Social Prescribing: Developing a "Made in North Wales" approach

1. Purpose of report

- To consider the evidence supporting social prescribing programmes.
- To consider what would best fit the North Wales context.
- Outline a specific regional programme, and a "Made in North Wales" approach to social prescribing.
- To demonstrate how the proposed development links with core primary care and community services.
- To quantify the anticipated impact of the programme in terms of admission avoidance and GP attendance.
- Identify the resource requirements for the proposed programme.
- Identify the evaluation framework for the regional programme

2. Aims

The aims of the "Made in North Wales" Social Prescribing programme are to:

- Achieve more appropriate use of health and social services.
- Improve health and well being outcomes for residents across North Wales.
- Enable residents to be pro-active in managing their own conditions and well-being.
- Maximise the use of community assets, and build on the use of volunteers and existing voluntary services so that people can access the right support
- Be accessible to as many people as possible within the community.

3. Introduction/Context

3.1. What is Social Prescribing?

- Social prescribing is a way of linking individuals to sources of non-clinical, community-based support.
- Programmes that can improve outcomes for patients by promoting self-help, lessening the demand on services and resources by reducing clinical demand, and by developing a well-being vision for the population that looks beyond the clinical model of support.
- Interventions that can involve a variety of activities such as volunteering, arts activities, group learning, and a range of social activities (e.g. gardening, befriending, cookery, healthy eating advice), in addition to a range of sports-related activities.
- Programmes that can become the trigger for cultural change in service delivery; that can change perceptions to health and well-being, and can be a catalyst for the wider change needed to deliver a challenging agenda of re-orienting services from the traditional medical model.

3.2. The increasing demands on health and social care services across Wales are driving innovative approaches to look at different models of delivery and support. Social prescribing schemes harness the social assets within local communities, giving individuals choices to improve their own health and wellbeing by accessing non-medical and community based and focused

support. Best practice social prescribing helps guide individuals to choose from a wide range of options, and is driven by person-centred interests and priorities.

3.3. Long-term conditions are associated with increased social isolation and poor physical and mental health. But there is a gap in health provision between providing medical treatment and effectively addressing psychosocial well-being. One potential way of addressing this gap is by utilising social interventions which link patients from health services to community-based sources of support, enabling them to take ownership of their own conditions and to benefit from a community support structure.

3.4. In identifying outcomes, many existing social prescribing schemes set the following as successful outcome criteria:
- strengthening of an individual's social networks.
- a reduction in the use of health care.
- an improvement in psychosocial problems.
- uptake of employment opportunities.
- a positive impact on healthy behaviours and use of preventative services.
- an improvement in mental well-being.
- improvements in clinical outcomes and quality of life measures.
- improvements in the self-management of long-term conditions.

3.5. Although there is little good quality evidence to inform the commissioning of social prescribing programmes[1], there is a growing evidence base to suggest that empowering patients to manage their own conditions and engaging with communities to develop a social model of health brings tangible benefits to patients and to the traditional health and social care services that support them[2]. The overall evidence base for social prescribing schemes, and agreement on terminology (i.e. what does social prescribing mean), is still evolving and can be informed by the current proposal.

3.6. Some successful social prescribing programmes have demonstrated that the cost of managing patients with long-term conditions could be reduced by up to 20%, and that there could be a three-fold return on the initial financial investment in services that are delivering positive outcomes[3].

4. Strategic context

4.1. In Wales, there are numerous national and regional policy drivers and programmes that pave the way for a "Made in North Wales" toolkit/ approach to social prescribing. *Taking Wales Forward 2016-2021*, the Welsh Government Programme for Government, has a core priority around being *Healthy and Active* and focuses on social prescribing as a model to address this challenge.

4.2. The *Well-Being of Future Generations Act* (2015) focuses on the need to map local well-being priorities and, in particular, drive towards a resilient and

[1] University of York Centre for Reviews and Dissemination, Evidence to Inform the commissioning of social prescribing, (February 2015).
[2] Public Health Wales Observatory, Social prescribing evidence map: summary report, (June 2017).
[3] University of York, Centre for Reviews and Dissemination, Evidence to inform the commissioning of social prescribing (February 2015); Sheffield Hallam University, The Rotherham Social Prescribing Service for People with Long-Term Health Conditions, (January 2016); Health Education England, Social Prescribing at a glance: A scoping report of activity for the North West, (March 2016)

healthier Wales, working towards greater integration via the Public Service Boards. In particular, the proposal to establish the “Made in North Wales” social prescribing model addresses all five sustainable development principles embodied within the *Well Being of Future Generations Act*:

- Long-term
- Prevention
- Integration
- Collaboration
- Involvement

4.3. The *Social Services and Wellbeing Act* (2014) ensures that local authorities focus on the population needs for well-being within the social services setting. Many of these needs can be addressed through the social prescribing route.

