfamiliar with.

For people who do need more support from the service, Be Well works flexibly to tailor that support to their specific needs (social prescribing). At the initial assessment the person is allocated a coach depending on which area of the service they can be best supported by (e.g. support for work-related health issues, or for healthy living

issues). Coaches provide and coordinate the support an individual needs, helping them to develop skills, connect with groups and activities that will help them achieve their goals, and access support from other parts of the Be Well service if required (e.g. work and health team). People who are assessed as having fewer/less complex support needs are initially offered a limited number of 'social prescribing' support sessions (usually up to 6), however if their needs change then they can be offered further support and are able to stay with the same coach for this.

2.1.7 Around 70% of individuals referred to Be Well have multiple, or more complex needs. Be Well workers offer 'health coaching' support – more intensive motivational support to address a range of issues, which could include building healthier habits, improving mental health and wellbeing, and tackling issues with work, housing, money; as well as support to connect with other services and community groups. Be Well also offers specialist 'work and health' coaching support, to help people maintain or return to employment while managing their health conditions. This can include support with a range of employment-related issues including finding work, accessing psychological or physiotherapy support for common work-related health conditions, returning to work after a period of unemployment, and accessing training/volunteering to develop skills. During the Covid-19 pandemic, this has also included supporting people to manage additional Covid-related work issues.

Good practice example: health coaching and work and health support

When the initial assessment identifies that a person has several issues to address, or more complex issues that require more support, Be Well can offer more intensive support (usually up to 14 sessions), again this is provided flexibly to meet the individual's specific needs, and a support plan is developed with the individual. This more intensive support (health coaching) focuses on building their motivation to make changes, strengthening their resilience and support networks (friends/family and community), sequencing support to address a range of issues in a person-centred way, and ensuring people are linked into and able to access other specialist support services. Be Well is not intended to provide long-term ongoing support for individuals, however the service recognises that many people with more complex needs will have experienced trauma and long-standing difficult life circumstances. For this reason, it is especially important that the service supports individuals in a way that builds their strength and resilience to prepare them for supporting themselves beyond the initial support they receive from Be Well.

The Be Well offer includes specialist person-centred work and health support, which used to be provided as a standalone service in Manchester (through Fit for Work/Healthy Manchester). Referrers can specify that they are referring an individual for work and health support (e.g. someone who is off work sick and needs support to return), and all referrals for people who are employed are initially assessed by a coach in the work and health team. This is to ensure that the person gets to the right place within Be Well as quickly as possible and without having to repeat their story. If this assessment indicates a person does not need specific work and health support, or is more likely to benefit from more general health coaching support, they are allocated to a coach in the core Be Well team (and do not need to have a further assessment). People who are employed and whose main need is support to return to

work are supported by an 'in work' coach in the Be Well work and health team (this support is provided by Pathways CIC who are one of the delivery partners for the Be Well service). People who are unemployed and identify that their main focus is getting back into work, training, volunteering or education are supported by an Out of Work Employment Coach (this support is provided by One Manchester, Northwards, Southway, and Wythenshawe Housing who are all delivery partners for the Be Well service). The work and health team also provide focussed support sessions for people with a 'generic Be Well health coach' who want to address particular issues (e.g. updating their CV to apply for jobs)

2.2 Social prescribing and primary care

2.2.1 Supporting primary care services to manage patients' social and non-medical issues and provide more personalised care was one of the key drivers behind the development of the Be Well service. This means that from the outset, the Be Well service has worked closely with primary care services in Manchester, establishing convenient referral systems, communicating with primary care staff and patients about the benefits of social prescribing, and making sure that practices have named link workers so that strong relationships are developed and maintained. 100% of primary care practices in Manchester now have active referral pathways established with Be Well.

