CWM TAF PUBLIC SERVICES BOARD - JOINT OVERVIEW & SCRUTINY COMMITTEE

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	PSB Support Team
Committee Date	7th February 2020

Agenda Item: 6

Update Report on the work to date on developing a shared regional (Cwm Taf Morgannwg-wide) understanding and approach to Social Prescribing.

1.0 SUMMARY OF THE REPORT

1.1 To provide the Joint Overview and Scrutiny Committee (Committee) with oversight of the role of and work undertaken by the Board in relation to Social Prescribing in Cwm Taf and beyond, working to the Health Board footprint and inclusive of the Regional Partnership Board (RPB) and Bridgend PSB.

Social Prescribing has been identified as a priority for Cwm Taf Morgannwg and an area of work where the involved Boards can collaborate to maximise the collective impact. This work will directly contribute to delivering on the Well-being Plan and Objectives.

This Report is a summary of the work to date and an outline of the proposed next steps.

2.0 RECOMMENDATIONS

2.1 The Committee is requested to:

i. Consider and note the content of this report.

ii. Identify any further information it would like to consider in support of the delivery of the Well-being Plan and the wider remit of the PSB in respect of well-being and sustainable development principles (the five 'Ways of Working').

3.0 INTRODUCTION AND BACKGROUND

3.1 As Members are aware, the Cwm Taf Well-being Plan 2018-2023 was published on the 4th of May 2018 and contained four Objectives:-

- Thriving Communities
- Healthy People
- Strong Economy
- Loneliness & Isolation (cross cutting Objective)

Social Prescribing features throughout the Plan and its Objectives, particularly in the Thriving Communities 'Zone' development work and as a method for tackling loneliness and isolation. It is also discussed in the RPB's Regional Plan and Bridgend PSB's Well-being Plan.

A concept paper (Appendix 1) was produced by Sara Thomas, Consultant in Public Health; Gillian Day, Health and Wellbeing Development Manager, Primary Care, CTMUHB; Simon James, CEO, Interlink; Ian Davy, Chief Officer, VAMT in March 2019. This was reviewed and updated in May 2019 following the further involvement of Andrew Thomas, BCBC; Helen Hammond Bridgend PSB; Sally Rees, WCVA; Anne Morris, Interlink; Kay Harries, BAVO; Kirsty Smith, Bridgend PSB; Sarah Mills and Nia McKintosh, Regional Commissioning Unit.

3.2 This concept paper was presented to the Strategic Partnership Board (SPB) of Cwm Taf PSB on 25 June 2019, and the RPB on 11 July 2019. It was also received by Bridgend PSB's Asset Board.

4.0 CURRENT POSITION

4.1 At the June SPB meeting a request was made from the Vice-Chair that focused attention be given to understanding the mechanism for social prescribing, looking at the roles acting as connectors and understanding what we've got, both within the Public Sector and community owned/developed.

4.2 The Social Prescribing group comprising representatives from all the involved Boards met on 22 October, 2 December and 20 January.
Membership and terms of reference for the group has been agreed. The initial focus has been on agreeing a definition of Social Prescribing, as set out in the concept paper (Appendix 1) and trying to develop a baseline of current social prescribing arrangements across Cwm Taf Morgannwg as well as the funding streams being accessed for supporting the work.

The Project Initiation Document (Appendix 2) outlines the planned approach for the group.

4.3 There has also been some funding allocated from the Minister for Health and Social Services directly to Health Boards to support the effective interventions in relation to early years and the prevention of ill health, with the intention of using the funding as part of a wider shift towards prevention.
One of the proposals for Cwm Taf Morgannwg Health Board is to use the funding to look at sustainability and supporting community assets for social prescribing, as identified in the concept paper (Appendix 1) and help to meet identified gaps in provision. The group supported that the proposals, and these were submitted to the

Boards for approval, with submissions for the proposals being entered before Christmas.

5.0 FUTURE REQUIREMENTS

5.1 The Group remains conscious of integration with the Valleys Regional Park work around green spaces, and ongoing work with the Enhanced Community Cluster Team.

This work remains central to demonstrating effective collaboration and integration between the two Public Services Boards of Cwm Taf Morgannwg as well as the Regional Partnership Board

6.0 NEXT STEPS

6.1 The Social Prescribing Group is next due to meet 24 February.
As set out in the Project Initiation Document (Appendix 2), the key milestones for the Group are to include:

- Baselining current delivery across the three local authorities and undertaking a collective community asset gap analysis.
- Developing a best practice model framework, including communication methods both internally for sharing information and externally for public awareness raising.
- Looking at sustainability and funding, including proportionate funding opportunities to ensure equity in provision.
- Agreeing a Common Outcome Framework to help demonstrate an evidence base and measure the impact of Social Prescribing across the region.

The Group asks that JOSC note the content of this Report and Appendix, and identify any further information it may need to scrutinise this approach and its contribution to delivering the Well-being Plan and Well-being of Future Generations Act in Cwm Taf.

Social Prescribing

Purpose

The purpose of this concept paper is to:

- Develop a shared understanding of social prescribing and what good looks like; why social prescribing improves outcomes and experiences for people, their families and carers, as well as achieving more value from the system

- Recognise the three key components of social prescribing (referrer, link-worker and sustainable community assets) and the importance of striking a balance between the resourcing of all three

- With reference to the current model inform future commissioning/planning of social prescribing schemes locally including how it can be scaled up to achieve a population level effect by enabling other agencies to refer people with wider social needs to a link worker and community based support

- Build on collaborative working amongst all partners at a locality level, to recognise the value of community groups and assets which enable people to build or rebuild friendships, community connections and a sense of belonging, as well as accessing existing services

Introduction

There is increasing acceptance that sources of support in local communities have an important role to play alongside clinical care or even as an alternative in improving an individual's health and wellbeing outcomes. The concept of S*ocial Prescribing* or *community referral (to support within the community)* can reduce social isolation and loneliness, improve individual emotional and physical wellbeing[1]. Though there is a need for more robust and systematic evidence on the effectiveness of social prescribing[2], in addition to improved individual wellbeing, social prescribing schemes may lead to a reduction in the use of statutory public services including reduced attendance at GP and accident and Emergency departments [3], 59% of GPs think social prescribing can help reduce their workload[4].

