Lincolnshire COUNTY COUNCIL
Working for a better future

# LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Lincolnshire's Clinical Commissioning Groups and the Sustainability and Transformation Partnership

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| Report to | **Lincolnshire Health and Wellbeing Board** |
| Date: | **11 December 2018** |
| Subject: | **Neighbourhood Working – The Social Prescribing project** |

**Summary:**

This paper updates the Health and Wellbeing Board on the progress being made in implementing a Social Prescribing model into Lincolnshire that has been part funded by the Health and Wellbeing Grant Fund.

The Social Prescribing project is being run as a 'proof of concept' and is an integral part of the Neighbourhood Working programme. It is also closely linked to the NHS England Personalised Care Demonstrator sites of which Lincolnshire is one of three across the Country.

This paper sets out how the project has been expanded from its initial conception in Gainsborough to rolling out across the County from September this year, the progress to date, some of the early findings and the actions that are needed to be able to demonstrate to the system the value and importance of social prescribing to the health and care community.

**Actions Required:**

The Health and Wellbeing Board is asked to:

a. Note the content of this report
b. Note the current progress and key actions
c. Discuss and agree how the interface between the Neighbourhood Working programme and the Health and Wellbeing Board can be developed and strengthened – in particular in the development of a strategic approach for social prescribing in Lincolnshire.

## 1. Background

### National Context

There is a national commitment that by 2023 all local health and care systems will implement social prescribing connector schemes to support the government's aim to have a universal social prescribing national offer available in GP practices. The Lincolnshire health and care system has been selected as a personalised care demonstrator site and a key element of the programme being the delivery of social prescribing connector schemes.

The NHS England personalised care team are developing programmes to support social prescribing which includes:

- Publication of a best practice guide to coincide with the long term plan for the NHS;
- Launching an online social prescribing platform;
- Developing regional social prescribing networks;
- Publishing a common outcomes framework for social prescribing;
- Piloting new accredited learning programmes for social prescribing link workers.

### Local Response

In September 2017 the Health and Wellbeing Board agreed that the remaining unallocated funds from the Health and Wellbeing Grant fund should be transferred to the four CCGs to support the development of neighbourhood working, with a particular focus on building resilience in the infrastructure of the Voluntary and Community Sector to enable high quality multi-agency cooperation.

The purpose of the award was;

- To support neighbourhood working to engage effectively in enabling local people to meet their own needs through the community and voluntary sector; and
- Ensure the developments are focused on the system goals of shifting towards preventative and self-care interventions.

The initial agreement was to utilise the funding as part of a match funded submission to the Department of Health's Voluntary, Community and Social Enterprise Health and Wellbeing Fund 17/18: Social Prescribing. In March 2018 we were made aware that we had not been successful.

Therefore the System Executive Team (SET) agreed that the funding should be pooled to be able to demonstrate social prescribing as a proof of concept in Lincolnshire, recognising that the funding was non recurrent and would therefore need to be able to demonstrate both impact on people, as well as financial and social value return on investment.

The decision was made locally to expand on the social prescribing pilot that had already started in Gainsborough as part of the Neighbourhood Working programme.

Voluntary Centre Services (VCS) and Lincolnshire CVS are Lincolnshire-based charities working together to deliver sector support and development services to voluntary and community groups across Lincolnshire. The organisations are well placed, not only geographically, but also through reputation and the breadth and strength of their

connections within the local community, to provide consistent, coordinated referral hub services for local GPs and clinical practitioners. Their established networks of local organisations, charities and informal community-based self-help groups provide services and activities across the themes of mental health, dementia care (including carer support), physical sport and activity, youth provision and more.

## 2. Social Prescribing – National definition

When medical help alone is not enough, social prescribing enables people to focus on what else matters to them, through referral to non-medical link workers. Their role is to connect people to community groups and other services for practical and emotional support. This could include befriending, volunteering or activity groups.

