CABINET

Tuesday, 04 January 2022

Subject	Acceptance of funding from Ipswich and East Suffolk Clinical Commissioning Group (CCG) for the re-procurement of the Connect for Health Social Prescribing Programme
Report by	Councillor Mary Rudd Cabinet Member with responsibility for Community Health
Supporting Officer	Nicole Rickard Head of Communities nicole.rickard@eastsuffolk.gov.uk 07766998074

Is the report Open or Exempt?	OPEN

Category of Exempt Information and reason why it is **NOT** in the public interest to disclose the exempt information.	Not applicable
Wards Affected:	Aldeburgh & Leiston Deben Eastern Felixstowe Carlford and Fynn Valley Framlingham Kelsale and Yoxford Kesgrave Martlesham and Purdis Farm Melton Orwell and Villages Rendlesham and Orford Rushmere St Andrew Saxmundham Western Felixstowe Wickham Market Woodbridge

Purpose and high-level overview

Purpose of Report:

To seek approval to accept funding from Ipswich and East Suffolk Clinical Commissioning Group (CCG) for the Connect for Health Social Prescribing Programme in the south of East Suffolk, Babergh, Mid Suffolk and Ipswich, and to commence the re-procurement of the service in January 2022.

Options:

The former Suffolk Coastal District Council led the procurement of the original Connect for Health Social Prescribing Service on behalf of Ipswich and East Suffolk CCG, Suffolk County Council and Babergh and Mid Suffolk District Councils in 2019. This contract is due to expire on March 31, 2022, and East Suffolk Council has been asked to lead the re-procurement of the service. The CCG currently funds one day a week of the Head of Communities time plus an Integration and Partnership Manager post supporting the Integrated Neighbourhood Teams in the south of the District. This staffing capacity will work with the Council's Procurement and Legal Teams on the re-procurement of Connect for Health.

Recommendation/s:

That it be retrospectively agreed that the Council accepts a grant of a minimum of £1,626,000 from Ipswich and East Suffolk CCG, and that East Suffolk Council should lead the procurement process to secure providers to deliver Connect for Health in each of the eight Integrated Neighbourhood Team (INT) areas that make up the Ipswich and East Suffolk Alliance area. Should additional funding be secured for social prescribing this may be added into the contract.

Corporate Impact Assessment

Governance:

Monthly meetings are currently held with the four current Connect for Health providers and monthly monitoring reports are provided to the CCG. Progress with the contracts is reported to the Cabinet Member at monthly briefing meetings. The lead provider for Connect for Health in each Integrated Neighbourhood Team (INT) area is now part of the INT Core Leadership Team. These arrangements will continue with the new Connect for Health providers.

ESC policies and strategies that directly apply to the proposal:

The Council's Enabling Communities Strategy emphasises that *"it is important that people look after their own mental and physical health and wellbeing. This includes managing what are known as 'long term conditions' such as diabetes, dementia, depression, heart disease and arthritis. We want to help people to make good choices, ensure that they do not put themselves or others at risk and encourage them to look out for and after each other".* Social Prescribing is a great way of enabling and supporting people to take control of their own health and wellbeing. The beneficiaries of Social Prescribing are often people with protected characteristics identified within the Equality Act 2010, for example older

people (Age), Deprivation (Socio-Economic Disadvantage) and people with disabilities or long-term health conditions (Disabilities) – see below.

Environmental:

Social Prescribing Schemes such as Connect for Health often link people into green and blue sources of support (land and sky-based activities). This is known as green and blue social prescribing.

Equalities and Diversity:

Age is one of ten Protected Characteristics identified by East Suffolk Council (the nine protected characteristics identified in the Equality Act plus deprivation/socio-economic disadvantage). Connect for Health supports people across the Age spectrum but in some areas a significant proportion of clients are those aged 65 and over. In some parts of the District there is a correlation between the level of deprivation and the clients accessing Connect for Health. Approximately a third of clients accessing the current Connect for Health programme have a disability or long-term health condition. Connect for Health therefore has, and would continue to have, a positive impact on Equality and Diversity.

