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Social Prescribing Case Studies: Full report

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RHAGLEN STRATEGOL AR GYFER GOFAL SYLFAENOL

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Introduction

Social prescribing is defined in Wales as **an umbrella term that describes a person-centred approach to connecting people to local community assets. It can help empower individuals to recognise their own needs, strengths, and personal assets and to connect with their own communities for support with their personal health and wellbeing** (WSSPR & PHW, 2023).

This document presents fourteen case study examples from across Wales in relation to social prescribing.

The case studies aim to showcase the breadth of social prescribing practice, its cross-sectoral and person-centred approach, and how it can support individuals with a broad range of health and wellbeing needs. The case studies are in four sections:

- Individuals who have used social prescribing services
- Social prescribing practitioners
- Referrers to social prescribing services
- A community asset

In addition, a number of case studies highlight barriers and facilitators of the social prescribing pathway. These will therefore be reported within the section:

- Perceived barriers and facilitators

We would like to thank all those who have contributed their time and expertise into the development of these case studies. The methodology used to develop these case studies is documented in appendix A.

Social Prescribing Pathway

Social prescribing has grown organically across Wales, producing a range of different delivery models, with the dominant model being one which is both holistic and person-centred. A core principle of social prescribing is that it utilises and interacts with statutory services across sectors, requiring multiple organisations to work collaboratively. The key components of the social prescribing pathway (see Figure 1) include: Referral, Social Prescribing and Community Assets.

Figure 1: Social Prescribing Pathway

It has been recognised that a diverse range of terminology associated with social prescribing is used across Wales. In response, a Glossary of Terms for Social Prescribing has been developed for Wales to improve clarity and communication, regarding the intervention of social prescribing, across sectors as well as with and by the public (WSSPR & PHW, 2023). This document therefore adopts the use of following terms and descriptions, aligned to the key components of the social prescribing pathway:

- **Referral** "describes the act of sending someone to another person or place for treatment, help, advice, etc. Within the context of social prescribing, a referral can be to a social prescribing practitioner and from a social prescribing practitioner or someone who undertakes social prescribing as part of their role to appropriate community assets. The term social prescription might also be used to describe the act

of referral in social prescribing. For example, an individual might receive a social prescription from a social prescribing practitioner for nature-based activities.

Referrals to a social prescribing practitioner can be from a professional working in a clinical setting (e.g. GP, pharmacist or physiotherapist), statutory services, or a community and voluntary sector organisation. An individual can also directly access social prescribing through self-referral. Self-referral describes the process of an individual contacting someone who works in the role of a social prescribing practitioner or someone who undertakes social prescribing as part of their role, without having received an onward referral to that person. Self-referral does not describe someone directly accessing community assets (for example, attending an art class)."

- **Social prescribing practitioner** is “an umbrella term that is used to describe someone who assists individuals with identifying their non-medical needs through a ‘what matters’ conversation, and helps them co-produce an action plan and access local community assets, such as groups, interventions or services. If they identify a potential medical need, they may also refer to e.g. a GP or pharmacist. Social prescribing practitioners will work with individuals to find activities tailored to their preferences and needs, explore barriers and challenges to attending, and encourage ongoing participation. While there are preferred terms for the social prescribing practitioner role within sectors, they may also be known by a variety of terms that can be specific to the organisation in which they work. Social prescribing practitioners can be employed by a range of different organisations, such as local authorities, health boards or Community & Voluntary Sector Organisations”.

- **Community assets** “provides a collective term for anything that can be used to improve the quality of community life. This can include community groups, interventions and services which could be delivered online or in-person, as well as buildings, land or even a person within the community.

  For example, swimming is not considered a community asset but a swimming group and the location in which they swim could be considered community assets."

Case Studies: Individuals who have used Social Prescribing Services

This section consists of four case studies from:

- Gwen who cares for their partner, who is living with dementia
- David who has experienced financial and mental health concerns
- Thomas who was experiencing low mood and anxiety
- Neve who is a carer for their mother, who has dementia

The name and age of the individuals interviewed have been changed

Social Prescribing: The story of Gwen, who cares for her partner, who is living with dementia

The following case study describes Gwen's experience of being supported by a Social Prescribing Practitioner in the Cwm Taf Morgannwg University Health Board area. Gwen, aged 71, cares for her partner, who has Alzheimer's Disease.

Reasons for referral

Gwen and her partner were referred to social prescribing following an Alzheimer's Disease diagnosis, to identify local community groups, interventions or services which could support them both.

Social prescribing pathway

After her partner's diagnosis, Gwen contacted her local Carer's Centre to find out what support was available. The Carer's Centre referred her and her partner to a social prescribing service. The Social Prescribing Practitioner then met with Gwen and her partner to discuss other sources of support. Gwen and her partner tried a range of community groups, interventions and/or services in line with their needs and preferences.

> *"[The Social Prescribing Practitioner] was very aware of the services available in the area. They gave me all the information that was available. We discussed what the different groups were, what I thought [partner] would be open to trying, and also what is available to me to give me advice, help, and respite"*

Community assets

Gwen and her partner were signposted to the following community groups, interventions and/or services:

- Dementia-focused community groups, e.g. dementia café; dementia choir
- Physical activity groups, e.g. a football group
- Men's Sheds, a group that aims to tackle loneliness and isolation among men
- A support group for carers of people with dementia.

Although her partner was reluctant to try most of the community groups, interventions and services which were offered to them, they did engage successfully with some. Gwen partly attributes this to the Social Prescribing Practitioner's pleasant and patient approach. The Social Prescribing Practitioner's knowledge of and collaboration with local community assets facilitated referral. If the Social Prescribing Practitioner could not help with something, they referred to someone who could.

"I was so appreciative of all the help [social prescribing practitioner] gave. [Their] personality overall. I just felt [they] had the right way of dealing with [partner]. [They were] very comforting to me, and very helpful. But [they were] never pushy. [They] just had the right attitude in gently offering what was available and suggesting things in a non-patronising way".

Impacts of social prescribing on health and wellbeing needs

The Social Prescribing Practitioner introduced Gwen's partner to a football group aimed at improving physical health and wellbeing. The Social Prescribing Practitioner referred Gwen to a carer's group which provided information, advice, and support for carers of people with dementia, and respite care so that carers could engage fully with the group. Gwen greatly valued this opportunity. The Social Prescribing Practitioner continued to support Gwen by telephoning them periodically to ask how they and her partner was doing.

"I think it's so important [that the Social Prescribing Practitioner] had the right balance of understanding that carers need to be cared for as well. It improved my wellbeing. If ever I had any problems, they were there, and quite happy for me to contact them for advice"

Social Prescribing: The story of David, who has experienced financial and mental health concerns

The following case study describes David, aged 47, who has been signposted to community assets by a Social Prescribing Practitioner. David was experiencing financial and mental health concerns.

Reasons for referral

David had experienced drug and alcohol addiction for many years. He had recently become homeless, and his mental health had worsened as a result.

Social prescribing pathway

David was linked to the Social Prescribing Practitioner via the Job Centre when he applied for a food parcel. The Social Prescribing Practitioner delivered the food parcel in person, where they had a 'what matters' conversation with him to identify and discuss their health and wellbeing concerns.