The benefits of social prescribing for individual outcomes and creating the headroom for sustainable health and social care transformation are well rehearsed. The important thing now is to make sure that we understand how social prescribing, as a policy tool, can work best in Lincolnshire to ensure that people, mainly those who are on the frailty pathway and/or isolated, are able to stay healthier for longer through prevention and self-care

## 3. Project outline

Following the successful pilot in Gainsborough (June 2017-May 2018), and the increasing body of evidence from other areas of the country, social prescribing is now established as a vital component of Neighbourhood Working (NW)

The release of Health and Wellbeing Fund (HWBF), with additional funding from the CCG's, is being used to scale up and deliver social prescribing across the county. Central to this is improved patient outcomes, which continue to be evident in Gainsborough and in other areas where NW is being established. The HWBF has been essential in enabling capacity on the ground.

| CCG Area | INT areas | Capacity | Start dates |
|---|---|---|---|
| West | Gainsborough<br>Lincoln North<br>Lincoln City South<br>Lincoln South | 1 FTE Lead<br>2.8 FTE Navigators/Link Workers | June 2017<br>Sept 2018<br>October 2018<br>Sept 2018 |
| South & South West | Grantham & Rural<br>Sleaford & Rural<br>Stamford<br>Spalding<br>Bourne and The Deepings<br>Holbeach and the Suttons | 1 FTE Lead<br>3 FTE Navigators/Link Workers | Sept 2018<br>Sept 2018<br>October 2018<br>June 2018<br>November 2018<br>November 2018 |
| East | Boston<br>Skegness & Coast<br>East Lindsey North and Middle | 1 FTE Lead<br>2.8 FTE Navigators/Link Workers | Aug 2018<br>Posts currently vacant – interviews held November 2018 |

Each CCG area is supported by a senior/lead who is responsible for managing the local referral hub and social prescribing team and, importantly, plays a key role in ensuring integration with NW and care navigation, developing key strategic and operational

relationships, identifying and supporting the development of community-based social prescribing networks (capacity building) and developing quality assurance.

Each NW area has a Navigator/Link Worker who provides the face-to-face support to clients, works with the core teams on care and support planning, works with clinical practitioners, neighbourhood teams and other stakeholders to enhance the person-centred support.

Project administration staff provide central support, coordinating referrals, managing our database system, supporting groups and key volunteers and providing an essential administrative function for the navigators.

The HWBF, alongside CCG funding, will initially fund the service for a period of 12-18 months across the county. During this period, VCS / LCVS will;

- Play a direct role in delivering the aims of the Joint Health and Wellbeing Strategy;
- Support others who are delivering the Joint Health and Wellbeing Strategy Priorities (e.g. Active Lincolnshire, the Wellbeing Service and the integrated Lifestyle Support);
- Support implementation of the Library of information and services;
- Work together to develop consistent social prescribing services based on a countywide model with locally nuanced delivery;
- Extend the delivery of MECC+ training and awareness to a wide audience of health care professionals and community organisations.

## 4. Progress to date

| **Activity Area** | **Progress June-November 2018** |
|---|---|
| Service development & working alongside Integrated Neighbourhood Working | • Social prescribing standard operating procedures developed.<br>• Social prescribing outcome measures developed that sits within the suite of system outcome measures, demonstrate value and support return on investment modelling.<br>• Staff teams appointed and embedded within the Neighbourhood Networks.<br>• Staff training undertaken.<br>• Referral routes and processes developed.<br>• Referral hubs established to support INW and enable consistent referral pathways to social prescribing advice and services.<br>• Lincolnshire Social Prescribing Network developed to ensure consistency across Lincolnshire, creating an opportunity for staff to come together and discuss issues, challenges, best practice and opportunities.<br>• Supporting the Neighbourhood Leads to embed navigation and integrate with the GP forward developments.<br>• Enabling NH Leads through engaging with Multi professionals and project group meetings, including widening voluntary sector representation. |
| Partnership working and cross-sector engagement | • Cross sector networking, stakeholder engagement events and Voluntary Sector Forums have been facilitated across the county to increase awareness of NW and social prescribing. The events |

