NHS ENGLAND'S SOCIAL PRESCRIBING MODEL AND IMPLEMENTATION IN THE NOTTINGHAM AND NOTTINGHAMSHIRE INTEGRATED CARE SYSTEM

1. Introduction

The NHS Long Term Plan commits to personalised care as one of the five major, practical changes to the NHS that will take place over the next five years.

A key aspect of the personalised care agenda includes a substantial investment in social prescribing, with an ambitious pledge to:

- develop over 1,000 trained social prescribing link workers nationally by 2020/21, rising further by 2023/24.
- enable 900,000 people to be referred to social prescribing schemes by 2020/21

This is part of the drive to Universal Personalised Care that will see at least **2.5 million** people benefiting from personalised care by 23/24.

This is being implemented locally by the Universal Personalised Care Programme within the Nottingham and Nottinghamshire Integrated Care System (ICS), in partnership with key partners.

2. Background

2.1 The Comprehensive Model of Personalised Care

The Nottingham and Nottinghamshire Integrated Care System (ICS), of which Nottinghamshire County Council is a member, has a longstanding commitment to universal personalised care. In May 2018, the Nottingham and Nottinghamshire ICS agreed to deliver this at scale as a demonstrator site for the NHS England (NHSE) Comprehensive Model of Personalised Care.

The Nottingham and Nottinghamshire ICS footprint covers Mid Nottinghamshire (Mansfield, Ashfield and Newark & Sherwood), Nottingham City and South Nottinghamshire (Broxtowe, Gedling and Rushcliffe). Bassetlaw is part of South Yorkshire and Bassetlaw ICS and is therefore not directly affected by this report, although it is referenced.

The NHSE Comprehensive Model of Personalised Care comprehensive:

- Whole-population approaches to supporting people of all ages and their carers to manage their physical and mental health and wellbeing, build community resilience and make informed decisions and choices when their health changes
- A proactive and universal offer of support to people with long-term physical and mental health conditions to build knowledge, skills and confidence and to live well with their health conditions
- Intensive and integrated approaches to empowering people with more complex needs to have greater choice and control over the care they receive

The model requires six key elements to be embedded in the ICS, that is, across the NHS and the wider health and social care system. These include:

- Shared decision making
- Personalised care and support planning
- Enabling choice, including legal rights to choice
- Social prescribing and community-based support
- Supported self-management
- Personal health budgets and integrated personal budgets

The Universal Personalised Care programme is responsible for the coordinated delivery of the NHSE Model for Personalised Care across the Nottingham and Nottinghamshire ICS. The Programme's vision is to maximise independence, good health and wellbeing throughout our lives, shifting the focus from 'what is wrong with you?' to 'what matters to you?'

As a Demonstrator site for the Comprehensive Model of Personalised Care, the Nottingham and Nottinghamshire ICS has signed a Memorandum of Understanding (MOU) for 19/20 to deliver Personalised Care at scale across the footprint in order to achieve the scale committed to in the NHS Long Term Plan.

For 19/20, the Nottingham and Nottinghamshire ICS has a target to support 15,000 people into community based support, which will predominantly be achieved through social prescribing. This signifies a significant gear shift for social prescribing in the system and the importance of a coordinated and unified effort across the ICS.

From April 2020, the system will have clear trajectories to achieve for social prescribing predominantly focused on the number of Link Workers and the number of referrals they receive:

Social Prescribing Referrals

	19/20	20/21	21/22	22/23	23/24
SP Link Workers	24	39	54	68	83
Link Worker referrals	n/a	4,188	8,377	13,612	15,706

2.2 What is social prescribing?

Social prescribing focuses on non-clinical activities (i.e. not medications or formal therapies) to help people of all ages manage their health and wellbeing through a person-centred approach that focuses on what matters to them.

Social prescribing helps people find ways to manage their health and wellbeing by connecting them to wider community support and activities that meet their emotional, physical and social needs, and deal with some of their underlying causes of ill health. This encompasses a wide range of possible activities such as exercise schemes, arts, educational courses, social activities and practical services such as benefits advice.

