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Evaluation of the Cwm Taf Social Prescribing Initiative

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Evaluation of the Cwm Taf Social Prescribing Initiative

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Intended Audience: The Project Review Team, Cwm Taf University Health Board and Director of Health and Healthcare Improvement Division, Public Health Wales.

Purpose of Document: To report on the implementation of the Cwm Taf Social Prescribing Initiative.

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- The Project Review Team, Cwm Taf University Health Board
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- Executive Director of Health and Wellbeing, Public Health Wales
- Director of Health Improvement, Public Health Wales
- National Exercise Referral Scheme Lead and local co-ordinators
- Stop Smoking Wales Programme Lead
- Specialist Registrar in Sports Medicine
- Welsh Centre for Postgraduate Pharmacy Education

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- Faiza Kennedy, ScriptSwitch

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List of abbreviations

CASPA	Comparative Analysis System for Prescribing Audit
CPSSS	Community Pharmacy Stop Smoking Service
NECAF	National Electronic Claim and Audit Form
NERS	National Exercise Referral Scheme
NRT	Nicotine Replacement Therapy
POM	Prescription Only Medicine
SSW	Stop Smoking Wales
ULHB	University Local Health Board

Summary of key points

This paper presents the findings from the initiative which has become known as the Cwm Taf Social Prescribing Initiative. It should be read in conjunction with the earlier *Review of the role of the health workforce in reducing inequalities in Cwm Taf through Social Prescribing initiative* reported in July 2014.

The initiative was designed to encourage social prescribing by primary care clinicians, in particular GPs. The intention was for social prescribing to become part of the Prescribing Advisor Team agenda. The aim was to encourage GPs and practice staff to increase the number of brief interventions they undertake and whenever possible refer and signpost their patients to specific health improvement services.

The project focused on the opportunistic application of a model of educational outreach. Training was provided and toolkits were developed to support the Prescribing Advisory Team in implementing the initiative.

Resources to support the initiative were minimal with no protected time, budget or additional resources allocated. Support for planning, provision of training, development of the toolkit and evaluation was provided by a Consultant in Pharmaceutical Public Health, Public Health Wales and key members of the Local Public Health Team.

In particular this evaluation highlights:

- There was an overall decrease in the number of people in Cwm Taf accessing NHS smoking cessation services despite an annual upward trend in 2014 for Stop Smoking Wales (SSW). The overall decrease is mainly a result of a large reduction in the number of contacts with the Community Pharmacy Stop Smoking Service (CPSSS).

- Generally there was little change in the number of contacts with the National Exercise Referral Scheme (NERS) over the study period.

- During the first 3 months of the initiative the CPSSS and NERS reported an increase in the number of contacts compared to the same period the previous year. This was against a general overall downward trend in contacts during the study period. The timescales of peak observed coincided with the introduction of the social prescribing initiative.

- There was a decrease in the supply of smoking cessation pharmacotherapy and drugs for the treatment of obesity resulting in savings on the GP prescribing budget.

- There were mixed views reported by the Prescribing Advisory Team regarding their role in advising GPs on social prescribing compared with providing general prescribing advice. Those interviewees reporting the

role to be acceptable indicated that a programme of continued support and training would be needed to underpin the role if it was to continue.

- In practice there was limited time given by Prescribing Advisory Team to the initiative and this appeared to decrease with time. This may have been a result of the limited resources to support the initiative and therefore free up protected time for the Prescribing Advisory Team to apply the model proposed.

- During this study it became clear that there is no single agreed understanding to the term social prescribing or what interventions could be considered as social prescribing.

The pre-implementation work indicated that primary care health professionals would benefit from regular reminders and updates on social prescribing. This evaluation has provided some findings for consideration. It is debatable whether the results of this evaluation suggest that there is value in pursuing this model further in its current format.

1 Aim

The aim of the evaluation was to identify whether the initiative was a success and make recommendations regarding the future working.

The initiative attempted to answer the following:

i. What methods could be used to increase brief interventions and social prescribing to non-pharmacological public health interventions and health improvement programmes by the primary healthcare workforce?

ii. Do brief interventions and social prescribing of non-pharmacological public health interventions in primary care have an effect in reducing the GP prescribing budget?

2 Background

Social Prescribing has been defined as a method of impacting on the wider determinants of health such as the social, economic and environmental factors, through linking people with health problems to non-medical sources of help and support in the community, usually referral by primary care.[1]

The publication of a consultation report by the Institute of Health Equity, University College London 2012 describing the potential role of the primary healthcare workforce in influencing the social determinants of health and thereby tackling inequalities[1] was the stimulus for this initiative.

The concept of social prescribing is not new. Across the UK, and Scotland in particular, there have been many initiatives implemented in populations of high deprivation and exploring ways to support the role of the primary healthcare workforce in improving signposting and social prescribing for their patients.[2,3,4]

Cwm Taf University Local Health Board (ULHB) serves one of the most deprived populations in Wales with reported poorest health and lowest life expectancy in Wales. Examples of social prescribing good practice in similar populations across the UK may be applicable to some localities in Cwm Taf ULHB.

3 Introduction

3.1 Primary care in Cwm Taf

Cwm Taf ULHB has a population of approximately 295,000 (2013). Data reported in 2009 indicates around 302,500 patients registered with Cwm Taf ULHB general practices.[5]

Primary care services are commissioned from 48 GP practices and 77 community pharmacies across the borough. The health board area is divided into four localities; Merthyr Tydfil, Cynon, Taf Ely and Rhondda. Each locality is further divided into two cluster areas (north and south).

3.2 The model

The Prescribing Advisory Team delivered educational outreach messages to primary care healthcare professionals and staff with an aim to influence and increase social prescribing interventions.

The initiative focussed on social prescribing interventions to increase physical activity and encourage smoking cessation and in particular referral to the following services:

- Stop Smoking Wales
  A national service hosted by Public Health Wales

- The Community Pharmacy Stop Smoking Service
  A local enhanced service commissioned by Cwm Taf ULHB

- The National Exercise Referral Scheme
  A national service hosted by Welsh Local Government Association

The model relied on opportunistic messaging by the Prescribing Advisory Team. The initiative was designed to encourage social prescribing to be embraced as part of the wider prescribing advisory agenda and to become part of everyday activity. There was no protected time made available for

the initiative nor was any funding allocated to support the preparation and implementation.

3.3 Preparation

The initiative was originally considered in May 2012. With the support of a Consultant in Pharmaceutical Public Health, Public Health Wales and key members of the Local Public Health Team the following activities were undertaken to support implementation:

- A literature review
- A survey of healthcare staff (GPs, GP practice staff and community pharmacists – this was presented as a poster at the Welsh Public Health Conference in 2014.
- A series of semi-structured interviews with GPs (Appendix 1)
- Preparation and delivery of three training events focused on smoking cessation, physical activity and motivational interviewing and influencing skills
- Development of Smoking Toolkit and Physical Activity Toolkits
- Key slides to use in GP practices

Details of the structure and functions of the Prescribing Advisory Team, descriptions of the local services, preparation work including the training events and support material are covered in the 2014 review.

3.4 Implementation

Implementation began in July 2013 with the majority of practice work starting in October 2013. Implementation consisted of 4 key activities:

- The Prescribing Advisory Team discussing smoking cessation and physical activity with the GPs and practice staff during their day to day prescribing work.

- The inclusion of contact data with SSW and NERS in each individual GP Prescribing Performance Review Report (2013 only).

- Social prescribing discussed for the first time during GP Prescribing Annual GP Prescribing Visits (2013 only).

- ScriptSwitch* used to prompt prescribers to signpost and refer to SSW, NERS and the CPSSS. Messages were added to pharmacotherapies for smoking cessation and for the treatment of obesity.

*ScriptSwitch is a computerised prescribing decision support tool installed in every GP practice in Cwm Taf. It is used in primary care to deliver guidelines, local initiatives and formulary choices. It works at the point at which a drug is prescribed by the GP system and automatically displays a recommendation.

4 Methods

4.1 Period under study

The initiative began with three training events for the Prescribing Advisory Team. These were delivered between December 2012 and June 2013. Practice work was reported to commence in October 2013 following the GP Prescribing Annual GP Prescribing Visits. Data were therefore collected to cover the following periods:

- Baseline
  - 1 October–31 December 2012

- Study period
  - 1 October–31 December 2013 and 2014, as a measure of 3 months and 12 months post implementation
  - 1 January-31 December 2013 and 2014 to compare annual trends post implementation

4.2 Data collection, analysis and reporting

4.2.1 Quantitative data

For the 2014 review, where possible and appropriate, data were standardised using GP practice list size and presented by GP practice and GP cluster. Presentation of data this way was useful for feedback to practices but upon analysis, no conclusions could be drawn when analysing contact rates by GP practices and GP clusters. Standardised data were therefore not used to inform this evaluation.

4.2.1.1 GP practice activity

At the start of the study, for six months only, each member of the Prescribing Advisory Team completed an activity report (1 July 2013–31 December 2013). The activity reports were analysed and reported in the 2014 review.

Early findings indicated there to be no relationship between the time spent in GP practice and increase in contacts with either of the smoking services or NERS. As a result, activity was not recorded beyond 31 December 2013.

4.2.1.2 Service contacts

In order to measure the model being tested rather than the effectiveness of the service once the individual had enrolled, data were collected on the number of contacts with the services under study.

A contact is defined as an individual who was scheduled to attend and attended at least one treatment/exercise session.

Contact data were collected from various sources and were provided in different formats (Table 1).

