NHS
Liverpool
Clinical Commissioning Group

STRENGTHENING SOCIAL PRESCRIBING IN LIVERPOOL: CONNECTING FOR HEALTH AND WELL-BEING

POSITION STATEMENT

1 NOVEMBER 2017

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INTRODUCTION

Liverpool CCG is committed to contributing to the design and delivery of comprehensive and joined-up social prescribing and wellbeing in partnership with Liverpool City Council, as well as the voluntary, community and social enterprise sector (VCSE). Social prescribing is a key component of the Healthy Liverpool programme. This paper is provides additional detail from the CCG's perspective on social prescribing priorities, and its hopes for progression and future development.

Social prescribing is increasingly cited as a mechanism for improving preventative health outcomes, supporting recovery after an episode of illness, and helping to manage demand for primary and secondary care services *(NHS Five Year Forward View 2014, and General Practice Forward View 2016*). Evidence to support these claims is still emerging, but a recent national review concluded that social prescribing has the potential to protect demand on services as well as improve health and well-being outcomes.[i] It is increasingly understood that non-clinical factors, particularly socio-economic factors have a significant contribution to make to health outcomes.

Social prescribing is defined by DoH as *'enabling healthcare professionals to refer to a link worker, to co-design a non-clinical prescription to improve their health and well-being'.*[ii] In order to stimulate the growth of social prescribing schemes that meet this definition, as well as develop the evidence-base, the DoH has set up a £5 million project fund for England. The competition closes 21st November 2017. Applications to the fund must be led by an eligible VCSE organisation, maximum funding is £300,000 for first year of the scheme, reducing by 50% in year 2, 80% in year 3, 100% in year 4. For applications to be viable, they must be endorsed by the CCG, sustainability and transformation partnerships (STP) or accountable care systems (ACS), with a firm commitment to provide matched funding in years 2, 3 and 4.

Since the launch of the DoH Health and Wellbeing fund, a number of organisations have requested endorsement and matched-funding from Liverpool CCG. While the CCG will endorse proposals that further strategic and systemic priorities outlined in this paper the DoH remains responsible for deciding which application will receive funding from the Health and Wellbeing fund. If a single Liverpool submission is successful, the CCG will provide match funding. If more than one application from Liverpool is successful, the DoH will consult further with the CCG on the determination of the preferred scheme. The CCG will provide match funding for only one scheme.

The CCG is particularly interested in the expansion or enhancement of existing schemes, particularly where they have an emphasis on the creation of accessible and co-ordinated entry points or 'one-stop connector services', and the development of link-workers. New schemes may be supported, but they must be able to show that they contribute to the CCG's priorities, and that they do not duplicate other schemes in operation. Greater detail regarding the CCG perspective on priorities is found pages 5 – 9.

STOCKTAKE ON SOCIAL PRESCRIBING IN LIVERPOOL

Social prescribing schemes

There are several schemes in operation in Liverpool that meet the DoH definition of social prescribing and are integrated into mental and physical health care pathways (see Appendix 1 for more detail on key components of schemes) Those of note include:

- Advice on Prescription (funded by LCCG)
- The Stroke Association (funded by LCCG)
- Exercise on Prescription (LCC)
- Active Me initiative (LCC/Sports England)
- Macmillan Cancer Support Wellbeing service

Liverpool also has a Health Trainers service supporting people to adopt healthier lifestyles and helping them to set a personal health plan. While not a social prescribing service per se, the Health Trainers service makes an important contribution to Liverpool's health and well-being offer.

The Live Well directory

The Live Well directory, integrated into Healthwatch in Liverpool, provides information about a wide-range of health and well-being services. There are approximately 1,300 registered voluntary sector organisations in the city. Details for the majority of funded or formal groups and services are found on the Live Well directory. It is estimated that a further 1,700 groups provide activities,[iii] many of these are neighbourhood-based or a community of interest, without formal constitutions, often accessed via word-of-mouth networks.

The need for greater transparency and connectedness

The diversity of the VCS in Liverpool is its great strength, but it can sometimes result in fragmentation and duplication. A 2015 strategic review of social prescribing in Liverpool, carried out by LCVS, noted that there was no cross-agency leadership, or city-wide system or framework in place to support delivery of social prescribing. Greater connectedness and synergy across delivery systems would be aided by clearer system leadership from the lead agencies. [iv]

Improving understanding of need.

