Health and Wellbeing Board
14th September, 2017

HWB JOINT COMMISSIONING GROUP REPORT – HEALTHY LIVES

Responsible Officer
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1. Summary

1.1 This paper serves as an update on the Healthy Lives and includes the first draft of the Social Prescribing business case in Appendix A.

1.2 The business case highlights key achievements of Healthy Lives. In brief these are:

- **Safe and Well visits** - Pilot and county area roll out of Fire Service Safe and Well visits. This model is an expansion of the Fire Service Home Safety Check to include the identification of health and wellbeing issues including, home warmth, falls, lifestyle choices (smoking, physical activity), and isolation and loneliness (including carers);
- **Social Prescribing pilot** – Implemented social prescribing in the Oswestry area with referrals from 4 GP practices, Adult Social Care, the VCS, Family Matters, and working towards referrals from mental health services. There are approximately 18 providers offering approximately 50 interventions;
- **Diabetes Prevention protocol** – Pre-diabetes protocol agreed and being tested in 2 demonstrator sites, Shrewsbury and Oswestry. The protocol involves searching GP records for pre-diabetics and offering a 2.5 hour information session along with advice, guidance and information about accessing community support. The demonstrator in Oswestry is linked to Social Prescribing and those who attend the sessions there are offered Social Prescribing to support non clinical approaches to improving lifestyle and addressing social issues; this programme will link with the National Diabetes Prevention Programme in 2018/19;
- **All age Carers Strategy** – The carers strategy has been agreed and is linked to Social Prescribing, Safe and Well visits and dementia companions. The strategy is focussed on working with partners to identify carers and to connect carers to the support they need, as well as ensure that services take carers needs into consideration (eg. Hospital discharge processes);
- **Dementia Companions** – agreement has been reached to implement dementia companions in 2 demonstrator sites (Oswestry and Ludlow), and to link the dementia companions to social prescribing pilot sites;
- **Mental Health** – linking mental health to Social Prescribing to ensure a person centred approach can be delivered through social prescribing; development of a mental health needs assessment for Shropshire and strategy during 17/18; development of a system approach to developing services to support people with mental health needs through a Mental Health Partnership Board;

- **Process for programme evaluation** – contracted with Westminster University to evaluate the Social Prescribing programme.

1.3 The Business Case is still in draft form, but is being shared for comments feedback and endorsement. The Business case seeks to articulate how we can support the development and scaling up of Social Prescribing throughout Shropshire and highlights the opportunity for closer working between Adult Services Let's Talk Local, Community Care Coordinators and Social Prescribing. Following a Shropshire CCG There are a number of geographical areas and GP practices that are keen to progress with the development of Social Prescribing.

1.4 Key considerations include:

a) Use the step by step checklist (developed in the Oswestry Social Prescribing demonstrator site) and apply to those primary care teams/localities interested
b) Identification of resources to support the expansion of the model across Shropshire.
c) Produce a paper outlining the model and endorsement through respective boards of the CCG and the Council (based on the Care Navigation Paper)
d) Workforce mapping and agreement for the model
e) Development of a reference group to sense check the model and identification of leads from the CCG and the council to support the workforce change management programme
f) Trial the new way of working in Bishops Castle to ensure key learning takes place
g) Continue to work with the voluntary sector to support their leadership role
h) Continue to work with existing networks such as the Compassionate Communities and wider voluntary sector groups to ensure they are part of the solution.
i) Identify a site suitable to include Children's Services to pilot joint working
j) Continue to learn from the existing model in Oswestry
k) Learn from the progress being made through the formal evaluation being carried out on the Social Prescribing Demonstrator site.

1.5 As a reminder - **Healthy Lives** focuses on taking a whole system approach to reducing demand on services and relies on working together in partnership to deliver activity; it works across organisations and partnership groups and supports integration across health and care as set out in the Health and Wellbeing Strategy and is an integral component of the STP Out of Hospital Workstream. The Delivery Group (now the Joint Commissioning Group) has made a report on Healthy Lives to all recent HWBBs.

1.6 The HWBB Delivery Group has renewed its terms of reference ToR) and is now the HWBB Joint Commissioning Group. Please see Appendix B for the Final Draft ToR.

2. Recommendations

2.1 To discuss and support the development of Healthy Lives and the Social Prescribing Business Case;
2.2 To discuss and endorse the scaling up of Social Prescribing across Shropshire.
2.3 To agree the updated Terms of Reference of the Joint Commissioning Group.

3. **Risk Assessment and Opportunities Appraisal**

3.1. (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

3.2. The HWB Strategy requires that the health and care system work to reduce inequalities in Shropshire. All decisions and discussions by the Board must take into account reducing inequalities.

3.3. The component parts of Healthy Lives and other system planning have been done by engaging with stakeholders, service users, and patients. This has been done in a variety of ways including through patient groups, focus groups, ethnographic research. The STP plan as a whole will require engagement and consultation in the future.

4. **Financial Implications**

4.1 There are no direct financial implications as a result of this paper, for decision. However, the prevention element of system planning will require financial input and the Board is asked to endorse investment in prevention activity. As well, integration and transformation processes may impact on budgets and service delivery.

5. **Background**

5.1 Healthy Lives is part of system plan through the Better Care Fund and the STP and is made up of the following programmes – 3 HWB Strategy Exemplars highlighted in bold:

- Social Prescribing
- Falls Prevention,
- **CVD & Healthy Weight and Diabetes Prevention,**
- **Carers**/Dementia/UTIs,
- **Mental Health**,
- Future Planning & Housing,
- COPD/ Respiratory & Safe and Well
- Additional developments include prevention work in relation to Musculoskeletal health (MSK)

5.2 Healthy Lives is supported by a Steering Group that reports to the HWB Joint Commissioning Group and the Out of Hospital Programme Board.

5.3 The approach of Healthy lives has been endorsed by Optimity review (included in the May HWBB report) with recognition of population health programmes, a framework for population health (Healthy Lives) and robust project documentation, data on population health need, and individual programmes of work (including social prescribing) and governance.

5.4 In addition to the above highlighted achievements:

5.4.1 Shropshire is leading the regional Midlands and East Social Prescribing Network. More information regarding the regional network and the first regional social prescribing event can be found here.

5.4.2 The **Falls** Community Postural Stability Instructors (PSI) programme is progressing; Energize has won the contract to deliver this service that will see the development of more support for people in their communities in Shropshire, to keep themselves from falling and improving musculoskeletal health as people age.

5.5 The prevention activity of Healthy Lives is included in the STP 90 Day Plan for Shropshire Out of Hospital work.

6. Additional Information

6.1. Reports regarding Healthy Lives have been made regularly to the HWBB which can be found here.

7. Conclusions

N/A

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) **Previous HWBB reports: https://shropshire.gov.uk/committee-services/ieListMeetings.aspx?CommitteeId=217**
Cabinet Member (Portfolio Holder) **Cllr Lee Chapman**
Local Member n/a
Appendices **Appendix A – Social Prescribing Business Case** **Appendix B – Joint Commissioning Group Terms of Reference**

Appendix A

Healthy Lives – Social Prescribing Across Shropshire - DRAFT

1. Purpose

The purpose of this business case is to outline the proposal for the expansion of the current Healthy Lives programme (in particular Social Prescribing) across Shropshire. This includes the resources required to expand the programme and also includes a description of what has been achieved so far, the vision, outcomes, design approach and stages of delivery, with proposals for the future implementation programme including the processes required to support delivery.
This will include update on progress for:

- Developing the Social Prescribing model to further integrate the roles of Let's Talk Local and the Community Care Coordinators as part of a model of Care Navigation;
- Working with primary care to further develop chronic disease protocols for diabetes and cardiovascular disease prevention, mental health, support for carers, and avoidance of carer breakdown.
- Rolling out Social Prescribing and a new model of Care Navigation across the county to connect people to non-clinical support they need in their communities.

2. Introduction

Shropshire Council with its partners have an ambition to support Shropshire people to become the healthiest and most fulfilled in England. To support this aim, local leaders of health and care organisations are shifting their focus from 'fixing disease' towards promoting and maintaining health; recognising there are no easy solutions to this but working collectively to identify and test out solutions.

The Healthy Lives Programme combines the key prevention deliverables of the Better Care Fund, Shropshire CCG, Public Health, NHS providers and the voluntary sector to take a whole system approach to reducing demand on services and improving health & wellbeing. One of the central programmes within the Healthy Lives Framework is the social prescribing programme which provides a solution to the increasing demand that both adult social care and primary care is experiencing.