2.2.2 In the 2019 Long Term Plan, NHS England committed to building the infrastructure for social prescribing in primary care by establishing new social prescribing link worker posts for Primary Care Networks (PCNs), intended to work alongside other new primary care roles to form multi-disciplinary teams for providing person-centred primary care. Decisions on how this funding is used sits with individual PCNs, of which there are 14 in Manchester. During 2019/20, Population Health and Be Well worked with colleagues in Manchester Health and Care Commissioning and PCNs to explore options for aligning this additional provision as closely as possible with the existing Be Well infrastructure. From April 2020, 10 of Manchester's 14 PCNs have made formal arrangements for Big Life Group to employ and manage their social prescribing link workers, meaning that these workers provide dedicated support to practices within those PCNs as part of the Be Well service infrastructure. Practices within the PCNs that have chosen not to make these arrangements are still able to refer patients who need social prescribing and health coaching support, to be assessed and supported by the core Be Well service.

Case study: Primary Care Network social prescribing

R is a 73-year-old woman who was referred to a Be Well PCN Coach by her GP. She has several long-term conditions and was experiencing depression and social isolation. Before meeting with R, the coach spoke to her GP about her health and who was already involved in her care. This meant that at R's first appointment the Be Well coach was able to totally focus on what she was feeling and her goals, without R having to repeat her health history. This joined up approach meant that it was easier for R to engage with the service (she had previously been referred but struggled to engage).

The coach and R came up with a shared plan together for where R wanted to focus and build goals. R identified that her housing was very poor and that she was spending a lot of time in parks during the day just to be away from home because it was cold and damp. R had been unable to get on Manchester Move as she did not know how to use a computer. The Be Well coach supported R to contact Manchester Move, and referred R into the Digital Inclusion team to develop computer skills (R had also identified that it would be good if she could use a computer so she could talk to her family more). R's coach accompanied her to a first meeting with Healthy Me, Healthy Communities (one of Be Well's community host organisation partners) at No.93 Wellbeing Centre and this made a big difference to her feeling able to seek support from them that would be ongoing. R's coach was able to help R's GP understand some of the challenges that she was facing and why it had been hard for her to engage with services and take medications on time etc. This helped R's GP to support her better and link her with nursing support so that she felt less alone with her health difficulties.

Be Well worked with R for a reasonably long period (around 16 sessions) before her case was closed. When a case is closed, Be Well coaches schedule a follow-up session (usually after 3 months). At R's follow-up session, she reported she was in a new house which she was very happy about, she had managed to attend all her medical appointments, and she had been provided with a laptop and internet from the Digital Inclusion team and was signed up to an IT course at her local Library. At this call R also said she now felt ready to engage in counselling with the Improving Access to Psychological Therapies (IAPT) service and more able to take part in this process. R had also continued to engage with Healthy Me Healthy Communities and was finding this a massive support socially and had even started volunteering with them!

2.3 Be Well activity, outcomes and impact

2.3.1 In the first 6 months of 2021-2022 (April – October) Be Well received 5,413 referrals and provided 25,046 support sessions (initial assessments and ongoing support). The number of referrals received by the service has increased substantially over the past 2 years, from an average of 400 per month in 2019, to around 550-600 referrals per month now. This reflects an increased need for social and wellbeing support as individuals and communities manage the ongoing impact of the Covid-19 pandemic and its emerging social and economic implications.

2.3.2 As outlined above, Be Well offers person-centred support tailored to the specific needs and goals of each individual. When the service was initially established, it was envisaged that around 70% of those using the service would need 'lower intensity' social prescribing type support, to connect to ongoing sources of support in their community; whilst around 30% would need 'higher intensity' health coaching type support, to address a range of more complex issues and build strengths and resilience. In reality, experience has shown that a far higher proportion of individuals accessing the service (around 70%) require more intensive support, and in particular that many of these support needs relate to improving mental and emotional health and wellbeing.

Whilst Be Well is not a mental health treatment service, the support the service offers has made a real difference to the lives of many, improving both their physical and mental health and their quality of life. The two case studies below illustrate this:

Case study: social isolation and mental health

A is a 59-year-old male who lives in north Manchester. At the time of referral to Be Well A had been struggling to manage his mental health for some time. His initial referral stated anxiety and difficulties sleeping. During his strengths-based assessment the underlying reasons for his anxiety were explored (including housing, poor diet and low confidence due to speech issues). A received 'higher intensity' support from Be Well (14 sessions).

