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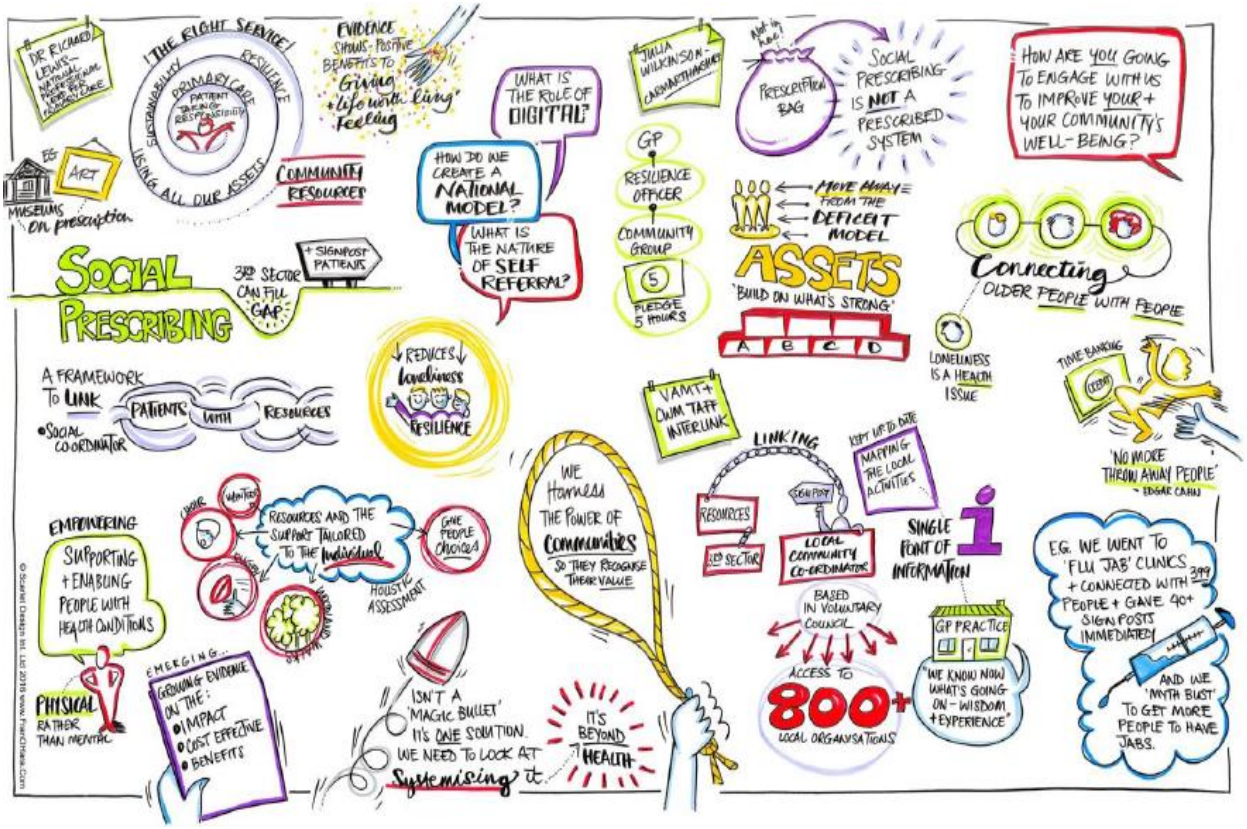

SOCIAL PRESCRIBING IN WALES

Primary Care Hub
May 2018

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1. INTRODUCTION

1.1 BACKGROUND

There is increasing acceptance that sources of support in local communities have an important role to play alongside clinical care or even as an alternative in improving someone's individual health and wellbeing outcomes. Wellbeing services offer people a wide range of sources of support within the community, improving emotional and physical wellbeing and reducing social isolation. The services are often provided by people working and volunteering in the third sector or independent sector, complementing the role played by statutory organisations.

Social prescribing is a systematic mechanism for linking people with wellbeing services. It has been in place for a good number of years, albeit on a relatively small scale. Social prescribing projects are widely acknowledged to have existed in some form since before the 1990s. The Bromley by Bow Centre[1] in London, which is widely regarded as the first social prescribing initiative to become fully operational, was established in 1984.

1.2 STRATEGIC CONTEXT

The Social Services and Well-being (Wales) Act 2014, the Wellbeing of Future Generations (Wales) Act 2015, and the Programme for Government *Taking Wales Forward* and *Prosperity for All*, are all founded on a model of health which recognises the impact of social determinants on health and wellbeing and draws on all sources of help and support.

The objectives of social prescribing align with national policy encouraging a focus on well-being, prevention, integration and the role of the third sector in delivering person-centred care in community settings. Social prescribing projects also contribute to wider government priority areas such as housing, employment, volunteering and learning. Although the National Institute for Health and Care Excellence (NICE) does not refer explicitly to social prescribing, some of its guidelines relating to mental health, such as those relating to the independence and mental well-being of older people (NG32), may be considered examples of such initiatives. The role of voluntary third sector organisations alleviating demand on GP surgeries through social prescribing initiatives was emphasised in the *General Practice Forward View*[2]*.* Identified as one of the *10 high impact changes to release capacity in primary care* social prescribing represents an original and innovative approach to addressing the challenge of managing the increasing demand placed on the NHS. This is largely because unlike conventional models of medical care, social prescribing models seek to encourage changes of behaviour pre-treatment, during treatment and post-treatment.

> *"The approach can improve self-esteem, mood and self-efficacy, social contact and the development of transferable skills to help the management of chronic conditions. Demand for health services can also be decreased where the medical model is not the most effective solution"*
>
> Chief Medical Officer Report, Welsh Government, 2017

[1] Bromley by Bow Centre, London https://www.bbbc.org.uk/about-us/

[2] NHS England (2016) General Practice Forward View, London

1.3 PURPOSE OF THIS REPORT

This report has been produced by the Public Health Wales Primary Care Hub to record the progress made on social prescribing in Wales over the last two years and highlight arrangements put in place to build on this work going forward.

There is wide professional and political support in Wales for the concept of linking individuals to community based assets. Work undertaken by Public Health Wales (PHW) has identified that there are gaps in the published evidence for social prescribing; there are many excellent examples of social prescribing projects in primary care in Wales, but they are short-term funded and often poorly evaluated. There is a lack of awareness of the well-being services that are available in the community, how they are accessed and funded; several national initiatives already exist in this space which could be a source of confusion to professionals and the public and which would achieve more if they were better aligned.

Good progress has been made thus far on the actions to progress social prescribing in Wales. There is an opportunity to continue this through the combined efforts of the newly established All Wales Social Prescribing Research Network, Regional Communities of Practice for social prescribing and Welsh Government in support of statutory and non-statutory organisations working together at a national and local level.

2. WHAT IS SOCIAL PRESCRIBING?

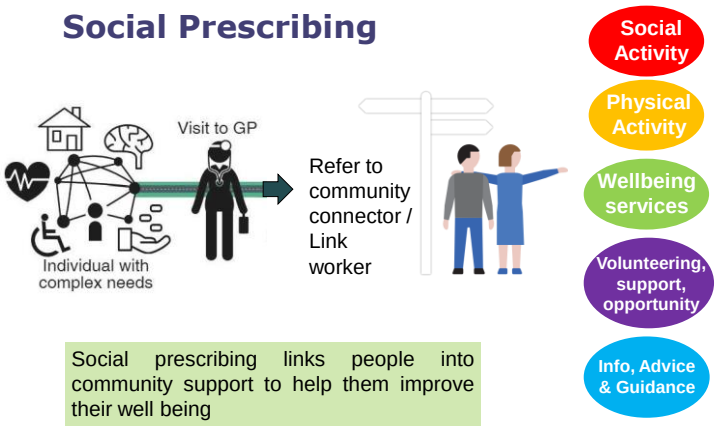
The terms “social prescribing”, “community referral” and “linking to community well-being services”, have all been used to describe a way of expanding the range of non-medical options that could be available to healthcare professionals when a person has needs that are related to socioeconomic and psychosocial issues.

> ***“a means of enabling primary care professionals to refer patients with social, emotional or practical needs to a range of local, non-clinical services”.***

Recognising that people’s health is determined primarily by a range of social economic and environmental factors, social prescribing seeks to address people’s needs in a holistic way. It also aims to support individuals to take a greater control of their own health.

Social prescribing schemes can involve a variety of activities which are typically provided by voluntary and community sector organisations e.g. volunteering, arts activities, gardening, befriending cooking, healthy eating advice and a range of sports. There are many different models for social prescribing, but most involve a link worker or navigator who works with people to access local sources of support (Figure 1).

Figure 1: Social Prescribing



Social prescribing is designed to support people with a wide range of emotional, social or practical needs, and many schemes are focussed on improving mental health and physical wellbeing. Those who could benefit from social prescribing schemes include people with mild or long-term mental health problems, vulnerable groups, people who are socially isolated and those who frequently attend either primary or secondary health care.

Social prescribing initiatives also symbolise a systematic shift towards making available new life opportunities for those who need them most, opportunities to form new relationships, be creative and be independent while improving both physical and mental health. Examples include voluntary work agencies, exercise classes, self-help groups, book groups, social or lunch clubs and hobby clubs. To put it concisely, social prescribing is about treating the patient – not the illness.