At the system level, planning is being done through the Sustainability and Transformation Plan (STP). The Shropshire Neighbourhoods programme (also known as Out of Hospital programme) will use place based planning to reduce demand on acute and social care services. Healthy lives is part of this programme that works as a partnership across key agencies who are committed to a model that identifies risk, supports integration and uses an asset based approach. The programme draws together local community-based programmes within adult social care, children's services, the CCG, the local hospice, public health (Help2Change behaviour change services) and community development teams in the council to:

1. 1. Building resilient communities and developing social action
2. Developing whole population prevention by linking community and clinical work – involving identification of risk and social prescribing
3. Designing and delivering integrated health and social care community services that provide alternatives to hospital care for mild, moderate and severe long term conditions; rapid access urgent and crisis care
4. Designing and delivering end-to-end community pathways that effectively interface community health, adult social care and children's services with secondary care (with a focus on frail elderly and mental health)

3. Background

Shropshire demographic and health profile

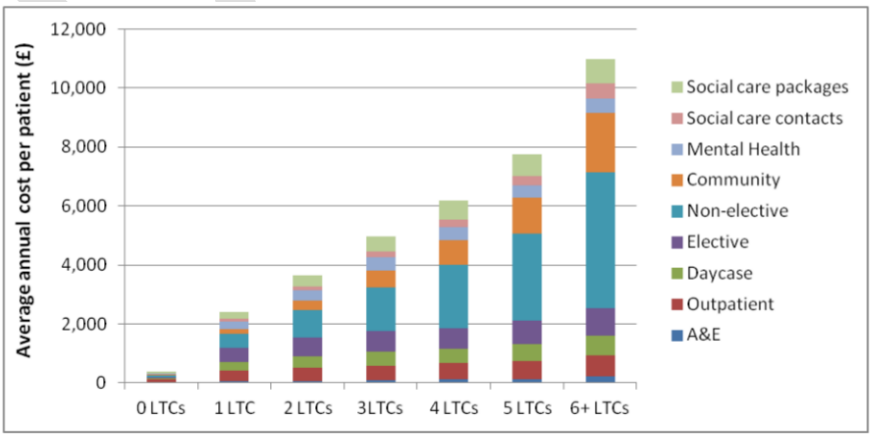
The Shropshire population of 310,000 are mainly white British, with a high proportion of over 50 year olds that is projected to increase significantly in the next decade. Health issues arise from the ageing population, significant lifestyle risk factors, long term conditions, rural inequalities in health and respiratory issues for over 65 and 0-5 year olds. Whilst the county is fairly affluent there are areas of deprivation and the rurality means access to services can be difficult. Unemployment is low, but despite significant employment in the public sector, Shropshire can be described as a low wage economy; consequently the wider determinants of health including education, access to employment and housing significant issues to consider when developing services that support good physical and mental health.

In addition to challenges we face due to an ageing population, Shropshire has seen a rise in the number of people with long term health problems due to illnesses such as diabetes and linked to high levels of obesity.

Most of these long term conditions and illnesses, which are the cause of premature death (before the age of 75 years), are preventable and simple changes to our lifestyle can make a significant difference in reducing the risk of developing, for example, heart or lung disease. A number of key factors such as increasing the level of exercise we take, reducing the amount of food we eat, including controlling the sugar content of our diet and stopping smoking cigarettes can all make a significant difference in reducing our risk of chronic illness or premature death.

Long term conditions (LTCs) carry a multitude of issues for people, from understanding how to manage their conditions to receiving holistic support that takes into account the person, rather than the condition(s). There is significant strain and cost to the system to address long term conditions, as highlighted in the graph below.

Chart 1: Annual cost of long term conditions per patient



Changing how we working with people to prevent and manage LTCs will require a significant sea change in the way we approach keeping people well and will include the delivery and expansion of 'prevention' programmes.

One solution is to scale up the place based population model for Healthy Lives and specifically the social prescribing programme as this provides opportunities to offer non clinical interventions based on behaviour change and which impact on the social needs of residents. In addition it provides an opportunity to bring together the key elements of existing effective practice such as Community and Care Co-ordinators, Behaviour Change programmes and the Let's Talk Local models, Community Enablement Team, Help2Change Behaviour Change Teams, the Community Enablement Team and grant funded third sector programmes and services This would supplement the existing hospice led community based Compassionate Communities model (Co-Co) and other community led projects.

Local services have made strides in transformation, for example a new model of delivering adult and children's services in Shropshire. This programme works to draw together service delivery and people to support a new model of health and care that is owned across the system and by service users and the wider public.

Case for change

As a system we are working together to solve a number of key issues:

- **Deficit reduction**

The health and care system in Shropshire must work to reduce its mounting deficit. Simply put, we are unable to balance our books across the health and care service in the county. The current predicted deficit by 2020/21 is approximately £120m (across health and care), and until we make some significant changes, this will continue to grow.

Service users/ patients too often have a poor experience of care, particularly when needing to cross organisational boundaries

There is a pressing need for integrated working which improves the quality, co-ordination, collaboration and consistency of care delivered across the whole system both through the placement of integrated teams, but also at a more basic level through effective networking and communication across the whole system.

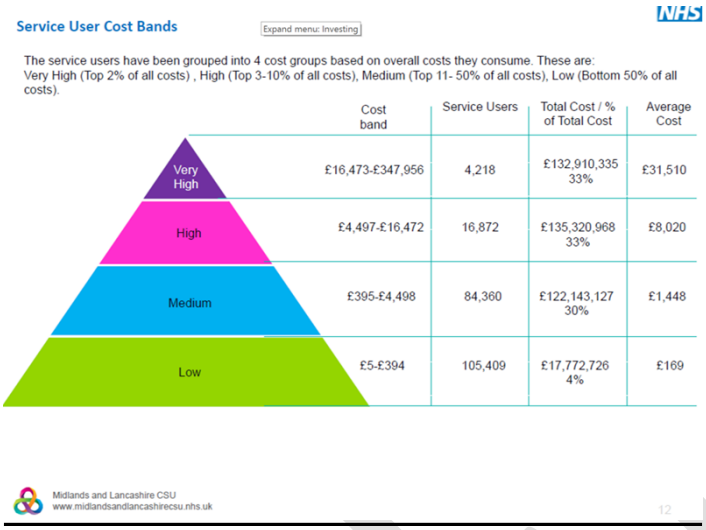
- **Access to services has been articulated as a key priority for our communities**

Service users have told us that access to services is a key priority. Barriers to accessing services have included lack of information about services and where to access them, waiting times, and services not working in a joined up way (meaning that service users are passed from one service to another).

- **Capacity across primary, secondary healthcare and social care is extremely limited as resources are directed towards those people with multiple high level needs**

Currently a small proportion of the population utilising a large proportion of spend (the graph below highlights 10% of the population utilising 2/3s of the spend.

Diagram 2: Service user cost by banding



As a system these challenges are demonstrated through specific symptoms that are facing the NHS, social care and many members of the population who have long term health needs.

These include:-

- Increasing pressures on GP practices – attendances and increasing complexity of patient needs
- Increasing pressures on hospital services
- Increasing pressures on adult social care services
- Growing burden of disease in relation to long term conditions
- Growing burden of mental health
- Reduction in resources across the public sector
- Growing health inequalities

The most recent research highlights that primary care is seeing increasing numbers of patients presenting with more complex health conditions and including social needs which many GP's do not feel able to deal with. A recent report from the National CAB found that increasingly patients are seeking non-medical support from GP's which results in a greater proportion of time given to social concerns. These coupled with increasing number of patient attendances and increasing strategic expectations is resulting in over-pressurised and over-burdened primary care. Other services in particular Adult Social Care are also reporting similar challenges.

One of the responses to this in some areas has been the growing interest in and the practical development of social prescribing projects whereby GP's have recognised the need to work differently to address these challenges. This has resulted in various responses, in different areas with some Social Prescribing formally commissioned by CCG's and/or Local Authorities and in other areas small scale projects in GP practices have flourished either in collaboration with the voluntary sector or through the creation of a primary care support scheme. Other projects have grown organically often championed by forward thinking GP's or community leaders with backgrounds and understanding in community development approaches and multi-agency working.

Nationally interest is growing in this area with the creation of a national network and the commissioning of a national evidence based review by NHS England. The recently launched document outlines some key insights for commissioners on how to co-produce a high quality social prescribing programme that makes the best use of local resources and reflects the latest thinking about what will work.

There is evidence from exemplar sites that social prescribing can reduce demand on health and care services, places like Halton, Gloucester and Rotherham have make significant strides in improving health, and reducing costs, through Social Prescribing. Please find more information in **Appendix A**.

What has Healthy Lives Delivered so far?

The Prevention Programme, **Healthy Lives**, draws together current prevention activity (from Public Health, the Health and Wellbeing Board, Better Care Fund, Adult Social Care, Shropshire CCG and Provider partners), as well as development of new prevention activity, into one programme that focuses on taking a whole system approach to reducing demand on services. This programme relies on working together in partnership and with our communities to improve Shropshire people's health and wellbeing.