Housing: A's coach supported him to access specialist support from Shelter and One Manchester. A's flat was cold and damp, but A didn't feel confident to contact his housing provider, due to his speech issues. A's coach was able to liaise with his housing provider on his behalf, and with A's permission explained A's worries about speaking to them and what he might need to feel safer doing this. This resulted in the heating issues A had been struggling with for years being fixed., and A receiving more support from a Housing Officer, who supported him to connect with Manchester Move to look for more appropriate accommodation.

Isolation: A wanted to connect more into the community and become more active. During lockdown, A was feeling isolated, and this had a negative impact on how he viewed himself. A and his coach came up with goals and a plan for how could achieve these in a realistic way. A engaged with the Physical Activity on Referral service, and started attending exercise classes at the Velodrome, which helped him feel healthier and meet new people. A's coach worked with him on his confidence and motivation, and this led to him attending a gym regularly, and helping there and considering more volunteering opportunities. As a result of his support from Be Well, A also felt able to increase how often he sees friends and family.

By the end of his time with Be Well, A's mental wellbeing had increased significantly, and he was feeling more connected with his community, and less worried about his housing.

Case study: Physical and mental health

R is a 63-year-old male who was referred to Be Well via his GP. Referral stated client has diabetes, increased weight during lockdown, GP was seeking support around diet advice for client. Referral also discussed low mood and isolation. R's initial strength-based assessment allowed him time to explore a range of issues relating to mental health, isolation, family relationships, and managing his diet and physical health. R had 7 sessions of support from a Be Well coach.

Physical health and wellbeing: R's coach helped him set and work towards goals around diet and nutrition, and physical activity, taking into account his health conditions. R also asked his coach to refer him to the stop smoking service, as he

wanted to reduce his e-cigarette use as he felt this was impacting on his mood and diet.

Mental health and wellbeing: Alongside support from his Be Well coach, R also accessed support from Citizens' Advice to deal with welfare benefit issues, which he felt improved his situation. As a result of the support to make changes to his diet and exercise routine, R has reported feeling healthier and more in control, and is sleeping better. These initial changes that he worked on with Be Well have resulted in him feeling more confident to go out, and join a gym, which will further increase health and wellbeing. R's improved wellbeing also means he now feels more in control of how his home is, which means he feels better about inviting family members round, which means he feels less lonely and isolated. When R was referred to Be Well, he was on the waiting list for Improving Access to Psychological Therapies (IAPT) support, however by making other changes in his life he felt he no longer needed that service.

2.3.3 The specialist work and health support provided by Be Well and delivery partners (Pathways CIC, Northwards, One Manchester, Southway and Wythenshawe Community Housing) is an innovative approach that is believed to be unusual in social prescribing and wellbeing support services. The benefits of this approach are that people can receive person-centred work-related health support, alongside holistic support to improve other aspects of their physical and mental health and wellbeing. In the first half of 2021-22 (April to October):

- Around 42% of individuals receiving ongoing support from the service were receiving work and health support (n=863), exceeding a target of 30%, which indicates an increased need for work-related health support as part of individuals' overall support package.
- 100% of employed individuals who received work-related health support from Be Well were back in work by the time they left the service (exceeding a target of 80%).
- 47% of unemployed individuals who receive work-related health support from Be Well were engaged with further employment support, training, volunteering, or work experience by the time they left the service (slightly below a target of 50%), and 42% had secured employment (well exceeding a target of 15%).

Case study: work and health support

L was referred into Be Well via her GP for additional support for mental health and social isolation, however, it became apparent she had lost significant income during Covid-19 as she was a publican. For this reason, L was supported by the 'in work' team in Be Well (Pathways CIC). L reported she had been impacted significantly by lockdowns and Covid-19. She explained that this had affected her livelihood and her mental health declined as her lifestyle changed in a short space of time. L felt her physical health had also deteriorated due to stress and anxiety which resulted in a suspected heart attack and being rushed to A&E. L also had other ongoing physical health issues which were made worse by stress, causing her to lose weight and appetite. L was struggling to pay bills which had never been an issue for her and

was worried about losing her home. Although L was supported by friends and family, she felt she had lost her sense of community and her social life.