To fully address the social determinants of health, social prescribing schemes view a person not as a “condition” or “disability”, but quite simply as a person.

2.1 THE REASON FOR DEVELOPING SOCIAL PRESCRIBING SCHEMES

Social prescribing shares the values that underpin the social model of wellbeing.

NHS England commissioned a guide to social prescribing[3] which highlighted the fact that many people in the UK are in situations that have a detrimental effect on their health. The Marmot Review provided comprehensive analysis on the causes of health inequalities[4]. Factors contributing to health inequalities can include financial, educational, poor housing, low self-esteem, isolation, relationship difficulties and physical and mental health problems. There are also more people who are living longer and struggling to cope and adapt to living with Long Term Conditions which can't be addressed by a clinical consultation.

Almost without exception people want to improve their situation, particularly those with complex needs. These changes can seem impossible to navigate or achieve without sustained support and the motivation needed to make a positive change. Without support, negative consequences can build, such as anxiety, depression and social isolation.

The traditional medical options might have only a limited impact if, for example, poor housing is a factor in a person's emotions; finance and employment concerns also have an adverse impact. It has been estimated that around 20% of patients consult their GP for what is primarily a social problem[5]. The Low Commission reported that 15% of GP visits were for social welfare advice[6].

As well as facilitating the use of non-clinical support for people, social prescribing also leads to NHS health care professionals developing wider relationships with their communities and the third sector and vice versa. Social prescribing is an opportunity to implement sustained structural change to how a person moves between professional sectors and into their community.

Social prescribing is part of a wider movement that signifies a shift from traditional top-down models of care delivered in hospitals and GP surgeries to a non-medical, more networked approach by placing the patient at the centre of their care, promoting independence and personal responsibility, and contributing to the common good. Such projects may also be seen as part of a concerted effort to reduce the number of referrals into the acute sector and the uptake of more costly medical interventions[7]. It places value on establishing and maintaining personal relationships, helps to de-medicalise health conditions and represents a formal means of making links to locally accessible opportunities for patients[8].

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[3] University of Westminster (2017). Making Sense of Social Prescribing

[4] Marmot, M (2010). Fair Society, Healthy Lives: the Marmot Review: strategic review of health inequalities in England post 2010

[5] Torjesen, I (2016) Social prescribing could help alleviate pressure on GP's, BMJ 352; 1436

[6] The Low Commission (2015). The role of advice services in health outcomes: evidence review and mapping study. Available at: https://www.lowcommission.org.uk/News/Advice-and-Health

[7] The OPM Group, 2013 http://www.opm.co.uk/blog/social-prescribing-offers-a-model-to-prevent-ill-health-but-shared-decision-making-could-be-the-mechanism-that-makes-it-happen/

[8] Hall Aitken (Big Lottery Fund), 'Social Prescribing and Older People: A Guide to Developing Projects', (November 2014).

Social prescribing can offer many people a personalised and flexible support back to health at a pace that is appropriate to the person.

There are many models of how social prescribing schemes have been organised. These models have a range of aims and therefore enable a range of outcomes to be achieved. In 2016, the Social Prescribing Network in England asked stakeholders to list the outcomes achieved by social prescribing[9] (Figure 2).

Figure 2: Outcomes described by social prescribing stakeholders

Physical and emotional health & wellbeing	Cost effectiveness & sustainability	Builds up local community	Behaviour Change	Capacity to build up the VCSE	Social determinants of ill-health
Improves resilience	Prevention	Increases awareness of what is available	Lifestyle	More volunteering	Better employability
Self-confidence	Reduction in frequent primary care use	Stronger links between VCSE & HCP bodies	Sustained change	Volunteer graduates running schemes	Reduced isolation
Self-esteem	Savings across the care pathway	Community resilience	Ability to self-care	Addressing unmet needs of patients	Social welfare law advice
Improves modifiable lifestyle factors	Reduced prescribing of medicines	Nuture community assets	Autonomy	Enhance social infrastructure	Reach marginalised groups
Improves mental health			Activation		Increase skills
Improves quality of life			Motivation		
			Learning new skills		

Source: Social Prescribing Conference Report 2016

More recently a review of the evidence[10] assessing the impact of social prescribing on healthcare demand and cost implications showed average reductions following referrals to social prescribing schemes of 28% in GP services, 24% in attendance at A&E and statistically significant drops in referral to hospital.

[9] Social Prescribing Network Conference report 2106

[10] Polley, M et al (2017). Review of evidence assessing impact of social prescribing on healthcare demand and cost implications Report https://www.westminster.ac.uk/file/107671/download

3. SOCIAL PRESCRIBING IN WALES

3.1 POLITICAL SUPPORT

The Welsh Government has signalled strong support for social prescribing approaches through legislation and a range of policy statements. The Social Services and Well-being (Wales) Act 2014, the Wellbeing of Future Generations (Wales) Act 2015, and the Programme for Government *Taking Wales Forward* and *Prosperity for All*, are all founded on a model of health which recognises the impact of social determinants on health and wellbeing and draws on all sources of help and support.

A plenary debate on social prescribing was held in the National Assembly on Tuesday 23 May 2017, generating cross-party support for the approach in Wales.

In August 2017, the Cabinet Secretary for Health, Well-being and Sport and the Minister for Social Services and Public Health wrote to all Chairs of health boards, local authorities, regional partnership and public services boards and WCVA (21 August 2017) urging bodies "*to use the PHW work on social prescribing to inform their research proposals and plans to develop better ways to link people to well-being care and support*".

In its National Strategy *Prosperity for All* (September 2017), Welsh Government set out its vision, which includes:

- expanding the community health and social care workforce, with innovative new roles, such as 'community connectors' that support social prescribing and more formal partnerships with volunteers and the third sector.
- building the capacity of communities as places which support better health and well-being using approaches such as social prescribing.
- delivering a pilot to explore how social prescribing can help to treat mental health conditions.

Following discussions with Vice-chairs of Health Boards and NHS Trusts the Cabinet Secretary indicated in a letter (17 October 2017), that "*Welsh Government is championing social prescribing*" and expressed an interest in *"the development and sharing of the principles that underpin the harnessing of effective community health and well-being services to support population needs... (and)..timescales for incorporating social prescribing into future activity...".*

The Parliamentary Review of Health and Social Care in Wales (January 2018)[11] also supports a social prescribing approach, through its recommendations of one seamless approach across sectors with strengthened individual and community involvement which puts the individual at the centre, with better information and shared decision making.

3.2 CHAMPIONING

The National Professional Lead for Primary Care in Wales, has championed the role of wellbeing services and called for more systematic ways for people to access or be referred to such support. Following a National Primary Care event in October 2016 social prescribing has gained a strong profile in Wales, both locally at Primary Care Cluster level and at a national level through discussions facilitated by the National Professional Lead for Primary Care and the Future Generations Commissioner for Wales. It has subsequently been identified as an area of interest by the Directors of Primary Care and the National Primary and Community Care Board.

[11] The Parliamentary Review of Health and Social Care in Wales (January 2018) available at: https://gov.wales/docs/dhss/publications/180116reviewen.pdf

4. PRIMARY CARE HUB SUPPORT

In October 2016, the Primary and Community Care Development and Innovation Hub (Primary Care Hub), hosted by Public Health Wales NHS Trust was tasked with supporting the emerging interest in social prescribing in Wales. This work would specifically seek to explore the evidence base for social prescribing, identify current Social Prescribing project activity in primary care in Wales and share learning arising from these activities.

A multiagency, multidisciplinary group[12] was convened to advise and oversee this work. The group had a broad membership and met monthly (Annex A). Scrutiny was provided by the Hub Programme Board, the Primary Care Reference Group and National Primary and Community Care Board.

The Primary Care Hub and the Social Prescribing Project Team have:

- Implemented a systematic process for gathering and sharing activity in respect of social prescribing. A repository of social prescribing projects in Wales can be viewed at Primary Care One Wales
- Published, in collaboration with Public Health Wales Observatory Evidence Service, *Social prescribing evidence map:* Summary report (June 2017)
- Organised and supported regional and national events to develop and share learning
- Identified key themes and recommended actions to progress social prescribing in Wales which were endorsed by the NPCCB (December 2017)
- Identified key individuals and organisations to pick up the social prescribing baton and mechanisms to maintain the momentum going forward (e.g. All Wales Social Prescribing Research Network, Communities of Practice)

4.1 MAPPING THE EVIDENCE

The concept of Social Prescribing is not new, but over the last 18 months, there has been a renewed interest in what the approach has to offer patients, communities and services in Wales and the UK as a whole. Despite wide support for linking individuals to community based assets, evidence mapping undertaken by the PHW Observatory Evidence Service (June 2017) Summary report identified that there are gaps in the evidence base for social prescribing.

[12] A multiagency Social Prescribing Project Group, with representation from Primary Care Clusters, Heads of Primary Care, Local Public Health Teams, Local Government, Third Sector and individuals with links to wider networks e.g. Green Health, has overseen the implementation of the three Primary Care Hub commitments. The members of this group (Appendix A) were identified to provide useful connections to other national programmes that relate to social prescribing in Wales e.g. community development, use of green space and time banking.

