SOCIAL PRESCRIBING
TORFAEN

Social Prescribing in Torfaen 2017-18

"It's nice being able to offer some positive support for social things instead of saying 'you need to go and see housing'"

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

TORFAEN COUNTY BOROUGH
BWRDEISTREF SIROL TORFAEN

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Front page quote, page 14, Gregory, K (2018). An exploration of Primary Care experiences of Social Prescribing: A Qualitative Interview Study

A Day in the Life[1]

My day starts with an early morning wake-up call from my dogs around 6:30am. I have breakfast watching morning TV and take my time to get ready, mentally preparing myself for the day ahead, yet always rushing out the door like a whirlwind.

I check my emails and make a couple of calls before seeing my first appointment in surgery at 9.30am.

During the 45 minute consultation with the patient, as a Social Prescriber I spend this time trying to unpick some of the issues they may be facing such as housing, relationship breakdown, employment or financial issues, loneliness, mental wellbeing and so on.

The patient will start to tell their full story, probably for the first time. The patient will feel overwhelmed and relieved all at once for having the opportunity to be listened to, and heard. We will discuss their priority issues and will make a plan on how best to move forward – discussing what support services may be available to them, what they are willing and able to help themselves with and how best I can support them to achieve their goals. The patient will remember historical issues that they haven't discussed before, that could be impacting on their current situation, and emerging issues may change the priorities we had started to set. We will run over by 5-10 minutes.

I will add to their medical notes for the practitioner/referrer to be able to see the work we have done and make a list for myself of things I need to do, calls I need to make, information I need to obtain, forms I need to fill out.

I see another 3 patients this way supposedly until 12.30 but this will likely run until 1pm. I then take a moment to make sure I have updated everything correctly and have a thorough to-do list to go away with.

I will either grab a sandwich to eat in my car before heading to another surgery to see another 4 patients in the afternoon, or head back to the office for an admin afternoon and a catch up with my colleagues.

If the latter, I will try to eat a mindful, healthy lunch before cracking on with returning calls, replying to emails, sending lengthy referrals, feeding back to patients and any other correspondence.

I'll leave the surgery or office, get in my car and choose something upbeat to drive to the gym or home to around 5.30/6pm. When I get in, I'm welcomed by my partner and 3 dogs who I need to walk. After a quick cup of tea and catch up about our days, we'll take turns to walk or cook and sit to eat around 8:30pm. A quick chance to watch something cheesy (unashamedly) on TV like Made in Chelsea or First Dates lets me unwind from my day before going to bed and doing it all again.

[1] As featured in the Western Mail, 27 November 2017

Introduction

Torfaen is one of the early adopters of social prescribing in Wales and has delivered the service in the north of the borough since October 2015 and the South since January 2017. Each of the 13 practices it serves have access to a Social Prescriber for one half day session (3 appointments) per week where patients can book directly with the practice for a one-to-one *conversation*[2] about any challenges they face, what matters to them and the support available to help. Two Social Prescribers cover a population of 92,000; our general sense is that this ratio is not sufficient to allow for follow up, i.e. a 'warm handover' and, as a result, impacts on the effectiveness of the service. Many vulnerable individuals need a lot more support to take the next step on their journey. In comparison, the General Practice Support Officer (GPSO) model piloted in Merthyr employs 6 FTE posts across 9 practices, a ratio of one GPSO to 10,500 patients[3].

In our discussions with Bromley by Bow[4], it was suggested that one hour of client facing time requires two hours of follow up. In our model in the North there is capacity within the appointment schedule to see 18 patients a week for one hour each which, based on this concept, require an additional 36 hours to do adequate follow up work, without the time needed for service development, reporting and networking. In the South there is capacity to see 21 patients which would require an additional 42 hours for patient follow up. If we were to implement the ratios suggested by Bromley then each Social Prescriber would see a maximum of 12 patients a week. Using the existing timetable of one half day session per surgery that would require additional resource of 1.25 FTE; this would not enable any more patients to be seen than currently but would provide the capacity for more effective 'handovers' of vulnerable individuals to services.

We have seen an increase in the numbers of very vulnerable individuals presenting to the service in comparison to those seen in 2016/17. This has had a significant impact on staff wellbeing which we started to explore early in 2017/18 making a change to the job description and person specification leading to a re-evaluation (and subsequent increase) of salary grades. While this recognised and valued the challenges of the role, further work was needed to ensure that appropriate support was provided to staff. Between October and March we discussed pausing delivery while these challenges were explored and while we did not take this action we chose not to address the decline in referrals in some practices or to actively promote the initiative. We extended appointments from 45 minutes to 1 hour, providing staff with the opportunity for a 15 minute break between patients. In February and March our two existing Social Prescribers moved onto new opportunities and we recruited new

[2] Moving away from the language of consultations and referrals to conversations and making connections

[3] See Cwm Taf example,http://www.primarycareone.wales.nhs.uk/social-prescribing-projects-by-area

[4] No specific reference to this ratio in the report, Social Prescribing in Tower Hamlets: Evaluation of Borough-wide roll out 1 December 2016 – 31 July 2017 file:///C:/Users/1301678/Downloads/Social_Prescribing_Evaluation_FINAL_FULL_REPORT_03_2018_update.pdf

individuals into the roles. These pressures and changes go some way to explaining the decline in use of the service in the second part of the year.