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| | have been very well received with between 30 and 90 attendees at each. Health-focused events were held in Gainsborough, Lincoln, Lincoln South, Boston and Stamford, complementing our existing networking programme for the sector.<br>• Continued development of the NCVO 'increasing voluntary sector involvement in the STP' working group following initial workshops in Manchester. The working group has focused on building on cross sector partnership working and enhancing the prospect of streamlined engagement with the voluntary sector at all levels, resulting in the establishment of a Voluntary Executive Team of senior execs drawn from across the spectrum of third sector stakeholders.<br>• Supported wider engagement of the community and voluntary sector through Involving Lincs and development of the Health and Wellbeing Engagement Strategy.<br>• Engagement and relationships established with core partners including the Wellbeing Service, LCC Adult Care and Community Wellbeing Service, Carers First, St Barnabas, Lincs Fire & Rescue and Age UK. |
| Person centred, community-based support | • Commenced 1-2-1 support and navigation for individuals to access community support to promote a preventative approach.<br>• Started recruiting volunteer 'champions' to support social prescribing activity.<br>• Navigators / Link workers undertaking Helen Sanderson training on Personal Care and Support Planning.<br>• Commenced development of the navigation role alongside the GP forward view within GP surgeries, integrating Bronze, Silver and Gold levels of navigation support.<br>• Navigators/Link workers regularly working from GP practices and hot desking spaces (e.g. John Coupland Hospital, Birchwood Medical Practice, Nettleham Medical Practice, Hereward Practice Bourne and Stamford Hospital, with plans developing to link in with GP practices and INW hubs in line with local developments)<br>• Development of community advice sessions and community cafés to offer a weekly opportunity that enables people to begin their self-care journey.<br>• Commenced delivery of the care navigation element of the Making Every Contact Count (MECC) training framework developed by Public Health. Training scheduled to be rolled out across GP practices within the County.<br>• Referrals primarily received through the Neighbourhood Teams with other referrals received directly from GP's, LPFT, DWP, Fire & Rescue, Adult Care, Carers First, St Barnabas and the Wellbeing Service.<br>• Initial referrals highlighting key areas of mental health, loneliness and social isolation |
| Promotion and awareness raising | • General wide promotion of social prescribing, increasing GP and local partner awareness. Through engagement activity, one-to-one meetings, social media and engagement with the GP lead for the INT areas. |

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| | • Promotion of the community offer for individuals, spreading key messages around self-care and prevention, therefore enabling and empowering individuals, rather than reactive problem solving (Co-ordinated through the Self Care delivery group, Neighbourhood meetings and engagement with the CCG's).<br>• Promotional activity as part of key health campaigns, such as Self Care Week. |
| Support for the community and voluntary sector | • Work with local partners and Volunteer Centre staff to increase knowledge and awareness of local activities, groups and services in INW areas.<br>• Support to increase resilience of local organisations within the SP network.<br>• Support to develop and increase the range and diversity of local activities within the SP network.<br>• Launch of the Adult Care Community Development Fund to support capacity building in local groups and organisations.<br>• Commenced initial work to identify and address gaps within localities. Early gaps include an urgent need for mentoring and befriending support services in some areas of the county. |
| Quality Assurance | • Quality assurance workshops facilitated with community providers in partnership with Every-One, in line with national activity taking place around quality assurance, supported by NHS England.<br>• 5 core principles agreed as good practice for community groups in Lincolnshire:<br>o Welcoming & Accessible<br>o Safe<br>o Well Governed<br>o Supporting People to Grow<br>o Making A Difference to Wellbeing<br>• The 5 core principles built into support to community providers and the Adult Care community grants funding guidance. |
| Data & Outcomes Monitoring | • Development and implementation of the 'V-base Lincolnshire' social prescribing database.<br>• Development of tools to measure quantitative and qualitative impact of social prescribing including the 'How am I doing' web.<br>• Contributed to the development of the neighbourhood working outcomes framework, taking the lead on social prescribing and care navigation.<br>• Implementation of the Social Value Engine as a tool to measure the impact and social return on investment. Social Prescribing metrics/measures identified and agreed. |

## 5. Outcomes so far…

### Activity levels from 1st September – 19th November 2018 (6 weeks)

There has been a recent rapid growth of referrals where social prescribing offers have been introduced and where GP engagement has been high – this is particularly evident in the Lincoln area, Gainsborough, Bourne and Spalding.

| Area | Referrals |
|---|---|
| Boston | 1 |
| Bourne & Deepings | 13 |
| Crowland | 1 |
| East Lindsey | 1 |
| Gainsborough | 24 |
| Grantham | 5 |
| Lincoln City South | 16 |
| Lincoln North | 13 |
| Lincoln South | 14 |
| Out of County/ Unknown/ Other | 8 |
| Sleaford | 5 |
| Spalding | 17 |
| Stamford | 6 |
| **TOTAL** | **124** |

The level of activity and engagement is really encouraging with an average of 20 referrals per week – and recognising that in the East of the County the Neighbourhood Working and social prescribing offer is less mature than in other parts of the County.

As the project is in such an early stage of implementation it has not been possible to report on the outcome measures that have been developed for the project however the qualitative feedback from staff and individuals has been very positive. Appendix A is the first draft of the outcome measures and financial proxies that have been developed for this project, it is hoped that early in the New Year is will be possible to report on them and this will be shared in the next report to the Health and Wellbeing Board.

