HEALTH AND WELLBEING BOARD: 30th MAY 2019

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

LEICESTERSHIRE SOCIAL PRESCRIBING AND CARE COORDINATION MODELS

Purpose of report

1. The purpose of this report is to update the Health and Wellbeing Board on the progress made in Leicestershire to develop the existing social prescribing and care coordination models and detail potential options to further develop the models aligned with developments of the NHS Long Term Plan (LTP).

Link to the local Health and Care System

2. Prevention and specifically social prescribing is a key component of the NHS LTP, published in January 2019. The plan specifically mentions implementation of over 1,000 trained social prescribing link workers within Primary Care Networks (PCNs) across the country by the end of 2020/21. This will rise further by 2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes.

3. One of the key developments in the new NHS LTP service model is to boost 'out-of-hospital' care and dissolve the historic divide between primary and community health services through an integrated care system. This will ensure services are more joined up, proactive and differentiated to support individual needs. The new model will involve the development of PCNs, which are groups of local GP practices and community teams managing the needs of a 30-50,000 population. These will be supported by risk stratification and predictive prevention tools which generate lists of individuals for multidisciplinary teams (MDT). To support the management of these patients GP practices use care coordination/ navigation roles to integrate health, social care, prevention and community services around the patient's needs.

Recommendation

4. It is recommended that the Board supports the development of the social prescribing and care coordination models across Leicestershire which would include identifying a systematic approach to embedding these roles into the existing social prescribing system (as detailed in paragraph 19 of the report) , engagement with PCNs through planned PCN engagement events and the newly established care coordination task and finish group.

Policy Framework and Previous Decisions

5. The Health and Wellbeing Board endorsed the model for social prescribing at its meeting of the 5th May 2016. A further update was provided in the Unified Prevention Board update on the 25th January 2018.

Background

Social Prescribing Nationally

6. The King's Fund and Local Government Association define social prescribing, (sometimes referred to as community referral or locally as the unified prevention offer) as a means of enabling GPs, nurses and other professionals to refer people with social, emotional or practical needs to a range of local, non-clinical services. In April 2017, this was adapted locally by the Unified Prevention Board who define social prescribing as; "*A mechanism for empowering people to help themselves and link individuals that need it, with non-medical sources of support within the community. It will ensure that the response given is appropriate to the individual and allows them choice and influence over their wellbeing*"[i].

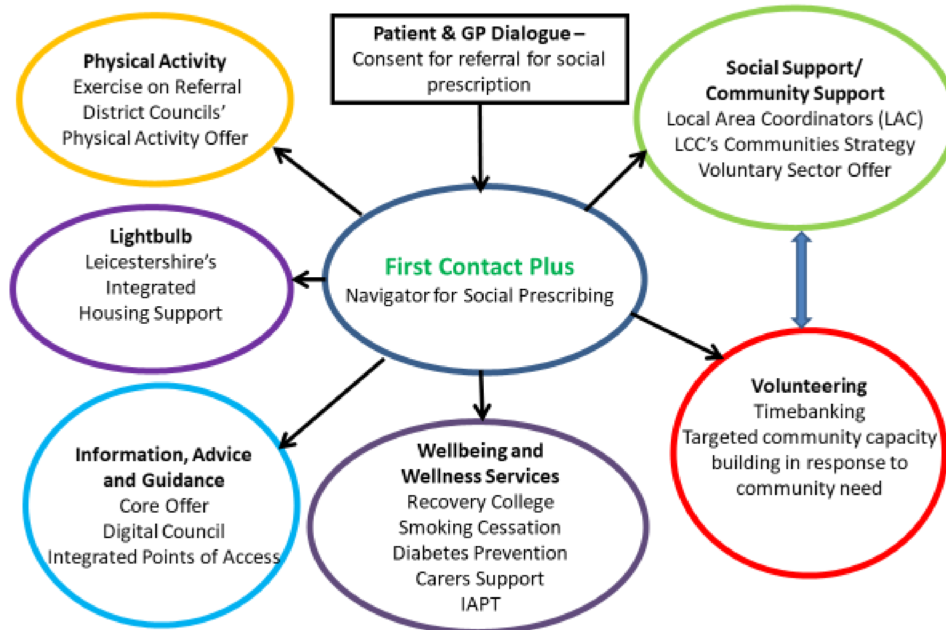
7. Social prescribing takes a holistic person-centred approach that recognises that people's health is determined by a range of social, economic and environmental factors. It aims to support individuals to take greater control of their own health by involving individuals into a variety of activities which are typically provided by public, voluntary and community sector and social enterprise organisations. Examples include public health services (stop smoking, weight management, substance misuse, physical activity), fire alarms, volunteering, arts activities, group learning, gardening, befriending, housing/ benefits support, home first safety checks and debt management. Across the country there are different models for social prescribing, but most involve a link worker or navigator role who works with people to access local sources of support and build local community capacity.