"Initially it was a food parcel: they delivered that straight away. They asked a little bit more about my situation and gave me the leaflet. I explained about my housing situation…They offered if I needed any clothes or anything like that. They were very helpful"

David welcomed the Social Prescribing Practitioner's positivity, proactivity, and efficiency in understanding and addressing their concerns. He felt that the Social Prescribing Practitioner understood his needs and cared about his wellbeing. Checking in regularly with David to ensure they were benefitting from the support they had accessed, and to identify if he needed any different or additional support was key to helping him to progress on his journey to improving his mental health and wellbeing.

"They check in…They say, 'Let me know if the ball's not rolling and I'll get it moving again'. They have persevered for me when I've felt like I couldn't"

Community assets signposted and referred into

The Social Prescribing Practitioner supported David to access the following community groups, interventions and/or services:

- Adferiad Recovery: a non-profit organisation that supports people recovering from drug and alcohol addiction
- Food parcels
- Home goods such as a microwave to improve his living situation
- Information on community activities.

Impacts of social prescribing on health and wellbeing needs

Receiving support through social prescribing has supported David in his health and wellbeing journey. For example:

- David has improved his physical and mental health by re-joining the gym and going on walks regularly.

> *"I want to feel healthier now that I'm not drinking and taking drugs. I feel really good every day: I love it. No one ever comes back from a walk and goes, 'That was [rubbish]'. It's just amazing once you're out there"*

- David has plans to improve his social wellbeing through taking up some volunteering opportunities that the Social Prescribing Practitioner has suggested.

> *"They do a lot of volunteering work, like litter picks, that I would definitely want to get involved in"*

Social Prescribing: The story of Thomas, who was experiencing low mood and anxiety

The following case study describes Thomas, aged 15, who has been supported by a Social Prescribing Practitioner as part of a social prescribing pilot service in Cardiff and the Vale of Glamorgan.

Reasons for referral

Thomas was experiencing anxiety and low mood which was negatively impacting on his sleep and day-to-day functioning. He wanted to find ways to improve his health and wellbeing.

Social prescribing pathway

Thomas was referred to the social prescribing service via their GP. Within a week of referral, a Social Prescribing Practitioner telephoned him to arrange an in-person meeting. The Social Prescribing Practitioner had an initial understanding of Thomas' needs from the referral information that the GP provided but used a 'what matters' conversation to obtain more detail.

> *"[The referral came] from my GP: they linked me up with the organisation. It was about less than a week later in that period that they contacted me, and we started to arrange sessions"*

The Social Prescribing Practitioner listened to Thomas' concerns and signposted him to relevant community assets in an encouraging and friendly way.

> *"[Social Prescribing Practitioner] was very open and willing to help with different issues. They were very encouraging and asked if I needed any of the services. I'd say all bases were covered. …. They were all friendly and supportive"*

Community assets

Thomas was referred to one-to-one support sessions by the Social Prescribing Practitioner. The support sessions took place over a few months. They helped Thomas address his social anxiety and other concerns he had.

> *"[The one-to-one support] sessions definitely gave me a chance to acknowledge a lot of issues in my day-to-day life that I hadn't acknowledged, and I'd left to not deal with or confront"*

Impacts of social prescribing on health and wellbeing needs

Thomas noticed significant improvements to his mental, social, and physical wellbeing since receiving support through social prescribing. The support he received through one-to-one support helped him improve his social anxiety and sleep routine through encouraging him to learn healthier coping strategies. This enabled Thomas to focus more on school and consider employment opportunities.

"With help from [Social Prescribing Practitioner] I was able to create a more sustainable routine which I've started and it's really helped me feel more physically full of energy when I wake up every day…[I now] feel more focussed in more of my classes... Also, with my social anxiety, it pushed me to be more outgoing with extracurricular activities like part-time work or work placement opportunities"

Social Prescribing: The story of Neve who is a carer for her mother, who has dementia

The following case study describes Neve, aged 52, who has been signposted to community assets by a Social Prescribing Practitioner. Neve is a carer for her mother, who has dementia.

Reasons for referral

Despite having a good network of friends and family, Neve started to feel overwhelmed by her caring responsibilities. This exacerbated her anxiety, and she started to feel depressed.

"I think I was just feeling a bit overwhelmed… a friend of mine noticed that I'm just not myself… things were getting to me, little things, and worrying about things that wouldn't have got to me before. It was all just building up and building up"

Social prescribing pathway

Initially, Neve visited her GP to discuss her symptoms. In addition to talking through medication options and signposting the person to online resources, the GP told Neve about the social prescribing service and booked her an appointment with the Social Prescribing Practitioner at the practice for the following week. The Social Prescribing Practitioner had dedicated time to discuss Neve's concerns, encourage her to talk about how she was feeling and suggested potential support options.

"[The Social Prescribing Practitioner] was lovely, very welcoming… when I went in, [they] said, 'take your time'… [They] didn't interfere, [they] just listened. It's hard at first to talk about what's going on with yourself, but [Social Prescribing Practitioner] was very patient with me. It wasn't just about what's going on with mum: [Social Prescribing Practitioner] asked about how I was feeling and what I used to do when I had more time to enjoy myself and anything I miss doing; also, about if I was struggling at home with the money situation"

Being enrolled on an online course for support helped Neve with accessibility; she would have struggled to engage face-to-face due to her caring responsibilities. Neve was grateful that the Social Prescribing Practitioner made the initial contact with the carer's support group for them, as she lacked the time and confidence to do this herself.

"[Social Prescribing Practitioner] … linked me in with the carer's support project whereas I don't think I would have taken that initiative and made contact. I might have taken a leaflet or a link, thought about it and then time would've passed, and I wouldn't have got around to it"

Community assets

The Social Prescribing Practitioner signposted Neve to:

- Citizen's Advice, for guidance with applying for carer's allowance
- An online anxiety management course and supporting resources
- A local carer's support group which provided practical information and guidance.

Impacts of social prescribing on health and wellbeing needs

Engaging with community assets through social prescribing has supported Neve in her health and wellbeing journey as follows:

- Improved understanding and management of her anxiety through attending an online course.

"Over the years, I have struggled with anxiety… But going on the online course and seeing different causes of anxiety and that anxiety is normal and natural, that's helping me to manage better in a stressful situation"

- Better informed about how to support herself in her caring role. For example, accessing a carer's allowance enables Neve to live a little more comfortably and have days out with her mother.
- Neve hopes that engaging with the carer's support group will enable her to build relationships with those who are in a similar position. She also hopes to share learning about sources of support for carers with others in the community.

"Even though I've got friends and family, they don't understand sometimes, and you don't want to burden them with your problems. But speaking to somebody in a similar circumstance who is independent of you…would be beneficial. I didn't know about these things before, so I guess community wise it has benefitted me because I can tell someone else about it then and they can get support"

Case Studies: Social Prescribing Practitioners

This section consists of six case studies from:

- A GP Wellbeing Links Advisor
- A Community Support Hub Manager
- A Social Prescribing Project Manager
- A Community Navigator Team Leader
- A Wellbeing Coordinator
- A Student Support Navigator

Social Prescribing Practitioner: A GP Wellbeing Links Advisor's story

This case study is based on feedback from a GP Wellbeing Links Advisor. They support people in Monmouthshire with social rather than medical needs, as part of a county-wide GP wellbeing service. This case study tells us about their work, and how people's health and wellbeing needs have been supported through social prescribing.