Table 1: Contact data sources and formats

Service	Source	Format
SSW	SSW monthly Cwm Taf ULHB reports *Reported to Health Board by SSW*	WP practice code and by cluster
CPSSS	CPSSS payment data (unpublished) *Supplied to Health Board by NHS Wales Informatics Service*	Community pharmacy name and address
NERS	Rhondda Cynon NERS database and Merthyr Tydfil NERS database (unpublished) *Not reported to Health Board; bespoke reports provided to inform evaluation*	GP practice name and locality (RCT or Merthyr)

Where possible and appropriate data were converted to the same format and population area and aggregated to provide a Cwm Taf wide dataset.

Contact data from NERS were provided by GP practice name and locality (Rhondda Cynon Taff or Merthyr). Data were converted to WP practice code and aggregated to provide a Cwm Taf wide dataset.

Contact data from SSW were provided by WP practice code and by GP cluster. Cluster data from SSW were aggregated to provide a Cwm Taf wide dataset. The CPSSS provided data by community pharmacy name and address. Data from both smoking cessation services were aggregated to provide a Cwm Taf wide dataset. This enabled comparisons in contact rates for smoking cessation services in Cwm Taf.

4.1.1.3 Supply of medicines to aid smoking cessation and obesity

Data on the supply of smoking cessation pharmacotherapy were collected from two main sources:

i. Data collected routinely by the Health Board for reimbursement of the community pharmacies providing the CPSSS. The National Electronic Claim and Audit Form (NECAF) system reports CPSSS data but not for the timescales required.

ii. Primary care prescribing data from the Comparative Analysis System for Prescribing Audit (CAPSA) system. Data were collected and analysed for a basket of 31 different smoking cessation pharmacotherapies available via NHS prescription (Appendix 2).

Data used for this evaluation included all products available through all the services, namely nicotine replacement therapy (NRT), bupropion and varenicline. It should be noted that certain smoking cessation products (bupropion and varenicline) were only available by NHS prescription.

Data on volume of supply of smoking cessation pharmacotherapy supplied via the CPSSS and by NHS prescription were available in different formats that cannot be easily aggregated. Data on the value of smoking cessation pharmacotherapy were therefore used to examine the trends in supply by the services in Cwm Taf.

Although there were no significant changes in product costs identified during the study, caution is needed when comparing values of product supplied in very small quantities and by the different services.

There is only one medicine indicated for the treatment of obesity (orlistat) and this is classified as a Prescription Only Medicine (POM).[6] Data on the supply of orlistat via NHS prescription were therefore collected from the CAPSA system (Appendix 2).

4.1.1.4 ScriptSwitch data

Data on the number of reminder messages made to prescribers during the study period were provided directly by ScriptSwitch.

4.2.2 Qualitative data

A series of semi structured interviews were conducted with members of the Prescribing Advisory Team. All members of the Prescribing Advisory Team who had attended the initial training and had worked on the initiative were invited to participate. Ethics approval was granted by the Welsh School of Pharmacy and Pharmaceutical Sciences Ethics committee to undertake the qualitative work.

The interviews were undertaken in November 2014 by an independent researcher who visited the participants' at their place of work. The researcher undertook this work as part of a 4th year pharmacy degree research project with the Welsh School of Pharmacy.

Each interview took approximately 20 minutes. The interviews were recorded transcribed and thematically analysed.

5 Results

5.1 GP practice activity

Results of analysis of the activity reports were reported in the 2014 review.

In summary:

- Activity reports were completed for 79% (n=38) of GP practices over a six month period.
- 8 different members of the Prescribing Advisory Team undertook GP practice visits.
- Ten practices were not visited, 28 practices for less than a quarter of a working day, and 10 for half a day or more.
- The total time reported on the activity reports was 97.5 hours.
- There was no relationship between the time spent in practice and contacts with either the smoking services or NERS identified.

As a result of these findings activity was not recorded or reported for the remaining duration of the study.

5.2 Service contacts

5.2.1 Smoking cessation services

5.2.1.1 All smoking cessation services under study

Figures 1 and 2 illustrate the trend in contacts with the Cwm Taf smoking cessation services under study.

Figure 1: Trend in contacts with NHS smoking cessation services under study (quarterly data : 1 October 2012–31 December 2014)

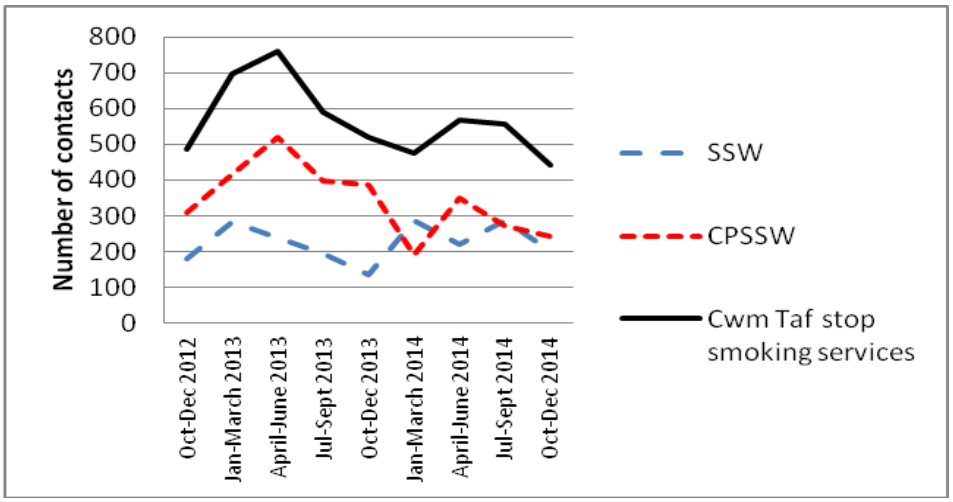
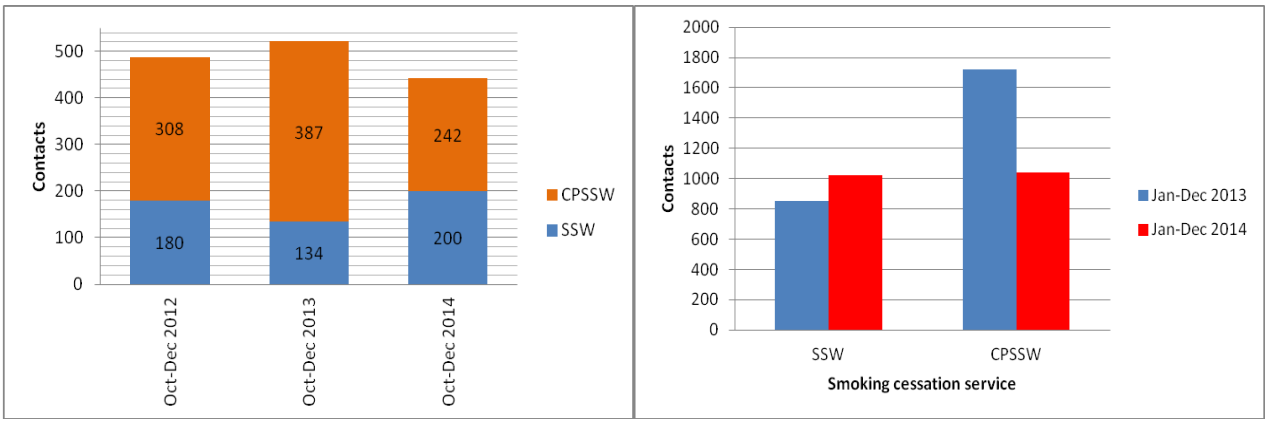


Figure 2: Contacts with NHS smoking cessation services under study



With reference to Figures 1 and 2:

- There has been a general decrease in contacts with the smoking cessation services since April 2013.
- Between 1 January–31 December 2014 there had been 2059 contacts with the smoking cessation services.
- There has been a 20% (n=511) decrease per annum (between 2013 and 2014) in contacts with the smoking cessation services.
- Data for 1 October–31 December 2013 and 2014 indicates:
    - an increase in contacts of 7% (n=33) for 2013 and a decrease of 10% (n=46) for 2014 compared to the baseline (1 October–31 December 2012)
    - a decrease of 15% (n=79) for 2014 compared to the same quarter in 2013

5.2.1.2 Stop Smoking Wales

Table 2 presents data reported by Stop Smoking Wales.

Table 2: Contacts with Stop Smoking Wales by locality (quarterly and annual data: 2012, 2013 and 2014)

Area	No. of GP practices in locality	Contacts with SSW (quarterly data)			Contacts with SSW (annual data)	
		Oct – Dec 2012	Oct – Dec 2013	Oct – Dec 2014	Jan – Dec 2013	Jan – Dec 2014
Cynon	12	27	26	33	151	174
Rhondda	15	56	36	25	249	259
Merthyr Tydfil	11	39	36	64	197	259
Taf Ely	10	58	36	78	254	329
Cwm Taf	48	180	134	200	851	1021

With reference to Table 2:

- Between 2013 and 2014 there has been a 20% (n=170) increase in contacts with SSW per annum. The number of contacts in all 4 localities during this time period increased.

- Data for 1 October–31 December 2013 and 2014 indicates:

    - a decrease in contacts of 26% (n=46) for 2013 and an increase of 11% (n=20) for 2014 compared to the baseline (1 October–31 December 2012)

    - an increase in contacts of 49% (n=66) for 2014 compared to the same quarter in 2013

At the time of this evaluation, all Wales data for 2014 for SSW had not been published. It is therefore not possible to compare NHS smoking services contacts for either service across health boards for the purposes of this evaluation.

5.2.1.3 The Community Pharmacy Smoking Cessation Service

Table 3 presents data on contacts with the Community Pharmacy Smoking Cessation Service.