[1] Dayson, C. and Bashir, N. (2014), The social and economic impact of the Rotherham Social Prescribing Pilot. Sheffield: Sheffield Hallam University: https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham.pdf
[2] Bickerdike, L., Booth, A., Wilson, P.M., et. Al. (2017), Social prescribing: less rhetoric and more reality. A systematic review of the evidence, BMJ Open 2017;7:e013384. doi: 10.1136/bmjopen-2016-013384
[3] Polley, M. *et al.* (2017), A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications. London: University of Westminster
[4] RCGP (2018). Spotlight on the 10 high impact actions. Available online http://www.rcgp.org.uk/about-us/news/2018/may/rcgp-calls-on-government-to-facilitate-social-prescribing-for-all-practices.aspx (accessed 2 June 2018)

Whilst there has been a generally positive response to the concept of social prescribing, there has been some debate about the term used. There is suggestion that on the one hand use of the word “prescribing” is unhelpful as it perpetuates a reliance on a medical model of care with other views that it promotes acceptance by patients who might otherwise view a non-medical solution as inferior. *Social Referral* has been suggested as an alternative term.

The community support and wellbeing services are often provided by people working and volunteering in the third sector or independent sector, complementing the role played by statutory organisations. Knowledge of the support and services available in a community is often poor, highlighting the need for improved Information, Assistance and Advice (IAA).

Properly resourced and coordinated, social prescribing presents a real opportunity to work together and make a significant positive impact on both individual and community health and wellbeing in Cwm Taf Morgannwg.

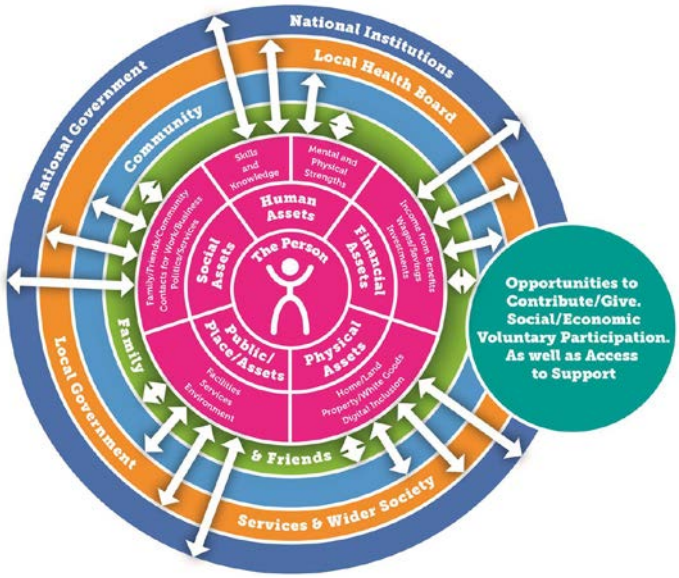
Background

Underpinning the psycho-social model of social prescribing is the fact that for many people, what happens in their neighbourhoods and communities is essential to their wellbeing. Resilient communities have significant social capital, they have effective and connected community organisations that can act as the ‘glue’ to hold communities together. These local networks and community organisations, especially for people on lower incomes in areas of high deprivation, are critical for helping people to cope with life challenges and for individual and community wellbeing.

To bring about lasting change in communities involves supporting communities to connect and work together, to build on the ability of individuals and the community to help themselves, to build on what works.

A model depicting the relationship between individuals and their wider community (Figure 1) highlights an individual’s need for opportunities to give and volunteer as well as their access to support.

Figure1: From Humanising Services and Building Communities (O’Hara-Jakeway, 2017)



Asset Based Community Development - It is imperative that public service provision is planned with regard to what already exists and works in that community, listening to the community voice. Otherwise there is a danger that resources may be inadvertently taken away or prevented from reaching community organisations in favour of paying professionals to 'help' the community. The resources available must be directed at what matters most to people, where they need it to improve their own health and wellbeing.

What is Social prescribing?

Social prescribing is a process to help people make positive changes in their lives and within their communities by linking people to volunteers, activities, voluntary and community groups and public services that can help them to:

- feel more involved in their community
- meet new people
- make some changes to improve their health and wellbeing
- reduce social isolation and loneliness

It aims to understand and address people's needs in a holistic way and to support them to take greater control of their own life.

There are many different models of social prescribing and most involve a referral to a link worker or co-ordinator who work with people to understand their situation and goals, co-produce a plan and help connect them to local sources of support. Typically provided by voluntary and community sector organisations, support may include volunteering opportunities, arts activities, gardening, befriending, cooking, financial advice, lifestyle behaviour change, physical activity.

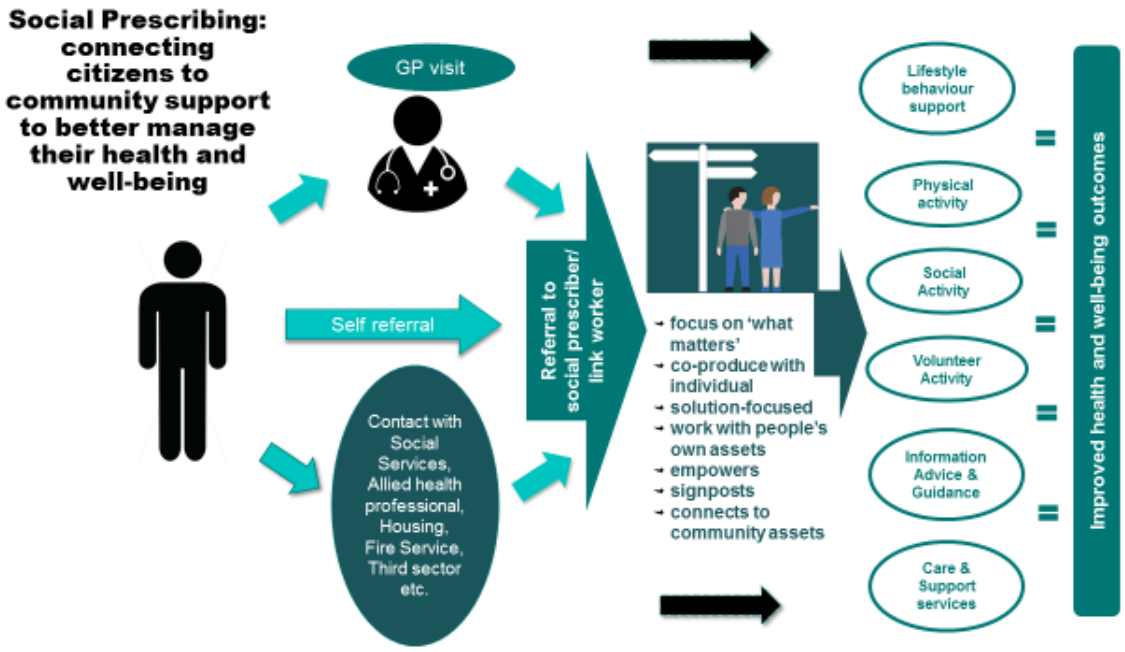
In General Practice, an estimated 20% GP appointments are of a non-clinical nature[5]. Figure 2 represents social prescribing where the referral follows a GP consultation; the referral to link worker/ co-ordinator could however be generated by another healthcare professional, other agency or self-referral.