In October 2018, the service will have been delivered in North Torfaen for 3 years and is still dependent on annual funding arrangements. We accept that part of the challenge in securing long term commitment to the initiative is the lack of a strong monitoring framework able to evidence the impact on primary care. We continuously seek to improve our data recording and monitoring processes and further changes will be implemented during 2018/19 alongside the commissioning of an independent review. We hope that this will prepare the way for discussions around how social prescribing becomes embedded in and fundamental to the delivery of primary care in Torfaen.

Progress against 2017/18 priorities:

*Identify and secure funding to commission a formal evaluation***:** Funding identified and review commissioned in 2018/19.

*Continue to develop and improve monitoring systems***:** Evaluating social prescribing is challenging and there are a number of pieces of research being led nationally to understand and develop systems. We are working with a number of partners to improve our monitoring and evaluation including:

- *1000 Lives Improvement (Public Health Wales)* who are supporting the development of our monitoring spreadsheets to simplify the extraction of data into reports. We have attended an '***opportunity cost'*** workshop to start to quantify the financial value of primary care consultations that are saved as a result of social prescribing interventions.

- A research project exploring attitudes to social prescribing among primary care teams in Torfaen has been conducted. The report was published in 2018-19, however, some extracts from it are included in this report

- A coding system is now in place and a back dating exercise was completed by practices. As and when some data analysis capacity becomes available there is, therefore, the opportunity to track patient clinical outcomes and interventions pre and post social prescribing intervention.

Review the person specification and job description: Completed and included as an action in the review brief for further scrutiny.

Develop new marketing materials to encourage patients to self-refer: Completed, see Appendix 2.

Provide training to reception staff to empower them to sign-post directly to the service: No formal training undertaken but discussions facilitated through the new marketing materials. Wider work outside the scope of social prescribing being delivered to practice staff on 'care navigation'.

Strengthen key relationships, in particular, with housing support services and social care: On-going work enhanced by the Integrated Wellbeing Network model now a priority for the Neighbourhood Care Network.

Identify opportunities to create additional resource to further support primary care and extend model to secondary care: Targeted work delivered to fibromyalgia sufferers detailed in this report

Setting the scene

There are several interpretations of what social prescribing is and what it does, with a range of successful models operating along a spectrum, from the early intervention and prevention work within the community, to the more intensive support provided within a clinical setting, generally found in primary care. Our model works at the more complex end, where the individuals that present have multiple social challenges that need to be understood before they can be connected to appropriate services to support them. Somewhere along this spectrum there is a place for co-production, where an individual can be supported to identify and build on their assets. We actively promote this approach where an individual is able to engage in this way.

In order to set the scene for the work that is delivered in Torfaen, below are three scenarios that are based on actual social prescribing interventions.

A is referred for support with her finances as in lots of debt. Her benefits have been stopped and she discloses she has been borrowing money from family and friends to pay bills. She is in rent arrears and received a letter threatening eviction from her landlord. She has 2 children who she has not been sending to school as she is too tired every morning to get them dressed and ready. She breaks down during the session advising everything is going wrong and she feels very unwell and has been self-harming. She has not told the GP for fear social services will come and take her children away.

B is referred for support with housing as he has advised the GP he is homeless. He has a history of being violent with women. He is struggling with anxiety and depression and is very isolated. During the session he discloses he has been staying with his ex-partner and sleeping on the sofa although he can't stay at the house long term. Further discussions reveal he should not be staying at the property due to the level of domestic violence in the relationship and a child protection order in place.

C is referred by his GP to access further support as he is isolated. During the appointment he discloses he was subject to abuse as a child and feels a failure in life. His wife takes all his wages each month, shouts at him all the time and has assaulted him, which he said he 'deserves'. His wife has had several affairs but moves back home when she runs out of money. He has no one to talk to about his situation as his daughter is going through her own difficulties as lost a child last month so he doesn't want to upset her. He is also grieving for the loss of his first grandchild and finding everything difficult to cope with. He has no other family or friends to turn to and hasn't eaten for days. He advised he is sleeping about 2 hours a night and waking up with panic attacks and can't breathe. He tells you that he has not been taking his anti-depressants and been storing his medication up for the past month as he doesn't see the point anymore.

Highlights

- 564 holistic conversations were led by Social Prescribers
- 684 onward referrals were made to 86 different services
- 71% of individuals reported that they felt more positive at the end of the session[5]
- A research project exploring attitudes to social prescribing among primary care teams in Torfaen[6] was conducted.
- We agreed a brief for a review to be commissioned during 2018/19
- We supported the development of a support network for fibromyalgia sufferers.