Table 3: Contacts with the Community Pharmacy Smoking Cessation Service by locality (quarterly and annual data: 2012, 2013 and 2014*)*

Area	No. of pharmacies in locality		Contacts with CPSSS (quarterly data)			Contacts with CPSSS (annual data)	
	Dec 2013	Dec 2014	Oct – Dec 2012	Oct – Dec 2013	Oct – Dec 2014	Jan – Dec 2013	Jan – Dec 2014
Cynon	4	4	38	79	19	328	146
Rhondda	9	14	151	169	121	786	541
Merthyr Tydfil	8	8	48	48	29	213	114
Taf Ely	10	11	71	91	73	392	237
Cwm Taf	31	37	308	387	242	1719	1038

With reference to Table 3:

- Between 2013 and 2014 there has been a 40% (n=681) decrease in contacts with the CPSSS per annum. The number of contacts in all 4 localities during this time period decreased.

- Data for 1 October–31 December 2013 and 2014 indicates:

    - a increase in contacts of 26% (n=79) for 2013 and a decrease of 21% (n=66) for 2014 compared to the baseline (1 October–31 December 2012)

- a decrease in contacts of 37% (n=145) for 2014 compared to the same quarter in 2013

Data for the CPSSS are not routinely available or published across Wales as not all health boards commission a Level 3 CPSSS service. It is therefore not possible to compare NHS smoking services contacts for either service across health boards for the purposes of this evaluation.

5.2.2 National Exercise Referral Scheme

Figure 3, 4 and Table 4 illustrate the trend in contacts with NERS since October 2012.

Figure 3: Trend in contacts with the National Exercise Referral Scheme by locality (quarterly data: 1 October 2012–31 December 2014)

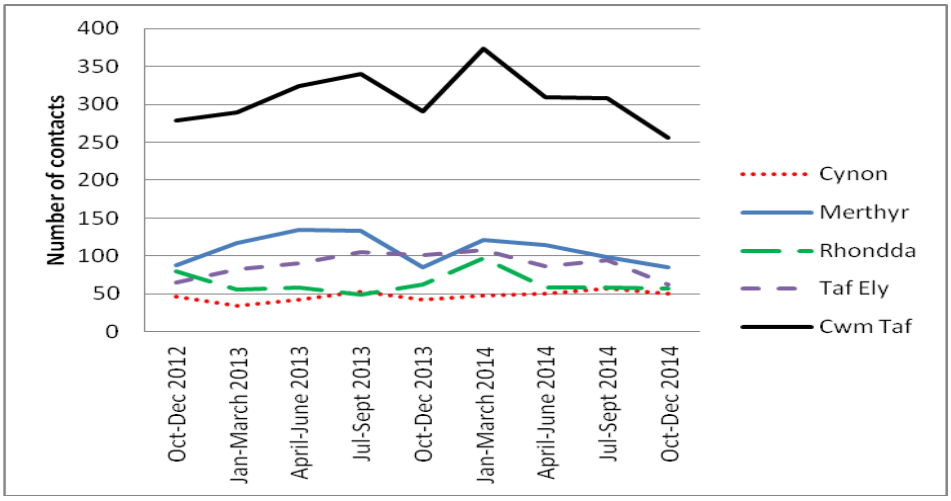
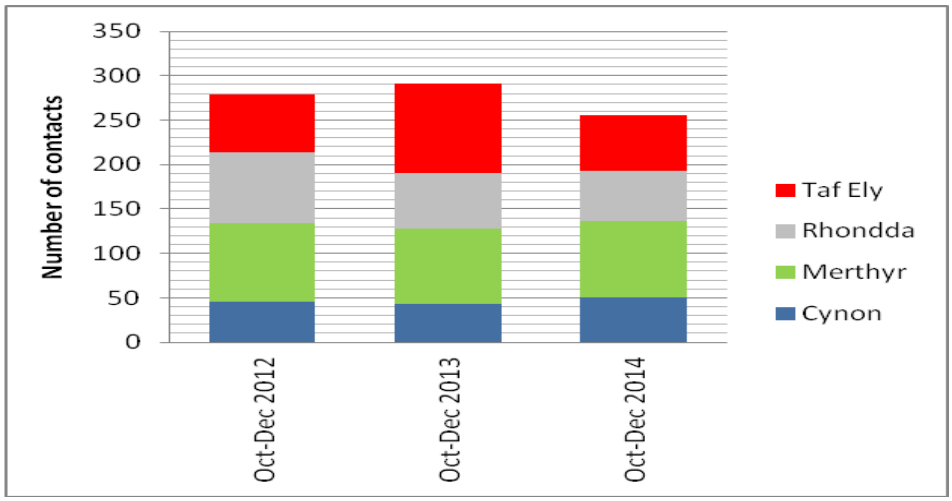


Figure 4: Contacts with the National Exercise Referral Scheme by locality (quarterly data: 1 October–31 December 2012, 2013 and 2014)



With reference to Figures 3 and 4:

- Generally there has been little change in number of contacts with NERS in Cwm Taf since October 2012.

- A number of troughs are observed during the winter quarters in 2013 and 2014 (October–December) with similar sized peaks in the January–March quarters for both 2013 and 2014.

Table 4: Contacts with the National Exercise Referral Scheme by locality (quarterly and annual data: 2012,2013 and 2014)

Area	No of GP practices in locality	Contacts with NERS (quarterly data)			Contacts with NERS (annual data)	
		Oct – Dec 2012	Oct – Dec 2013	Oct – Dec 2014	Jan – Dec 2013	Jan – Dec 2014
Cynon	12	46	43	51	176	207
Rhondda	15	80	62	57	472	418
Merthyr Tydfil	11	88	85	85	243	270
Taf Ely	10	65	101	63	342	352
Cwm Taf	48	279	291	256	1233	1247

With reference to Table 4:

- Between 1 January–31 December 2014 there had been 1247 contacts with NERS.

- There has been a 1% (n=14) increase per annum (between 2013 and 2014) in contacts with NERS. The number of contacts increased in 3 of the 4 localities with an 11% (n=54) decrease observed in one locality specifically during this time period.

- Data for 1 October–31 December 2013 and 2014 indicates:

    - an increase in contacts of 4% (n=12) for 2013 and a decrease of 8% (n=23) for 2014 compared to the baseline (1 October–31 December 2012)

    - a decrease in contacts of 12% (n=35) for 2014 compared to the same quarter in 2013

NERS data are not routinely available or published across Wales it is therefore not possible to compare NERS contacts across health boards.

5.3 Supply of medicines

5.3.1 Smoking cessation pharmacotherapy

5.3.1.1 Smoking cessation pharmacotherapy by all services

Figure 5 and Table 5 illustrate the trend in value of NRT supplied by NHS primary care services in Cwm Taf.

Figure 5: Trend in value of smoking cessation pharmacotherapy supplied by NHS primary care services in Cwm Taf (1 October 2012–31 Dec 2014)

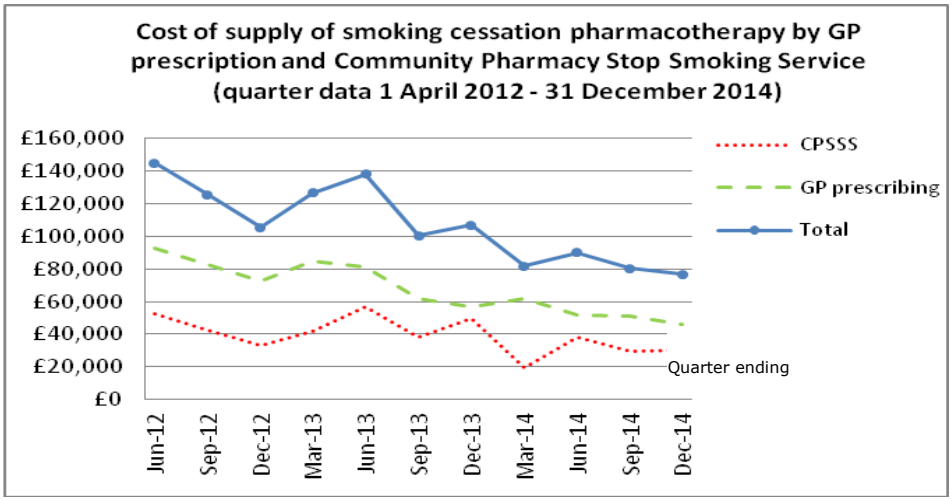


Table 5: Value of smoking cessation pharmacotherapy supplied by NHS primary care services in Cwm Taf (quarterly and annual data : 2012,2013 and 2014)

Service	Value of smoking cessation pharmacotherapy (£)				
	Oct – Dec 2012	Oct – Dec 2013	Oct – Dec 2014	Jan – Dec 2013	Jan – Dec 2014
CPSSS	£32,872	£49,859	£30,534	£195,700	£117,815
GP prescribing	£70,581	£54,253	£46,074	£285,309	£210,751
Cwm Taf Total	£103,453	£104,111	£76,608	£481,009	£328,566

With reference to Figure 5 and Table 5:

- Generally there has been a downward trend in supply of smoking cessation pharmacotherapy by NHS primary care services in Cwm Taf since October 2012.

- Between 1 January 2013 and 31 December 2013 NHS primary care services in Cwm Taf supplied smoking cessation pharmacotherapy to the value of £481,009. This decreased by 32% (£152,443) for the same period in 2014.

- Data for 1 October–31 December 2013 and 2014 indicates:

    - an increase in the value of smoking cessation pharmacotherapy supplied through the NHS primary care services of 0.6% (£658) for

2013 and a decrease of 26% (£26,845) for 2014 compared to the baseline (1 October–31 December 2012)

- a decrease in the value of smoking cessation pharmacotherapy supplied through the NHS primary care services for 2014 of 26% (£27,503) compared to the same quarter in 2013.

