Appendix B

Healthier Lancashire & South Cumbria

An overview of Social Prescribing in Lancashire and South Cumbria and appraisal of digital options to support delivery

April 2019

Version 1.2

Lancashire County Council

Blackpool Council

Blackburn with Darwen

Cumbria County Council

NHS

Contents

1. Background

This paper was prepared as part of the Healthier Lancashire and South Cumbria Personalised Care Demonstrator Site, supported by NHS England, 2018-2019. It was written for presentation to the Personalised Care steering group, chaired by Dr Sakthi Karunanithi, and is designed to:

- provide an overview of the current status of social prescribing across the region
- compare digital products to support the social prescribing process and
- make recommendations to support the further development of social prescribing projects across the region.

Key points are made in **bold** throughout the document.

1.1 What is social prescribing and why do we need it?

There is an increasing body of evidence to support the impact of wider behavioural and social determinants on health and wellbeing, including lifestyle behaviours, mood, social inclusion and loneliness, employability, financial and debt situations. It has been estimated that healthcare input may represent as little as 15% of the total determinant of health with genetic, health behaviour, socioeconomic circumstances and environmental exposure contributing the remainder.

Determinants of Health: [1]

Further, it is estimated that approximately 20% of patients consult their general practitioner (GP) for what is primarily a social problem (Low Commission, 2015[2]). These non-medical factors often present alongside one or more long term conditions. In England, more than 15 million people have at least one long-term condition (LTC). This group tend to be heavy users of the health service, accounting for at least 70% of all NHS spend.

Loneliness, in particular, has been identified as one of the greatest public health challenges of our time:

- Loneliness is linked to a greater risk of inactivity, smoking and risk-taking behaviour, increased risk of coronary heart disease and stroke, an increased risk of depression, low self-esteem, reported sleep problems and increased stress response and with cognitive decline and an increased risk of Alzheimer's
- There is evidence showing loneliness can be as damaging to health as obesity or smoking
- There are around 200,000 older people reported not to have had a conversation with a friend or relative in more than a month, and
- Up to a fifth of all UK adults feel lonely most or all of the time.

In light of this evidence, the UK government has recently appointed a Minister for Loneliness and just launched the first Loneliness Strategy, confirming that **all GPs in**

[1] , Reproduced in Broader Determinants of Health: Future Trends, The King's Fund report: https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health

[2] Low Commission (2015): The role of advice services in health outcomes: evidence review and mapping study.

England will be able to refer patients experiencing loneliness to community activities and voluntary services by 2023.

Social prescribing is considered a means for healthcare practitioners to address these non-medical causes of ill-health with non-medical interventions, and has been described simply by Ceri Jones (Nesta, 2017[3]) as a "process for healthcare professionals to connect people with non-medical community interventions which enable them to become confident in managing their conditions. These could be for arts and creative activities, social groups, physical activity, education and learning new skills, self-help, volunteering and befriending as well as support with welfare advice." Social prescribing can add social value and reduce health inequalities[4].

These non-medical interventions are usually provided by the community, VCSE (voluntary, charity and social enterprise) or VCFS (voluntary, charity and faith sector), which may be commissioned by the local health and care ecosystem, grant funded or independently resourced. These resources may have been developed following identification of a community or systemic need:

a) using a top-down approach, led by the public sector,
b) following a collaborative co-production model, or
c) taking an asset-based community development approach, whereby the residents and community members build on the assets they have to support their community needs best.

Social prescribing doesn't replace the opportunity for individuals to access community resources independently, but offers support for those who require signposting and assistance in identifying needs and accessing local resources. While the term has been criticised for promoting a medical model, if the correct systems are in place social prescribing can be seen as a mechanism to facilitate signposting of people toward services that can help them live healthier lives - promoting a salutogenic approach to health (with the emphasis on a positive state of wellbeing, rather than a focus on illness or disease). Further information on salutogenesis and its relation to social prescribing can be found in Social prescribing at a glance ~ A scoping report of activity for the North West (Health Education England, 2016) section 2.2.2.

1.2 Commissioning and funding for social prescribing schemes

[3] https://www.nesta.org.uk/blog/social-prescribing-and-innovate-to-save/
[4] Institute of Health Equality 2018 Report Reducing Health Inequalities Through New Models of Care: A Resource for New Care Models

NHS England estimates that 60% of Clinical Commissioning Groups (CCGs) have commissioned some form of social prescribing scheme[5]. Alongside this, a number of voluntary sector organisations, such as the British Red Cross and its Connecting Communities initiative supported by the private sector, run referral or connector schemes to support public services.

The NHS Long Term Plan, published in January 2019, sets out a vision and actions to be taken to ensure that people have more access to personalised care including social prescribing. NHS England have shown commitment to supporting developments by funding over 1,000 additional trained social prescribing link workers across the country by the end of 2020/21, rising further by 2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes by then.

In July 2018, the Department of Health and Social Care announced that 23 social prescribing projects in England would receive a share of £4.5 million to extend existing schemes or establish new ones through its Health and Wellbeing Fund.

Through the £3.3 million Communities Fund, the Ministry of Housing, Communities and Local Government has also funded partnerships to deliver social prescribing interventions to help tackle loneliness amongst the elderly and young people.

A further Local Digital Fund - a "digital pledge" backed by £7.5 million of government funding – was announced in July 2018 to help councils transform their digital services in line with the Local Digital Declaration. This initiative is helping to change the way councils invest in technology, share expertise and ensure members of the public are receiving the best quality digital services and some of that funding, available for the financial years 2018/19 to 2019/20, has been awarded to social prescribing schemes.

1.3 Delivery models for social prescribing

The goal of social prescribing is to address people's needs more holistically and therefore more effectively, and social prescribing may reduce demand for health services in a cost-effective way, by improving health and wellbeing measures, as well as confidence in self-managing health conditions (see below for evidenced impact).

There are many models of delivery, whereby a person can access resources in their community, and often these models exist side by side within a locality, as follows:

[5] A connected society A strategy for tackling loneliness – laying the foundations for change, Department for Digital, Culture, Media and Sport (October 2018). This publication is available for download at www.gov.uk/government/collections/governments-work-on-tackling-loneliness

- The person can be referred by a GP or other health care professional (HCP) (or administrative staff in a clinical environment) direct to community / VCSE / VCFS providers
- The patient can be referred by a GP (or other HCP or administrator as above) to a link worker / community connector / wellbeing worker / health advisor who then performs a holistic assessment and signposts the patient to appropriate community / VCFS services
- Referrals can be generated from within other sectors, e.g. Citizen's Advice Bureau, non-health council services, religious or other community groups, VCFS internal referrals
- A person may independently research and access via self-referral local community / VCSF services independently, to meet their individual needs and interests.

1.4 Impact of social prescribing

At the recent King's Fund Social Prescribing conference, Matt Hancock, current Secretary for State, said the following in his address:

> "Music and the arts aren't just the foods of love. They're not just right in their own terms as the search for truth and expression of the human condition.
>
> We shouldn't only value them for the role they play in bringing meaning and dignity to our lives. We should value the arts and social activities because they're essential to our health and wellbeing.
>
> And that's not me as a former Culture Secretary saying it. It's scientifically proven. Access to the arts and social activities improves people's mental and physical health. It makes us happier and healthier."

Social prescribing has been subject to a surge of recent study and analysis, in an attempt to demonstrate what seems apparent anecdotally, that the arts, nature and social activities are essential to our wellbeing.

1.4.1 Cost effectiveness and impact on healthcare resource utilisation

A review of the literature by Polley et al (2017)[6] reports quite inconsistent but notable service demand changes demonstrated following referral to social prescribing interventions:

- Reduced demand on GP services by 2 to 70% (average 28%),
- Reduced attendance at Accident & Emergency (A&E) departments by 8 to 26.8% (average 24%)
- Reduced emergency hospital admissions by 6 to 33.6% in the "months following referral"
- Statistically reduced secondary care referrals at 12 months (55%) and 19 months (64%) following referral
- One study however showed that the likelihood of referral to secondary care mental health care more than doubled following referral.

The same review reported a Return on Investment (ROI) of only 0.11 to 0.43 or indeed higher costs of care per patient in an intervention group than a control group, and a mean Social Return on Investment (SROI) of £2.3 per £1 invested in the first year. It was noted that in one study, reduced demand on health services only applied to sub-groups of patients who completed the interventions, and in another study, patients who failed to engage fully with social prescribing had much higher rates of health service use both before and after referral.

This highlights the need to track people's attendance as well as outcomes for a given intervention, and may support use of an integrated Patient Activation Measure (PAM) to identify patients who are more likely to engage fully by their prior level of knowledge, skills and confidence; it may also help identify people who may require further support for example through befriending services due to lower levels of activation. Evidence has shown that patients who have higher Patient Activation Measure scores utilise healthcare resources less. [7]

The inconsistent results of the studies reported in the review above may reflect the variability in the nature and quality of a local social prescribing offer and / or the reporting mechanisms, and were attributed to a high drop-off rate in many evaluations, with loss to follow-up biasing results as only those who completed interventions gave feedback. Further, many studies seeking to determine the impact

[6] A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications Polley, M., Bertotti, M., Kimberlee, R., Pilkington, K., and Refsum, C. June 2017

[7] Barker I, Steventon A, Williamson R, *et al* Self-management capability in patients with long-term conditions is associated with reduced healthcare utilisation across a whole health economy: cross-sectional analysis of electronic health records. BMJ Qual Saf Published Online First: 23 August 2018. doi: 10.1136/bmjqs-2017-007635

of a social prescribing scheme on demand compared rates of use before and after referral, rather than between a control and intervention group.

This highlights the need to be able to cross-reference social prescribing reported data with other patient healthcare data such as GP attendances and secondary care referrals, in order to demonstrate the impact of social prescribing schemes on healthcare resource utilisation. It suggests that commissioning could be better targeted to yield a higher Return on Investment with better, digitised, referral and reporting processes.

The review concludes "the evidence that social prescribing delivers cost savings to the health service over and above operating costs is encouraging but by no means proven or fully quantified."

1.4.2 Clinical and wellbeing outcome measures

A review by Chatterjee et al (2018)[8] provides the most comprehensive summary to date of the evidence regarding clinical and wellbeing improvements following referral to social prescribing schemes.

These authors reviewed 40 research papers including pilot studies, of which comprised:

- 14 for exercise referral
- 9 for arts on prescription
- 3 for supported referral
- 2 for sign posting
- 1 for each of education on prescription, health living initiatives and time banks, and
- 9 for social prescribing in general containing a range of local offers.

Positive outcomes included:

- Increases in self-esteem and confidence, sense of control and empowerment
- Improvements in psychological or mental wellbeing, and positive mood
- Reduction in anxiety and / or depression, and negative mood
- Improvements in physical health and lifestyle
- Reduction in visits to general practitioners, referring health professionals and primary or secondary care services

[8] Helen J. Chatterjee, Paul M. Camic, Bridget Lockyer & Linda J. M. Thomson (2018) Non-clinical community interventions: a systematised review of social prescribing schemes, Arts & Health, 10:2,97-123, DOI: 10.1080/17533015.2017.1334002

- Provision to general practitioners of a range of options to complement medical care for a more holistic approach
- Increases in sociability, communication skills and social connections
- Reduction in social isolation and loneliness, support for hard-to-reach people
- Improvements in motivation and meaning in life providing hope and optimism
- Acquisition of learning, new interests and skills.

This highlights the need to measure wellbeing or clinical impact of interventions in order to demonstrate efficacy and improve commissioning processes.

2. Overview of the (Digital) Social Prescribing landscape across Lancashire and South Cumbria

Across the region, we see various models in place for the commissioning, development of, and signposting toward community resources. These include:

- grass roots (locally / independently funded) asset-based community developments (ABCD),
- third sector collaborations,
- micro-commissioning facilitated by an intermediary such as a Council for Voluntary Services (CVS).

Referral routes include self-referral and referral via an intermediary link worker / wellbeing practitioner / care navigator (role titles vary across the region and nationally). While Making Every Contact Count underpins many clinicians' practice, often time restraints mean that auxiliary staff are better placed to deliver the more personalised aspect of care. Referrals are made by paper and in some locations electronically, either by email or within a bespoke social prescribing system or the GP EMIS patient record.