The scope of the mapping commissioned by the Primary Care Hub was developed with stakeholders and agreed by the Social Prescribing Project Group. The evidence map[13] explored the question:

How, why and in what circumstances might targeted, non-clinical interventions, services or programmes benefit the health and wellbeing of individuals and families with social, emotional or practical needs?

The mapping identified two types of evidence: research evidence assessing the effectiveness of interventions and evidence from experience, the lessons learned from the experience of designing and implementing non-clinical intervention programmes.

Headlines from the evidence mapping were that:

- the time required to set up social prescribing schemes is often underestimated
- Primary Care staff need to understand the services and interventions available and what they can offer. Patients need to understand why they are being referred and what benefits are anticipated
- the social prescribing referral process should fit in with existing referral processes and be simple to use. Feedback to referrers on the outcome of the referral was seen as encouraging appropriate referral
- consideration should be given for evaluation and associated data collection at outset, including processes to do this
- a substantial proportion of those referred, do not take up or do not engage with or complete the intervention to which they are referred
- link worker schemes vary with regard to their base (e.g. GP premises, voluntary organisations, home visits) and also the role they undertake (e.g. motivational interviewing, coaching, ongoing support)
- a link worker model requires resource to employ, train and support staff.
- There are gaps in the evidence base specifically in relation to:
    - the barriers and facilitators to uptake of social prescribing and adherence to the intervention,
    - actions to address these and how to target interventions more effectively
    - the extent to which link workers are an active ingredient in social prescribing.

The Summary report of the Evidence Mapping and a supporting Technical report were published June 2017 and are available on Primary Care One Wales.

[13] Evidence mapping enables systematic and comprehensive identification, organisation and summarising of evidence on a broad topic but does not include critical appraisal of the identified sources. Evidence maps are useful for exploring broad questions and identifying gaps in evidence.

4.2 MAPPING THE SOCIAL PRESCRIBING PROJECT ACTIVITY ACROSS WALES

The Social Prescribing activity known to Primary Care Clusters across Wales, as reported by Heads of Primary Care, was gathered and collated between December 2017 and February 2018. There were 52 different projects of which 31 identified a clearly defined mechanism of referral involving an individual or link person.

Summary information is available to view by Health Board Area on a dedicated Social Prescribing webpage on Primary Care One and can also be navigated from individual Health Board/ Primary Care Cluster pages. Where more detail about the projects was provided by local teams, this is also accessible from the webpage.

The following are examples of current projects reported as part of the activity mapping:

Torfaen Neighbourhood Community Network Social Prescribing Project, a jointly funded project between Torfaen Primary Care Clusters and Torfaen County Borough Council (TCBC). The social prescriber's primary objective is to "tackle the underlying causes of ill health and to promote self-help by connecting primary care with the range of services that exist across the community and public sector". The initiative has been fully operational since January 2016.

The role improves access to community based services supporting with social needs and behaviour change. Social prescribers refer into a wide range of support based on individual need. More importantly, they have the time and space to have a holistic conversation with individual patients to fully understand their circumstances and what matters to them. In this way they can support people to address their primary concerns and start to take action for themselves. The most significant example of this is someone who presents with stress, depression or anxiety and might ordinarily be referred to primary care mental health and / or prescribed anti-depressant medication. A conversation with a social prescriber will identify any social issues that may be causing the poor mental health, for example, financial concerns. By addressing these issues they go some way to improving mental wellbeing.

Referrals GPs report that the impact of the social prescriber had resulted in patients making fewer appointments with their GP and felt more in control of their own health and well-being. The top three priority areas cited by patients were concerns about mental health, housing/financial issues and extended periods of loneliness and anxiety. Many of the patients being referred experience barriers to social engagement and suffer from a complex mental illness and so there is a need to ensure that there is a certain element of support in putting patients in touch with the appropriate service in a timely manner. In short, it is vulnerable people who are the most likely to use a social prescribing service.

Project Team Social prescribers are hosted by Torfaen CBC and work across General Medical Practices

Funded Torfaen NCN's and Torfaen County Borough Council

Evaluation As the resource to deliver the intervention is limited, the scale of impact on individual surgeries is small, however, early anecdotal evidence suggests that social prescribing reduces repeat consultations with GP's, therefore, contributing to reducing the demand on primary care.

Valleys Steps is a free and innovative programme to assist people manage stress, anxiety & depression. Working with Cwm Taf UHB it provides courses addressing stress control and developing skills and awareness around personal mindfulness.

Underpinning this project is the recognition that getting people to engage with and address their health conditions is an important part of therapy in itself. The Valleys Steps project is considered an alternative not only for seeking medical treatment for an ongoing mental health issue, but also for those who wish to be more active and engage with more people in their localities to prevent feelings of loneliness and isolation.

For some patients, this may be as simple as attending a twice-weekly knitting club; for others, attending exercise and dance classes may be more appropriate, or for those suffering with stress and anxiety brought about by financial problems, a simple point of contact for the Citizens Advice Bureaux. The advantage of the Valleys Steps project working as a 'one-stop shop' is significant because some people, particularly the elderly and the vulnerable, honestly do not know where to go, where to turn or who to speak to in times of need.

Referrals GPs refer a patient to Valleys Steps (either by providing them with a telephone number to call or the addresses of the community centres across the Health Board), where they can discuss their concerns with a member of the team who can signpost them to the most appropriate service. 30% referrals are via GP Practices, the rest from other providers in the communities.

Duration the stress and mindfulness course lasts six weeks (1.5 hours a session).

Project Team Lead by Project Team members drawn from a variety of backgrounds but all with considerable experience in psychology, human behaviour or counselling.

Funded Welsh Wellbeing Fund; Big Lottery; SLA with Cwm Taf UHB; supported by The Welsh Institute of Health and Social Care (WIHSC),

Evaluation Annual Year End Review for Cwm Taf UHB. Full quantitative assessment, linked to anti-depressant prescribing planned and supported by WIHSC.

4.3 SHARING THE LEARNING

4.3.1 PRIMARY CARE ONE WALES - SOCIAL PRESCRIBING WEBPAGES

The webpage hosts resources and information relating to the evidence for social prescribing, activity mapping by health board area across Wales and wider information (Figure 3)

Figure 3: Social Prescribing Webpage (Primary Care One**)**

4.3.2 NATIONAL AND REGIONAL EVENTS

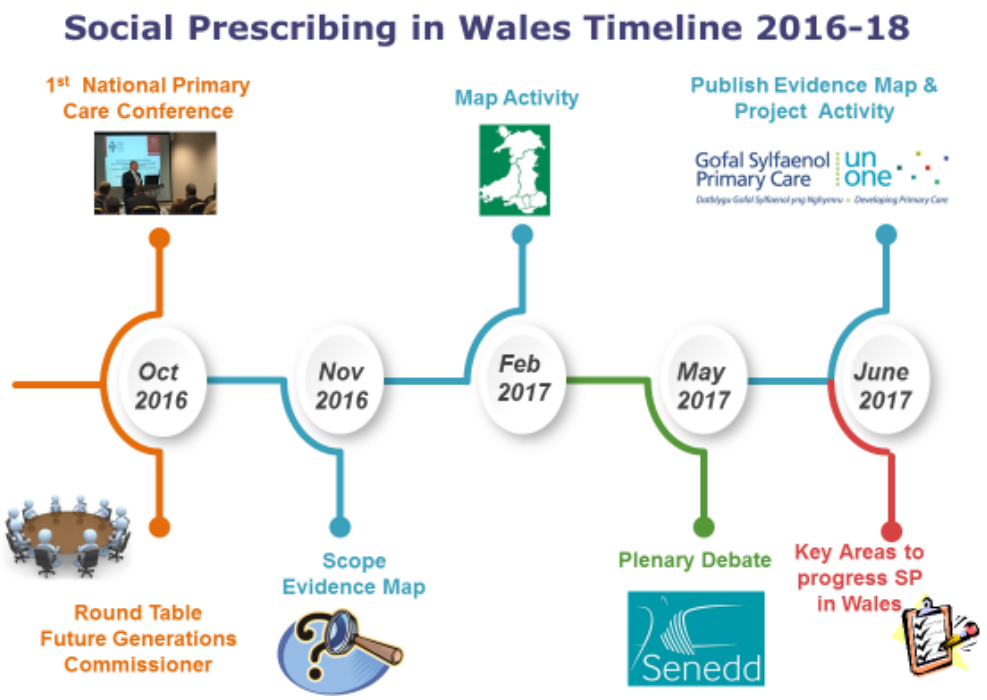
There have been a number of events during the last 18 months which have raised the profile of Social Prescribing in primary care. Many of these events have been organised by the Primary Care Hub whilst others have been Health Board events with input from the Primary Care Hub/ Social Prescribing Project Group.