Financial:

Whilst East Suffolk Council has been asked to be the Accountable Body on behalf of Ipswich Borough Council, Babergh and Mid Suffolk District Councils and the CCG, all of the funding for Connect for Health in Years 4 and 5 is being provided through the Ipswich and East Suffolk Alliance via the CCG. This funding totals £1,626,00 for a two-year project but this may be supplemented if additional funding is secured through Alliance partners or from external sources.

This is made up of £240,000 for a Community Chest to be used to fund VCSE organisations in each INT area who receive referrals from Connect for Health and/or funding for new projects to fill identified gaps. The remaining £1,386,000 will be allocated across 8 lots – one per INT for 21 months from July 2022 to March 2024.

There is no East Suffolk Council contribution to the project, although there is an implication in terms of staffing to lead and run the procurement project.

Human Resources:

The Head of Communities and Integration and Partnerships Manager are both part-funded by the CCG and will lead the Procurement process, supported by colleagues in the Procurement and Legal Teams who already have it factored into their work programmes.

ICT:

None

Legal:

A contract will be developed on the basis of both the procurement documentation and the existing contracts for each of the successful providers. Each provider could deliver between one and eight contracts as there are eight lots – one per Integrated Neighbourhood Team area.

Risk:
The main risk is likely to be the transition from one provider to another if a different provider (to the current one) is successful with one or more lots. TUPE applies as the staff working on this project have all been in post for up to three years (the original contract was a 1+1+1 contract)

External Consultees:	This proposal has been developed in conjunction with Ipswich and East Suffolk CCG and considering feedback from a Connect for Health provider workshop held in October 2021.

Strategic Plan Priorities

Select the priorities of the Strategic Plan which are supported by this proposal: *(Select only one primary and as many secondary as appropriate)*		**Primary priority**	**Secondary priorities**
T01	**Growing our Economy**		
P01	Build the right environment for East Suffolk	☐	☐
P02	Attract and stimulate inward investment	☐	☐
P03	Maximise and grow the unique selling points of East Suffolk	☐	☐
P04	Business partnerships	☐	☐
P05	Support and deliver infrastructure	☐	☐
T02	**Enabling our Communities**		
P06	Community Partnerships	☐	☒
P07	Taking positive action on what matters most	☐	☒
P08	Maximising health, well-being and safety in our District	☒	☐
P09	Community Pride	☐	☒
T03	**Maintaining Financial Sustainability**		
P10	Organisational design and streamlining services	☐	☐
P11	Making best use of and investing in our assets	☐	☐
P12	Being commercially astute	☐	☐
P13	Optimising our financial investments and grant opportunities	☐	☐
P14	Review service delivery with partners	☐	☐
T04	**Delivering Digital Transformation**		
P15	Digital by default	☐	☐
P16	Lean and efficient streamlined services	☐	☐
P17	Effective use of data	☐	☐
P18	Skills and training	☐	☐
P19	District-wide digital infrastructure	☐	☐
T05	**Caring for our Environment**		
P20	Lead by example	☐	☐
P21	Minimise waste, reuse materials, increase recycling	☐	☐
P22	Renewable energy	☐	☐
P23	Protection, education and influence	☐	☐
XXX	**Governance**		

XXX	How ESC governs itself as an authority	☐	☐

How does this proposal support the priorities selected?