"Just thought I'd drop a message as I'm in surgery this morning and one of the GPs came in to say thank you for the support we have offered to A. She said she was close to welling up after seeing him, which is very much how I felt too, she said that she saw him yesterday and he was a completely different person to the man she's been seeing, and is looking forward to the fibromyalgia support group, he's hopeful and positive again". Note from Social Prescriber to the lead on our fibromyalgia support

[5] For 18% it was not appropriate to ask; data on this question is not available for 11% and there was 1 negative and 2 neutral responses

[6] *An exploration of Primary Care Team experience of Social Prescribing was published in May 2018, however, most of the research was undertaken during the 2017/18 period, therefore, it is referenced in this report.*

The data: North Torfaen

1 April to 30 June

	Abersychan	Blaenavon	Churchwood	Mount	Panteg	Trosnant	Total
Available appts	36	36	16	16	44	32	180
Appts booked	28	32	14	16	27	9	126
% booked	78%	89%	88%	100%	61%	28%	70%
Consultations	18	20	7	10	22	12	89
Patients seen	13	19	6	10	10	9	67
DNA's	10	12	7	6	5	6	46
DNA rate	36%	38%	50%	38%	19%	67%	37%

1 July to 30 September

	Abersychan	Blaenavon	Churchwood	Mount	Panteg	Trosnant	Total
Available appts	44	37	34	32	48	44	239
Appts booked	26	24	10	22	16	5	103
% booked	59%	65%	29%	69%	33%	11%	43%
Consultations	21	20	9	16	14	4	84
Patients seen	18	17	8	13	12	4	72
DNA's	4	4	1	4	2	1	16
DNA rate	15%	17%	10%	18%	13%	20%	16%

1 October to 31 December

	Abersychan	Blaenavon	Churchwood	Mount	Panteg	Trosnant	Total
Available appts	33	34	24	28	47	36	202
Appts booked	23	27	7	20	22	11	110
% booked	70%	80%	29%	71%	47%	31%	54%
Consultations	17	18	10	23	20	7	95
Patients seen	17	15	8	23	15	7	85
DNA's	6	8	4	8	5	4	35
DNA rate	26%	30%	57%	40%	23%	36%	32%

1 January to 31 March

	Abersychan	Blaenavon	Churchwood	Mount	Panteg	Trosnant	Total
Available appts	24	18	27	18	21	24	132
Appts booked	17	15	11	8	8	9	68
% booked	71%	83%	41%	44%	38%	38%	51%
Consultations	17	11	9	2	5	5	49
Patients seen	16	11	6	2	5	5	45
DNA's	1	2	5	6	3	4	21
DNA rate	6%	13%	45%	75%	38%	44%	31%

Note: there are some discrepancies in the data when cross referenced with GP systems; some of this is due to patients being seen outside of allocated surgery times. Improvements to monitoring have been implemented for 2018/19. Some patients are seen more than once, therefore, number of consultations may be more than number of patients seen.

Gender and age

The following table illustrates the breakdown of patients by gender and age[7]:

Surgery	Patients	Male	Female	16-18	18-25	26-64	65 +
Abersychan	65	30	35	1	9	49	6
Blaenavon	62	23	39	0	3	52	7
Churchwood	28	9	19	1	4	19	4
Mount	47	18	29	0	4	33	10
Panteg	42	22	20	0	1	38	3
Trosnant	25	8	17	0	1	22	2
Total	**269**	**110**	**159**	**2**	**22**	**213**	**32**

"It's citizen's advice on your doorstep with a practice friendly face"

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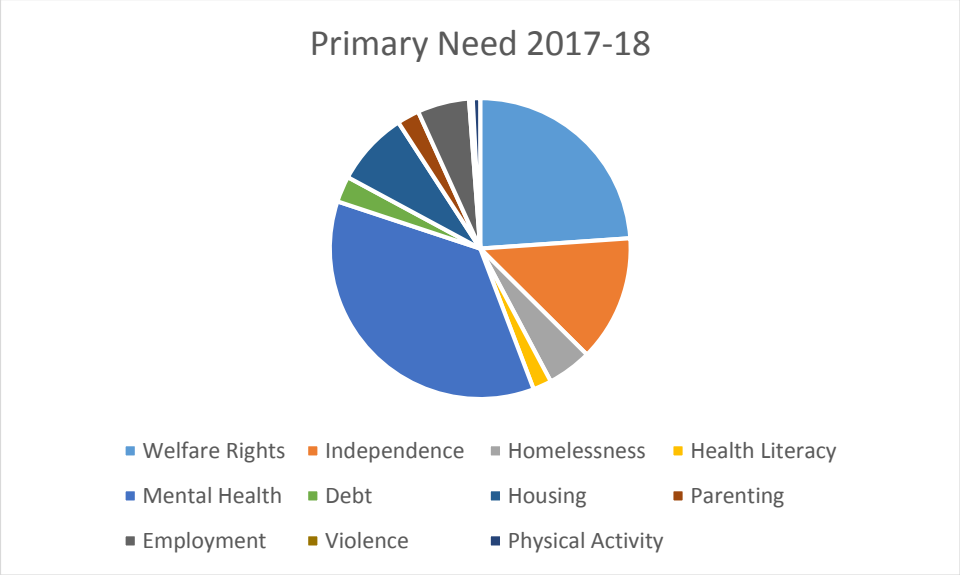
Primary needs

Further work is needed on the categorisation of need. Although poor mental wellbeing is illustrated here as the most significant need, in most cases there are underlying issues that are significant contributors, which we need to better capture. Our current assessment is that the other high need groups, welfare rights, housing and loneliness and isolation (captured under 'independence') are key drivers.