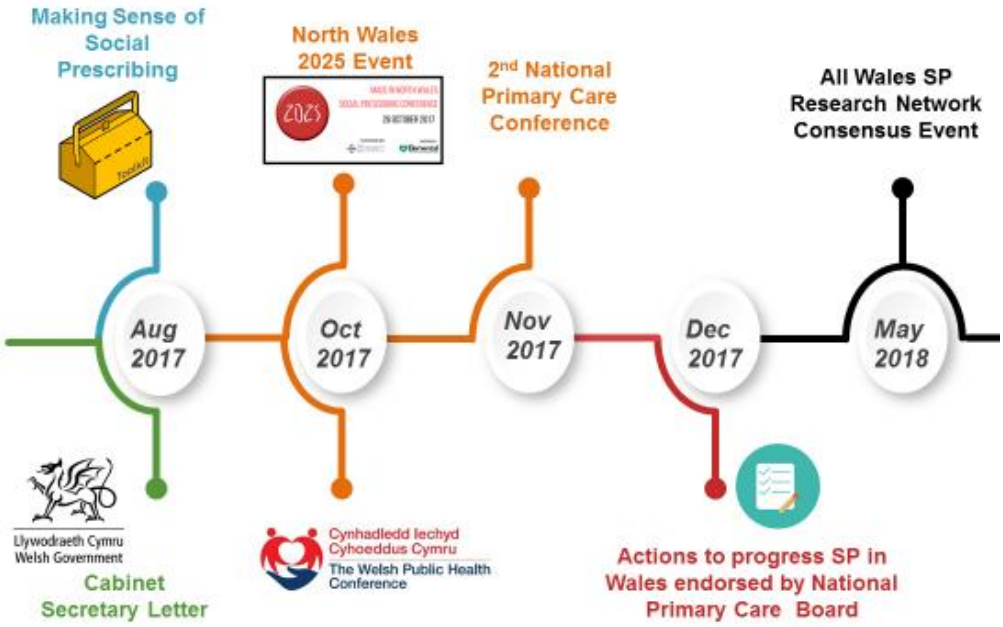
A timetable of these events is given in Appendix C.

At each of the events, the Primary Care Hub issued Flyers to raise awareness of Social Prescribing (Appendix D) and demonstrated the Social Prescribing webpages on Primary Care One.

The opportunity was also used to capture information about Social Prescribing projects, to add to the Primary Care One Repository as well as establishing a network of interested contacts.

4.4 SOCIAL PRESCRIBING IN WALES TIMELINE 2016-18





5. SOCIAL PRESCRIBING BY HEALTH BOARD AREA

Social Prescribing Contacts and Project Group members in each Health Board provided the following summaries, providing a snap-shot of local activity.

HYWEL DDA

There is a range of activity across Hywel Dda University Health Board that falls within the 'social prescribing' umbrella. There is engagement and investment from GP clusters within each County, and established partnership working that is embedding a range of 'alternatives to prescription' within primary care, social care, community, and voluntary organisations. Innovative evaluation methods such as 'Most Significant Change' are being implemented with support from Swansea University, and research into the role of the link worker is underway with Aberystwyth University. The Local Public Health Team are developing a Community of Practice' (CoP) for those involved with social/green prescribing, as well as those who identify their role as supporting community resourcefulness. The purpose of the CoP will include support around evaluation, training, funding, sharing of best practice and resources, and the development of peer support networks across geographical and organisational boundaries.

CARDIFF & VALE

Across Cardiff and Vale of Glamorgan, a number of initiatives are being developed including the following highlights:

South West Cardiff Cluster is developing a sustainable approach to social prescribing through engagement with all members of the Cluster, including community organisations, at Cluster meetings and via facilitated workshops at a CPET session. A mapping exercise has been undertaken and an action plan agreed. The future planning of a sustainable model incorporating existing initiatives is the focus of the project being undertaken by a Welsh Clinical Leadership Training Fellow who is working with the cluster under the supervision of the Cluster Community Director for 12 months from August 2017.

Initiatives being evaluated include:

- A social prescribing system has been established by ACE (Action in Caerau and Ely) to enable primary care to signpost patients to local services and projects within the western area of the cluster. ACE also delivers two mental wellbeing courses 'ACTion for living' and 'Stress Control'. It is hoped to extend these courses to all areas of the cluster.
- The Grow Well Project. Following a successful bid to the Neighbourhood Partnership Fund, Cardiff SW Cluster has collaborated with a local charity, Grow Cardiff to establish a gardening project within one of the GP practices in the cluster. This is the first of its kind in Wales and the group is supported by a gardener who promotes health and wellbeing through a variety of projects centred on the garden. The aim is to support patients through physical exercise, healthy eating and mental health. An additional benefit is to promote GP surgeries as a focus for wellbeing rather than focussing on ill health and the traditional medical model. Following the initial pilot phase, the project is being extended to other areas of the cluster following a successful bid to the Innovate to Save Fund. The R and D phase of this project will allow more in depth evaluation including the cashable savings resulting from the project. These will form the basis of the next phase of the grant, which will be to extend the project across the Cardiff and Vale UHB area.
- An innovative approach to social prescribing is currently being developed in order to establish a sustainable system for social prescribing across the cluster. The project is the result of a

collaboration between the cluster and the charity SPICE and formed the basis for a successful bid to the Innovate to Save Fund, which is supported by Nesta (an innovation foundation) and Cardiff University. The project will deliver Time Credit social prescribing in the Cardiff South West Cluster, initially to three practices in the cluster during the pilot phase. Time Credits are a well-established community currency that enables an asset-based approach to community development and encourages active citizenship via earning and spending in the network. In Cardiff 120,000 hours of Time Credit have been earned by community members engaging in volunteering opportunities in 171 groups across the city. The project will allow the outcomes of social prescribing to be evaluated in terms of benefits to patients, primary care staff and also the economic benefits in terms of cashable savings. The role of the social prescriber will also be evaluated and this will inform future standards and training associated with this rapidly expanding role. It is hoped that the information gained will help to inform a sustainable model for social prescribing which may be applicable across Wales.

East Cardiff Cluster established an informal system with East Cardiff, Llanedeyrn and Pentwyn Communities First prior to the ending of the Communities First Programme.

The Well-being 4U Team is a primary care based well-being service funded by the UHB for 2 years (using Welsh Government primary care funds). The UHB commissioned United Welsh to deliver the service via a team of dedicated wellbeing co-ordinators working as part of the extended primary care team. The service is provided across three GP clusters including 20 practices to support individuals' wellbeing, and improve patient access to community activities and services. The Clusters receiving the service are City & South, South West Cardiff and Central Vale. Other clusters have used non-recurring monies to commission short -term services from the team.

Community Well-being Coaches, part of the Barry Communities First Cluster, provides activities centred on the key topic areas of physical activity, food and health, smoking, mental health and sexual health. Referrals are received from mainly primary care teams and schools.

ANEURIN BEVAN

Integrated Well-being Networks (IWNs) provide the strategic approach to social prescribing for Gwent, across health and social care and will enable better integration of well-being services with Primary Care. The Public Health Team has reviewed the elements of IWNs already in place across Gwent, and have made recommendations for taking IWNs forward. These have recently been agreed by Regional Leadership Group, with Integrated Partnership Boards overseeing a programme of work to progress IWNs on Neighbourhood Community Network (NCN) footprints during 18/19. It is recommended that this programme will include the following three elements:

1. Place-based Integrated Well-being Networks (IWNs)

Development of place-based IWNs that bring together well-being services collaboratively on NCN footprints (i.e. healthy living, mental well-being, secure home and finances, working, learning and participation). Partners representing these wider well-being services will become core members of NCNs with a clear purpose of creating good links with the place-based IWNs.

2. Linking Roles

Developing capacity across the workforce to ensure patients can be linked effectively with local well-being services, based on a three tier 'care navigation' competency framework. To support this, *Dewis Cymru* will be fully populated with well-being services in every area, as the online platform for social prescribing; GP receptionists will be offered Reception Navigation training in order to signpost to other agencies; existing 'linking roles' will be reviewed in order to ensure GP surgeries have an identified link role attached to the surgery for those individuals who need more intensive support than just signposting; a care navigation competency framework and training for the well-being workforce across Gwent will be agreed, including alignment with the developing Health and Social Care Academy.

3. Health and social care hubs

Ensuring new and existing health and social care hubs (e.g. Integrated Health & Social Care Resource Centres and Primary Care Health & Well-being Centres) play a key role as part of integrated well-being networks, providing appropriate community based well-being services and access to information, advice and assistance.

ABERTAWE BRO MORGANNWG

Clusters in ABMU HB recognise the added value of the Third Sector and the need, through a prudent healthcare approach, to support patients for social and non-medical issues which could impact upon their health and wellbeing in the longer term. As such Clusters have commissioned through dedicated funding schemes, Third Sector and other partner agencies, to deliver on this agenda. Some of this work has been mainstreamed to be delivered via other funders or the community themselves. This includes:

- Primary Care Children and Families Support Service
- Social Prescribing Link Worker & Local Community Coordination Links
- Carers Centre Helpdesks
- Citizens Advice in Primary Care practices
- Training Cluster Pharmacists in Social Prescribing
- Training Frontline staff in Social Prescribing
- Asylum Seeker support worker
- Close cluster working with Local Area Co-ordinators
- Third Sector counselling for Young People and Adults
- Action for Elders and Red Café to help manage social isolation
- Down to Earth programme to support low level mental health and learning disability needs
- Development of patient information leaflets
- Undertaking of patient questionnaires to assess their perception of value of social prescribing
- Healthy Homes Projects
- Dementia Café & Dementia Swimming
- HALO Diet & Exercise Support

A range of other smaller grants have also been awarded including Care and Repair Western Bay, Swansea Carers Choir, Stroke Association, Ty Croseo Clydach.

