

DRAFT Service Specification

Service Specification No.	
Service	Leeds South and East Social Prescribing Service
Commissioner Lead	Patricia Kirk, Leeds South & East CCG
Provider Lead	
Period	Envisaged: 2 years + 1 Year Extension Option
Date of Review	

1. Population Needs

Definition of Social Prescribing

Social Prescribing is often referred to as: A means of enabling primary care services to refer patients with social, emotional or practical needs related to their health and well-being to a range of local, non-clinical services, often provided by the voluntary and community sector, and to broader universal services, Age Concern (2011).

National/local context and evidence base

This section of the service specification provides an overview of the key drivers and evidence, both on a national and local level to support the commissioning of this service.

- 1.1 The NHS Five Year Forward View specifically highlights the need for NHS organisations to carry out new different approaches that utilises community and combines community assets.
- 1.2 The Marmot Review (2010) building on Wanless (2004) made a number of recommendations to address wider determinants of health including the need to create and develop healthy and sustainable places and communities to tackle health inequalities; requiring the creation of opportunities to support empowerment of individuals to take control of their own lives. The Marmot Review cited primary care as having a crucial role in integrating services and promoting healthier communities suggesting this should be encouraged and incentivised. This scheme fulfils this recommendation by offering general practice a route for signposting into community groups and activity with the aim of improving patient's health and wellbeing.
- 1.3 Using a social prescribing approach will complement the approach suggested and been taken as a follow up work programme action from the Due North Report (2014).
- 1.4 The LSE Social Prescribing Project will provide a pathway for GPs and health / social care professionals to refer patients to and connect patients with community, provision, activity and groups to reduce social isolation and promote social connectiveness. This LSE Social Prescribing Project will work alongside existing local programmes including healthy living advice & support services and advice services, including welfare and benefits advice.
- 1.5 This work programme will support Leeds South and East CCG work towards fulfilling *Strategic aim 1, which aims to improve the health of the whole population and reduce inequalities in LSE CCG communities and work towards Leeds fulfilling The vision of the Leeds Joint Health and Wellbeing Strategy.*

1.8

Social prescribing is an emerging field and the evidence base for the effectiveness of different approaches and interventions is still been developed. The long-term aim of social prescribing is to improve mental health and improve quality of life. Short- and medium-term outcomes include:

- Increased awareness of skills, activities and behaviours that improve and protect mental wellbeing – e.g. the adoption of positive steps for mental health.
- Increased uptake of community activity provision, arts, leisure, education, volunteering, sporting and other activities by vulnerable and at-risk groups, including people using mental health services.
- Increased levels of social contact and social support among marginalised and isolated groups.
- Reduced levels of inappropriate prescribing of antidepressants for mild to moderate depression, in line with National Institute for Health and Clinical Excellence (NICE) guidelines.
- Reduced waiting lists for counsellors and psychological services.
- Reduced levels of frequent attendance (defined as more than 12 visits to GP per year), North West development Centre (2011).

1.9 In other regions of the UK social prescribing services have been commissioned to be delivered. Some of these services have been evaluated and shown the benefits to patients of providing a social prescribing service.

Research into social prescribing highlights the benefits of social prescribing into three key areas, Friedli and Watson, (2004):

- Improving mental health outcomes
- Improving community wellbeing
- Reducing social exclusion which is particularly relevant for older people with depression or who are socially isolated.

Looking at the evaluation of a range of social prescribing projects Kimberlee (2013) found that GP practices with access to social prescribing services universally reported high levels of patient satisfaction, and where social prescribing holistic models are gathering outcome data this indicates measurable improvements in mental wellbeing and positive changes in health behaviours among patients living with highly complex needs. Kimberlee also notes the social return on investment and preventative benefits which accrue simply from preventing individuals from spiraling into worse scenarios with potentially high costs to a range of services.