The Leicestershire Social Prescribing Model

8. In 2017 Leicestershire partners at the Unified Prevention Board developed a vision for social prescribing stating, '*We will work together to create a coherent social prescribing offer across Leicestershire that will benefit citizens by allowing them greater access to our menu of services and community resources, to enhance their health and wellbeing'*.

9. The Council's 'First Contact Plus's service acts as the coordinating "front door" for accessing a range of social prescribing solutions, as illustrated by Figure 1. The social prescribing model recognises that the 'offer' would not be the same in the two areas as, for example, the physical activity services and approach to community development vary by district council.

Figure 1 Leicestershire Model for Social Prescribing using First Contact Plus as the prevention front door.



10. First Contact Plus provide information, advice and guidance over the telephone or email by making a referral to preventative services. (Further details available at http://www.firstcontactplus.org.uk/). If vulnerable individuals require more in-depth face to face interventions, they may be referred to a Local Area Coordination (LAC). LAC is an approach to supporting people and their families to have a good life as part of their local community and hence is a central part of the social prescribing model. Rather than waiting for people to fall into crisis, assessing deficits, testing eligibility and fitting people into more expensive (and increasingly unaffordable) services, it works alongside people to:

    - Build and pursue their personal vision for a good life,
    - Stay strong, safe and connected as contributing citizens,
    - Find practical, non-service solutions to problems wherever possible, and
    - Build more welcoming, inclusive and supportive communities.

    N.B. There are currently a limited number of LACs operating across the County, meaning that not all localities or neighbourhoods have a dedicated resource.

11. There has also been substantial work completed across Leicestershire GP practices with regards to the NHS England Active Signposting training. This training has support practice staff (including reception) to complete a social prescribing role within the practice to signpost and refer patients into the existing Leicestershire social prescribing model or specific local interventions.

Care Coordination Nationally

12. Due to the publication of the NHS Long Term Plan, further work has been completed to explore and align the social prescribing offer and Integrated Neighbourhood Teams (INTs) building blocks (population profiling (including risk stratification), multi-disciplinary team (MDT) , care coordination and prevention) with the latest NHS link worker guidance (which suggests that each PCN should have a social prescribing link worker by

the end of 2020/21 and that a risk stratification, predictive prevention approach should be implemented in GP using a care coordination role.)

13. Health Education England (HEE) have developed a three-tiered care navigation competency framework which describes the core competencies for people providing care navigation or coordination across a wide range of health, social and voluntary care sectors. The framework recognises three success levels; essential, enhanced and expert (see Figure 2)[ii].

Figure 2 Care navigation competency framework[ii].

Leicestershire Care Coordination Model

14. As discussed in a review of care coordination across LLR, there are many services/models in place which provide care navigation/coordination across the three levels. However there is scope to develop the ‘essential’ offer and aspects of the ‘enhanced’ offer, as analysis shows this is an area where there are gaps and/or limited resource.

15. In East Leicestershire and Rutland Clinical Commissioning Group (CCG) have commissioned a Clinical Case Manager from Leicestershire Partnership Trust to manage clinical care coordination and work closely with the Integrated Care Coordinators (known as link workers) provided by adults social care in Leicestershire County Council for non-clinical support.