4.4. Social prescribing can help the public sector by connecting all service areas across sectors to support the population with a health and well-being focus, aligning with the key policy drivers from Welsh Government by tying together initiatives focusing on health and well-being, mental health, resilience and social isolation. By bringing together education, social services, housing, the wider public sector, third sector and private sector, the most efficient use of existing resources can be maximised. This also ties in with the Prudent Health approach advocated by the Bevan Commission.

4.5. Strategic links:

4.5.1. BCUHB strategic drivers: The Health Board is developing “*Living Healthier, Staying Well*”, a long term strategy that will have a clear focus on health and wellbeing in the community. The evolving Mental Health strategy will also play a significant role in supporting the social prescribing agenda.

4.5.2. BCUHB has established the *Well North Wales* programme, which is a framework for local communities and organisations to work together to improve health and well-being and reduce inequalities. The emphasis on partnership working and establishing community hubs supports the social prescribing agenda, and provides a visible focus from which local initiatives can be delivered.

4.5.3. The prevalence of people living with long-term conditions is increasing, linked to an expectation that patients will become more involved in self-management. In this respect, the delivery of the evolving *Care Closer to Home* strategy will provide the community context within which the social prescribing programme can be delivered, enhancing the work of the Area teams in particular. The themes identified in developing the *Care Closer to Home* strategy, around:

- Digital inclusion
- The development of community hubs
- Supporting care homes, residential homes and day care
- More personal control
- More care at home
- Primary care services
- Prevention programmes
- Rehabilitation and re-ablement

clearly fit with the objectives outlined in the current proposal.

4.5.4. Progress has been made with the 2025 movement to tackle health inequalities through a series of established workstreams, with a particular

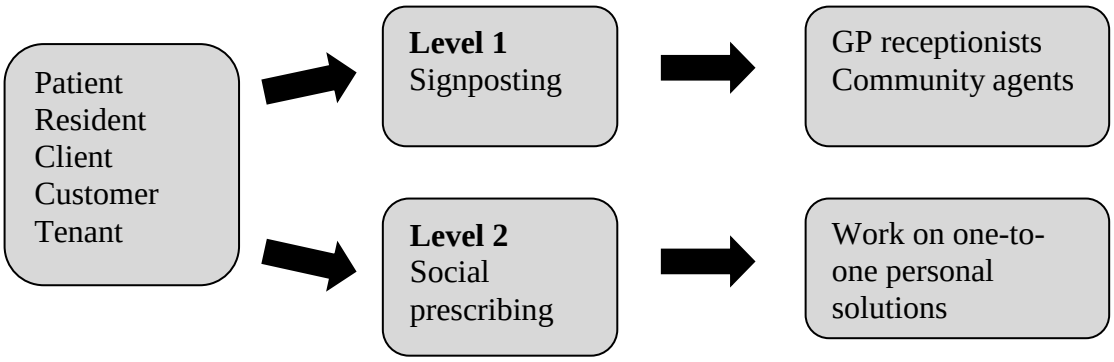
focus on housing and health. The 2025 movement has an active interest in social prescribing, and will be taking the lead to organise a conference in October 2017 to promote the proposed programme in North Wales.

The infrastructure is therefore already established from which to grow the local social prescribing model, building on existing good partnership arrangements and local operational delivery mechanisms.

5. Links with existing schemes

5.1. A number of social prescribing schemes are already in operation across North Wales. However, these have evolved to serve specific geographical areas and patient groups rather than being a co-ordinated and equitable region-wide programme. Many are reliant on short-term funding and lack the infrastructure to be stable and sustainable in the longer term.

5.2. Social prescribing can be defined through two specific routes



The main schemes pertinent to the current proposal are:

Level 1:

Conwy Wellbeing Programme

This programme is complementary to social prescribing, and prepares the ground for dovetailing with a social prescribing model through supporting communities. The proposed programme will need to link effectively with existing schemes such as the Wellbeing Programme to ensure that the best use is made of resources at a local and community level in order to meet individuals' needs.