Liverpool CCG continues to seek to develop a detailed understanding of the economic and social needs of its patients. To this end, work has started on the analysis of approximately 18000 records linking primary care and Citizen's Advice Bureau 'Advice on Prescription' service data. The study is expected to report preliminary findings in early 2018 and will be important for informing ongoing plans relating to social prescribing as well as clinical service redesign.

There is also learning from the evaluation of the Healthy Liverpool Community Grants scheme. Using data from over 12,000 participants, the scheme showed positive impacts on well-being using a wide range non-clinical approaches[v].

POSITION STATEMENT ON SOCIAL PRESCRIBING

Summary

Everyone who delivers and organises health and care services in Liverpool shares a goal to improve health and wellbeing outcomes for local people, while operating in a context which requires all of us to work together to create system efficiencies in order to manage demand on public services. Social prescribing is increasingly cited as a mechanism for achieving this aim, for example in the *NHS five year forward view* (2014),and the *General practice forward view* (2016).

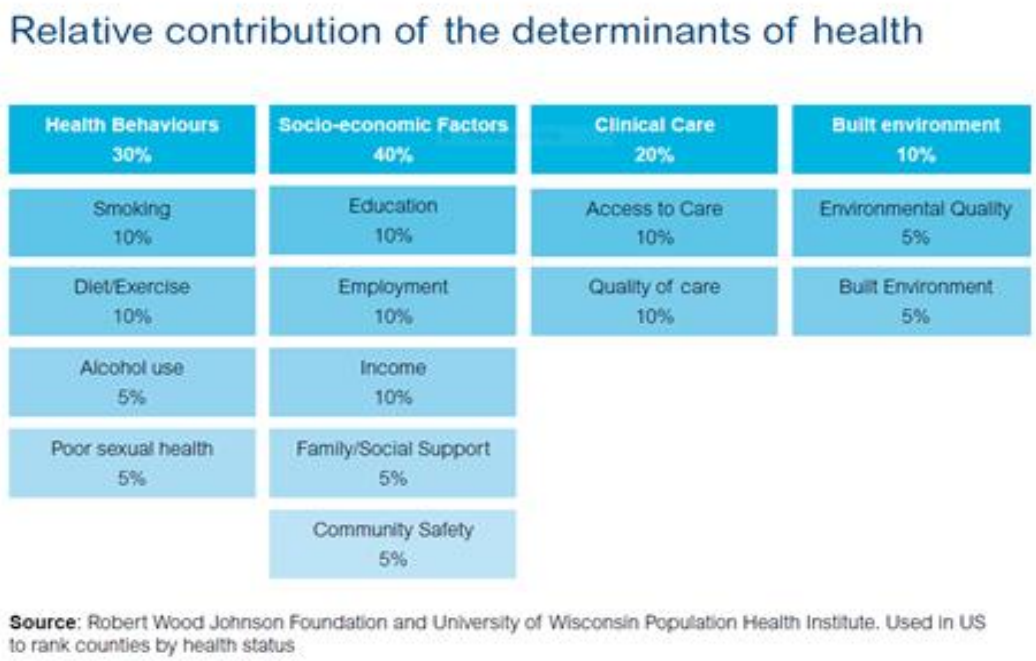
Liverpool is in a good position to capitalise on the potential of social prescribing to deliver improved health and wellbeing outcomes at community and at individual levels. It is well-served by a substantial voluntary and community sector that includes a number of well-established and innovative social prescribing initiatives. [vi] [vii] [viiiix] It is home to a vibrant and diversified social enterprise sector, applying innovative approaches to multi-faceted social and economic problems.[x] There is plenty of good evidence that together these sectors propagate a wealth of health and well-being assets, and help the public sector to mediate the exigencies of austerity.

Social prescribing sits alongside clinical interventions to help people live their lives in a way that feels like living, rather than just coping and surviving. It provokes a shift in focus from conditions and ages to wellbeing and quality of life, “from what’s wrong, to what’s strong”. Social prescribing can be a mechanism for connecting people to people in their local neighbourhood, sharing strengths and assets. The empowerment of individuals and communities needs to be at the centre of actions to reduce health inequalities[xi].