16. In West Leicestershire CCG a hybrid LAC/ care coordinator model has been piloted with the Hinckley/ Bosworth early implementer site. Results from the pilot have suggested that 80% of the role utilises the traditional LAC strength-based approach, while 20% has involved more targeted support including linking with the wider MDT. Due to the positive results seen, a business case has been developed by West Leicestershire CCG and partners to expand the pilot.

17. A review of care coordination across LLR identified six key principles that should be consistent in a model of care coordination across LLR. These include providing a local interface between partners/ organisations, management of the MDT, patient identification, care planning and delivery, maintenance of IT and performance data and personal development. Both Leicestershire models discussed above are able to meet these principles and illustrate that within INTs care coordinators are currently providing a similar but distinct role to the proposed new social prescribing link workers. The main

difference of which is that care coordinators take a more clinical case management and trusted assessor approach than the social prescribing link worker role.

Future Development

18. The Leicestershire social prescribing model is well established. It is well received with referrals to First Contact Plus increasing 20% year on year. It is therefore important that the Health and Wellbeing Board partners are aware of the opportunities for, and risks to further expanding social prescribing and care coordination across Leicestershire. These are summarised in Table 1 below.

Table 1 Opportunities and risks of further expansion of the social prescribing and care coordination offer across Leicestershire

Opportunities	Risks
• Reduces pressure on existing services. (For example, ~30% of GP practice appointments are for none medical reasons.) • Increased health and wellbeing, improved healthy life expectancy and reduced health inequalities. • Increased access and uptake to prevention services. • Improved community cohesion and social capital, reduction in loneliness. • Savings to the Leicestershire system with regards to taking a preventative approach (including reducing hospital, social care etc demand.)	• Step change to increase prevention referrals could destabilise preventative services with current resources. • Not enough services available to meet the social prescribing demand. Reduces quality or increased waiting times for prevention services. • Increased risk to individuals if there is not the correct quality framework to make informed choices about services/ activities available through social prescribing.

Proposals/Options

19. As discussed above, a significant amount of work has already been completed to develop a successful Leicestershire social prescribing offer. With the latest NHS LTP and NHS England guidance there are opportunities to further develop this model through the PCNs social prescribing link workers and consider the implications for care coordination, without destabilising the existing social prescribing system. Table 2 below summarises the range of potential approaches that could be taken to embedding the social prescribing link workers and care coordinators, with the advantages and disadvantages for each option. N.B. if different approaches are taken for social prescribing link workers and care coordinators this will add further complexity to the options.

Table 2 Summary of approaches to embedding link workers and care coordinators into the current Leicestershire social prescribing model.

Social Prescribing Link worker/ Care Coordinator option	Advantages	Disadvantages
A. Each PCN to recruit own link worker or care coordinator	• PCN flexibility • Very local offer	• Higher cost model of social prescribing

to act specifically in their PCN area, develop community capacity and work independently of the wider Leicestershire social prescribing model	• Currently integrated care coordinators established in ELR CCG. • Easy link to current practice work completed on Active Signposting. • Can engage in local Patient Participation Groups (PPGs) to deliver low level social prescribing.	delivery than the existing system. (Previously piloted in NWL) • Lose connectivity and potential for silo working. Patient's may not get access to the wider social prescribing offer. • Confusing for the patient. Potential duplication of LAC, care coordinator and link worker are in the same neighbourhood, locality. •
B. Each PCN to recruit own link worker or care coordinator to act specifically in their PCN area, develop community capacity. The post would work independently but link into the wider Leicestershire social prescribing system.	• Similar to option A plus; • Ability to link into wider Leicestershire social prescribing model. • Potential option for link workers to be based in areas without a LAC and work closely with them.	• Similar to option B but reduced silo working. (However the system would not be fully integrated.) • If link worker just passed all referrals to FC+ this would recreate duplication.
C. Each PCN to commission link worker or care coordinator from another broader organisation (examples include local health trust, federations, Public Health, voluntary sector, etc.) Options A&B could then be repeated.	• Similar to options A&B plus; • Ability to link/ integrated into other parts of social prescribing system. Less likely to cause duplication of resource. • Professional management and development of link workers.	• Duplication of capacity and social prescribing function. • Higher cost model of social prescribing delivery than the existing system. (Previously piloted in NWL) • PCNs potentially have less control of specific link worker recruitment and management. • PCN/ federations would need to complete a procurement and have contract management of link worker contract. • PCNs may not be able to use the funding for overheads.
D. Develop a consistent local link worker/ care coordinator definition that encompasses the currently piloted LAC/ link worker/ care coordinator model across Leicestershire. Current hybrid role is delivered by Public Health in Leicestershire County Council.	• Efficient and cost-effective model. Results demonstrate reduction in duplication across the roles and system. • One approach across Leicestershire, avoids fragmentation across the place. • Well connected posts to the wider social prescribing system, developing a more integrated and cohesive	• Only piloted in one area of West CCG. • PCNs potentially have less control of specific link worker recruitment and management. • PCN/ federations have contract management of link worker contract. • Complexities of PCNs all contributing towards LAC model with varying needs