1.10 Rotherham has piloted a social prescribing project, an evaluation of the project (see Appendix A) two years in showed that this social prescribing project had the following outcomes:

- 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 case management approach,
Dayson et al (2014)

1.11 Bradford has also piloted a social prescribing type project the evaluation of this project highlighted the following benefits of using a social prescribing type service:

- A service that can respond to a variety of social issues which patients bring, particularly in areas of high deprivation.
- Staff with time to spend with patients over a number of weeks.
- Reduction on use of GP time with patients whose problems are at least in part, social
- A means of building links with and making use of the wide range of community based services and activities offered by other agencies in the locality.
- An effective way of supporting people who want to make lifestyle changes
- High patient satisfaction with the service, South (2010)

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	

National Priorities

This work programme will fall into the Public Health Outcomes Framework 2013 – 16:
 DOMAIN 1: Improving the wider determinants of health, Objective: Improvements against wider factors that affect health and wellbeing, and health inequalities

2.2 Local defined outcomes

LSE CCG Outcomes:

This work programme will support Leeds South and East CCG work towards achieving:

LSE CCG Strategic aim 1: To improve the health of the whole population and reduce inequalities in our communities.

LSE CCG Strategic aim 3: To ensure that patient, public and carer voices are at the centre of our healthcare services from planning to delivery (Maximise opportunities for individuals to participate in their own health and wellbeing).

Leeds Joint Health and Wellbeing Strategy 2013-2015:

This work programme supports The vision of the Leeds Joint Health and Wellbeing Strategy 2013 – 15 is that 'Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest. This Third Sector Single Point of Access Service will contribute to Leeds achieving this vision. In particular by supporting the following priorities outlined in the JHWS. This proposal has a particular focus on:

Outcome 2 – people will live full, active and independent lives, priority 6: Ensure more people cope better with their conditions

Outcome 4 - People will be involved in decisions made about them, priority 10: Ensure that people have a voice and influence in decision making, priority 11: Increase the number of people that have more choice and control over their health and social care services

Outcome 5 - People will live in healthy and sustainable communities

JSNA priorities 2013-15:

This work programme also supports the objectives in the Leeds JSNA to move towards more holistic management of people with long term conditions, rather than along disease specific pathways with a focus on the whole person and their needs. The JSNA emphasises co-production including self-care, as an underpinning principle, ensuring that patients have a better experience of care that promotes personalisation, choice and control - 'no decision about me without me'. The proposal supports changing behaviours and increasing healthy behaviours, having a universal application that is tailored towards those communities with higher health need. This work programme supports the promotion of health and wellbeing of communities in greatest need, and contributes to the improvement of both physical and mental health outcomes across the population of Leeds S&E CCG. The programme will be targeted to reduce inequalities in health, both within Leeds S&E CCG, and between Leeds S&E and the rest of the city, as part of the CCG's commitment to improving the health of the poorest fastest.

3. Scope

3.1 Aims and objectives of the service

The overall aim of this service specification is to ensure delivery of the LSE Social Prescribing Project which aims to:

- a) Increase the number referrals made by GP's and health professionals to local community activity provision, targeting communities most in need and leading to more local people accessing local community activity in areas of greatest need. (comment – need to be specific around the nature of this provision – i.e. community activity (whoever provides it)
- b) Increase the number of local people accessing local community activity provision.
- c) Improve the social support available for individuals by supporting, signposting and connecting people to community groups, activity and provision in the local area.
- d) Reduce social isolation and improve community connectiveness to contribute to overall improvements in the health and wellbeing of individuals and communities.

All provisions of this service will be expected to meet and comply with NHS standards for IT Governance, Data Protection, security of general and personal information, data and records held and processed and transmitted (via and over all mediums).

All provisions within the specification and related documentation will form part of the core service and not be subject to additional charges or cost to the CCG.

The aims and objectives of the service to be delivered are outlined below:

3.11 Aims

Overall service aims:

To develop and implement a pathway for Service Users, GP's and Health & Social care professionals to refer patients into a central social prescribing single point of access and to provide one to one assessment sessions for service users in order to identify opportunities to explore their social support needs and provide them with information, support & guidance in relation to accessing local community activity to improve their health & wellbeing.

[Capacity, volumes and numbers to be determined following consultation – Specification to be updated.]