5.3.1.2 Smoking cessation pharmacotherapy by NHS prescription

Figure 6 and Table 6 illustrate the trend in supply of smoking cessation pharmacotherapy by NHS prescription during the study.

Figure 6: Trend in prescription items of smoking cessation pharmacotherapy supplied by NHS prescription in Cwm Taf (2012 -2014)

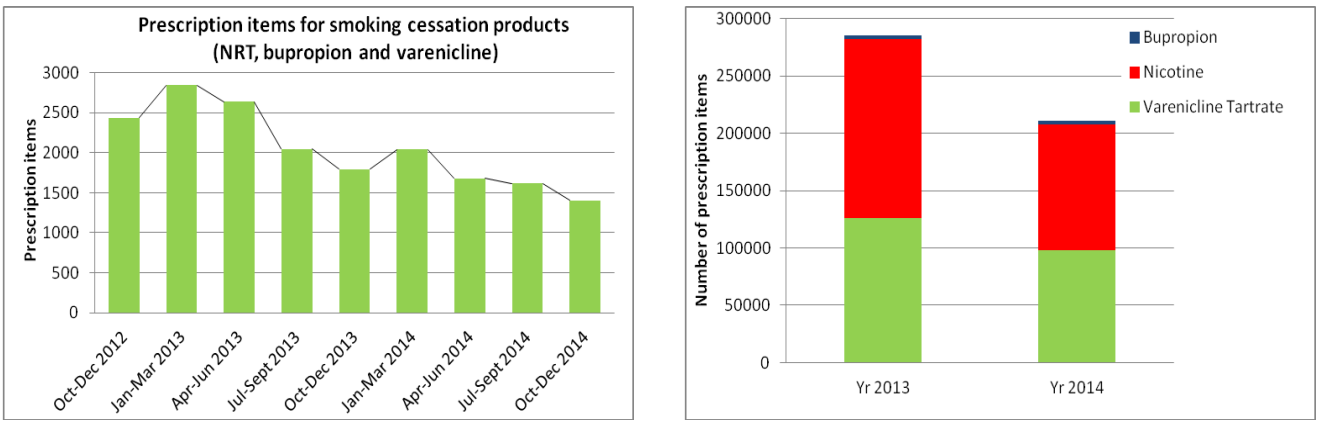


Table 6: Number of NHS prescriptions for smoking cessation pharmacotherapy and associated cost (2013 and 2014)

Period	Number smoking cessation items prescribed	Cost of smoking cessation prescriptions	% of prescriptions written by non medical prescriber
1 January – 31 December 2013	9318	£285,309	2.6%
1 January – 31 December 2014	6740	£210,751	4.7%

With reference to Figure 6 and Table 6:

- Between, 1 January and 31 December 2014, primary care prescribers (GPs and non medical prescribers) supplied 6740 prescriptions for smoking cessation pharmacotherapy at a cost of £210,751.

- A small proportion of prescriptions each year (2.6% in 2013 and 4.7% in 2014) were written by non-medical prescribers with the majority written by GPs.

- Between 2013 and 2014 there was a 28% (n=2578) decrease in prescription items and a 26% (£74,558) decrease in the value of smoking cessation pharmacotherapy via NHS prescription per annum.

- All Wales data between 2013 and 2014 reports a 45% decrease in prescription items and a 26% decrease in the value of smoking cessation pharmacotherapy via prescription (source CAPSA).

5.3.1.3 Smoking cessation pharmacotherapy by the CPSSS

Using cost as a measure of supply, Figure 7 illustrates the trend in value and therefore supply of NRT via the Community Pharmacy Stop Smoking Service over a 3 year period. Table 7 presents the value of NRT supplied via the Community Pharmacy Stop Smoking Service. The value of NRT supply through the CPSSS by locality was not available.

Figure 7: Trend in value of NRT supplied though the Community Pharmacy Stop Smoking Service (1 April 2012 – 31 December 2014)

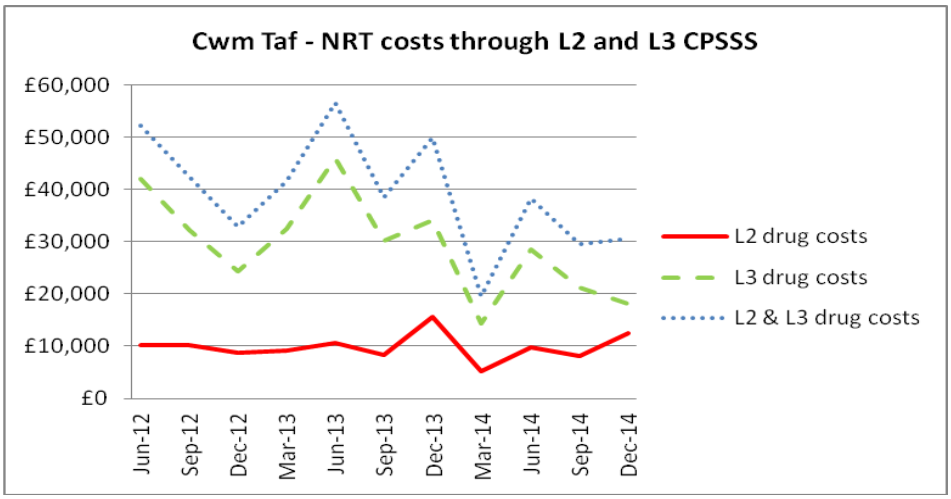


Table 7: Value of NRT supplied by the Community Pharmacy Stop Smoking Service by locality

Service	Cost of smoking cessation pharmacotherapy (£)				
	Oct – Dec 2012	Oct – Dec 2013	Oct – Dec 2014	Jan – Dec 2013	Jan – Dec 2014
Level 2	£8,649	£15,687	£12,449	£43,766	£35,613
Level 3	£24,224	£34,172	£18,085	£151,934	£82,202
Cwm Taf total	£32,873	£49,859	£30,534	£195,700	£117,815

With reference to Figures 7 and Table 7:

- Between 2013 and 2014 there has been a 40% (£77,885) decrease in the value of NRT supplied through the CPSSS per annum.
- The value of NRT decreased for both the L2 and L3 CPSSS but the decrease was greater for the level 3 service (46%) compared with the level 2 service (19%).
- Overall value of NRT via the L3 service was three times that of the L2 service in 2013 and twice that of the L2 service in 2014.

5.3.2 Drugs for the treatment of obesity

Figure 8 and Table 8 illustrate the trend in NHS prescribing in general practice of drugs for the treatment of obesity (orlistat) during the study.

Figure 8: Trend in prescription items of orlistat over a 3 year period (1 January 2012–31 December 2014)

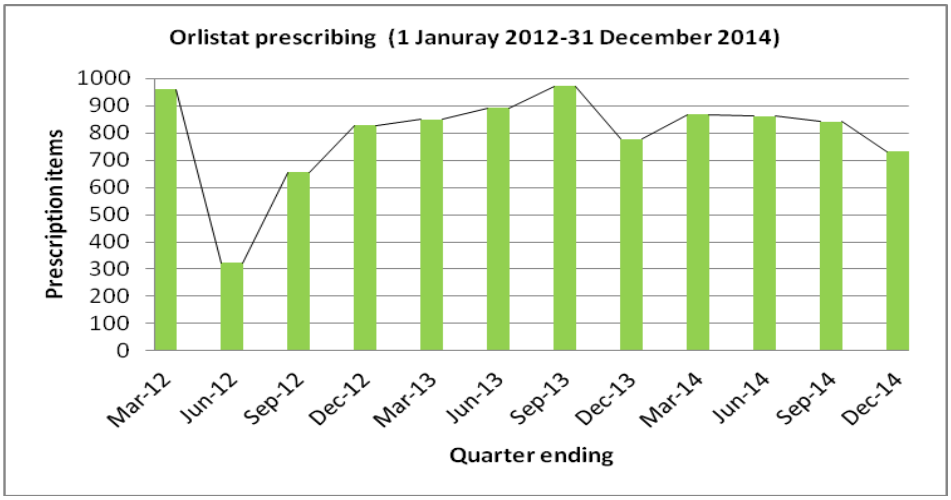


Table 8: NHS prescriptions for orlistat (annual data: 2012,2013 and 2014)

Year	Number of orlistat items prescribed	Value of orlistat prescriptions	% of prescriptions written by non medical prescriber
2012	2721	£86,589	1.63
2013	3455	£114,488	1.09
2014	3256	£91,332	1.36

With reference to Figures 8 and Table 8:

- Between, 1 January and 31 December 2014, primary care prescribers (GPs and non medical prescribers) supplied 3256 prescriptions for orlistat at a cost of £91,322.

- Approximately 1% of prescriptions each year were written by non medical prescribers (n=2).

- Between 2013 and 2014 there was a 6% (n=199) decrease in prescription items and a 20% (£23,156) decrease in value of prescriptions written for orlistat per annum.

- All Wales data between 2013 and 2014 reports a 6% decrease in prescription items and a 20% decrease in value of smoking cessation pharmacotherapy via prescription (source CAPSA).

- The peak of prescribing was observed to be in quarter ending September 2103, after which there has been a sustained decrease in prescriptions written for orlistat.

- For quarter ending December 2013 there was a larger decrease in items reported compared to other quarters under study. This correlates with the initial implementation and practice work of the project.