Community agents:

- Wrexham scheme, funded through ICF, with the Association of Voluntary Organisations in Wrexham (AVOW) contracted to project manage the scheme.
- The Community Agents have generally been recruited from their local area, and have knowledge about local support groups.
- Role is to identify vulnerable adults and signpost to appropriate support. Also support people to set up their own groups.
- Social Prescribing Officers link in with Community Agents

Level 2:

Community navigators:

- Operating in Conwy West and Denbighshire.

- Supports social signposting within the community for non-clinical problems.
- The Community Navigator service provides patients with a face-to-face conversation during which they can learn about the possibilities and co-produce their own personalised, holistic solutions. The scheme aims to enable people with psychosocial needs such as isolation, loneliness and low confidence, as well as those with certain medical conditions, to be empowered to find solutions which will improve their health and wellbeing.
- Community Navigators provide the patient and their family/carers with a link between primary care, community services and support groups, whilst having close working relationships with the Single Point of Access (SPOA) service.
- Age Connect North Wales Central employs 1WTE Community Navigator in Conwy West. There are 6 community navigators in Denbighshire
- The West Conwy service had 12 patients on the caseload between September 2016 and January 2017, which has increased steadily as the service becomes more established.

Occupational Therapist (OT) role:

- The OT role has developed as part of Healthy Prestatyn Iach, and provides robust clinical input into the social prescribing role. The OT is known within the practice, and is able to assess the patient's needs in order to refer.
- The Occupational Therapists work closely with the community navigators to ensure that the real needs of people referred to the scheme are identified and addressed. The positive emphasis on prevention, allied to the clinical background and the liaison with others to signpost individuals, has been very successful.
- The scheme works extremely well within the Prestatyn model, but has not been tested to serve a much larger patient population. A corresponding programme in Pembrokeshire identified the need for two OT's to work across five practices.
- The OT input, allied to the overall social prescriber role, could be developed in other areas as resources become available.

Mantell Gwynedd scheme:

Operated by the County Voluntary Council (CVC) in Gwynedd, the social prescriber has dealt with 120 referrals from 2 GP practices in Bangor during the initial 12 month period[4]. As a result of being based within the voluntary sector, the social prescriber has an up-to-date knowledge of all the local organisations that come under the CVC. The proof of concept work around frequent attenders to ED Departments in North Wales followed this model, and proved to be successful in signposting individuals appropriately. The proposed pan-North Wales programme is largely based on the Mantell Gwynedd scheme.

6. The proposed "Made in North Wales" model

6.1. The proposed model will build a sustainable framework for social prescribing, linked to existing operational structures, from which further initiatives can develop. Although the scope of the programme aims to reach the whole of

[4] Mantell Gwynedd, The social impact of the Arfon social prescription model Social Return On Investment evaluation and forecast report, (June 2017)

North Wales, for effective delivery and attention to local priorities, the delivery will be at primary care cluster area level, as the clusters represent a manageable geographical size from which to co-ordinate activity, acknowledging also the key role of primary care.

6.2. The programme will have a broad scope of referring bodies and client selection. In being broad-based in its approach, and making provision for many groups not usually associated with social prescribing schemes - the homeless (many of whom are not registered with a GP), people in care homes (for whom befriending schemes would be invaluable), and individuals involved in anti-poverty programmes (where the social priorities could be linked to employability, finances and self-esteem) - it provides an all-encompassing programme that goes outside the narrow definition of social prescribing.

6.3. In drawing referrals from a wide range of partner agencies, the proposed scheme will have both a direct and indirect impact on mainstream primary care services. May of the individuals who would be referred by an agency such as housing or an anti-poverty programme are likely to be the same individuals who would be accessing their primary care service for support on issues that would often be non-medical in nature, and could be addressed through the social prescribing route.

6.4. A broad outline of the current proposal has been shared with all GP cluster leads across North Wales, as well as with a number of individuals actively involved with existing social prescribing schemes. The overall response has been very positive, particularly on how the new proposal can dovetail effectively with existing social prescribing programmes, anti-poverty programmes, and community health services.

6.5. In the first instance, the initial development will dovetail with the “Ein Dyfodol” component of the Well North Wales programme, and focus on the geographical areas identified for that programme. There will then be a roll-out programme to cover all GP cluster areas.