Here follows examples of different approaches across the region; these examples are not meant to be exhaustive, as it is beyond the scope of this paper to report every opportunity to access community resources across the region. Some of these and other local examples are documented in Social prescribing at a glance ~ A scoping report of activity for the North West (Health Education England, 2016) which also highlights the importance of asset-based approaches to social prescribing delivery.

2.1 Morecambe Bay

Community activities to support the health and wellbeing of residents are quite well established and developed across the Bay region. An example of this is the Morecambe Community Collective where local residents have connected to drive forward a social movement to address health and wellbeing, loneliness and social isolation, education, employment, belonging and purpose. This has been grass roots driven, supported by a local GP, and without any digital means of referral or impact monitoring. In terms of CVS presence/support, Penrith CVS provide some support to South Cumbria, but the VCFS network is mostly supported through Mind and AgeUK.

In (South and North) Cumbria and under development in Morecambe Bay, the fully EPR-intergrated (primary, secondary care and local authority) system Strata Health (see further detail below) has been deployed, the social prescribing element of which is supported and maintained in collaboration with AgeUK. This Whole System Patient Flow mechanism also facilitates referral from primary or secondary care to care homes, public community services (e.g. physiotherapy), hospices and social care.

To date they have begun rolling out a number of social prescribing workflows as follows:

- Slimming World
- Bereavement services – self-referral as well as clinical referral
- Positive Living Group
- Complementary Therapy services
- Community neighbours programme
- Age UK - Referrals and integration that includes 25 separate services including the following -
    - Welfare benefits
    - Debt advice
    - Sensory loss support
    - Poverty crisis / support
    - Home aids and adaptations.

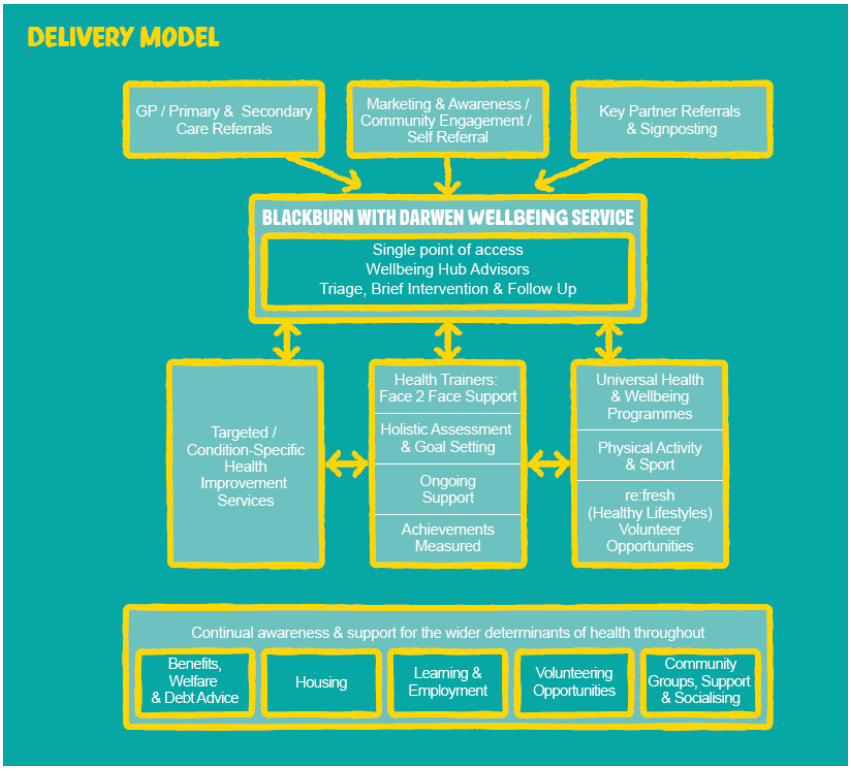
2.2 Pennine Lancashire

Blackburn with Darwen have had care navigation in place through their Wellbeing service, Re:fresh since 2014. The service has hub advisors, and offers face to face appointments with health trainers, who are behaviour change specialists, offering brief interventions as well as signposting to further services. The service receives approximately 2000 referrals per year via a single point of access, and utilises the DCRS – national data collection and recording system – which accompanies their

health trainer IT package and incorporates the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) wellbeing assessment tool.

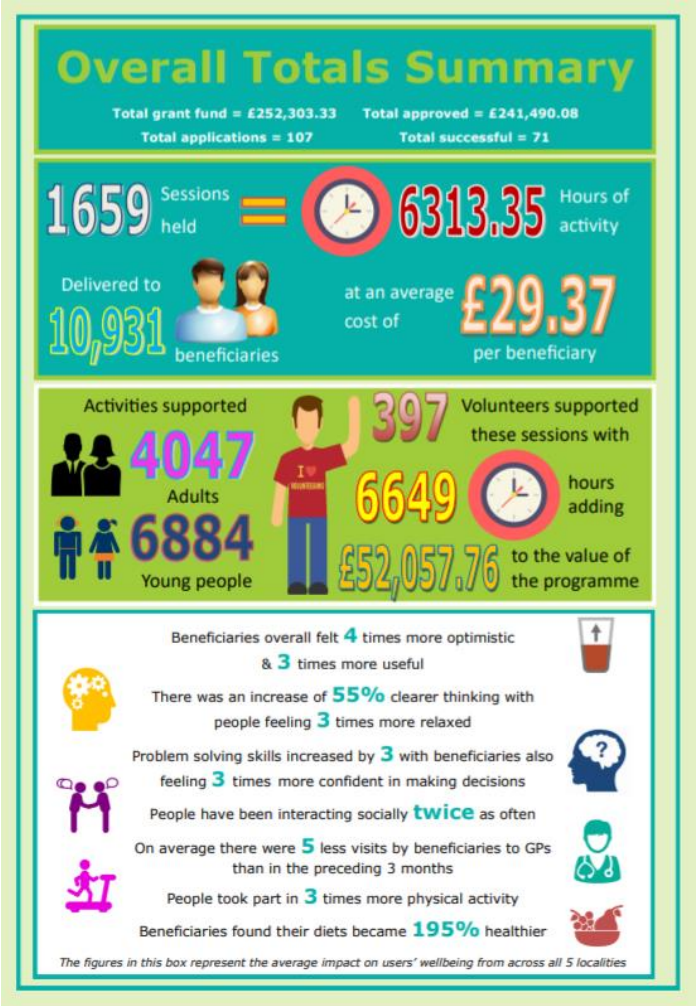
GPs make approximately 60 per cent of referrals via EMIS to a secure inbox. Patients can also self-refer, and it is believed that a number of 'self-referrals' are indirectly from GPs who have given a leaflet about the service to patients. Reporting is available, but is felt not to be very systematic or convenient. The Re:fresh website does contain a directory of services which hosts contact details for community groups.

Delivery model for Re:fresh Wellbeing service, Blackburn with Darwen:



East Lancashire CCG hosts a Prescription for Wellbeing Service in collaboration with their local CVS organisations, who micro-commission services from third sector providers. A summary of the activity for the Prescription for Wellbeing service for 2017-2018 is provided below, and the final 2017-18 report can be viewed here. Care navigation can be directed from a GP or receptionist, via EMIS to community connectors in the CVS (who all have a social work, health or third sector background) who perform an holistic assessment centred around the question "what matters to you?" and with outcome monitoring via the WEMWBS tool mentioned above.

Total activity in the East Lancashire Prescription for Wellbeing service 2017-2018:



Outcomes are mostly reported in the form of case studies, and the success of the service is believed to be due to underlying “human desire to help others with compassion” (Michelle Pilling, Deputy Chair of NHS East Lancashire CCG), and due to the investment that has been provided to more than 600 groups, the strong relationships between stakeholders, and the fact that local stakeholders have prioritised investment based on the needs identified by the local communities and the Joint Strategic Needs Assessment, where asset development has been led by the communities themselves. East Lancashire CCG also commissions the award-winning Green Dreams CIC project.

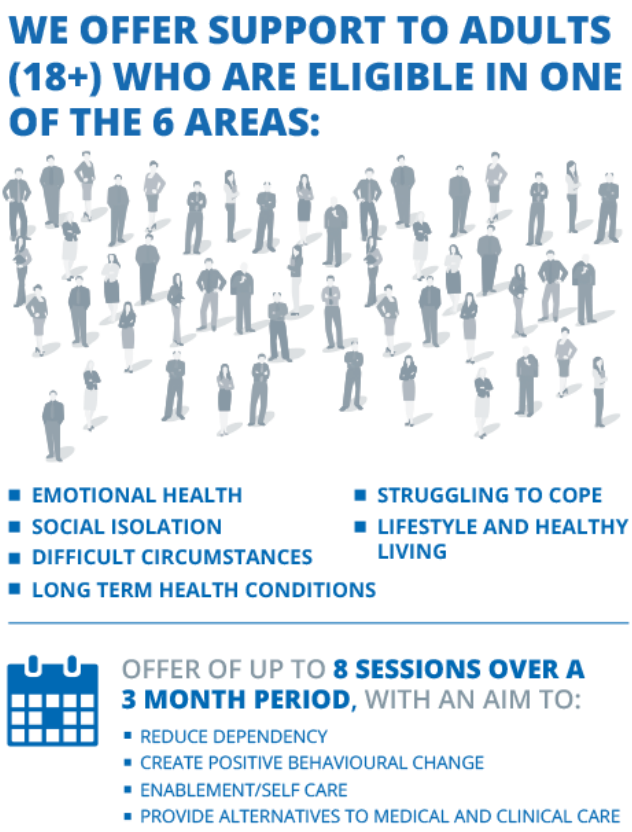
East Lancashire also has a third-sector held hyper-local directory of services in the form of the REAL website, an information and service directory supporting connecting communities, volunteering, and information to people living in the Rossendale area as well as patient support in the area.

A request from East Lancashire regarding digital support for social prescribing is around **how we can better capture data, avoid onerous reporting mechanisms by having a central point for data capture and build our relationships with academic institutions, to better understand the impact of social prescribing across the region**. There are also some local concerns in the Pennine Lancashire region that a digital solution might leave some third sector organisations behind – this **highlights a possible need to include digital upskilling and training to third sector providers to facilitate rollout and uptake of any digital solutions procured.**

2.3 Central Lancashire

Lancashire Wellbeing Service is a key deliverer of social prescribing in Central Lancashire, is funded by Lancashire County Council, and delivered by a consortium of three established charities: Age Concern Central Lancashire, Richmond Fellowship & n-compass. The website hosts a directory of services, and an online referral form, and reports a social return on investment of £7 for every £1 spent (see Appendix A for full report).

The Lancashire Wellbeing Service offer:



Further social prescribing is offered via the Building Recovery in Communities fund, managed by Red Rose Recovery, which supports open cinema, arts workshops, and referral on to physical activitiy, singing groups, etc. CVS organisations across Central Lancashire have closed over the past few years, and so VCFS organisations support each other with more local network arrangements; e.g. Chorley has a strong VCFS network. The VCFS network does hold a seat on the Central Lancashire ICP board.

2.4 West Lancashire

West Lancashire CCG has been host to a Well North Pathfinder for some years now and is currently piloting the Elemental platform (commenced July 2018, further details of platform below) for digital social prescribing in the Skelmersdale region, as follows, with a view to rolling out more widely in the future:

“West Lancs GP Federation are working in partnership with West Lancs CVS to deliver a Social Prescribing pilot in the Skelmersdale locality. The life expectancy in Skelmersdale is lower than in other parts of West Lancashire and the difference is patterned by deprivation, lifestyles and other social and economic influences. By addressing social issues through a holistic approach to health and wellbeing we are

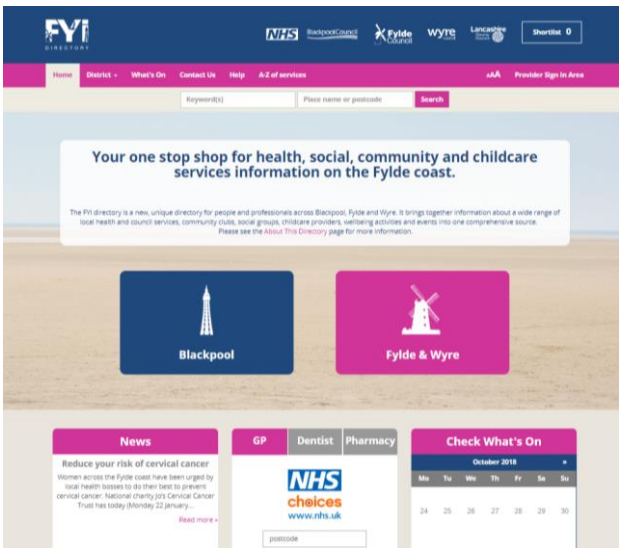
hoping that we will prevent individuals from developing long term conditions and ultimately increase their life expectancy and quality of life.