L's support sessions focused on encouragement and guidance, recognising her strengths, and focussing on her passions and hobbies which contributed to L having a more positive outlook. This encouragement also supported L in building on her confidence. During the sessions L and her coach discussed L's physical health and the importance of getting out for a walk with her dog, these small steps helped to build L's confidence and as L is well-known in her community, the more she was going out the more she was receiving positive recognition from the community, which helped her also daily. This increased confidence and positive outlook also encouraged L to attend all her hospital appointments and receive the treatment she needed, therefore having a positive impact on her physical health.

L's coach also linked her in with HR support and Citizens Advice to ensure she had the correct and most up to date information on Covid-19 support for the hospitality industry. L felt she had been struggling to know where to turn and this support really helped her feel like she could take some control in a time when she had felt she has none.

Following 7 sessions with a Pathways coach L felt able to continue to make progress on her own. She reported feeling more in control of her financial situation and her health. L also reported a massive increase in her wellbeing and stated she felt more confident in her ability to manage the stresses that were to come.

2.4 Independent evaluation of Prevention Programme – Be Well delivery, outcomes and impact

2.4.1 Population Health commissioned SQW, a leading independent provider of research, analysis and advice in economic and social development, to carry out a mixed methods evaluation of the Prevention Programme during 2018-2021. The final evaluation report will be published shortly. Findings from the evaluation were presented to stakeholders in December 2021. In summary, key findings of the evaluation in relation to the Be Well service are:

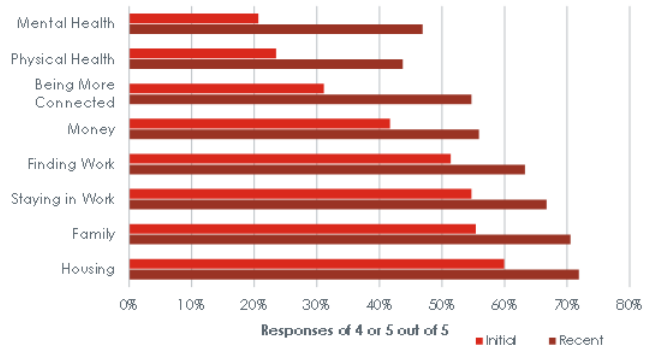
- **Be Well succeeded in reaching those from deprived and diverse backgrounds, in line with Prevention's aim to tackle social determinants and health inequalities:** More than half (52%) of service users were unemployed (compared to the unemployment rate in Manchester of 7.4%); more Be Well service users self-identified as having a disability (35%) than people in Manchester as a whole (18%); the ethnic diversity of service users was roughly the same as amongst the population of Manchester.
- **Be Well users improved their confidence in coping with issues in their lives and connecting to their community:**

Outcomes – social determinants

Be Well users improved their confidence in coping with issues in their lives

- Confidence among users improved in relation to all eight defined social determinants
- The biggest improvement was in respect of mental health, which started from the lowest base
- Confidence in relation to physical health and being more connected also increased a lot.

Proportion of 'good' responses (scored 4 or 5 out of 5) to questions around social determinants, as measured by the service user's initial score (n=7,717) and their more recent score (n=3,309)



SQW

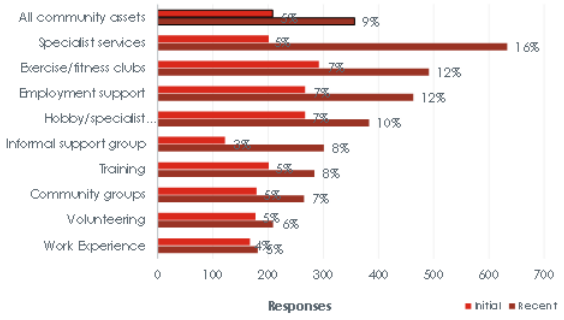
These data are drawn from the areas that Be Well explores with each service user at the beginning of their involvement with the service, and periodically at reviews. Individuals are asked to score how confident they feel about coping with issues, on a scale of 1-5.