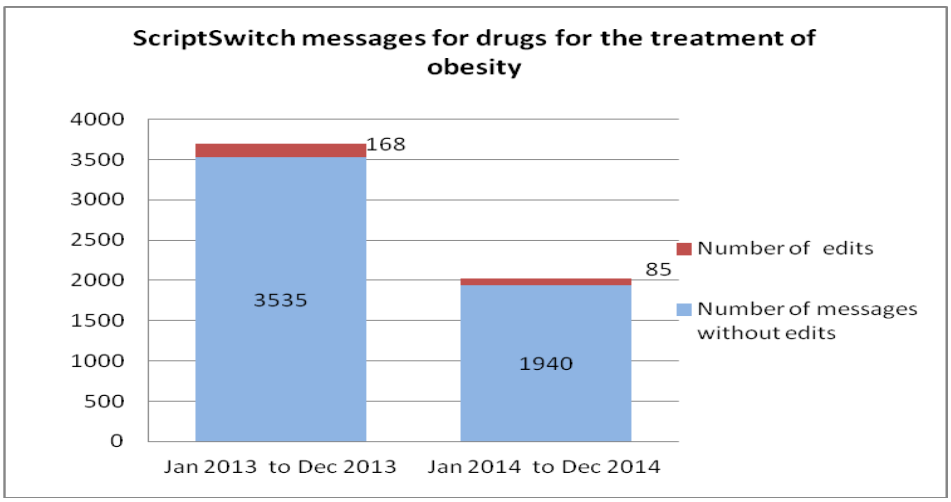
5.4 ScriptSwitch

A stop smoking information message was added to 31 Nicotine Replacement Therapies (Appendix 3) and a physical activity information message was added to the only medicine recommended for the treatment of obesity, orlistat.[6]

Messages were added to in August 2013.

The number of alerts for each message for 2013 and 2014 are detailed in Figures 9 and 10.

Figure 9: ScriptSwitch smoking cessation reminder messages to prescribers (1 January 2013-31 December 2014)

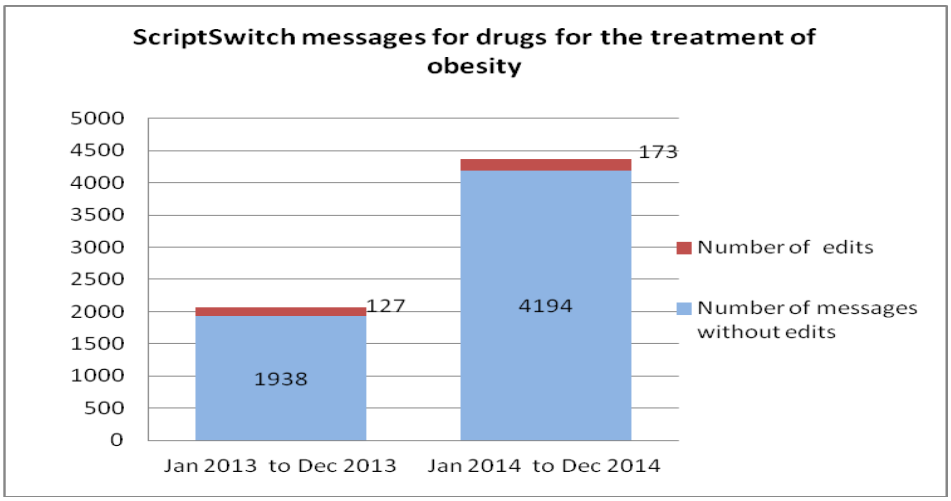


With reference to Figure 9:

- ScriptSwitch software reminded prescribers on 2025 occasions over the 12 month period 1 January -31 December 2014 to check that the patient being prescribed the NRT was enrolled with a smoking cessation service For 96% of the time the prescriber continued to write a prescription. On 85 occasions another action may have been taken.

- There was a 45% decrease in the number of alerts the software made in respect of NRT in 2014 compared to the same period the previous year.

Figure 10: ScriptSwitch physical activity reminder messages to prescribers (1 January 2013-31 December 2014)



With reference to Figure 10:

- ScriptSwitch software reminded prescribers on 4367 occasions over the 12 month period 1 January -31 December 2014 to signpost the patient being prescribed orlistat to NERS. For 96% of the time the prescriber continued to write a prescription. On 173 occasions another action may have been taken.

- There was a 53% increase in the number of alerts the software made in respect of orlistat in 2014 compared to the same period the previous year.

5.5 Qualitative data

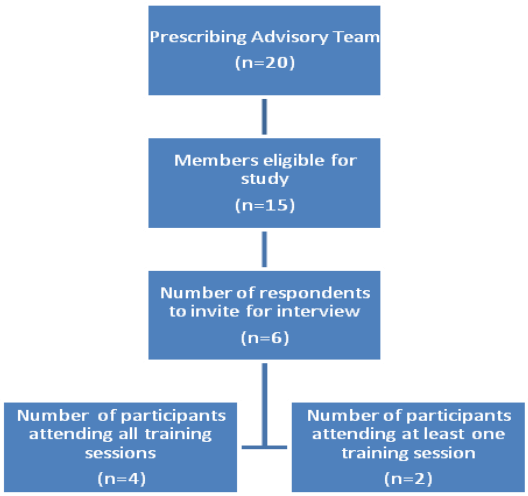
Detailed results of the qualitative work and findings can be found in a series of slides presented as part of a poster presentation for marking by the Welsh School of Pharmacy (Appendix 4)

5.5.1 Sample under study

Figure 13 illustrates the sample under study for qualitative purposes.
Of the 20 members of the Prescribing Advisory Team (consisting of pharmacists and non-pharmacist support staff), 15 were identified as eligible to be included in the project and were invited for interview. Five members of staff were excluded according to the following exclusion criteria:

- not attended at least one training event provided to support the initiative.
- not undertaken any work in practice to implement the project.
- had a long period of time out of the Prescribing Advisory Team (e.g maternity leave).

Figure 11: Flow diagram illustrating the members of the Prescribing Advisory Team and those participating in the qualitative study



Of the 15 staff eligible to be included in the study, six participants agreed to be interviewed providing a response rate of 40%.

Two thirds (n=4) of the participants had attended all three training sessions with the remainder attending only one of the three training sessions provided.

5.5.2 Themes

The findings reported describe the participants' experiences of working in general practice as a result of the Cwm Taf social prescribing initiative. Extracts from interviews are shown in italics. These are quoted verbatim to retain the authenticity of the participants' narratives.

Six key themes emerged from the interviews. Themes which recurred across the interviews included: confidence in advising general practice about social prescribing, knowledge of social prescribing, training, proactive behaviour, appropriateness and usefulness of the annual prescribing visit to discuss social prescribing and continuation of the initiative.

5.5.2.1 Confidence in advising GPs and practice staff

There was variation in the level of confidence reported amongst the participants in implementing the model under study. Some participants reported to feel confident in advising GPs on prescribing issues but expressed difficulty when applying this to social prescribing even after attending the training sessions. Other participants were comfortable in discussing social prescribing with GPs and described how the training helped to increase their confidence.

> *GPs aren't used to us talking to them about it [social prescribing]… My confidence would be a lot lower than just day to day prescribing advice because it's a new thing for us to discuss with them.* P1

The training sessions that we had were really good so I felt quite confident explaining to them [GPs] some of the data, success rates and actually being able to direct them to all the appropriate places. P5

5.5.2.2 Knowledge of social prescribing team

Generally most participants reported to have increased their knowledge about social prescribing as a result of the initiative.

I feel a lot more knowledgeable from the education sessions. P3

It's having the information available to you in order to pass on to somebody else. P5

5.5.2.3 Training

The training events held at the start were reported to have been helpful. These became the main source information during the initiative.

The training was really good, we received lots of information… and were given lots of information to take away with us as well so we each had really large files and it all had really detailed information in. P6

Participants reported that although the training was helpful they felt they needed additional ongoing training to feel knowledgeable and confident in discussing social prescribing with GPs.

The training was really good but it was such a long time ago that we probably need a slight update now. P6

I think it's got to be live, up to date info so that we know that we're talking about now, not what was happening 6 months ago.... P4

When participants were asked about how they felt they could keep themselves up to date with social prescribing the majority reported further training sessions and reminder training sessions to be their method of choice.

Regular or quarterly information (could increase our knowledge)… because if you just do it once a year I think you forget information...or maybe a contact in Public Health Wales that we can ask (for updated information). P2

5.5.2.4 Proactive behaviour of the Prescribing Advisory Team

When the participants were asked how proactive they had been in including social prescribing into their day to day work or using opportunities to discuss social prescribing with general practice colleagues there was a mixed response.

One participant described how they had successfully influenced the practice in a specific area of work when the opportunity arose. The medicine described during the interview as been anonymised as [medicine A] below to prevent identification of the participant.

> *I was involved in doing a bit of work on [medicine A]… We just wrote that into the work plan that [medicine A] went hand in hand with other lifestyle measured for those patients.* P1

Another participant described how they implemented their learning into their own practice. The type of clinic described during the interview as been anonymised below to prevent identification of the participant.

> *I've run some [chronic disease] clinics ..... giving verbal advice on where patients can go for exercise referral.* P6

The remaining participants reported difficulty integrating social prescribing into their role and unable to identify opportunities themselves to discuss social prescribing with their practices.

> *Apart from doing the annual visits, I don't really get much more opportunity than that really to speak individually to GPs to be honest.* P5

> *I think it's quite difficult to be actively involved with the role that we're in.* P6

5.5.2.5 The annual prescribing visit

Social prescribing information was included in the Annual Prescribing Report for each GP practice in 2013 but not for 2014. When participants were asked about how this information was used in visits during 2013 and whether social prescribing was discussed during 2014, there were mixed responses.