6.5. Making it happen:

6.5.1. Setting primary care at the heart of this agenda allows for local partnerships and programmes to be implemented that can make a real difference to individuals and communities, and enabling the opportunities available to primary care practitioners to be extended to cover a number of new areas. Social prescribing is a benefit to both patients and the primary care staff who support them, and can therefore enhance the range of services, opportunities and experiences available to patients to ensure that their real needs can be addressed appropriately. Providing new and exciting opportunities can also lead to less reliance on primary care services, relieving many of the existing demands placed upon staff and resources.

6.5.2. The proposed service model links in with the delivery of existing primary care and community services. The broad referral base, in linking with existing navigator and community schemes, and focusing on working with BCU staff and colleagues from a range of other organisations, will require the operational delivery of the proposed programme to link in with the core business of Area teams, primary care clusters, and their established community networks.

6.5.3. A number of social prescribing schemes have already been developed within North Wales. These are largely unconnected and often rely on short-term

project funding. The new programme will have to link effectively with the existing schemes, and ensure that there is local co-ordination between the different levels of social prescription; agreement around monitoring and evaluation criteria; and a consistent approach to delivery.

6.5.4. In addition to the traditional referral routes, the proposed model will also utilise the unique outdoor environment within North Wales, and work with the providers of these facilities to enhance access to, and use of, facilities and services that are currently under-utilised by North Wales residents.

6.5.5. The proposal is also ground-breaking due to the increased scope offered by the housing sector. Building on the excellent working relationships with housing associations and local authority housing services, this proposal encompasses a desire from the housing sector to invest resources into the programme to ensure that the range and outcomes are co-ordinated, and serve the requirements of organisations outside the traditional reach of the NHS. Collectively, the housing sector would like to get to a future position where a significant part of their community investment activity is socially prescribed. This represents a potentially significant resource investment into the delivery of the programme, and provides a unique feature in comparison with more routine primary-care based social prescribing programmes. Most housing organisations provide a range of activities and interventions for their tenants, and believe that a formal link to the social prescribing programme will address a number of their tenants' social requirements which, in turn will alleviate some of the pressures experienced by the NHS.

6.5.6. In each of the 14 delivery areas, a local assessment will be undertaken to determine which organisation is best placed to lead the. By providing the service at a cluster level, as well as forging close working relationships with individual GP's and their teams, the North Wales-wide programme will have local accountability and will utilise the community assets, resources and knowledge, whilst also linking to a co-ordinated North Wales social prescribing network for governance, monitoring, and developmental arrangements.

6.5.7. A review of social prescribing schemes undertaken by the Public Health Wales Observatory identified that the majority of social prescribers were employed by voluntary agencies[5]. The aim of the "Made in North Wales" model is to promote integration across public services, partnered with the voluntary and community sector, aiming to embed a collaborative approach across all sectors. This proposal utilises the strengths of each organisation, and will establish common goals and measurable outcomes without stifling innovation and locally-determined priorities. There is also scope for further development, and for some areas to enhance the programme through local funding streams as part of the wider delivery model.

6.5.8. The core model is based on a successful proof of concept programme sponsored by the BCUHB Chairman, and run as part of the Winter Pressures strategy in early 2017. In this scheme, the frequent attenders to ED Departments were offered the opportunity to participate in a social prescribing scheme, with the six county voluntary councils facilitating the process. The facilitation of this programme through the County Voluntary Councils was a key factor in its success, and one that can be built upon. In turn, the role of the

[5] Public Health Wales Observatory, Social prescribing evidence map: summary report, (June 2017).

CVCs was influenced by the work undertaken in Rotherham, for which detailed evaluation reports have been produced[6].

6.6. Delivery

6.6.1. Initially, the "Made in North Wales" social prescribing programme will dovetail with existing social prescribing programmes. However, as the programme becomes embedded, there will be an evaluation of the totality of schemes funded in North Wales to ensure that processes are streamlined, to identify any unnecessary duplication, and to extend provision as determined by local circumstances and need. This will inform and shape a model that can be used in the longer-term across the region, and help support the efficient planning and sustainability of services.