Elemental will bring this vision together and allow for collaborative working between primary care and community and voluntary sectors. The ability to measure the impact that these community services have on patients will be instrumental in designing new models of care. The use of Elemental will empower patients to take responsibility for their own health and wellbeing resulting in improved access to a GP for those that really need them. Time with patients is limited in a GP practice, therefore processes need to be quick and easy, Elemental is both of those things which really impacts on the buy-in we need from the primary care workforce in order adopt this approach" (Alex Rowlands, Operations Manager, West Lancashire GP Federation - OWLS CIC Ltd.).

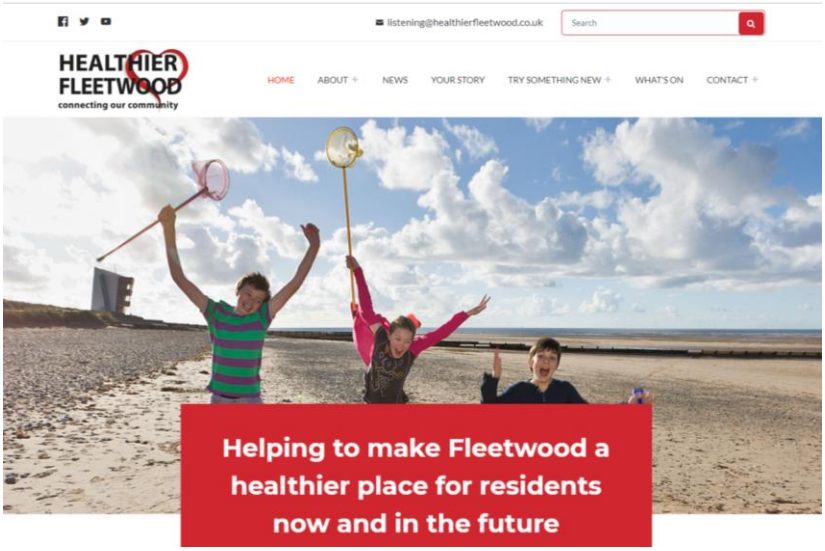
2.5 Fylde Coast

Across the Fylde Coast, NHS organisations and councils have collaborated to create a public-facing directory of local community services. The FYI Directory is a new information resource that can be accessed by the public and health and care professionals across Blackpool, Fylde and Wyre, bringing together information about a wide range of local health and council services, community clubs, social groups, wellbeing activities and events into one comprehensive source. It also includes Blackpool's Local Offer for Children and Young People with Special Education Needs or Disabilities. The FYI Directory was accessed by 117,035 users over 161,556 sessions from its launch in September 2017 to June 2018.

FYI Directory Homepage, to be found at https://www.fyidirectory.co.uk/ :



In the Wyre region, Healthier Fleetwood (HF) is an example of another grass-roots community movement which has actively engaged and empowered community members taking a proactive asset-based approach. Established in Spring 2016 as a partnership of residents, healthcare professionals, local authorities and services, businesses, voluntary and faith groups to improve the health and wellbeing of those living and working in the town, from approximately Spring 2017 social prescribing was available on a self-referral basis through the HF website to activities including gardening, walking sports, beach cleans, swimming, singing, dancing and much more.
Healthier Fleetwood homepage, accessed at https://www.healthierfleetwood.co.uk/ :



The service now employs two wellbeing workers who receive direct paper referrals from GPs and follow this up with a phone call or email to patients for a conversation about their needs and signposting to appropriate community activities. Outcomes are good in terms of quality of life improvement, but are anecdotal to date as the group are looking to embed WEMWBS or a similar outcome measure in their impact monitoring. A report on the activity and impact of Healthier Fleetwood can be found in Appendix A, and HF are keen to engage in conversations about a more robust digital referral and impact monitoring solution.

As part of the Enhanced Primary Care Fylde Coast vanguard site developments, neighbourhood based wellbeing support workers are now signposting patients and their carers in Blackpool to appropriate voluntary sector services including carer support, whilst also offering direct provision of health coaching and PAM measurement. A further pilot project run by Social Enterprise Solutions, a Blackpool third sector organisation, is offering social prescribing to the patients of two GP practices with anecdotal improvement in health outcomes. Blackpool CVS has

folded but Wyre and Fylde CVS provide some ongoing support to Blackpool VCFS organisations.

3. Digital support for social prescribing

3.1 Defining standards

Explicit standards for social prescribing or IT system functionality to support social prescribing do not exist at present; however we may extrapolate standards from existing personalised care standards and data standards provided by NHS England, NHS Digital and the Local Government Authority (LGA), and can also consider embedding quality standards within commissioning processes for providers.

3.1.1 IT requirements for personalised care

NHS England has outlined the IT requirements for personalised care, expecting all IT solutions to integrate with the NHS.uk platform, which will be the common platform for public access to NHS IT services. Solutions should take into account NHS Digital standards (the three products appraised below are measured against the standards in Appendix B), some of which are highlighted below.

Core IT requirements for personalised care, from IT requirements for personalised care, NHS England 2017:

- An IT solution must have been designed with people at the heart, such as through agile development methodology
- An IT solution must enable genuine choice and control for people and their families to achieve the desired outcomes from the personalisation agenda, in line with the IPC key shifts and consistent with the statutory regulations. It should allow for flexibility and innovation in people's lives
- An IT solution must meet the relevant data security and privacy standards, in line with NHS policy, and must be consistent with the IT security requirements of the Information Governance (IG) toolkit
- An IT solution must allow appropriate access, taking into account different user needs and including the capability to verify identity
- An IT solution must enable connectivity and interoperability to support integration between health, social care and education in a local area
- An IT solution must allow for the analysis and reporting of data, to understand whether and how the outcomes from personalisation are being delivered
- The individual's information must be portable between different IT solutions to facilitate ease of movement
- An IT solution must be capable of providing management information and user feedback that will enable development and improvement, to ensure it is successfully supporting the policy outcomes
- The solution must provide appropriate availability to meet people's needs, through appropriate access channels, and support assistive technology

- IT solutions must provide accurate record keeping for all users

Community IT requirements for personalised care, from IT requirements for personalised care, NHS England 2017:

- [Community]: this functionality, if available, should support health empowerment and service improvements, including access to peer support.
- [Individual] "I can access peer support through a safe, online forum. This helps me make choices about my care and support"
- [Individual] "I can rate and comment on services; this feedback supports my care and support review and enables the system to identify common issues and / or successes"
- [Individual] "I am able to link my other health apps / health data to the IT solutions so that I can better self-manage my health condition"
- [Professionals] "The IT solution helps me to understand better what services people are choosing and benefiting people in my local area so that I can improve the way I commission services and investigate where there appear to be problems.

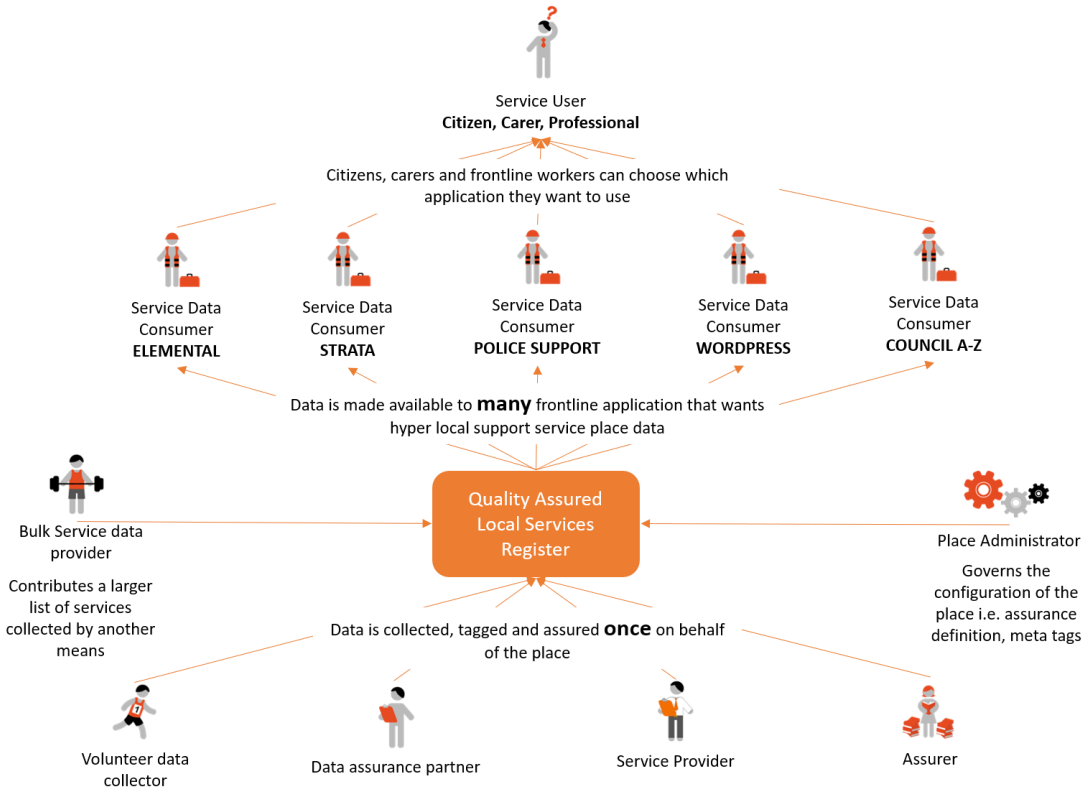
3.1.2 Local Government Association Data Standards

The Local Government Association (LGA) has defined standards that can support the nomenclature of service descriptions and needs assessments when creating directories of services. These have been developed into LGA Locally Delivered Services Schema Guidance (see Appendix A for full details) and **these data standards ideally should underpin any platform Healthier Lancashire & South Cumbria or any of our partner organisations decide to procure. Opportunities are currently under discussion to host an LGA pilot site within Lancashire and South Cumbria. The LGA hope to run four national pilots in the next few months to work with local government "places," health, voluntary and private sector to collect and publish data about local services in a standard capable of being consumed by apps for use in social prescribing.**

A pilot site project would involve the creation and maintenance of a single, place-based directory of services which would collect hyper-local service information once and make it available to many, allowing any platform/app procured across health and care, Citizens' Advice Bureau or other organisations (e.g. Our Lancashire, see below) to consume such single-source

service data and make it available to the public and professionals on a variety of platforms, where overlap might exist.

The diagram below provides an overview of this model, which is further expanded upon in Appendix A, in the documents 'Place-based Directory of Services pilot project proposal based on LGA Data Standards' and 'LGA proposal to cabinet office for local services data collection to address loneliness.'



3.1.3 Quality standards for service providers

When commissioning services from third sector organisations, commissioners may wish to consider embedding quality standards into the commissioning process. Examples of these might include the NCVO Quality Standards, which although not specific to health "offer organisations, both in and outside the voluntary sector, an externally-verified seal of approval, which publicly demonstrates your organisation's commitment to quality assurance and continuous improvement."

Another quality framework and certification process is offered by the Quality Improvement for Self-Management Education and Training who are "an independent not-for-profit body that supports self-management providers and commissioners to

achieve the highest possible quality service for people living with long-term health conditions" … "by developing Quality Standards defining good practice and certificating providers against these Standards."