Outcomes – community connectedness

Be Well users improved their connection to the community

- Connection improved in relation to all community assets explored.
- Connections to specialist services, fitness clubs and employment support improved the most.
- Connections to work experience and volunteering improved the least, perhaps because these assets are harder to access, it is challenging for the service to find appropriate opportunities, and/or the Covid-19 pandemic reduced opportunities, or other reasons.
- Service users reportedly found it difficult to answer these questions; comparison across categories should only be undertaken with care.

Number of 'Connected a lot' responses to question on links to community assets. Data labels give the number as a percentage of the sample (n between 3,750 and 4,000)



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These data are drawn from the areas that Be Well explores with individuals as part of their support planning, this is a person-centred approach and so may not involve all of the areas above. These data reflect general conversations with all service users, not the specific work-related health support provided to some individuals using the Be Well service (see paragraph 2.3.3 above).

- **Be Well service users improved their wellbeing:** Service users' wellbeing was measured at the beginning and end of their involvement with the service, using a validated tool for measuring wellbeing – the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), which considers a range of factors that influence wellbeing.

Outcomes – wellbeing

Be Well service users improved their wellbeing

- Users with low mental wellbeing at the start of their engagement with Be Well improved their wellbeing while accessing the service
- The central value of the distribution moved from 'possible depression' for initial scores towards the upper end of 'average mental wellbeing' for recent scores (categories from Warwick Medical School guidance)

WEMWBS scores from service users, taken from the first and most recent occasion they completed the questionnaire (n=2,689). (Note, a higher score indicates higher self-assessed wellbeing)

SQW

- **A&E attendance and emergency hospital admissions are reduced for Be Well service users:** On average, Be Well users that engaged with the service had 13% fewer A&E attendances and 19% fewer emergency hospital admissions in the six months following exit from the service compared to the six months prior to joining the service; those service users receiving more support sessions experienced a greater reduction in A&E attendances, and those receiving 6-9 sessions experienced a greater reduction in emergency admissions.

- **A modelled Cost Benefit Analysis for Be Well estimates a financial Return on Investment (ROI) of £1.51 per £1 spent on the service, and a public value ROI of £17.2 per £1 spent.** These benefits are modelled to continue for the medium term (up to 8 years). Changes in employment (people who have used Be Well retaining and gaining employment) are estimated to make up 65% of the financial savings, and reduced emergency hospital admissions contribute 20% savings. Individual service user wellbeing and reductions in social isolation contribute 97% of the 'public value' benefits modelled.

2.5 Other social prescribing and wellbeing initiatives in Manchester and Greater Manchester

2.5.1 Social prescribing and wellbeing support for young people in Manchester

Manchester has been awarded a 9-month grant from the Better Mental Health fund and is using most of the funding to pilot a social prescribing and wellbeing support project for young people. Big Life, the provider of the Be Well service, is the lead provider for the project, which is being delivered in partnership with 42nd Street (a Greater Manchester young people's charity providing free and confidential services to young people who are experiencing difficulties with their mental health and emotional wellbeing) and Greater Manchester Youth Network (a Greater Manchester charity that delivers a range of development programmes and drop-in activities to help young people transition to adulthood feeling skilled, supported and positive).

The pilot project is delivering a range of one to one and group support to young people with the aim of improving mental wellbeing, social connections, an increase in skills and confidence, and access to therapeutic support for mental health. The project has a particular focus on engaging with young people in the most deprived areas in north Manchester, and young people from communities experiencing racial inequality.

To date the project has worked with over 400 young people, who have received a range of support including health and wellbeing coaching, mental health support and therapeutic interventions, and positive engagement activities to develop life skills and experience to prepare for the transition to adulthood.