> *I think it was a good forum for discussion about it and I think that we could continue feeding back information in that way to practices.* P3

> *I think it's a good starting point but it's not enough… We have so many other messages that we're trying to tell them it's a lot to take in in one go...if we said can we have a meeting on lifestyle they probably wouldn't come so it's kind of a balance between trying to badge it with something that they want to turn up to and then having it as part of the agenda. P4*

> *We were asked to make it part of the annual visits… It was a very small part of the visit and in my opinion it was a bit of a tag on.* P1

They often over run and that's just going through the general prescribing data, let alone adding on the social prescribing element… I don't know if they are the best place to do it really. P2

We had the annual prescribing visits again this year… none of our team actually raised it. P2

5.5.2.6 Continuation of the initiative

There were mixed responses as the whether the initiative should continue. Most participants reported social prescribing to be important and that some work to encourage it should continue, whilst others expressed concern in the current format.

I think it's something that should continue forever. P5

I think it needs to stay on the agenda… It's national priorities… It's important what's being said. P1

Currently the way it is… I don't think it should continue into 2015. However, if there were small changes made to it then I think it would be worth continuing. P6

There was a mixed response regarding experiences of the Prescribing Advisory Team in testing this new role and whether this should be led by the Prescribing Advisory Team in the future.

Challenges and barriers included; difficulties in freeing up practice time to discuss social prescribing; limited opportunities to discuss social prescribing; limited capacity to take on this new role without additional support; unclear who the target audience was.

I think it's a very good idea. I think in practice it was more difficult to achieve than I think anyone thought. P3

If we had it in the informal meetings throughout the year it's not a guarantee that we do that (bring it up). P2

They [GPs] seem to think that it's more the support staff's role (to do brief interventions) P5

I think in the future, there could be a role for us in maybe talking to patients ourselves… Cutting that little barrier out. P1

Perhaps each health board needs a social prescribing champion… allocated to promote and push this initiative… Perhaps every 3 months meetings need to be held. P6

6 Limitations

This initiative focussed on referrals and signposting by primary care services to 3 particular health improvement services. It did not attempt to describe the full extent of contacts with these services arising from other sources. Data collected and used for this evaluation did not include contacts with SSW arising from secondary care services such as maternity and pre-operative services nor referral to NERS from cardiac rehabilitation services.

The initiative only looked at signposting and referral to two smoking cessation services and one service to increase physical activity. The scope of this study was kept intentionally narrow to test the model being implemented. It is questionable however whether the true benefits of social prescribing in its broader context has been tested within the narrow scope of this initiative.

Data were collected from various sources. Not all data were available from published reports, national databases or routine reports. It was therefore necessary for some data to be collected locally. Although believed to be correct, the quality and quality assurance of the locally collected data cannot be verified.

Data were not always available in a format that could be aggregated to analyse trends. This is particularly relevant when analysing GP prescribing data and supplies of smoking cessation products from pharmacies. A proxy measure of value of pharmacotherapy was used to investigate trends in supplies of smoking cessation products. Although there were no significant changes in product costs identified during the study, caution is needed when comparing values of product supplied in very small quantities and by the different services.

There is variation in the way people accessed the health improvement services under study. Stop Smoking Wales is accessed by self referral using the freephone number, the CPSSS is also accessed by self referral dependent on patients approaching the community pharmacy directly and NERS requires a signed referral form by the GP. Contact data therefore does not always reflect GP practice referral, signposting or brief intervention behaviour.

Understanding that not every GP referral or signpost to a service converts to a patient enrolling on a programme despite GPs best efforts is an important consideration when investigating the model under study and the trends in data presented.

The start date of the initiative for the purpose of evaluation was 1 July 2013. This included the period immediately after the third training event and also when the GP Annual Prescribing Visits commenced. Some pre-implementation work however had been undertaken before this date. The start date was chosen to enable comparison with a baseline period the

previous year. The quarter October–December was chosen to represent the time period that should report any impact following the start date. This was not a true representation however of when the implementation in practice actually started.

The study design did not enable comparison with a control group therefore the true effect of any changes reported in the study size cannot be determined. Some consideration was made where possible to compare changes with averages reported for the whole of Wales.

The study was designed to test the model being implemented and was not intended to report the cost-effectiveness of the intervention. Although no budget was identified to support the initiative, opportunity costs were employed in respect of the Prescribing Advisory Team time to attend the training events and implement the initiative and resources to provide training which would need to be taken into consideration in any cost calculation.

The qualitative study was undertaken by an independent researcher. Although all eligible members of the Prescribing Advisory Team were invited to participate in the semi-structured interviews, it is possible that the qualitative study may be subject to responder bias, reaching only a particular subset of the Prescribing Advisory Team.

7 Discussion

This evaluation used a number of data sources to assess the model under study. The initiative aimed to inform the following questions:

- How best to increase appropriate brief interventions and social prescribing to non-pharmacological public health interventions and health improvement programmes in primary care?

- If brief interventions and social prescribing of non-pharmacological public health interventions in primary care have an effect in reducing the GP prescribing budget?

7.1 The model

The application of an educational outreach model by prescribing advisors to influence traditional GP prescribing has been tested, evaluated[7] and become everyday practice across Wales and the UK. Prescribing Advisory Teams are employed by every health board in Wales and there is considerable published evidence regarding the effectiveness this model can have on GP prescribing.

The model of Prescribing Advisory Teams to implement educational outreach to influence and improve signposting, referral and social prescribing in primary care however has not been reported in the literature.

As Cwm Taf ULHB serves one of the most deprived populations in Wales any model to increase the uptake of health improvement services could be of benefit to the health and the population.

The Prescribing Advisory Team employed by Cwm Taf ULHB consists of pharmacists and pharmacy technicians working with and in GP practices across the health board. Their priority is to improve the quality, effectiveness, efficiency and safety of prescribing and medicines management.

Members of the Prescribing Advisory Team have a good working relationship with many of the GP practices in Cwm Taf and often discuss medicine management issues with them. The application of the model proposed therefore could be effective. This was reiterated during the survey and interviews with practice staff undertaken before implementation.

The initial findings of the 2014 review reported small increases in the number of contacts reported for two of the three services under study. The results reported in this evaluation, for full duration of the initiative, questioned the impact the model could have in the longer term.

7.2 The term social prescribing

During this study it became clear that there is no single agreed understanding to the term social prescribing or what interventions could be considered as social prescribing.

For the purpose of this study the following definition of social prescribing was used *'a method of impacting on the wider determinants of health such as the social, economic and environmental factors, through linking people with health problems to non-medical sources of help and support in the community, usually referral by primary care'.*[2]

Specifically this study focussed on interventions by GPs and their staff to increase physical activity and encourage smoking cessation.

7.3 GP practice activity

Activity reports completed for the first six months provided information about the time ascribed to this initiative. Detailed findings were reported in the 2014 review.

In summary during the six month only a small number of practices were reported to have had additional input (n=10) over and above the Annual GP Prescribing Visit. Analysis of the activity reports and contact data from the health improvement services under study, did not suggest an association between the time spend in practice and any increase in contacts with the services under study.

It was reported in the 2014 review that the GP Prescribing Performance Review Report and Annual GP Prescribing Visit was the main method used to discuss smoking cessation and physical activity with the GP practices in 2013. The GP Prescribing Performance Review Report 2013 included practice level and health board level information about contact rates with SSW and NERS. Despite the continuation of the social prescribing initiative during 2014 and the provision of data for 2014 to the health board, information about contact rates with SSW and NERS was not included in the GP Prescribing Performance Review Report for 2014. The Prescribing Advisory Team members reported that without this information the opportunities to discuss social prescribing with the GP practices during the Annual GP Prescribing Visits and at other times became challenging.

7.4 Resources

There was no budget allocated to support or implement the initiative. Resources to deliver the initiative came in the form of manpower. No protected time or additional manpower resources were provided to the Prescribing Advisory Team to implement the study.

Although the headcount of the prescribing team appear to be large in numbers, many members of the team provide sessional and part time work. Care should be taken in interpreting the capacity available to take on additional roles, particularly at a time where there are pressures to deliver existing prescribing priorities and cost savings.

This study took place as a result of joint working between the Medicines Management Team and the Pharmaceutical Public Health Team, Local Public Health Team, Cwm Taf ULHB and Public Health Wales. The limited resources meant that members of all aforementioned teams collaborated to support the initiative. Support was also provided by the service providers and Cardiff University without remuneration.
Support in the pre-implementation in terms of the literature review, speakers at the training events and provision of information to develop the toolkit was provided by key members of the Medicines Management Team, the Local Public Health Team and a Consultant in Pharmaceutical Public Health, SSW and NERS advisors and co-ordinators and other parties. Training events were held in health board premises thereby incurring no cost and no remuneration was provided for those providing the training.

The findings of this evaluation therefore should be considered in light of the limited resources made available for the initiative.

7.1 Contact with services

Despite small increases in contacts with certain services reported when the initiative first began, there has been a general decrease in contacts over time and any early increases reported have not been sustained.

The exception is SSW where there appears to have been an increase in uptake over 2014.

7.4.1 Smoking cessation services

In the 2014 review, it was reported that the total number of contacts with NHS smoking cessation services (SSW and CPSSS) in Cwm Taf increased by 6.7% (n=33) over the first six month of the study period, compared with the same period the previous year. The increase was attributed to the increase in use of the CPSSS offsetting the decrease in contacts with SSW.

It was suggested at the time that the model under study may in some part have contributed to the increases in contacts reported. Whether the increase was a result of the initiative alone was to be debated.

This evaluation presents a slightly different overall picture. There appears to have been a general decrease in contacts with the NHS smoking cessation services in Cwm Taf since 2013. In particular between 2013 and 2014 there was a 20% (n=511) decrease reported per annum. The increases reported over the first six months were not sustained and the same time period for 2014 reported a 10% decrease compared to the baseline period.