Definition of Social Prescribing:

"Social prescribing seeks to address people's needs in a holistic way whilst recognising that people's health is determined primarily by a range of social, economic, and environmental factors. It aims to support individuals to take greater control of their own health and wellbeing through linking people to support in their community."

5 https://www.citizensadvice.org.uk/Global/CitizensAdvice/Public%20services%20publications/CitizensAdvice_AVeryGeneralPractice_May2015.pdf

Figure 2:



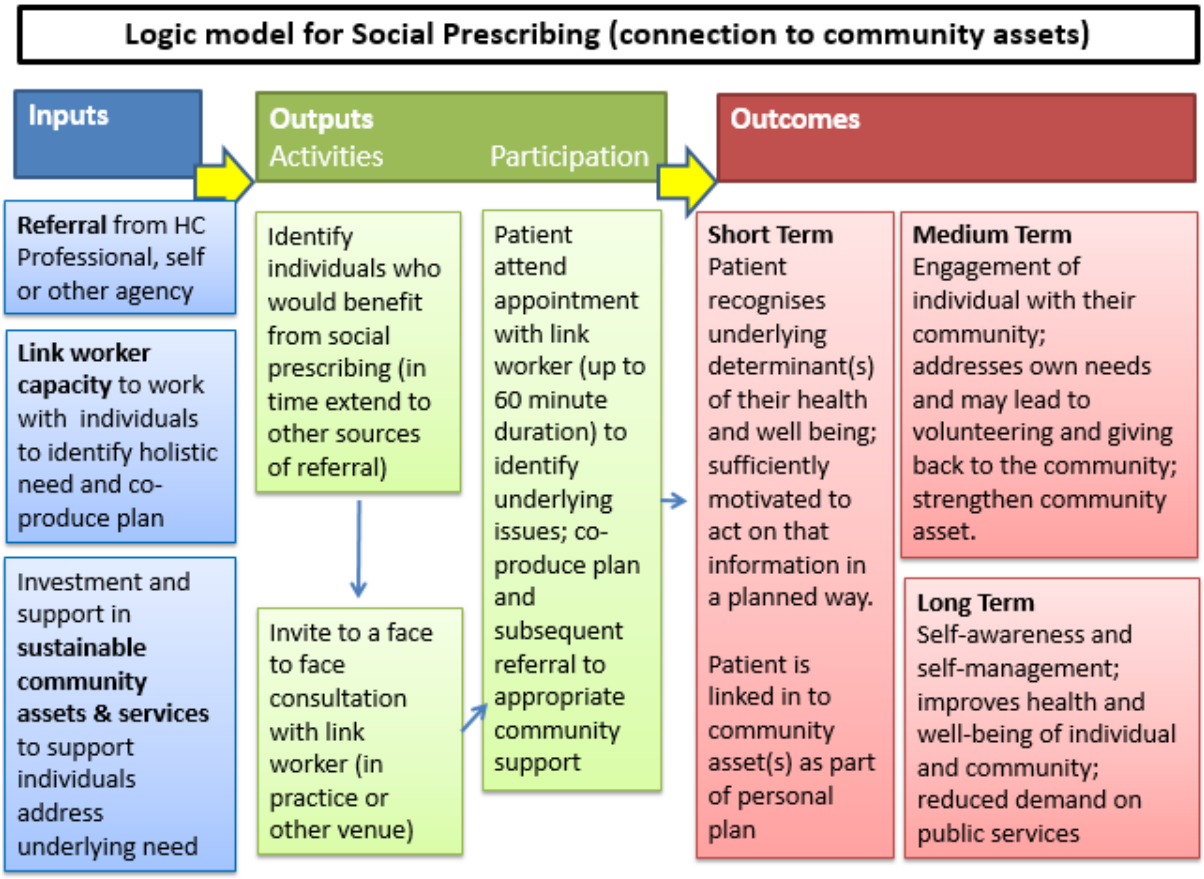
To date, social prescribing has predominantly been promoted within Primary Care as a means of improving wellbeing by more appropriately addressing patient's psycho-social needs. In due course it is anticipated that this would increase patient activation and reduce demand on general practitioner appointments. Many practices and Primary Care Clusters have funded social prescriber / link worker/ co-ordinator posts and also in some cases provided financial support for community assets e.g. gardening clubs.

Those who could benefit from social prescribing schemes include people with one or more long term conditions, who need support with their mental health, vulnerable groups, people who are lonely or socially isolated, have complex social needs which affect their wellbeing and those who frequently attend either primary or secondary health care.

Social prescribing initiatives also symbolise a systematic shift towards making available new life opportunities for those who need them most, opportunities to form new relationships, be creative and be independent while improving both physical and mental health. Examples include voluntary work agencies, exercise classes, self-help groups, book groups, social or lunch clubs and hobby clubs. To put it concisely, social prescribing is about supporting the person to improve their wellbeing.

To fully address the social determinants of health, social prescribing schemes view a person not as a "condition" or "disability", but quite simply as a person.