6.6.2. To receive the social prescribing service, individuals must be registered with a North Wales GP practice. At the initial assessment, consent to participate in the scheme will be sought by the social prescriber, prior to discussing which services and activities are of interest to the individual, and assessing for difficulties such as poor mobility, transport or low confidence. Monitoring systems will be established to follow-up with individuals, and the information will be fed into the patient record within primary care. For any group (e.g. the homeless) who are not registered with a GP, part of the social prescribing function will be to enable them to access the services necessary to support their health and well-being.

6.6.3. Wrexham Glyndwr University will facilitate the co-creation of an educational framework with all the partners participating in the model, building on their existing work, which has included GP Receptionist and Community Navigator training. The framework will acknowledge the different levels of social prescribing delivery, and the identified educational needs of service providers.

6.6.4. The proposed programme will focus on the 14 primary care cluster areas established in North Wales to ensure that there is both local implementation and direct links to primary care. By way of comparison, in the first 12 months of the Rotherham social prescribing scheme, each GP practice referred an average of 30 patients each to the scheme. From a workload perspective, therefore, the aim of having one social prescriber per cluster area is deemed the minimum requirement, with demand likely to grow as the programme becomes established and embedded. In co-ordinating with existing schemes, the workload and demand aspects can be mapped and quantified to determine future requirements.

6.6.5. The social prescribers will be linked to the county voluntary councils, but with a defined remit to ensure that they have accountability within the primary care cluster management arrangements, and can demonstrate their ability to link effectively to a range of public and third sector service providers.

6.6.6. The proposed programme differs from many existing schemes in that the number of referrers is expanded to included services beyond the traditional primary care setting (e.g. housing). The role of the social prescriber will be to assess the underlying issues for the referral, determine eligibility, and make an assessment of support needs before referring the individuals on to appropriate receiving services. The formal link back to primary care will be

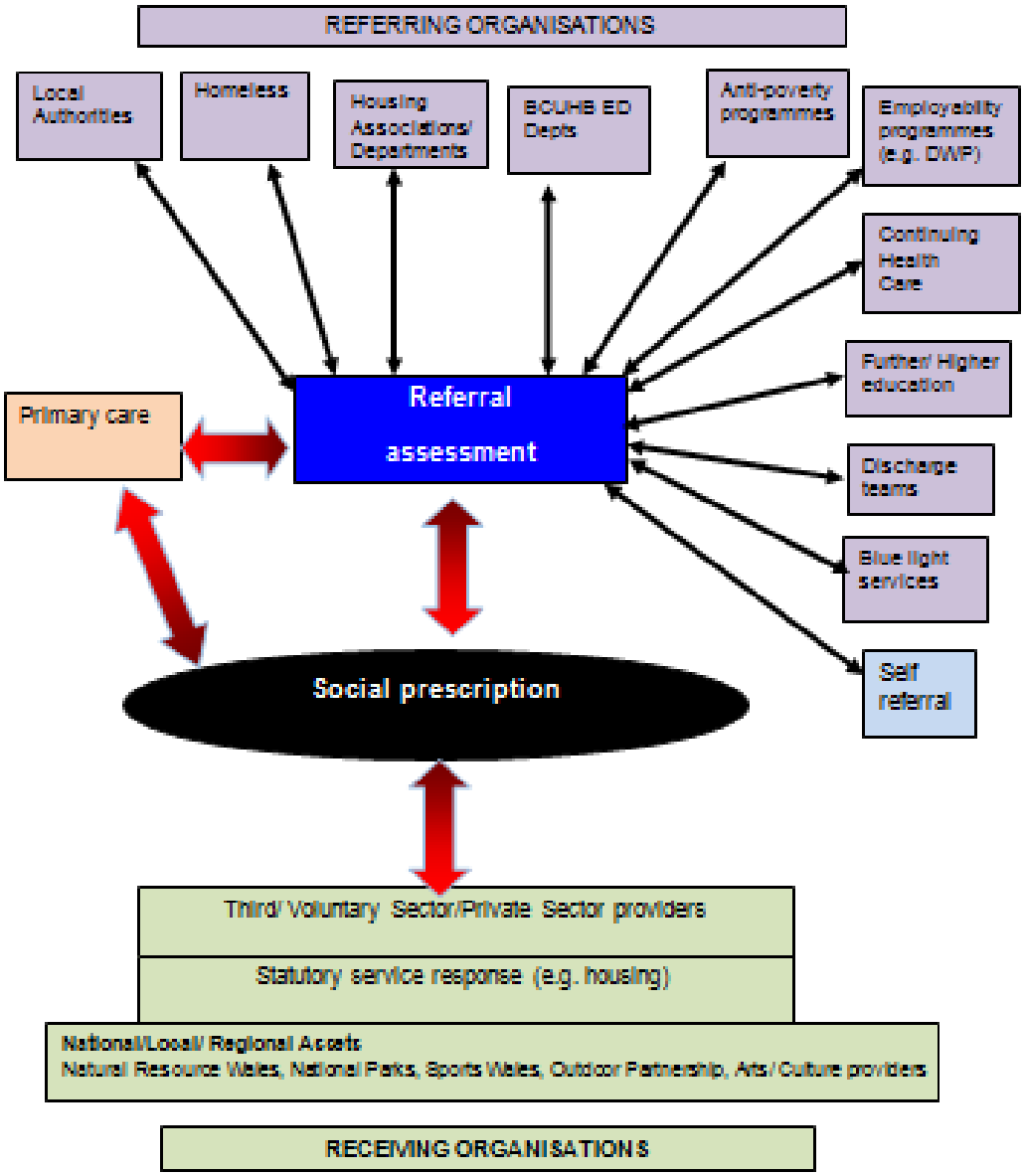
[6] Dayson, D. Bashir, N. Pearson, S, From dependence to independence: emerging lessons from the Rotherham Social Prescribing Pilot. Summary Report. Sheffield Hallam University, (2013).