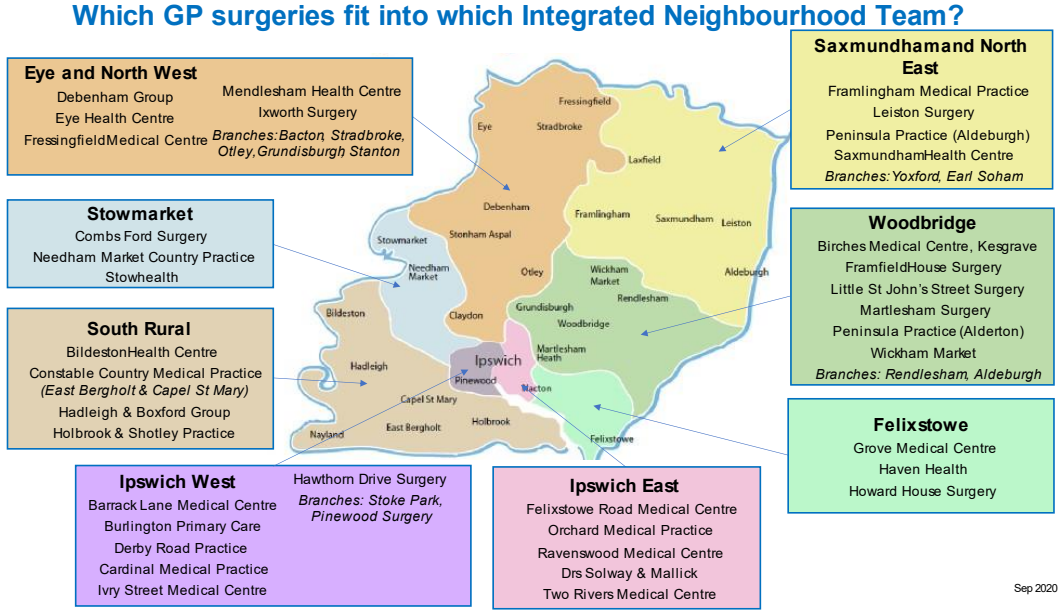
Social Prescribing is a person centred and asset-based approach to supporting people to maintain good physical and mental health and wellbeing. The description of P08 is *'We will provide the environment and opportunities for everyone to lead healthy, active, fulfilling and safe lives. We will connect communities together and help individuals and families to be more resilient, achieve their full potential and age well. We will ensure our communities are safe, helping communities to address issues as early as possible'*. Social Prescribing clearly contributes to this ambition in that it is all about understanding people's goals/ambitions and their personal assets, supporting them to be more resilient and connecting them into community groups and voluntary organisations in their local area.

Social Prescribing also contributes to P06 in that a number of the Community Partnerships have identified supporting mental and physical health and wellbeing as a priority. The Community Partnership Board has Mental Health and Wellbeing as one of its three priorities and more than a third of Connect for Health clients in the first two and a half years wanted support with their mental wellbeing.

P07 talks about using data and intelligence to provide a *'better experience for individuals, families and communities. We will take a targeted, place-based approach to tackling, deprivation, hidden needs and the challenges of rural areas – helping communities to access the tools to identify and tackle their own needs'*. The premise of social prescribing is helping to connect people into support and resources in their own communities and providing the tools and support to enable them to understand their own goals and needs and take the necessary steps to tackle their needs using both their own assets and the assets in their local community.

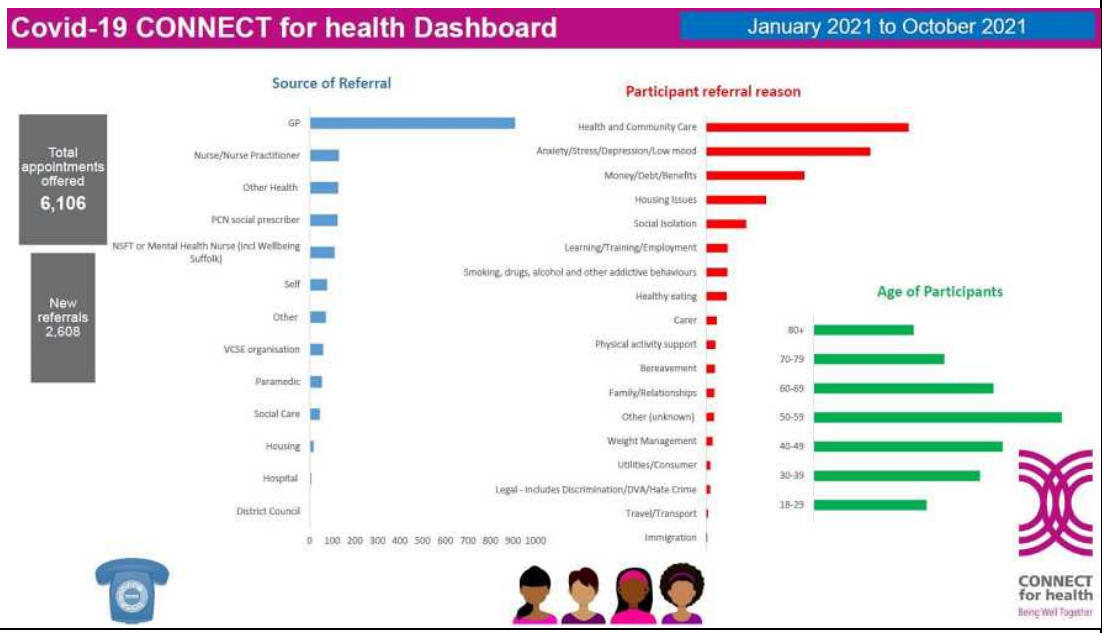
Background and Justification for Recommendation