2.5.2 Social prescribing in Greater Manchester

Since the start of the pandemic, social prescribing schemes across the city region have seen large increases in referrals, with estimates that 75% of referrals are for mental health support (Greater Manchester Local Survey of Social Prescribing Providers, October 2020). In Greater Manchester:

- a social prescribing referral now happens every five minutes of the working day
- 8 in 10 GPs are referring to social prescribing schemes
- 26,000 people have been supported through social prescribing over the past year
- 200 social prescribing link workers are helping people to make valuable community connections.

2.5.3 Green social prescribing

Greater Manchester successfully bid for green social prescribing funding to support initiatives to improve community mental health and wellbeing post Covid-19. £500,000 has been awarded to fund five nature-based projects in Greater Manchester for a two-year pilot.

The aim is to engage with individuals most at risk of developing poor mental health and create the activities and support they need, whilst making the most of the natural environment. These projects will support existing social prescribing initiatives in place to improve community mental health and

wellbeing. The Covid-19 pandemic has exacerbated mental illness and inequalities and many people find green space particularly important to their health and wellbeing.

In Manchester Sow the City is being funded to provide food growing schemes, working with the most deprived communities in Manchester, providing both social activity and access to free healthy food. Projects are rooted in the community, being run and staffed by local volunteers, and will see local partners working together led by voluntary sector organisations. Green social prescribing initiatives covering all Greater Manchester will also benefit Manchester residents.

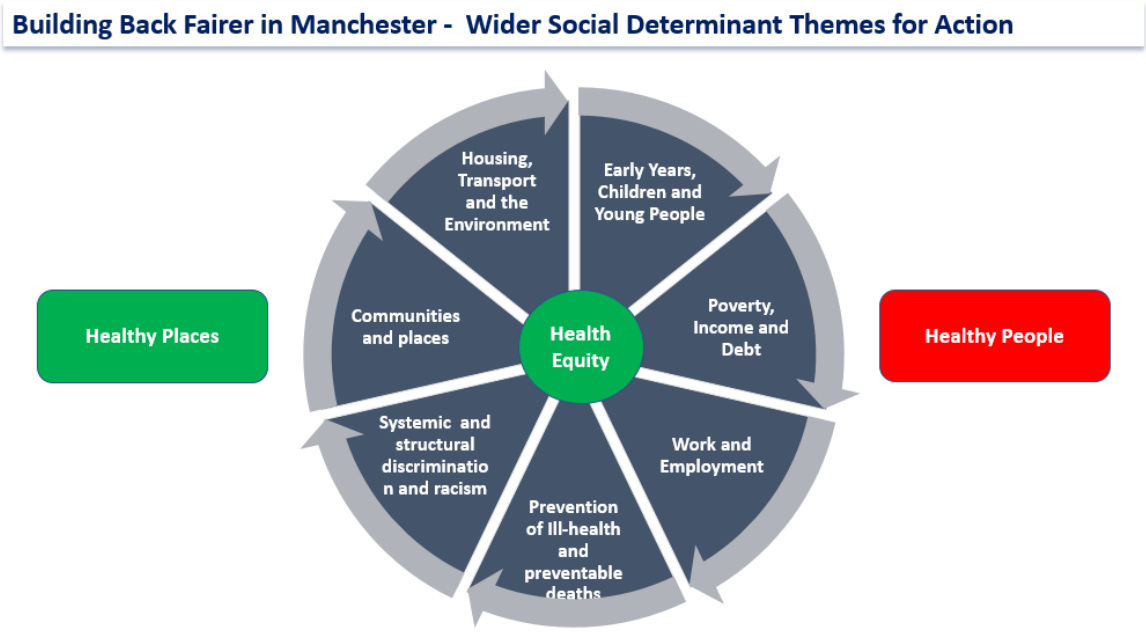
Be Well has developed links with Sow the City to ensure that Be Well service users are able to benefit from the green social prescribing activities on offer in the city, and to ensure that the roles of each organisation are clear to avoid duplication and present clear information to wider stakeholders.