essential to ensure that there is one defined point at which patient information related to social prescribing is collated.

6.6.7. In the proposed model, the primary care team is the focal point, and the operational delivery of the scheme will focus on managing referrals from within each cluster. Although the intention is to open up the number of referral routes into the social prescribing programme, evidence from existing schemes in North Wales and elsewhere demonstrates that the link with the primary care team is an essential component of the referral process to determine the appropriateness of the referral and to ensure that activity is recorded on the primary care information system[7].

"Made in North Wales":

Proposed delivery model for social prescribing



[7] Public Health Wales Observatory, Social prescribing evidence map: summary report, (June 2017).

6.6.8. In the first instance, a fixed-term programme manager will be appointed to oversee the introduction of the service. This role will:
- establish the governance structure.
- lead on the appointments process.
- ensure that robust monitoring arrangements are in place.
- lead on the development of the higher education contribution, specifically around the education and training framework and the evaluation links.

6.6.9. Going forward, the social prescribers will be supported by a service co-ordinator, who will be responsible for ensuring consistency of monitoring arrangements, staff training and other workforce support issues.

7. Benefits of proposed new service

7.1. Anticipated outputs

- A consistent, equitable and practical approach to facilitate social prescribing across the whole of North Wales for clinicians, other health professionals, local authorities, community groups/ third sector, by capturing good practice and sharing this across the region.
- Maximising the impact of existing schemes, whilst ensuring equity of access to social prescribing across the whole region.
- Developing a range of opportunities for individuals that will alleviate some of the pressures on existing NHS services, particularly primary care.
- Establishment of a system that can help monitor the impact and value for the North Wales £, with a focus on Social Return on Investment and economic benefits across all sectors, linked to robust evaluation.
- A system that links to primary care information systems and tracks outcomes for individuals.
- Development of a high quality educational framework and training programme for all aspects of the North Wales programme, based on practitioner-identified priorities.
- Bench-marked standards that will inform commissioning and evaluation processes, thereby assisting in the future planning and delivery of social prescribing initiatives.
- Building robust mechanisms to identify capacity issues for those organisations receiving referrals.
- Opportunities for further research and evaluation, extension of the programme, and establishing North Wales as a centre of excellence.

7.2. Desired outcomes

- Based on similarly-constructed schemes, the benefits are likely to include:
  - patients becoming more independent and able to access social prescribing activities with less intensive support;
  - patients becoming better at managing their long term condition themselves;
  - patients and carers feeling less socially isolated and enjoying more social interaction;
  - a general improvement in the quality of care available to patients as a result the role of the social prescriber.

- reduced demand on clinical and social services and more targeted use of resources across other sectors.