[7] We recognise the limitations of a broad working age category and will further breakdown the 26-64 age group in our monitoring for 2018-19

[8] Page 14, K. Gregory (2018). An exploration of Primary Care experiences of Social Prescribing: A Qualitative Interview Study.

South Torfaen

1 April to 30 June

Number of:	New Chapel Street	Clark Avenue	Cwmbran Village	Fairwater / Thornhill	Greenmeadow	Llanyrafon	Oak Street	Total
Available appts	28	38	36	32	44	0	32	210
Appts booked	12	23	22	23	32	0	16	128
% booked	43%	61%	61%	72%	73%	N/A	50%	61%
Consultations	6	12	11	13	24	0	9	75
Patients seen	6	10	11	12	22	0	9	70
DNA’s	6	11	11	10	8	N/A	7	53
DNA rate	50%	48%	50%	43%	25%	N/A	44%	41%

1 July to 30 September

	New Chapel Street	Clark Avenue	Cwmbran Village	Fairwater/ Thornhill	Greenmeadow	Llanyrafon	Oak Street	Total
Available appts	48	52	36	40	44	40	48	308
Appts booked	10	30	10	8	39	16	30	143
% booked	15%	58%	28%	20%	89%	40%	63%	45%
Consultations	7	23	4	8	30	13	27	112
Patients seen	7	23	4	8	23	12	27	97
DNA’s	3	7	2	0	9	5	3	29
DNA rate	30%	23%	20%	0%	23%	31%	10%	20%

1 October to 31 December

Number of:	New Chapel Street	Clark Avenue	Cwmbran Village	Fairwater / Thornhill	Greenmeadow	Llanyrafon	Oak Street	Total
Available appts	33	39	0	27	37	28	36	200
Appts booked	12	15	0	10	23	3	24	87
% booked	36%	38%	N/A	37%	62%	11%	67%	44%
Consultations	12	6	0	10	12	3	24	67
Patients seen	12	6	0	10	12	3	24	67
DNA's	0	9	0	0	5	0	0	14
DNA rate	0%	60%	N/A	0%	22%	N/A	0%	16%

1 January to 31 March

	New Chapel Street	Clark Avenue	Cwmbran Village	Fairwater/ Thornhill	Greenmeadow	Llanyrafon	Oak Street	Total
Available appts	33	32	6	27	25	52	27	202
Appts booked	4	14	1	4	4	8	18	53
% booked	12%	44%	17%	15%	16%	15%	67%	26%
Consultations	4	13	1	4	2	7	18	49
Patients seen	4	13	1	4	2	7	18	49
DNA's	0	1	0	0	2	1	0	4
DNA rate	0%	7%	0%	0%	50%	12%	0%	8%

Note: appointments booked and DNA information not available for New Chapel Street, Fairwater and Thornhill, therefore, data assumes no DNA's which is unlikely to be accurate. Improvements in monitoring for 2018-19 will ensure that social prescribers record DNA on their systems.

Gender and age

The following table illustrates the breakdown of patients by gender and age[9]:

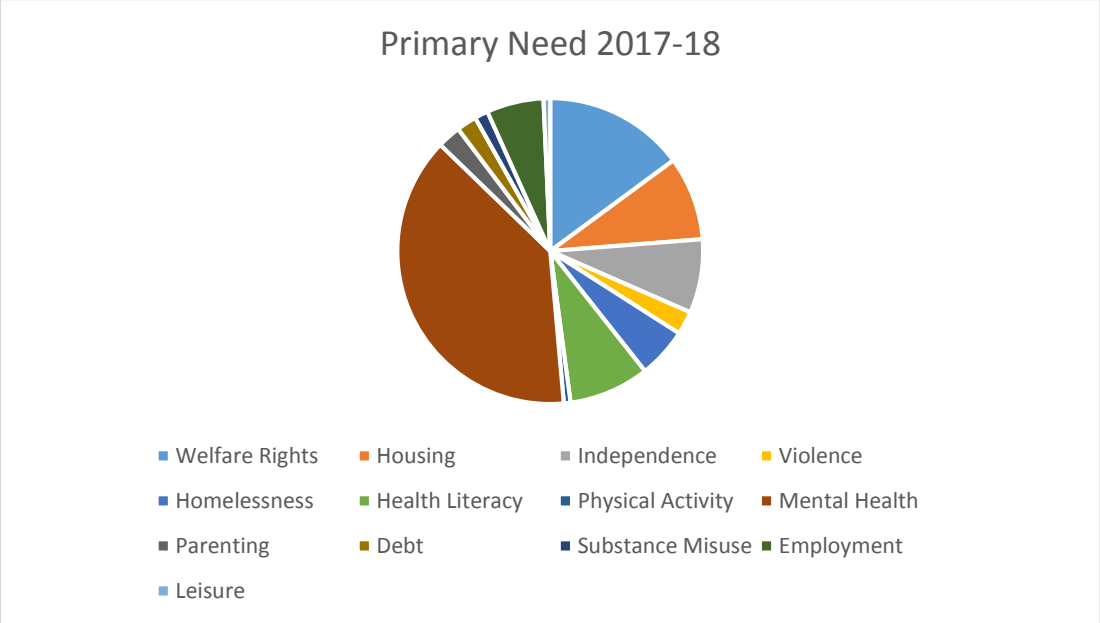
Surgery	Patients	Male	Female	16-18	18-25	26-64	65 +
New Chapel Street	29	15	14	0	3	19	7
Clark Avenue	52	13	39	0	7	39	6
Cwmbran Village	16	11	5	0	2	12	2
Fairwater / Thornhill	34	17	17	0	7	24	3
Greenmeadow	61	29	32	0	8	49	4
Llanyrafon	22	4	18	0	1	14	7
Oak Street	78	32	46	1	8	59	10
Total	**292**	**121**	**171**	**1**	**36**	**216**	**39**

"I think it is very valuable, especially in a practice area of high social needs like ours; the service is still embedding, with awareness among patients and staff still needing to spread; we would like more of this service please"

[10]

Primary needs

Further work is needed on the categorisation of need. Although poor mental wellbeing is illustrated here as the most significant need, in most cases there are underlying issues that are significant contributors, which we need to better capture. Our current assessment is that the other high need groups, welfare rights, housing and loneliness and isolation (captured under 'independence') are key drivers.

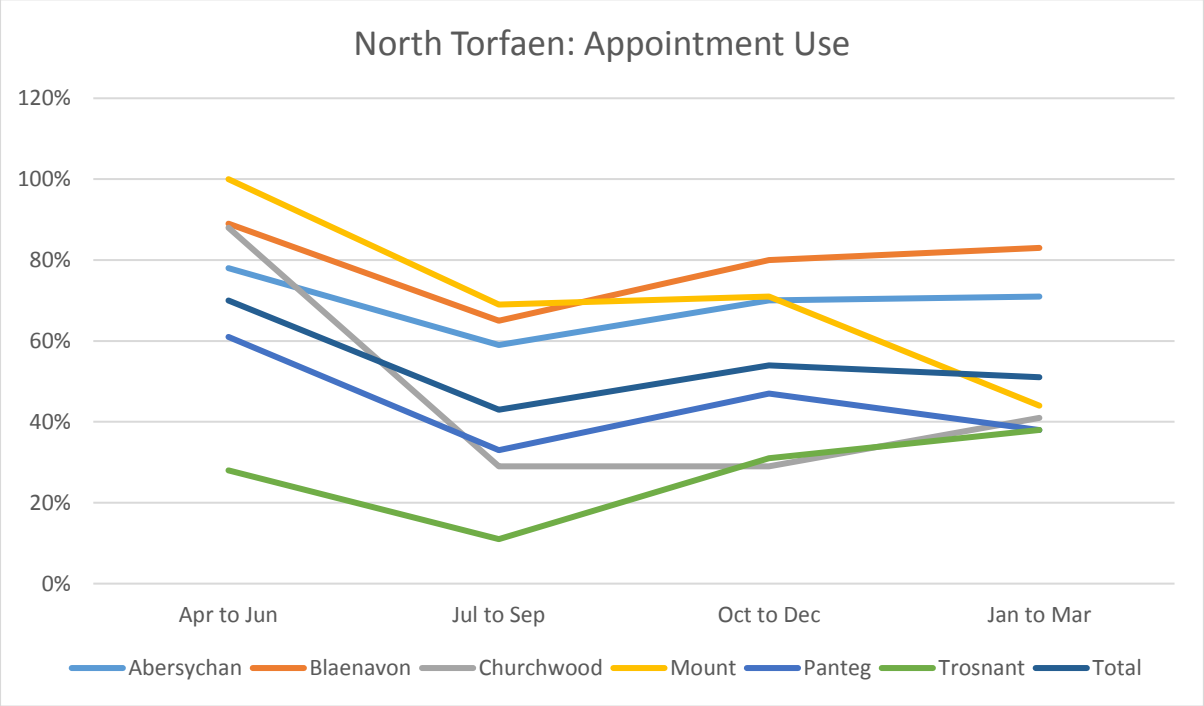


[9] We recognise the limitations of a broad working age category and will further breakdown the 26-64 age group in our monitoring for 2018-19

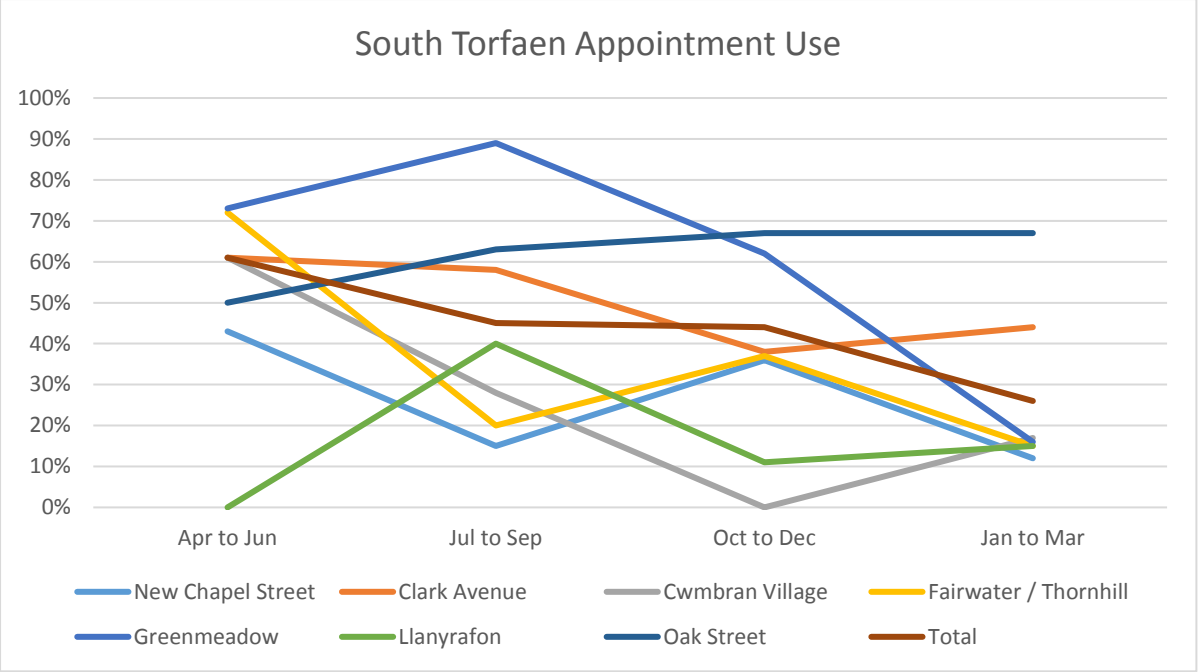
[10] Quote from response to survey carried out in July and August 2017 across practices in South Torfaen

Data: Appointment Use and Did Not Attend (DNA)

The charts below show the number of appointments booked as a percentage of the total available. In North Torfaen the picture is fairly consistent, increasing in some practices, following a dip earlier in the period. In South Torfaen, the data indicates a mixed take up of the service with an overall decline. The exception is Oak Street where the number of appointments used increased during the first half of the year and then remained consistent. The fluctuating nature of the DNA information makes any graphs challenging to interpret and draw conclusions from. Closer attention will be made to the monitoring of DNA's in 2018-19, including keeping a record of gender and age profile to identify any trends[11].



[11] There is a general sense in North Torfaen that younger people are more likely not to attend an appointment but no data is currently available.



"It has had a negative impact because they're waiting longer to be seen, so the longer you wait the more a problem escalates"

Challenges

Evidencing the outcomes of the service continues to be a challenge. The way in which we collect data hides some of the detail and only knowledge of the specific cases helps us to draw conclusions. Interrogating primary care databases is a time consuming process and capacity is limited, therefore, providing robust data to support conclusions that GP consultations have been avoided is not currently possible. We have previously used online tools to conduct short surveys to give us indication of primary care feedback. This was last used in the South in July and August 2017 when although the general response was that it was too early to reach any firm conclusions, 50% of those who responded felt that they had seen a reduction in and / or more appropriate use of GP consultations. In an earlier survey in the North in November 2016, 69% of respondents provided positive responses to this question and provided a range of examples. A further survey was delayed pending the results of the research study into primary care experiences of social prescribing, which reached a different conclusion. "*Whilst participants were agreed that the service had complemented their usual practice in enabling them to offer patients more support, they reported no reduction in primary care service usage".*[12]

[12] Page 16, K. Gregory (2018). An exploration of Primary Care experiences of Social Prescribing: A Qualitative Interview Study.