Figure 3: Logic Model



Key components of social prescribing

Based on the original descriptions of social prescribing, a social prescribing scheme has three key components:

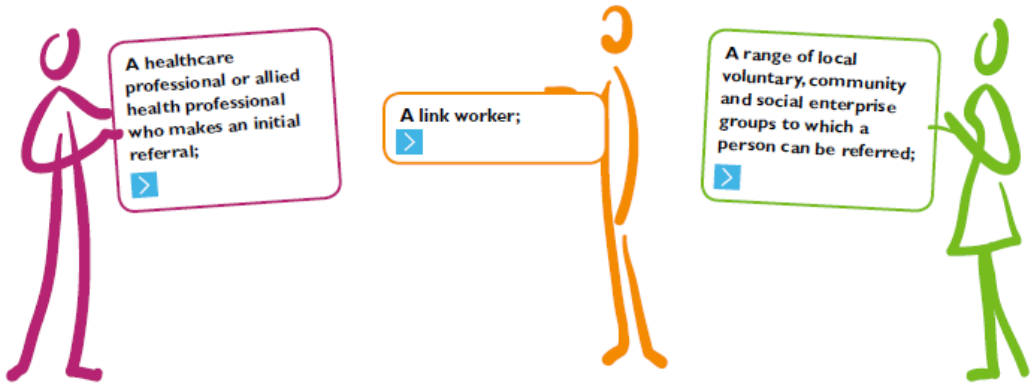
i) a referral (which in CTM model would extend beyond healthcare professional to include referrals from other agencies[6]),

ii) a consultation with a link worker/ co-ordinator and

iii) an agreed referral to a local voluntary, community and social enterprise organisation:

[6] When social prescribing works well, people can be easily referred to local social prescribing link workers from a wide range of local agencies, including general practice, local authorities, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise (VCSE) organisations. Self-referral is also encouraged.

Figure 4: Components of Social Prescribing



Source: Making Sense of Social Prescribing Toolkit, university of Westminster

Much focus has been given to raising the awareness of social prescribing among health care professionals and development of the link worker role. Further work is needed to embed Information, Assistance and Advice (IAA)[7] as routine practice within our public services as well as extending the access to the link worker support to other agencies. There is also an important balance to be struck between the first two components (referral and link-worker) and the need to develop and sustain the assets, strengths and networks available to people in their community. A system that involves supporting people to look after their own health and wellbeing in the community, has to allocate resources to those activities, services and facilities that are open, accessible, effective and no or low cost to the people who use them.

Paid Link Workers / co-ordinators are key to delivering social prescribing support. In addition to the role of connecting people to community groups and agencies for practical and emotional support, link workers collaborate with local partners to support community groups to be accessible and sustainable and help people to start new groups.

These roles identified in Cwm Taf Morgannwg as wellbeing co-ordination and community co-ordination may be undertaken by different or the same individual. The core elements of the link worker role and a generic link worker job description have been developed.

[7] "Section 17 of the Social Services and Well-being (Wales) Act 2014 places a duty on local authorities to secure the provision of an information, advice and assistance service. The purpose of the service is to provide people with information and advice relating to care and support, including support for carers, and to provide assistance to them in accessing it. Information, advice and assistance must be provided in a manner that makes it accessible to the individual for whom it is intended.)" https://law.gov.wales/publicservices/social-care/Local-authority-responsibilities/general-and-strategic-duties/information-advice-and-assistance/?lang=en#/publicservices/social-care/Local-authority-responsibilities/general-and-strategic-duties/information-advice-and-assistance/?tab=overview&lang=en

NHS England have recently published (January 2019) a social prescribing and community based support summary guide[8], which identifies what good looks like for people, communities and the system (Annex A). To achieve this, NHS England have identified key elements which will make up a robust local social prescribing service (Figure 5) and produced an implementation checklist for local partners and commissioners for these key elements. This provides the basis for discussion of a shared vision for social prescribing and community development in Cwm Taf Morgannwg.

Implementation – what needs to be in place locally

Figure 5:

Source: NHS England Model of Social Prescribing - Social prescribing and community-based support. Summary guide, Published January 2019

The key elements identified in the NHS England model which would make up a robust local social prescribing service in Cwm Taf Morgannwg are:

1. Collaborative commissioning and partnership working

Social prescribing works best when all local partners work together to build on existing assets and services. Successful schemes generally have collaborative commissioning and creative partnership working, with the following common characteristics:

- All partners build it together
- Local relationships matter
- The voluntary sector is involved from the start

[8] Social Prescribing and Community-based Support: Summary Guide. NHS England January 2019

2. Easy referral from all local agencies

- A wide range of local agencies are able to refer to social prescribing. Self-referral is also encouraged.
- Informed decision-making
- National social prescribing codes in GP IT systems to capture social prescribing referrals: NHS England has worked with NHS Digital to establish national SNOMED CT6 codes[9] for social prescribing
- Easy referral within general practice - typically, link workers are attached to general practices and primary care networks as an important part of the practice team. This makes it easy for general practices and all referral agencies to refer people to them. There also needs to be a clear process for self-referral, with awareness and understanding of this process in all agencies

3. Workforce development

For social prescribing to work successfully, link workers need suitable support and training. It is also vital that the wider workforce have an understanding of social prescribing to enable appropriate referrals.

4. Link workers employed to give time

Paid link workers are a fundamental feature of good social prescribing. They play a pivotal role by developing trusting relationships and providing personalised support. As a result, their work strengthens community resilience, reduces health inequalities by addressing the wider determinants of health, such as debt, poor housing and physical inactivity and increases people's active involvement with their local communities.

5. What matters to you? Co-produced simple plans or summary personalised care and support plans

An important element of social prescribing support is for the person and their link worker to co-produce a simple plan or a summary personalised care and support plan, which outlines:

- what matters to the person – their priorities, interests, values and motivations
- community groups and services the person will be connected to
- what the person can expect of community support and services

[9] National SNOMED CT6 codes for social prescribing:
871691000000100 | Social prescribing offered (finding)
871711000000103 | Social prescribing declined (situation)
871731000000106 | Referral to social prescribing service (procedure).

- what the person can do for themselves, in order to keep well and active
- what assets people already have that they can draw on – family, friends, hobbies, skills and passions.

6. Support for community groups

It is essential to ensure that local voluntary organisations, community groups and social enterprises are locally sustainable and can plan ahead, if social prescribing is to be embedded across all local areas. Support should include funding and safe referrals.

7. Common Outcomes Framework

As social prescribing is locally driven, different approaches to evaluation and the measurement of outcomes have emerged across England and Wales. To encourage consistent data gathering and reporting of outcomes, a Common Outcomes Framework has been developed for measuring the impact of social prescribing to include impact on the person, the health and care system and on community groups.