Provision of service will be free at the point of access for all Service Users and no further charges may be applied. This also applies to any telephone line provision where the lowest cost option must be provided, including mobile-friendly provision.

3.12 Objectives

The Social Prescribing project will include:

- Provide Service Users, GPs and Health & Social Care professional with one route of referring patients into community activity provision and social support.
- Provide a central hub including a telephone number where referrals can be made to.
- Provide individuals living in the LSE CCG area with up to date information in relation to the local opportunities available in relation to community activity provision.
- Provide a place, system and facilities to record the information sent in via the GP / Health & Social Care professional.
- Make contact with patients to undertake initial needs assessments and then provide them with relevant information in relation to local community activity provision and / or arrange an appointment with a Community Wellbeing Co-ordinator.
- Inform primary care of patient referrals been made into the service from their practice population and provide feedback to primary care in relation to interventions that have been made in relation to patients accessing the service.
- Collate, analyse and report to Commissioners on service provision, challenges and trends and to also identify gaps in required provision across geographical and health need categories.
- Flexibility to proactively present, and agree with commissioners, opportunities for provision improvements via efficiencies, system and provision enhancements within scope and continue to develop services in order to meet needs.

The Community Wellbeing Co-ordinators advisors will:

- Provide one to one sessions for service users that will explore their social support needs and encourage, motivate and support individuals to access local community activity provision.
- Enable service users to take the steps needed to link and attend local community activity.
- Build, maintain and keep up to date records on a secure database.
- Signpost and refer service users to mainstream health living and other local services if there is a need to include, but not limited to, Leeds Let's Change services (smoking cessation, weight management, alcohol services), welfare & advice services, IAPT service and other relevant local services.

3.2 Service description/care pathway

3.21 Service provision

- i) The service will aim to maximize service user's overall quality of life by supporting, signposting and connecting them with community groups and activity provision in their local area. The provider will operate a single point of access service for health professional and self-referrals. The LSE social prescribing project will provide patients with an assessment of their social support needs and will link service users to relevant and accessible community activity provision to meet their individual needs.
- ii) The provider will map and develop an information directory which outlines the community activity provision available in the Leeds South and East area. This will enable a comprehensive and up-to-date record of provision and also provide a platform to identify gaps in community provision for which local investment may be required. The information directory will be developed through the provider building positive and proactive working partnerships with stakeholders in the area. The information directory will be able to provide individuals with information about local community activity, groups and provision. Information from the directory could be accessed by for example the telephone, online or via

use by the Community Wellbeing Co-ordinators.

- iii) The provider will provide a central place where referrals can come into, this is to include a telephone contact point and portal web based referrals facilities from their website. Referrals will be made into the service through an established pathway from primary care or made directly by individuals themselves. The central resource will ensure appropriate allocation of a social support advisor to patient's referred into the service in line with language, gender and cultural needs of the LSE communities as part of the standard provision.

Referrals to the service will be generated by:

- At a patient's routine visit to a GP practice or social care service visit the consulting health or social care professional will undertake the normal medical appointment / assessment, but would also consider if the patient might benefit from addressing their social support needs including attending local community activity provision. The health professional or social care professional would obtain the patient's consent to refer them to the LSE Social Prescribing Project. The health professional or social care professional will then send a completed referral form to the Single Point of Access (fax/web/post). The healthcare / social care professional will explain to the patient what the service offers and give them a leaflet about the service they are being referred into. GP Practices and social care services will be provided with information about the social prescribing project and how they will refer into the service.
 - Self-referral to the social prescribing project telephone number. This number will be widely advertised to professionals to enable referrals from the community at large.
 - Innovative ways of obtaining referrals into the service will also be used by the provider, e.g. utilising technologies such as Skype/Facetime and in face to face formats setting up stalls in GP surgeries to increase awareness of the service and access into the service.
 - Both the written form, web based and telephone referral process will collect sufficient information in order to be passed-on to a relevant local Wellbeing to arrange contact and assessment.
 - Primary care will be informed of referrals made into their service from their practice population using an appropriate format and presentation agreed with commissioners.
- iv) Referrals made in to the social prescribing project will be assessed in order for the appropriate information to be provided to the service user in relation to local community activity provision and / or the service user been given an appointment with a social support advisor. The service will contact the referred patient to provide the requested information and / or inform the patient with more information about the service, what it can offer and arrange an appointment with social support advisor in a convenient local venue.
- v) As part of the service if appropriate individuals will be offered one to one sessions. A one to one should initially be offered as a face to face session. In some cases, service users may need to be seen at home and in order to comply with DDA requirements (Disability Discrimination Act) the provider will need to ensure that policies and supporting mechanisms are in place to facilitate this and to safeguard the wellbeing of the workers of the