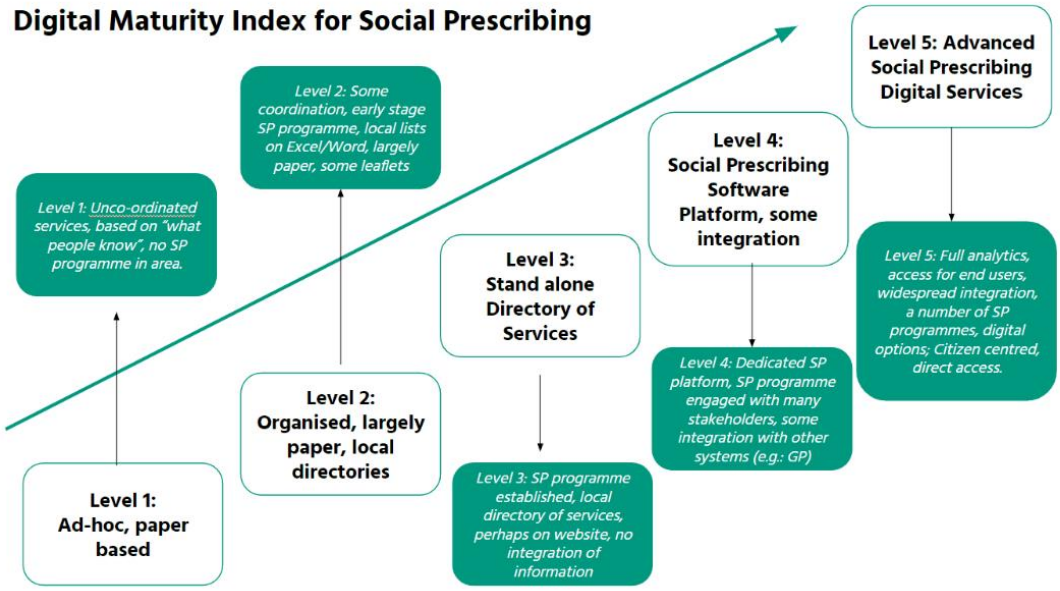
However, it must be considered that rigidly applying a quality standard may exclude small third sector providers who are offering very meaningful support to individuals to manage their health and wellbeing.

3.2 Local digital requirements to support social prescribing, identified by stakeholder engagement

Consultation and engagement with a range of stakeholders – including commissioners, referrers, link workers, service providers and users - across Lancashire and South Cumbria during September-October 2018 identified some core requirements central to any digital offer, all of which are compared across platforms in Appendix B:

- Integration with clinical (EMIS in primary care and other EPR systems utilised in secondary care) and other systems (e.g. those used by council services) to ensure referral process is simple and quick, without requiring duplication of demographics, etc.
- Integrated Patient Activation Measure to help identify pre-referral activation levels and possibly assist needs assessment
- Reporting of (at a minimum):
    - Referral numbers, reason for referral
    - Attendances
    - Final outcome (qualitative and / or use of PROMs / PREMs ~ WEMWBS is of particular interest as a standardised measurement of wellbeing, and may permit outcome comparison between services)
- Correlation/cross-referencing of:
    - Referrals and outcomes with GP attendance data
    - Author's note: correlation of referrals and outcomes with medication usage and attendance at other services, e.g. mental health/emergency department, may also prove valuable in terms of demonstrating impact
    - Comparison of pre- and post-intervention PAM and outcome data
    - Author's note: correlation of attendances and PAM score may prove valuable in identifying those who require enhanced support, e.g. befriending services to support initial attendance at groups for those who are particularly socially isolated and/or have social anxiety.

The [Digital Maturity Index for Social Prescribing] is a useful resource created by Elemental Software - one of the software providers discussed below - and might be a useful self-assessment starting point for the Integrated Care Partnership localities within Lancashire and South Cumbria to determine their current status and future digital social prescribing requirements. It is recommended that all our ICP organisations undertake this assessment in order to establish the digital maturity of their current social prescribing offer, and their ambitions for service enhancement.



3.3 Digital social prescribing platforms currently/imminently deployed

Three main platforms for digital social prescribing are currently in use or under development by Lancashire and South Cumbria health and care providers (Elemental and Strata) and the Citizens' Advice Bureau (Refernet), and are summarised below with links to documents containing full details of the respective functionality of the former two in Appendix A.

A table comparing core features of the products, comparing functionality against the standards outlined in 3.1.1 above, and comparing indicative costs can be found in Appendix B. Due to the commercial sensitivity of costing information, this appendix will be shared on a limited basis.

Further platforms/directories in use or development outside of health and care in Lancashire and South Cumbria, or in use or development elsewhere in the country, are outlined briefly, as a detailed evaluation of every product on offer is outside of the scope of

this paper. **Some conclusions can be drawn from the detail below, but given the breadth of the landscape (both locally and digitally), it is recommended that should the scope be insufficient, a full options appraisal is commissioned.**

3.3.1 Elemental

3.3.1.1 Overview

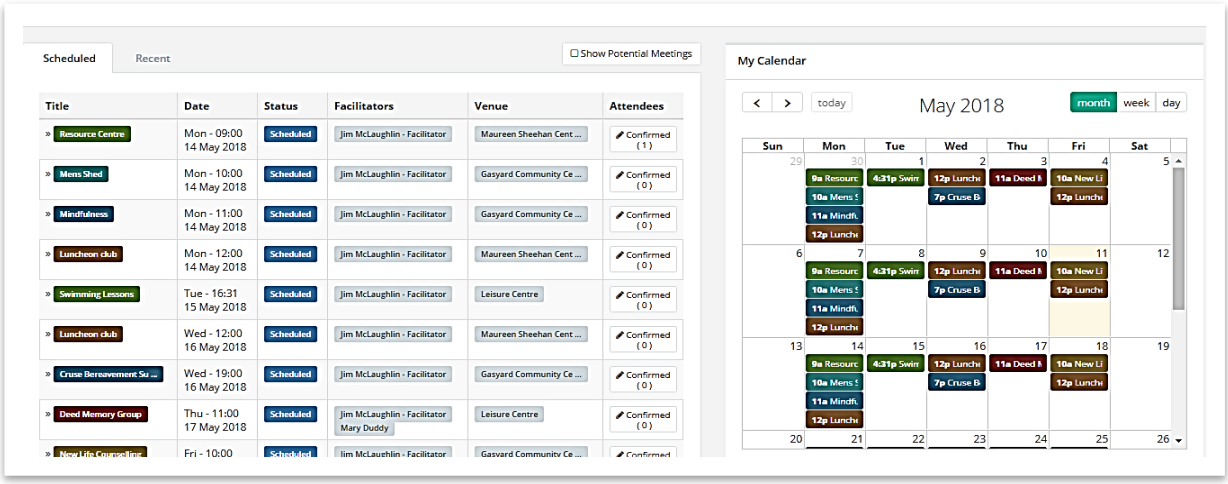
Elemental Software is a Tech For Good company with the purpose of engaging and empowering communities towards better health outcomes. Co-founded by former community development workers, and developed with input from service users and providers, Elemental's bespoke social prescribing platform connects, supports, measures and evaluates the uptake and impact of social prescribing referrals.

A full features document, platform overview and self-referral portal overview can be found in Appendix A, under separate cover. The Elemental proposal for Lancashire and South Cumbria can be found embedded in Appendix B, with limited access.

3.3.1.2 Clinical / social utility

The Elemental platform is easy to use, responsive and enables community referrals to be implemented, measured and delivered across numerous health and social care scenarios. The Elemental platform can be used by multiple health and wellbeing professionals as well as commissioners and providers of community based interventions such as smoking cessation, employability skills, mental health support and physical activity interventions. The platform facilitates tracking of attendance by service providers as the facilitators will be provided with a list of attendees, and to run attendance reports on their own interventions.

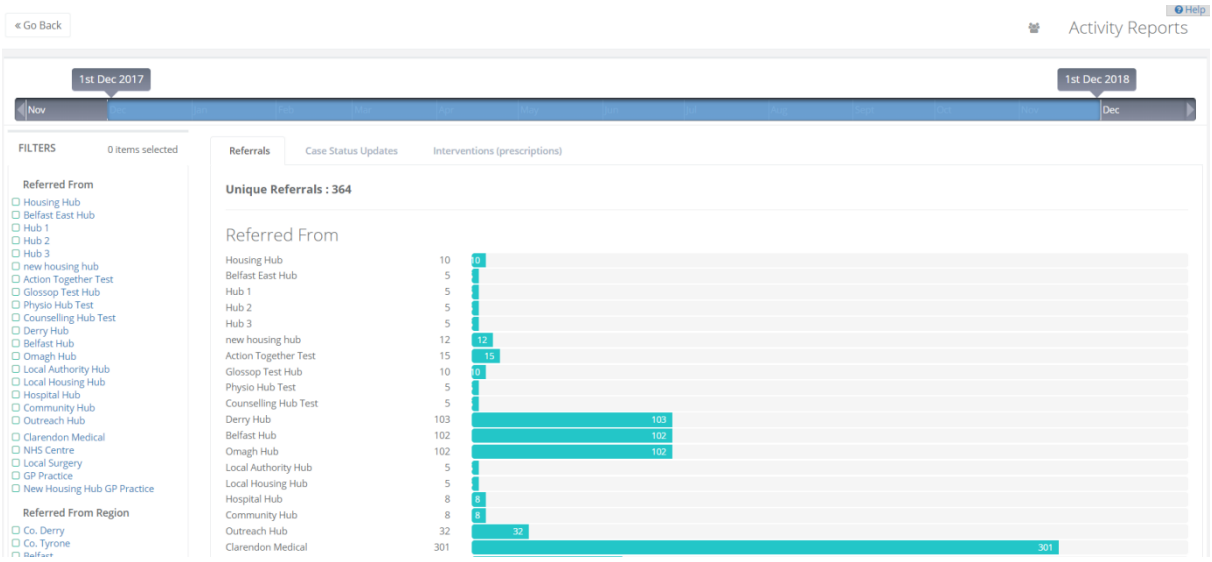
Elemental Service Provider view:



3.3.1.3 Data reporting

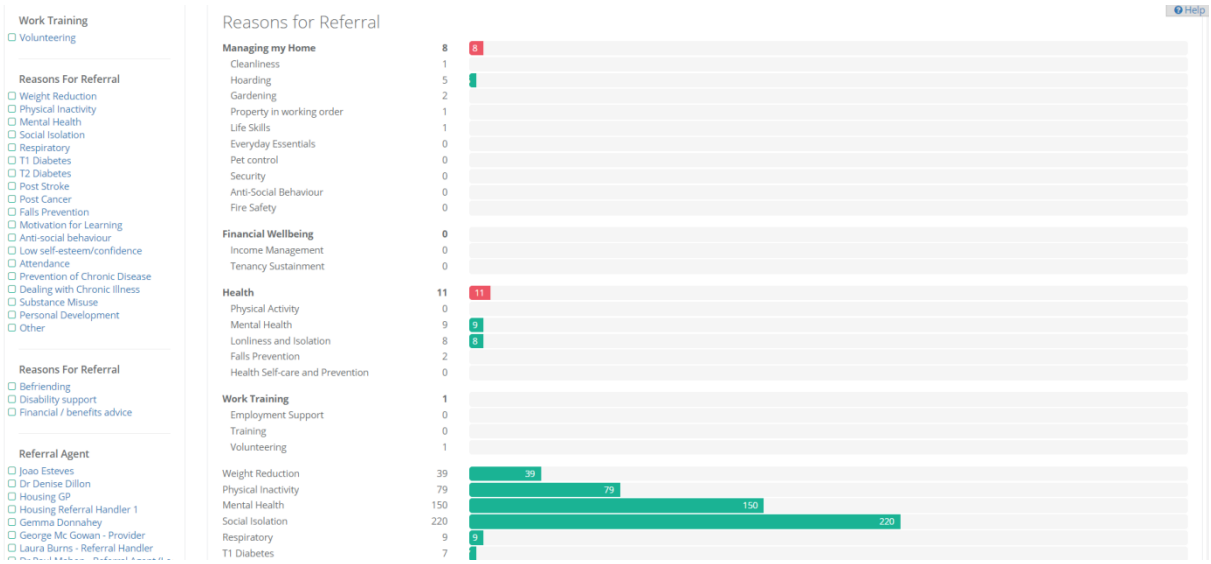
The platform contains a suite of measuring tools used to capture data and track measurements for individuals. The data entered into these tools populate dashboards and reports to monitor progress and track impact. The system is updated with new tools regularly and can be added to as part of the implementation process to suit the needs of your project.