Assessment of Position in Cwm Taf Morgannwg (May 2019)

There has been substantial interest and development of social prescribing/ community referral across Cwm Taf Morgannwg and examples of partnership arrangements between Health, Third Sector and Local Authorities (e.g. ICF funded Community Co-ordinators, Primary Care Cluster funded Well-being Co-ordinators, General Practice Support Officers).

Several linking and community roles have evolved to meet local need, providing a rich experience from which to learn. Preliminary work has been undertaken to better understand these roles with an aim of developing a shared understanding by professionals and the public of what they encompass.

Current Model

Local mapping of roles identified a number of posts primarily based within GP practice; the patient may be referred by their GP/Healthcare Professional or self-refer to the co-ordinator in post in the Primary Care Cluster and be dealt with by a variety of methods e.g. telephone consult, face to face or signpost. Patients may be live on the caseload for 12 months and supported within the community.

In the current model a patient would have to present to general practice first. However in order to reduce the public's reliance on attending surgeries for essentially non-

medical problems it has been suggested that referral be encouraged from other agencies and settings including secondary care. It has to be acknowledged that the current posts are funded in a way that lends itself to primary care referral only. Also that as the role is developed and understanding improved by everyone, Health and Wellbeing coordinator clinics could be held in a variety of venues.

Identification of Roles

A task and finish group met on 16th May 2019 to consider initiatives in place across Rhondda Cynon Taf, Merthyr Tydfil and Bridgend and agree a common definition and understanding of social prescribing. The group endorsed three functions to enable effective social prescribing and linking to the community:

- "Connector" - spends time with client to have "what matters conversation" and co-produce plan. This requires knowledge and understanding of available community assets and how they are accessed.
- "Mentor/Befriender" – there may be need to undertake more supportive work to ensure client can access services, and in some cases, accompany them physically to venues/community locations.
- *"Community development" – support for community groups and where gaps in provision are identified help support groups to develop that will meet this need.

*To some extent community development already goes on within the third sector, with CVC's having a defined community development role, but this was not universal across Cwm Taf Morgannwg.

How these functions are delivered may vary from one area to another dependent on local need and circumstances. As a minimum there are likely to be two roles:

- **Health and Well-being Co-ordinator (link worker/ connector) – typically holding a caseload based in primary care or community hub settings.** To receive referrals and work with the individual to co-produce a plan, connecting to the community as appropriate. There would be multiple referral routes in addition to primary care, such as social care, housing associations, third sector, A&E, Fire Service. There may be capacity for this role to include mentor/befriender function too.
- **Community Co-ordinator – acting as brokers between citizens and community groups and potentially developing new community support / services / assets.** To build strong partnerships with identified communities of interest operating across health and social care; improve alignment with all relevant locality teams to identify and increase capacity within communities; work closely with communities, providers, Health and Social Care and the Health and Wellbeing Coordinators to identify any gaps in provision and work to increase capacity within identified areas.

Research and Evaluation

There is need for collaboration on what works, sharing of learning to address gaps in the evidence base. An agreed shared evaluation framework is essential to measure and understand outcomes. There is further work to be undertaken across the regional partnership to consider and agree use of technology to monitor activity and outcomes.

Cwm Taf Morgannwg has firmly established links with the Welsh Social Prescribing Research Network and has secured funding for two PhD studentships based on social prescribing (appointed January 2019).

Support for staff

It is important that there is appropriate induction, training and clear supervision available to support the post holders undertake their roles. Development of support and training for individuals undertaking social prescribing roles in primary care is being progressed by Health Education Improvement Wales. However, if individuals are employed by different agencies consistency across sectors will be essential.

Sustainability of Community Assets

The Regional Partnership Board and Public Service Board will need to consider the sustainability of and support for key community assets (community activities, facilities, services and organisations) which are often short term grant funded and /or volunteer-based and also address gaps in provision. Also to be cognisant of the existence of the inverse care law whereby those individuals and communities most in need could have poorest access to activities and support in their community.

Information Advice and Assistance

There is real opportunity as part of the social prescribing approach to support the current networks in the community including volunteers and carers to have access to information, assistance and advice. This would avoid the risk of funnelling all requests to a social prescriber / community connector and the consequent overload of the service. Possible solutions could include appropriate and effective use of on-line directories of services e.g. *DEWIS Cymru* and *Info Engine* as well as the local coordination of effort to address gaps and barriers, support people to come together in a locality to collaborate, and link in key community facilities / hubs, etc.

Recommendations

To realise the potential of social prescribing to positively impact on individual and community health and wellbeing across the region, it is recommended that:

1. Endorsement is given to a shared definition, understanding and regional collaborative approach to social prescribing at a strategic level (page 4).
2. Progress is continued to embed social prescribing and community support across Cwm Taf Morgannwg that takes account of the developments at national level in Wales and England, drawing on the excellent resources and toolkits available and also capturing learning from community level activity locally and across Wales.
3. Consideration is given to the additional capacity required to widen the scope of referral to social prescribing link-worker from the current General Practice model to include other agencies and self-referral.
4. Regional Partnership Board, Public Service Boards and partner organisations recognise and seek to address the support and funding requirements to achieve sustainable community assets that meet community needs, guided by the communities themselves.
5. Establish an effective multi-agency, cross-sector group that can further develop the social prescribing model and link worker/ co-ordinator role across Cwm Taf Morgannwg, addressing the issues identified in this paper including:
    - taking forward an integrated and collaborative approach to improve information, advice and assistance in community settings
    - establish a baseline understanding of roles within partner organisations that encompass the identified functions of social prescribing which will support planning, improve sustainability and reduce duplication of roles
    - agree a consistent approach to measuring need, impact and outcomes of social prescribing activity
    - contribute to national learning and networks

Original Paper prepared by:

Sara Thomas, Consultant Public Health, Cwm Taf Morgannwg Local Public Health Team; Gillian Day, Health and Wellbeing Development Manager, Primary Care, CTMUHB; Simon James, CEO, Interlink; Ian Davy, CEO, VAMT. March 2019

Reviewed and updated May 2019 with contributions from:

Andrew Thomas, BCBC; Helen Hammond BCBC; Sally Rees, WCVA; Anne Morris Interlink; Kay Harries, BAVO; Kirsty Smith, PSB; Sarah Mills and Nia McKintosh, Commissioning Unit.