There is also a growing body of research into wellbeing which has found that positive well-being is associated with positive health outcomes. Actions and interventions that are known to improve and enhance well-being are commonly summarised as the Five Ways to Well-being.[xii]These often form the basic framework for an asset-based social prescribing offer.

The conundrum facing health systems is that those with lowest levels of well-being will often find it most difficult to make use of a well-being offer. This is because a strong ‘sense of coherence’ is thought to be a pre-requisite for ability to self-care and make use of wellbeing assets. Sense of coherence is affected by socio-economic factors, mental health, as well as close and successful social relationships during childhood and adulthood’ [xiii] The evidence suggests therefore that one of the challenges for any effective social prescribing system is to make it accessible and relevant to those who need it most.

The NHS has a significant part of play in improving the health and wellbeing of the local population but it has not been designed to provide the integrated response to patient care that is necessary to fully realise the potential of social prescribing approaches. As the figure on the next page shows, some deeper changes in what we value in health and care systems are needed.



For the CCG, excellent clinical outcomes remain paramount, but conversations about wellbeing, strengths, independence, self-care and support networks need to gain currency. A social prescribing infrastructure that is comprehensive and accessible could be the thing that makes the difference. To be effective and viable, however, it needs to be co-produced. We see the local authority and the VCSE as essential partners in this endeavour.

Based on all that we know at this point about the local context and emerging evidence-base, how do we frame the priorities that will release the benefits of social prescribing at scale? What solutions need to be activated?

Firstly, we think we need to create a different type of relationship at community level. We have already started on this journey in partnership with the City Council and local NHS services by aligning community health and social care services at neighbourhood and locality levels. Each neighbourhood is now also developing a community-facing collaborative – a place where local community and voluntary sector organisations can meet with the health and social care leadership to focus on health and wellbeing. It is hoped that this will create a platform based on equality and mutual respect that will build relationships and enable the sharing of learning, assets and resources.

Secondly, we wonder if there is more that can be done to make the VCSE health and well-being offer more transparent and accessible to all patients. Liverpool already has the Live Well directory, which is growing in capability all the time. Could Liverpool also develop a gateway system for social prescribing to make it easier for front-line health who may be dealing with upwards of 30 patients a day? That said, we know we cannot just throw 'referrals at local charities and hope for the best'.[xiv] VCSE sustainability needs to be part of whole-system change[xv].

Thirdly, we need to continue to improve the ways we address health inequalities and the inverse care law, getting better at identifying those of our patients who are vulnerable, and dealing with social and economic hardships, often in addition to ill-health and mental distress. We need to be able to engage patients without stigmatising, encouraging and supporting conversations about strengths, quality of life and wellbeing. It is essential therefore that the social prescribing model integrates across the determinants of health and well-being. We need to use approaches that bolster low sense of coherence.

Finally, we need to work with all our stakeholders to ensure that we are able to respond to the needs of those in our communities for whom active signposting is not enough. This needs to include ready access to a link worker who is skilled in liaising with health and social care professionals, listening to and empowering people, and if necessary helping them navigate the voluntary and community sectors to discover the wellbeing activity that interests them most.

The following sections provide greater detail on these four main priorities, and include a 'checklist' summarising the CCG's main areas of interest.

Priorities for action

NEIGHBOURHOOD COLLABORATIVES - '*WHAT'S STRONG, NOT WHAT'S WRONG'*
What do we mean by Neighbourhood Collaboratives?
Liverpool's community model for health and social care includes the idea of 'neighbourhood'. Liverpool is divided up into 12 neighbourhoods or place-based delivery systems, (see map) and most adult services health and social care professionals have now been aligned to a particular neighbourhood. Each neighbourhood has a population between 30,000 and 50,000. Key professionals from the patch meet regularly together sharing their skills and expertise to provide better and more effective care for local people. Each neighbourhood is supported by a leadership team, made up of key professionals from primary care and community services, usually at team leader level, and including a lead GP. Neighbourhood teams feed into locality hubs and delivery units. The idea of Neighbourhood Collaborative expands this model to include local community organisations with an interest in health and well-being. Influenced by the principles behind asset-based community development, the first step is listening and learning about each other's roles. By forging relationships, it is hoped that local health and wellbeing assets can become more 'visible'. Most collaboratives are using the Five Ways to Well-being as a framework to support discussion and action.
What progress have we made?
Collaboratives are up and running, though still in the early stages of development. Most neighbourhoods are planning to host a collaborative meeting every two months. Invitations are sent from the lead GP to local VCSE organisations, children's centres, registered social landlords, domicilliary care providers, library services, adult skills and learning. Some practices now have receptionists working in 'active signposting' roles, and they are invited

too.

Mental distress, loneliness and social isolation, supporting families, poverty, are key themes that frequently emerge at meetings.

A recently updated health profile is available for each neighbourhood.

Dr Jane Roberts has set up a blog based on visits to community projects explore the themes of social prescribing and wellbeing. https://conversationsaboutwellness.wordpress.com/

Some of our ideas and hopes for what's next

We hope that local organisations, particularly those with a community development ethos, will start to play a stronger role as partners in developing the Neighbourhood Collaboratives.

We would like to work with partners to explore ideas for clustering around particular practices. Because of the large size of neighbourhoods, for some areas it might make more sense to look at 'buddying up' with a smaller number of practices to develop networks across natural communities.

We are piloting the idea of using social media as a way of making it easier to share information about local health and well-being assets. Aintree Collaborative will be the first to receive training, provided by PSS digital inclusion service. Our aim is to make it as easy as possible for members of the Collaborative stay in touch with each other. We want to support the Live Well directory by helping it connect more easily into neighbourhoods.

MAKING THE THE HEALTH AND WELL-BEING OFFER MORE ACCESSIBLE &SUSTAINABLE.

Why is this important?

The growing interest in the prevention agenda has led many health and care systems to start to create services which aim to improve access to voluntary and community organisations, recognising that the sector provides a diverse and varied health and wellbeing offer.

Many health professionals working in the community may be dealing with upwards of 30 patients a day. They may not have the know-how or the time to investigate routes into non-clinical services. Many health professionals also want to be assured that if they do make an active referral, the recommendation is safe and quality-assured.

What progress have we made?

It is necessary to take a strategic, whole system approach to engaging with the sector. With the support of LCVS, Liverpool CCG is working on the development of a Memorandum of Understanding, signalling a shared commitment to collaboration and innovation in the delivery of public services. The MoU defines and formalises the relationship between the parties and sets out their roles and responsibilities within the partnership.

The Live Well directory is an important part of the infra-structure, centralising and co-ordinating much information about health and wellbeing services in Liverpool, supported by a responsive telephone signposting service.

Some of our ideas and hopes for what's next

We would like to build constructive and transparent relationships with the sector based on mutual respect, shared values and endeavour. We know we need to take into account capacity and capability in the sector.

We need to contribute to the development of building the case for change. We would like to help develop the evidence-base for social prescribing, including improving understanding of the social and the health returns on investment.

We would like to work with the sector to ensure that safeguarding and quality-assurance mechanisms are appropriate and fit for purpose.

We would like to understand whether there is scope for the creation of social prescribing 'trusted provider' networks or collaboratives.

TACKING THE INVERSE CARE LAW AND REACHING VULNERABLE PEOPLE

Why is this important?

Evidence suggests that those with lowest levels of well-being are least likely to be able to access the support and services they need. A strong 'sense of coherence' is thought to be a pre-requisite for ability to self-care and make use of wellbeing assets. Sense of coherence is affected by socio-economic factors, mental health, as well as close and successful social relationships during childhood and adulthood' [xvi] The evidence suggests therefore that one of the challenges for any effective social prescribing system is to make it accessible and relevant to those who need it most.

Socially and economically deprived populations suffer disproportionately from ill-health. Socio-economic factors are 40% of the relative contribution of the determinants of health. Disadvantaged populations are more difficult to engage in existing self-management programmes. In Liverpool, approximately 25% of people have a long-term condition (LTC), 11.5% have more than two LTCs . Those living in areas with the highest deprivation scores will develop co-morbid health conditions approximately 10 years earlier than those living in areas with the lowest deprivation . A recent impact assessment carried out by LCC shows that the people In Liverpool who are currently most likely to be facing severe socio-economic hardship will be of working age, have a LTC, be disabled, a woman, caring for a relative or a young child.

What progress have we made?

The Liverpool Advice on Prescription project (APP) run by Citizens Advice South Liverpool, was set up in 2014 in order to help alleviate poverty and hardship among people with long-term conditions and/or co-morbid mental health problems. It provides a Liverpool-wide social

treatment option for people in contact with primary care, mental health and cancer services. This includes those experiencing financial hardship, housing problems, debt, relationship breakdown, bereavement, domestic abuse, unemployment, social isolation and fuel poverty.

Since the service's inception, health staff have become better at identifying patients with high levels of social and economic needs. Of the 9000 referrals made 2015/16, 70% of people had one or more long-term physical and mental health condition, 30% were living on less than £400 pcm, 60% had not used an advice service before, 20% of clients had severe and enduring mental health difficulties. Households were £2,150 a year better off on average as a result of the referral.

The service works as part of an association of 'trusted partners', who have developed inter-referral protocols. This allows each partner to provide a 'no wrong door' approach for people with several presenting needs.. For example, the IAPT can refer directly to the APP is there is a practical as well as a psychological need. The APP can refer directly to PSS health and well-being services if there is a well-being as well as a practical need. And so on.

Some of our ideas and hopes for what's next

We want to develop a better understanding of the impact of socio-economic factors on the health and wellbeing of people with long-term conditions, mental distress and other illnesses. We have embarked on a study which is expected to report preliminary findings early 2018. This will be important for informing ongoing plans relating to social prescribing as well as clinical service redesign.

We also want to continue to work with front-line staff to build their skills in screening for non-clinical need, and engaging patients in conversations about wellness using tools such as Making Every Contact Count, motivational interviewing and strengths-based approaches

We are interested in the use of outcome measurement tools to monitor improvements in areas such as economic wellbeing, personal dignity and quality of life, and what this data can tell us about the effectiveness of social prescribing interventions, particularly for people who are typically further away from support and services.

We are interested in 'no wrong door' approaches, such as the trusted partners collaborative described above. We would like to understand more about the potential of these types of approaches.

We are interested in services that have the flexibility, within a citywide approach, to anticipate greater levels of need in areas of highest deprivation, but still reach into the pockets of poverty that exist within apparently affluent areas. We want to understand how we can help the sector address this more systematically.

DEVELOPING A POOL OF LINK WORKERS
Why is this important?
A skilled link worker, sometimes also called a care or community navigator is a non-clinically trained person who spends time with a person working out their preferences, strengths and goals. Their role is to motivate and support and this may include accompanying the person of their 'wellness' journey. A link worker may also identify local gaps in meeting specific requirements or interests of an individual, and encourage the creation of new groups and services as appropriate.
What progress have we made?
We see link-workers as one of the most significant gaps in social prescribing provision in Liverpool.
Some of our ideas and hopes for what's next
With willing partners, we would like to explore the viability of a 'pool' of skilled link workers, accessible via referral from primary care, Careline and Healthwatch, expanding in due course to include other access points.

CHECKLIST

Proposals that we are particularly interested in will be those that….	
Support and enhance neighbourhood place-based delivery systems, align with localities	
Aim to increase health equity and health equality across Liverpool	
Take an integrated approach to work-force development	
Enable front-line staff to engage in strengths-based and 'wellness' conversations	
Help tackle the inverse care law	
Make existing health and well-being assets and resources more visible and easier to access for those with a low sense of coherence	
Help create a 'pool' of skilled link workers or care navigators to support and empower those with a low sense of coherence	
Take an integrated approach to delivery of health care, action to address the wider determinants of health, and wellbeing interventions	
Promote collaborative working and seamless service delivery, reduce duplication and fragmentation	
Address safety, governance and quality assurance issues in appropriate ways	
Work with service-users to co-produce and co-design models	
Have the potential to help attract further resources and investment in health and well-being	

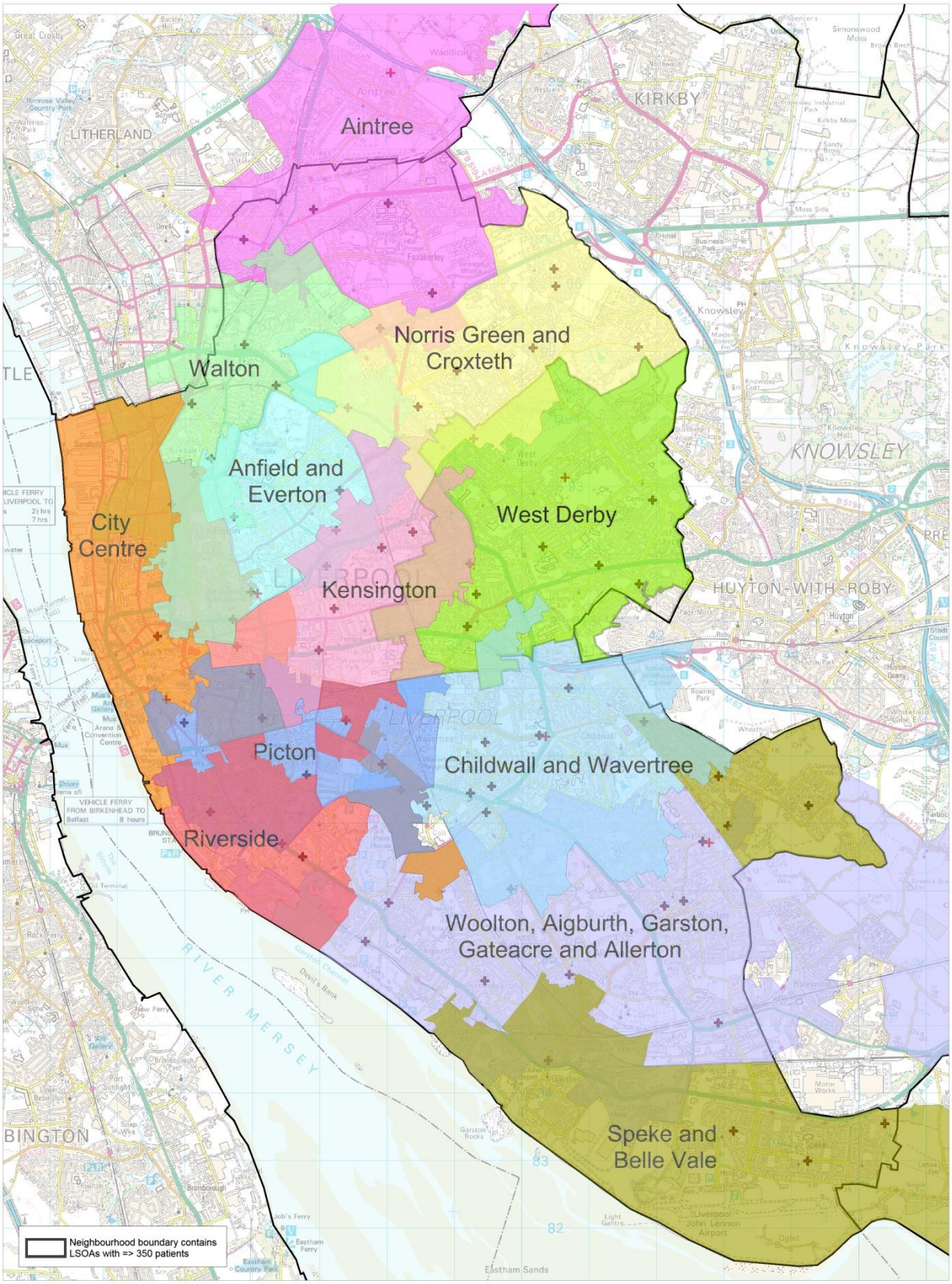
CONCLUSION

The potential benefits of developing a more coherent and cohesive social prescribing system are significant. It could help reduce inappropriate admissions, support stepdown/discharge of services, provide access to a social treatment or well-being offer for those with unmet needs. It could contribute to the production of social capital, and enhance the sustainability and vibrancy of the VCSE sector. Most importantly, for patient and carers it could improve quality of life, reduce social isolation and mental distress, promote self-care and self-actualisation.

The development of a comprehensive ecosystem of health and wellbeing services requires a significant degree of synergy and connectedness across relevant service systems and sectors. For this, the CCG and other key stakeholders will need to work in partnership. .To be effective in addressing the social determinants of health, it will be important to intervene at many levels, simultaneously and consistently[xvii]. If the assets of Liverpool's local wellbeing offer were harnessed as part of a social prescribing system, it would be possible to strengthen resilience at the level of the individual, as well as in community and neighbourhoods.

APPENDIX ONE - Key elements of a social prescribing scheme

Key elements of a social prescribing scheme	
Intended beneficiaries	People with mild, fluctuating or long-term mental health problems and/or other long-term conditions, people suffering from ill-health, vulnerable groups such as people with mild to moderate learning disabilities, people who are socially isolated and/or on low-incomes.
Screening and initial referral	A healthcare, allied health or adult social care professional identifies those who would benefit from a social prescription either through routine enquiry or professional curiosity. They then make an initial referral using an agreed pathway.
The role of the link worker	A skilled link worker, sometimes also called a care or community navigator is a non-clinically trained person who spends time with a person working out their preferences, strengths and goals. Their role is to motivate and support and this may include accompanying the person of their 'wellness' journey. A link worker may also identify local gaps in meeting specific requirements or interests of an individual, and encourage the creation of new groups and services as appropriate.



Liverpool GP Neighbourhoods

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Public Health Liverpool I E: sophie.kelly@liverpool.gov.uk

Liverpool City Council

GLOSSARY

Salutogenesis	Developed as an underpinning theoretical perspective by medical sociologist, Antonovsky in 1979. This approach understands health as being a positive state of wellbeing (salutogenic) rather than seeing health as just about illness and disease (pathogenic). In this context the 'assets' are any factors that support the creation of health and wellbeing - the skills, strengths and resources of individuals, communities and organisations that contribute to health.
Asset-based community development	Unlike needs-based community development, which emphasises risk-factors, problems and concerns, asset-based community development is based on the principle of mobilising individual and community assets. Asset-based approaches are concerned with identifying the protective factors that support health and wellbeing. There is an emphasis on systems leadership, coming together as equals, relationship-building, listening, asking for ideas, everyone to be viewed as an 'actor' not a recipient, making the hidden or invisible, visible. Common tools are asset-maps, time-banks, communities of learning and practice. At the heart of ABCD is a focus on social relationships. ABCD is the practical application of the concept of social capital.
Social Capital	Social capital is a form of economic and cultural capital in which social networks are central, and interactions and transactions are characterised by trust, cooperation and reciprocity. Social capital increases a society's or community's productive potential. People in their community succeed or advance for the common good through associating together. Social capital is conceptualised as a '*store of good-will and obligations generated by social relations'*.
Sense of coherence (SOC)	Antonovsky raised the key question, 'why do some people stay well despite highly stressful situations and significant hardship whilst others succumb to ill health'. Antonovsky argues that the presence or absence of SOC – the belief that life is comprehensible, manageable and meaningful – is fundamental to healthy life outcomes. His essential argument is that salutogenesis depends on experiencing a strong sense of coherence. His research demonstrated that the sense of coherence predicts positive health outcomes.
Health inequalities	Caused by differences in distributions of income, power and resources ie poverty, environmental conditions, early years care and education; economic and food security, control over decisions that affect your life; social support and feeling part of the society in which you live.
	It is a paradox of recent epidemiology that as material inequalities grow, so the pursuit of non-material explanations for health outcomes proliferates. At one level, a greater recognition of psycho-social factors has deepened the understanding of the societal determinants of health, the links between mental and physical health and the social nature of human need. Too often however, psycho-social factors are abstracted from the material

	realities of people's lives and function as an alternative to addressing questions of economic power and privilege and their relationship to the distribution of health. The growing influence of salutogenesis and asset-based approaches is one example of this trend. This paper reflects on the theories of public health that lie behind the discourse of assets, together with some of the reasons for, and consequences of, its popularity and influence.
Inverse care law	In 1971 Julian Tudor Hart, a general practitioner in South Wales, proposed the inverse care law: "The availability of good medical care tends to vary inversely with the need for the population served.
National Social Prescribing Network	Set up to provide support and share practice on social prescribing at a local and national level. https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network In June 2016, NHS England appointed a national clinical champion for social prescribing to advocate for schemes and share lessons from successful social prescribing projects.
Wellness service	A Wellness Service provides support to people in order to improve their health and well-being. The service aims to build people's capacity to live healthy lives by addressing the factors that influence health and wellbeing.
Co-production	Co-production is the contribution of service users to the design and delivery of health and social care services, challenge the notion of them as passive recipients of care.

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