2.5.4 Active Travel social prescribing

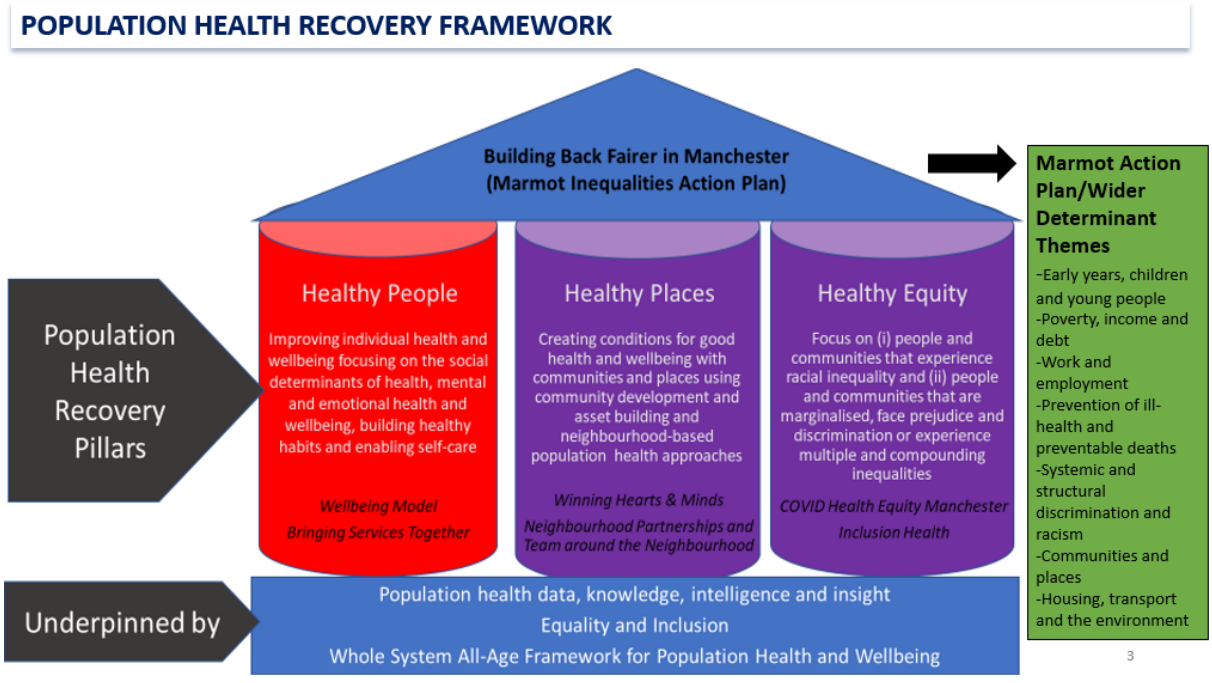
After two rounds of application and assessment Greater Manchester has been awarded £100,000 funding to carry out a feasibility study for active travel social prescribing pilot schemes. All successful local authority feasibility studies will be assessed to decide which authorities will then receive funding to create future active travel social prescribing schemes for the financial years 2022 to 2025. The pilot schemes are trialling new walking and cycling programmes to enable increased active travel and physical activity.

2.6 Future delivery of social prescribing – Population Health Recovery Plan and Manchester's Wellbeing Model

2.6.1 The next steps for addressing health inequalities in Manchester were discussed in a report to the October 2021 meeting of this Committee, which outlined the current and planned responses to the most recent Marmot Report, 'Building Back Fairer in Greater Manchester'. The Director of Public Health has now convened a focussed task group to develop Manchester's 'Building Back Fairer' approach and plans, supported by a clear population health action plan relating to the wider determinants of health.