The Healthy Lives Programme has been working now for approximately 18 months and has delivered some key prevention work. Social Prescribing is the cornerstone of this work. Key deliverables have included:

- **Safe and Well visits** - Pilot and county area roll out of Fire Service Safe and Well visits. This model is an expansion of the Fire Service Home Safety Check to include the identification of health and wellbeing issues including, home warmth, falls, lifestyle choices (smoking, physical activity), and isolation and loneliness (including carers);
- **Social Prescribing pilot** – Implemented social prescribing in the Oswestry area with referrals from 4 GP practices, Adult Social Care, the VCS, Family Matters, and working towards referrals from mental health services. There are approximately 17 providers offering approximately 50 interventions;
- **Diabetes Prevention protocol** – Pre-diabetes protocol agreed and being tested in 2 demonstrator sites, Shrewsbury and Oswestry. The protocol involves searching GP records for pre-diabetics and offering a 2.5 hour information session along with advice, guidance and information about accessing community support. The demonstrator in Oswestry is linked to Social Prescribing and those who attend the sessions there are offered Social Prescribing to support non clinical approaches to improving lifestyle and addressing social issues;
- **All age Carers Strategy** – The carers strategy has been agreed and is linked to Social Prescribing, Safe and Well visits and dementia companions. The strategy is focussed on working with partners to identify carers and to connect carers to the support they need, as well as ensure that services take carers needs into consideration (eg. Hospital discharge processes);
- **Dementia Companions** – agreement has been reached to implement dementia companions in 2 demonstrator sites (Oswestry and Ludlow), and to link the dementia companions to social prescribing pilot sites;
- **Mental Health** – linking mental health to Social Prescribing to ensure a person centred approach can be delivered through social prescribing; development of a mental health needs assessment for Shropshire; development of a system approach to developing services to support people with mental health needs through a Mental Health Partnership Board;
- **Process for programme evaluation** – contracted with Westminster University to evaluate the Social Prescribing programme.

4. Developing the Shropshire Social Prescribing Model

This section includes:

- **What is social prescribing?**
- **Brief description of how we developed the Shropshire model**
- **A programme approach**
- **What Social Prescribing is delivering now in Shropshire**
- **What health and wellbeing concerns are we focussing on?**
- **What more could we achieve?**

What is Social Prescribing?

Social prescribing provides GPs and other accredited healthcare providers with a formal referral pathway into these health-promoting community assets, targeting patients with social or behavioural factors that pose a risk to their health. Illustrated in the diagram below. The programme offers more than signposting, as it includes support from an advisor, along with data recording and governance. The community interventions are quality assured, with outcomes reported back to the prescriber:

People expected to benefit from social prescribing include:

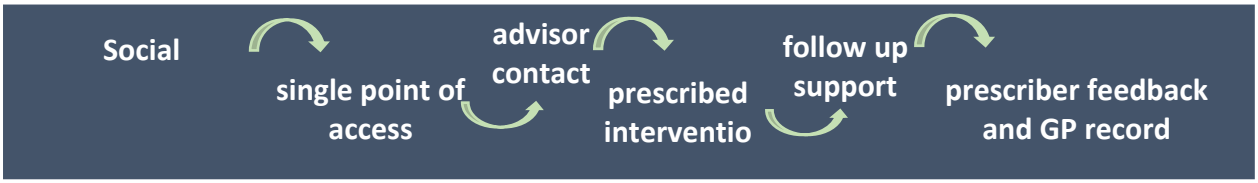
- Patients with long term conditions e.g. diabetes, COPD, MSK disease
- Patients with low-level mental health problems
- Patients with high CVD risk
- Patients with risk behaviours e.g. smoking, alcohol
- Frequent attenders in general practice
- People who are unemployed or on low income
- People living in poor housing e.g. cold homes
- People who are lonely and socially isolated
- People with significant caring responsibilities

By addressing the wider determinants of health, and targeting patients most at risk, social prescribing helps to reduce inequalities in health.

How have we developed a model in Shropshire?

In brief, the Social Prescribing model for Shropshire has been developed through a 'design' and collaborative approach of the Healthy Lives Programme. The programme has used national and international research (**Please see Appendix A for national examples and return on investment**), understood the wealth of community and Voluntary Sector support and the good will of many in Shropshire to support the health and wellbeing of people, and tested out new ways of working in order to develop the model.

A demonstrator site has been established in Oswestry to help contribute toward the growing evidence of the impact of social prescribing and work out the practicalities of running a local service. A simple illustration below shows how the pathway operates.



Evaluation will take into account specific programmes including diabetes, cardiovascular disease and social isolation. Pseudonymised data from individual patient records will be aggregated to determine change across population groups and metrics include:-

GP	GP appointments, nurse appointments, community care coordinator contacts
Hospital	A&E attendances, unplanned hospital admission
Mental Health	contact with mental health providers – CMHT, hospital admission
Social Care	Social care support packages
Wellbeing	feeling positive, self-care, managing symptoms, work/ volunteering/ accessing training, money (benefits), family/ friends, housing (using evidence based scales)

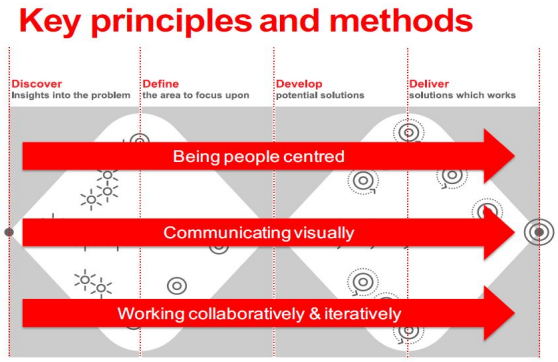
Whilst the formal evaluation has yet to be completed the programme has captured early learning on how people can be supported by Healthy Lives (**see appendix C for patient stories and Appendix F highlights the data and measures being used**). The programme has required commitment, energy, and a significant amount of investment in time by partner organisations to deliver. The programme will continue to grow by connecting people, connecting services and influencing transformation but it also needs to be included in investment plans for the healthcare system.

A Programme Approach

For the Healthy Lives Programme, a programme methodology has been used throughout, based on the Design Council principles. Each programme area of Healthy Lives has developed a range of solutions using, where possible, a 'double diamond' approach to considering the problem: the approach begins with a wide focus to gain insights and ethnographic research into the problem; it is then refined into a smaller area of focus for development; before returning to a wider focus in order to develop potential solutions. Through trial and learning, this produces solutions that can be delivered.

The approach is people focussed, working to understand the population, communities and the issues facing the population. It requires a good understanding of how the problem affects people and provides a solid foundation for transformation planning.

Diagram 4 – the double diamond



The programme approach requires appropriate documentation as part of each development area including PiDs, logic models, project trackers, and risk registers; and have implemented an agile working process. A staged approach has been used to establish the Social Prescribing pilot/ demonstrator site which is now live and operational. Further information on all of the programme documentation is available.

Additionally the model has built on existing assets both within teams but also recognised and respected the input from local good practice and community based resources. Some of this is delivered through the existing public sector and is classified as a service and other things have developed organically over a period of time led by third sector, charities or local leaders. This includes:-

- A dedicated behaviour change team in place through the Help2Change team
- Changing model for community health trust with re-design of clinical pathways with a focus on prevention
- Community and Care Co-ordination project in 42/43 practices
- Compassionate Communities led by the local Severn Hospice
- Resilient Communities through the Community Development Teams in the Council
- Let's Talk Local Hubs developed through adult social care
- Varied third sector and locally developed groups and initiatives in many areas
- Good multi agency working and positive working relationships with organisations such as Fire and Rescue Services

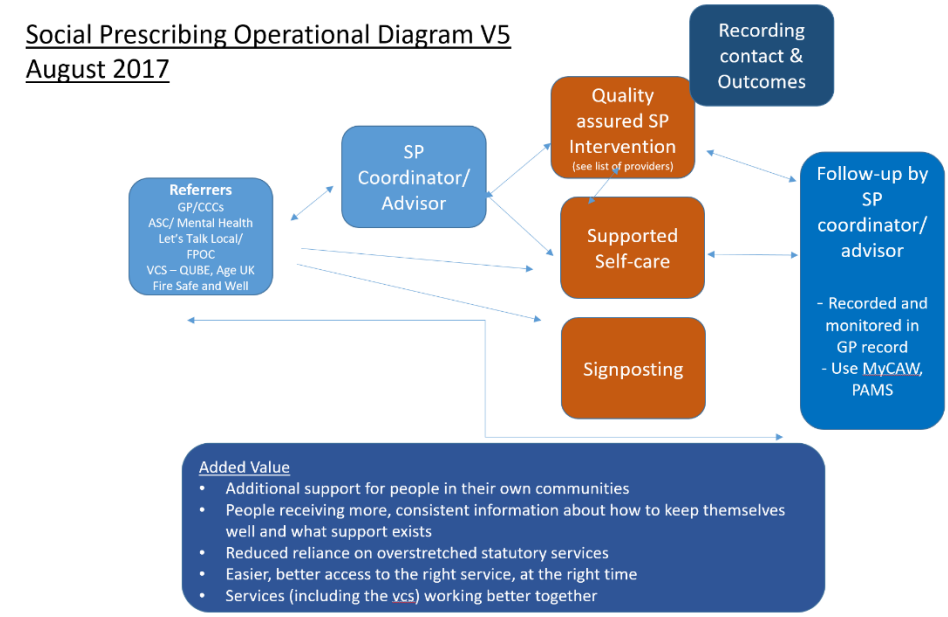
A staged approach has been used to establish the pilot/ demonstrator site and details of each stage can be found in **Appendix B,** which highlights the activity and required resource and in brief includes:

- **Stage 1** – understanding the area
- **Stage 2** – Engaging the local stakeholders
- **Stage 3** – Identify need in relation to demand and work with local referrers, those delivering interventions and build the project team including a dedicated co-ordinator and an enhanced social prescriber. Develop a community directory and agree the measures
- **Stage 4** – Go live, receive referrals and implement agile working
- **Stage 5** – Evaluate the programme (external scrutiny) including the numbers of cases, the outcomes for the individuals and the cost of the intervention. Cost of the interventions will be completed locally
- **Stage 6** – Agree funding, build contract, and commission providers

What does Social Prescribing actually do now in our demonstrator site?