Reasons for referral

People's support needs vary greatly, ranging from mental and physical health; drug and alcohol use; help with benefits and finances; to support with caring responsibilities.

Social prescribing pathway

Initial requests for support are received through GP practice staff. Staff making requests outline what they feel people's needs are. People can also request support themselves. The GP Wellbeing Links Advisor then meets with individuals to have a 'what matters' conversation. Having a 'what matters' conversation is key to working out what support people benefit from. Some may present with one need, but require help with other things, too.

> *"It's looking at the whole package, at absolutely anything and everything an individual might present with... You just help them with that process and link them to the services that are appropriate to them. That might be just giving them the information for them to act upon themselves, or it can be a case of that person needing further support and needing us to make those initial contacts and referrals on to another organisation for them"*

The GP Wellbeing Links Advisor and their team keep abreast of what community assets are available in their area through informal networking. If they find out about a group that is on, they like to visit, so they know what they are signposting people to. As a team, they host a local wellbeing network, where they invite local services and individuals who work in the community to come in and have a conversation to share information on what they can offer. Through doing this, the GP Wellbeing Links Advisor and their team build up a network of community groups, interventions and services in the area.

The wellbeing network helps to promote local community groups, interventions and services and raise awareness of volunteering opportunities to increase services' capacity. It also helps to identify gaps in provision which are escalated for discussion at a strategic level within the health board area.

Community assets

People are signposted to support for a wide variety of health and wellbeing needs, including:

- Social isolation and loneliness, e.g. activity-based groups such as “knit and natter”
- Financial concerns, debt, and benefits
- Mental health and wellbeing
- Dementia, e.g. Alzheimer’s support groups
- Physical health, e.g. stroke, mobility concerns, walking groups
- Carers' support
- Education, training, and employment, e.g. tailored support for neurodiverse students; volunteering.

“I met a lady who had a stroke…We sat and chatted it all through…and I said, ‘Do you know there’s a stroke group that meets here [today]?’, and she said, ‘No’”… I did a supported introduction [and] she was just amazed…sometimes people need that little bit more support…in linking in with that service or actually me…
going along physically with the person for that first introduction to get them through the door…so they don’t feel anxious about going along themselves”

Impacts of social prescribing on health and wellbeing needs

People who have engaged with wellbeing activities, or community groups, interventions or services that this GP Wellbeing Links Advisor has introduced them to have achieved improvements in the following areas. These are captured anecdotally through speaking to individuals themselves, and through a follow-up review.

- Linking people with the local employment and skills team, and the learning disabilities service, has helped people to overcome barriers to engaging with education, training, and employment. Volunteering has also helped people to start engaging in these areas, with a view to progressing on to training or employment once they are ready.
- Engaging with support can help improve people’s mental health and wellbeing, even if it is not specifically targeted at that. A ‘what matters’ conversation encourages people to talk through their concerns and often marks the start of their health improvement journey.
- Introducing people to activity groups has helped to improve their physical health. It has been observed by the GP Wellbeing Links Advisor that some people who have accessed support now attend the GP practice less often, suggesting that they have started to address the causes of their health concerns.

Social Prescribing Practitioner: A Community Support Hub Manager's story

This case study is based on feedback from a Community Support Hub Manager who works as a Social Prescribing Practitioner for a third sector organisation in Conwy. In this case study, we find out about their role as a practitioner, and how the support people have accessed through social prescribing has improved their health and wellbeing.

Reasons for referral

The focus of this service was initially on improving people's wellbeing by engaging them in activities like volunteering, walking groups, or yoga. However, it was quickly realised that people's wellbeing needs were closely related to the cost of living crisis, which affects people's physical, mental, and social wellbeing.

Most people request food bank and fuel bank vouchers; and advice on benefits, debt, and housing. The Social Prescribing Practitioner often meets people intending to address one concern, and soon realises that there are multiple aspects they could help with.

Social prescribing pathway

People mainly self-refer or are referred through local organisations such as the Job Centre.

Having an initial informal conversation builds understanding of individual's needs and concerns. Most people are ready to speak openly because they need support.

The Social Prescribing Practitioner and their team can refer to local community assets. The Social Prescribing Practitioner mainly finds out about community groups, interventions and services through word of mouth. Once the Social Prescribing Practitioner is aware of different services, they enter them into their in-house database and categorise them by type of concern, such as mental health, disability, or fuel poverty. The key to being well informed is maintaining good working relationships and networking within the community.

Building trust with individuals is key to helping them engage with the Social Prescribing Practitioner and with the support or services offered. This is achieved through being approachable, genuine, and empathetic. Services which mirror this approach also tend to engage better with those accessing them.

Community assets

People are signposted or referred to support for a broad range of health and wellbeing concerns including:

- Foodbank vouchers or food parcels
- Purchasing essential items, e.g. a bed to replace one which was broken and unusable
- Mental health, e.g. a walk-in support group
- Benefits and debt advice, e.g. local Benefits Advice Shop
- Training and qualifications, e.g. a construction skills training course
- Housing / homelessness.

"There are lots of things we can do…we can feed into all of these groups and we can suggest different things. We can make phone calls on their behalf…I have gone with people to meetings…It's that access to services which is required"

Impacts of social prescribing on health and wellbeing needs

- People who have newly retired or moved to the area often feel socially isolated. Engaging with various social groups that they are referred to through social prescribing has helped them to feel part of the community.

"We have a lot of people moving into the area to retire… People become very isolated. It's trying to build those networks in place before that happens. That's the important thing: building that sense of community"

- Volunteering has increased due to social prescribing. Volunteering can be a great pathway back into work, but also improves people's social wellbeing. Having a Volunteer Coordinator within the organisation has helped build connections and create volunteering opportunities for people.

"Quite a few people got into volunteering…especially the people out of work… People see it for the benefits it provides: they seem to always get something out of it. I referred somebody to a local social enterprise, and he got a job from it. He volunteered there for about six months, and when a job did come up they thought 'he's the guy'. Little things like that"

Social Prescribing Practitioner: A Social Prescribing Project Manager's story

This case study is based on feedback from the manager of an NHS-funded social prescribing pilot service which works with young people in Cardiff and the Vale of Glamorgan. The service has two Community Connectors who link with schools and community organisations to support young people aged 11 to 18 to engage with a range of community assets to help them achieve their health and wellbeing goals.

Reasons for referral

Most young people are introduced to support with mental health concerns, low mood, loneliness, bullying and anxiety.

Social prescribing pathway

GPs and schools refer young people into the service through the Single Point of Access (SPoA). Referrers often include information about young people's health and wellbeing needs, concerns, and interests, with the request for support.

> *"Before [the referral] comes to us, the SPoA clinician rings up the family to see how they are doing and runs the idea [of social prescribing] past them, because we know some people will have expectations of what they think they need. A lot of people haven't heard the term social prescribing before, so we've basically put together FAQs for this…We arrange to meet with them for their first session. We meet them wherever they want to meet really: home, school, in the community…we arrange a time to meet, and we go from there"*

Some young people have never engaged with structured support before support is requested for them. For others, social prescribing can be an alternative to or additional support alongside a mental health intervention. The Community Connector meets with the young person and their parent or carer to discuss how social prescribing can help, and to start supporting them.