Considering the individual services under study, the number of contacts with SSW increased by 20% (n=170) per annum between 2013 and 2014. Unlike the decrease reported by SSW in the six month review, suggesting that the social prescribing initiative appeared to have no impact on the contacts with SSW during the initial implementation, a 49% increase in contacts for the quarter 1 October–31 December 2014 compared to the same period in 2013 was reported. This may have been in some part a result of the initiative but consideration needs to also be given to other efforts known to have been implemented by SSW during 2014.

The CPSSS however reported a 40% (n=681) decrease per annum between 2013 and 2014 compared to the increase reported in the six month review. A 37% decrease in contacts for the quarter 1 October–31 December 2014 compared to the same period in 2013 was reported. It is possible that the increase in contacts with the CPSSS reported in the six month review may have been a result of the social prescribing initiative but as the initiative continued this increase could not be sustained. The increase in contacts was reported was during the time when the initiative first started and the training had recently been delivered. This also correlated with the time that the GP Prescribing Performance Review Reports for 2013 were distributed and the GP Prescribing Annual GP Prescribing Visits took place.

7.4.2 National Exercise Referral Scheme

In the 2014 review, it was reported that the number of contacts with NERS over the first six month of the study period increased by 4.3% (n=12) compared to the same period the previous year.

This evaluation however reports little long term change in the number of contacts with NERS since October 2012 with an increase of 1% per annum being reported between 2013 and 2014.

Similar to the CPSSS, it is possible that the increase reported in the six month review for NERS may have been a result of the social prescribing initiative but as the initiative continued initiative continued this increase could not be sustained.

7.5 Supply of medicines

7.5.1 Smoking cessation pharmacotherapy

Despite the 2014 review reporting a small increase of 0.6% in the supply of smoking cessation pharmacotherapy the supply of smoking cessation pharmacotherapy (NRT, bupropion and varenicline) appears to have gradually decreased since January 2012. This would be expected considering the downward trend in contacts with the smoking cessation services during the same time period.

This evaluation reports a continual decrease in the value and therefore supply of smoking cessation pharmacotherapy NHS smoking cessation services in Cwm Taf of 32% (£152,443) per annum between 2013 and 2014.

Considering the individual services under study, the number of prescriptions for smoking cessation pharmacotherapy had decreased by 28% per annum (n=2578) between 2013 and 2014. The value of these items reported a decrease of 26% (£74,558) for the same period (Wales average 45% decrease in prescription items and 26% decrease in prescription cost). The CPSSS reported a 40% (£77,885) decrease in the value of NRT supplied (46% decrease for L3 and 19% for L2).

Consistent with the findings of the contacts with NHS smoking cessations services, when comparing quarterly data, an increase in value and therefore supply of smoking cessation pharmacotherapy was reported the quarter covering the time when the initiative first started compared to the same period the previous year. This increased was not sustained and the same time period for 2014 reported a decrease compared to the baseline period.

Although in one respect the downward trend in supply of smoking cessation pharmacotherapy has yielded savings on the prescribing budget, this should not be considered a marker of success. An increase in the use of smoking cessation pharmacotherapy as a result of more people in Cwm Taf accessing services and using smoking cessation products to quit smoking would be considered an improvement.

7.5.2 Anti-obesity drugs

The 2014 review reported a 7% decrease in prescription items for drugs for the treatment of obesity for the quarter under study and a predicted annual cost saving of £10,000 based on quarterly savings against an annual spend in 2013 of £113,200.

This evaluation reports a 6% (n=199) decrease in prescription items and a 20% (£23,156) decrease in prescription value per annum. Prescribing savings have therefore been identified and realised.

Whether the initiative has influenced the decrease in use of orlistat alone is to be debated considering the Wales average for the same time period reported a 6% decrease in prescription items and 20% decrease in prescription cost.

7.6 ScriptSwitch

ScriptSwitch triggered a large number of messages relating to smoking cessation (n=2025) and physical activity (n=4367) throughout 2014. Of these, the software reported over 200 possibly resulted in an action other than a prescription being written. ScriptSwitch does not record what this action was but it is possible that a number of those actions could have been referral or signposting to SSW, CPSSS and NERS depending on the drug prescribed. It should be noted that the ScriptSwitch message is triggered when a prescription is prepared and does not reflect the number of patients being prescribed the individual medicines.

There has been a 45% decrease in the number of messages triggered by ScriptSwitch for smoking cessation in 2014 compared to 2013. This reflects the downward trend in prescriptions reported over the same time period.

There has however been a 53% increase decrease in the number of messages triggered by ScriptSwitch for physical activity. During this time period the number of prescriptions for orlistat decreased and the number of contacts with NERS remained unchanged. It is possible that advice on physical activity and referrals to NERS are being made in preference to writing a prescription is occurring but this is not being captured through NERS alone or people are not enrolling with the service regardless of a GP referral.

The number of messages reported over the study period nevertheless reinforces the potential of ScriptSwitch as a tool to remind prescribers to refer or signpost patients to the relevant services.

7.7 Perspectives of the Prescribing Advisory Team

Generally the members of the Prescribing Advisory Team participating in interview stated that they were less confident in advising GPs on social prescribing compared with providing general prescribing advice.

Only two participants felt that they had been proactive within the initiative outside of the annual meetings with the GPs, whilst the others were unsure on how to be more involved or felt that time was a limitation.

Participants reported mixed views and some concerns over using the opportunities through Annual Prescribing Visit to discuss social prescribing. Some reported this to be an acceptable mechanism to introduce the topic whilst others were concerned that was not the focus of the meeting, this is reflected in the fact that for many social prescribing was not discussed in the Annual Prescribing Visits during 2014.

The training events were well received. Despite most finding the training sessions useful and to have increased their knowledge, the lack of updates and follow-up sessions throughout the initiative meant not everyone had the same level of knowledge. This may be one factor affecting the confidence of the team with social prescribing messages and embedding this into everyday practice.

The members of the Prescribing Advisory Team interviewed stated that they were generally happy to embrace new roles such as social prescribing however in practice this was much more difficult to achieve than anticipated. The overall opinion was that the initiative should continue if certain adaptations were made such as regular training to increase the confidence of pharmacists in adopting these roles.

8 Conclusion and recommendations

8.1 Conclusion

This evaluation studied the 18 months following implementation of the initiative in July 2013. A review of the first six months was reported in July 2014. Recommendations were made at that time that the initiative continue for a further 12 months (until December 2014). This was to assess whether the small increase in patient numbers for some of the services reported were sustained.

This evaluation highlights the following:

- The study relied on opportunistic messaging of the Prescribing Advisory Team to GPs and their staff. Financial investment for this initiative was limited. There was no budget or protected time allocated. Opportunity costs were borne primarily by the Prescribing Advisory Team, the Pharmaceutical Public Health Team and the Local Public Health Team.

The conclusions of this report therefore should be considered against in light of the limited investment.

- The initiative provides an example of joint partnership working between local teams, with each other and also with Public Health Wales.

- There was an overall decrease in the number of people in Cwm Taf accessing NHS smoking cessation services despite an annual upward trend for contacts with SSW. The decrease is a result of a large reduction in the number of contacts with the CPSSS.

  The timescales of this initiative coincided with the introduction and observed increase use of e-cigarettes. It is possible that smokers are self managing their smoking cessation using e-cigarettes products not available via the NHS and this is having an impact on the number of people accessing NHS smoking cessation services.

- For the CPSSS and NERS in particular, the downward trend in contacts was reversed for the first 3 months of the initiative where an increase in the number of contacts compared to the same period the previous year was reported. This may have been a result of the introduction of the social prescribing initiative. Any improvements reported during this period were not sustained and a decrease was reported the following year.

- There was little change in the number of contacts with NERS over the study period.

- There was a decrease in the supply of smoking cessation pharmacotherapy and drugs for the treatment of obesity during the study period resulting in savings on the GP prescribing budget.

- There were mixed views reported by the Prescribing Advisory Team regarding their role in advising GPs on social prescribing compared with providing general prescribing advice. Those interviewees reporting the role to be acceptable indicated that a programme of continued support and training would be needed to underpin the role.

- Using a model of educational outreach to disseminate social prescribing information to GPs and staff was found to be an acceptable concept. The survey of health professionals and interviews with GPs and staff conducted before the study began, reported that the idea to have someone as an expert visit the practice with up to date information and details of local services was deemed useful. This was reiterated during the interviews with the Prescribing Advisory Team. It is without doubt that there is benefit in the Prescribing Advisory Team being more aware of social prescribing opportunities. The issue is whether the Prescribing Advisory Team members are best placed to be the expert visiting GP practices with no protected time to do this and juggling competing

priorities. This study showed it was much more difficult to put this model into practice than first anticipated and as a result the impact has been minimal.

With reference to the aim of the initiative which was to identify how best to increase appropriate brief interventions and social prescribing and assess whether this had an effect in reducing the GP prescribing budget, it is questionable whether the model tested had an impact in increasing social prescribing. Savings were identified against the prescribing budget in particular for drugs for the treatment of obesity. The trends in savings however were consistent with that reported for the Wales average. Whether these savings were a result of the initiative is therefore debatable.
Whilst the evaluation has provided some interesting findings, the final conclusions are hampered by the size of the sample and the very small changes reported during the study period. It is debatable whether the findings that have been generated suggest that there is value in pursuing the use of this model further in its current format. The development of a systematic project with adequate funding to support implementation may however be worth considering.