	approach. • Truly holistic approach. One combined role, therefore no need for individuals to navigate the system/ different people or agree funding decisions across health and social care. i.e. adult care trusted assessor. • Can utilise the active signposting and PPGs within PCNs. • Lasting trusted LAC relationships so individuals can go back to worker directly for follow up if needed. • Strong evidence from H&B early implementor from clinical, and social care partners. • Economies of scale with regards to larger LAC team and ability for cover/ flexibility. • LAC roles already employed by local authority so processes in place. • PH have evidence to flex capacity as reflected by local needs.	and priorities. • PCNs may not be able to use the funding for overheads.
E. Proportion of social prescribing link worker funding is diverted to develop and implement very local social prescribing initiatives and programmes. Applicable for all options A-D.	• Current estimated NHS funding (~£34,000) is unlikely to be needed for one link worker per PCN. • Increases prevention capacity. • Ability to develop a very local social prescribing offer. • Options B-D could build on existing system. • Could be delivered/ supported through a range of providers including the PCN itself.	• PCNs may not be able to allocate funding to services (potentially salary costs only, additional national guidance is needed.) • Reduces proportion of link worker/ care coordinator role etc within the PCN.

Consultation/Patient and Public Involvement

20. A range of consultations and patient and public involvement have been arranged regarding the social prescribing model including;
    i. Leicestershire County Council are currently completing the Prevention at Scale research which includes approximately 30 qualitative interviews with patients across Leicestershire about what non-clinical conditions they are currently accessing their GP for.

ii. Partner engagement was completed when developing the Leicestershire social prescribing model through the Unified Prevention Board in 2016/17.
iii. Health Watch are planning to consult the local population on social prescribing in summer 2019.
iv. Options in table 2 were discussed with health and local authority partners at a Leicestershire social prescribing workforce meeting on 3rd May 2019.
v. The draft paper was discussed at Unified Prevention Board on 14th May 2019. Partners welcomed the opportunity to further develop the social prescribing model across Leicestershire but confirmed potential risks regarding fragmentation and the need for additional prevention capacity. Whilst acknowledging that PCNs are independent organisations, partners would want to ensure the social prescribing system is joined up and capacity appropriately supported across Leicestershire. Further work is also needed regarding varying language across the model. UPB are keen to engage with PCNs to further develop the model collectively and maximise the impact of the social prescribing link worker funding across the system.

Resource Implications

21. The current social prescribing model is funded by a range of partners across Leicestershire including the County Council, district councils, health, police, fire, voluntary and community sector. First Contact Plus, the prevention front door, is funded 50:50 between Public Health and Better Care Fund (BCF). This funding has been approved for 2019/20 however risks are associated with this due to uncertainty on the continuation of the BCF beyond 2019/20. LAC's are currently funded 90% Public Health and 10% district councils. ELR CCG commission the clinical case management role and Leicestershire County Council provide the integrated care coordinators. West CCG do not specifically currently commission any care coordination resource but are piloting the LAC/ care coordination hybrid model with Public Health.