In Oswestry, Social Prescribing is working with the Oswestry GP practice cluster, Adult Social Care, Mental Health teams, the Voluntary and Community sectors who refer people who they think would benefit from social prescribing support. A structured referral pathway has been developed along with guidance to demonstrate who would benefit from social prescribing. As described above, those who are referred are provided one-to-one sessions with a Social Prescribing advisor to understand the key health, wellbeing and social issues that they may be facing. The advisor works with the person to develop an action plan and the advisor makes referrals to appropriate service providers. Please see diagram below for an illustration of how this works.

In Oswestry there are currently 20 quality assured providers offering 50 interventions. The interventions are recorded and the providers return attendance and other appropriate information to the advisor. To date 37 people have been referred to Social Prescribing – **please see Appendix C for some of their stories.**



What health and wellbeing concerns are we focussing on?

Social Prescribing demonstrator has focussed on referrals of people with:

- One or more long term conditions
- Pre-Diabetes
- Frequent attenders at GP practices
- Social isolation and loneliness
- Mild to moderate mental health issues

Areas that are in development include:

- Falls
- Musculoskeletal health
- Cardio-vascular disease

Please see Appendix D for the evidence base for prevention work on these key health and wellbeing issues.

What more could Social Prescribing do?

Public Health intelligence work is currently being carried out to assess the impact of this work, however we believe that SP will have significant impact on:

- Major changes for individual health and wellbeing, particularly those with LTCs
- Support people with diabetes, pre-diabetes, CVD
- Reduce social isolation and loneliness
- Improve mental health
- Reduce pain
- Significantly reduce falls
- Achieve
- Support primary care capacity
- Reducing unplanned hospital admissions
- **See Appendix D for further evidence of potential impact**

5. Our Proposal: What we want to do next – A Community Centred Locality Model

Building on lessons from the demonstrator site, we want to scale up the model of Social Prescribing across the county. To do this we would like to do more to draw together the role of Social Prescribing with Community Care Coordinators and ASC's Let's Talk Local role into one Care Navigation model. We would like this model to integrate the assets and community services that are already delivering support to people in their communities; to provide integrated support and better understanding of what is available for people.
We feel that this will build on the current vision of transformation in Shropshire, through the Out of Hospital work stream that is developing a locality one team approach; working across the system, with regular people, with GPs, with Adult and Children's Services, and NHS providers, to support individuals, families and communities to take more control over their health and well-being. This model is a bolder and braver model of working that will result in enduring change and transformation across the system. This new model will be influenced by and driven by the needs of the community and makes a concrete difference to people's lives.
We are building on an asset based locality model led by Shropshire Council and which makes the best use of the assets that already exist within localities. The approach now adopted by the local NHS provider and the CCG recognises the value and impact of a stronger more collective public sector response. In addition the contribution and value that the third sector and the wider community brings is crucial given the significant changes required to really change the current system.
All too often we think we need something new to replace an existing service or 'plug a gap' rather than looking at what we already have. Our approach is to work with what we have, change the parameters of that so that we support a self-care approach which draws on the capabilities of local people and local teams.

Central to the development of the work is the integration of the core functions of a number of teams which are complementary and support the development of a locality based model of prevention which recognises the uniqueness that each service area brings. This includes the following:-

- Community Enablement Team
- Let's Talk Local Teams
- Community Care Coordinators
- Social Prescribers
- Help2Change Team
- The Voluntary and Community Sector

Please see **Appendix E** for a more full description of these services and their unique selling points.

What will the new model look like?

The Care Navigation and Prevention Model may look slightly differently depending on the community they are working in due to the services and facilities available. Whilst there is no universal definition of care navigation or a 'care navigator'; navigation at its heart is a coordination process and key ingredient to achieving integrated care provision to improve health and well-being
The model will work within Primary Care and across services (including social care) to support people access the right services in their community. It will support the proactive approach to identifying frailty, vulnerability and inequality and support people to improved health and wellbeing working with and utilizing the existing assets within the communities in Shropshire, to support people to find the best solution to help their health and wellbeing.
The model will draw together current functions within community care coordinators, let's talk local and social prescribing and will support new community services models of working.
The model will draw together current programmes that include community care coordinators, let's talk local and social prescribing. The model will work with the assets that exist within the

communities in Shropshire, to support people to find the best solution to help their health and wellbeing.
The model will support the proactive approach to identifying frailty, vulnerability and inequality and support people to improved health and wellbeing**.**

The Combined Impact of the Above

To meet the challenges outlined in the above sections new ways of working are needed which maximise the skills expertise and roles of employed practitioners but which also draw on and working alongside the extensive experience of the third sector.

In addition working with the community itself and residents on their needs recognising their capabilities and assets has been shown to demonstrate benefits and long term change. This is apparent in the locally derived community development model led by Severn Hospice and local GP's in direct collaboration with local residents. Working more collaboratively on a prevention agenda but supporting the wider health system including primary and secondary care will assist that sea change required.

Our approach will be about developing new ways of working that provide more 'rounded' support based on health and wellbeing needs rather than addressing physical health conditions. It is not our intention to recruit and train new workers but to bring different roles from different teams to work more closely together developing new ways of working that support wider health and wellbeing needs of people supporting and developing their capabilities rather than identifying solutions. This would mean working with teams and practitioners to adapt and change rather than recruitment of new roles.

The Benefits

Benefits to the System

- Increased engagement of and involvement of local residents in their own care decisions
- Ensure more people remain independent at home
- Avoidance of permanent admissions to residential and nursing homes
- Reduction of emergency admissions to hospitals
- Greater capacity across the system driven by population health need but working on capabilities of individuals
- Additional resource for those rural areas with more limited provision
- Strengthening of existing programmes which might be vulnerable
- Supports the local ambition to the clear ambition to work proactively to develop an integrated care navigation model going forward

Benefits to the Community and Local People

- Greater awareness and understanding of the different roles and resources that practitioners can bring resulting in a better offer for residents
- Increased ability of the practitioners to work differently with residents on a solution based model Residents with long term conditions will be offered behaviour change support to improve quality of life and wellness
- Support for patients to navigate the complex web of health, social and community care systems
- The coordination and promotion of agreed local web and app-based portals that can provide self-help and self-management resources

- Time to listen and engage people in a way that works for them
- Access to and opportunity to resourceful community members who can prolem solve and develop projects
- Residents with long term conditions will be offered additional options to improve health and influence service development

Benefits to Primary Care, Adult Social Care

- Additional capacity for primary care and adult social care
- Non clinical solutions offered to more people with existing medical conditions or to those people with social needs (ranging through debt advice to mental health support to physical activity to creative arts therapy
- Changing practice of existing roles into 'a community based' approach
- Wider access to Let's Talk Local discussions or forums
- A more consistent approach to training around behaviour change, and Healthy Conversations
- Offer of behavioural change and motivational support to compliment existing workforces
- Better use of existing resources that are currently in different organisations but which are fulfilling similar functions
- More streamlined information points and directories
- Increased capacity and resource for the individual teams struggling to meet demand

Benefits to the Third Sector

- Extended role for the third sector working more closely with health and care systems
- Support for the third sector to develop quality assurance processes for commissioning
- Additional services working more collaboratively with health colleagues such as housing support, benefits advice and mental health
- A wider range of voluntary sector providers commissioned to support health and wellbeing needs
- Value of the third sector identified through impact and evaluation
- Third sector offer an alternative approach to the public sector including arts, creative approaches and cultural opportunities
- Third sector are recognised as an essential part of the solution to long term system change

6. Timeline and resources needed to roll out the Social Prescribing Model

How will it be delivered?