Community Connectors have dedicated time to expand and update their knowledge of community groups, interventions and services. This helps them to signpost young people appropriately.

> *"It's… really important to us that this is a working relationship with the young person: it isn't telling them what to do, it's working together. Often that's managing expectations of what this looks like and what they can expect from us [and] what we can expect from them"*

Community assets

Community Connectors support young people directly through a bespoke programme which involves:

- An initial meeting to get to know young people, discuss rights and responsibilities, and start developing plans, goals, and actions
- Follow-up sessions to work towards goals, and identify barriers or challenges and how to address them.

The sessions are structured using a "wellbeing journal", which was developed with the health board's Youth Board. Once young people have gained in confidence through one-to-one support sessions, Community Connectors can then introduce some young people to community assets such as:

- Open-access youth clubs
- Sports, e.g. boxing or rugby.

Impacts of social prescribing on health and wellbeing needs

The social prescribing service uses the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) to measure changes in young people's mental wellbeing after they have accessed the service. They also ask young people for informal feedback on the service.

Some examples of how the social prescribing service has helped improve young people's mental wellbeing are outlined below:

- Improved routines and self-care to address anxiety

> *"One young person…was in a bit of a spiral because [they] would get stressed out about exams and [they] didn't know how to best prepare or do [their] work around it. Because [they were] stressed, [they] didn't shower frequently [or] do [their] face care routine, then [they] felt bad about [themselves]… [Community Connector] did some nice work with [them] about prioritising and planning, really focussing on sleep [and] self-care routines to try and tackle some of those things in the cycle"*

- Increased self-confidence through engaging in physical activity, such as, boxing classes

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"[The young person] was having a horrific time of it in school… [and had] been bullied… [They were not] comfortable going to school [or]…youth club. [They] didn't want to use the bus any more… Even though [they were] going through a really tough time of it, [they were] always open to…making changes. [They] would meet with our Community Connector [and the] …change they've seen in [them] has been remarkable… [They are] now using the bus, going back to youth club, [they have] joined a rugby team and [they] have started boxing [classes], neither of which were things [they] felt comfortable doing before"

Social Prescribing Practitioner: A Community Navigator Team Leader's story

This case study is based on feedback from a Community Navigator Team Leader. They manage a team of Community Navigators and a Brokerage Officer who work across South East Wales. In this case study, we find out how they support people through social prescribing.

Reasons for referral

People are mainly referred for support with practical assistance and with physical and mental health concerns, and to be connected to activities and groups to reduce loneliness.

Older people tend to be the main service users, but the service has been supporting all age groups.

Social prescribing pathway

Referrals are received via many routes, including social services, NHS practitioners, third sector partners, housing providers, people themselves, or their family and friends. Once referrals are received, Community Navigators often telephone referrers to obtain further details of people's health and wellbeing needs. This helps prepare for a 'what matters' conversation.

"It's really about that network building: knowing who's out there and supporting those groups…my colleague…supports groups to develop from the ground up. As navigators, the team can identify gaps or see things that are working really well and maybe if they could be fitted into another community"

The team use a Customer Relationship Management system to record referrals which helps to ensure that people are referred to appropriate community assets. Community Navigators network with local community groups, interventions and services, taking an asset mapping approach to understand what they offer.

"I had a [person] referred…[with]…really bad anxiety, and it was initially to support her to get to her appointments in the hospital. Over time, we built her confidence by supporting her to go there. [Community navigator] joined her up to community transport, then [went] with her on community transport to an appointment…I'd say, 'Right: you lead the way to the appointment', because it was even anxiety over which bit of the hospital she needed to be in…that led on to encouraging her to access more stuff in the community and to be more social to reduce her isolation"

Assistance from Community Navigators empowers people to access community assets, as does knowing that they can return for further support, if required.

Community assets

Community Navigators refer people to a range of community groups, interventions and/or services, such as:

- Groups to increase physical activity and strength, e.g. Dance to Health, which is aimed at falls prevention; and Feel Good for Life, which is for people with dementia and their carers
- Support groups for those experiencing specific health issues, e.g. stroke; anxiety
- Home safety adaptations, e.g. Care and Repair
- Wellbeing-focused arts and crafts groups
- Accommodation support, e.g. guidance on completing tenancy paperwork
- Debt and benefits advice, e.g. through referrals to Citizen's Advice, and Warm Wales (an organisation which advises people on home energy efficiency)
- Employability Wales, which promote employability through developing skills and confidence
- Food bank vouchers or referrals to community pantries.

Community Navigators also support people directly to help them to access public or community transport and attend hospital appointments.

Impacts of social prescribing on health and wellbeing needs

The Community Navigator Team Leader has observed the following impacts for people who have engaged with wellbeing activities, or community groups, interventions or services:

- Engaging with local activities has encouraged people to connect with others in similar situations, often sparking meaningful relationships and extending community engagement.

"People often build their confidence and end up supporting the group they went to, to deliver activities to other people. It's that sense of belonging to a community…Our whole project really is about social connections…often people will share lifts and make friends and have friendship groups outside of that activity and meet for coffee"

- Activity-focused groups such as “Feel Good for Life” and “Dance to Health” have increased people’s physical activity.
- Being supported to engage with community services and support, such as food pantries and lunch clubs have promoted healthy eating, suggesting potential benefits to physical health and wellbeing.

“Feel Good for Life… is a session run for people with dementia and carers of those people, but that’s broadened a little bit now. It’s those skittle type games, but those games do really improve people’s health and mental wellbeing [through] moving more… [In] food pantries…random fruit and veg might turn up in those bags, but they’ve got recipe cards and things like that so people can cook better in their homes”

- Some people’s financial situation have improved through receiving advice on benefits, budgeting, and debt. Others have boosted their employability, confidence, and self-esteem to help prepare them to re-enter employment.

“There’s maximising of their income through referrals to Citizen’s Advice and Warm Wales, so then that means they’re able to do more things [and] eat better… Bringing more money to people brings more money to communities, and that will support the community and activities to prosper a bit more”

Social Prescribing Practitioner: A Wellbeing Coordinator's story

This case study is based on feedback from a Wellbeing Coordinator, who works in an NHS-funded role for a third sector organisation in Rhondda Cynon Taf. In this case study, we find out about how they support people through social prescribing.

Reasons for referral

Around half of all referrals are for mental wellbeing support. The remaining half relate to a range of health and wellbeing concerns. People also have different levels of need.

"Sometimes it is just information, advice, and guidance…sometimes it's just being with an older person who's a bit lonely and they're looking for local groups in their community…sometimes it is very soft support: they come and go, and that's it. Or it could be that someone is coming to you with so many needs that they've got to the point where they don't know what to do…They come with all of these impacted needs, and then I try to make a bit of a short, medium [and] long-term plan"

Social prescribing pathway

Referrals are mainly received from GPs, but also come via self-referral, other healthcare professionals, social services, the Job Centre, the National Probation Service, and local authority housing departments. The Wellbeing Coordinator is also based part-time at community venues, where people drop in to speak to them.

"I do my introduction of who I am and what my role is, and I would say, 'The doctor or housing have referred you or you've self-referred to me to look at what support needs I might be able to help with'. I'm really mindful not to say, 'I'm here to fix anything'…so it's what I might be able to help with. Then they usually have half an hour to 40 minutes to tell me what's going on"

After the initial referral, people have a three or six-week follow up with the Wellbeing Coordinator to ensure that the right services and support are in place. The Wellbeing Coordinator and their team engage with communities directly to see what community groups, interventions and services are available.

Having simple one-page referral forms and access to the correct information about individuals all facilitate referring to support. People engage better with wellbeing activities, or community groups, interventions or services when Wellbeing Coordinators or services themselves help them to do so.

Community assets

People are signposted to a variety of community groups, interventions and/or services, including those for:

- Financial / cost of living, e.g. benefits or debt advice; food banks, “community cupboards”, and “fair share” schemes; fuel poverty
- Mental health, e.g. wellbeing groups, dementia-friendly cafés
- Social isolation and loneliness, e.g. gardening groups; arts and crafts groups
- Housing and accommodation, e.g. adapting homes to increase safety, domestic abuse-related issues
- Education, employment, and training, e.g. CV building, confidence building, job seeking; specific training courses; and volunteering
- Physical health, e.g. healthy eating and exercise groups; antenatal groups.

Impacts of social prescribing on health and wellbeing needs

The Wellbeing Coordinator has observed the following impacts for those who have engaged with wellbeing activities, or community groups, interventions or services:

- Through local groups and follow-on support, people have improved their diets and engaged in regular physical activity to achieve healthier lifestyles.

“One of the biggest issues within RCT and Merthyr is obesity, so that’s something that is really pushed within the [primary care] cluster and the groups and funding. So, lots of groups focus on that… that makes a difference to a person, because it’s setting realistic goals…It’s more about supporting the person than just telling them they’re doing something wrong. That makes a big difference”

- Combining targeted community-based support with counselling and advice and/or medical treatment from the GP has helped improve people's mental health and wellbeing.

"Having that safe space where they feel they can talk about how they feel and they're not going to be judged, no stigma, that makes a massive difference to people who are struggling"

- Signposting people to services and support which align to their interests, as well as their needs helps to ensure their success in improving people's social wellbeing.

"Part of our role…is to know what's available in the community and to know what those groups are like…Then when we meet people, we can say, 'There's a knitting group, a gardening group, [and] an arts and crafts group. What might you be interested in?' Then we try to be really person centred…because there's no point me sending somebody to a gardening group if they've got absolutely no interest in gardening because they're not going to engage"

- People have gained specific knowledge through support and services accessed via social prescribing, which has helped them upskill and ultimately find employment.

"Somebody says, 'My end goal…is to work with children', but they don't know how to get from a to b. Part of my role is to give them information, advice, and guidance. I have to say, 'Here are some of the options I think might be suitable'. It might be starting with an online course, a course in person, a course in the local group, a first aid course…Then when they go to that course in college, they can say, 'These are all the courses I've done so far'"

Social Prescribing Practitioner: A Student Support Navigator's story

This case study is based on feedback from a Student Support Navigator. They work in a university setting in North Wales. Following an initial trial, social prescribing is now available to all students at the university. In this case study, we find out how the social Student Support Navigator supports students through social prescribing.

Reasons for referral

Over 65% of students at the university are aged 25 and above. Many experience stress arising from balancing their studies with family and work commitments. Others require support with mental and physical health needs; domestic abuse or challenging relationships; and financial difficulties.

> *"…a significant proportion of our students have diagnosed mental or physical health conditions that they bring to university with them. We have a significant uptake in our mental health services, broadly for self-harm, suicidal ideation, managing their conditions day to day, medication issues…It's broad. It's anything and everything"*

Social prescribing pathway

Students can self-refer via an online form or in-person at the university. Alternatively, students approach a member of university staff, who refer them to the social prescribing service. The Student Support Navigator and their team then review the referrals which are documented on a central system. Following referral, the Student Support Navigator meets with students. During the meeting, they have a 'what matters' conversation. This involves motivational interviewing techniques to fully understand their needs.

> *"We'll stay engaged with that student to make sure that support is working for them…or if we need to look at an alternative…We follow them through that journey to make sure they're engaged and that it's worthwhile for them, then…we can review and reflect with them then and look at what they've learnt from that process and how in the future they can support themselves to build resilience and encourage that empowerment"*

The Student Support Navigator then co-creates a bespoke action plan in partnership with students. This often includes referrals to in-house services and community assets, with support from the team to help them to engage. The Student Support Navigator then liaises with students to assess the helpfulness of the support and plan how to sustain improvements over the longer-term.

The Student Support Navigator and their team find out about local community assets through networking rather than using directories.

Having the time and capacity to work with students in-person, for as long as they need, helps ensure that they receive appropriate support. Referrals are made easier when they contain more detailed information about people's needs. The availability of services within the university facilitates referrals because this removes the need to refer out to community-based and/or statutory services which often have long waiting lists.

"If their wellbeing is at an all-time low, they're not going to be motivated, they're not going to be engaged, they're not going to be able to progress with their studies… So, we work really closely with the tutors to encourage them to understand what the student is going through, if there's any support they can put in place from their side of things such as extensions…"

Students seem to appreciate having consistent support from the Student Support Navigator to help them engage with wellbeing activities or groups, interventions or services, both initially, and over the longer-term. The Student Support Navigator also works with tutors to help them to understand how best to support their students to succeed in their studies.

Community assets

The Student Support Navigator and their team support students directly and refer them to a range of in-house support and services, including:

- Mental health services, e.g. counselling, mental health nurse
- Advice on course funding and managing finances
- Careers services, e.g. CV building, job seeking
- Learning support, e.g. providing equipment and additional support to students with diagnosed learning difficulties or disabilities.

Impacts of social prescribing on health and wellbeing needs

The Student Support Navigator has observed the following impacts for people who have engaged with the university social prescribing service:

- Social prescribing can help people to reflect on their behaviours, learn healthier coping mechanisms, and increase their resilience should they experience health and wellbeing concerns in the future. This helps promote sustainable improvements in mental health and wellbeing.

"A lot of the work we have done has got people to reflect on their behaviours and encouraged them to look at how they could support themselves"

- The Student Support Navigator feels that the intensive support offered through their service has enabled some students to gain qualifications that they may have struggled to achieve without social prescribing.

"A lot of our students would not have been able to go anywhere else to undertake these degrees. They don't have the educational background…We get them that degree by the support we put in place and the extensive support we give to follow them through those two or three years to make sure we are liaising with tutors to let them know they might need a bit of extra time or whatever it is…to give them that equal opportunity"

Case Studies: Referrers to Social Prescribing Services

This section consists of three case studies from:

- A Clinical Lead Occupational Therapist
- A General Practitioner (GP)
- A Frailty Nurse

Referrer: A Clinical Lead Occupational Therapist's Story

This case study is based on feedback from a Clinical Lead Occupational Therapist for Mental Health and Learning Disability services across Primary and Community Care in the Betsi Cadwaladr University Health Board area. In this case study, we find out how their teams utilise social prescribing services and community assets to support people.