service.

Areas covered in the one to one sessions might include:

- Assess an individual's social support needs.
- Provide detailed information on local community activity provision opportunities. Provide individuals with opportunities for example to access areas such as, social groups, arts and creativity groups, physical activity sessions, learning new skills opportunities and local volunteering opportunities.
- Providing individuals with a "hand holding" visit to their first visit to a community activity or group, to include evening and weekend support
- Make service users aware of, signpost and refer individuals to other appropriate services for support, e.g. employment, benefits, housing, debt, legal and relationship advice.

vi) In addition the social support advisors will be accepted as part of their role to:

- Make links with workers at local third sector and community organisations to increase their knowledge and understanding of provision of the local area to link into.
- Carry out activity and outreach work in the local area to promote the LSE Social Prescribing project in order to generate referrals into the service.
- To attend training courses relevant to their role.
- Carry out the administration tasks associated with the community coordinator role.
- Keep their clients records up to date.

vii) Primary care and refers into the service will be provided with feedback of any interventions provided to patients by the social prescribing service and outcomes of these interventions made in an agreed format to enable ease of collation with patient records

Provider responsibilities:

The provider will be responsible for

- Offering services in accessible locations and venues that are suitable to clients, taking into consideration the geographical demographics, cultural needs and community based provision of this service;
- Collecting and maintaining accurate records and data systems to ensure high quality performance management information is available; this will include providing output and outcome data on a regular basis as specified by Leeds South and East CCG.
- Provide information in relation to relevant appropriate local community activity provision to individuals.
- Accompanying individual service users to community group, at suitable times in order to attend group activities, and activity where requested, to maximise benefit and support and where the confidence levels of clients are low.
- Long term follow up needs to be carried out to establish outcomes achieved by the

project.

- Consulting and gaining views from local people and service users in relation to the development, implementation and running of the service
- Following analysis from internal systems and intelligence gathered, working proactively with Commissioners and Voluntary Sector Organisations to highlight gaps in provision, community needs, demand on additional services and priority measures.

The above description will be adaptable to change in line with revised national and local guidance and local population needs as defined by LSE CCG.

It will be the responsibility of the service provider to also ensure that the following factors apply in delivering the service:

- a. All workers receive the appropriate training needed to carry out their role
- a. All workers will receive regular supervision
- b. All workers will be in receipt of an enhanced DBS and relevant checks and valid employment references to ensure the safeguarding of vulnerable adults and children.
- c. A method of systematic feedback will be undertaken to all referring parties, including patients, who make a direct referral to the Single Point of Access
- d. The provider will liaise with LSE CCG regarding any addition, new or proposed advanced training and development needs that the workers may need to ensure best practice.

In addition, it is expected that the provider will work closely with the Grant Allocation Service provider, Leeds Community Foundation, to inform them of identified gaps in community activity provision in the Leeds South & East area either by area knowledge build by proactive work of the social support advisors or by the Single point of access/Administration team identifying that emerging patterns of gaps in community provision exist. The Leeds Community Foundation can then encourage local organisations to apply for funding to set up and run community provision which fills the identified gaps in community provision.

3.22 Service delivery sites and times

Location of service delivery:

The LSE Social Prescribing Project will have central base within Leeds, preferably in the LSE CCG area, where operational management, staff base will be provided.