The benefits of social prescribing

There is emerging evidence that social prescribing can lead to a range of positive health and wellbeing outcomes for people including, but not limited to:

- Increases in self-esteem and confidence
- Sense of control and empowerment
- Improvements in psychological or mental wellbeing
- Positive mood linked to a reduction in symptoms of anxiety and depression
- Reduction to feeling of social isolation

Encouraging patients to become proactive in decisions about their own health, as well as increasing social contact and support in local communities, is anticipated to lead to reductions in levels of reliance on health and social care services, as a social prescribing approach support preventing, delaying or avoiding the need for more costly health and social care interventions.

Currently one in five GP appointments focus on wider social needs rather than acute medical issues, and 59% of GP's think social prescribing can help reduce their workload and increase their capacity. A 2017 report exploring the impact of social prescribing on healthcare demand and cost implications suggests that social prescribing leads to an average reduction in demand of 28% for GP services, 24% for A&E and small reductions in admissions and referrals.

Social prescribing has the potential to address the wider determinants of health and wellbeing that can lead to potential long term social care needs. For instance, it can support older residents whose combination of health, social and environmental indicators mean they are at higher risk of losing their independence. This has the potential to impact positively on social care services in Nottinghamshire, who are predicted to experience an 85% increase in care home admissions by 2030 if current demand stays the same.

See Appendix 1 for a case study example of the impact social prescribing can have on an individual's life as well as its impact on public services.

2.3 The social prescribing Link Worker role

As part of the NHS Long Term Plan commitment funding has been made available to embed a Link Worker within each of the 15 Primary Care Network multi-disciplinary teams across Nottinghamshire (including Bassetlaw) to deliver social prescribing.

Link workers will:

- Provide access to good quality information
- Encourage strength based conversations about what is important to a person
- Support and empower people to gain knowledge, skills and confidence to manage their health and wellbeing
- Support people to make decisions about the support they access
- Support people to have choice and control over the way their care is planned and delivered, and develop personalised plans based on 'what matters to them'
- Promote healthy and active lifestyles
- Help people plan for the future e.g. Financial services, housing
- Connect people into their networks and local communities
- Provide early interventions, such as access to a falls clinic

- Provide support to carers to help them improve quality of life while still caring e.g. peer support group for those caring for someone with dementia

Link Worker's will work closely with local voluntary and community sector groups, to support community development to ensure that there is sufficient community capacity to support individuals referred by Link Workers.

From July 2019, funding has been made available across England for each PCN to access £34,113 per year to employ 1 Link Worker post. This funding is available annually until 31 March 2024 currently. Year 1 of the funding is described as a development year, with the majority of service requirements being introduced from April 2020 onwards.

As the funding is awarded directly to the PCN's, the PCN has ultimate discretion as to the delivery model it employs for Link Workers, or indeed, if it applies for the funding for the post at all. However, the role of the ICS is to ensure a consistency of approach to social prescribing across the whole Nottinghamshire ICS footprint (including Mid-Notts, South Notts and City), whilst recognising that delivery of the model may differ depending on local area need. The ICS will support each ICP area to ensure that the principles underpinning the social prescribing service are consistent across the whole ICS, ensuring that Link Worker roles are consistent and work to the same outcome framework. This will ensure equity of offer across the ICS and also ensure that evaluation of the programme can be undertaken accurately.

3. The local social prescribing model

3.1 Developments to date

To ensure consistency across the Integrated Partnership Areas (ICP's), the ICS has developed a Social Prescribing specification to ensure that all schemes have a set of guiding principles and key outcomes in the form of KPI's that they will need to deliver. In this way, regardless of the local model developed for social prescribing, individuals in each area will have access to Link Workers that deliver the same type of support.

Each ICP area has agreed a shared local plan for social prescribing, with the local authority being a key stakeholder involved in shaping and agreeing the plan.

A Social Prescribing Task and Finish Group, comprised of CCG and local authority commissioners, are responsible for rneasuring a level of consistency across the ICS footprint, currently focused on:

- A clear and consistent referral process
- Consistent training plan
- Data recording systems
- Key communications messages and marketing materials to share information on the Link Worker offer
- Long term developments to align new and existing social prescribing schemes across the ICS
- Long term developments to support community development

Mid Notts

Mid Notts has recruited 7 Link Workers. All Link Workers will be in post in November 2019, with an in depth induction and training process planned and in place. The service will formally launch in January 2020, with some referrals being accepted prior to this.