1	Background facts
1.1	It is estimated that GPs spend a minimum of 20% (and up to 40%) of their time dealing with non-clinical, social issues - social prescribing is a way to deal with this demand more appropriately and release capacity in the system by connecting people back into their communities and into local support from community groups and voluntary organisations, with services as a last resort.
1.2	In August 2018, Ipswich and East Suffolk CCG announced a new, one-off transformation funding pot of £3 million across the whole Ipswich and East Suffolk area. A Steering Group was convened to develop a bid around Social Prescribing at scale across the CCG area. The bid was written by the ESC Head of Communities working closely with partners from the County Council, CCG and Babergh and Mid Suffolk District Councils, in consultation with GP leads on social prescribing and patient representatives. This bid secured the second biggest funding award from the Transformation Fund of £549,507.
1.3	Despite the size of the award, this funding was not sufficient to roll out Social Prescribing across the whole area as per the model proposed in the bid and therefore a second bid for match funding was submitted to the Suffolk Transformation Challenge Award (TCA). This bid was agreed in November 2018 by

	the Suffolk Public Sector Leaders and secured a further £137,260 (including an allocation for Waveney). The CCG made a separate allocation of £250,000 available for social prescribing in Ipswich and therefore the CCG Transformation and Suffolk TCA funding only covered the three Districts of (then) Suffolk Coastal, Babergh and Mid Suffolk.
1.4	Connect for Health is a person centred, health coaching approach to working with individuals with a focus on 'what matters to me?' rather than 'what's the matter with me?'. It includes agreeing an action plan with clear goals, large and small. The ultimate aim of Social Prescribing is to ensure better outcomes for individuals and more appropriate use of NHS, social care and other public sector resources. This releases capacity across the system to enable those who require specialist/clinical support to access it sooner. Specific benefits for individuals include managing long term conditions more effectively, reduced social isolation and loneliness, enabling people to identify, prioritise and manage their own health and life needs and reduced need to access GP, social care, A&E and prescribing services.
1.5	The original Connect for Health Social Prescribing contract focussed around the areas covered by 6 Integrated Neighbourhood Team (INTs) - health and social care teams working together - in the three Districts. Each of the INTs covers between 3 and 6 GP practices.
1.6	The Tender process commenced in February 2019 and the Connect for Health programme went live from July 2019.
1.7	**Which GP surgeries fit into which Integrated Neighbourhood Team?**  The successful providers for each of the six Integrated Neighbourhood Teams are shown below: Saxmundham and North East (4 GP practices and 2 Branch Surgeries) – Access Community Trust Woodbridge (6 practices) – Shaw Trust Felixstowe (3 practices) – Access Community Trust South Rural (4 practices) – Suffolk Family Carers Stowmarket (3 practices) – Suffolk Family Carers Eye and North West) (5 practices with 5 branches) – Suffolk Family Carers
1.8	The contract was on a 1+1+1 basis depending on the performance of the Provider organisations and the ability to secure further funding on the basis of performance

	in year one of the contract. Additional funding was secured from Ipswich and East Suffolk CCG for a further 21 months of Connect for Health (to March 2022).
1.9	Ipswich Citizens Advice, who deliver Connect for Health in the Ipswich area were added into the contract held by East Suffolk Council in April 2021.

2 Current position

2.1	East Suffolk Council and Ipswich and East Suffolk CCG now jointly manage the contract with the four providers that cover the Ipswich and East Suffolk Alliance area. These providers are Access Community Trust (2 INT areas), Ipswich Citizens Advice (2 INT areas), Shaw Trust (1 INT area) and Suffolk Family Carers (3 INT areas). Connect for Health has been live for more than two years across the Alliance area and is demonstrating clear benefits.
2.2	Regular reports are received by the Alliance Executive Delivery Group and Board on Connect for Health impact. An example of the dashboard presented to the Executive Delivery Group in December 2021 is shown below: 
2.3	A recent Provider Workshop identified a range of benefits and challenges associated with the current programme, some of which are highlighted below: **Current Examples of Good Practice** • Asset based approach with the person at the heart of the service • 'Discovery Sessions' with each individual • Focus on goals and work around 'micro-goals' • Development of asset maps of the INT area • Two providers have an emerging group support offer • One provider is piloting therapeutic services in community settings • Motorhome to meet with those who are isolated (SFC) • Opportunities to influence Population Health Management work • Focus on an exit strategy to avoid danger of creating dependency • Use of the NHS England Social / Biological / Psychological Social Prescribing model

	Challenges • Increase in demand across all areas • Lots more admin support needed than anticipated • More mental health related and complex referrals • Some confusion about relationship with separate PCN funded Link Workers • Challenge of providing outreach support to rural areas • Limited groups and services to refer to, particularly in rural areas • Density, demographics and complexity in Ipswich • Awareness of Community Chest low • Challenges with SystmOne • Lack of consistency across C4H areas

3	How to address current situation
3.1	The proposal is to go out to tender in January 2022 for a Connect for Health provider for each of the eight Integrated Neighbourhood Team areas. The funding available will enable a 5% uplift from the funding available in 2021/22.
3.2	Given the increase of associated programmes around High Intensity Users, Ageing Well, Learning Disabilities and Hospital Discharge each of which draws upon social prescribing approaches and resources, ideally additional funding, roles and/or capacity will be wrapped into the programme when it commences on July 1st, 2022. The CCG is currently trying to secure additional resources from a number of sources and to ensure that funding for social prescribing is built into future programmes, particularly those focussing on personalised care.
3.3	It is proposed that the funding be accepted by East Suffolk Council and that the Council leads the procurement process on behalf of the other District and Borough Councils and the CCG. The procurement process would run from January to March 2022, with the successful providers being notified by the end of March. The existing Connect for Health programme will continue to run to the end of June 2022. The new contract will start on July 1st, 2022 and will be let on a 21 month + 12 + 12-month basis.
3.4	The tender will be based up the original tender document but will reflect learning from the first 2 plus years of Connect for Health. Much work has been done during this period to identify a core learning and development programme for Social Prescribing Link Workers and to refine the performance measures. All providers are now using SystmOne – although it is important to note that the Link Workers do not have access to GP and other health practitioners' notes relating to individual patients.
3.5	The funding available from the CCG also includes funding for a £15,000 Community Chest for each of the eight Integrated Neighbourhood Team areas for both 2022/23 and 2023/24 to be allocated through the Integrated Neighbourhood Team.

4	Reason/s for recommendation
4.1	Connect for Health has had a proven impact both in terms of achieving outcomes for individuals and reducing pressure on health and care practitioners, particularly

	with the advent of Covid-19. Social Prescribing is a core element of the emerging personalised care agenda and health and wellbeing programmes increasingly include an element of social prescribing to support and enable individuals and increase both individual and community resilience.
4.2	Having led the initial procurement of Connect for Health working with the CCG, East Suffolk Council is best placed to lead the re-procurement process.

Appendices

Appendices:
None

Background reference papers:
None