Delivery of the one to one sessions will take place in a variety of appropriate and suitable venues within the LSE CCG area. The service provider will need to make sure suitable venue choices in terms of service accessibility e.g. use of venues on bus routes. The service provider will also need to make sure the one to one sessions are delivered at venues which provide good coverage across the LSE CCG area and build positive partnership relationships with venue stakeholders in order to provide geographical flexibility of provision. Ideally many of the venues chosen to deliver one to one sessions at will be at venues where other public sector services are delivered.

3.4 Days/Hours of operation

The social prescribing project central hub will be able to accept referrals and provide information to individuals by providing opening hours which make the service accessible to individuals making referrals into the service, individuals requiring information and the service

been able to contact individuals to make appointments with the social prescribing advisors. The telephone booking line should as a minimum operate between practice hours Monday to Friday and Saturday mornings.

In relation to the provision of the Community Wellbeing Co-ordinator 1:1 sessions provision of service should meet the needs of communities e.g. full week coverage, time, day, location, consider for carers. The provider should as a minimum offer 1:1 appointments over 6 days a week, offering appointments on a Saturday and early evenings. The provider will ensure the service is accessible, utilising culture, language and jargon free communication to reach and be accessible for local residents across South & East Leeds.

3.23 Monitoring and evaluation

The social prescribing project will be a key element in the development of services commissioned by LSE CCG that aim to reduce health inequalities and support LSE CCG to meet its strategic aims. Consequently, it is important to ensure that a range of reporting requirements are established which will determine how effective the service is and whether it is meeting the needs of the Leeds South and East population.

Activity data in respect of outputs is important in ensuring that a comprehensive picture of patients coming and been referred into the service which can be mapped against known areas of need. Regular review meetings will form part of the SLA with the provider agency and particular importance will be placed on the provider to work with LSE CCG on the development of the Third Sector Single Point of Access whilst ensuring maximum referrals into the system.

The monitoring arrangements of this service will be subject to review to ensure that the effectiveness and efficiency of the programme can form part of the ongoing development of the service.

An electronic data capturing system will be developed, maintained and reported from by the provider. Data management, capture, entry and analysis will be the responsibility of the provider.

Outputs

The provider will arrange for suitable staffing numbers to facilitate a successful, dynamic and sufficient service. It shall provide resources to cover:

Management and leadership of the Service including marketing and raising awareness of the service

Administration, facilities, reporting and technological support

Telephony, initial assessment and response resources to cover all inbound referrals promptly, via post, phone and internet.

Sufficient FTEs of "social prescribing advisors" to cover the neighbourhood ward areas that make up the LSE CCG area and additional advisor time in the 10 % most deprived areas to support the additional needs of these communities. Ensuring face-to-face assessments can take place without delay, communities are supported and accessed and positive, partnership relationships are built with primary care, community groups and relevant stakeholders.

Outcomes

Meeting the aims and objectives of this project will be monitored through outcome reporting arrangements which will indicate the following:

- Number of referrals into the service.
- Number of self-referrals into the service.
- Assurance that at least 50% of patients accessing the LSE CCG social prescribing project go to access a local community activity provision.
- Evidence that there is a reduction in social isolation, increased social connectiveness and improvements in social support and overall mental health & wellbeing reported at follow up by the clients who have accessed the service.
- Referrals to Assessment timescales, including steps taken to sign-off, are within agreed targets with efficiencies, proactive solutions and options explored by the provider to achieve outcomes
- Patients provide positive feedback that show their outcomes have been achieved
- Patient's experience and feedback is proactively sought throughout their social prescribing journey and packages of care are patient centered and fully inclusive.
- Systems and processes collate community provision data and intelligence which is reported on monthly in order to support community development, investment and growth of provision.

Evaluation

LSE CCG will carry out an evaluation of the LSE social prescribing project. This will require access to workers of the service, and other staff including staff at the provider service as well as with clients. The provider service will assist in this process in pursuance of the delivery of a value for money service that delivers key outcomes for the target population.

The provider organisation will also have an ongoing evaluation process which will inform service delivery at a local level.