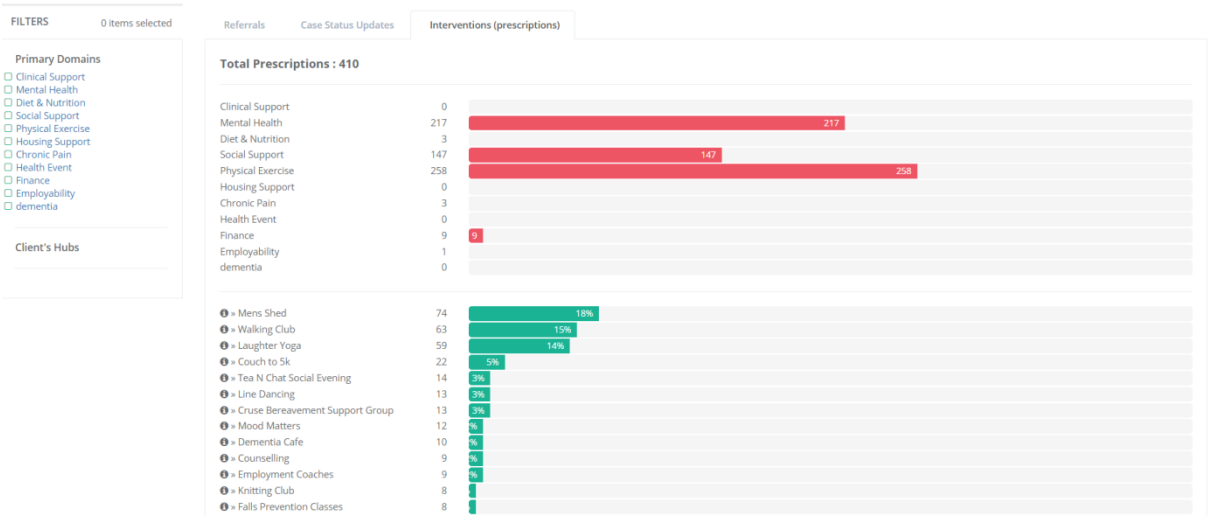
Elemental activity report (part 1):



Data captured within Elemental can be used to provide impact reporting and will aid in the evaluation of services. Further developments within the platform will combine the social economic value of outcomes within the reporting module.

Elemental activity report (part 2):



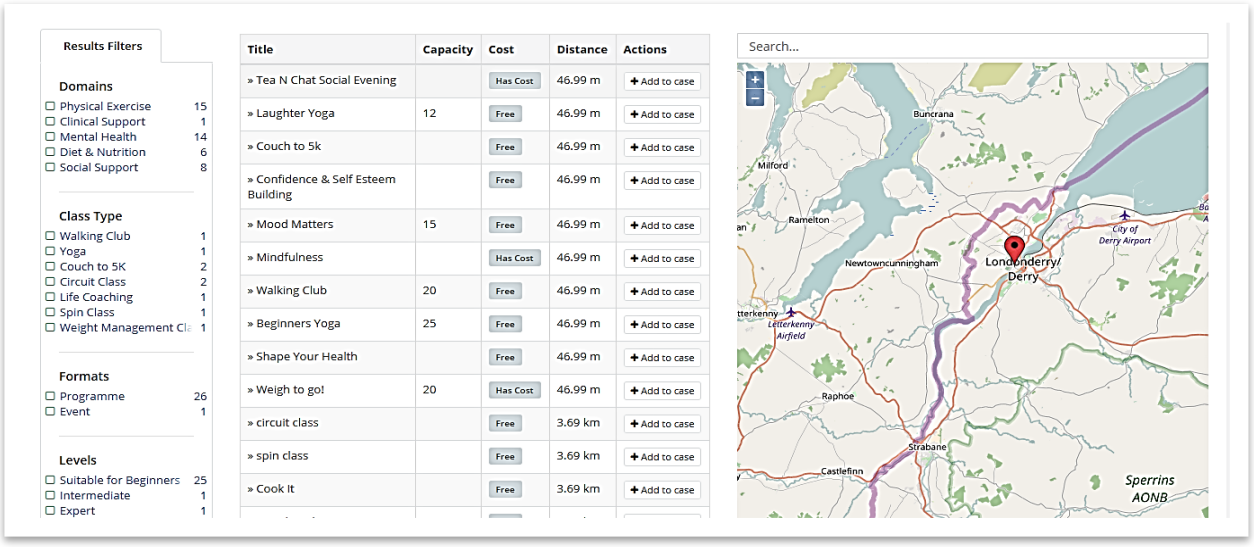


3.3.1.4 Technical / Integration

Elemental are an EMIS Accredited Partner and an approved supplier on the G-Cloud 10 framework. Elemental can work with existing directories of services (DoS) or create an enhanced directory of services which can be populated in a number of ways:

- Option 1 - Integrate via the Elemental API to existing DoS in the area
- Option 2 - Provide login details to the select list of providers
- Option 3 - A static list is created by the social prescribing link workers
- Option 4 - A combination of the above 3 options

Example Elemental Directory of Services:



Extracts of data from Elemental can be provided or a direct link via an API to connect to other BI / Analytic software that may be in use in order to collate data from other sources. Elemental are researching correlating different data sets such as A&E attendances with the social prescribing data captured within the platform to be used at a local level.

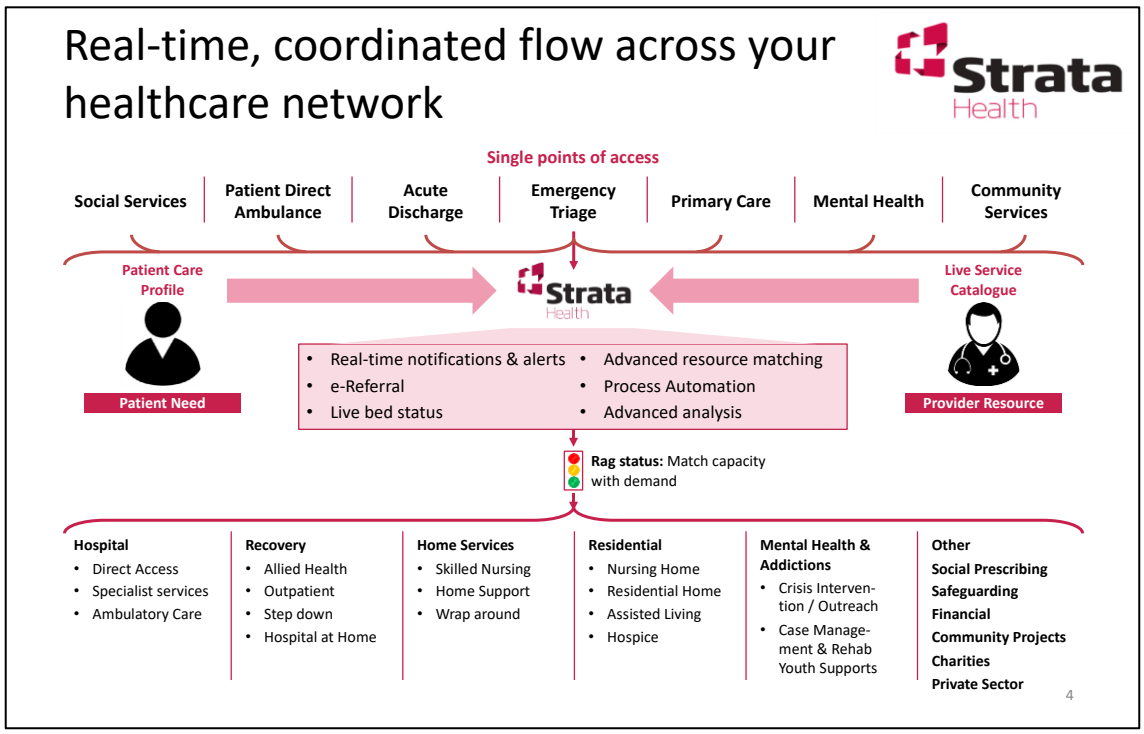
3.3.2 Strata

3.3.2.1 Overview

Delivered through a fully integrated cloud-based platform, Strata Pathways™ is a whole health and social care flow system that includes, but is not limited to, social prescribing to services delivered by charities, social enterprises, private sector and health and wellbeing programmes etc. Strata optimise the transition of patients to the most appropriate setting of care across the health and care system.

A full paper outlining Strata functionality can be found embedded in Appendix A, under separate cover.

Strata flow overview:



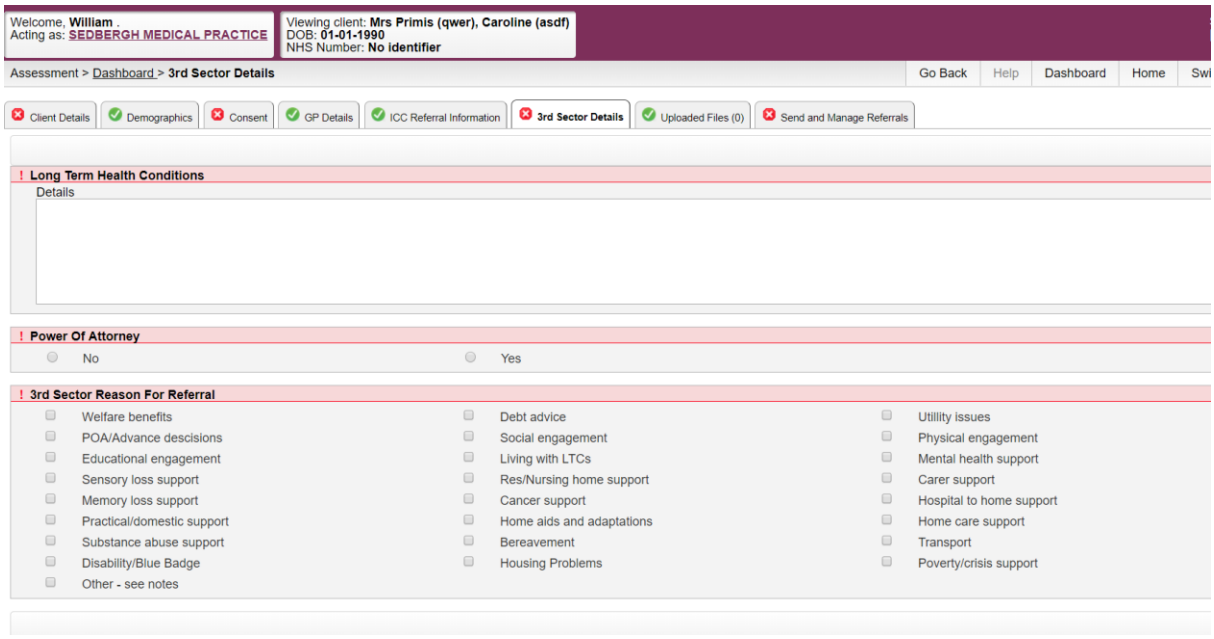
3.3.2.2 Clinical / social utility

Strata matches patient needs, including clinical information, geographical preference, and financial capabilities to the best available resources from a live directory of services. For frontline staff, it means that they can see real-time availability of the services and with the bi-directional transfer of care; all stakeholders are continually updated on progress of the patient and adherence to the pathway.

Social prescribing referrals are treated exactly as a clinical referral would be and are encompassed into other care types, where a referrer can complete a single referral form (several pages) that can be matched to all available and appropriate services and then sent to multiple endpoints (providers) within the Strata directory of services.

Through the use of PathWays™, patients can be directed to the most appropriate care settings; the solution would match a list of relevant places or packages of care based on the patient's specific criteria, and then flag the results based on availability. The referral can be sent digitally from the GP EMIS system. In Cumbria the matching has also been linked to a GP clinical decision-making tool to show available services matched to NICE guidelines for the presenting condition.

Strata third-sector referral options:



Once the referral is sent and accepted, the GP will receive notification that the referral has been acted upon and even that the patient has been adhering to the services prescribed, all within their GP system. This will allow effectiveness to be tracked using the data behind the Pathways system to manage outcomes from the social prescribing services.