The **capacity of the service** is limited to half a day a week per surgery with 3 appointments available during this period. Bromley by Bow suggests that for every appointment there should be a further two hours of follow up work. In the North 18 hours are allocated to appointments with 19 additional working hours available; in the South there are 21 appointment hours leaving 16 hours for follow up. This is without considering the need for administration, supervision and networking time. Many of the patients accessing the service are complex but feel listened to and are able to share their concerns. Once they have trusted the social prescriber with their stories, they are sometimes hesitant about accessing further support without this being bridged by the social prescriber. Additional time to facilitate a 'warm handover' to the next service would make a real difference to supporting individuals on the next stage of their journey. Equally, several practices are keen for there to be more available appointments in order to avoid or limit waiting lists.

It was recognised during the second half of 2017-18 that the back to back nature of appointments, the levels of vulnerability displayed by individual's accessing the service and the limited capacity to provide follow up support was impacting on the **wellbeing** of the social prescribers. Monthly professional supervision continues to be provided with an open-door policy by management to support staff. In addition, the number of appointments each session were reduced from 4 to 3 and the question of service delivery on staff wellbeing included as an important question in the independent review.

Some GP's have expressed frustration at the **lack of communication and feedback** on the outcomes for their patients[13]. The current system enables social prescribers to input directly onto patient notes meaning that the next clinician to see the notes can view any content. However, these notes will only relate to the outcomes of the conversation and any proposed follow up action; there is no capacity to go back into the system at a later date and provide feedback on outcomes. It should also be noted that in many cases once the individual has accessed an appropriate service there is limited feedback from that service to the social prescriber. This is listed as a priority action to address during 2018-19

Opportunities

Early on in the development of social prescribing in North Torfaen it was recognised that there was a perceived lack of services in place to support individuals diagnosed with **fibromyalgia**. Since April 2017 we have started, with support from a range of partners a dedicated resource in the form of a Physical Wellbeing Officer[14], to address this. Two open events held in September 2017 and January 2018 attracted over 150 attendees, many of whom were unaware of the range of services across the community that they could access. We have widely promoted existing services,

[13] K. Gregory (2018). An exploration of Primary Care experiences of Social Prescribing: A Qualitative Interview Study.

such as National Exercise Referral Scheme (NERS), Educating Patients Programme (EPP), Disability Advice Project (DAP), the Road to Wellbeing (an ABUHB initiative), Torfaen and Blaenau Gwent Mind and Disability Sports as well as employment support for individuals with health conditions such as Communities For Work and Bridges into Work. Monthly support groups began in February 2018 covering a wide range of topics and encouraging peer support and attract over 20 individuals each session. This work has been actively supported by ABUHB Rheumatology and Occupational Therapy Services.

"D has fibromyalgia and suffers with social anxiety and depression, including a phobia of the weather, which limits her ability to get out and about. After being referred by a Social Prescriber, and encouraged through text messages and phone calls, D attended an open event. She was extremely nervous and was met outside; once in the event she sat in one place unable to move around the room. She began to share her story and agreed to meet with the Physical Wellbeing Officer at the gym the following week where she was met at her car which was parked right outside the door. Over the weeks and months that followed her confidence grew and she was able to set and achieve a number of short term goals such as going into town with friends, walking around Pontypool Park and having her photograph taken, all things she hasn't been able to do in years. She is now a regular attender at the fibromyalgia support groups, has completed an EPP course and often goes for coffee with people she has met. Her biggest achievement, however, is going on her first holiday in years.

Priorities for 2018/19

The following have been identified as priority actions for 2018/19:

- Increase the number of appointments used as a percentage of those available
- Explore ways in which to improve the 'feedback loop' to primary care.
- Complete the review of the service and respond to its findings
- Continue to improve data monitoring using the information from 2017/18 as our baseline.

Conclusion

2018-19 is an important year in the development of social prescribing in Torfaen as we reach three years since inception. We need to evidence the strength of the service, overcome any challenges and make the case for more long term commitment. Changes in management structures have freed up some capacity to undertake regular, objective, analysis of performance and to take a fresh look at how social prescribing sits strategically within a wider transformational context. We have the opportunity to test out the Integrated Well-being Network model being developed across Gwent and to work with the Public Service Board to consider new approaches to working with vulnerable people across public services. We hope that alongside the growing national focus on this model as an important part of primary care we can develop a fit for the future social prescribing service in Torfaen.

If you have any questions or comments on the content of this report or would like further information, please contact Emma Davies, Collaboration and Improvement Officer (Torfaen CBC) on 01633 647493 or emma.davies3@torfaen.gov.uk

Social Prescribing:
An exploration of Primary care team experiences

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BACKGROUND & AIMS

It's estimated that 15% of all GP visits are for social welfare advice, with up to 70% of health outcomes being determined by social, environmental and economic factors. (1) Social prescribing aims to impact on these wider health determinants, utilizing a 'social prescriber' to help patients access sources of support, which vary from housing and monetary advice to community and leisure activities. A social prescriber receives referrals from any member of the primary care health team (PCHT) or self referrals from patients.

There is currently little literature on PCHT experiences of social prescribing services. The primary aim was to explore the attitudes and experiences of the PCHT to the service. We also aimed to understand any barriers to service usage and explore their suggestions for further service developments and improvements.