3.3 Population covered

The LSE social prescribing project will work across the LSE CCG area with patients registered with LSE practices. A greater portion of the service provision will be delivered in the 10 % most deprived areas in Leeds South and East to reflect higher levels of need in these areas, in addition to targeting the needs of specific communities who would benefit from increased community activity (e.g. socially isolated men, people experiencing multiple deprivation, specific BME communities etc.)

i)

The service provider will need to establish links with local third sector organisations that cover the Leeds South and East area and those of the whole city. The establishment of good working relationships with the Leeds South & East network of GP Practices is also essential. The service provider will also link to and make contact with other relevant teams and projects operating in the LSE CCG area including the neighbourhood teams, LCH Better For Me Project and the Leeds Directory.

ii)

The service provider will need to demonstrate a robust and proven track-record effective networking and relationship management with the provision of community services in Leeds. This should include the ability to demonstrate an understanding of the social support issues that typically impact on the population of South and East Leeds, local knowledge of third sector assets and proof of relationships with the South and East Leeds based third sector organisation. The organisation will need to provide evidence of effective working relationships with GP Practices and a good working knowledge of the local GP Practice networks and health and social care teams are essential.

iii)

The service provider will need to demonstrate a methodology for the measurement of patient progress, experience and the outcomes, to be agreed jointly with LSE CCG. Specific measures will form part of any work programme, and the organisation will ensure that these are robust according to LSE CCG guidance. The organisation would be required to fully

cooperate and support a compressive evaluation process to be undertaken by an independent body for the duration of the pilot.

lv)

It is essential that this project demonstrates that it is systematic; robust and reliable. Monitoring of agreed outcomes, challenges and outputs will be undertaken by the service provider. The service provider will develop an agreed set of monitoring tools with the LSE CCG giving consideration to proportionality, NHS priorities and particular focused areas.

v)

The service provider will need to demonstrate a commitment to Social Value, the reduction of poverty and inequities, and what plans they have in place over the course of the pilot to ensure that these commitments materialise in a measurable and tangible way.

vi)

The LSE social prescribing project should make sure that it meets the requirements of The Equality Act 2010, the Data Protection Act to NHS standards, and all relevant legislation standards to ensure lawful practice, for which the responsibility lies with the provider..

To comply with this, LSE CCG will require the service provider to:

- Identify and remove the barriers that hinder equality of access so that patients and communities can effectively access services
- Provide appropriate communications support and information about services to people so that they can make informed health related choices tailored to their needs
- Help people feel listened to and respected, and assured that the services they receive are safe, effective and personalized to their specific needs
- Services should be accessible to all groups with protected characteristics covered by Equality Act 2010 (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation, marriage or civil partnership) including wheelchair accessibility.
- The service should be sensitive to the cultural needs and backgrounds of all people in its local population.

3.5 Interdependence with other services/providers

The service provider should make links with and work with other Third Sector organisations, community providers and health & social care providers to deliver this service.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

4.3 Applicable local standards

- Local Safe Guarding policy
- Policy for transferring of serviced user information by fax/post/email securely
- Confidentiality policy
- Storing of confidential information policy

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

- **Compliant with compassion in practice**
<http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf>
- **Compliant with CQC standards**
- **<http://www.cqc.org.uk/content/national-standards#1-hospitals>**
- **Compliance with all applicable NICE guidance and technology appraisals**
<https://www.nice.org.uk/guidance>
- **Compliance with all local safeguarding requirements of adults and children as outlined in Schedule 2 Part L Duty of Candour**
<https://www.gov.uk/government/consultations/statutory-duty-of-candour-for-health-and-adult-social-care-providers>
- **Equality statement The Public Sector Equality Duty – as per contract and schedule 6 requirements**
- **Compliance with timely implementation of National Patient Safety Alerts.**
<http://www.nrls.npsa.nhs.uk/alerts/>
- **Compliance with professional standards, professional regulatory body, workforce capability, skill mix and training and development.**

5.2 Applicable CQUIN goals

- **Integrated neighbourhood teams CQUIN – Multi-disciplinary working**

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement