UNDERSTANDING SOCIAL PRESCRIBING IN WALES: A MIXED METHODS STUDY.

A final report

Carolyn Wallace, Mark Davies, Megan Elliott, Mark Llewellyn, Hayley Randall, Jonathan Owens, Jodie Phillips, Leanne Teichner, Sam Sullivan, Victoria Hannah, Bethan Jenkins, and Amrita Jesurasa.

Wales School for Social Prescribing Research (WSSPR) · PRIME Centre Wales · Data Cymru · Public Health Wales

September 2021

University of South Wales Prifysgol De Cymru

Canolfan PRIME Cymru PRIME Centre Wales

Ysgol Ymchwil Rhagnodi Cymdeithasol Cymru WSSPR Wales School for Social Prescribing Research

Data Cymru

GIG CYMRU NHS WALES Iechyd Cyhoeddus Cymru Public Health Wales

Llywodraeth Cymru Welsh Government

ACKNOWLEDGEMENTS

The team would like to thank Public Health Wales for coordinating this grant collaboration and to the Social Prescribing Connected Communities Coordinating group for their valuable input. This is an important study which has generated some understanding of social prescribing in Wales. Also, to Data Cymru for building, distributing, analysing, and reporting the online survey. The whole study was only possible thanks to the involvement and commitment of the social prescribing practitioners, managers, commissioners, and other stakeholders who willingly gave their time to participate in the online survey, the focus groups and workshop.

EXECUTIVE SUMMARY

Social prescribing in Wales is defined as *'connecting citizens to community support to better manage their health and well-being'* (Rees et al, 2019). It is a person-centred approach to empowering an individual to better manage their health and wellbeing through a number of activities (SCIE, 2020). There are multiple models of social prescribing working in Wales with practitioner roles based in places such as local authorities, third sector, housing, higher education, and primary care; and social prescribing activities most commonly based within third sector and community spaces.

The aim of this work is to understand the landscape of social prescribing activity across Wales, and where possible, to quantify and describe its functions. To meet this aim we used three methods to achieve an all-Wales representation, mixed methods online survey comprising of 61 questions and yielding n=130 responses from n=89 organisations, focus groups (n=6) with a total of n=33 participants and a single workshop with n=30 participants.

The synthesised findings underpin four key messages:

1. **Variation in provision of social prescribing across Wales provides both opportunities and challenges.**

   Social prescribing is utilised, defined, and runs variably across Wales. Most social prescribers are based in the Local Authority and third sector organisations with few based in primary care. There are accordingly therefore differences in underlying philosophy, approach and delivery which may need to be surfaced, addressed, and rebalanced. That is not to say that there has to be a centralised 'offer', but that this variation may act as a rate-limiting factor on the impact of social prescribing. This could be exacerbated when seen in the context of the confusion and lack of awareness within the public of what social prescribing can offer and the varying terminology used. There is an opportunity here for sectors to work together and ensure a coherent, seamless social prescribing service which meets the needs of its local and national population.

2. **Social prescribing is a 'growth' activity, and expectations of it are high**

   Social prescribing is increasingly seen as a solution to a number of the challenges within communities across Wales. There is a commitment to expanding social

prescribing capacity and in some areas the scope of the role that it plays. There is also a commitment to developing pathways that are focused on holistic approaches which place people at the centre and are integrated with existing and statutory services across sectors. This is a real challenge to deliver upon and there are issues to be duly considered so that social prescribing reaches its potential. One such issue pertains to the growing social prescribing workforce; their employment contracts, how the workforce is managed locally and how social prescribing is coordinated nationally.

3. **Technology key to the future of social prescribing, especially as the pandemic persists**

Social prescribing, at its heart, is a relationship-centred form of support. It relies on the connection between individuals. COVID disrupted the emergent social prescribing models to such a degree that it is important to recognise that 'remote' forms of social prescribing will be an important and core feature of its ongoing evolution and development for many years. Finding ways that technology – whether in systems, or in ways of making remote connections between individuals – works for people is central to social prescribing's growth. Using a digital directory and digital platform across pathways will ensure that social prescribing services are person centred and responsive to changes required in the future.

4. **Resources, as always, are fundamental to sustaining the social prescribing pathway**

Concerns were expressed throughout the study about the 'fundamental problem of the funding model' and the challenges for sustainability that this brings. A variety of routes have been used to resource social prescribing services to date, but there are serious concerns that without guaranteed or at the very least much longer-term funding settlements in place for both social prescribing services and the community assets, the promise of social prescribing could be undermined.

The following eight recommendations are made:

- The planned national framework should be embedded across Wales to provide a national vision for social prescribing whilst promoting a standard model, terminology, and structures that support it. This would raise professional and public awareness and reduce confusion.

- Local/regional organisational structures and partnerships should consider the role of a social prescribing champion to drive regional social prescribing strategy and coordinate communication throughout the pathway.
- A whole system approach to developing and delivering the social prescribing pathway which is informed by intelligent commissioning should be adopted both locally and nationally.
- To review the role and scope of the social prescriber to understand what should or should not be included within it and its points of referral onto other services such as mental health and social work teams as appropriate.
- To provide a professional infrastructure for the social prescriber which includes for example a suite of job descriptions, salary guide, skills and competency framework, supervision requirements, appropriate and recognised training, and education opportunities.
- To evaluate the usability of national single digital directories for Wales (such as DEWIS and InfoEngine); and digital platforms used across the pathway (e.g., Elemental) to manage referrals, collect national core service activity, individual outcome measures. This will ensure that the specific needs of the social prescribing services are being addressed.
- To reconsider the funding model used for social prescribing to promote a sustainable pathway for the future.
- To repeat this research study in the next 5 - 10 years to further understand the progress made in establishing and developing social prescribing services across Wales. In addition to triangulating the findings of this report with a 'deep dive' investigation at one University Health Board geographical area and in collaboration with Shared Services Partnership and the Wales National Workforce Reporting System (WNWRS).

CONTENTS

1. INTRODUCTION AND BACKGROUND

Professor Carolyn Wallace and the team at the Wales School for Social Prescribing Research (WSSPR) and PRIME Centre Wales, based at the University of South Wales (USW), have been working in partnership with Data Cymru and Public Health Wales to quantify and describe the functions of social prescribing in Wales. The study was funded and coordinated by Public Health Wales within the context of Welsh Government (2020) '*Connected Communities: a strategy for tackling loneliness and social isolation and building stronger social connections*'. Where Welsh Government committed to further support the development of social prescribing schemes across Wales through four deliverables. The first is being addressed by this report:

- *To undertake a baseline survey to understand social prescribing in Wales.*

Social prescribing in Wales is defined as *'connecting citizens to community support to better manage their health and well-being'* (Rees et al, 2019). We recognised some time ago that there were multiple models of social prescribing working in Wales with practitioners based in places such as local authorities, third sector, housing, higher education, and primary care. We understand that it is a person-centred approach to empowering an individual to better manage their health and wellbeing through a number of activities (SCIE, 2020). These involve the use of a strength-based approach often including a 'what matters conversation', co-producing an action plan, engaging with local community assets, and managing feedback loops (Figure 1). We define community assets as service groups or activities that an organisation refers individuals to through social prescribing (e.g., choir, walking group, etc.).

Throughout this report the term social prescriber will be used but this is intentionally used interchangeable with other terms such as community connector, wellbeing worker, link worker etc. It refers to any person performing social prescribing activities.

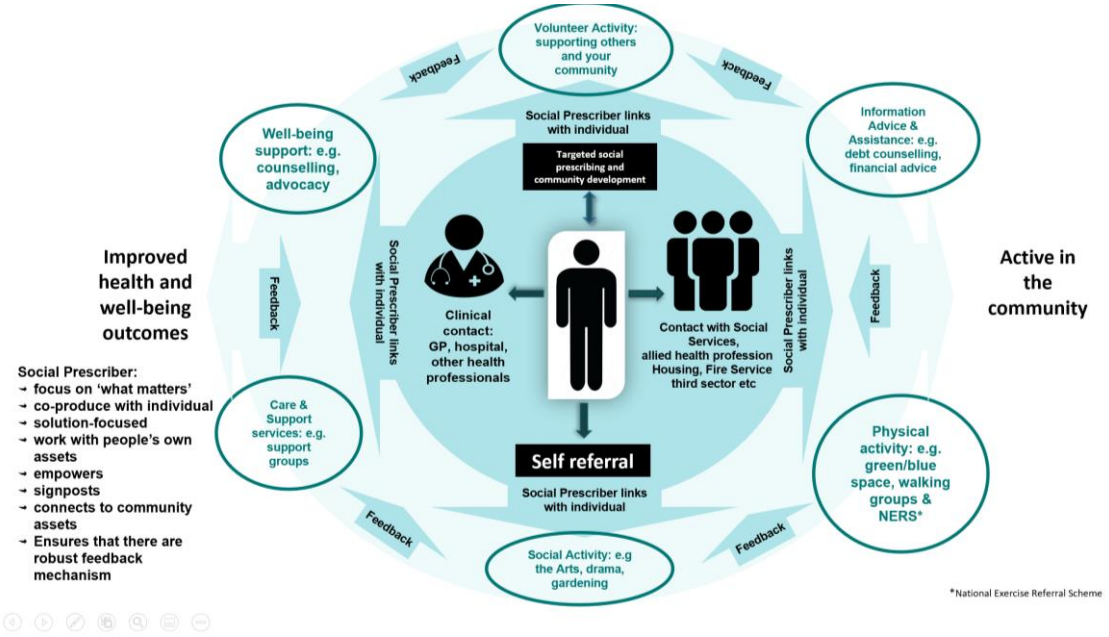


Figure 1. Social prescribing in Wales (Rees et al, 2019)

This report summarises the key findings and provides some recommendations for the future.

BACKGROUND TO THE STUDY

Social prescribing is a multi-dimensional concept of intervention and prevention which seeks to support and promote the health and well-being of the population (Moffatt et al., 2017). Social prescribing has been conceptualised and defined differently in different contexts and different nations (Husk et al., 2016). Whilst the primary care model of social prescribing, in which individuals are referred from general practice into social prescribing, is dominant in the literature and in England, other community-based models have emerged and are becoming more commonplace. The Welsh definition and model of social prescribing moves away from this medicalised approach, instead proposing social prescribing as a community-based holistic intervention (Rees et al., 2019). As such, individuals may access social prescribing through primary care, but are more likely to access social prescribing via community resources, social care and third sector, or self-referral. The model seeks to empower individuals to recognise their own needs and access support within their communities. To date, social prescribing services and community assets in Wales have been developed from the bottom-up, in an organic way, due to short-term funding within the voluntary and community sector.

The aims of social prescribing interventions recorded in the literature and reported anecdotally are wide-ranging, although improved mental, social and physical well-being is the most commonly

reported (Rempel et al., 2017). This encompasses aspect of psychosocial health, healthy lifestyles and behaviours, resilience, social engagement, and self-management of long-term conditions.

In Wales, well-being is at the forefront of the health, social care, public health and third sector agendas, and is central to key policies and legislation. Key Welsh legislation: the Well-being of Future Generations (Wales) Act (Welsh Government, 2015) and Social Services and Well-being (Wales) Act (Welsh Government, 2014) have a profound impact on how well-being is being understood, enhanced, and promoted across Wales. Social prescribing represents a mechanism for furthering these agendas and achieving the well-being goals set out within these Acts. It also facilitates working across health, social care and the third sector to achieve a preventative and holistic approach to population and individual well-being, as set out in *A Healthier Wales* (Welsh Government, 2017).

The concept of social prescribing has received significant political attention and cross-party support (Senedd debate June 2017; Welsh Government, 2021) and Welsh Government first proposed expansion of the community health and social care workforce, by developing additional social prescribing roles in the community (*Prosperity for All;* WG, 2017*)*. This was further progressed in the *Connected Communities* strategy for loneliness and social isolation (Welsh Government, 2020) which committed to supporting the development of social prescribing schemes across Wales through four deliverables:

- Work with Regional Partnership Boards to identify the number and functions of social prescribing roles across Wales.
- Develop a national skills and competency framework for the social prescribing workforce in Wales.
- Develop and launch an online resource portal to support social prescribing activities in Wales.
- Continue to work in partnership to develop the evidence base and an outcomes framework for social prescribing.

The Welsh Government Programme for Government 2021-2026 commits to introducing an all-Wales framework to roll out social prescribing to tackle isolation. This research sought to understand current social prescribing activity in Wales to inform the development of this national framework.

2. METHOD AND APPROACH

The aim of this work is to understand the landscape of social prescribing activity across Wales, and where possible, to quantify and describe its functions. Since 2020, COVID-19 has changed the way in which social prescribing has been delivered. This report will therefore also comment on the way in which the pandemic has impacted on social prescribing projects and services in Wales. The study was completed between May and September 2021.

To achieve this aim the following methods were used:

MIXED-METHODS SURVEY

A mixed-methods survey of 61 questions in total yielding n=130 responses from n=89 organisations. This was distributed through the following mailing lists:

- Public Service Boards (PSBs)
- Association of Directors of Social Services (ADSS)
- All Wales Heads of Adults' Services Group (AWASH)
- Welsh NHS Confederation
- Wales School of Social Prescribing Research (WSSPR) and its associated Communities of Practice (West and North Wales) and networks (e.g., the Wales Social Prescribing Research Network (WSPRN),
- RIIC Hubs
- CONNECT Wales
- Welsh Council for Voluntary Action (WCVA) and its networks
- Public Health Wales networks including:
    - Heads of Primary Care
    - Primary Care Cluster Development Officer Support Network
    - Primary Care One (newsletter and twitter)
    - PHW comms
    - Allied Health Professional Networks
    - Strategic Programme for Primary Care

Some organisations provided a response, or series of responses, that covered the entire organisation. Other organisations provided a response, or series of responses, that represented only a part of the organisation. For example, only two of the four regional managers in an organisation may have

submitted responses. Therefore, entire organisations are not always fully represented in the results. The survey aimed to get the opinions of managers, commissioners, and practitioners.

Please note that by the very nature of a survey there are always limitations, and it is important to consider that this is not intended to provide a census of activity across Wales but provide a snapshot of what we understand about social prescribing.

FOCUS GROUPS

Focus groups (n=6) with a total of n=33 participants with representation from across Wales, comprising practitioners, managers, commissioners, and a member of the public. This gave survey participants and other people involved with social prescribing the opportunity to provide more detail on the survey themes. Participants were recruited through the Wales Social Prescribing Research Network, the North and West Wales Social Prescribing Communities of practice, CONNECT Wales and the local Aneurin Bevan Public Health Team.

The data was analysed using a thematic analysis (Braun & Clarke, 2006). It resulted in seven themes and are described in full in Annex B which is available upon request.

WORKSHOP

Finally, a workshop with a total of n=30 participants of key stakeholders, recruited via the Wales Social Prescribing Research Network, were asked to review the preliminary findings from the online survey and the focus groups. This provided them with the opportunity to make comment on the survey and focus group findings. The participants were then divided into three breakout rooms where the facilitators asked them to discuss the following questions:

1. Should the community asset development be part of the social prescribing role, and in what form?
2. There is a risk that services may evolve according to a funder's specific agenda, rather than local need. How should organisations address this risk?
3. What does your organisation contribute to the social prescribing agenda? How does your organisation engage with the NHS in delivering social prescribing?
4. The salary of social prescribers ranges from £16,000 - £32,000 and there are different models and levels of social prescribing (e.g., holistic approach integrated with statutory services vs signposting only). How should we reconcile these?

5. What networks, support, technology, and management are required to embed social prescribing in Wales?
6. Why do you think there were more survey responses in certain areas [see heat map]?

Further detail on the analysis and findings of each of these methods are available on request, *Annex A: Results from the Social Prescribing Activity in Wales Survey* and *Annex B: Results from the Social Prescribing Focus Groups and Workshop*. The key findings presented in this document are a result of a synthesis of the mixed methods used.

3. KEY FINDINGS

OVERVIEW OF SOCIAL PRESCRIBING ACROSS WALES

Social prescribing appears to be used and defined variably across Wales. Despite this, many of the organisations who responded to our survey have been delivering social prescribing since before 2011. This suggests that organisations practice social prescribing with varying purposes, levels of expertise and different user groups.

> *'I think that actually the social prescribing exists in various formats differently in each county' (Focus Group 2).*
>
> *'It's confusing as to who is where, which areas, what they cover, how many there are....so that has been a big stumbling block from our perspective' (Focus Group 5).*
>
> *'And its understanding of what their actual role is like I said there's a variety....you've had twenty job descriptions or whatever and a lot of different roles come through...if it's that complicated to those that are doing it, the ones sitting on the outside, we stand no chance of knowing' (Focus Group 5).*
>
> *'You know in the title what they do, isn't it? And I think that's where we have to start. We have to, have that title that says you're a social prescriber because we're all working and very much so many different titles right across Wales. And I think once you have that embedded, UM, you will identify clearly then who in those communities are delivering that social prescribing' (Workshop Breakout Room 3).*

There also appears to be significant confusion and lack of awareness within the public, with people unsure about exactly what social prescribing can offer them and terminology which stakeholders find confusing.

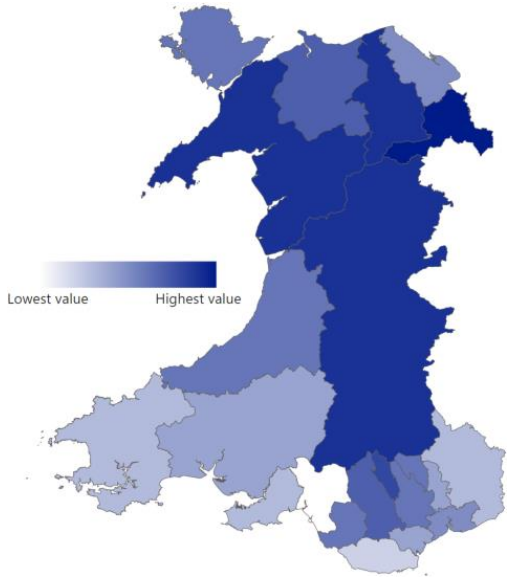
> *'People can be quite confused about who I am, why am I calling them' (Focus Group 2).*
>
> *'That's what's been confusing as well, yeah...there's been too many different names and it's like 'oh which ones do which' (Focus Group 4).*
>
> *'You know in the CVC's we do social prescribing but it was not called social prescribing and in the third sector we do exactly what they are doing but they are calling it social prescribing now they are talking about green prescribing (Focus Group 6).*

To better understand the landscape of social prescribing across Wales this report starts with two heat maps generated from survey data (See Figures 2 and 3). The first provides us with the number of organisations in each local authority providing social prescribing services. From this we can see that

Wrexham reports the highest with 19 and Neath Port Talbot the least with 9 organisations.

Figure 2: Total number of organisations that cover each local authority.

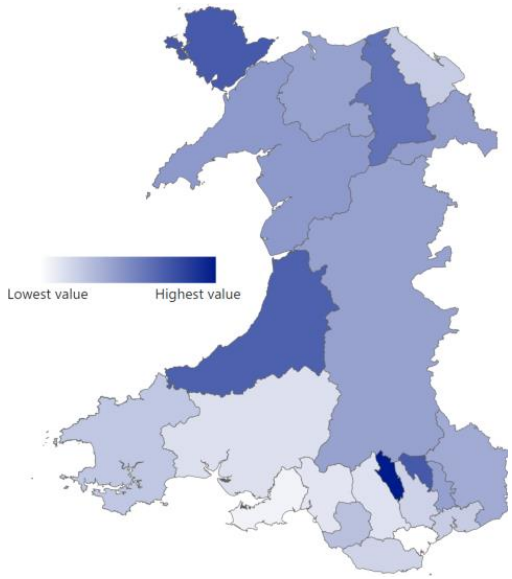
	Number of organisations providing social prescribing services
Isle of Anglesey	15
Gwynedd	18
Conwy	16
Denbighshire	18
Flintshire	14
Wrexham	19
Powys	18
Ceredigion	15
Pembrokeshire	12
Carmarthenshire	13
Swansea	12
Neath Port Talbot	9
Bridgend	15
The Vale of Glamorgan	11
Cardiff	13
Rhondda Cynon Taf	16
Merthyr Tydfil	17
Caerphilly	15
Blaenau Gwent	15
Torfaen	13
Monmouthshire	12
Newport	14



The second heat map provides us with information in relation to the size of the population i.e., the rate of coverage of social prescribing per 100,000 of the population. When we adjust for population in this way, we can see that Merthyr Tydfil (28.13 organisations) reports the highest number of organisations providing social prescribing services per head of population. Whilst Cardiff (3.52 organisations) reports the fewest organisations providing social prescribing services per head of population. The majority of organisations that responded were represented by the third/voluntary sector (n=32), the local authority (n=19) with only between 5-10 organisations identifiying as either health board, primary care cluster or GP surgery, others included housing, universities and well-being centre/hub.

Figure 3: Number of organisations that cover each local authority per 100,000 of the population.

	Number of organisations providing social prescribing services, per 100,000 of population
Isle of Anglesey	21.29
Gwynedd	14.38
Conwy	13.54
Denbighshire	18.62
Flintshire	8.93
Wrexham	13.96
Powys	13.53
Ceredigion	20.58
Pembrokeshire	9.47
Carmarthenshire	6.84
Swansea	4.87
Neath Port Talbot	6.23
Bridgend	10.17
The Vale of Glamorgan	8.13
Cardiff	3.52
Rhondda Cynon Taf	6.62
Merthyr Tydfil	28.13
Caerphilly	8.25
Blaenau Gwent	21.42
Torfaen	13.71
Monmouthshire	12.61
Newport	8.95



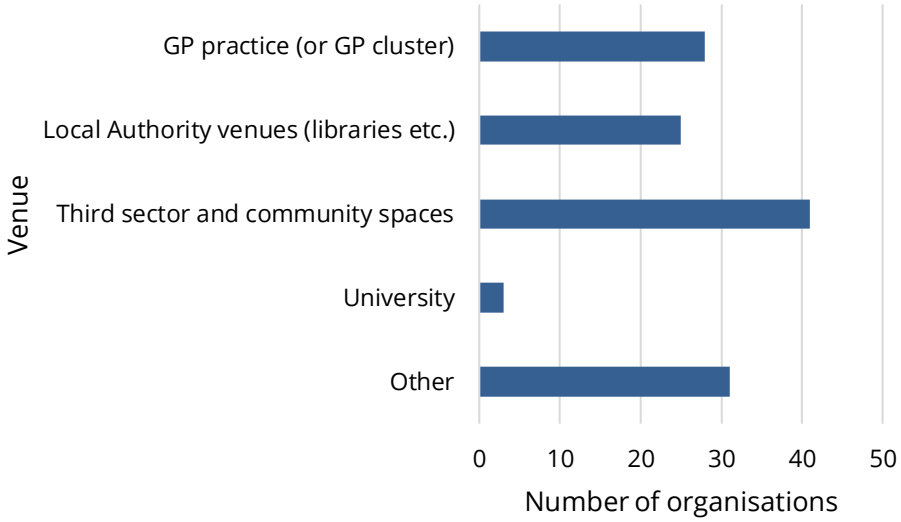
The survey also asked where respondents' social prescribing services were based (Figure 4). This question was asked of managers and practitioners, and again, we received 78 organisational responses.

Social prescribing activity was most commonly based within the third sector and community space, with 41 organisations indicating that this is where their social prescribing roles were based. There were 28 and 25 organisations which identified to have social prescribing roles based in GP practices and local authority venues respectively, and only 3 organisations which stated that they had social prescribing roles based in universities. Whilst the majority of organisations chose one venue type (n=46), we also received a number of responses (n=32) of two or more venue types from the given options.

Participants in the workshop commented on the heat maps suggesting that factors such as strategic drivers, cross sectoral working and local networks had influenced the results of the survey.

'I think we've got quite a few strategic drivers behind social prescribing in the area and we do a lot of cross sectoral working. So, the third sector is working in partnership like with the Health Board and I think it's quite strong and we have a network there we have. Hopefully everyone who's delivering a form of social prescribing attends our network. We share good practice up there. Well, school of social prescribing, research links, and so we're updating everyone all the time and I just think having someone driving it strategically really supports the development of social prescribing…. I know we did a local drive as well to make sure everyone who was delivering social prescribing to complete the UM the mapping exercise for this bit of research as well, so hopefully that's shown. And that's probably why we've got some high levels of social prescribing. Maybe compared to other areas where they may be delivering, but they just haven't completed the survey. But I think you definitely need that someone driving it strategically to make it a known agenda' (Workshop Breakout Room 3).

Figure 4: Number of organisations that have social prescribers based in each facility



Source: Social Prescribing Activity in Wales, by Data Cymru

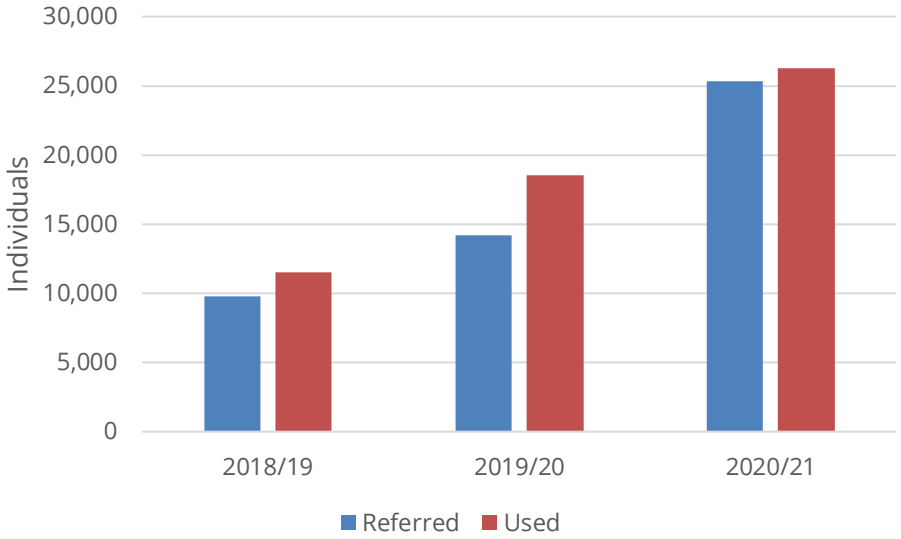
Managers were asked to provide data on the number of people referred to their services in the past three years and the number of people who used their services in the past three years. The number of organisations that provided a response was 45. For the three years that we requested data, we can see a clear year-on-year increase in referrals and use of social prescribing services (Figure 5). Self-referrals account for why those using services was greater than those referred.

This activity was reflected in the workshop discussions.

'So initially it's from social services and our relationship with GP practices and is very hit and

miss. Some buy into it more than others…. but we do get quite a few referrals through from GPS now. Uh, but it's self-referral tend to be the main thrust of people coming to us and friends of friends' (Workshop Breakout Room 2).

Figure 5: Number of individuals referred to and using social prescribing services in Wales, by year



Source: Social Prescribing Activity in Wales, by Data Cymru

THE SOCIAL PRESCRIBING MODEL

Looking broadly at services in Wales, there is a strong commitment to develop pathways that transcend signposting, offering a *holistic* approach (Kimberlee, 2015) that is fully person-centred and integrated with existing and statutory services across sectors.

'It's way beyond signposting you know, it's the relationship itself that is the intervention or that can be the intervention and can be the thing that makes a difference … the kind of catalyst for people to have an improved sense of wellbeing. But that person, once they've developed that relationship with whoever it is, they might then … within their role, signpost them to a particular organisation, or they might take them to a group or they might see a need within the community and set up a group looking within you know, working within the community's resources' (Focus Group 2).

'When something is person-centred, truly person-centred, and asset based you can't have a one size fits everyone because people are different, and assets are different, and you'll need slightly different things in different areas depending on your starting position' (Focus Group 2).

'We work on 3 levels so well; first level is signposting. The second is a case work…..There's no limit on how long we work with people, and although we try to avoid the dependency and the third level community development' (Workshop Breakout Room 2).

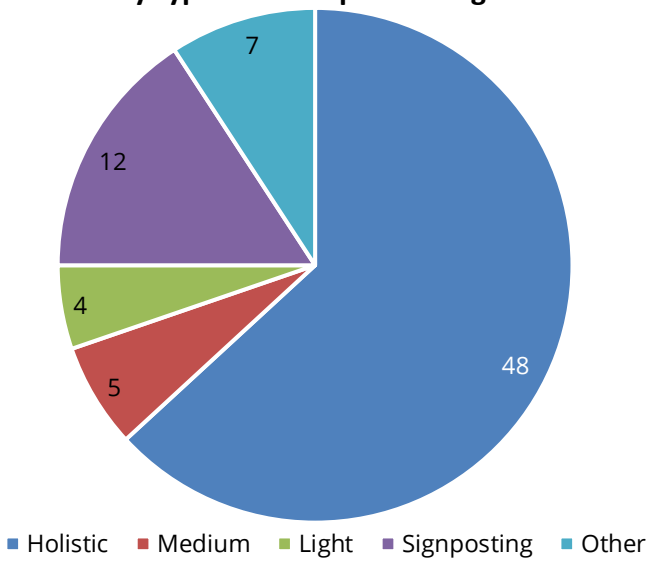
Using the following classification managers and practitioners were asked the type of social prescribing projects that they delivered, defined below (holistic is considered the most

comprehensive, and signposting the least).

- **Signposting**: the social prescriber only directs people to appropriate networks and groups.
- **Light**: the social prescriber engages in signposting and refers people to a specific programme to address a particular need or meet clearly defined objectives within a specified timeframe.
- **Medium**: the social prescriber provides signposting and support across a range of areas that may include both managing physical health and psychological well-being within a specified timeframe.
- **Holistic**: the social prescriber provides a broad range of interventions and connects the person to local services and networks. There are no limits to the number of times the person is seen; this is determined by a holistic assessment of the person's needs.

The results are shown in Figure 6, calculated from 76 organisational responses. The most popular response was Holistic, accounting for 62% of the response total.

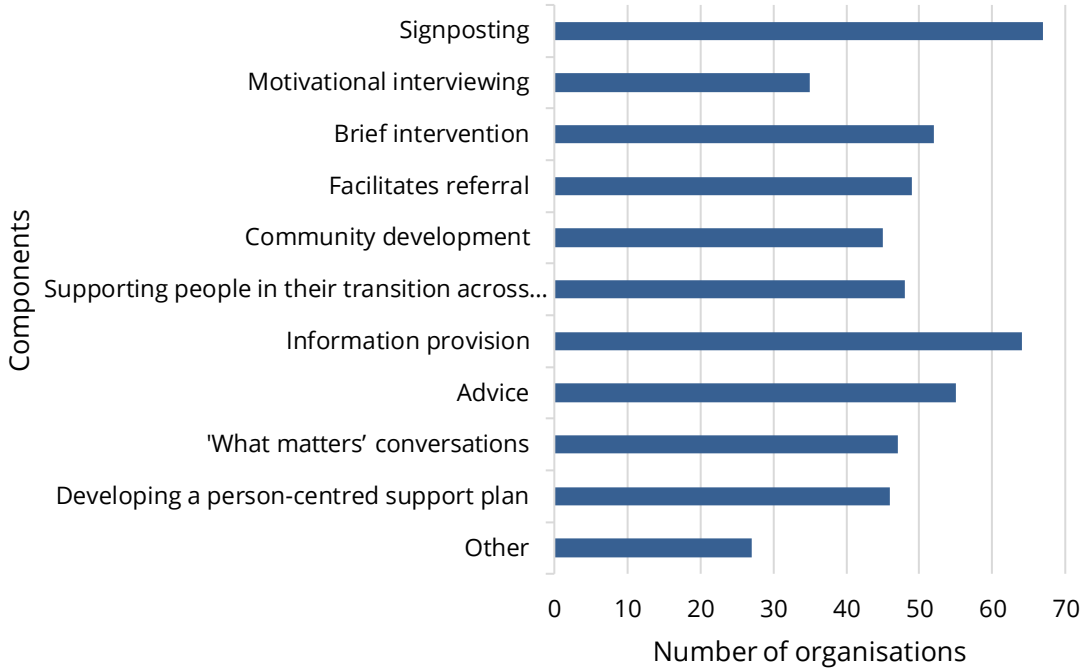
Figure 6: Number of organisations by type of social prescribing offered



Source: Social Prescribing Activity in Wales, by Data Cymru

The results are shown in Figure6, were calculated from 76 organisational responses. The data showed that the most chosen components of social prescribing were signposting and information provision, with over 60 organisations choosing each (Figure 7). The least chosen component excluding other was motivational interviewing, which had 35 organisations claiming to offer it. Each of the multiple-choice options had between 45 and 55 organisations select them as a service that they offer.

Figure 7: Number of social prescribing services offered by organisations



Source: Social Prescribing Activity in Wales, by Data Cymru

Time spent with people referred to social prescribing services varied depending on the organisational model and the needs of the individual.

> *'We have that 'what matters' conversation and once we pick somebody up, we will work with them however long it takes....so whereas other services say 6 weeks to 12 weeks, we actually work with people pretty much indefinitely' (Focus Group 6).*

An integrated model of social prescribing, which brings together multiple agents was praised as fitting together in order to be able to meet need.

> *'The model for us works really well, we have the social prescribers at the top in all the GPs then below that we have the community agents doing all the outreach, and then below that we just have the community, the amazing community with all the volunteers...so within our model it all fits together' (Focus Group 3).*

Whilst being integrated with existing services, the pathway is also seen by some as being an alternative to statutory provision. However, focus group participants were also mindful of the importance of avoiding duplication of provision.

> *'I think the principle of the early intervention/prevention self-caring agenda was that that would release pressure on the statutory services eventually and on health boards and the idea in terms of that whole systems approach was that that funding would come further down the path to the early intervention services so that....because you were relieving the pressure from the acute' (Focus Group 6).*

'Over the years I've found that the concept of it is tackled … from different directions and very often there is not a joining up and one doesn't know about the other … so … apart from it being … repeated shall we say, and perhaps like a waste of resource, there is no real joining up or there hasn't been, depending whether you are a statutory body or whether you are third sector organisation, I think you may go at it in a different kind of way as well' (Focus Group 4).

There are some concerns regarding the capacity within the social prescribing pathway and about sustainability, particularly with regards to the availability of community assets.

'I appreciate there are community agents but they are very thin when you actually look at 16 hours a week for whole community areas, so we can't be assuming that just because there's somebody in an area therefore they are being well serviced, we need to look at where the gaps are and that's a significant one I think where the community based services are not operating in those communities' (Focus Group 3).

'I think for me one of the key issues is that we talk about social prescribing and we talk about link workers, connectors, working with people and what matters to them, connecting them to the community but we very often ignore the other side of the equation which is the actual activity services, groups etc., that you are actually referring people into, that some point that will get saturated' (Focus Group 4).

This is exacerbated if clear guidance is not provided in relation to the appropriateness of the social prescribing referral. Where inappropriate referrals were made, social prescribers discussed the challenges of addressing needs and issues outside of their remit, which required more intensive, counselling services.

'We've had cases over the last, you know before Covid, where quite inappropriate referrals were made in, where somebody was referred in who were in perhaps quite an acute phase of their mental illness and was suicidal and you know it was completely inappropriate' (Focus Group 5).

'The idea was that the GP would refer to the social prescriber and the person would have a 45 minute slot and talk to the social prescriber and I think what happened on quite a few occasions was that actually once a person started speaking to somebody, that actually they were disclosing things that had happened to them in the past... you know domestic violence, sexual abuse, and this is just my personal view but I'm not sure that they were actually equipped to be able to deal with some of the aspects that were revealed to them and I think what happened was the 45 minutes wasn't long enough, so they were booking people in and almost becoming a counselling service which was not what was the social prescribers were set up to do' (Focus Group 6).

THE ROLE OF THE SOCIAL PRESCRIBER

The social prescribing workforce is growing with employees across Wales performing social prescribing as either their main role or part of their role. Salaries for individuals undertaking social

prescribing activity vary and managers are starting to think about how they should manage and provide professional support to what has become a key role in linking people with the community, developing relationships with people who need social prescribing in order to improve their own wellbeing.

The mean number of employees per organisation where their main role was social prescribing was 5.6 (See Table 1). The number of employees per organisations that performed social prescribing as part of their role was similar at 6.5.

Table 1: Number of employees by role indicated by all respondents

	Social prescribing is the employee's main role	***Social prescribing is a part of the employee's role***
Number of organisational responses	*48*	*41*
Total number of employees	*267*	*265.5*
Mean	*5.6*	*6.5*

Source: Social Prescribing Activity in Wales, by Data Cymru

We asked managers for annual salary (minimum salary offered, maximum salary offered, and the average) of social prescribing practitioners in their organisation. The results are shown in Table 2. Data on annual salary was calculated from 27 organisational responses. The lowest reported salary was £16,219, and the highest reported salary was £36,000. The mean and median salaries are £24,584, and £23,750, respectively.

Table 2: Annual salary information of social prescribing practitioners

	Minimum	Maximum	Average
Mean	£23,321	£27,784	£24,584
Median	£22,292	£25,481	£23,750

Source: Social Prescribing Activity in Wales, by Data Cymru

The workforce 'shouldn't be oversimplified' (Workshop Breakout Room 3) is made up of 'layers of social prescribers' (Focus group 1) who require professional support, supervision, training and managing effectively because of the complexity of cross sector working.

> *'And they do require professional support … we gave some training and some clinical supervision if they'd been traumatised by some of the experiences that they'd had, we wanted to offer them that, so we commissioned that, we bought it in with some grant money that we*

managed to secure (Focus Group 1).

'And that role, that manager's role is so key you know and I can't overstate that enough, in terms of making sure that those local links are made, people like yourself [participant name]....there's somebody...[name] would have got in touch....things like that, its having that time to go into meetings, make connections and talk to people and be involved in other programmes and other projects so that you can align things and I think it's that development role like you said [participant name], that's what's really key here because of the cross-sector working that's needed' (Focus Group 5).

Looking more specifically at the mechanics of the social prescribing role, three facets of the role are highlighted i.e., the referral or signposting (1), relationship building which ultimately leads to maximising the agency of the pathway user (2). Therefore, reconnecting them to their own community and improving their wellbeing (3).

'When you turn up, you actually find they've been devastated by their hospital visit or trip, it's not that they want this thing done, it's that they want that ear, they want that idea that they are not alone and some of these people are very alone, they don't have close family member and what's been really nice having said that is that we managed to form a relationship' (Focus Group 1).

'Beyond that [referrals] there's the relational bit, so it's then clearing out the sort of just doing what you can immediately but … that's not the end of it because really it's about building that....so that word relational is really important....so it is a bit of both but the important thing is the relation bit and actually seeing what you can do to connect that individual with other people in their local area as much as they can so they start to build networks of support around them' (Focus Group 2).

The value of simply listening and providing emotional support to the individual was highlighted repeatedly.

'A lot of times when you hear some of the stories, it comes down to people saying it was such a simple thing but just having somebody listen to me and somebody sort of give me the confidence to go to a group and then from that first step, people are able to take the next steps themselves but they wouldn't never of made that step without that support' (Focus Group 5).

'We very often start with one thing that comes up in the conversation about what really matters to them, what do they want help with or what do they want to explore and that leads into other things....so it's having that open ability to respond as well, so no constraints, I think that's what really worked well' (Focus Group 4).

Focus group participants also highlighted the strengths and assets-based approach, which social prescribers employed to empower people to get involved with their communities.

'Quite often the person might end up volunteering, they are joining a group but as an active

volunteer as opposed to a recipient of the service and actually that gets people, gets people meeting others and it also will increase somebody's increase of self-worth actually and that has a massive impact on individual wellbeing' (Focus Group 2).

'Our ethos is very much that we work with people's strengths and assets and enable them to access the community, get back in touch with their community, their hobbies, volunteering and hopefully in some cases employment' (Focus Group 6).

'We are very community based....so it's not about sitting in a GP surgery, it's not about sitting in an office, it's about getting out into a community building, going to a coffee morning, going to a library and it's about really engaging communities and again it's about speaking to volunteers and being very much community focussed' (Focus Group 6).

There was only one reference to social prescribing as a therapeutic interaction within one of the focus groups, in which a participant specifically talked about using therapy to influence behaviour change (*Focus Group 3*) and another in the workshop which discussed the need for knowledge and expertise for social prescribers to be able '*to provide a specialist help*' for people with mental health problems. This suggests that there is a need to review the role of the social prescriber (and its referral pathways) to understand what should or should not be included within it.

'So they are delivering talking therapy to patients to influence behavioural change and also to promote patients to independently have better self-care for themselves in terms of their medication, also in terms of anxiety and all the different lifestyle patterns that come off the support we offer but they also offer a support and referral service to additional services across the third sector and potentially back into health and social services to make sure people have a holistic response to whatever issues they present with' (Focus Group 3).

'I just I just feel so strongly that any model we have needs to take into account the time and the knowledge and expertise of the link workers and the capacity that they have to be able to provide a specialist help. So, alongside the community activities there might be things like need for counselling, anxiety management, mindfulness, things like that' (Workshop Breakout Room 2).

Whilst the 'linking' work of the social prescriber was acknowledged and described as '*stepping stones*' (*Focus Group 2*).

'Potentially like stepping stones so hopefully there will be an end result and that's to improve somebody's wellbeing and the stepping stones should link to improve somebody's wellbeing (Focus Group 2).

There is more than simple signposting within this role. The participants within the focus groups indicated a degree of criticality on the part of the practitioner in terms of co-producing an appropriate solution for pathway users following a 'what matters' conversation.

'They have a 'what matters' conversation and its 'what matters' to the individual rather than 'what matters' to us or as in terms of service provision' (FG2).

'For example somebody who is going to the GP all of the time couldn't really pin down what they wanted exactly and it turned out that they were lonely, isolated.....they were unhappy with their body weight, they'd put on a considerable amount of weight and all they wanted to do was to go back to swimming, so it was working with that individual to find out what exactly it was they needed' (Focus Group 4).

COMMUNITY ASSETS

Social prescribers refer to a range of community assets and sustaining them was considered a matter of importance. Both the focus groups and the workshop generated discussion about the *'fundamental problem of the funding model' (Workshop Breakout Room 2)* and concern about getting the economic model right to ensure a sustainable pathway.

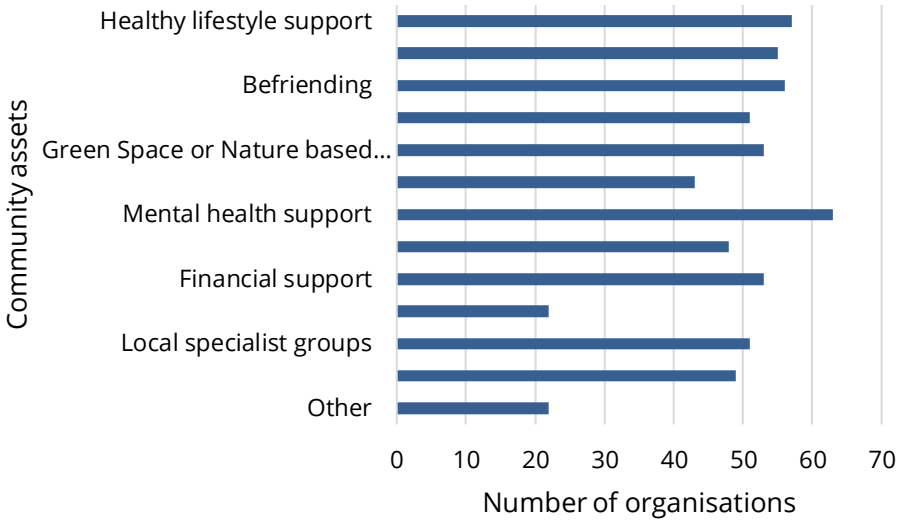
'There's no point us having loads of referrals from GPs to keep them out of GP's, out of [university health board], out of social services if you've got nothing in the community, the community has to be strong, and we use the assets are already there' (Focus Group 3).

'So, we need to ensure that the third sector and community groups even tiny grass roots ones are enabled to function properly so that part of what we do as well is the asset-based community development' (Focus Group 4).

'There may be sometimes that misconception that third sector I've got the staff there and there isn't. There's no core staff and a lot of third sector. Unless it's in, there's a sustainable funding model there, so you could have people referred in from social connectors in the future, but there'd be no, there'd be nothing to offer them because there's nothing on that end. The other end that it needs to be funded. So, without that sustainable funding coming in this way, there will be nothing in the community' (Workshop Breakout Room 2).

In the survey, social prescribers were asked which community assets their organisation refers people to. Respondents (managers and practitioners from 76 organisations) were free to choose as many as appropriate, and we can see a fairly even spread of all assets, excluding blue space activities (See Figure 8).

Figure 8: Community assets referred to by organisations



Source: Social Prescribing Activity in Wales, by Data Cymru

Community asset development was explored quite passionately across the focus groups and the workshop, and there is significant discussion present within the data regarding the difference between community asset development and service development. Whether community asset development should be a separate role or integrated within the social prescribing role was debated.

> *'I was a community development worker and its completely different to the role of a connector and I think that sometimes we are at risk of conflating the two things and I don't think they are the same and I think that asset-based community development practitioners are absolutely essential (Focus Group 2).*
>
> *'We do help the community groups because you can't expect the community to take all these referrals and support all these people, if they are not being supported as well. So, I think the community development and the social prescribing should always go hand in hand really, the way we work at it I think' (Focus Group 3).*
>
> *'The social prescribers don't do the community development work, the CVC staff do, so there is a clear distinction between them, but we recognise that there's a link between both elements' (Focus Group 3).*
>
> *'I see them [community connectors] as having, looking perhaps of the overall needs of our population, our sort of you know, looking at our population needs assessment really ok, what does our population need, and they are developing that across the board. The social prescribing work is targeted to individuals, whereas the community connector role is more generic across the population' (Focus Group 5).*
>
> *'I would say that community asset development is a key part of the role within social prescribing because he's sort of naturally identified gaps and by working with the referrals within the cluster you're working within' (Workshop Breakout Room 1).*

Despite the debate and varying perspectives, participants agreed that community development and asset development was critical to the success of social prescribing.

> *'And I don't know whether it falls within social prescribing in every context but there does also need to be that support for communities to come together and for groups to come together....so either that happens through the service, or it needs to happen alongside it' (Focus Group 5).*

Some of the participants had been involved in asset mapping within their localities. They all agreed that it was an essential component of social prescribing in order to ensure that the community asset was available to enable the social prescription.

> *'For me it falls a little bit short of what I would call community development, cos I do think that's....if you've done community development as a practitioner, it is different and it is needed because unless you've got strong resourceful communities, you've got nothing to connect people to, so it is important' (Focus Group 2).*

The perspective of the social prescriber and social prescribing team was considered valuable in being able to identify existing gaps in community assets and service provision and connect people and identifying people who may be able to address these. This was described as *'insider knowledge' (Workshop Breakout Room 1).*

> *'So we never, we don't set up a new group unless there is a gap that then we'll speak to that community and see if that community is there a gap for older men or younger children or...we wouldn't set anything up ourselves would we [name of participant], you know we'd go out to the community and say 'what are you missing', find that key person in the community, that says its missing and then they have a go to fill that gap, we'll support them, we'll try and do everything for free' (Focus Group 3).*

> *'Regarding the developing of services in communities, we are placed within the third sector to deliver our community connectors service and without the support of our colleagues, our development officer colleagues to be able to help support from identified needs to our locality networks, it's really hard to support those communities sometimes to develop, so that's where we are reliant on our development team to support us within that as community connectors (Focus Group 4).*

Furthermore, it was critical that these people worked together to create a more cohesive social prescribing system.

> *'And I think that's the conversations that you've just been having shown how difficult it is to have any one role that has all of it and actually I guess what we...the ideal would be to have a system that has these component parts within it but that are linked and work together' (Focus Group 5).*

During the focus groups it became apparent that some larger third sector organisations experience challenges when trying to link into social prescribing in Wales. They don't always know how to link into the pathway although some areas talked about '*speed networking events*'.

> *'within the sight loss sector there's lots of services … that could improve an outcome for somebody, make life easier and better hopefully so I would see it as a stepping stone and whether it's to a rehab officer, whether it's to the Macular Society, whether it's to an eye clinic liaison officer, the hope is once you hit one there's a link to the other so that doesn't always work, so its first point of contact which lead onto other points of contact to improve somebody's outcome' (Focus Group 2).*

> *'Our team leader for connectors, she runs quite regular speed networking events, I don't know whether [name] has been to any of them but she runs speed networking events and people come along just as [participant] has described and updates everybody on what's going on (Focus Group 2).*

THE USE OF TECHNOLOGY IN SOCIAL PRESCRIBING IN WALES

The survey and focus groups intended to understand the use of data collection and digital platforms. The aim was to better understand whether there is uniformity around the type of data collected and the digital systems used in social prescribing across Wales.

The majority of organisations who responded to the survey question (41/48) collect data about their services for monitoring and evaluation purposes.

Those who used a digital platform either used a commercial IT platform or an in-house/locally developed IT platform. However, 63% of organisations claimed that their social prescribing services had not moved to a digital platform whereas 25% of organisations had moved their social prescribing services to a digital platform. Of those 25% there was an indication that organisations found that participation had increased since moving to a digital platform.

When participants were asked if digital case/referral management solutions were used, 48% said they did and 42% said they did not. Welsh Community Care Information System (WCCIS) (listed six times) and in-house systems (listed five times) were the most popular.

When asked in the survey about potential blockers or issues in adopting digital case/referral management systems, the following themes were identified:

- GDPR and accessibility

- Cost/resources
- Infrastructure – managing multiple platforms among different services

The relative efficacy of databases and software systems for social prescribing services were debated across all focus groups. National level databases such as Dewis were generally not well received, although some participants found some aspects of these databases useful. Participants reported that other professionals such as GPs are also *'not keen on DEWIS' (Focus Group 6)*. This was because the databases were viewed as not being up to date with information about the assets, containing duplications, challenging to complete or not reflecting the availability of assets at a local level.

> *'With DEWIS, it's really, really, really difficult to capture all the facts and when you have multiple offers like for example if we were to put our offer of support on DEWIS, we'd have to go into lots of different places on DEWIS to put that single offer' (Focus Group 1).*

> *'So, they should have a very good database of opportunities, you know I think we are all in agreement DEWIS certainly isn't one of those, we have a database which is probably four times larger than DEWIS, we have no vested interest, we just refer the patient to the best place possible for them' (Focus Group 3).*

> *'We've been asked by other professionals locally for directories and lists ever since we started our job and we can't provide it because what's happening very locally could be, it's so....it can shift from one week to the next, so the person that runs a community car scheme might be a different person the following week. The coffee morning that meets in the local library might 'be different the next week, so it's just impossible for us to do that, it would be a full-time job to keep the list up to date' (Focus Group 4).*

The risk of national advertising of assets resulting in oversubscription was also discussed.

> *'I've literally had some big organisations that say don't want to advertise because they are quite cliquey for instance and they don't want to allow other people in, including things like walking groups that have been fab, you know coming out of the woodwork and even developing throughout Covid but then I've had walking groups that used to be on DEWIS that have said 'sorry you've got too many people, we want to get off there cos we can't have any more people coming', which seems really strange cos obviously it doesn't cost anything and it's all kind of one of those things, a viscous circle sometimes' (Focus Group 4).*

There was concern that a larger national database would not be able to contain sufficient depth of information and comprehensively cover smaller areas and capture the smaller, informal activities and assets available.

> *'A directory has a place, we've used in the past on occasion but whenever people are identifying that they want a better connections locally, then a directory that covers the whole of [locality] would not be useful for a lot of those people' (Focus Group 4).*

Despite this, there did seem to be some appetite for a single resource and contact hub if these issues

can be mitigated. The usability of the database is also key, and difficulties in this area lead to rapid disengagement and creation of local asset directories instead.

> *'There was a separate directory that was established during Covid actually, but you know as far as possible we are trying to avoid people setting up lots of different directories and trying to encourage people to use Info Engine and DEWIS' (Focus Group 2).*

> *'We'd search InfoEngine or DEWIS Cymru cos DEWIS pulls the stuff from InfoEngine anyway, so we would use that as our starting point so if you're on there that's then your group would come up alongside you know, we'd search for the [local authority] area so provided it was in there listed for [local authority] then it was come up alongside any other offer I guess' (Focus Group 2).*

> *'I think we just need to actually promote and get behind one thing you know, and I think all the information is merged between Info-engine and DEWIS now anyway, it doesn't really matter which people choose to put it on, as long as people get the information that they need, when they need it, that's the important thing....' (Focus Group 4).*

Software solutions specifically designed for social prescribing were also discussed in the focus groups, and some social prescribing providers had purchased existing services or were developing local solutions.

> *'We have that in our gift, I've got colleagues who are amazing....you'll see when you look at our website later, if it's an online form everybody fills it in the same form, it's not [#####] questions about rubbish that we don't need, its asking the pertinent questions to get your referrals, your requests for assistance to the place that it needs to go as quickly as possible to illicit that response that you really need and is sometimes in an emergency because you have run out of food and there is no food in the shop, or you have something that is really troubling you and you feel that you might self-harm. All of those things are on that one-stop page as an E-form and one dedicated number' (Focus Group 1).*

Access to these platforms for all the agents involved in the social prescribing pathway, including GPs and commissioners, was seen as useful, particularly in providing more data beyond the social prescribing component.

> *'We talked about having a professionally accessible platform that GPs could go on, they could look at all of the social prescribing activities kind of responders in the bottom and choose one to veer away from that medical response into a community response per se. So, we are not there yet but my question about that would be, why has it got to be necessarily health led, why can't it be led by 'A' Another' (Focus Group 1)*

> *'Elemental is going to be one of those tools hopefully that will integrate because we need it to fulfil more than just the social prescribing element' (Focus Group 3).*

> *'It's about commissioning being informed by intelligence as provided or captured by social prescribers themselves. So, for example where gaps have been identified and so other people*

coming through for what matters conversations, or there's gaps in the services or assets to refer them to. It should be captured in some systematic way and then provided back as intelligence for commissioning. That would be my preference. How you do that is another matter. There's potential for software and to do that, and the Elemental I believe would potentially do that for us, but I think it has to be from a needs-based population, needs-based upon approach' (Workshop Breakout Room 1).

FUNDING AND CONTRACTING

To better understand the funding and contracting situation in Wales, we asked a number of questions about commissioning, workforce, and employment landscape around social prescribing in Wales.

Commissioners from nineteen organisations told us that that they used various routes to commission new projects, but these mainly involved tendering and professional networks.

Managers and commissioners reported using the integrated care fund, GP cluster funding, health boards or local authority funding for their social prescribing projects.

We asked managers to provide some details around the type of contracts their social prescribing staff are on. Based on 39 organisational responses, Table 3 shows that the majority of contracts are fixed term. Readers should be aware that the number of contracts indicated in this question did not match the number of employees indicated as providing social prescribing as their main role and should be careful about using these numbers as fact and instead treat them as estimates.

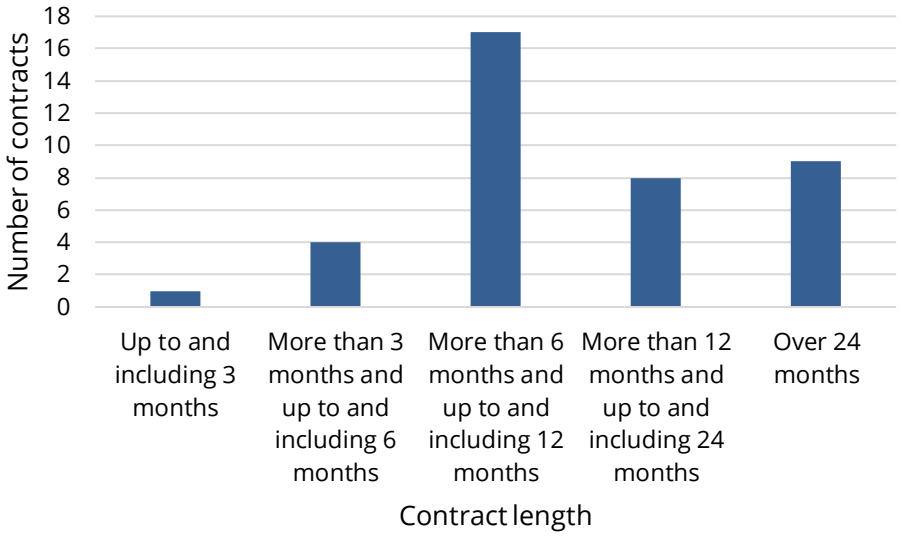
Table 3: Contract types of social prescribing staff

Number of organisations	Number of roles on fixed-term contracts	Number of roles on permanent contracts	Number of roles on other types of contract
39	195	71.5	7

Source: Social Prescribing Activity in Wales, by Data Cymru

Managers who reported awarding fixed-term contracts were asked about the contract length that they award (See Figure 9). 34 organisations responded to this multiple-choice question, with more than six months, and up to and including 12-months contracts being the most commonly awarded. We can see that overall longer length contracts were more common than contract lengths of less than 6 months.

Figure 9: Number of fixed term contracts by contract length



Source: Social Prescribing Activity in Wales, by Data Cymru

We also wanted to understand whether the contract type differed depending on organisation type. Table 4 shows the number of roles by contract type and organisation type. It is important to take the number of responses into account when comparing data across the types of organisations (e.g., local authority, health board etc.). In this scenario, trends are more informative than absolute numbers. The overarching trend is that the number of fixed contracts within each organisational type was consistently greater than or equal to the number of permanent contracts.

Table 4: Contract types by organisation type

Organisation type	Number of organisations who responded	Number of roles on fixed contracts	Number of roles on permanent contracts	Number of roles on other types of contract
Local Authority	9	43	32.5	0
Health Board	4	18	1	1
Primary care cluster	1	6	0	0
Third/voluntary sector	20	114	33	5
Housing	1	2	2	0
University	2	3	3	0
Other	2	9	0	1

Source: Social Prescribing Activity in Wales, by Data Cymru

This was a subject discussed at length within the focus groups. Although there are notable exceptions, social prescribing services are defined by short term precarious funding mechanisms, and this impacts across the full scope of provision.

'I'd say that's about us as well, everyone wants to do an outstanding job and deliver an

outstanding service and the contracts are so tight that that's not possible, so you get a weaker version of what you are delivering' (Focus Group 3).

'We are funded by the health board and even though we've been operating this model since 2016 it's a year on a year funding contract, so literally you know from 12 months to 12 months usually a financial year' (Focus Group 3).

'It's been really hard for them [social prescribers], this funding has taken quite a long time to sort out and you know, it was like we were promised you know, it will be sorted out by such and such a date, by such and such date it hasn't been and then you've got to give them another kind of temporary contract and it's kind of gone on like that (Focus Group 5).

There is a burden on services to identify and secure funding, which draws the focus away from the actual delivery of services.

'Could mean the difference between an extra couple of clients in the time found to source that funding which doesn't make a lot of sense when you think of how limited the resources for our populations in the first place' (Focus Group 5).

'You don't want them spending a lot of their time on admin or whatever and the lack of funding of a manager of a social prescribing service has the same sort of impact, they're all having to do their own data collection, their own admin and it takes away from what they are actually able to deliver in my opinion' (Focus Group 5).

Social prescribers and service providers also report challenges in accessing data and feedback to provide evidence for their service for commissioners and future funders.

'When we go to particularly small organisations and voluntary sector, not third sector as I've we get much better response from them, but they seem to be upfronted by our request for feedback, it seems to be that we are asking too much because local authorities should not ask that of the voluntary sector but given that we were the referring agent, my view is that we've got every right to do that and it helps with protecting residents. We've got an absolute given responsibility to protect our general public, that's what we are. So, there's the rub for me and I'm just thinking in my head because there's no longevity to the arrangements we've got [researcher name], our funding is short term its via ICF, there's no Welsh Government commitment for us to continue this work as a 5-year plan' (Focus Group 1).

Specific expertise is required within the team to successfully secure funding for example social value practitioners (*Focus Group 3*).

'It's a huge amount of work obviously to wrap social return model around the service but that's what we've done in order to facilitate the funding application year on year' (Focus Group 3).

There is also a potential risk that rather than being shaped by local need, a service may evolve according to a funder's specific agenda.

'Everybody is looking to improve their service provision but sometimes that service needs to be bent slightly shall we say to meet a particular funding requirement and I think there's a real danger on that occurring quite often' (Focus Group 3).

'It's so short term and sometimes the priorities change so sometimes they'll tell us 'well we don't want you to give it for that now, we want you to give it for that' you know, and you thinking we've got.....so the strategy behind it isn't, is short term and the funding that follows that just goes to reinforce that really, its short term thinking and until we get to that whole system approach that's longer term for everybody, we are all stuck in this cycle of you know' (Focus Group 4).

'So you know if there's funding floating around, then you know it's 'oh let's have a social prescriber role', like [name] said whether its needed or not or whether that is the description of the role that's needed, it tends to get put on that, you know that role....because it's about where they place it then in the pay scales' (Focus Group 6).

The short-term nature of provision impacts both upon stakeholders (who may not wish to engage with a service that would seem to have no longevity), and training and recruitment of staff (who may seek more secure employment elsewhere).

'So the service...it is needed and its used a lot and 4 of our connectors are funded by [health board] and 5 are funded by ICF and my biggest concern is funding, you know that funding comes to and end next March and I have 9 really, really competent staff that if that funding doesn't come from somewhere, we are going to lose really, really good knowledgeable skilful staff, that's my biggest concern at the moment' (Focus Group 6).

THE COVID-19 IMPACT

The pandemic (specified as starting in March 2020) impacted both positively and negatively upon social prescribing services.

In the survey the questions asked mainly focussed on the impact of COVID-19 on the type and level of social prescribing service offered. We understand from 68% of the organisations who responded that the pandemic had a large or very large impact on their social prescribing services, with the type of referrals changing.

The majority of organisations surveyed (81%) indicated that social prescribing services offered had changes since the beginning of the pandemic. The major change in service provision was the replacement of face-to-face appointments with telephone and online appointments. Respondents did note that as well as lockdown restrictions having an impact on the type of service, they were able to offer, the need also changed in that there were more requests for practical support, such as shopping, befriending, and digital access. Support needed to be bespoke and flexible.

Managers and commissioners were asked about discontinuation of social prescribing services as a result of the pandemic. The number of organisations that had either a manager or commissioner respond was 62. Of these organisations, 34 indicated that no services had been discontinued. This was approximately 55% of those organisations that provided a response, whereas only approximately 23% stated that services had been discontinued. The respondents who specified that social prescribing services had been discontinued were then asked to highlight some of the reasons why the services had been discontinued. These reasons included:

- Lockdown restrictions had an impact on operations and activities
- Reduction in service user participation
- Work need/focus changing due to the pandemic, including staff restructures

There was a lack of clarity around whether community assets which organisations referred people to had been discontinued due to the pandemic, with 21 organisations (44%) being unsure whether any assets that their organisation refers to had been discontinued. Those who reported discontinuation of community assets were then asked to highlight some of the reasons they think this has happened. Some of the themes from the responses were:

- Face-to-face support and workshops have stopped
- Some organisations have struggled with the transition to virtual working
- Funding has ceased

Managers and practitioners were also asked if their organisation had measures in place to help their social prescribing projects overcome challenges associated with the pandemic. The vast majority of organisations (82%) had measures in place, which included:

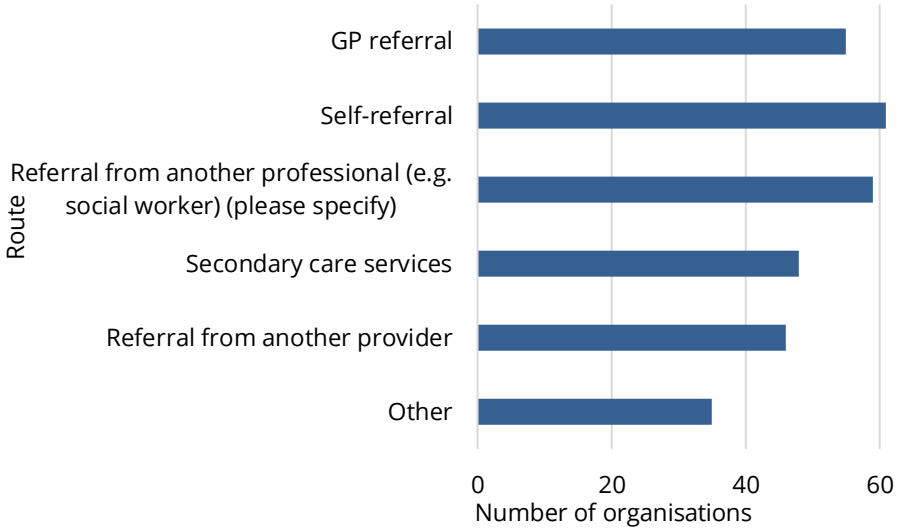
- Digital and phone provision
- Training relevant to remote working
- Staff wellbeing measures such as check-ins
- New directories to advertise local and new support
- Funding and provision of protective measures – sanitisers, PPE, risk assessments
- Support to voluntary sector (funding and practical) to provide related support including:
    - Information
    - Transport
    - Food

- COVID-19 response groups

- Mental health support, including:
  - Befriending
  - Counselling
  - Online wellbeing courses

Managers and practitioners were asked to list the routes via which individuals could access their social prescribing services (See Figure 10). The number of organisations that provided a response to this question was 74. There was a varied response to the routes through which people have been able to access their social prescribing services, although a point of interest is that self-referral was the most common response, where 61 organisations had answered that this was a route that people were able to use.

Figure 10: Access routes for social prescribing services since the pandemic



Source: Social Prescribing Activity in Wales, by Data Cymru

As one might expect, the data reflects the way in which Covid 19 curtailed emerging social prescribing services – often these were just becoming established.