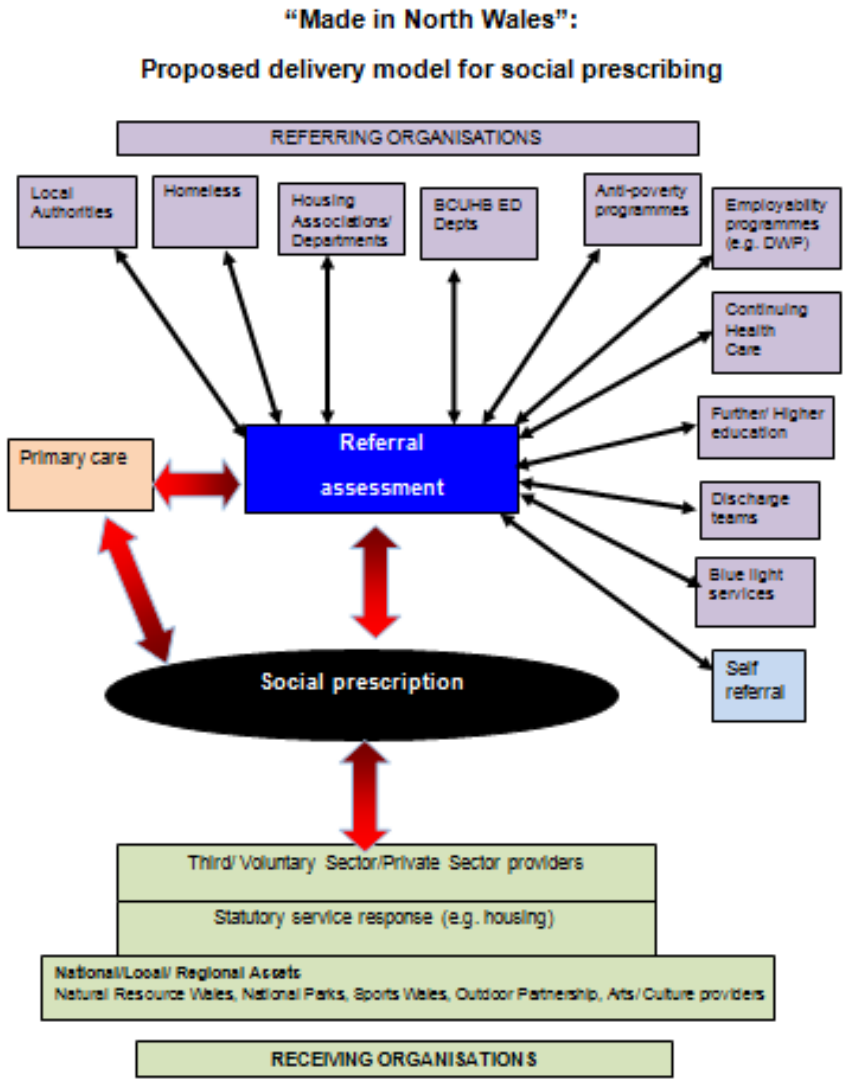
Clusters continue to expand and improve their approach to social prescribing.

"MADE IN NORTH WALES" SOCIAL PRESCRIBING PROGRAMME

Work is on-going in North Wales to build a regional profile for social prescribing. The "Made in North Wales" approach aims to open up the referral routes into social prescribing, whilst also building the knowledge base for increasing the number of options individuals can access.

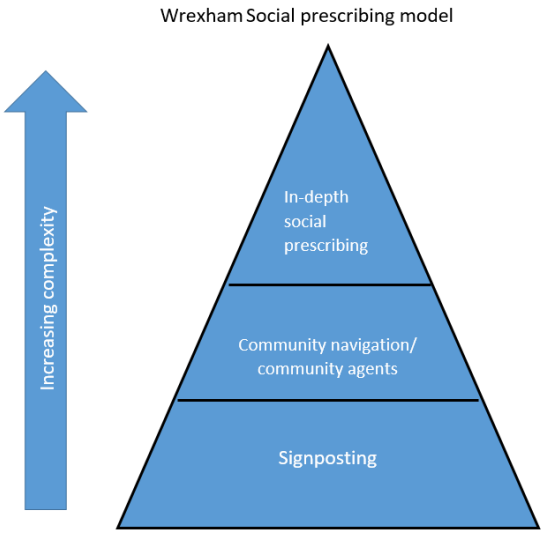
A number of unrelated, largely un-coordinated social prescribing programmes have been established across the region. Over the next 12 months, there will be greater co-ordination and refining of the different models, with a greater emphasis on targeted interventions within specific communities.

Each area will develop its' own integrated system, ensuring that the programmes are tailored to the needs of individuals and communities, and reflective of the identified needs. In providing greater co-ordination, the aim is to develop a multi-agency focus, and a model that is both broad in scope, but can demonstrate how the different elements and programmes can work in tandem:



Examples of work in North Wales include:

Wrexham – the development of a 3-tier model, encompassing initial signposting, community navigation, and a service for those individuals with more complex needs who require additional support:



In Ynys Mon, a model developed by utilizing the Integrated Care Fund, GP cluster monies and 3rd sector funding, will provide a team of 5 Local Area Co-ordinators, who will work across the island to provide a comprehensive social prescribing programme.

Underpinning the different elements will be:
- A multi-agency steering group, reflecting the broad spectrum of referring agencies.
- A unified data collection system
- A practitioner network, which will also identify future education and training requirements.
- A robust monitoring and evaluation programme, particularly around social value.

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

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

CWM TAF

Primary Care Clusters in Cwm Taf are engaged with a range of initiatives that actively link patients to support in their community. These projects have developed to meet locally identified need and include Third Sector based Community Coordinators funded via Intermediate Care Fund working with practices and a range of Cluster funded roles based in General Practice that support and signpost individuals with varying levels of social and non-clinical needs. Work is planned to co-ordinate and refine the different models, with a greater emphasis on targeted interventions within specific communities.

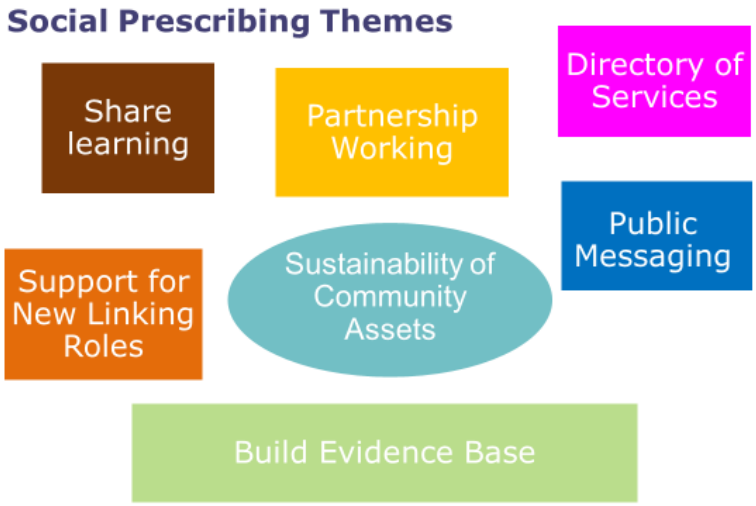
Practitioners across Cwm Taf will be supported by a South East Wales Community of Practice which will operate across geographical and organisational boundaries.

POWYS

The Powys Association of Voluntary Organisations (PAVO) are currently working on placing Health and Wellbeing Co-ordinators within communities throughout Powys, whose roles are going to be focussed on accumulating information about local third sector organisations and working with Virtual Wards and Multi-Disciplinary Teams within those communities. Community Connectors continue to identify gaps in support across Powys, working closely with PAVO Development team and Powys Volunteer Centre, third sector and statutory service colleagues to look at how the sector can meet these demands.

6. KEY THEMES AND RECOMMENDED ACTIONS

During the course of delivering the three commitments, linking with the Social Prescribing Network in England and contact with interested parties in Wales, the Primary Care Hub multiagency social prescribing project group identified key themes to be addressed:



Within these themes, there were several areas for action highlighted:

Theme	Action
Share Learning	**Mapping & sharing learning** from existing social prescribing work to generate ideas and enable primary care clusters and partners to collaborate and learn from each other in a systematic way
Build Evidence Base	**Access to and use of evidence base** to enable easy access to findings of published literature & experience drawn from grey literature. **Research** to address the gaps in the evidence base together with the development of an **Evaluation framework/ toolkit** to enable structured, meaningful evaluation of local projects to inform learning and identify successful approaches
Directory of Services	**IT solutions** to host and maintain information on services/ assets available in the community to enable easy referral and access
Partnership Working	**Support at local level to develop approach to social prescribing** A successful approach to Social Prescribing needs to be developed locally by partners to meet local need, utilising available assets; approach needs to reflect variation in maturity of local partnership working

Support for new roles	**New roles to deliver joined-up approach** New models and roles have and will continue to emerge to effectively sign-post/ link individuals to the appropriate asset/ wellbeing service in the community. These roles will require funding and training support for the staff
Public Messaging	**Public message around social prescribing and links to other initiatives** The success of the social prescribing approach will depend in part on patients' acceptance of a non-medical solution/ community referral; would ultimately anticipate that citizens would self-refer/ manage/ seek solutions from within their community as alternative to approaching GP. There is opportunity to progress this through the Implementation of the Emerging Model for Primary Care.
Sustainability of community Assets	**Sustainability of community assets** Social Prescribing is dependent on the existence of assets or well-being services in the community to support and meet needs of individuals

6.1 ACTIONS AND PROGRESS TO DATE

The recommended actions were endorsed by the National Primary Care Board (December 2017). The detailed actions and an update of progress to May 2018 are attached as Appendix E. The following are being raised with the Board in June 2018.

PROGRESS HIGHLIGHTS

Generic Evaluation Tool – The Primary Care Hub developed a generic tool for use by Primary Care Clusters and partners. Training events on accessing evidence and use of the evaluation tool were delivered to Primary Care Clusters during September /October 2017

Research & Evaluation – An All Wales Social Prescribing Research Network was launched in Cardiff City Stadium on 21 May 2018. This will be led by Dr Carolyn Wallace, PRIME and hosted by WCVA. This has been made possible through a small research capacity building grant from the School for Social Care Research. The network will identify and support research priorities for Social Prescribing in Wales, addressing the need for evaluation of projects and gaps in the evidence base.

Sharing Information - Having successfully completed the three actions, the Primary Care Hub role going forward will be to maintain the Social Prescribing web pages on Primary Care One Wales. This has been included in the Hub work plan for 2018-19 and will be picked up through the regular PC One Wales update work. This arrangement will however need to be reviewed in light of other web developments going forward e.g. Research Network website.

Local Support – Three Communities of Practice to support practitioners and others working or interested in social prescribing are in the process of being set across Wales (North, West and South East), with support from 1,000 Lives.

Links to Social Prescribing Initiatives outside of Wales Strong links have been established with the Social Prescribing Network in England, Scotland and Ireland. Academic links to areas of Europe have also been developed.

AREAS REQUIRING FURTHER ATTENTION

Health Board planning commitment – following on from the Cabinet Secretary letter to Health Boards (August 2017) urging bodies "*to use the PHW work on social prescribing to inform their research proposals and plans to develop better ways to link people to well-being care and support*" and the inclusion of social prescribing in the NHS Planning Framework (October 2017), it would be timely to establish the commitment of Health Boards to Social Prescribing in their IMTPs.

Sustainability of Community Assets – Community services and support are the foundation of social prescribing. Often provided by the Voluntary Sector and Charities, the funding is short term in nature. Uncertainty of ongoing funding for these assets has been highlighted as one of the major risks to social prescribing.

Sustainable Community Assets has been identified as a key component of the Primary Care Transformation Framework. However, the sustainability of these services is dependent on funding. To achieve a successful transformation of primary care that includes communities and third sector partners, a sustainable solution to funding this provision must be found.

A third sector response to the recent Parliamentary Review of Health and Social Care in Wales prepared by the WCVA highlights:

Social prescribing needs to be clear in providing designated funds to small groups which are providing 'care closer to home'. This type of organisation is usually volunteer-led and run, may not have the capacity to dedicate to grant-seeking or fund-raising. Without recourse to an accessible, designated 'pot', the demand resulting from increasing 'social prescriptions' will exceed supply and provision will cease.

Anecdotal feedback from third sector organisations highlights a need for a greater understanding of LHB and Cluster funding for the third sector and co-ordination between third sector services that are commissioned by LHBs and Clusters. In addition, County Voluntary Councils (CVC's) are well placed to be able to enable relationships to build and ensure that local third sector provision is developed to meet local needs.

Developing Roles – the Transformation of Primary Care (TPC) Programme has identified new roles in primary care. In relation to social prescribing there are various titles attributed to such roles – community connector, co-ordinator, social prescriber, link worker etc. The governance and training needs of these roles need to be addressed. (Some insight has been obtained through a recent survey of Primary Care Reference Group members).

Directories of Services – work is being progressed to bring together *DEWIS Cymru, Infoengine* and *NHSD* databases. Awareness of the resource and how to access it should be raised amongst Primary Care Clusters to maximise its use.

APPENDIX A: SOCIAL PRESCRIBING PROJECT GROUP

Name	Organisation	Role
Shareen Ali	Aneurin Bevan UHB	Public Health Practitioner
William Beer	Aneurin Bevan UHB	Primary Care Cluster Lead and Consultant Public Health
Rhian Bond	Cardiff & Vale UHB	Head of Primary Care
Gemma Burrows	Aneurin Bevan UHB	Principal Public Health Practitioner LPHT
Karen Chambers	Flintshire County Council	Wellbeing & Partnership Lead
James Duckers	BCUHB	Project Manager
Russell Dyer	Public Health Wales, Primary Care Hub	Project Team Manager
Victoria Edwards	Hywel Dda UHB; South Pembs Cluster	Locality Development Manager;
Jennifer Evans	Aneurin Bevan UHB	Senior Health Promotion Specialist LPHT
Rosemary Fletcher	PHW, Primary Care Hub	Programme Director
Maria Gallagher	Public Health Wales 1000 Lives	Senior Manager 1000 Lives
Jane Holloway	Public Health Wales, Primary Care Hub	Project Team Programme Support
Wayne Jepson	Public Health Wales 1000 Lives	Person Centred Care Lead
Wendy Jones	BCUHB Conwy	Conwy Voluntary Services Council
Sue Leonard	Pembrokeshire Association of Voluntary Services	Chief Officer
Carol Owen	PHW, Health Improvement Team	Principal Health Promotion Specialist
Sian Price	Public Health Wales Observatory	Head of Observatory Evidence Service
Diana Reynolds	Welsh Government	Sustainable Develop't Change Manager
Glynne Roberts	BCUHB	Well North Wales Programme Director
Ian Scale	HDUHB	Consultant in Public Health LPHT
Sara Thomas	PHW Primary Care Hub & Cwm Taf LPHT	Social Prescribing Lead, Public Health Consultant
Sue Toner	C&V UHB LPHT	Principal Health Promotion Specialist
Bethan Williams	BCUHB	Support voluntary and community groups
Victoria Wood	HDUHB	Senior Public Health Practitioner LPHT

APPENDIX B: SUMMARY EVIDENCE MAP – KEY MESSAGES

The Public Health Wales Observatory Evidence Service produced an evidence map and narrative summary to enable the Primary and Community Care Development and Innovation Hub to share evidence related to the effectiveness and practice of social prescribing in support of colleagues looking to implement these interventions within primary and community care settings across Wales. The Summary report of the Evidence Mapping and a supporting Technical report were published June 2017 and are available on Primary Care One Wales.

The evidence map looked at social prescribing and explored the question *How, why and in what circumstances might targeted, non-clinical interventions, services or programmes benefit the health and well-being of individuals and families with social, emotional or practical needs?*

Evidence mapping identified two types of evidence. These were research evidence assessing the effectiveness of interventions and evidence from experience: the lessons learned from the experience of designing and implementing intervention programmes.

Based on the needs that were targeted, two main types of non-clinical programmes or interventions were identified:

Schemes targeting psychosocial needs, including link worker programmes (schemes linking people to a facilitator who assessed them and referred them on to sources of support in the community), community arts programmes, a horticultural programme and referral to welfare rights advice. The research evidence base for these programmes is largely characterised by before-and-after evaluations without comparison groups. This means that the evidence base is insufficient to robustly answer questions about their effectiveness. However, the evaluations of these programmes contain much evidence on the experience of designing and implementing programmes.

Exercise referral schemes and commercial weight loss programmes intended for those who are sedentary and/or overweight or obese. The research evidence base for these interventions is characterised by evaluations using a control group. It should be possible to answer questions about the effectiveness of these programmes, although these evaluations contain little evidence on the experience of designing and implementing programmes.

Key messages about the design and implementation of interventions, services and programmes

Evidence from the experience of those setting up programmes suggests that the time required to establish social prescribing schemes is often underestimated.

Where social prescribing is new to primary care staff and their patients, evidence from experience suggests that it is important to engage with both groups. Primary care staff need to understand the services and interventions available and what they can offer. Patients need to understand why they are being referred and what benefits are anticipated.

Many evaluations note the need to establish a clear referral pathway, with documentation that supports assessment of eligibility and evaluation. Evidence from experience suggests that the social prescribing referral process should integrate with existing referral processes and be simple to use. Feedback to referrers on the outcome of this was seen to encourage appropriate referral.

Many evaluations report difficulties in collecting outcome data. Evidence from experience suggests that evaluation and data collection to support this should be considered when programmes are set up. A particular issue was the expectation that community and voluntary organisations would collect outcome data. This may require them to set up processes to do this and may be particularly difficult when community and voluntary organisations do not receive specific funding to take part in social prescribing schemes.

Evidence from experience suggests that a link worker model where post-holders are employees rather than volunteers might be the better option for a flexible service able to support patient need. Resources are necessary to recruit, train and support link workers. Experience from link work and other programmes where staff are not experienced in working with people with mental health problems suggests additional training will be required to ensure this client group is provided with the support needed to fully engage with interventions.