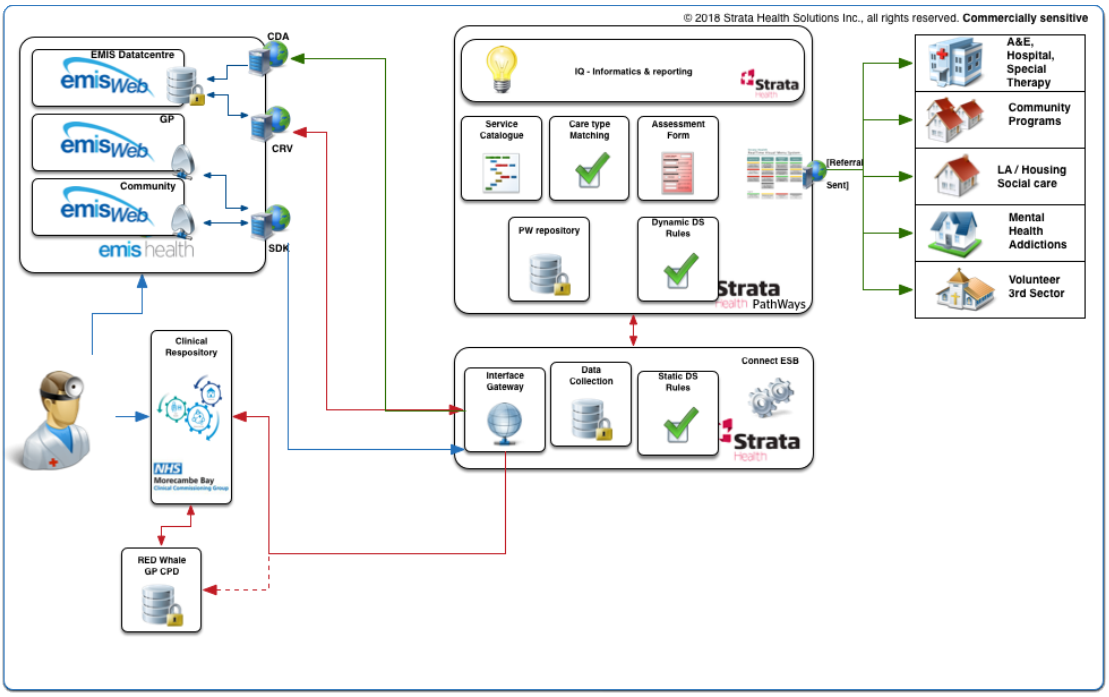
3.3.2.3 Data reporting

A full suite of reports and dashboards are also available through Strata IQ™ in order to provide a full view of solution performance and to help direct clients towards good decision making based on real-time evidence. As an example, the diagram below demonstrates how referrals are delivered from primary care with a CCG.

3.3.2.4 Technical / Integration

PathWays™ can integrate and communicate with existing health and social care applications through its integration engine, Strata Connect™ and has in-built communication tools for messaging and alerting.

Strata integration overview:



As well as bringing improvement to managing the flow of service users / patients, integration across NHS and Local Authority IT systems will improve process, collaboration and information flow. By then adding service integration with the external health and social care providers, the entire health and care system would see significant service benefits in transitioning patients to the most appropriate service. Throughout the process activity data allows measurement of improvements against set targets and metrics.

3.3.3 Refernet

3.3.3.1 Overview

Across all of Lancashire, the Citizens' Advice Bureau (CAB) have developed and are working toward full deployment of Refernet later this year, and are keen to engage partners from health and care. Refernet is a secure, online referral management system developed to provide secure communication between partners, offering external agencies and organisations a fool-proofed method of referring their clients for help.

Following almost ten years of development and after successful testing in other geographical areas, CAB have secured the licence for the whole of Lancashire and see this as a pan Lancashire project, with initial rollout due imminently in Chorley. In

the lead up to that initial launch, Chorley Borough Council / Lancashire Care Foundation Trust Integrated Wellbeing Team are currently testing the system.

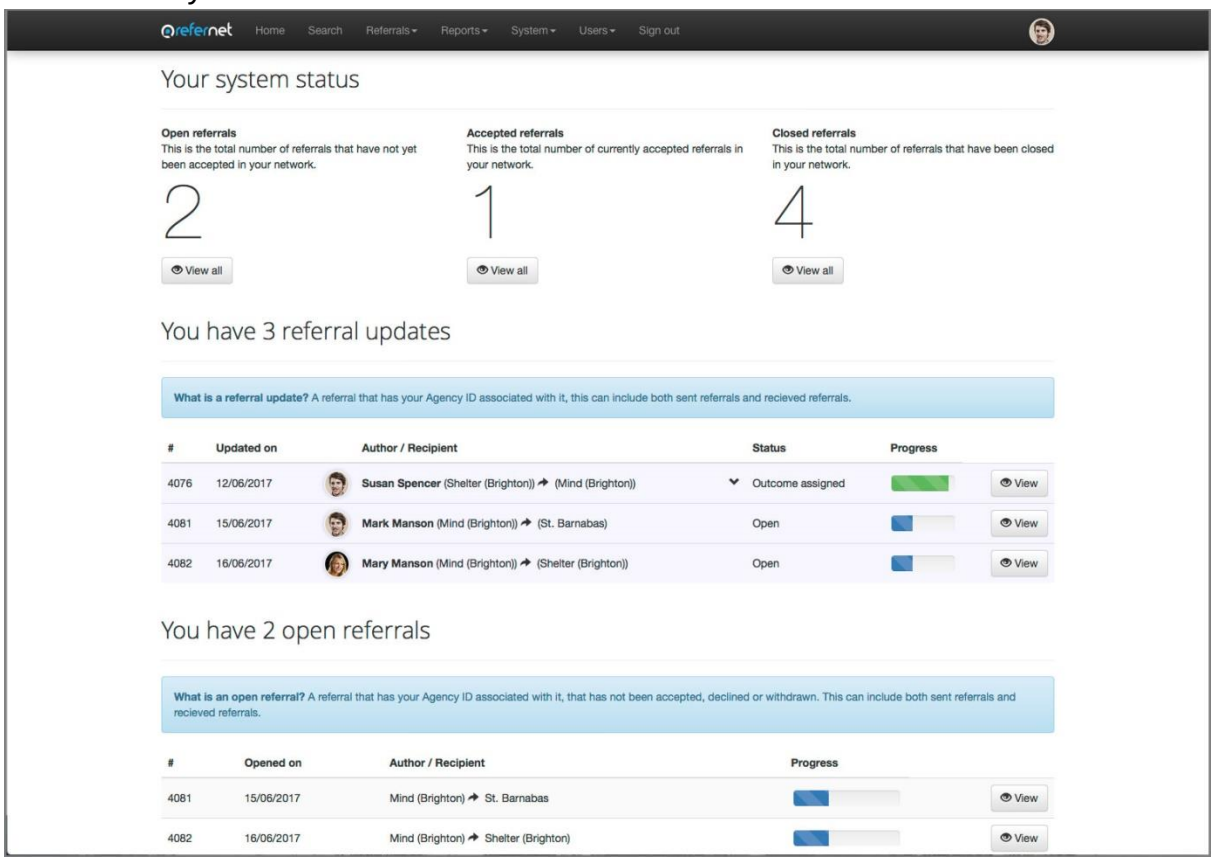
Full details of the Refernet platform can be found on the product website.

3.3.3.2 Clinical / social utility

Refernet is designed to complement existing case management tools or it could act as a simple case management system in its own right. It can be accessed by Citizens Advice, legal services, GP surgeries, housing trusts, mental health services, debt advice agencies, parole services and education services.

Referrals are made in-system (not within EPR; during an initial referral, demographics must be populated but are pre-filled for future referrals for the same individual) and received by the third sector organisation or care navigator in-system with an email alert. The patient interface is by text message only, and self-referral is not currently an option but may be developed at a later date.

Refernet in-system referrer view:



The overall goal of Refernet is one referral system that brings together all Statutory Bodies, Local Authorities, Health Agencies and the Third Sector in one place

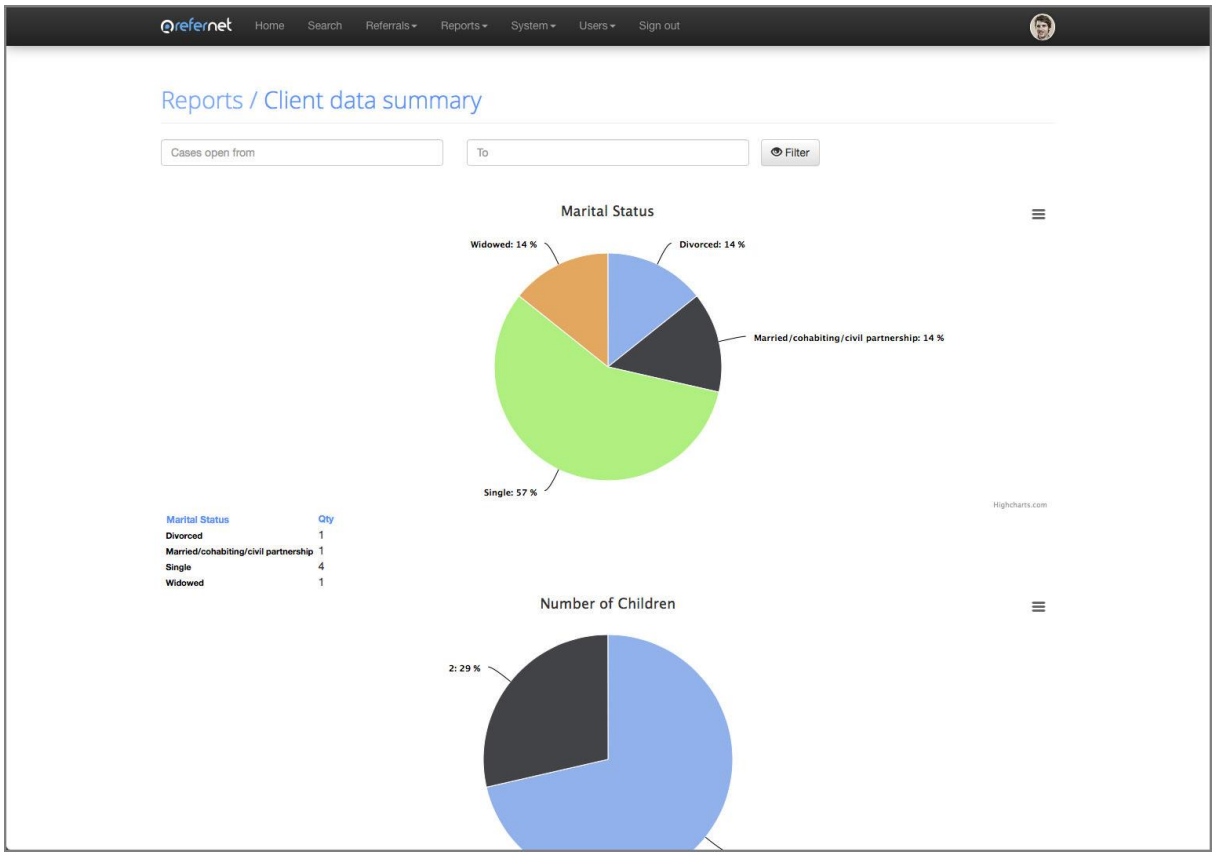
together with some carefully selected commercial organisations. It is completely customisable and is a bespoke system that can be adjusted in every way to tailor it to the needs of the partners.

Refernet provides network of partners with:

- An easy to use, simple and intuitive system
- Bespoke branding and identity
- Password protected accessibility for different user levels
- Network and individual agency reports available to system administrators
- Data security and password protected accessibility
- Wide application for national, regional and sub-regional partnerships
- No limit to the number of organisations or users
- Full search facility and filtering by category and level of service, geographical locations and more
- Enhanced service profiles
- Secure document transfer.

3.3.3.3 Data reporting

Refernet provides a trackable and auditable client journey with recorded outcomes:



3.3.3.4 Technical / Integration

Refernet does not currently offer integration with clinical or council EPR/PAS systems, and is only available as a stand-alone cloud-based system.

3.4 Other platforms/models outside the scope of detailed discussion in this paper

3.4.1 IEG4

IEG4's software solutions promote digital engagement between citizens and Local Government and Health Service providers. Together with the LGA and iStandUK, IEG4 worked toward the development of the LGA Data Standards discussed above and further in documents embedded in Appendix A. Due to commercial restrictions and the lack of alignment of public and commercial needs, pilot projects that were due to be completed in Blackburn with Darwen, West Lancashire and Central Lancashire never came to fruition.

The IEG4 platform has therefore not been explored in further depth. However, further details of their place-based solutions for social prescribing can be found on their website.

