NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
Commissioning Committee
Wednesday 28th September 2016

Title of Report:	**Social Prescribing Proposal**
Report of:	Andrea Smith
Contact:	Andrea Smith
Commissioning Committee Action Required:	☒ **Decision** ☐ **Assurance**
Purpose of Report:	To present a proposal of Social Prescribing to be delivered as a 12 month pilot
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	N/A
• **Domain 2a:** Performance – delivery of commitments and improved outcomes	**Developing a social prescribing model will support care closer to home and improved patients wellbeing**
• **Domain 2b:** Quality (Improved Outcomes)	**Developing a social prescribing model will support care closer to home and improved patients wellbeing**
• **Domain 3:** Financial Management	**N/A**
• **Domain 4:** Planning (Long Term and Short Term)	Developing a social prescribing will improve patients wellbeing and reduce social isolation leading to a longer term impact of reduction on health and social care services]
• **Domain 5:** Delegated Functions	**N/A**

1. BACKGROUND AND CURRENT SITUATION

1.1. The CCG previously explored a model of Social Prescribing through a Social Impact Bond financial model. The financial model proposed was deemed to result in a level of risk to the CCG that meant the proposal was not viable. The operational model of Social Prescribing however is a model that we would wish to pilot as evidence shows that it improves patients well being and reduces social isolation.

2. MAIN BODY OF REPORT

2.1. The Proposal describes a model for a 12 month pilot for Social prescribing, delivered during the pilot by Wolverhampton Voluntary Sector Council.

2.2. Social prescribing is described as:

*"**Social Prescribing** is about linking people up to social or physical activities in their community with a wide range of benefits" (North Tyneside)*

*"**Social prescribing** is a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector. (Age Concern, Yorkshire and Humber)*

2.3 The model proposed would see 3 trained "link workers" across the City working with and supporting individuals that require low level, non-clinical support but whom access Health and Social Care services regularly.

2.4 The outcomes of Social Prescribing are expected to be:-

- Reduction in social isolation
- Improved health and well being
- Reduction in demand on primary care
- Reduction in secondary care activity

3. CLINICAL VIEW

3.1. The business case has been shared with Dr DeRosa and with the three locality leads. They were also involved in previous discussions when the Social Impact Bond model was being developed and were supportive of the principles of Social Prescribing

4. PATIENT AND PUBLIC VIEW

4.1. Patient feedback will be collected and analysed and acted upon during the pilot.

5. RISKS AND IMPLICATIONS

Key Risks

5.1. No risks identified to date

Financial and Resource Implications

5.2. There is a financial investment required as outlined in the business case.

Option 2 – cost of WVSC delivering model as a 12 month pilot

Service Element	**Cost year 1**
Project Manager @ 30K + 16% on –costs 0.5WTE	17,400
Community Development Officers @ 25K x 3 + 16% on costs	87,000
Administration @17K + 16% on costs 0.5WTE	9,860
Staff Training	1,500
Desk space at community location (assuming employment and management by accountable body) 2000 x 3	6,000
Staff Travel @ 45p x200 pm x 4	4,320
Central and management costs: Management, reception, payroll, rent, Insurance, IT maintenance, utilities, payroll, reception, photocopying, finance . HR etc.. @15% of hosted staff salary costs and 10% outreach.	8,178 8,700
Marketing/publicity	500
Telephone @ £35 x 3 x 12	1,260
Laptop/ipad x 3 PC x 1	2,952 646
Totals	**£148,316**

For Financial Year 2016/17 there is a part year effect equivalent to (148.316/12) x3 = £37,079.

Whilst it is difficult to demonstrate the impact from this specific project, other areas report that a reduction of demand on Primary Care is a key impact, in both telephone calls from the patient to the practice and in GP consulting time for patients who currently present high demand due to underlying social factors.

It is anticipated that each Link worker would hold a patient on their caseload for approximately 3-6 months. The contact time for each patient would be variable but as an estimate we would model an initial 1 hour meeting with fortnightly telephone calls (approx. 20 mins) thereafter.

Taking into account travel time, for each average 7.5 hour day the Link Worker could undertake 3 New referrals (I hour face – face meetings) and up to 6 follow up (20 minute calls), with an hour for admin each day.

Based on a rolling programme of patient discharge/drop out and new referrals each Link Worker could hold a caseload of approximately 442 patients per annum - Total for 3 Link Workers 1326 patients.

This proposal is very much for a qualitative project which will reduce demand on Primary Care releasing capacity to more appropriate interventions, reducing social isolation and improving the wellbeing of patients referred to the service. This in turn, however, may have an impact on secondary care activity and the table below depicts scenarios through estimating a reduction of 1 A&E attendance and 1 emergency admission for a percentage of the patient cohort. (Assuming A&E attendance of £81 and emergency admission of £2,000).

Table 2

	No. of patients	A&E	Emergency Admission	Total
Reduction of Activity for 10% cohort	132	10692	264000	274692
Reduction of Activity for 30% cohort	398	32238	796000	828238
Reduction of Activity for 50% cohort	663	53703	1326000	1379703
Reduction of Activity 100% cohort	1326	107406	2652000	2759406

Quality and Safety Implications

5.3. If the business case is approved quality and safety implications will be identified and risk assessed. As an example we would need to identify where link workers meet with patients ensuring a safe environment in line with the lone worker policy.

There would also need to be a clear escalation route if a clinical need was identified.

Equality Implications

5.4. If the business case is approved an EIA will be completed upon development of the service specification.

Medicines Management Implications

5.5. No medicines management implications have been identified

Legal and Policy Implications

5.6. None identified

6. RECOMMENDATIONS

Members of the Commissioning Committee are asked to f the policy

- **Receive** and **discuss** this report.
- **Approve funding for the pilot**.

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Job Title Head of Integrated Commissioning
Date: 09.09.16

ATTACHED:

Social Prescribing Business Case