Reasons for referral

Occupational Therapists work with individuals whose needs are more complex and require a more tailored approach for them to be able to actively engage and participate in social activities. Combining risk assessments with a shared decision-making approach to understand people's needs and concerns, and plan how social prescribing can help address them.

Social prescribing pathway

Occupational Therapy focuses on people's strengths and enables individuals to carry out the activities or occupations they want and need to do in their lives. Occupational Therapists may make a number of referrals depending on the person and their needs. Referrals are made to a variety of statutory services and third sector organisations. They may refer or signpost people to a social prescribing service, or directly to appropriate community assets.

> *"The referrals out of our services are multitudinal and various. Really, what we need to do is make sure we've got consent from that individual, we're documenting that consent and then we're completing that referral either with them or for them: whatever works best"*

Enabling people to successfully engage with social prescribing services is an important aspect of Occupational Therapy support. For example, Occupational Therapists achieve this through encouraging people to learn techniques to manage their anxiety and build their confidence.

A 'what matters' conversation helps build up a complete picture of people's support needs.

Having a good understanding of, and a strong referral relationship between social prescribing and Occupational Therapy service is vital. Therefore, Occupational Therapists tend to have a good understanding of appropriate community assets, and spend time networking with community groups, interventions and/or services to understand their offer.

Community assets

People are encouraged and supported to access social prescribing services and a variety of support based on their needs, including the following community groups, interventions and/or services:

- Pain clinics
- Audiology services
- The National Exercise Referral Scheme (NERS)
- A support group for survivors of sexual abuse
- Men's Sheds
- MIND, for mental health
- Online mental health resources, e.g. Cognitive Behavioural Therapy (CBT)
- Counselling, for bereavement (e.g. Cruse); relationships
- A carer's support group
- Support for drug and alcohol misuse
- A women's mental health group
- An outdoor wellness group.

"This person had lost a parent, and…they were consumed by grief… So, the practitioner did a bit of work with them, explaining how grief functions…what it feels like and that it's normal… They referred them into Cruse…Then they said, 'When you're waiting for Cruse, is there anything else you'd like to talk about?'. They came and said, 'actually, I'd really like to get a bit physically fitter'.

So, after three weeks of intervention, this person was out walking the dog again…they were out doing stuff that was important to them… We referred them into the National Exercise Referral scheme as well…they'd gone from this really dark and difficult place, and I think right support at the right time, ability to overcome and unpick the barriers with that person"

Impacts of social prescribing on health and wellbeing needs

- The Occupational Therapist observes that people with low-level mental health needs tend to achieve the greatest mental health and wellbeing impacts through accessing services and support via social prescribing.
- They also feel that with the right support, there is potential to support more people with complex needs through social prescribing, and that over time, this support could reduce people's medication needs, and help improve their mental health

> *"I think about all the people with schizophrenia, depression, anxiety, and dementia. Their lives become fully focused on medication….Those people, if they had access to the right support, I think that could make a massive difference"*

- The Occupational Therapist has observed that some people have successfully gained or returned to employment through the community assets they have been directed to through social prescribing.

> *"If you've got someone saying, 'I'm really struggling with employment', there are organisations out there that can help…[the Department for Work and Pensions] commissions loads of stuff to try and help people back into work [but] I don't think it's widely taken up"*

Referrer: A GP's story

This case study is based on feedback from a GP that referrers individuals with health and wellbeing needs to a social prescribing service in the Cardiff and Vale University Health Board area.

Reasons for referral

Although people often present at the GP practice with medical concerns, alongside this many have general health and wellbeing needs. Most referrals to social prescribing relate to social isolation or mental health concerns, and others relate to housing or financial concerns. As a referrer, the GP has a 'what matters' conversation with the person to understand how they can be supported through social prescribing.

Social prescribing pathway

The GP utilises a variety of referral pathways depending on the person and their needs. They refer people either to a Social Prescribing Practitioner, or directly to community assets.

> *"There needs to be lots of different routes into social prescribing… We're trying to have as many different pathways in as possible, really. It shouldn't all be through the GP, but from a GP referral perspective, having a good referral system is the best way for us to refer. We feel Elemental fulfils that"*

Community referrals are facilitated by networking with community organisations. This involves connecting with various community groups, interventions and/or services to find out what support is available. Self-referrals are also encouraged. The GP uses Elemental software to manage social prescribing referrals, a digital system that links to patient record systems.

The GP emphasised that social prescribing has provided a new way for GPs/practice staff to help people with non-medical concerns. As a GP, time is limited, Social Prescribing Practitioners have the time and capacity to listen to people's concerns, which is key to understanding people's needs and interests, and in making appropriate referrals. Social Prescribing Practitioner's support enables people to commence engagement with community assets. After that point, most people feel empowered to engage on their own.

> *"Previously, we would see patients with a lot of these problems, which we didn't really feel equipped to help and support with. Medication isn't necessarily going to help with those problems. I feel it's really empowering to help us as GPs to support our patients in the whole of their lives. That in turn obviously improves health outcomes as well"*

Community assets

People access all kinds of support based on their needs, including:

- Housing and debt
- Collecting shopping and prescriptions for people, particularly throughout the COVID-19 restrictions
- Bereavement
- Social isolation, e.g. befriending; activity groups such as “the Grow Well Project”
- Support for young parents, e.g. cooking classes; healthy living information; parenting support
- Food banks.

Impacts of social prescribing on health and wellbeing needs

The GP has observed that social prescribing has mainly helped to improve people’s mental health and wellbeing, although they have also seen improvements in some people’s physical health. This was indicated through wellbeing questionnaires administered by the GP practice. Improved outcomes around housing and financial concerns have positively impacted people’s mental health and wellbeing. Social prescribing has also helped some people return to employment.

“So many people have been helped with things like financing and housing. The other thing we’ve seen is people getting back into employment after they’ve been out of employment for some time. This has obviously got huge gains for them personally and on a wider society basis as well”

Referrer: A Frailty Nurse's Story

This case study is based on feedback from a Frailty Nurse, who is using a Population Health Management approach to support people to address fuel poverty needs in the Taff Ely Primary Care Cluster area, in Cwm Taf Morgannwg University Health Board.

Reasons for referral

This project tested the feasibility of applying a Population Health Management approach to address winter pressures and use targeted, proactive case finding to identify individuals most at risk of adverse health effects of fuel poverty, including exacerbation of chronic conditions.

Individuals were identified using a combination of Population Segmentation and Risk Stratification (PSRS) data and GP clinical data.

> *"We were trying to identify patients at risk of fuel poverty and around 1 in 10 patients that participated in the project were signposted to a warm home service but a much larger number had unmet health needs (1 in 5)."*

Individuals were included in this project based on a number of characteristics including age (65+), deprivation, number and type of chronic conditions and being in certain segments of the population related to their health needs. During the initial contact, a 'What Matters' conversation identified significant unmet need. This related to social isolation or mental health concerns, and issues relating to housing, finances, or domestic tasks.

Social prescribing pathway

The Frailty Service targeted those at highest need first using a prioritisation criteria co-developed with the Health Board's Population Health Management Unit. This enabled a proactive approach to contacting individuals.