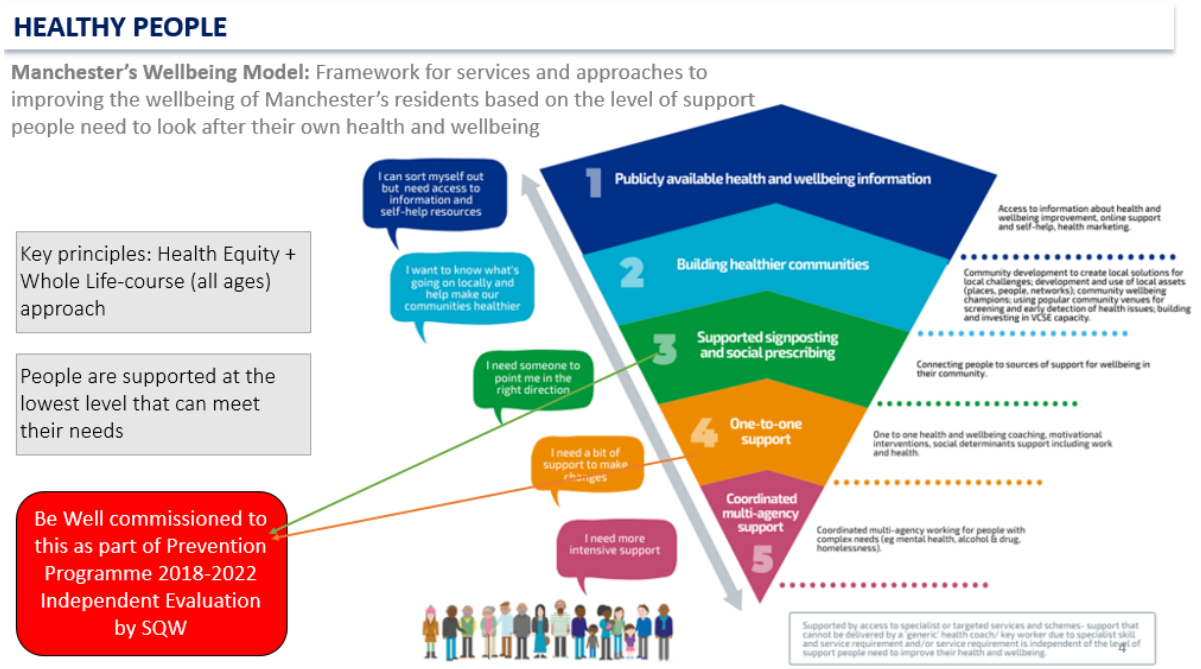


Manchester's Population Health Recovery Framework supports these by outlining three priority 'pillars' for population health recovery from the COVID-19 pandemic, which will support delivery of these plans.



2.6.2 Each pillar has a 'flagship' programme of activity to address the root causes and wider determinants of health inequalities alongside the broader partnership working to create the conditions for healthy lives. The Healthy People pillar of the recovery framework recognises the impact of social disadvantage and socio-economic circumstances on health outcomes.

Income, housing, work, environment, and transport access and conditions impact on physical and mental health and wellbeing, and people's ability to lead a 'healthy lifestyle'. These social determinants of health' are often experienced cumulatively, and impact more people in areas of socioeconomic deprivation, leading to health inequalities. The Wellbeing Model has been designed to address this using the principle of proportionate universalism – giving people the level of support that they need to look after their own health and wellbeing. The model was due to launch in 2021 but development and delivery has been delayed because of the pandemic.



2.6.3 Funding has been secured to maintain the current Be Well service for 2022/23, pending a redesign of Population Health-commissioned health and wellbeing services for individuals and communities in the context of the Population Health Recovery Plan and wider 'Building Back Fairer' agenda. This will build on learning from the delivery of Be Well services over the past 4 years, and the findings from the Prevention Programme evaluation. It is not anticipated that the current Be Well service model will change significantly, however referral pathways will be expanded to support a wider range of programmes and the city's broader recovery from Covid-19, and there will be further work on optimising the benefits of the additional social prescribing resource for primary care and working in a more integrated way with Primary Care Networks.

3.0 Recommendations

3.1 The committee is asked to consider the report and note the next steps for developing health and wellbeing support for individuals, including social prescribing, within the context of the Population Health COVID-19 Recovery Plan and Wellbeing Model.