METHODS

Setting and Recruitment

- The study was set within one county in South Wales, an area of moderate to high socioeconomic deprivation. (3)
- We aimed to recruit a purposive sample of service referrers from both high and low service use practices. All practices within the county (n=11) were invited to take part.
- In total, 10 PCHT members were recruited, including 8 eight GPs, one practice manager and one receptionist.
- The participants were from five practices, mainly moderate to high users of the social prescribing service.

Data collection and analysis

- Semi structured interviews were conducted by one researcher (KG) between January and March 2018.
- Interviews were based around a topic guide, informed by the literature and after consultation with two representatives of the social prescribing service.
- Interviews were then transcribed, anonymised and imported into NVivo.11 to support a thematic analysis. Four main themes were identified:

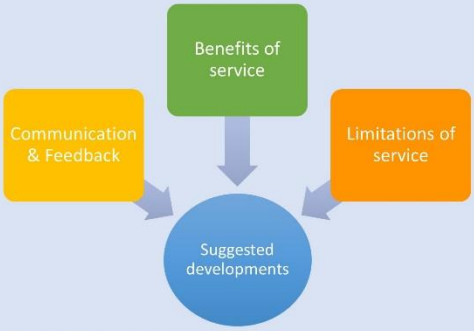

Figure 1: Emerging themes

RESULTS

COMMUNICATION &FEEDBACK

"we don't get a lot of communication...which is a bit disappointing. We have asked for feedback, as to if the referrals are appropriate what was the outcome, be it positive or negative...so none of that has been forthcoming."

BENEFITS OF THE SERVICE

"it's citizens advice on your doorstep with a practice friendly face."

"to be able to say I don't know the rules...I can send you to someone who does at least know what to access, where to access, what the rules are."

LIMITATIONS OF THE SERVICE

"For us it's probably not enough to meet the demand."

(On waiting lists) "I think it's had a negative impact because they're having to wait longer to be seen, so the longer you wait the more a problem escalates"

SUGGESTED DEVELOPMENTS

"It might be useful if we had some written examples of what they could do, sometimes its's the last person you think of in a medical consultation...so concrete examples would be good."

"We would like quarterly updates...how they feel the service is going...by the time another quarter goes past they may have another string to their bow, but if we don't get that feedback we might be sat on a few patients."

IMPLICATIONS

Participants provided valuable insights into the current service. The social prescribing service is valued by members of the PCHT as a useful resource to offer their patients. Continued communication and feedback between the PCHT and the social prescriber is key in maximizing the benefits of the service. This knowledge of PCHT attitudes and experiences of the social prescribing scheme, alongside their suggestions for further service improvement, will help to inform the the continued development of the service in the county and influence future schemes across Wales.

References

1. The Marmot Review, Fair Society, Healthy Lives: A strategic review of health inequalities in England. London; 2010
2. Bickerdike L, Booth A, Wilson PM, Farley K, Wright K. Social prescribing: less rhetoric and more reality. A systematic review of the evidence. BMJ Open. 2017;7(4)
3. Welsh Government. (2014). *Welsh Index of Multiple Deprivation*.Available: http://wimd.wales.gov.uk/explore?lang=en#z=14&lat=51.702&lng=-3.115&domain=overall. Last accessed 01/03/18.

SOCIAL PRESCRIBING
TORFAEN

Your Doctor isn't the only person who can help you feel better...

Addressing difficult issues needs extra time and support

Our **Social Prescribers** can help you look after more than just your health.

We listen to you and help you to access services that can provide social, emotional and practical support.

MANY OF LIFE'S PROBLEMS CAN MAKE YOU FEEL UNWELL:

Living alone
Work and unemployment
Money worries
Children and families
Language barriers
Addictions
Weight problems
Smoking
Housing issues
Health and Fitness

"I WOULD LIKE TO SAY A BIG THANK YOU FOR GETTING ME THE HELP I NEED TO LIVE A NORMAL LIFE AGAIN."

- Housing, benefits and financial support and advice
- Education and learning
- Arts, music, outdoors and creative activities
- Family support and parenting
- Healthy lifestyle advice and physical activity
- Employment, training and volunteering
- Befriending, counselling and emotional support groups
- Anything else that matters to you

Make an appointment to see us and together we can:

- Discuss issues you're facing
- Explore what is important to you
- Find local activities and services
- Give you support to access them

Our appointments last up to 45 minutes, giving you the time you need to talk through the things that matter to you

Your GP practice can make an appointment for you, just speak to the practice team. If coming into the surgery is difficult we can talk on the phone

WITHOUT YOUR HELP
I WOULD HAVE STAYED
STUCK IN A RUT,
IT'S NICE NOT
TO BE JUDGED

I FEEL SECURE
WITH YOU BECAUSE
YOU LISTEN

THE ADAPTATIONS HAVE
ALL BEEN DONE AND MY
SON NOW RECEIVES
CARER'S ALLOWANCE.
THANK YOU SO MUCH
FOR WHAT YOU HAVE DONE

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