> *"Been useful to target a specific group and identify those that may be more at risk of adverse health outcomes due to financial deprivation."*

The Frailty Nurses and Health Care Support Workers contacted individuals via telephone and engaged in a 'What Matters' conversation and needs assessment. Although most

individuals present with health related concerns, there are often social concerns that worsen people's health. To address these concerns, referrals were made to Social Prescribing Practitioners and links established with third sector organisations, allied health professionals, social services, Nest and others including the Warm Hub.

"We've always been led by the 'what matters most'. Sometimes you might identify someone who's got chronic conditions, you might ring them and that might not be an issue to them. Their biggest issue could be they can't get a taxi to go and do their shopping. From a winter fuel project perspective, we did have a lot of people sat in cold homes. it was really important from a social prescribing element that these people were aware of where to get that support, and for us to know where to refer onto"

Successful collaborative working between all project partners helped ensure that people were able to access appropriate support in a timely way without reaching crisis point. Social prescribing facilitated this by providing an alternative intervention to traditional health services by supporting people through community groups, interventions and/or services.

Having direct access to PSRS and clinical data, prioritised patient lists, and community assets facilitated the success of the project.

Community assets

People are signposted or referred to a variety of support based on their need(s), including:

- Housing and living support, including domestic tasks such as cooking
- Food banks and 'meals on wheels'
- Cognitive screening and further medical assistance
- Referrals to physiotherapy, occupational health etc
- Physical health concerns such as hearing/vision loss, and others
- Social isolation and mental health support
- Carer support.

"Had a call from the frailty team today, had never heard of the service what a wonderful idea, was so lovely to know that there was someone looking out for us and also was very knowledgeable with their advice. Made my day…" (Recipient of project)

Impacts of social prescribing on health and wellbeing needs

- The Frailty Nurse observed that individuals who are most at risk of the adverse health effects of fuel poverty report improvements to their quality of life. This was achieved in part by supporting and educating them on their individual energy costs.

> *"One gentleman [had] switched his water off at the mains because he was scared of his gas bill … He saw the stories on the news and couldn't think of anything else. It was education about the fact that yes, bills were increasing, but he only had half the information"*

- The project collated feedback in different ways depending on individual's circumstances. Paper questionnaires, QR codes/online surveys, and post-intervention follow ups with individuals evidence the impacts this project had on physical health, mental health, and social wellbeing of those it engaged. A full evaluation of this project is being conducted and is due to be reported early 2024.

Case Studies: A Community Asset

This section consists of one case study from:

- An Outdoor Project Manager

Social Prescribing: A green prescribing story

This case study is based on feedback from an Outdoor Project Manager. They work with local outdoor providers in Gwynedd to help them create wellbeing programmes. In this case study, we find out how they support people and organisations through green social prescribing.

Reasons for referral

People's needs vary, although most are referred for support with mental health concerns, bereavement, and social isolation.

Social prescribing pathway

Most people self-refer. Some are referred by NHS services, local support organisations, the Green Health Wales network, and through health professionals on the organisation's own outdoor network.

"[For] people from the psychosis unit, … their practitioner knows about us… So, she refers and registers them, because a lot of people don't want to talk on the phone, and then she brings them along…. Another method is say someone has contacted…the Red Cross and [they] think our programmes will be beneficial, [they] then refer them to us…Then you've got the average person on the street who sees a poster and thinks, 'I need a bit of support with wellbeing', then…they just fill [the registration form] out and come along"

People find out about the wellbeing programmes through social media or through voluntary sector organisations. Upon referral, a registration form is completed which documents physical capabilities and mental wellbeing.

Referrals are made easier by strong collaboration between the project and the referring organisations. Offering consistent, high-quality provision helps organisations feel confident that people will benefit from attending the wellbeing programmes. Gentle encouragement is key to helping people to access support. Ensuring the suitability of support for those accessing it is also important in fostering their engagement.

"Just no pressure and complete acceptance. I've got a girl who wants to come on to our bushcraft course. We're three weeks into the programme and she just keeps messaging me saying, 'I'm sorry, I'm having a really anxious day today. I understand if you want to give my place away', and it's like, 'No: this is your course and part of your programme and this is what you get out of it'. If the thing you get out of it is you turn up, then that's going to be a celebration"

Community assets

The project offers six-week outdoor programmes incorporating walking, gardening, and bushcraft. The programmes are offered in partnership with local community organisations which signpost people to various services.

"We offer…programmes for those who are a bit nervous to go into the outdoors and meet new people. [They are] closed programme[s] just as a gentle introduction to getting out and about…Once they complete [a] six-week programme and they feel a bit more confident…they can then start to open themselves up to other opportunities with organisations in the area"

Impacts of social prescribing on health and wellbeing needs

The Outdoor Project Manager has observed the following impacts for those who have accessed their services and support. People also complete feedback forms after engaging with the programme which capture some of the impacts they have achieved.

- People have increased their physical activity levels through accessing walking groups. Some people have joined or set up new groups with others they have met on programmes, helping to embed and extend these impacts.

"We've got a walking group, and there's a guy on there who didn't believe he could walk and just walked a very small amount of time…The woman running that programme is ace, and she's just been encouraging him and being playful. Now he walks a couple of miles every time he does it, and him and his friends that he's met through that programme have started a walking group"

- The programmes have helped to reduce social isolation and have increased a sense of belonging for many people.

"A [person] had a bereavement… just felt like getting out and connecting to other people has helped [them] to feel less isolated…"

- Feedback indicates that nearly everyone who engages with the programmes benefits from improvements in their mental health and wellbeing.

"I don't think there's a single group that hasn't had most of the people saying that their mental wellbeing has improved. One of them has fed back to me that she thinks it saved her life, and that she's now gone into music and dance…and she's really close to her community"

- Some people have gained skills, qualifications, and jobs through the programmes. Others have taken up training and volunteering opportunities.

"One of our volunteers…started off on the programme because of a bereavement, became a volunteer, and now they're a member of staff. We've had schemes like build a bench and woodland skills. We've got someone at the moment who has come on because of her wellbeing, but she's built quite a few skills now and she's wanting to do something around becoming an outdoor wellbeing practitioner herself. I think it's inspiring a lot of people"

Perceived Barriers and Facilitators

This section summarises the perceived barriers and facilitators relating to the social prescribing pathway, which have been identified through the semi-structured interviews with social prescribing practitioners, individuals, referrers and a community asset, used to develop the case studies. These barriers and facilitators have been categorised into the following overarching themes:

1. Sustainability and funding
2. Referral process and pathway
3. Understanding and awareness
4. Individual's capability, opportunity and motivation

Sustainability and funding

Insufficient and short-term funding were identified as challenges affecting availability and accessibility of community assets. Funding bound to certain geographical areas and/or to specific health and wellbeing needs was also highlighted as a barrier. Funding was felt to be linked to limitations in adequate levels of service capacity, presenting a barrier to referring individuals to community assets, and leaving gaps in the provision of support.

Establishing an evidence base to illustrate the impact of social prescribing on people's lives was identified as one way to support funding and sustainability issues. Reflecting on their experience, interviewees felt that social prescribing could achieve greater impact by having increased capacity to be able to support people for a longer duration.

Referral process and pathway

Some participants expressed concerns that referral processes can be complicated. For example, differences in digital systems between organisations can make it difficult to share

information. However, when used in isolation digital systems were considered to be helpful in managing referrals.