- Improved patient outcomes and creation of healthier communities.
- Inclusive service for traditionally hard-to-reach groups (e.g. homeless).
- Better use of community assets and collaborative working across sectors, particularly housing.
- Enhanced partnership working between the public sector and voluntary/ private sector providers.
- Better co-ordination across agencies, driving out inefficiencies and duplication, and providing opportunities to meet the prudent health agenda.
- More informed commissioning processes.
- Greater sustainability and financial stability for voluntary organisations.

7.3. Activity levels

Based on the experiences within North Wales and from projects in other areas, it is anticipated that the "Made in North Wales" programme will deliver the following activity levels:

Referral source	**Year 1 2017-18**	**Year 2 2018-19**	**Year 3 2019-20**
Primary care	90	1,200	1,700
Housing	100	700	800
Other	100	300	500
New model total	**290**	**2,200**	**3,000**
Existing schemes	1,000	1,000	1,000
Total	**1,290**	**3,300**	**4,000**

Based on this assessment, a total of 4,000 individuals would be successfully managed through social prescribing routes annually when the scheme is fully operational. Many of these individuals would otherwise have been attending a number of NHS services for mainly non-clinical issues.

7.4. Other groups

In opening up the referral process to groups such as those at risk of homelessness, the programme will be more far-reaching than traditional social prescribing schemes, and will address a deficit in current service provision. Under the auspices of the Well North Wales programme, a homelessness strategy will be developed, from which formal links to the social prescribing programme will be established.

8. Quality, monitoring and evaluation

8.1. Monitoring framework:

8.1.1. Through developing a common framework to evaluate the impact of the initiatives, and to prove the return on investment, a "Made in North Wales" toolkit will be developed for organisations participating in the programme. In turn, this will assist in the co-production of an education and training framework that will provide a quality assurance "kite mark" for providers of

social prescribing and commissioners in the monitoring and evaluation of local schemes. This will establish a core skills set; support the future planning, delivery and monitoring of the model; and meet the strategic objective to provide robust and sustainable solutions.

8.1.2. Consideration will be given to the most appropriate informatics system required to facilitate the referral process and to track compliance and completion of any social prescription programme. Evidence from existing schemes suggests that the social prescribing referral process should integrate with existing referral processes and be simple to use[8]. Given the link with non-primary care referrers (e.g. housing associations and anti-poverty programmes), a robust monitoring system will be essential to determine the impact at an individual level, aggregated to a service, neighbourhood, practice, or wider geographical profile.

8.1.3. Wrexham Glyndwr University will develop a regional collaboration centre to provide a platform for evolving the education and training elements of the model, linking with other academic institutions to provide a solid research base, and to share good practice across the region, UK wide and internationally. This will connect with the recently-established Innovation Hub for Inequalities, supporting the Health Board's partnership with the Bevan Commission, and ensuring that there is synergy with the wider BCUHB strategic agenda.

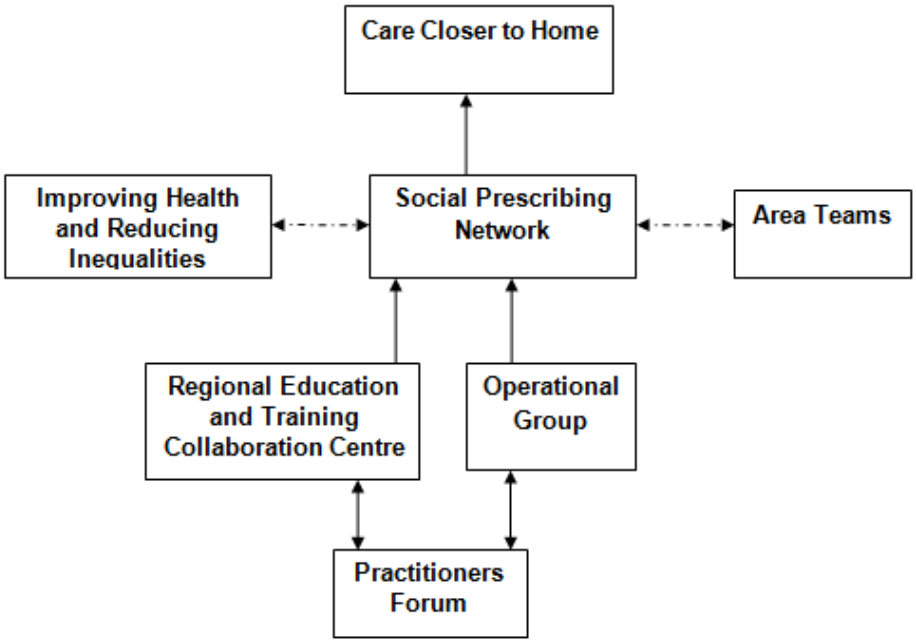
8.1.4. To facilitate the operational delivery of the programme, a North Wales Social Prescribing Network will be established, forging a partnership between BCUHB, Higher Education Institutions, regional leadership forums, the 2025 movement, and the voluntary/ third sector. The academic collaboration centre will be accountable to the Network