- Through Community Based Locality Teams working in a multi-practitioner team around a single geography and with specific groups of patients/residents
- Working on a proactive model identifying through risk stratification the health and care needs of individuals making sure that the right support is provided in the best place
- Using an asset based approach which builds on the existing strengths and capabilities of patients, their families and carers, their local network or the wider community

Timescales for Roll out

September – November 2017

- Expansion of the programme to new areas/practices – Albrighton, Bishops Castle, Sevenfields, exploratory discussions with Market Drayton and Whitchurch
- Evaluation of the Oswestry demonstrator site
- Develop the dataset for the evaluation (to be used for future shaping of the programme)

- Workforce Mapping and agreement of the model
- Papers on the integration of the teams to the respective board for the CCG and the council
- Reference group developed and key officers identified from the CCG and the council to support the workforce change management programme
- Expand the use of MYCAW to adult social care staff
- Work with Children's Services to ensure they are part of the roll out
- Trial new ways of working in Bishops Castle – including integrated teams (Social Prescribing, CET, Community and Care Co-ordinators, Co-Co and community NHS Trust)
- Development of the offer for the creative arts
- Delivery of the workshop for the voluntary sector in Oswestry to feedback on progress and support evaluation

December – February 2018

- Expand the model to additional areas and practices
- Use interim findings from the mid-term evaluation project to inform the future development of the programme

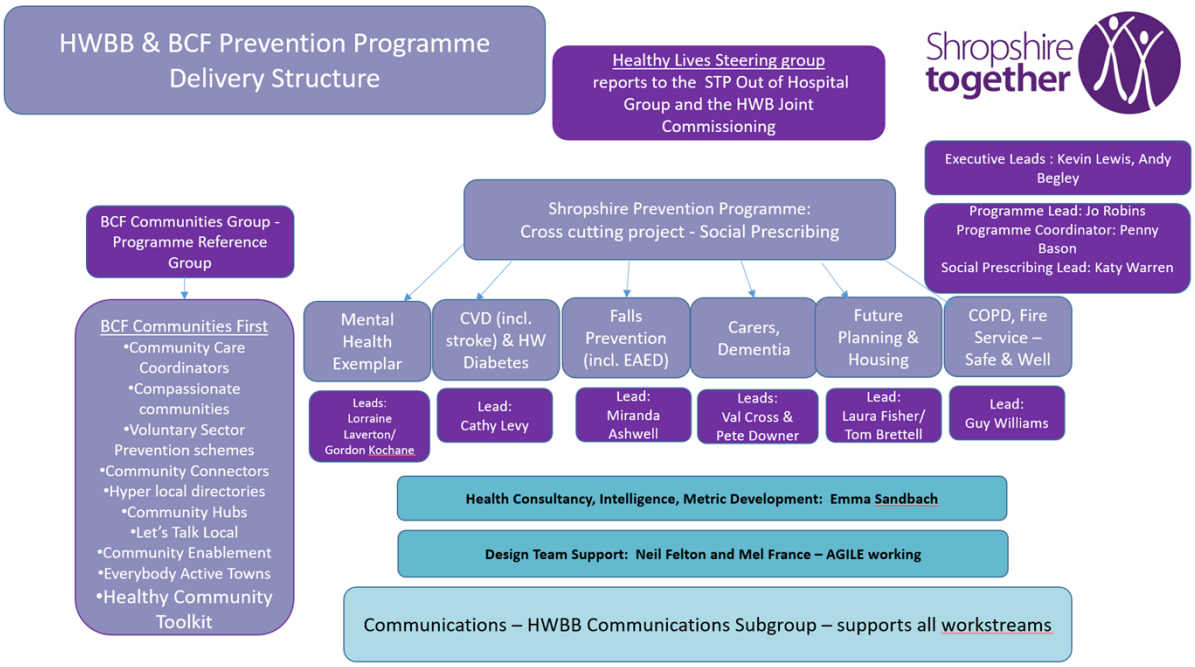
7. Support for the Model – Resource Requirement

Based on the model in the Oswestry area (which has been tried and tested) the following would be required to roll out across Shropshire:-

1. Three WTE, locality co-ordinators (based on the role currently being delivered in the Oswestry demonstrator site).
2. Dedicated support funding for the third sector to support their capacity to deliver a similar function as used by the QUBE in Oswestry – they have been able to co-ordinate and work with local voluntary sector providers to ensure they are quality assured for commissioning purposes.
3. Development of five WTE, Enhanced Social Prescribing roles (using existing resources across the ASC system).
4. A .5 WTE communications lead to ensure a more consistent approach to marketing and promotion of the programme
5. Continued integration support from the PH department
6. PH Consultant support from the PH department

8. Governance

The Social Prescribing Programme is overseen by the Healthy Lives Steering group which consists of representatives from the Council, (including commissioners, and the design team) NHS (CCG), (Better Care Lead and Locality Managers) Fire and Rescue Service. It is chaired by public health and in turn reports to the Joint Commissioning Group and the STP Neighbourhoods Group and the Health and Wellbeing Board. Structure below –



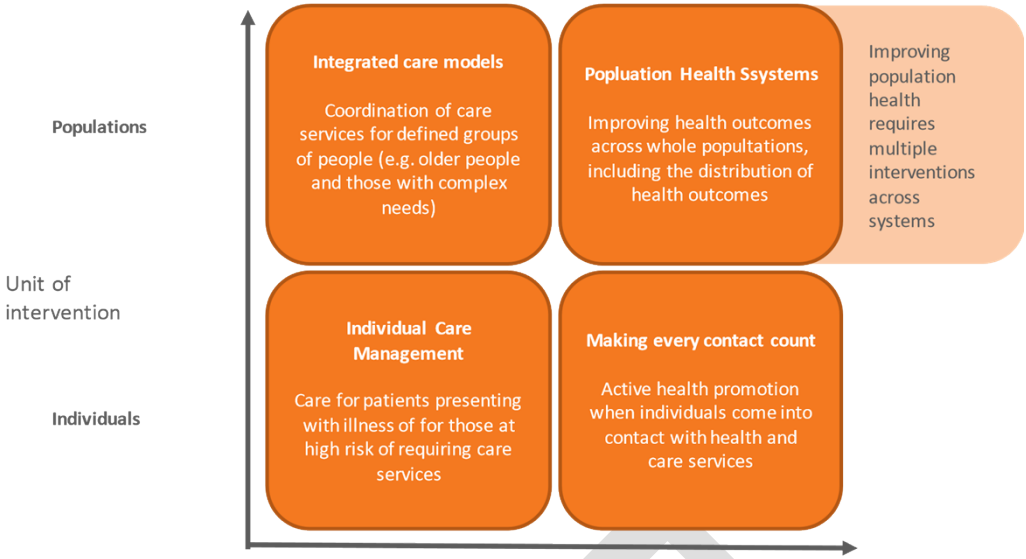
9. Supporting the system wide vision

The Social Prescribing Model, and the Wider the Healthy Lives Programme proposals support the vision of the Health and Wellbeing Board and the wider health and care economy.

The HWBB provides our vision: **to be the healthiest, most fulfilled people in the country**. To achieve this goal we need to deliver place-based integrated health and care models that support independence into older age for the majority of our population. Integrated technology and data moving freely across our system will support the placed-based delivery models, backed up by a one public estate philosophy which maximises the use of public assets to the full. These transformational changes will support the investment shift into prevention, maintenance, early detection and treatment and allow a shrinking of secondary care provision.

> *The transformation required is **not** a mere shifting of activity from acute providers to other place-based community services including general practice, but is a fundamental shift in thinking and in the ways of working to improve population health by working as a system and not constrained by organisational boundaries. The Council articulated this as a move to a health and wellness service rather than illness service, the CCG articulated a need to deliver clinical and financial sustainability by sharing collective responsibility for health and care outcomes, and the community provider stated they want to deliver transformed services within a clear strategic commissioning framework that sets out the commissioners expectations for population health (Optimity)*

Diagram 3: Population Health Systems



*Source: Kings Fund, Population Health Systems*Focus of intervention *(Feb 2015)*

Appendix A

Wellbeing Enterprises CIC (Commissioned in part by Halton CCG)

Wellbeing Enterprises CIC has been in place for ten years. Funded by Halton CCG GP's prescribe into the programme combination of personalised 1 to 1 support, education courses (social Prescribing) and social action (volunteering, social entrepreneurship) A comprehensive data base is in place with data from a number of years. They have seen significant **improvements** in the overall health of those using the programme

MOVE THIS PARAGRAPH BELOW TO THE INVEST TO SAVE SECTION

- Financial savings to the public sector of .55p for each £ invested enabling .55p of future savings to the NHS.
- Calculated return on investment, ratio for every £ spent produces a value of £8.90 in terms of wider impacts on society including economic and health benefits.
- Meets the cost effectiveness for QALY improvements calculated as 60.4. using a cost effectiveness benchmark of £30,000 per QALY this equates to £1.82m
- The programme is considered to be cost effective and provides good value for money

Gloucester CCG

Whilst the evaluation was completed over a short time period of six months a number of improvement were seen, including: _

- Improvements in wellbeing with positive outcomes for patients
- Reductions in emergency admissions
- Reductions in emergency attendance
- Reduction in the cost of emergency admissions
- Reduction in primary care consultations
- Some savings assumptions identified

Rotherham CCG has commissioned a service over a period of years with accompanying data and **improvements have been seen in**

- Long term conditions
- Reduction in patient admissions
- Reduction in A and E attendance
- Reduction in non elective inpatient admissions
- Reduction in out-patient attendance

Additionally in Rotherham wider health and wellbeing benefits have also been seen such as

- major wellbeing improvements with 83% of patients made progress in one outcome area (feeling positive, lifestyle, reduced social isolation and lonliness, increased independence) and improved quality of life for patients and carers.