Those involved in social prescribing initiatives in Wales should be encouraged to maintain a lesson log to help facilitate onward dissemination of learning no matter what is ultimately achieved.

Key messages about the research evidence base

Many evaluations report that a substantial proportion of those referred do not take up or do not engage with or complete the intervention offered. Research could be undertaken to identify barriers and facilitators influencing uptake and adherence, actions to mitigate these barriers, and suggest how interventions might be targeted more effectively.

Models for link worker schemes varied. Some were based in general practice (GP) premises and were seen as members of the primary care team, while others were based within voluntary organisations or saw clients in their own homes. Research could help to identify the best model to encourage appropriate referrals and investigate whether the model used has an impact on uptake of and engagement with interventions delivered.

Research could consider the extent to which link workers are the active ingredient in social prescribing, in some schemes, the link worker role is intensive, involving in-depth assessment of clients. In some examples, this includes motivational interviewing and goal setting. Some link workers make appointments on behalf of clients with the services to which they refer, and may accompany participants to appointments or activities. Some are in regular contact with participants and offer ongoing support. The extent to which the link worker–participant relationship is in itself a psychosocial intervention could be explored.

This evidence mapping exercise was informed by a theory of change which postulates that social prescribing interventions lead to a reduction in demand for primary and community care, which would in turn increase the long-term sustainability of the system. The evidence map suggests that there is insufficient evidence, in terms of both its likely quality and the outcomes reported, to be able to answer this question. Under these circumstances, with the goal of improving population health and well-being, appropriate attention should also be directed towards alternatives to social prescribing initiatives where the evidence base for intervention may be more robust, and the return on investment proposition more certain.

APPENDIX C: EVENTS

Date	Event	Location
16th March 2017	Green Health Event	Aberystwyth
8th May 2017	Social Prescribing: from rhetoric to reality	Kings Fund London
11th May 2017	Aneurin Bevan Primary Care Cluster Event	Newport
26th October 2017	Made in North Wales (Focused on North Wales Stakeholders, but open event)	Mold
26th / 27th October 2017	Public Health Wales Conference	Celtic Manor Newport Gwent
16th November 2017	National Primary Care Conference	Swansea
21st May 2018	All Wales Social Prescribing Research Network (Launch and Consensus event) Invited attendance of stakeholders across Academia, Statutory and Voluntary Sectors	Cardiff

APPENDIX D: FLYER

Canolfan Datblygu ac Arloesi Gofal Sylfaenol a Chymunedol
Primary and Community Care Development and Innovation Hub

Social prescribing

What is social prescribing?

Recognising that people's health is determined primarily by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way by improving access to wellbeing services and community assets.

Who is involved in social prescribing?

Social prescribing, sometimes referred to as community referral, is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. Social prescribing schemes often involve a link worker or navigator to connect individuals to the most appropriate community support.

Where does social prescribing take place?

Social prescribing schemes can involve a variety of activities which are typically provided by voluntary and community sector organisations.

Why social prescribing?

In addition to supporting individuals to take greater control of their own health, social prescribing schemes may also lead to a reduction in the use of NHS services.

Public Health Wales' Primary Care Hub has coordinated the delivery of three commitments to social prescribing:

1: Mapping of evidence for social prescribing

2: Collation of information about social prescribing activity in primary care across Wales

3: Regional and national events to develop and share learning

All these resources can be viewed on the social prescribing page on the Primary Care One website.

If you'd like to share information on social prescribing projects in your area, get in touch: **PrimaryCare.One@wales.nhs.uk**

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

For more information visit:

www.primarycareone.wales.nhs.uk

APPENDIX E: ACTIONS TO PROGRESS SOCIAL PRESCRIBING IN WALES (PROGRESS UPDATE MAY 2018)

Access to and use of evidence base The PHW Observatory was commissioned to map the evidence for Social Prescribing (SP) Evidence (published June 2017). Both the summary report & technical document can be accessed at Primary Care One Wales website together with links to other evidence reviews and reports. No further request for evidence reviews has been received.		
Action	**Lead**	**Progress**
None, but scope to commission further work if required	**N/A**	**N/A**
A. Mapping & Sharing Learning The Primary Care (PC) Hub undertook mapping of SP activity at Primary Care Cluster level (Dec 2016 –Feb 2017). Projects reported by Heads of PC/ Clusters are hosted on Primary Care One Wales. As mapping was undertaken within primary care only, it did not necessarily pick up all of the initiatives that were Local Authority (LA) or Third sector led. Hence PC webpage repository is not an exhaustive repository of all SP projects across Wales. During 2016/17 the PC Hub has supported sharing of learning at regional and national events.		
Action	**Lead**	**Progress**
1. Set up and maintain Primary Care One Wales Social Prescribing web-pages as an on-line repository with links to wider resources; actively encouraging the sharing of projects and evaluations for inclusion in the central repository for SP; Pro-actively share SP in Wales news via PC One Wales Newsletter	Primary Care Hub	Website formally launched October 2017. Ongoing maintenance of web pages and repository is included in Primary Care Hub work plan for 2018/19; Future of PCOne SP web pages/ repository will need to be reviewed in light of other developments that might offer this function e.g. All Wales SP Research Network (hosted by WCVA)

B. Support at local level to develop approach to Social Prescribing A successful approach to SP needs to be owned and developed locally by partners to meet local need utilising available assets and in a way that takes account of variation in maturity of local partnership working.		
Action	**Lead**	**Progress**
2. Encourage and support PC Clusters to link with local partners (e.g. Third Sector and LAs) to join up approaches locally through cluster development initiatives	Directors /Heads of Primary Care	There has been a widespread endorsement of promoting local ownership and development of SP; skills programmes such as *confident leaders* support this work; SP given a high profile at Primary Care national conferences (2017 & 2018) and championed by National Professional Lead for Primary Care Importance of primary care "linking to sustainable community assets" has been identified in the framework and work plan of the *Transformation of Primary Care Programme*
3. Public Health support for linking to wellbeing services in the community: Make available facilitation and co-production expertise for local multiagency events (on a Regional Partnership / Health Board footprint) to progress SP and if required, initial support to help Health Boards set-up a local forum/ Community of practice using a co-production approach. Access to PHW support through Directors of Public Health (DsPH) /Local Public Health Teams	PHW (Directors Public Health, PHW 1000 Lives and Health Improvement Team working together to support local approach)	1,000 Lives has previously supported a number of approaches and initiatives at cluster/ locality/ neighbourhood level. A number of established fora exist e.g. Cartrefi Cymru, Big Lottery funded Co-production Network; Green and social prescribing Network. PHW Health Improvement Team also engaged with Third Sector and CVCs across Wales in 2016/17 to identify their development needs identifying local partner engagement and social prescribing.

		December 2017 Meeting of DsPH endorsed Local Public Health Teams support for Primary Care Clusters providing link to wider PHW resource and local Partners. Patient Centred Care team of 1,000 Lives have committed to provide expertise to establish a Community of Practice for Practitioners in South East Wales (June 2018) with links to similar recently formed networks in North (BCU) and West (Hywel Dda)
4. Identify Health Board vice-chairs as local champions for social prescribing	Vice Chairs Local Health Boards	Vice Chair of BCUHB has championed SP among the Vice-chairs group; Cabinet Secretary and Minister for Social Services and Public Health joint letter to Chairs of Health Boards, Regional Planning Boards, Public Service Boards and CEO's Local Authorities and WCVA (August 2017) re linking people effectively to well-being care and support; NHS Planning Framework Guidance for health Boards (October 2017) urges NHS organisations in their Integrated Medium Term Plans (IMTP's), to "*use the work by Public Health Wales to inform research proposals, plans to develop better and sustainable ways to link people to well-being care and support, and public messaging to promote the use of well-being care and support*"
5. Explore connections with interested groups and national fora e.g. Cymru Well Wales, Social Care Wales, WCVA, Future Generations Commissioner Office to support national and local working.	PC Hub	Numerous conversations to make connections among stakeholders and align interests and work programmes (including Public Health Conference 2017; National Primary Care Conference 2017 and round table conversation chaired by Future Generations Commissioner for Wales (October 2016))

		Formation of All Wales Social Prescribing Research Network (May 2018); Formation of regional Communities of Practice as a mechanism to connect interested parties/ stakeholders of social prescribing (2017/2018)
6. Facilitate sharing of successful strategic approaches from outside of Wales	PC Hub	Established formal links with University of Westminster and Social Prescribing Network in England. UK News and activity shared widely within Wales via PCOne Newsletter. Connections made to research networks outside of UK. Formation of All Wales Social Prescribing Research Network and Community of Practice as a mechanism to connect interested parties/ stakeholders (May 2018) Use of PCOne as repository of projects
C. Evaluation Framework/ Toolkit Enable structured, meaningful evaluation of local projects to inform learning, identify successful approaches with potential for scaling–up (inform business case) and/ or further study (research grant submission) Recognise need to commission and share learning from independent evaluations. Development of a common outcome framework would assist identify system–wide benefits; consistent use of validated measurement tools would allow impact on individual wellbeing to be captured.		
Action	**Lead**	**Progress**
7. Encourage and support evaluation of SP projects through development of framework and skills	PC Hub	A generic evaluation framework for cluster initiatives was developed by PC Hub; workshops delivered on how to use the framework with applicability to social prescribing

		(September/ October 2017). Resources available on PC One
8. Identify need for SP–specific outcome measures that could enhance evaluation /Common Outcome framework (captures wider impact and value of social prescribing to all stakeholders)	Academic Lead	A priority area identified by the All Wales SP Research Network (May 2018)
9. Explore mechanisms to support evaluation	Academic Lead with support from NWIS	A priority area identified by the All Wales SP Research Network (May 2018)
10. Template to capture evaluation which could form basis of business case to mainstream successful pilot projects	Directors of Finance	DoFs developed an approach to identifying impact of primary care activity on secondary care (NPCB Feb 2018);could consider developing this further
11. Identify nationally agreed clinical **READ or SNOMED codes** to capture SP activity in primary care record	NWIS/ Cluster Leads/ AMDs for Primary Care	Awaiting new codes

D. Research

Gaps in the evidence base for Social Prescribing (SP) are acknowledged; there is a place for developing successful feasibility projects into larger scale controlled research studies. Collaboration through an academic network could enable faster learning, resolution of common problems experienced e.g. ethical approval and also attract funding for robust studies.