8.2. Project management

Detailed below is the proposed project management framework, with the programme, due to its links to the core services of Area teams and primary care cluster areas, accountable under the Care Closer to Home strand of the Living Healthier, Staying Well strategy:

[8] Public Health Wales Observatory, Social prescribing evidence map: summary report, (June 2017).

Proposed delivery and accountability model



8.3. Each of the social prescribers will monitor activity and evaluate the effectiveness of the service. Detailed monitoring will be accessible due to the link to primary care information systems.

8.4. Quarterly reports will be produced by practice in the cluster served, and will include:

- Number of referrals (by age and sex)
- Types of interventions/ support accessed
- Patient outcomes
- Successful interventions
- Primary care outcomes and impact
- Link with Social Return on Investment/ Social Value

8.5. The project manager will ensure that the following are in place:

- All relevant project management documentation
- Information sharing protocol
- Confidentiality agreements around patient information and agreement on what is fed back to primary care teams.
- A system of “red flags” for re-referral for clinical support, particularly around the key areas of mental health and substance misuse.
- Promotion of the North Wales Social Prescribing Network and the related educational requirements, and partnership agreements.

8.6. The project co-ordinator will oversee the day-to-day running of the pilot, and act as a liaison between the employing organisations, primary care, and the wider social prescribing network.

9. Finances

The financing for the programme will be from Primary Care funds

Requirements	Details	2017-18 (Part-year costs)	2018-19	2019-20
One social prescriber[9] per cluster area	Posts @ £28,000	Appoint 3WTE social prescribers. Operational from 1.12.17 linked to Well North Wales **£28,000**	Maintain 3 posts and from April 2018 increase to 10 **£280,000k**	Increase to 14WTE from April 2019 posts **£392,000**
	On costs (@25%)	**£7,000**	**£70,000**	**£98,000**
Project manager	Fixed term 12 months Band 8A with on-costs	6 month appointment **£35,660**	6 month appointment **£35,660**	-
Project co-ordinator	Band 6 with on-costs	3 month appointment **£11,207**	1WTE **£44,828**	1WTE **£44,828**
Training and set up costs		**£8,000**	**£10,000**	**£10,000**
Conference		**£10,000**		**£10,000**
Evaluation		**£10,000**	**£15,000**	**£15,000**
Total		**£109,867**	**£455,488**	**£569,828**

10. Conclusions / Next Steps

The proposed model establishes a strategic and equitable model of social prescribing across the whole of North Wales, building on evidence of success elsewhere, but adding a specific “Made in North Wales” approach.

The proposal is ambitious, in that it extends the traditional boundaries for social prescription schemes, and involves a wide range of potential referral points into the proposed programme. Building on partnership arrangements already in place, and reflecting the opportunities brought about by the *Well-Being of Future Generations Act*, this is the opportune time to introduce this bold programme. The enhanced relationship with the housing sector provides a unique dimension that potentially opens the door to pooled budgets, closer collaboration, and more streamlined service delivery.

[9] Based on social prescriber pay rates paid as part of the proof of concept project in early 2017

Given the pressures on existing services – both primary and secondary care – the scheme offers an opportunity to take a prudent approach to healthcare, and offer social opportunities to individuals who would ordinarily be accessing mainstream medical services. In linking with existing operational services, there will be better co-ordination, understanding and delivery of the programme. The added links with higher education enhance the proposal, and allow for the distinctive North Wales approach to be developed further.

If the proposal is accepted, it is anticipated that the Project Manager would be in post for October 2017, with the other appointments being made rapidly after that.

It is anticipated that the newly established North Wales Social Prescribing Network would meet by October 2017.

11. Recommendations

The Executive Team is asked to consider and agree the principles laid out in this paper to establish the “Made in North Wales” social prescribing programme, and agree the funding requirements as set out in Section 9.