> *'Those kind of smaller slightly more informal kind of groupings of people coming together, those stopped....what some of the bigger organisations were delivering carried on all be it in a slightly different way, so there were different levels and different kinds of services available rather than the kind of widespread that we probably would have linked with' (Focus Group 5).*

The pandemic did however result in an increasing number of people volunteering to work as part of/within local assets across the age range, cultivated the development of new assets, and helped

services to become more agile in terms of securing short term funding or navigating organisational roadblocks.

> *'I looked at the demographic of the people who came forward and volunteered, everybody assumed they'd be middle aged or retired and lots of free time on their hands, maybe not the very elderly because they were shielding but looking at the demographic, we had every single age group covered, from the late teens...cos we were only able to offer the volunteering opportunity to respond...so for example our volunteers are like our social prescribing response, so we had people in their late teens all the way up and I'm not even joking, to their late 80s' (Focus Group 1).*

> *'But prior to Covid we were receiving between 220, 250 referrals a month in April alone last year we received well over 1600 referrals in that month alone and I think that is because the third sector has that real agility to turn things round very rapidly' (Focus Group 4).*

New groups and activities were also set up to address emerging and new needs that were identified at the start of the pandemic.

> *'Although then we had kind of 96 new organisations that set up within a matter of weeks to try and address some of those issues that were being identified in communities so a completely different set of groups to work with, I guess in a different way, so yeah things started, and things stopped very quickly' (Focus Group 5).*

Covid 19 has also catalysed the development of more digital/virtual provision, although one focus group member raises the issues of accessibility, inclusivity, and digital poverty that are associated with such approaches.

> *'We managed to get funding for a digital loan scheme so that we could connect people to all the online activities that were springing up everywhere, our third sector partners were fantastic in what they delivered in such a very short time and with very limited staff and equipment. So, we managed to perhaps get on board the digital journey and hopefully that will still be an element of the connector role to encourage people if they want to be connected digitally' (Focus Group 6).*

> *'We've kept going, a lot of services have moved online but I know that we've had to use small grant schemes to support people with learning disabilities, be able to access peer support you know, that has been quite a big issue and I think as we continue, I think we are still not fully out of the woods are we and I think there's going to be a lot of still blended work going on' (Focus Group 6).*

4. CONCLUSION

The commitment to introducing an all-Wales framework to roll out social prescribing in order to tackle isolation within the Welsh Government Programme for Government 2021-2026 represents somewhat of a 'high-water' mark for social prescribing within public policy in Wales. Expectations of what social prescribing may be able to deliver have never been higher. This research project has provided a greater understanding of social prescribing in Wales. We now have a baseline of evidence upon which to base this expectation which hitherto did not exist.

The planned framework should provide a clear vision and action plan for practitioners, managers, and commissioners to deliver against this ambition. In drawing this report towards a conclusion, it is worth reflecting on the implications of the findings. The four points made below need to be thought through and addressed if the framework is likely to have the kind of impact and traction that is envisaged.

1. **Variation in provision of social prescribing across Wales provides both opportunities and challenges.**

   Social prescribing is utilised, defined, and runs variably across Wales. Most social prescribers are based in the Local Authority and third sector organisations with few based in primary care. There are accordingly therefore differences in underlying philosophy, approach and delivery which may need to be surfaced, addressed, and rebalanced. That is not to say that there has to be a centralised 'offer', but that this variation may act as a rate-limiting factor on the impact of social prescribing. This could be exacerbated when seen in the context of the confusion and lack of awareness within the public of what social prescribing can offer and the varying terminology used. There is an opportunity here for sectors to work together and ensure a coherent, seamless social prescribing service which meets the needs of its local and national population.

2. **Social prescribing is a 'growth' activity, and expectations of it are high**

Social prescribing is increasingly seen as a solution to a number of the challenges within communities across Wales. There is a commitment to expanding social prescribing capacity and in some areas the scope of the role that it plays. There is also a commitment to developing pathways that are focused on holistic approaches which place people at the centre and are integrated with existing and statutory services across sectors. This is a real challenge to deliver upon and there are issues to be duly considered so that social prescribing reaches its potential. One such issue pertains to the growing social prescribing workforce; their employment contracts, how the workforce is managed locally and how social prescribing is coordinated nationally.

3. **Technology key to the future of social prescribing, especially as the pandemic persists**

Social prescribing, at its heart, is a relationship-centred form of support. It relies on the connection between individuals. COVID disrupted the emergent social prescribing models to such a degree that it is important to recognise that 'remote' forms of social prescribing will be an important and core feature of its ongoing evolution and development for many years. Finding ways that technology – whether in systems, or in ways of making remote connections between individuals – works for people is central to social prescribing's growth. Using a digital directory and digital platform across pathways will ensure that social prescribing services are person centred and responsive to changes required in the future.

4. **Resources, as always, are fundamental to sustaining the social prescribing pathway**

Concerns were expressed throughout the study about the 'fundamental problem of the funding model' and the challenges for sustainability that this brings. A variety of routes have been used to resource social prescribing services to date, but there are serious concerns that without guaranteed or at the very least much longer-term funding settlements in place for both social prescribing services and the community assets, the promise of social prescribing could be undermined.

The following eight recommendations are made:

- The planned national framework should be embedded across Wales to provide a national vision for social prescribing whilst promoting a standard model, terminology, and structures that support it. This would raise professional and public awareness and reduce confusion.
- Local/regional organisational structures and partnerships should consider the role of a social prescribing champion to drive regional social prescribing strategy and coordinate communication throughout the pathway.
- A whole system approach to developing and delivering the social prescribing pathway which is informed by intelligent commissioning should be adopted both locally and nationally.
- To review the role and scope of the social prescriber to understand what should or should not be included within it and its points of referral onto other services such as mental health and social work teams as appropriate.
- To provide a professional infrastructure for the social prescriber which includes for example a suite of job descriptions, salary guide, skills and competency framework, supervision requirements, appropriate and recognised training, and education opportunities.
- To evaluate the usability of national single digital directories for Wales (such as DEWIS and InfoEngine); and digital platforms used across the pathway (e.g., Elemental) to manage referrals, collect national core service activity, individual outcome measures. This will ensure that the specific needs of the social prescribing services are being addressed.
- To reconsider the funding model used for social prescribing to promote a sustainable pathway for the future.
- To repeat this research study in the next 5 - 10 years to further understand the progress made in establishing and developing social prescribing services across Wales. In addition to triangulating the findings of this report with a 'deep dive' investigation at one University Health Board geographical area and in collaboration with Shared Services Partnership and the Wales National Workforce Reporting System (WNWRS).

Study limitations

This study provided a snapshot of what we understand about social prescribing in Wales. Although

representation across Wales was achieved across all methods employed, there are always limitations to be acknowledged when using an online survey to gather data. Further triangulation of this study exploring local health board information and capturing the work of Shared Services may enable us to validate the findings. However, it is anticipated that this exercise could become much easier in the future with the use of developing technology.

REFERENCES

Braun, V. and Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), pp.77-101.

Husk, K., Blockley, K., Lovell, R., Bethel, A., Bloomfield, D., Warber, S., Pearson, M., Lang, I., Byng, R., Garside, R., 2016. What approaches to social prescribing work, for whom, and in what circumstances? A protocol for a realist review. Systematic Reviews 5:93.

Moffatt, S., Steer, M., Lawson, S., Penn, L. and O'Brien, N., 2017. Link Worker social prescribing to improve health and well-being for people with long-term conditions: qualitative study of service user perceptions. BMJ open, 7(7), p.e015203.

National Assembly for Wales, 23rd May 2017. NDM6314 Debate: Social Prescribing. Accessed from http://senedd.assembly.wales/ieIssueDetails.aspx?IId=19094&Opt=3 on 16.09.2021.

Rees S, Thomas S, Elliott M, Wallace C, 2019. Creating community assets/social capital within the context of social prescribing. Findings from the workshop held 17/7/2019. *WCVA, Cwm Taf Morgannwg University Health Board, University of South Wales.*

Rempel, E.S., Wilson, E.N., Durrant, H., and Barnett, J., 2017. Preparing the prescription: a review of the aim and measurement of social referral programmes. *BMJ open*, *7*(10), p.e017734.

SCIE, 2020. Evaluating personalised care. Last accessed from https://www.scie.org.uk/person-centred-care/evaluating-personalised-care on 16.09.2021.

Welsh Government, 2014. Social Services and Well-being (Wales) Act. Last accessed from http://www.legislation.gov.uk/anaw/2014/4/pdfs/anaw_20140004_en.pdf on 16.09.2021.

Welsh Government, 2015. The Well-being of future generations (Wales) Act. Last accessed from http://www.legislation.gov.uk/anaw/2015/2/contents/enacted on 16.09.2021.

Welsh Government, 2017. Prosperity for All. The national strategy. Last accessed from https://gov.wales/prosperity-all-national-strategy on 16.09.2021.

Welsh Government, 2018. A Healthier Wales. A plan for health & social care. Last accessed from https://gov.wales/healthier-wales-long-term-plan-health-and-social-care on 16.09.2021.

Welsh Government, 2020. Connected communities. A strategy for tackling loneliness and social isolation and building stronger social connections. Last accessed from https://gov.wales/loneliness-and-social-isolation-connected-communities on 16.09.2021.

Welsh Government, 2021. Welsh Government Programme for Government 2021-2026. Last accessed from https://gov.wales/sites/default/files/publications/2021-06/programme-for-government-2021-to-2026.pdf on 16.09.2021.