Annex A

What good social prescribing looks like – for people

- People, their families and carers know about social prescribing and can easily be referred to social prescribing link workers from a wide range of local agencies
- People, their families and carers can refer themselves to social prescribing link workers.
- Building on 'what matters to me', people can work with a link worker to co-produce a simple plan or a summary personalised care and support plan, based on the person's assets, needs and preferences, as well as making the most of community and informal support.
- People, their families and carers may be physically introduced to community groups, so that they don't have to make that first step to join a group and to meet new people on their own.
- People, their families and carers are encouraged to develop their knowledge, skills and confidence by being involved in local community groups and giving their time back to others. For some people, this may provide volunteering and work opportunities to help find paid employment.
- People, their families and carers may be supported to work with others to set up new community groups, particularly where gaps exist in local community support.
- The sense of belonging that comes from being part of a community group and having peer support can reduce loneliness and anxiety. It helps people to find a new sense of purpose, enjoying activities they might not otherwise have tried before, such as arts, cultural activities, walking, running, gardening, singing and making connections to the outdoors.
- Being connected to community groups through social prescribing enables people to be more physically active and improves mental health, helping them to stay well for longer and lessen the impact of long-term conditions.

Source: Social prescribing and community-based support. Summary guide, NHS England Published January 2019

What good social prescribing looks like – for communities

Communities:

- are stronger and more tolerant, because people from all backgrounds are supported through social prescribing to be involved in community groups.
- There are more people who volunteer and give their time back to others.
- understand the power of social prescribing in reducing health inequalities, by supporting a power shift, enabling people to take more control of their lives, be less isolated and make connections.
- are aware of how social prescribing encourages community development and increases local community assets. Resources and support are available locally to spot gaps in community provision, help people to create new groups and provide informal support in their neighbourhoods.
- work with social prescribing to ensure that services are fully accessible to all communities, including those in greatest need, who may be hardest for agencies to reach.
- recognise that the NHS, local authorities and statutory services alone cannot meet all people's support needs. This understanding releases energy across all stakeholders in addressing the wider determinants of health.
- are actively involved in developing and delivering social prescribing. Voluntary organisations such as advice agencies are commissioned to receive referrals and deliver services. Local community groups are able to take referrals from link workers because they have sustainable grant funding.
- support the improvement of health literacy of professionals and local residents through social prescribing service development and referrals.
- are able to support people who participate in social prescribing, improving their confidence and ability to manage their own wellbeing.

Source: Social prescribing and community-based support. Summary guide, NHS England Published January 2019

What good social prescribing looks like – for the system

- Social prescribing connector schemes are locally and collaboratively commissioned by partnerships of primary care and local authority commissioners, working with the voluntary sector and people, their families and carers.
- Whilst social prescribing link workers are attached to general practices and primary care networks, they may be employed by local social prescribing connector schemes, typically hosted within the voluntary sector. Connector schemes may also be hosted by other agencies, depending on local partnerships.

- There is a clear and easy referral process for all local agencies involved. Referrals are received from general practice, local authorities, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary organisations. Self-referral is encouraged.

- Social prescribing connector schemes provide local agencies with a single point of contact for appropriate referrals of people who need link worker support in a local area. This reduces pressure on statutory services and facilitates a more integrated approach, particularly where people have complex lives and may come into contact with a number of local agencies and services. This requires a strategic approach to integration at local level with all partners recognising the value of link worker roles.

- Connector schemes have an important role in supporting the development of local community groups, working in close partnership with local infrastructure agencies, where they exist. Link workers have strong knowledge of local community groups, map community assets, recognise gaps in community provision and find creative ways of encouraging asset-based community development approaches, alongside local commissioners and partners.

- Typically, social prescribing link workers support people on average over 6-12 contacts, which can be done in a variety of ways, depending on people's preferences. Link workers typically have a caseload of up to 250 people per year. Where people are isolated or lonely, it may be helpful for link workers to carry out home visits.

- Link workers complement, and connect to, other relevant approaches in an area where they exist, such as active signposting or local area coordinators.

Source: Social prescribing and community-based support. Summary guide, NHS England Published January 2019

Project Initiation Document

Social Prescribing across Cwm Taf Morgannwg (CTM)

CTM Social Prescribing Group

Target start date: October 2019

Target end date: 31st March 2021

Contents

1. Project Brief Description

- Cwm Taf Morgannwg (CTM) Social Prescribing Group to oversee the implementation of Social Prescribing (SP) and referral schemes across Bridgend, Merthyr Tydfil and Rhondda Cynon Taf.
- To build on collaborative working amongst all partners to realise the potential of social prescribing, enabling citizens to build or rebuild friendships, community connections and a sense of belonging to reduce isolation and improve well-being.
- To take forward a shared integrated and collaborative approach to improve information, advice and assistance in community settings.
- Establish a baseline understanding of roles within partner organisations that encompass the identified functions of social prescribing which will support planning, improve sustainability and reduce duplication of roles.
- Agree a consistent approach to identify and measure need, impact and outcomes of social prescribing activity.
- Contribute to national learning and networks.

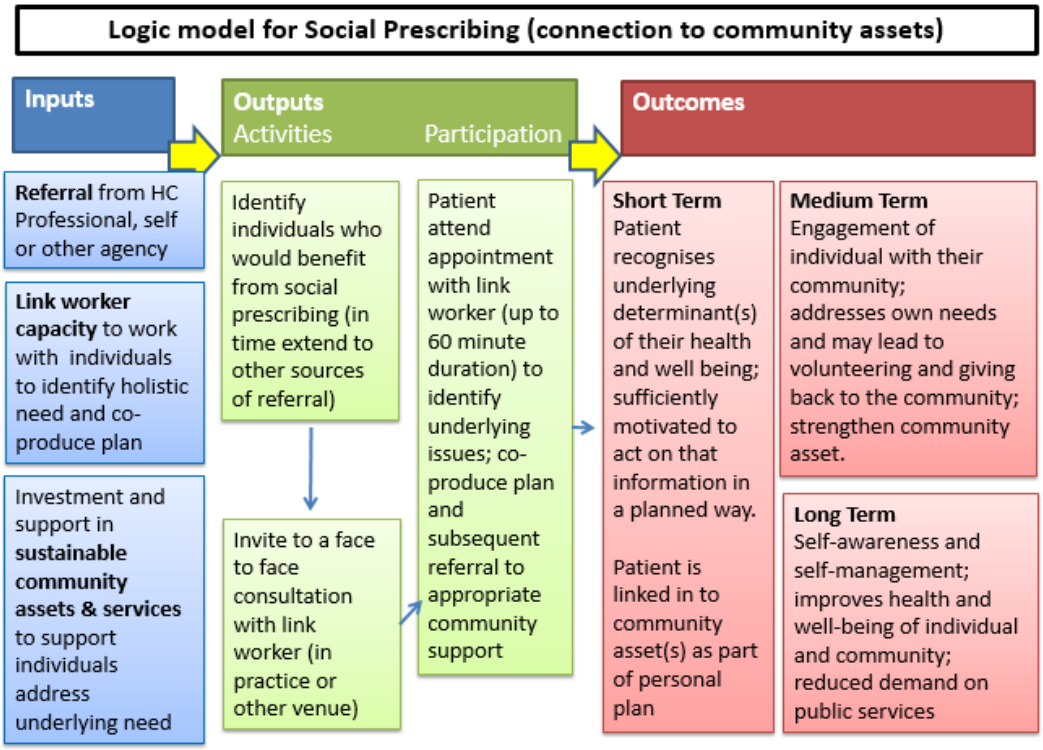
2. Basis for Project:

- There is increasing acceptance that sources of support in local communities have an important role to play alongside clinical care or even as an alternative in improving an individual's health and wellbeing outcomes. Social Prescribing can reduce social isolation and loneliness, improve individual emotional and physical wellbeing. In addition, social prescribing schemes may lead to a reduction in the use of statutory public services including reduced attendance at GP and Accident and Emergency departments.
- A successful social prescribing scheme has three key components and requires appropriate resourcing of all three:
    - a referral to link worker (which in CTM model would extend beyond healthcare professional to include referrals from other agencies),
    - a consultation with a social prescriber/ link worker/co-ordinator to have a "what matters conversation"; co-produce a plan which may include sign-posting or referral to a local voluntary, community or social enterprise organisation.
    - Sustainable assets in the community to meet the support needs of the individual
- In order for Social Prescribing to be effective there needs to be adequate provision of support and activities in the community which meet local population needs, which requires an 'Asset Based Community Development' approach. It is imperative that public service provision is planned with regard to what already exists and works in that community, listening to the community voice.

- Social Prescribing works best when all local partners work together to build on existing assets and services. Successful schemes generally have collaborative commissioning and creative partnership working with the following characteristics: all partners build it together, local relationships matter and the voluntary sector is involved from the start.
- Strategic Partners including Regional Partnership Board, Cwm Taf Public Service Board and Bridgend Public Service Board within Cwm Taf Morgannwg have endorsed the concept of Social Prescribing and have tasked the multi-agency Cwm Taf Morgannwg Social Prescribing Group to oversee its implementation across CTM.

3. Objectives and Outcomes

- Establish a baseline of activity, funding and assets in the provision of SP across CTM.
- Establish a strategic view of local community development needs. Develop and pilot a process for capturing community asset development and resilience need (both placed based and specific interest groups) that can be consistently applied across CTM
- Link with established means of communication (e.g. IAA, DEWIS, Infoengine) in order to ensure that partners delivering social prescribing have access to updated information on their local community assets and services in order to be able to refer as appropriate whilst recognising that there may be some information held which is not suitable to be shared.
- Ensure an active learning approach is taken to aid evaluation systems as appropriate.
- Co-ordinate and have oversight of Research & Service Evaluation activities relating to social prescribing in CTM.
- Establish a reciprocal link to local and national networks e.g. Wales SP Research Network and CTM Practitioner network.
- Provide support and guidance to the CTM practitioner network.
- Advise on SP element of Transformation Programme and Strategy for Primary Care.
- Explore digital solutions to providing information and the monitoring activity and outcomes.



4. Scope and exclusions

- To include all partners and key stakeholders from both the Public and Voluntray sectors engaged in the delivery and or commissioning of Social Prescribing across all three local Authoities including Merthyr Tydfil, Bridgend and Rhondda Cynon Taf in the Cwm Taf Morgannwg Footprint.

5. Approach

Priorities	Key Milestone	Lead	Time fram e
A: Baseline	1) Map current delivery of social prescribing across all 3 Local Authority areas within CTM including both the public and voluntary sector. To include high level resource and asset information	ST & SJ	January 2020
	2) Identify all operating models for SP currently being delivered and map associated job descriptions, roles and remits across all 3 Local Authority areas.	AM/ ATh/ GD	January 2020

Priorities	Key Milestone	Lead	Time fram e
	3) Identify methodologies used to collate and share existing knowledge of community assets (maps/registers/ directories).	CVC reps (AM/KH/SR)	January 2020
	4) Map and capture baseline of current capacity for Community Development work across all 3 Local Authority areas.	CVC reps (AM/KH/SR)	January 2020
B: Need (maps and gaps)	5) Develop and pilot a process for **capturing community asset development and resilience need** that can be consistently applied across CTM 6) Develop an approach that will translate the identified need into a commissioning specification for community assets	LPHT/ CVC's & practitioners **Link with Prevention Fund Actions**	March/April 2020
C: Best Practice Model Framework -Communication and access to information	7) Explore the potential to develop and implement a best practice SP framework across CTM. 8) Look into feasibility of a structured referral pathway and appropriate measures of quality assurance. 9) Identify the range of communication methods available (e.g. DEWIS/Info-engine/local knowledge) to ensure that partners delivering Social Prescribing have access to updated information on their local community assets and services in order to be able to refer as appropriate. 10) Support the SP practitioner group as a means of communication amongst professionals. 11) Public awareness raising of SP and IAA.	To be decided… ST Primary Care Communicati ons Officer AL	June 2020

Priorities	Key Milestone	Lead	Time fram e
-Workforce Development	12) Conduct a workforce training analysis for all partners delivering Social Prescribing to ensure continuity in approach.	Tom Roberts (PhD)	
D: Sustainability / Funding	13) Identify current funding streams available for SP across CTM. 14) Develop proposal for "Prevention & Early Years" Funding to act as a community asset funding stream to support the delivery of SP in CTM. (See funding application). 15) In response to baseline exercise, develop an equitable **process of awarding funding** for community asset development. Identify who will manage, oversee and evaluate this funding steam when released into the community. 16) Ensure any future potential funding opportunities are considered in addition to the transformation funding and current funding streams of partners.	ST & SJ (ALL) ST & SJ (ALL)	December 2019 November /December 2019
E: Outcome Framework & Evaluation	17) Agree a Common Outcomes Framework to help measure the impact of Social Prescribing across CTM. 18) SP schemes across CTM to use the Outcomes Framework to capture core outcome data to help create an evidence base to demonstrate the impact of SP.	GD/AM/CW	20/01/2020 April 2020
F: Research	19) Ensure regular communication with Wales Social Prescribing Research Network (WSPRN) to provide steer and evidence based learning for the delivery of SP schemes across CTM. 20) To receive and apply to practice any evidence based learning from the eight research priorities identified by WSPRN.	CW/ST CW	