**Feedback from Neighbourhood Leads:**

*'I see social prescribing as a key foundation stone within the neighbourhood; enabling people to take proactive steps towards managing their future health, care and social needs'.*

Victoria Sleight, Neighbourhood Lead – Lincoln City South

*'GPs in Lincoln South are engaged with social prescribing and are already referring into the service. In one practice we are looking at how our social prescriber can work with a possible volunteer to build capacity in the village to support people – working in partnership'.*

Angela Shimada, Neighbourhood Lead for Lincoln South

*'Nettleham are excited to see how social prescribing can fit with the chaplaincy service. They are hoping by being present in the surgery they will be able build strong relationships with our social prescribers'.*

Beckie McConville, Neighbourhood Lead – Lincoln North

**Feedback from GP Care Co-ordinator**

*"Social prescribing is absolutely life changing for patients and families. I think social prescribing will be the key in driving change in our health and social acre system'.*

Carly-Jayne Fisher, Practice Care Co-ordinator, Hereward Practice, Bourne

**Case Study 1 - Ms P**

P has Parkinson's and a history of low mood and low motivation. She lives with her partner and main carer who is 90yrs. In the past she had tried the day centre in Bourne which she did not enjoy and went to a Parkinson's group but found both quite isolating as no one wanted to sit with her. In the past P has enjoyed walks, crocheting, bowls and social activities without her partner but sometimes becomes quite nervous at having to attend these on her own or how to access these and what is available. One of the most important things to her is getting some enjoyment and purpose back in her life. During the last two years P has become very isolated.

P often speaks of just wanting to die.

P and her partner often argue for no reason other than they are both struggling with health challenges and vulnerability. Both need more support to help them with day to day.

Since the social prescriber visit P's mood has lifted. The social prescriber took a holistic approach to help her clear her head of things that were of concern. Some of the issues were not something that the social prescriber could deal with directly and referrals have been made to Carer Sitters, Carers First and the Wellbeing Service. The social prescriber took P to the U3A open day on a Saturday morning and after the first midweek session took her shopping for crochet needles and wool.

P now attends a 'crochet group' run by the U3A group. The attendees are very friendly and have taken her under their wing and given her 1-1 support with her crocheting. P is quite frail and does struggle but she is given such wonderful support which seems to be boosting her confidence. The social prescriber has attended this group with her and will do for the next 10 weeks or until P feels confident to go their alone. Carer sitters are going to visit P on a regular basis and take here for a little walk.

At the moment P feels that this is enough for her because she does get very tired but she has said that the social prescriber has made her feel so much better.

The social prescriber has reported to the Bourne INW that P's partner needs more support and a better support plan for him to confidently care for P. This is being reviewed and actions will be taken to ensure that they are happier in their own home and have access to services that could make a substantial difference.

One key outcome from this has been support for the carer in addition to the primary referral.

**Case Study 2 - MY**

MY completely lost her confidence since being hospitalised for falling; "My physical strength was poor and I was struggling with everyday tasks. My mood was low. I had not been outside because I was scared of falling again. I was relying on friends and neighbours to get my shopping for me."

The community OT referred MY to the SP team as she recognised that lack of confidence was delaying her recovery.

MY said; “The SP link worker has been invaluable in helping me see that I didn’t have to accept my current situation as final. She has supported me and at the same time challenged me to think and act differently. I would not have had the confidence without this support and would have probably been unable to leave the house and become frailer and socially isolated. My link worker took me out for a drive and then for a coffee. This was the first time I had left the house for a few months and I was very nervous but she helped me to overcome my fears. We also went to a seated exercise class for three weeks to help me to build my physical strength further.”

Outcome: “I have had small successes along the way such as being able to use my hoover and start cooking again. My physical strength and mood have improved significantly. I am regularly practising exercises at home and have been motivated to do so because I can see the difference it has made. I am now hoping to build up my strength so that I can take part in a 30 min walking for health walk in December.”