22. Additional funding will be made available to PCN's in 19/20 through the NHS Long Term Plan for the social prescribing link workers. This should initially be equivalent of one link worker per PCN ~45,000 population (~£34,000 per PCN). PCN's will decide how this funding is to be spent within their neighbourhood. Additional national guidance is needed regarding how this funding is spent as initial discussions suggest this may only cover salary costs.

23. There is also likely to be further demand on prevention services, including First Contact Plus as the social prescribing offer continues to build momentum. Additional pathway and capacity and demand modelling will help identify the implications of this, however it is an important risk that needs to be considered.

Timetable for Decisions

24. PCNs are currently agreeing their geographies across Leicestershire. PCN boundaries are to be submitted to NHS England by the end May and new contracts will start on 1st July 2019. Social prescribing link worker funding can be drawn down and implemented from the 1st July 2019.

Conclusion and Next Steps

25. Overall Leicestershire has a well-established social prescribing model but varying care coordination approach. This paper highlights the key options for potential future development following implications of the NHS LTP with regards to embedding link workers and care coordinators into the existing social prescribing model. Decisions regarding link worker employment will be made by PCNs, however an approach that embeds the PCN social prescribing link workers and care coordinators seamlessly into the current social prescribing model is preferable to avoid fragmentation of the established system. Next steps will include further developing conversations from the social prescribing workforce meeting through the PCN engagement events and newly established care coordination task and finish group.

Background papers

NHS England (2019) NHS Long Term Plan, NHs England, London. [Available online at https://www.longtermplan.nhs.uk/]

King's Fund (2017) Social Prescribing, The King's Fund, London. [Available online at https://www.kingsfund.org.uk/publications/social-prescribing]

LGA (2016) Just what the doctor ordered. Social prescribing – a guide for local authorities. Local Government Association, London. [Available online at https://www.local.gov.uk/sites/default/files/documents/just-what-doctor-ordered--6c2.pdf

LCC (2016) Leicestershire's Emerging Social Prescribing Model. Leicestershire Health & Wellbeing board, 5th May 2016. [Available online at http://politics.leics.gov.uk/documents/s118653/Approach%20to%20Social%20Prescribing.pdf

LCC (2018) Unified Prevention Board, Health & Wellbeing Board Update. Leicestershire Health & Wellbeing board, 25th January 2018. [Available online at http://politics.leics.gov.uk/documents/s135058/UPB%20Update%20report.pdf]

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Relevant Impact Assessments

Equality and Human Rights Implications

26. Social prescribing takes a proportionate universal approach, in that the system is available to the whole population but it targeted at those most in need. This should therefore support a reduction in health inequalities. Due to many services involving volunteering within the local community it will also support development of stronger communities and social cohesion.

Crime and Disorder Implications

27. Social prescribing will also support improving social cohesion, reducing anti-social behaviour and work completed by the people's zones.

Environmental Implications

28. Social prescribing services include active travel, gardening and volunteering which will help reduce air pollution and improve the local environments.

Partnership Working and associated issues

29. As discussed above the social prescribing model was developed with Unified Prevention partners and is delivered in partnership across Leicestershire. Therefore, significant changes to the social prescribing offer are likely to impact on the entire Leicestershire system.

Risk Assessment

30. As discussed in paragraph 18 and 23, the key risk associated with social prescribing include the potential step increase in demand for prevention services. Anecdotal evidence from the Hinckley and Bosworth pilot has suggested that as the social prescribing and care coordination system gathers momentum, more complex patients are identified (i.e. those that no longer meet previous eligibility thresholds for health and social care services). These individuals can take longer to unpick and may put further pressure on the prevention system. If these are not appropriately funded by a range of Leicestershire partners current and future services are likely to see a reduction in quality and increased waiting times.

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[i] LCC (2018) Unified Prevention Board, Health & Wellbeing Board Update. Leicestershire Health & Wellbeing board, 25th January 2018. [Available online at http://politics.leics.gov.uk/documents/s135058/UPB%20Update%20report.pdf] [Accessed on 02/05/2019].

[ii] https://www.hee.nhs.uk/hee-your-area/north-central-east-london/our-work/attracting-developing-our-workforce/multi-professional-workforce/care-navigation-competency-framework - Care Navigation a Competency Framework