It was highlighted that some social prescribing services and community assets accept referrals from health and care professionals only (rather than self-referral), limiting the number of individuals who can access and receive support. Additionally, inconsistency of feedback loops between social prescribing services and community assets was identified as a barrier, preventing referrers from understanding how well individuals' have engaged, and whether further support is needed to enable better participation.

A simple one-page referral form and access to detailed information about people's needs were recognised as facilitators for referring people to appropriate support. For some Social Prescribing Practitioners, having dedicated time to expand and update their knowledge of community assets, as well as, developing a collaborative approach with community groups, interventions and/or services were considered key components for making referrals easier.

Understanding and awareness

Confusion about what Social Prescribing Practitioners do was reported, along with the need for a clearer distinction about the roles of organisations, services, and Social Prescribing Practitioners. Some cases expressed the need to improve understanding of the Social Prescribing Practitioner role to the wider workforce to ensure referrals are appropriate. Lack of public awareness of social prescribing and the services available to people, was also cited as a challenge. It was suggested that improving communication on what services are available and how to access them could help more people with their health and wellbeing.

Individual's capability, opportunity and motivation

It was recognised that there are many factors that can affect an individual's engagement with community assets, including their:

Capability

Psychological capability was perceived to negatively impact individuals' engagement with community assets. Feeling afraid, hesitant, overwhelmed and lacking confidence were mentioned when describing how individuals feel when engaging with a new activity through social prescribing. It was also recognised that for some individuals who have complex mental health needs, engagement can be more difficult.

A 'what matters' conversation was highlighted as a central part of the social prescribing process enabling people to identify and discuss their health and wellbeing needs. A 'what matters' conversation was perceived by some participants to help people overcome barriers which may have prevented them from achieving their goals and/or engagement with support. Some individuals who have used social prescribing services partly attributed their successful engagement due to the Social Prescribing Practitioner's approach. Examples of the qualities of a Social Prescribing Practitioner included, being approachable, positive, proactive, empowering, genuine, patient, pleasant and empathetic.

Opportunity

Transport availability and reliability was acknowledged as a challenge for individuals in accessing support, both in rural and urban areas. It was highlighted that transport can be expensive, that some individuals may be unable to use public transport due to a lack of confidence, or there may be physical barriers to using public transport e.g. living too far away from a bus stop.

The timing and location of community assets was also perceived to be a barrier. For example, employed individuals can find it difficult to engage with support groups that are held in the daytime. Additionally, some individuals have competing commitments making it difficult to find the time to participate in community groups, interventions and/or services. Digital services were also recognised to restrict access for people who do not have the digital technology or capacity to access such services. However, online digital services were

positively received by some individuals that do not have confidence or time to attend community groups, interventions and/or services in person.

Motivation

People's lack of motivation to engage with support was also identified as a key barrier to a person realising the benefits of social prescribing, as well as feeling hesitant to start something new. A high level of motivation can enhance a person's engagement with social prescribing and community assets. Having dedicated time to discuss the concerns and needs of an individual for as long as they need was perceived to be a facilitator to achieving positive engagement with social prescribing.

Appendix A: Methodology

This project was conducted by Opinion Research Services (ORS) in collaboration with the Primary Care Division within Public Health Wales (PHW) and with involvement of a multi-agency steering group, between December 2022 – September 2023.

Research purpose

The need for this project was identified by Public Health Wales to contribute towards addressing recommendation 4 from the Social Prescribing Interface paper (PHW, 2022):

- **To support those referring (including self-referral) to social prescribing with an understanding of the role and purpose of services, activities and assets to support different needs.**

A case study is a widely used methodology for investigating, reflecting upon and understanding experience and practice in public health. There are many types of case study approaches. For this project a descriptive case study approach was undertaken to:

1. Demonstrate real-life application of social prescribing in supporting individuals holistically with a broad range of physical, social and/or mental health and wellbeing needs throughout the life course
2. Illustrate that sources of referral into social prescribing are cross-sectoral and take a person-centred approach which involves partnership working.

Identifying cases

A purposive ‘snowball’ approach was used to recruit cases. A bi-lingual digital invite alongside an information sheet and consent form to take part in the project was circulated via email to the social prescribing workforce in Wales. A cascade process was used via key partners to share with their respective organisations, networks and teams. This included:

Wales School for Social Prescribing Research network, Wales Council for Voluntary Action, National Allied Health Professional (AHP) network, Health Education and Improvement Wales AHP & Primary Care network, Cwm Taf Morgannwg social prescribing network, Cluster Development Support Officer Network, along with directed contact with targeted individuals.

Expressions of interest to take part were made directly to ORS via a dedicated email address. Due to time limitations and the project being small-scale, a criteria for selection was in place to ensure a balanced sample from a variety of roles, sectors, geographical locations and the types of health and wellbeing needs being addressed.

The criteria for selection included:

- Health board region
- Job role and sector
- Referral routes (including self-referral)
- Services / activities / support referred to
- Health and wellbeing needs most commonly addressed
- Willingness to act as a ‘gatekeeper’ introducing individuals that have used social prescribing services to the researcher

ORS and PHW reviewed the list of potential cases and included or excluded based on the criteria.

Gathering information

Selected cases were contacted by email and/or telephone to arrange a voluntary virtual interview and were provided with an information sheet detailing: purpose of the project, what the project involves, how data is stored and used, as well as contact information. Interested cases were then and asked to provide agreement and written consent to participate and were able to opt out at any point.

In May 2023, information was gathered through a one-to-one semi-structured interviews with an ORS researcher, conducted virtually using Teams or Zoom software or via telephone. Interviews were approximately 45-60 minutes in duration and conducted in English or Welsh, in line with participant preference. With the cases' permission, digital recordings of interviews were recorded to enable detailed notes of discussions.

Two discussion guides were produced to facilitate interviews, one for Social Prescribing Practitioner/Referrer and one for individuals that have used a social prescribing service. Whilst both discussion guides were tailored to capture different views and experiences, they both covered similar questions relating to the following topics: reasons for referral, referral pathways and processes, types of support and services accessed, facilitators and challenges to engaging with support, improvements achieved through accessing support and services via social prescribing and any other feedback.

Analysis and interpretation

Following interviews, ORS researchers transcribed interview data into detailed notes. A thematic analysis approach was undertaken to identify, analyse and interpret themes within the data. Due to a small sample size, analysis was conducted manually instead of using a qualitative analysis software.

Write up and presentation

Research insights were then written into anonymised case studies from the perspectives of Social Prescribing Practitioners, individuals who have used social prescribing services, referrers to social prescribing and a viewpoint from a community asset. Quotations were highlighted within the case studies to illustrate experience and key points.

In light of the publication of a Glossary of Terms for Social Prescribing in Wales (WSSPR & PHW, 2023), case studies presented within this document have adopted key social prescribing terms.

Limitations

- Case studies are based on personal opinions and may not represent the same viewpoints of all of the social prescribing workforce in Wales
- Cases are likely to have an interest in or have experience with social prescribing and therefore have different viewpoints and attitudes to those who did not choose to participate in this project
- Whilst a diverse sample was obtained, what happens in one sector, will not necessarily resonate with other sectors.

References

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