5.1. Assumptions

- The CTM SP Group will agree and follow the group's terms of reference and share their knowledge and expertise in achieving identified project priorities and milestones.
- Members of the group will provide a point of contact and communicate the work of the group to their employing organization and other project groups they me be a member of
- Strategic partners will continue to endorse the concept of SP and support recommendations made by the CTM SP Group.
- Funding opportunities will be explored and applied for.
- Access by public to IAA (Local Authority First Point of Access provision)

5.2. Constraints

- Funding
- Partner capacity (e.g. time)
- Key Stakeholder engagement
- Leadership, management and organisation
- Communication between partners and stakeholders
- Local infrastructure

5.3. External dependencies

- Public acceptance of SP
- Community assets and social capital (effective and connected community)
- Volunteers
- Alignment with Community Zones, First Point of Access, CYP Board

6. Project team arrangements

The project team will comprise of:

Chair: Sara Thomas Public Health Consultant

Vice Chair: To be decided

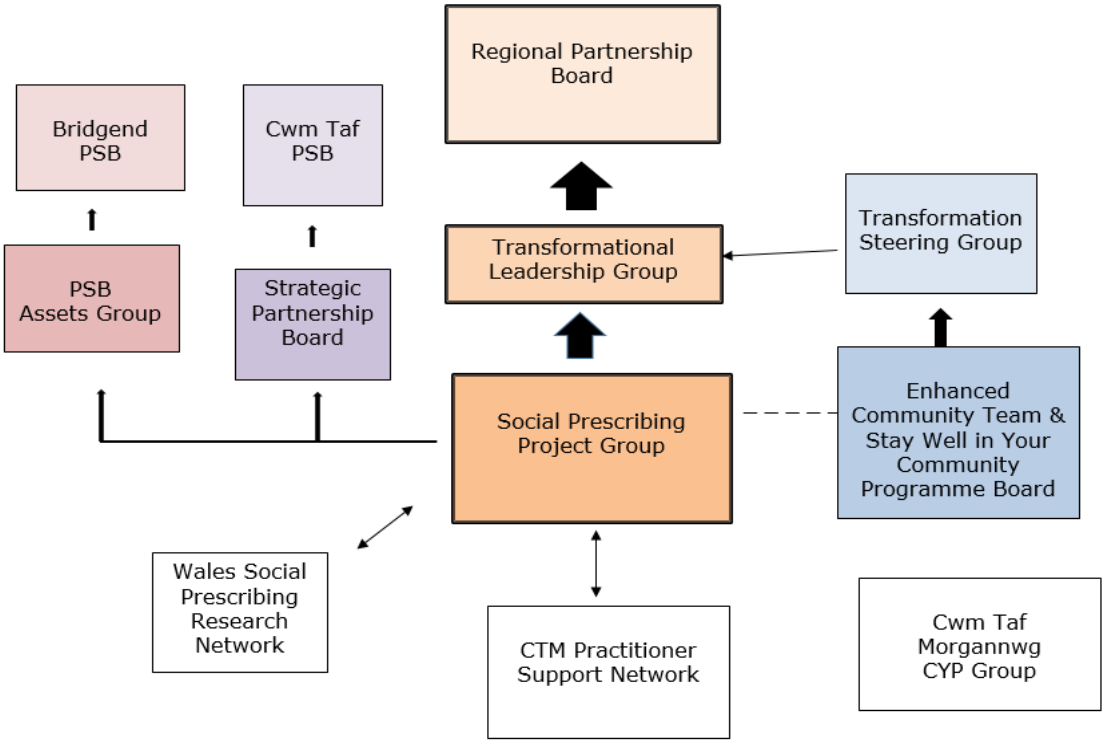
Sector	Organisation	Nomination
Third Sector	VAMT	Ian Davy/ Sharon Richards
	Interlink	Simon James/ Anne Morris
	BAVO	Kay Harries
	Third sector organisations	Nomination TBC
Local Authority (Community Asset Development/ partnership /planning)	RCT (Community Zones) RCT Adult Services	Syd Dennis Leanne Traylor

	Merthyr Tydfil	Chris Hole
	Bridgend	Andrew Thomas
Local Authority Social Services (Children)	CTM Children & Young People Partnership (Chair)	Ann Batley/ Lisa Lewis
Local Authority Social Services (Adults)	CTM Partnership group (Adults)	Andrew Thomas
Health Board	Partnerships	Amy Lewis
	Primary Care	Gillian Day (+ a GP when required)
PSB Partners	Police	Via PSB & "Early Action Together" Group
	South Wales Fire & Rescue	Chris Hadfield
	Natural Resources Wales	Nadia DeLonghi
	PHW	Sara Thomas/ Sarah Jenkins
Partnership Fora (if not already covered)	RPB Transformation	Toni Davies
	PSB CT	Kirsty Smith
	PSB Bridgend (Assets Group)	Helen Hammond
Social prescriber Practitioner	CTM Support network	Lucy Foster / Julie Lomas
Academia/ Research Network	Wales Social Prescribing Research Network	Carolyn Wallace
RPB Strategic Planning & Commissioning	Regional Commissioning Unit	Sarah Mills
Housing / RSL		Nomination
Digital Community		As required

7. Governance and Reviews

- The CTM SP Group will be accountable to the Cwm Taf Morgannwg Transformation Leadership Group (TLG).
- The CTM SP Group will meet every 2 months or in accordance to a work plan.

Organisational Reporting and communication (For discussion)



7.1 Key Stakeholders:

- Community Zones or equivalent geographical groups
- Third Sector groups
- IAA
- CYP

8. Sign-off Criteria / Quality Targets:

- See Gantt Chart attached for project timescales
- Project plan to be reviewed at each meeting and RAG rated
- Project success criteria achieved