3.4.2 Our Lancashire

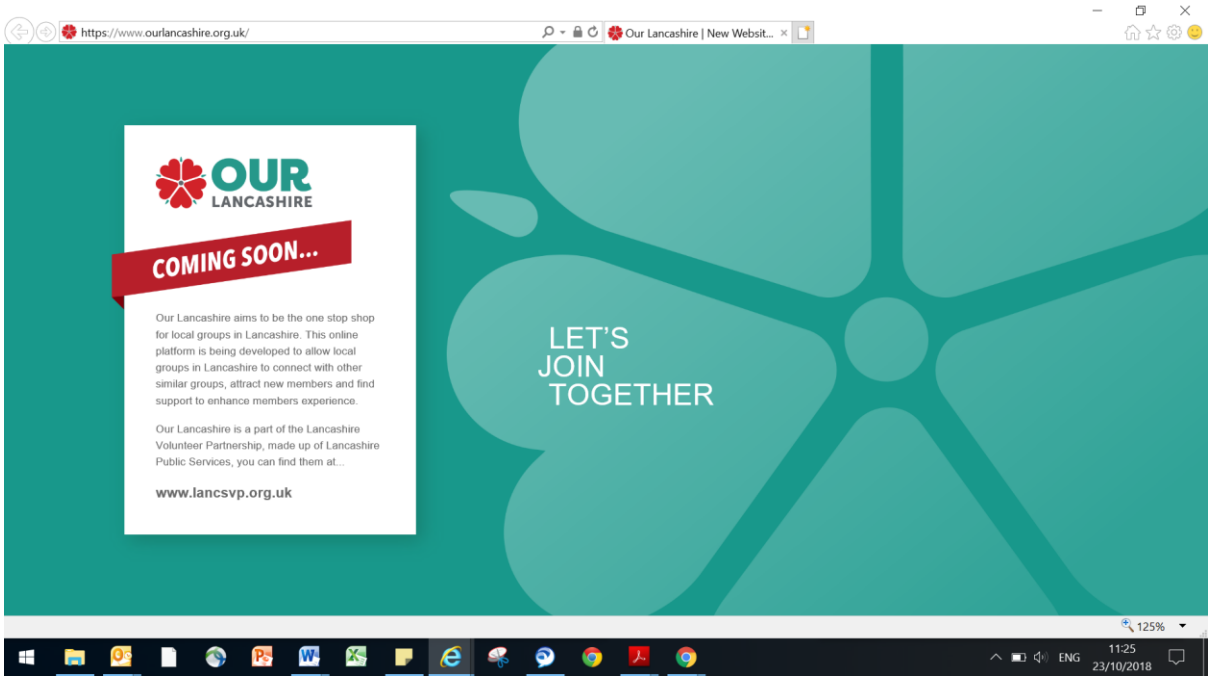
Lancashire Volunteer Partnership (LVP) are a well-established county-wide volunteer matching agency with the vision that "Lancashire Public Services have an integrated, efficient, effective and high quality Public Service Volunteer offer that matches resource with need, supports vulnerable people to get the help they need to become stronger and more resilient whilst reducing the demand on statutory services." A multi-agency strategy works toward integrated leadership and commissioning, integrated teams and workforce development, integrated data sharing and ICT systems, and the programme has delivered a social return on investment of £9.97. The impact of LVP in 2017/18 can be seen in the diagram below.

Next steps for LVP are to expand their work to "Our Lancashire," a new social action network for Lancashire hosting a new online platform/directory which would facilitate:

- A space where social action groups can register and advertise their work and interest category
- Linked to LVP ICT system and volunteer database
- Incorporate a crowd sourcing tool for good causes and provide access to partner funding grants
- An events diary for each area which would highlight the activities people could get involved in i.e. a litter pick, neighbourhood clear up, park support or public meetings etc.
- A mapping function allowing public services to target development time at those areas with less coverage
- A resource for public services, place based leaders and LVP Community Support Volunteers to see what community assets are available in any given area
- A facility that would allow similar social action groups or groups in the same neighbourhood to be able to contact each other and collaborate
- A data base of social action leaders across the County that public services could invite to local place based meetings

The vision for Our Lancashire is to:
"Bring together small local groups, clubs and associations across the county in one place, showcasing the work they do to support people in their community and helping them to grow." Our Lancashire aims to be more than a directory, it will be the place where people can find activities to get involved in, from go karting to knitting to litter picking, somewhere to make new friends and make communities stronger, providing a support network for people– hosted by the community for the community. It will feature an events diary for every area of Lancashire and will also serve as a resource for public services to see what community groups exist within an area, allowing them

to signpost people who could benefit from the network and to involve groups in meetings to improve where they live.



For the first time it will enable groups in the same neighbourhood to register their work, to see each other and create the opportunity to work together and access funding and support. This new and exciting programme will complete Lancashire's vulnerability triage and widen the County's capacity to keep people engaged and connected."

Our Lancashire will provide a county-wide directory of services, but not a professional referral mechanism. It must be noted, however, that the platform will offer further support and networking to registered community groups that does not appear to exist elsewhere at present. As this work is in progress (Project Manager currently being recruited and funds in place for website and database development) and will significantly overlap with existing and developing social prescribing models, collaboration should be considered to prevent duplication or inequality of community support (see 5.3 below)

3.4.3 FYI Directory

As discussed under section 2.5 above, the FYI Directory has been developed across the Fylde Coast as a public facing directory of services. However, like many directories, maintaining accuracy of the information can prove a challenge, and ICS engagement has suggested that many link workers/care navigators no longer access it due to lack of information currency. This could prove an excellent opportunity for collaboration and development under the LGA pilot proposals below (section 5.3).

3.4.4 MECCLink

MECC Link is a simple online tool designed to support to anyone delivering Making Every Contact Count within Yorkshire and the Humber, and is currently under consideration for rollout across Lancashire and South Cumbria.

MECC Link is designed to provide Very Brief Intervention (VBI) and signposting, to support people to embed and extend prevention and promotion of wellbeing and resilience into everyday practice by providing:

- Easily accessible information on key healthy lifestyle topics
- Suggested open questions using the Ask, Assist, Act model
- Information on a range of primary Self-care tools and resources
- Signposting to recommended national and local support services.
- On opportunity promote a social movement for MECC #MECCithappen

Although overlap exists with existing and future digital social prescribing and digital prescribing (via Orcha and the NHS Apps site) initiatives, MECCLink adds the unique opportunity for online very brief interventions. A single place-based directory of services, as proposed in section 5.3 below would ensure that this offer avoids duplication of service directory information and adds further value without additional costs of creating and maintaining a directory.

3.4.5 Active Lancashire

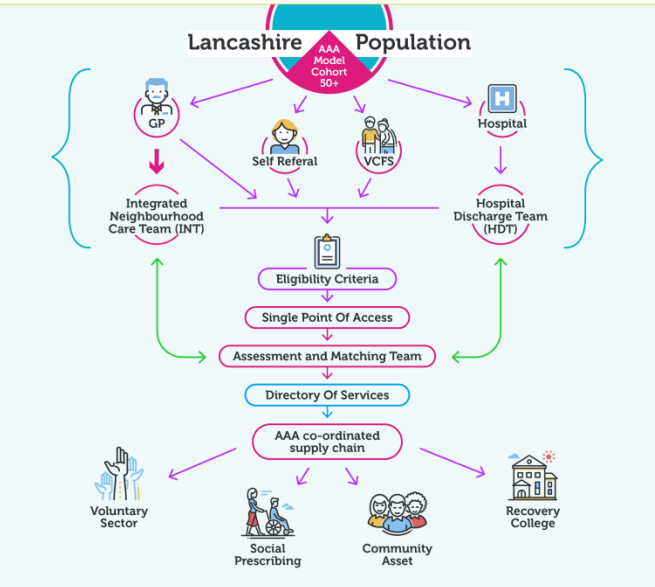
Active Lancashire have been supporting the Lancashire and South Cumbria health and care system with opportunities to increase access to physical activity for some years, and have actively engaged in supporting the third sector as a whole to support better health and wealth for all.

Active Lancashire have proposed an Active Ageing Alliance (full details in Appendix A) which aims to coordinate the social prescribing offer for people aged over 50 in Lancashire. This model could be incorporated into the proposals made in section 5.3 below, with Active Lancashire essentially acting as a broker for third sector organisations, offering the VCFS support and micro-commissioning third sector services in parts of Lancashire where multiple small contractual arrangements exist, rather than a unified approach such as in East Lancashire.

Active Lancashire proposed model for Active Ageing Alliance:

HOW DOES THE AAA WORK FOR THE CUSTOMER (1)?

- Person 50+ with LTC has non-medical need for support
- Identified/referred by self, GP, INT, VCF organisation
- Assessment and matching team works with customer to identify VCF support using Directory of Services
- Locality VCF provider works with others and community assets to deliver support by co-ordinated supply chain



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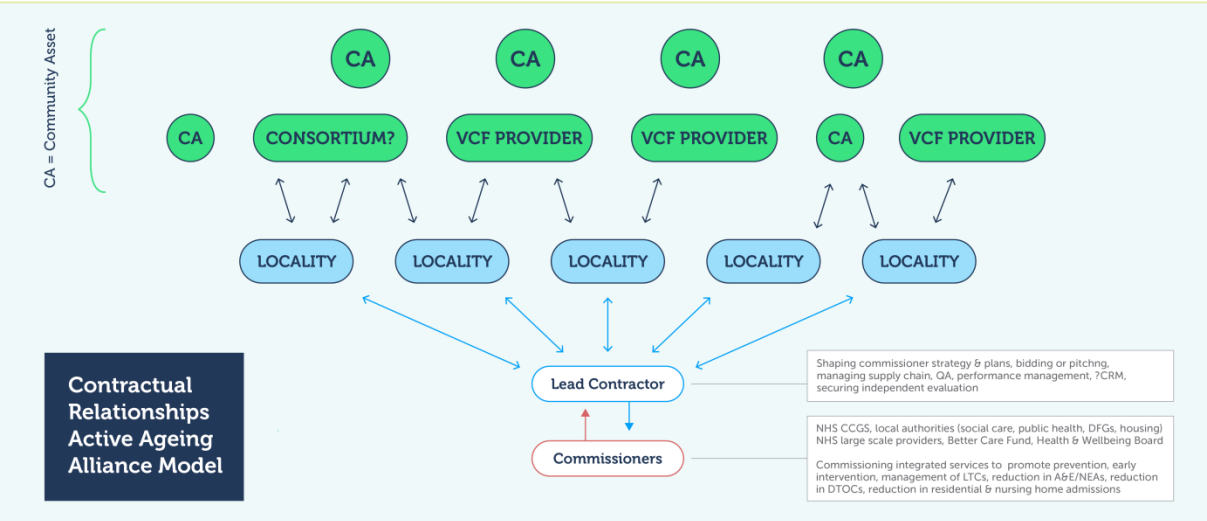
HOW DOES THE MODEL WORK FOR COMMISSIONERS AND PROVIDERS?



4. Other considerations

4.1 Integration with existing and proposed HLSC digital developments

At present, we are piloting a patient-facing app as a central portal to all our citizens' healthcare needs, the NHS Online Orb app. We are also in the process of

developing a Person-Held Record in collaboration with Parsek Vitaly, who host our shared care records platform; and a wellbeing platform, similar to the Good Thinking digital wellbeing service in London, is currently being considered as part of our delivery plan, but will be worked up with our citizens prior to any major financial investment or implementation. Any of these options, which would be fully implemented across the ICS, could offer a single point of access to any locally (ICP) procured social prescribing platform or directory of service. Further, these citizen-facing platforms would allow for a much more targeted approach to disseminating health, wellbeing, and health and care information, including both personalised care information as well as population and public health messaging.

Following successful adoption of the Patient Activation Measure (PAM) and training of both qualified professionals and those in care navigator roles as part of a Fylde Coast Vanguard, this model is now being rolled out across the Healthier Lancashire and South Cumbria integrated care system, including a Train the Trainer scheme. The Personalised Care demonstrator site programme provides an opportunity to facilitate this adoption at an increased pace, and adopting a digital social prescribing platform offers us an opportunity to embed PAM usage at scale across the region.

4.2 Digital literacy of third sector organisations

We take the view that digital literacy underpins digital health literacy, and recognise that not all of our frontline, including some smaller third sector organisations, will have high levels of digital literacy to support them to communicate digitally, to access social prescribing platforms at the provider end, or to gather and collate patient-reported or other outcome measures in a digital manner. Further exploratory work is being undertaken to see how we can support these smaller organisations across the system who may be delivering only small pockets of support, but which is very meaningful to the citizens they serve.