8.2 Future work and recommendations

On the basis of the findings of this evaluation the health board to consider whether the model tested in this study becomes part of the Prescribing Advisory Team's everyday work or whether an alternative model to inform, advise and promote to GP practices social prescribing opportunities should be considered.

If the model under study continues, certain considerations should be made regarding the following:

- The identification of a local lead from the Prescribing Advisory Team and the Local Public Health Team to provide a shared role in leading and continuing the momentum of this initiative locally.

- Resources and protected time for the Prescribing Advisory Team to undertake the work.

- Provision of future training, information and support to the Prescribing Advisory Team.

- The use of specific methods to support and introduce discussions about social prescribing e.g. toolkits, the GP Prescribing Performance Review Report and Annual GP Prescribing Visits and ScriptSwitch.

- The development of a local mechanism to collect and collate data and to provide regular feedback to GP practices and community pharmacies on contacts and referrals to SSW, the CPSSS and NERS.

9 References

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Appendix 1

Summary of results of semi-structured interview of GPs and practice staff.

There were different levels of relationships between the GP practices and the service providers. This varied according to GP practice and to service. As a result:

- Communication between service provider and GP practices differed. Where services were delivered from within the GP practice premises communication was good. Where services were delivered elsewhere communication varied, could be improved and be more frequent.

- Access to information about local health improvement programmes and activities was inconsistent. GP practices tended to rely on face to face contact of the service provider and a range of web based and electronic resources. There was little consistency between GP practices as to resources being utilised.

- There was variation in the information available to the GP practice to pass on to their patients. Replenishment of material and paperwork was identified as a problem.

- There was confusion over the different ways the various health improvement programmes and services were being accessed and delivered. Some required referral by a GP or nurse whilst others accept patient self referral. There was a suggestion made to simplify the point of access. This could be based on one service delivery model, for example, cards with one telephone number to be given to patients or one contact named individual at health board to signpost to information resources.

- Where information was made available some GP practices were not confident that this was up to date.

- The referral of patients to Stop Smoking Wales and the National Exercise Referral Scheme (NERS) tended to be adhoc. There appeared to be no systematic approach described by any respondent regarding what informs the decision to refer patients.

- Where patients were being referred, no standard READ codes for advice or referral to a health improvement programme were routinely being used by the GP practice.

- A number of barriers to referral were noted, in particular the paperwork and mechanism for referrals by GP only to some services.

- There was little feedback to GP practices on referral rates and trends in referrals. Feedback on individual patient's details was also variable.

- In practice resources such as TVs in waiting room, poster displays and GP practice websites could provide a resource to patient educational and signposting of information.

- The model of using the prescribing advisor as the messenger was acceptable.

For details of full report please contact sian.evans14@wales.nhs.uk

Appendix 2

CAPSA drugs baskets

Smoking cessation products	
Nicotine bitartrate	CAPSA BNF code 0410000AA
Varenicline	CAPSA BNF code 0410000AB
Nicotine	CAPSA BNF code 0410000PO
Bupropion	CAPSA BNF code 0410000QO
Nicotine dependence	CAPSA BNF code 0410020

Drugs to treat obesity	
Orlistat	CAPSA BNF code: 0405010P0

Appendix 3

ScriptSwitch messages

These formed part of wider clinical messages on the safety, use and guidelines for prescribing for these products already being given to prescribers via ScriptSwitch.

Smoking cessation information message

'Is the patient under a smoking cessation service (either via community pharmacy or Stop Smoking Wales)?'

Added to the 31 smoking cessation pharmacotherapies

Physical activity information message

'Consider referral to National Exercise Referral Scheme using the appropriate form'.

Added to the one product used for the treatment of obesity

Appendix 4

Presentation of qualitative findings - Experiences of Prescribing Advisors involved in the Social Prescribing Initiative, Cwm Taf.

Experiences of Prescribing Advisors involved in the Social Prescribing Initiative, Cwm Taf.

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2014-2015

Introduction

- In June 2013 a Social Prescribing project was initiated in Cwm Taf. The objective of the initiative driven by Public Health Wales was to reduce inequalities within the health board by introducing social prescribing into the wider prescribing advisory agenda. (1)
- Social Prescribing is a relatively new approach in primary care and "*is a method of impacting on the wider determinants of health such as social, economic and environmental factors, through linking people with health problems to non-medical sources of help and support in the community*". (2)
- An evaluation of the first six months of the implementation showed a small number of improvements can be achieved with minimal input. (1)
- The views and experiences of prescribing advisors involved in the initiative is key in order to conduct a further 18 month evaluation which is due to begin in January 2015.

Aims and Objectives

- The aim of the research study was to explore the views and experiences of the Prescribing Advisory team involved in the Social Prescribing initiative.
- Objectives were to:-
  - Determine whether the initiative should continue.
  - Identify what improvements can be made prior to its continuation.
  - Identify barriers to continuation.

Method

1. Ethical Approval was gained by The School's Research and Ethics committee and the Cwm Taf R&D department.

Inclusion criteria:-
- All Prescribing advisors, based in Cwm Taf who were involved in the Social prescribing project.

2. Recruitment of participants
- 15 PAs were identified by a gatekeeper and were contacted directly via email.
- 6 met the criteria/ consented

3. Design of topic guide using semi-structured interview questions.

4. Conducted interviews and transcribed the recordings.

5. Thematic analysis of Data (3)
- Transcribed data
- Read and coded data.
- Identified initial themes.
- Further coding and determination of final themes

Results (1)

6 Prescribing Advisors

- 6 Prescribing Advisors – 1 male (17%) and 5 females (83%)
- 33% were team leaders within their localities.
- 66% attended all training sessions provided by Public Health Wales in preparation for the initiative, whilst the other 33% attended only one training session due to maternity leave.

Results (2)

Theme 1: Confidence of Prescribing Advisors

Most PA's said they felt confident when advising GPs. However, a number of participants expressed the difficulty of advising on SP in comparison with giving general prescribing advice.

"It's my day to day job… You build up relationships with them [GPs] and you do get to know your own GPs… I guess we have to be fairly confident in it because it's our job, that's what we do." - P1

"The GPs aren't used to us talking to them about it [Social Prescribing]… My confidence would be a lot lower than just day to day prescribing advice because it's a new thing for us to discuss with them." – P1

Theme 2: Developing a greater knowledge

The prescribing advisors felt their knowledge on social prescribing had improved during the initiative, mainly due to the training sessions provided by PHW.

"I feel a lot more knowledgeable from the education sessions that we had…" – P3

Appendix 4 cont..

Presentation of qualitative findings - Experiences of Prescribing Advisors involved in the Social Prescribing Initiative, Cwm Taf.

Results (3)

Theme 3: Training sessions by PHW

The majority found the training session useful but felt that reminder sessions were required.

"The training was really good but it was such a long time ago that we probably need a slight update now". – P6

"The issue we've got in our teams now... is that we have a lot of rotations in staff. We didn't used to in the old structure... In my team now, there was only one or two of us who went on the training." – P4

Theme 4: Proactivity within initiative

Apart from a couple of participants, the majority did not feel that they had been proactive and were unclear on how to become more proactive within their roles.

"Apart from doing the annual visits, I don't really get much more opportunity than that really to speak individually to GPs to be honest." – P5

"I think it's quite difficult to be actively involved with the role that we're in." – P6

Results (4)

Theme 5: Frequency and settings

SP was added to the Annual Meeting agenda. However, there were varying opinions on the appropriateness and effectiveness of this.

"We were asked to make it part of the annual visits... It was a very small part of the visit and in my opinion it was a bit of a tag on in the visit rather then intergral." – P1

"They often over run and that's just going through the general prescribing data, let alone adding on the social prescribing element... I don't know if they are the best place to do it really." – P2

"I think it's a good starting point but it's not enough... We have so many other messages that we're trying to tell them it's a lot to take in in one go. But saying that, if we said can we have a meeting on lifestyle they probably wouldn't come so it's kind of a balance between trying to badge it with something that they want to turn up to and then having it as part of the agenda." – P4

Results (5)

Theme 6: Continuation of initiative

The overall opinion was that the initiative should continue but with relevant adaptions made to its design.

"Currently the way it is... I don't think it should continue into 2015. However, if there were small changes made to it then I think it would be worth continuing." – P6

"I think it's something that should continue forever." – P5

"I think it's a very good idea. I think in practice it was more difficult to achieve than I think anyone thought and the main reason probably being that there were so many confounding factors that could influence the prescribing." – P3

Discussion and Conclusion (1)

The majority of the participants agreed that the Social Prescribing initiative was a good idea but felt that its execution could be improved.

Despite most finding the training sessions useful, the lack of updates and follow-up sessions throughout the initiative meant not everyone had the same level of knowledge.

Resultantly, a large percentage said they felt less confident advising GPs on social prescribing elements in comparison with providing general prescribing advice.

Only two participants felt that they had been proactive within the initiative outside of the annual meetings with the GPs, whilst the others were unsure on how to be more involved or felt that time was a limitation. This suggests that more could be done if the correct guidance was provided.

Discussion and Conclusion (2)

Suggestions for improvements to the SP initiative:-

- More training sessions or 'booster' sessions.
- Regular meetings with GPs.
- Continual updates on the GP portal.
- Dividing the responsibility of providing brief interventions to patients, amongst other healthcare workers.

Limitations

The research was conducted within one health board in Wales so the results from this study may not be generalisable to other similar Social Prescribing initiatives.

Conclusion

The overall opinion was that the initiative should continue if certain adaptions were made to its design. The study showed that pharmacists are generally happy to embrace new roles such as social prescribing. If certain improvements were made to the initiative, such as offering more training sessions from PHW, the confidence of pharmacists in adopting these roles would be increased.

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