Invest to Save

In addition to the improvements being seen in health and wellbeing, reduction in pressures on hospital services some of the sites have also demonstrated return on investment on a social and financial level. Examples include

- Bristol where a £3 social return on investment per £1 was seen

- Rotherham have calculated a return on financial investment of .33p for each £ invested in the first year.
- This was even greater when over 80 year olds are taken out of the calculations with savings in the first year of £534 per patient with a return on investment of £0.46p. Rotherham are confident that the costs will be re-couped within under three years.

Modelling work carried out by London CCGs as part of their Sustainability and Transformation planning used Hospital Episodes Statistics to estimate the savings to the NHS that could be achieved by implementing social prescribing across London. Excluding intervention costs, it was estimated that the combined saving to London CCGs over 5 years would be £533 million.

Other similar projects to that of Social Prescribing are demonstrating successful outcomes are operating in Herefordshire

Other similar projects that show success are operating in Herefordshire through the healthy lifestyle trainer service which offers intense behavioural management support. The service has seen real changes in the health and wellbeing of local residents. Results from their annual reports both in 2014/2015 show they are targeting the right people (including those from areas of deprivation and with issues around diet, exercise, alcohol and smoking). The service reached 286 clients with improvements in diet, exercise and quitting smoking.

In 2016/17 this increased to 492 new people, (including the unemployed, homeless, and people caring at home or full time at home). A high proportion of the cohort achieved their goals with improvements in weight, BMI, increases in physical activity (especially around initial 30 minutes per week reduction in fatty foods and increase in healthy eating, and reduction in consumption of alcohol and improvements in generic well-being).

This demonstrated the impact once people have access to an intensive support service lifestyle changes are possible in behaviour and clinical indicators.

Furthermore the evidence base for public health interventions is well documented in different research papers and studies. A recent British Medical Journal systematic evidence review[1] assessed the return on investment from a range of existing Public Health interventions carried out in high income countries, in order to inform the potential impact of proposed disinvestments from austerity measures. The findings identified;

- For every £1 invested in Public Health, £14 will subsequently be returned to the wider health and social care economy.
- The outcomes suggest that local and national Public Health interventions are highly cost saving

Appendix B - Social Prescribing - Area Roll-out Checklist

Gather Area Data
- Local provision
- Staff in area
- Demand
- Performance

Customer Insight
Communication plan

Resource needed
- Community Enablement team x.5
- Data and intelligence x.5
- Administrative * x2
- VCSE input & infrastructure
- Multi-agency Steering Group

Community engagement events
- GPs, other referrers
- Potential providers
- Voluntary Groups
- Public?
- Communication plan

Local Member engagement

Resource needed
- Community Enablement team x.5
- Administrative * x2
- Locality SP lead x1
- Multi-agency Steering Group
- VCSE input & infrastructure
- Resource for engagement events

Agree services/LTCs to be targeted (based on demand)
Sign up Referrers
Sign up Interventions
Build Project Team
Build/identify Community Directory

Resource needed
- Community Enablement team x.5
- Locality SP lead x1
- Administrative * x2
- Business design x.5
- Multi-agency Steering Group
- VCSE input & infrastructure

Begin referrals
Begin meeting clients
Agree and check measures
Continue to engage new providers & referrers (and develop relationships)
Agile working

Resource needed
- Community Enablement team x.5
- Locality SP lead x1
- Administrative; project coordination x1.5
- Business design x.5
- Data and intelligence x.5
- SP advisor x1
- VCSE input & infrastructure
- Multi-agency Steering

Measure Pilot success
- No. of cases handled
- Outcome for individuals
- Cost of intervention (incl. comparison to traditional approach)

Resource needed
- Community Enablement team x.5
- Locality SP lead x1
- Administrative* x1.5
- Social Prescribing Advisor(band 6) x1
- Business design x.5
- Data and intelligence x.5
- Independent evaluator (cost variable)
- Multi-agency Steering Group

-Create Business Plan and agree ongoing funding
- Build contract
- BCF sign off
- Commission providers
- Communication

Resource needed
- **Commission ongoing development with the VCSE**
- **Embed and develop solution across organisations**
- **Employ appropriate workforce**
- **Multi-agency Steering Group**
- **Communication plan**

*Administrative includes senior leadership, programme coordinator, and admin

Appendix C – Case Studies from Healthy Lives – will be updated to describe impact on services

Lady in her 70's referred to Social Prescribing due to loneliness and isolation. Recently bereaved and moved into the area. She used to lead a full life and enjoyed socialising with her husband. She enjoys talking to others. She is unsure how to meet people and socialise in this area. She is also concerned about keeping mobile safely due to her arthritis and sight problems.
Claire, our Social Prescribing Advisor, had a good initial meeting with the lady, discussing her concerns and interests and agreeing the Social Prescribing interventions she would like to become involved with (Get Up & Go – activity sessions for the over 60's, improving balance, co-ordination and muscle strength; Age UK Day Centre).
Claire met the client at the first session of Get Up & Go and introduced her to another Social Prescribing client, to encourage them both to attend. Both ladies enjoyed the session which involved seated volleyball and Boccia and both ladies have continued to attend this class together.
The lady was also referred to the Age UK Day Centre and is currently on their waiting list for a place. Other Day Centre opportunities are available in Oswestry or nearby but are not at convenient times for the lady. Claire has also signposted her to the Oswestry Arthritis Self-Help group sessions at the Hydrotherapy Pool at Robert Jones Hospital,
Claire will remain in contact and offer 3 month follow-up.

Mrs M. was referred through the Fire Service Safe and Well Visits. She has peripheral neuropathy from the chest down which is the main cause of her unsteadiness. She is under the Gp for this and has received support from Physio and OT with equipment in place to minimise the risk. Her husband has heart issues. They have a 10 year old with Cerebral palsy and Autism and a healthy 7 year old daughter. We have agreed that a referral to Carers Trust4all would be useful to them as they are not currently being supported. This will give the 7 year old also access to the siblings group for respite.
She received information on FPOC and QUBE so that they were aware on where to find local advice and info as well as support from SC if needed. They are a family with although poor health a positive approach to life. Mrs M is interested in crafts so also made her aware that the Library would be a good service to support the whole family.
Mrs M is rather restricted in her access to some things as she has a plastics allergy, making the community a mine field for her.
Mrs M. requested additional grab rails at the property. It is owned by SC and managed by STAR Housing so after speaking to the housing support officer, additional grab rails and electrics were renewed and the plug points were made higher in order to reduce her risk of falls.
It was lovely to speak with them both and I think it shows a really good outcome once referrals have been made for 2 people who would otherwise still be unaware of how to resolve their respective issues.

Appendix D – Evidence Base

The Case for Preventing Diabetes and the Impact of Doing Nothing

Type 2 diabetes is strongly associate with increased weight and as a consequence prevalence has been rising rapidly

The estimated costs for social care resulting from complications of diabetes in Shropshire are £8.3 million per year.

This increases to £47 million per year for the costs to the wider NHS in relation to treating diabetes and associated complications.

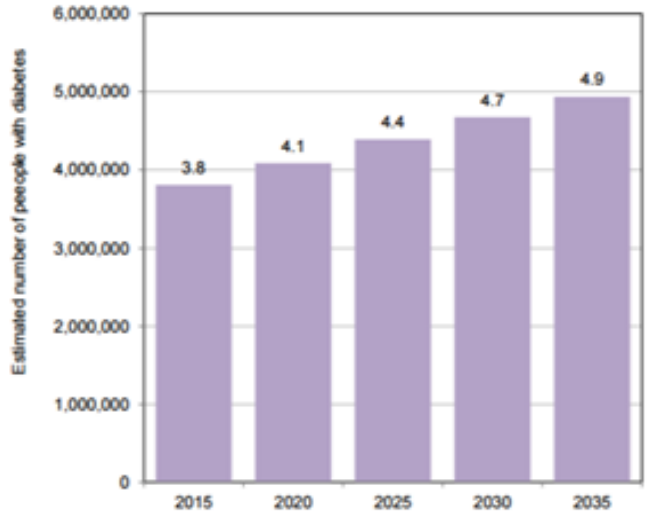
Type 2 diabetes is one of the most damaging health consequences of obesity. It accounts for 90% of all cases of diabetes, and is largely preventable through diet, physical activity and maintenance of a healthy weight.

Diabetes now affects 1 in 10 adults (around 23,000 in Shropshire) and leads to a range of serious and disabling complications including heart attacks, strokes, kidney failure, blindness and limb amputations. These costs are on a rapidly rising trajectory. Despite most diabetes being preventable, we invest only a tiny amount on this. In addition, most diabetics receive very little support in self-management, which is proven to improve quality of life and reduce complication rates.

It is estimated that as many as 1 in 5 adults have 'pre-diabetes' (non-diabetic hyperglycaemia). If not supported to improve their risk factors, around 6% per year will progress to become diabetic.

The chart below shows the projected estimates of the number of people with diabetes between 2015 and 2035 if no intervention is delivered. If this was realised, it can be seen that there will be an estimated increase of 1.1million people with diabetes by 2035.

Estimates of diabetes prevalence (2015-2035)



The following table shows a potential saving of £568k per annum in Shropshire could be achieved from reducing the number of people progressing from pre-diabetes within Shropshire.

The following table shows a potential saving of £568k per annum in Shropshire could be achieved from reducing the number of people progressing from pre-diabetes within Shropshire.

Achieving a 15% reduction in the number of people progressing from pre-diabetes to diabetes is estimated to save Shropshire NHS £568k p.a. (£2.8m over 5 years):

Prevention Potential	Scale of Need In Shropshire	Activity	Intervention	Objective	Impact/ROI
Diabetes Prevention	23,902 adults with diabetes (15,380 on GP registers) 31,600 adults with pre-diabetes 1 in 4 care home residents diabetic NHS costs = £47m p.a. Social care costs = £8.3m p.a.	The cost of diabetes in 2010 was 10% of NHS spend. If no action is taken, this is predicted to rise to 17% of NHS spend by 2035	- NHS Health Check - Pre-diabetes social prescribing pathway - Help2Slim weight management service - Digital health support	15% reduction in the number of people progressing from pre-diabetes to diabetes each year (based on 6% p.a. expected progression rate)	Type 2 diabetics averted = 284 p.a. NHS cost savings @ £2k p.a./diabetic = £568k p.a. Social Care cost savings @ £350 p.a./diabetic = £100k p.a.

WHAT WE INTEND TO DO

Structured education can help diabetes patients to stabilise blood glucose levels, reducing the risk of complications and improving quality of life, thus reducing the financial burden on the NHS and wider social care system. NHS England estimates that for every diabetic receiving structured education, there is a net saving to the NHS of around £70 p.a.

Achieving an increase in the number of diabetics in Shropshire receiving structured education from 10/month to 500/month is estimated to save Shropshire NHS £420k p.a. (£2.1m over 5 years):

Prevention Potential	Scale of Need In Shropshire	Activity	Intervention	Objective	Impact/ROI
Structured education for diabetics	23,902 adults with diabetes (15,380 on GP registers)	Only 100-150 diabetics p.a. receive structured education in Shropshire	- Structured education (e.g. Xpert programme)	Structured education delivered to 5,000 diabetics p.a.	NHS cost savings from structured education @ £70 p.a./diabetic = £420k p.a.

Musculoskeletal Disease

In Shropshire, severe back pain affects more than 1 in 10 people; the largest modifiable risk factor is obesity

In Shropshire 27% of obese adults suffer from osteoarthritis of the knee and 14% from osteoarthritis of the hip.

The leading cause of disability in England is musculoskeletal (MSK) disease, including osteoarthritis and osteoporosis with major risk factors caused from physical inactivity, obesity and smoking.

MSK disease accounts for around 30% of GP consultations and is the leading cause of sickness absence, with 32 million working days lost per year in the UK.

The Musculoskeletal Calculator estimates that 56,154 people in Shropshire live with back pain. This means that of the total Shropshire population, 18.2% are estimated to have back pain (overall prevalence). This is similar to the overall England prevalence of 16.9%.

Severity

It's estimated that there are 33,552 people in Shropshire with severe back pain, which equates to 10.9% of the population.

Shropshire:

Falls

One third of people aged over 65 and half of those aged over 80 fall at least once a year. In Shropshire it is estimated that around 400 older people fall every week with 1 in 5 of these falls resulting in significant injury. Approximately 10 people aged over 65 years facture their hip each week in Shropshire, 8 out of 10 of these fractures result from a fall. Falls are extremely expensive and in a study in Torbay health and social care costs in the first year following a fall amounted to 4% of the hospital budget and 4% of the adult social care budget.

Many falls result in fractures, particularly in those with osteoporosis. The consequences are often life changing or life threatening (30% of hip fracture patients die within 1 year; only 46% return to their normal residence).

The number of falls is predicted to rise significantly due to an ageing population and low rates of physical activity. Falls are not an inevitable consequence of ageing; they are mostly preventable. For example, half of all people with a hip fracture have had a previous fragility fracture which provided an opportunity for prevention.

Achieving a 10% reduction in hospital admissions from falls is estimated to avoid costs of £1.5m p.a. across health and social care (£7.5m over 5 years):

Prevention Potential	Scale of Need In Shropshire	Activity	Intervention	Objective	Impact/ROI
Falls prevention	Estimated 19,000 falls p.a. in older people	1,254 emergency hospital admissions p.a. (2014-15 data)	- Falls awareness programme - Falls assessment within NHS Health Check - Community-based Postural Stability Instruction (PSI)	10% reduction in the number of falls-related hospital admissions (preventing 125 p.a.)	NHS costs avoided @ £3,508/admission = £438k p.a. Social care costs avoided @ £8,721/admission = £1.1m p.a.

Appendix E – Current service provision and unique selling points DRAFT NOT COMPLETE

Shropshire Council's Community Enablement Team

Skilled practitioners with experience and expertise in working directly with community groups to build local networks of support based on issues being identified by communities.

They help to build the social infrastructure of a community and join up activities taking place often of a practical nature or provide information to professionals and local services about things that are taking place in a locality. Examples include local directories and information on Shropshire Choices

They know the community well and as a result are able to advise professionals and those working on service re-design now to develop schemes, programmes and services that reflect the needs of the community. They ensure that the knowledge, skills, time of individuals and the resources in communities are recognised by local professionals

Part of their role involves direct work with local councils and elected members briefing them on activity and working proactively alongside them to develop solutions to community challenges.

They have specialist knowledge and insight about each of the localities in Shropshire, are approachable with a hands on, can do practical approach.

USP

They are able to take pressure off local services by offering a community based non clinical solution which links people into local resources, information and social activities

Detailed local insight about the community based assets and resources for all of the localities across Shropshire

Community and Care Co-ordinators

Community Care Coordinators are non-clinical roles typically based in GP Practices to provide non-health interventions to address wider determinant concerns. The role is typically tailored to local community need with a focus on building relationships with statutory and non-statutory (including voluntary) organisations and linking with care support groups.

As each locality differs the C&CC identifies locally available resources and support for patients who are referred through. Patients are then signposted or offered support dependent on their level of need. Patients are categorised into the following:-

Complex – repeated contact and prolonged engagement with referral to other organisations
Moderate – home visit or further contact with referral to other agencies
Simple – sign posting and information giving

As of September 2017, 42 of the 43 GP Practices served by Shropshire CCG are actively engaged with the Community and Care Co-ordinator programme and 42 have a Community and Care Co-ordinators in post (C&CC's).

USP

They are well established, highly regarded by GP's, clinicians and patients. C&CCs work in a flexible way within GP practices and have good knowledge of their communities and the patients in need in their area.

Help2Change and Behaviour Change

Help2Change is Shropshire Council's in-house public health provider, with longstanding clinical and behavioural experience across the public sector. It works closely with primary care in Shropshire to deliver the NHS Health Check programme, stop smoking services and weight management support. It has been a prime mover in the development and implementation of social prescribing in Shropshire, through the provision of infrastructure , the enhanced social prescriber role, and delivery of behaviour change services to patients. Through its work with GP practices, it has the developed audit tools to search the patient record and proactively identify risk cohorts of patients who would benefit from support. As well as providing services within GP surgeries and

pharmacies, it delivers community clinics and has a mobile clinic. It also provides point of care blood testing, including testing for diabetes and pre-diabetes. Help2Change has a commercial remit and is developing a number of products and services to support behaviour change, including a digital Health Coach application to support self-management of long term conditions, and Health TV digital signage. It is a provider of education and training, with particular expertise in behaviour change techniques such as motivational interviewing, and supports the delivery of Making Every Contact Count. Working closely with maternity, Help2Change provides specialist services for pregnant mums, and is developing a Healthy Baby engagement platform in support of this work. Help2Change has a growing workplace health programme which provides services nationally.

Enhanced Social Prescribing Advisors

A newly developed role which brings a new set of skills to complement existing roles. The role offers one to one support to individuals and their family to understand their health and wellbeing needs and issues, supports the identification of realistic goals and develops an action plan to achieve those. The skills used are based on motivational interviewing, lifestyle and behaviour change and recognises the capabilities of each individual.

The social prescription is co-designed between the advisor and the individual and a nonclinical community based intervention identified to which a referral is made. Additional follow up support is offered via one to one, telephone, email, text. Crucial and additional elements of the role include time with the individual, listening and a genuine desire to work alongside the individual to identify solutions as opposed to offering them.

The advisor offers follow up support as required and monitors progress. Reliable measurement tools are used at the initial appointment and post intervention with mid-point review. Following other exemplar areas the Advisor will not 'close cases'; people will be able to come back for support in the future as needed

USP – supports behaviour change, offers healthy lifestyle options, offers extra time and works alongside individuals to identify solutions for change.

Let's Talk Local

Let's Talk Local Hubs are in place Across Shropshire in the five market towns and offer, they are part of the overarching adult social care service known locally as People2People. The over-arching aim is to, increase people's well-being by promoting choice and control, with a focus on developing and maintaining independence.

One of the ways in which people can expect to receive information and support quickly is through The Let's Talk Local sessions whereby paid staff and volunteers offer support in localities.

A Let's Talk Local advisor offers informal advice and provides information on what is available through adult social care services as well as providing information and guidance on a range of issues such as housing support, benefits, assistive technology, occupational therapy and covers different areas of a person's life

Each advisor uses a structured conversation which contains a number of prompts as a guide to identifying relevant issues relating to the individual. This is recorded and an action plan created with agreed goals.

USP

Locality based sessions across the county which can be easily accessed through First Point of Contact, the service is able to offer appointments in the community that are flexible and local. The service has totally transformed and changed its focus from a dependency model to one where people are encouraged to make better use of the community around them.

Easy access through First Point of Contact, council portal staffed by trained advisors.

Offer of appointment that is community based and flexible to sui needs of the individual which includes one to one support based around a structured interview on what is working well, what needs improving and harnesses he skills of the individual and prompts individuals to access to community support.

Also able to offer fuller care assessment where this might be needed.

Role of the Voluntary and Community Sector

The role of the VCS is vast, and there are many VSCE organisations who play a significant role in supporting people in Shropshire. One example is below.

Compassionate Communities A hospice led community development programme known locally as Co-Co
Volunteers drawn from the communities across Shropshire are trained to support the expansion of compassionate activities across the county and is now in place with a number of GP practices and communiites across the county. Patients groups within the GP practices are central to the delivery of the network however the model is not static and prescriptive but adapatable to different areas.
In short the practice GP identifies and refers individuals to the local co-ordinator who works with Co-Co volunteers and the needs are matched with one or two volunteers. An initial visit takes place and the type of support and frequency of contact agreed. This is reviewed at regular intervals and changed as necessary.
Volunteers are matched based on shared interests with the individual and initial visits take place once per week with additional support via telephone, the quantity of support is mutually agreed with the overall aim of supporting people increase connectedness within their community.
The resourcing of the network is the responsibility of the community therefore developing a model of sustainability which is not sector funding dependent.
The support can be of a practical nature, or more about social connections but there is a deliberate and conscious mapping of 'interests' between individual recipient and the volunteer.
USP
It is a non-statutory funded network not reliant on public sector funds which has been developed by the local hospice.
Launched in 2010 the Compassionate Communities network is now in place across a number of communities in Shropshire and is expanding. The network is invited by the practice to work with the community and volunteers are matched to individuals.
Leadership role is taken by the community and the difference in the way the network is co-ordinated at community varies according to the community resources and vision.

Appendix F
Monitoring Performance
The measures being used are linked directly to patient need and the local behaviour change programmes. An EMIS (GP recording system) template is being created to capture these measures at the point of the patient meeting the advisor for their assessment. This will ensure that there is a flow of information that can be added to the GP record if this is agreed by the practice. The EMIS record will also allow for benchmarking e.g. numbers of patients accessing social prescribing, where they are referred from and which interventions they require

As a result of the pilot we anticipate improvements in :-

1. Improved wellbeing – **Measured by MY CAW and PAMs**
2. Reduced demand on statutory services:
    a. attendances at GP practices
    b. attendances at accident and emergency
    c. callout to out or hours or emergency services
    d. unplanned hospital admissions
    e. prescribed medications
    f. ASC interventions

Measured by Practice and hospital data

3. Reduction in risk of future disease or disability
4. Improvement in pre-intervention concerns identified by client
5. Added social value, e.g. volunteering

Measured by programme data

Future measures will include

- Engagement of the community sector in supporting non medical health and wellbeing
- Patient satisfaction and feedback
- Awareness of social prescribing amongst healthcare and social care frontline staff

Initially the pilot will look at fewer measures to test out the viability of the model however in the longer term it is anticipated that measures will cover process, activity, self reported concerns and social return on investment. These will include the impact of interventions on well-being, a series of process indicators to measure activity and some measures that will demonstrate return on investment on a social and/or financial basis.

1. Purpose

The purpose of the Shropshire Joint Commissioning Group is drive forward system transformation; to develop and deliver joint commissioning for the Shropshire STP Out of Hospital work. The group will work to the vision and aims of the Health and Wellbeing Board and take a whole system approach to improving population health.

2. Health and Wellbeing Board Aim and Vision (from the Joint HWB Strategy)

Our Aim:

To improve the population's health and wellbeing; to reduce health inequalities that can cause unfair and avoidable differences in people's health; to help as many people as possible live long, happy and productive lives by promoting health and wellbeing at all stages of life.

Our Vision:
For Shropshire people to be the healthiest and most fulfilled in England

3. Role of the Joint Commissioning Group

a. To support the strategic direction of both the Health and Wellbeing Board and the Shropshire STP Out of Hospital work;

b. To lead on the development and delivery joint commissioning intentions;

c. To lead the development and implementation of the Healthy Lives Prevention Programme and provide joint commissioning recommendations and decisions;

d. To lead on the development, delivery and implementation of the Better Care Fund Programme, ensuring financial and performance monitoring and reporting to the HWBB;

e. To Manage the Better Care Fund Assurance Framework, ensuring that any areas of concern are reported to the Health and Wellbeing Board and mitigating actions are agreed and implemented;

f. To develop a genuinely collaborative approach to commissioning of improved health and care services which improve the health and wellbeing of local people;

g. To review the work plans (actions plans) and performance of the Out of Hospital work to identify areas for joint work, joint commissioning, and connectivity to cross organisational strategic planning and service delivery;

h. To ensure that appropriate stakeholders, including commissioners, provider organisations, patient and participation groups, and the VCSA, are involved with the development and delivery of the Out of Hospital work programme (to take place through scheme and programme development rather than at the Joint Commissioning meeting);

i. To ensure that stakeholders have appropriate methods for engagement including providing ideas, concerns, and feedback on action plans and Health and Wellbeing developments;

j. To discuss Health and Social Care issues affecting service delivery in Shropshire items and their relevance to the Health and Wellbeing Board and the Out of Hospital Programme Board;

4. Principles

The Group will follow principles as agreed by the HWBB.

- To work primarily to improve the health and wellbeing of the citizens of Shropshire.

- To work collaboratively and consensually.
- To add value over and above our current arrangements to really tackle key priorities and delivery outcomes for our communities.
- To have genuine levels of trust and an open and honest willingness to work collaboratively.
- To communicate, listen and engage with the communities we serve, actively seeking ways to enable stakeholders help define and develop the work that we do.
- Decisions will be based on evidence (both qualitative and quantitative) and data sharing will be the norm.
- To develop creative and constructive challenge to ensure that we are always working to maximise its potential as partners.
- To be pro-active by developing collaborative working to deliver system transformation and commissioning intentions, whilst maintaining appropriate flexibility to respond to issues as they arise.
- Responsibility and accountability - to our members, our staff and our public.

5. Membership – to send deputies when not available

- Director of Public Health – Shropshire Council
- Director of Children's Services – Shropshire Council
- Director of Adult Services – Shropshire Council
- Head of Adult Social Care – Shropshire Council
- Director of Contracting & Planning – CCG
- Director of Delivery & Performance – CCG
- Director of Primary Care - CCG
- Senior Finance Business Partner – Shropshire Council
- Director of Finance – CCG
- Clinical Director, Better Care Fund - CCG
- Representative from Housing
- West Mercia Police
- Fire Service
- Healthwatch
- Integration Lead, Public Health
- Better Care Fund Manager, Shropshire CCG
- Locality Manager, Shropshire Council

6. Governance

The Joint Commissioning Group will report to the Health and Wellbeing Board and the STP Programme Board. The group will also discuss and make recommendations to all partnership groups as needed.
Financial decision making remains within the constituent organisations.

7. Meeting Arrangements

Co-Chair – Meetings will be operated by a co-chair arrangement, one from the Council and one from the CCG; to be elected annually.
Notice of Meetings –Shropshire Together will provide administration
Meeting Frequency –meet minimum bi-monthly
Agenda and Papers – Partners are encouraged to provide agenda items and papers for the Group; and papers will be provided to the group at least 2 days in advance.