4.3 Co-production and digital delivery planning

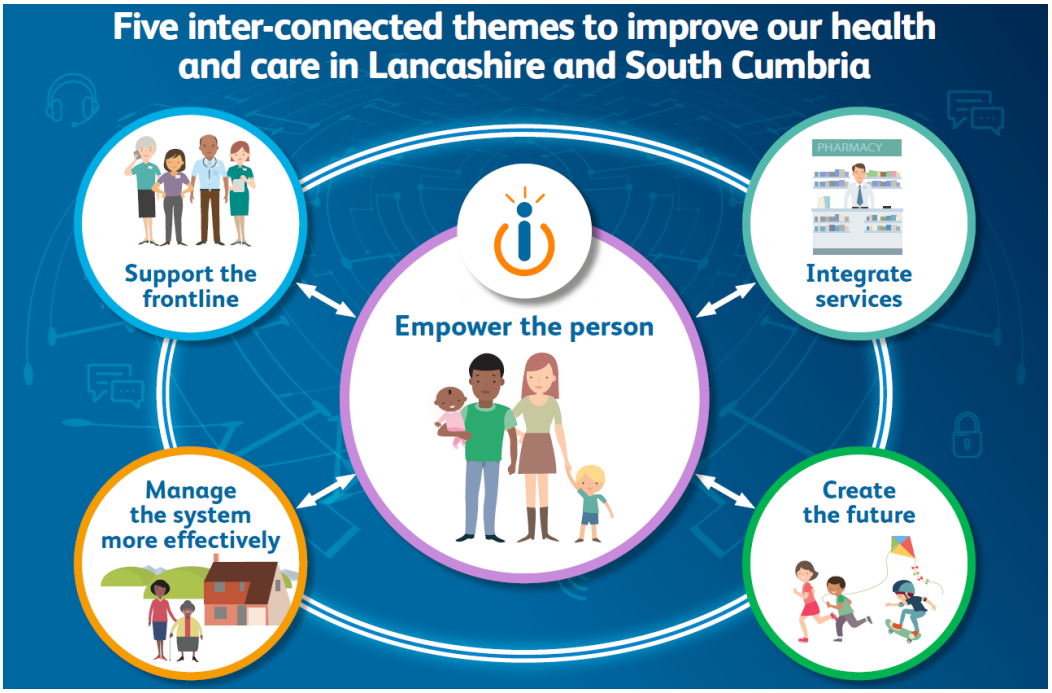
NHS England (2017[9]) have emphasised the importance of co-production with people with lived experience in delivering personalised care. They recommend that personalised care planning should:

- include patients and carers with lived experience on the development of the specification and the interview panels

[9] https://www.england.nhs.uk/wp-content/uploads/2017/09/harnessing-technology-personalised-care.pdf

- ensure co-production starts at the beginning of the development of the specification and not as an afterthought
- fully explore the requirements of care and support planning by identifying the experiences patient and carers want to have using a service
- understand what areas are important to the patient and carer
- think through and work with their IT supplier about how they link the different patient datasets to summarise and tell their story once
- facilitate engagement of IT suppliers with people with lived experience
- include people with lived experience in consideration of issues of information governance, information sharing and privacy.

At Healthier Lancashire and South Cumbria, we aim to embed co-production within all our digital transformation programmes, engaging authentically and proactively with our service users and partner organisations, including third sector organisations. Our Digital Delivery plan has recently been worked up with our stakeholders and service users to reflect our Digital Strategy and the needs of those partners. Our Digital Strategy can be seen to place Empowering the Person at the very heart of all our digital programmes of work (see diagram below) with all other workstreams being for the central goal of empowering our citizens and communities.



To take involvement of people with lived experience to a further level would mean to engage in an asset-based approach to community development, as detailed by McKnight and Russell (2018).

5. Recommendations

5.1 Proposed investment opportunities within Personalised Care demonstrator site year (2018/19)

Any proposals to invest in social prescribing should address the goal of empowering communities and individuals, rather than focussing purely on referral mechanisms.

Opportunities our stakeholders have expressed interest in support with include:

- A system-wide mechanism for measuring use and socioeconomic, as well as wellbeing outcomes, of social prescribing
- Deployment of one of the above platforms to facilitate local ICP referral pathways into social / community resources, including a self-referral pathway – this could be achieved across a single CCG locality, or in testbed areas across multiple CCGs within the ICS with a view to wider rollout if successful and sustainable funding sources secured
- Academic support for evaluation of the wider clinical, wellbeing and socioeconomic impact of social prescribing
- Supporting the integration/development of a place-based directory of services
- Supporting communities to adopt an asset-based community development approach – some useful tips to consider when developing a community's assets are explored by Russell (2017).

5.2 Wider considerations / potential collaborators

As referenced in the above discussion, opportunities exist to collaborate at scale with the Local Government Association, independent organisations such as Digital Gaps (supported the LGA place-based directory work in Bristol), Flexidigital (see below, and have worked extensively with Active Lancashire to create health data ecosystems and develop predictive modelling based on open-source data), and VCFS brokers such as Active Lancashire or the local CVS organisations.

Flexidigital's HealthHub gives people the power to share their health data with providers that can provide better care and services. They also help providers access, understand, and leverage their consumers' health information. Through a growing distribution network of integrations, Flexi have created a simple, on-demand way for everyone to exchange and use the health data they need, pioneering data-driven, consumer-centric health care.

Flexidigital approach to connecting healthcare data:

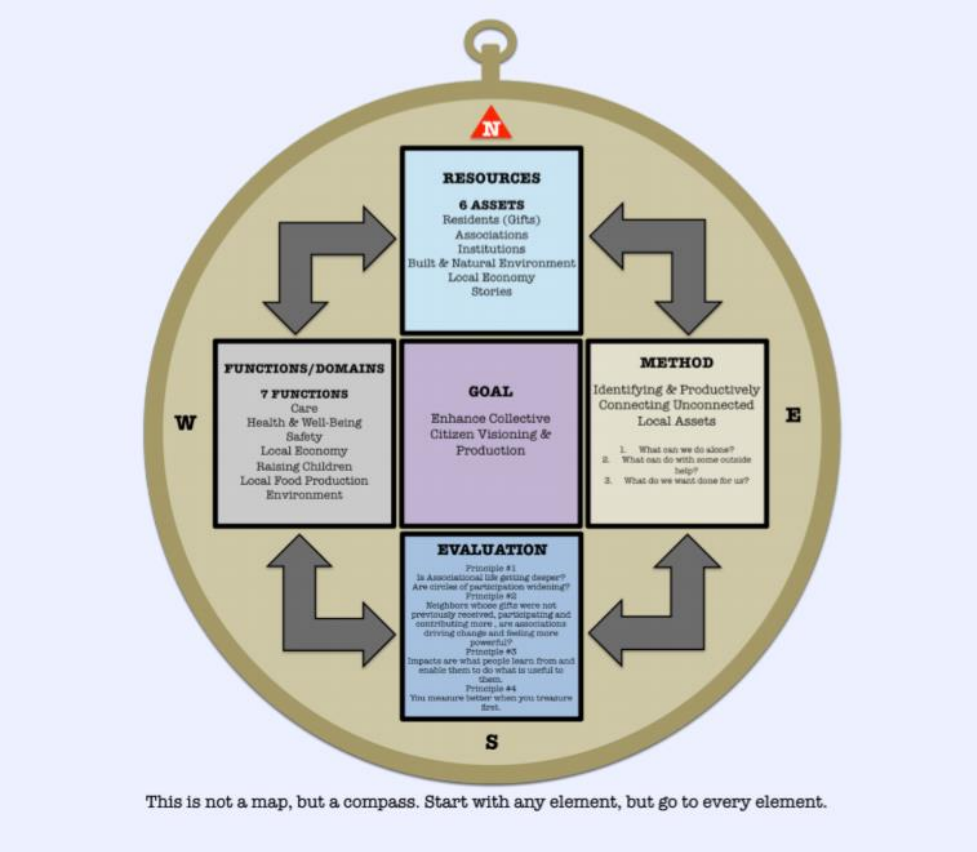
Further areas for exploration during and beyond the demonstrator site year could include:

- Incentivising volunteering and social activities. Well Skelmersdale in West Lancashire have been utilising the Better Points app to reward people for activities, this is discussed in more detail on the Well Skelmersdale blog. A similar scheme, Chorley Time Credits has been rewarding people for their time spent volunteering for local communities and public services. In East Lancashire, volunteer community connectors are recruited who provide a sustainable approach to expansion of the community connector scheme and are supporting groups to set up peer to peer support groups from external funding outside of the CCG social prescribing grants.

  Consideration should be given to integrating such schemes with a digital social prescribing offer in the future.

- Considering ways to support the development of sustainable cohesive communities. The work of Cormac Russell and Nurture Development is quite well known, and the principles of Asset-Based Community Development (ABCD) should be considered when developing any

community offering. The principles guiding this can be found in The Four Essential Elements of an Assed-Based Community Development Approach, and are illustrated below:



Further opportunities for community development could include exploring the approach taken by TGL Hubs who are currently exploring a community platform with Mydex, which will be available in 2019.

And any development of communities cannot overlook the funding and other resource necessary to support community development. In a recent Kings Fund blog, it was highlighted that Integrated Care Systems and their organisations "need to be serious about their role in supporting a vibrant voluntary and community sector, over and above investing in specific services."

5.3 Recommendations

Based on the overall findings and information reported in this paper, it is recommended that the Personalised Care Steering group propose the following on behalf of Healthier Lancashire & South Cumbria:

- **Community of Practice**

The ICS should support the development of a community of practice that includes representation from each ICP, including public sector providers and commissioners, members of VCSF organisations and patients/members of the public to share learning and help shape the strategic expansion of local social prescribing programmes and a standardised approach to the digitisation of social prescribing access and reporting across the region. This would help improve the equity of the social prescribing offer across the region and help facilitate streamlined regional support for local implementation. This group would feed into the Building Health Partnership group, the Personalised Care steering group under the Population Health portfolio and the Out of Hospital portfolio.

- **ICS-wide infrastructure: place-based directory of services**
  To further develop a unified regional social prescribing strategy, it is strongly recommended that we work in collaboration with the LGA and possible collaborators mentioned above to develop a single open-source place-based directory of services that can be maintained by a single team, the data of which can be consumed by any locally held and procured digital platforms, as well as other organisations seeking to develop alternative routes to community-based services, such as the Citizens' Advice Bureau and Our Lancashire.

  This will prevent the otherwise inevitable duplication of service lists as well as the inaccuracy and lack of currency of directories that are not maintained in a 'live' setting. Many of the organisations discussed above have expressed interest in working in a collaborative manner, and the work already conducted in Bristol has created the foundations on which this work can be built.

- **Support personalised care by offering digital social prescribing**
  Currently West Lancashire and Morecambe Bay are developing their social prescribing offer via a digital platform. It is recommended that East Lancashire and Blackburn with Darwen, Fylde Coast and Central Lancashire undertake the Digital Maturity Index assessment linked in 3.2 above, with a view to centrally procuring a digital social prescribing platform with demonstrator site funds, which would require ongoing local financial support after the first year. This support would facilitate an equal opportunity to access digital social prescribing across the region.

  During consultation, ICPs have expressed interest in piloting the Elemental platform, and it is proposed that the learning from the West Lancashire Elemental pilot study should be used as a basis for wider rollout across the

ICS, rather than repeating pilot studies within further neighbourhood localities.

The following conclusions can be made on the three digital social prescribing platforms reviewed:

- Refernet does not currently meet requirements, as it does not support integration with clinical or social care systems, and does not support a self-referral mechanism.
- Elemental meets all requirements and standards set out above, and could be considered by ICPs seeking to adopt a bespoke social prescribing platform without the added complexity of whole system patient flow. Elemental offers the most affordable option of those reviewed for system-wide rollout within this financial year. Other products not reviewed above may also meet requirements and be suitable for consideration.
- Strata meets all requirements and standards set out above, and could be considered by ICPs seeking to adopt a whole system patient flow approach across primary, secondary and social care, within the context of a wider review of inter-dependencies with other systems and processes (e.g. eRS). Other products not reviewed above may also meet requirements and be suitable for consideration.

Author	Responsibility	Date	Version
Linda Vernon	Digital Leader	01.11.18	V1.0
Linda Vernon	Digital Leader	30.04.19	V1.2