South Notts

South Notts has recruited 11 Link Workers by securing transformation monies to expand their model. All colleagues across the South have agreed to deliver the same social prescribing model, despite being employed by 3 different employers.
Following a training and induction process, the service will formally launch in January 2020, with some referrals being accepted prior to this.

Bassetlaw

Bassetlaw has a well established social prescribing model. Although Bassetlaw is part of South Yorkshire and Bassetlaw ICS, the good practice from this model is shaping development in the Nottinghamshire ICS footprint, and work is underway to align the models across Nottinghamshire to learn from each other and make best use of existing practice.

Nottingham City

Whilst not the remit of this Committee, it is helpful to understand that the same work is underway in Nottingham City, with the new service launching in January 2020.

3.2 Referrals to Link Workers

Initially, referrals to Link Workers will be predominantly from GP's while the service is first being implemented.

By April 2020, a wide range of local agencies will be able to refer to social prescribing in order to coordinate support around the person and encourage partnership working. All primary care staff and local agencies, including GP's, pharmacies, local authorities, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and VCSE organisations will be able to refer people to a link worker.

Individuals and families and carers will also be able to make a referral to a Link Worker.

3.3 Community Development support

Without strong and sustainable community assets, the social prescribing model will not work as there will be no community groups for the Link Worker to connect individuals with. A key aspect of the Link Worker role is focused on community development to ensure that local voluntary organisations, community groups and social enterprises are locally sustainable and can plan ahead and identify gaps in provision and respond to them.

Whilst the Link Worker role is first implemented, a non-recurrent Community Development Fund of £35,000 has been awarded to each ICP to support community development within the first year of the social prescribing model. Each area has

developed a different proposal for how to use the funding, with Mid Notts funding this support through their CVS's and South Notts funding a post for this work within Gedling Borough Council.

This is a short term focus on community asset building, and there is recognition that there will need to be a longer term approach to this in order to ensure long term community sustainability. Work will be undertaken over the coming months with partners across the ICS, CCG and County Council to explore how best we can collectively address this as a system.

3.4 Existing schemes

There are a range of existing social prescribing/community services in existence across the County, including Nottinghamshire County Council (NCC) funded services. These include, but are not limited to:

Mid-Notts (Mansfield, Ashfield, Newark & Sherwood):

- Connect (Age UK service funded by NCC)
- Nottinghamshire Enablement Service & Coproduction (funded by NCC)
- Everyone Health – focused on weight management, falls prevention and maternity (part funded by NCC)
- Ashfield Exercise Referral Scheme (funded by Ashfield District council)
- Nottinghamshire Warm Homes on Prescription (funded by Newark & Sherwood Homes)
- Mansfield Health & Wellbeing Services (funded by Mansfield District Council)

South Notts (Broxtowe, Gedling and Rushcliffe):

- Connect (Metropolitan service funded by NCC)
- Age UK Living Well Service (Funded by CCG)
- SPRIING – Social Prescribing Reducing Isolation IN Gedling (funded by Gedling Borough Council and Gedling/Jigsaw Homes)

Digital online tools, such as Notts Help Yourself, also support individuals to gain quality information about services available in local communities.

The NHS England funded model is intended to build on existing local social prescribing schemes, avoiding duplication and enabling all social prescribing link workers (wherever they are employed) to work together as a wider team across the local area. The purpose of the Link Worker role is to compliment, not replace, existing schemes.

Next steps

- A year 1 evaluation will also be undertaken to ensure learning from the developmental year and the application of best practice to be applied for scale up over the coming years in line with the NHSE trajectories

- Work to be undertaken to work with partners to align new and existing social prescribing schemes across the ICS footprint to reduce duplication and ensure value for money

- Work will be undertaken with partners to focus on a system response to the long term sustainability of community assets, which will support the social prescribing model

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