## 6. Risks, Issues and Mitigation

| Risk / Issue | Project mitigation | System mitigation |
|---|---|---|
| Non – recurrent funding for Social Prescribing | All posts are fixed term contracts.<br><br>Exploring the potential for attracting social investment through Social Impact Bonds with the CCGs and Lincolnshire Community Foundation and social investors. | Identified as one of the system intentions for 19/20. |
| A lack of strategic direction for Social Prescribing in Lincolnshire | Being able to demonstrate a proof of concept through this project. | Recruitment to a fixed term post to lead the self-care and social prescribing agenda for Lincolnshire.<br><br>Raising the awareness of a need for a Lincolnshire strategy for social prescribing that is sustainable and funded appropriately. |
| Not being able to demonstrate financial impact of Social Prescribing | Working with Rose Regeneration and the University of Lincoln to put in place a model for tracking outcomes and measuring return on investment. | National evidence is now readily available to be able to demonstrate the ROI of Social Prescribing to a wider Health and care system. |
| A lack of scale and pace. | Demonstrating a proof of concept.<br>Using the wider community networks and resources | Being part of the National Integrated accelerator programme will raise the profile of social prescribing in Lincolnshire – and will require a system response in terms of true commitment social prescribing. |
| Engagement with GP’s and wider community | Local engagement to continue as part of the Neighbourhood working programme – GP advocates to be identified. | Needs to form part of the wider system communication and engagement approach |

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| Public engagement and understanding of the value of Social Prescribing | Local engagement to continue as part of the Neighbourhood working programme – sharing stories and outcomes. | Needs to form part of the wider public engagement and |

## 7. Conclusion

Although the project in Lincolnshire is being run as a 'proof of concept' with non-recurrent funding, the national evidence and the very clear commitment from NHS England is that social prescribing is an offer that should be available to the health and care community by 2023.

Over the next 6-9 months as the pilot to continues to develop and expand and we start to understand the outcomes better from an individual, financial and social value perspective, it is our opportunity to come together as a system to develop a strategic approach for social prescribing that will bring together all the key partners to co-produce a sustainable and well-resourced offer for Lincolnshire.

Therefore, it is timely to work with the HWB to identify opportunities for closer working and support with this, that maybe available via the HWB's work programme.

## 8. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Groups must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

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| The social prescribing project is focused on supporting the health and wellbeing of the local neighbourhoods in Lincolnshire, with a particular focus on social isolation, mental health and older people – however no one is excluded. |

## 9. Consultation

N/A

## 10. Appendices

| These are listed below and attached at the back of the report | |
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| Appendix A | A copy of the Social Value Engine – outcomes and financial proxies (Draft – not confirmed) |

## 11. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were use in the preparation of this report.

This report was written by Kirsteen Redmile, Lead Change Manager Integrated Care, who can be contacted on 01522 307315 or kirsteen.redmile@lincs-chs.nhs.uk

## Social Prescribing – Social Value Engine - Outcomes and Financial Proxies

**Appendix A**

| Bristol Accord[1] Impact Area | Outcome | Financial Proxy | Unit |
|---|---|---|---|
| Active, Inclusive and Safe | 1a. Improved well-being through cultural, recreational and sports activities | Contribution of sport to wellbeing | Per person |
| | 1b. Improved social capital, community ties and strengthened civic engagement through greater use of community resources | Cost of mental health problems exacerbating a long-term health condition | Per person |
| | 1d. Increased volunteering and potential for grater community participant and development | Value per volunteer in the UK | Per volunteer |
| | 1e. Reduced social isolation for community members | Value of befriending adults and elderly | Per person per hour |
| Well Run | 2c. Strengthened public and civil engagement. | Value to an individual of being a member of a social group | Per person per year |
| Environment | 3e. Growing | Per Capita costs of obesity to society (£49.6bn/£64,000,100 population | Per person |
| Well Connected | 5b. Improved health and well-being for local residents | Ambulance journey to hospital & A&E Attendance | Per visit |
| | | Cost of a fall | Per person |
| | | Improved mental health | Per person |
| | | Cost of a GP visit | Per person |
| | 5d. Improve access to public, private and consumer for local residents | Additional cost in a rural area I terms of access to services | Per household |
| Thriving | 7e. Skills development and improvement for residents workers (Including migrant workers | Value to an individual of moving from unemployment to a secure job | Per person |
| | 7f. Learning/Participation | Average cost of a personal development course | Per person |
| Well Served | 8a. More substantive links between organisations and service providers | dfT estimation of business time savings | Saved by organisation per year |
| | 8e. Improved access to local facilities for local residents | Savings from transaction services online rather than face to face, by telephone or by post. Calculation from the average number of transactions multiplied by the difference between the average cost of an offline transaction vs an online. | Per transaction |
| | 8f Improved community health and services provision | Cost of community health visit | Per visit |
| | | Average cost of an inpatient stay in hospital | Per person |
| | | Unit cost of reduced benefit payments and health impact | Per person |

[1] The Bristol Accord is a national tool developed to measure social impact.

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