Independent evaluations of SP initiatives have previously been undertaken by Academic Institutions in Wales, but there has been no formal mechanism for sharing findings.

Action	**Lead**	**Progress**

12. Develop an approach that would bring academics together to support practitioners undertake evaluation and identify opportunities (and funding) for high quality research	Dr Carolyn Wallace, PRIME	Projects underway in Wales funded by NESTA 'innovate to save' fund, Health and Care Research including award of projects to be tested as part of WG commitment to a pilot of SP in Mental Health. Links with UK Social Prescribing Research Network (University of Westminster) and Academic Network established. School for Social Care research Capacity Grant secured to set up All Wales SP Research Network, hosted by WCVA and lead by Dr Carolyn Wallace (Launch May 2018)
E. IT Solutions (Directory of Community Assets & referral/ linkage mechanisms) Mechanisms to host and maintain information on services/ assets available in the Community i.e. an up to date directory of services that can be easily accessed by all stakeholders (including the public) in a timely manner. This may in time be developed to include a referral mechanism and service user rating function etc. Access to current information on wellbeing services available in the community was identified as an important function early on, and highlighted in the SP and Wellbeing service round-table conversation chaired by the Future Generations Commissioner for Wales (October 2016).		
Action	**Lead**	**Progress**
13. Development and integration of systems used across health social care/ third sector to host information on services/ assets available in the community;	National DOS Group	A National Group has been established to oversee development and integration of systems used across health/ social care/ third sector (DEWIS, INFOENGINE, NHSD 111 Directory, ReferNet, DoIt). Within NHS Wales this is being linked to the roll out of 111 and each Health Board will have a DOS co-ordinator to update service details for inclusion on the NHSD database. The focus for NHS Wales will be the population of NHS Direct (WAST)

		DOS and a lead has been appointed to update information from local services. The website has already been updated as has the on-line symptom checker. There is also a working group to provide a "technical" link between NHSD, DEWIS and INFOENGINE, with the latter two system links being the first priority and will be operational by July 2018. The final link between NHS Direct DOS and DEWIS Cymru is being finalised and joint content shared by November 2018.
14. Communicate vision and progress with directory developments to Primary Care Clusters to inform planning for Social Prescribing	NHSD 111 Project Primary Care IT Board National Primary & Community Care Board	Letter from Director General (June 2017) to NHS Organisations and Local Authorities re single Directory of Service Project in Wales to consolidate and combine existing directories into a single health and social care entity. *DEWIS Cymru* presence at Primary Care National Conference (October 2017) and Public Health in Wales Conference (September 2017); the creation of single directory of services also highlighted to Primary Care and partners during plenary sessions and presentations.
15. Explore further development of the system e.g. interface between the DoS facility and GP Clinical Systems and potential role of GP One; SP activity recording/ evaluation tool	NWIS/ Primary Care IT Board/ PC Hub	Being scoped for feasibility

F. Workforce

New models and roles have emerged to sign-post/ link individuals to the appropriate asset/ wellbeing service in the community. They have been attributed a range of titles such as Community Connector, Wellbeing Co-ordinator, Social Prescriber, Link Worker etc. There is recognition that the training and development needs of individuals undertaking these roles needs to be identified and supported, as well as issues around governance and indemnity.

Consider:

- Developing national role profiles for the new link worker roles;
- Data sharing, indemnity and governance
- Short term nature of funding e.g. ICF, Cluster development monies
- need for robust evaluation of role to establish what works and how which would underpin longer term funding/innovative resourcing

Need to make link to regional Social Care Workforce Development Plan and Emerging Models of Primary Care (Transforming Primary Care programme)

Action	**Lead**	**Progress**
16. Include new SP connector/ link worker roles in the workforce development action plan of the Implementation of Emerging Model Group supported by Health Education Improvement Wales (HEIW). Specific areas to address: • employment and governance arising from cross-sector working • Data sharing, indemnity and governance • Collation of Social Prescriber/ Link worker JDs and role profiles	IEMG (now Transforming Primary Care Group) and HEIW	Social Prescribing identified as one of the new roles to include in PCRG survey of primary care workforce which will seek to capture the role's contribution to improving access (April 2018) It is not known how many Social Prescribers (or equivalent) are employed in Primary Care; the role is not recorded on ESR for health board employed staff, and there is currently no means of robust primary care workforce data collection. WEDS compendium of Primary Care Roles and Models hosts some case studies and associated job descriptions in its job description library, none of which have been subject

		to the Agenda for Change process. Job titles include: Community Health Prescriber; Healthy Lifestyle Advisor; Care Facilitator; Active Monitoring Practitioner. The All Wales Primary Care Healthcare Support Worker (PC HCSW) Development Group is taking into consideration the education and training requirements for non-registered primary care staff. There is potential for this group to consider academically accredited education and training for the development of these new roles. Links can be established with new forums convened for social prescribing to inform any future work on this.
17. National approach to information governance and data sharing agreements between health and social care	NPCB/ PCCRG	Directors of Social Services (Claire Marchant, Monmouthshire CBC) has developed an agreed approach which can be shared as a template.

G. Public Message and links to other initiatives

The success of the SP approach will depend in part on patients' acceptance of a non-medical solution/community referral. One would anticipate that in due course, citizens would self-refer/manage/seek solutions from within community as an alternative to approaching GP

There is a need to link SP to other related national and local initiatives to ensure consistency of public messaging. There are many related initiatives that complement this approach (and even have potential to cause confusion if not aligned). Awareness raising and behaviour change can be achieved through alignment with existing Prudent HC programmes.

Examples of related initiatives in Health Care include:

- Making Choices Together (formerly Choosing Wisely Wales)
- Educational Programme for Patients (EPP)
- Making Every Contact Count (MECC)
- Choose Pharmacy Minor Ailments Schemes
- CVD Health Checks

All of the above have a role in achieving success in the Transformation of Primary Care		
Action	**Lead**	**Progress**
18. Communicate and promote social prescribing (use of wellbeing services) among professional groups, public and across sectors by linking to other public messaging campaigns	NPCC Board, Primary Care Reference Group, LHBs	The Transforming Primary Care Framework and Plan include reference to sustainable community assets and linking patients to these assets including wellbeing services in the community. Opportunity for inclusion in local cluster and health board developments as part of response to Parliamentary Review (2018)
19. Explicitly align social prescribing with Making Choices Together, Asset Based Community Development, Co-production, shared decision making initiatives delivered by PHW commitment to Prudent Healthcare. Help professionals and public internalise SP through inclusion of principles in delivery of related programmes e.g. MECC Explicitly align social prescribing/ community asset linkage with other initiatives such as MECC, Community Empowerment Principles	PHW 1000 Lives Team (Patient Centred Care) PHW Health Improvement Division	Work underway within 1,000 Lives
H. Sustainability of Community Assets and SP The sustainability of SP is dependent on the existence of assets or well-being services in the community to support and meet the needs of individuals. These range from volunteer- run walking groups to employment or debt advisory services. Historically community assets have		

been underutilised. However, as the sign-posting or linking of individuals to the assets improves, the demand will increase. Often funding is short-term. Current Funding sources include: PC Cluster development Money; Intermediate Care Fund (ICF) or SLAs with Third Sector; Charitable organisations or one-off project monies. WG Innovate to Save fund includes social prescribing as one of its themes.		
Action	**Lead**	**Progress**
20. Explore potential role of well-being bond to sustainably fund local wellbeing assets	WG (Public Health)	Stakeholder Workshops held 2017 to scope ideas
21. Apply collaborative (Community of Interest) approach of interested organisations / stakeholders at a national level to mirror and support local approach enabling the identification of once for Wales products and solutions (interested parties include: Citizens' Advice Bureau, Natural Resources Wales, CVCs, WLGA (Dirs Social Services), WG, Academia, WBFG Commissioner Office, Time Credits (e.g. SPICE), NHS (Primary Care & HBs), PHW Observatory	Championed by Vice-chairs as part of TPC agenda; Potential role for Cymru Well Wales (to be confirmed)	Progress here is limited; The All Wales SP Research Network identified "sustainability" as one of its priority areas