



“A must have for any GP surgery. It is like having our own Social Worker, CAB, Mental Health Worker all rolled into one ... who will chase up patients on the phone and even go out to their houses if needed”

Loneliness Debt **Relationships** Alcohol
Vulnerable Self-care Holistic
Community Training Support
Caring Isolation Drugs
Family Children Benefits
Housing Education Homelessness
Unemployment Motivation
Long-term-conditions **Smoking** Complex
Domestic-Abuse Eviction
Primary-care **Mental-Health**

Social Prescribing in Torfaen: A Partnership between North & South Torfaen Neighbourhood Care Networks (NCN's)

Our Learning so Far: October 2015-March 2017



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1. Social Prescribing: Context

Nationally, it is estimated that around 20% of patients consult primary care, mainly the GP, for what is primarily a social problem. A large proportion of health outcomes, estimated at 70%, are the result of social and economic determinants of health including employment, financial security, housing, diet and exercise, familial and social networks¹.

Often patients choose to consult their GP when they feel overwhelmed with the challenges they face. However, while mental health issues may be symptomatic of the underlying issues, a clinical intervention does not offer a sustainable solution.

Social prescribing provides an intervention that seeks to address patients' requirements for non-medical support in the community. There are several ways in which this has been developed; one of the most recognised is the Bromley by Bow Centre² where social prescribing principles have been applied for nearly 20 years.

In Wales, social prescribing is gaining a strong profile with discussions being facilitated by the National Professional Lead for Primary Care and the Future Generations Commissioner. The '*What Matters?*' principle underpinning the Social Services and Wellbeing Act 2014 and the five ways of working contained within the Wellbeing of Future Generations Act 2015 lead us towards the use of social prescribing as an important feature of primary care.

The *Programme for Government*³ includes a commitment to develop a '*Social Prescribing for Mental Health*' pilot and, increasingly, Torfaen recognises the need for a focus on mental health within its service. A mapping of the evidence relating to social prescribing is being led by the Public Health Wales Primary Care Hub with a report due in June 2017. There is also a commitment to *developing a systematic*

¹ The Marmot Review 2010, 'Fair Society Healthy Lives'

² <http://www.bbbc.org.uk/>

³ Welsh Government, Taking Wales Forward 2016-2021

process for gathering and sharing social prescribing activity and to organising regional and national events to develop and share learning⁴.

In Gwent, there is interest in including social prescribing in all Neighbourhood Care Network (NCN) plans with the local public health team working to support the sharing of learning and the development of a Gwent model of delivery. North Torfaen NCN was the first to fund and implement the initiative, closely followed by South Torfaen.

Fantastic service – helpful for busy GP’s as patients come with all sorts of problems.... Some of which are far more appropriate for Social Prescriber than us. Patients are delighted with the support

2. The Torfaen Experience

Torfaen’s model of Social Prescribing was developed in response to a need to better connect primary care with a range of services that exist across the community and public sector to tackle the underlying causes of ill health and promote self-help. Whilst Primary Care already utilise many of the services available in Torfaen, the catalogue of services is ever-growing and changing, and the substantial time required in researching and connecting with these services is often not practicable..

One of the challenges to this model is that, by being called ‘social prescribing’ and being based within primary care settings, it is too medicalised. In Torfaen we developed in response to a need to reduce demand on primary care and a recognition that many patients are looking for a clinical intervention or one that is, at least, recommended by a clinician. By basing the service in GP surgeries it is positioned as a viable alternative to medical intervention. We are giving patients the option to choose a non-medical solution but with the confidence that it comes recommended by their clinician. North Torfaen Neighbourhood Care Network (NCN) in partnership with Torfaen County Borough Council (TCBC) created the role of Social Prescriber to be this link and the post was appointed from 19th October 2015. There has been a weekly presence in participating GP surgeries since January 2016.

A Social Prescriber for South Torfaen was approved by the NCN in October 2016 and commenced in post from January 2017.

“Abersychan surgery covers some of the most deprived wards in Wales. These patients cannot access the services they need due to lack of education, knowledge and disengagement with providers. She is their advocate for helping them improve their lives”

⁴ <http://www.primarycareone.wales.nhs.uk/social-prescribing>



How it works in practice

There are six participating surgeries in North Torfaen and seven in South Torfaen.

The Social Prescribers are based within each participating practice half a day a week and receive referrals from anyone based within primary care or from the patient themselves⁵. The referral criteria is open, basically, anyone experiencing a social issue that is impacting on their physical and / or mental health.

“I feel secure with you because you listen”

Generally, appointments are booked in by the practice with the Social Prescriber having access to the patients records so that they can understand the background and add to the notes. Appointments are booked in for 45 minutes but can run over significantly if there is diary space and the patient needs more time. It is an opportunity for the patient to tell their whole story and to work with the Social Prescriber to prioritise issues and decide how best to resolve them. Sometimes patients themselves come to the conclusions about what needs to be done just by having the opportunity to talk about their situation.

The initial concept was that the patient would be seen, their needs understood, some actions developed and appropriate onward referrals made. Where the patient needed some support to access a service, for example, an introduction, then this would be facilitated. However, our experience is that some patients would benefit from on-going support to navigate services and to take positive steps to improve their own well-being and outcomes. At Bromley by Bow the service is delivered at three levels and we are considering how we might adopt and adapt their level 3 intervention which provides up to six sessions of support to set, implement and review personal goals. Other patients require more practical support which it is the role of other services to provide but, often, there are barriers to accessing this as quickly as we might like.

Co-production is an approach to public services based on equal and reciprocal relationships between professionals, people using services, their families and their communities. Transformative co-production, the most advanced form of this approach, is based on an assumption that individuals are ready to engage in an equal and reciprocal relationship with professionals, their families and their communities. Many of the individuals accessing our service are vulnerable with complex circumstances looking for someone to support them to tackle their presenting need. It is through a reciprocal conversation that underlying needs are identified, the outcomes they want are co-produced and they are helped to understand how they, with support, can take action to achieve them. The underpinning question is ‘what matters to you?’⁶, and the balance between individual and professional begins to shift.

⁵ The Mount and Churchwood Surgeries in Pontypool are co-located and currently share one half day. This is under review.

⁶ A key principle of Social Services and Wellbeing Act 2014



H was referred to the Social Prescriber by a concerned relative. There had been some issues with the payment of his Employment Support Allowance (ESA), he was not opening his mail or leaving his home and needed to see the GP but would not make an appointment. On initial visit the Social Prescriber and Communities First Financial Inclusion Officer were concerned, amongst other things, for his mental wellbeing.

The presenting needs of lack of food, re-instatement of benefits and accessing the GP were supported and focus shifted to the underlying needs and how H could resolve them. Within days H had gone from someone who would not answer the door, the phone or open his mail to someone who was re-arranging his own appointments, organising transport and arranging for a family member to undertake some domestic tasks. By providing the support to remove the immediate stresses, the Social Prescriber had enabled the capacity within H to support himself. This had a positive impact on his self-esteem which promotes his ability to cope. He has now been allocated a Support Worker from Gwalia to continue his journey to wellness.

3. What have we achieved?

North Torfaen NCN set the following outcomes to be achieved within the first 12 months of delivery

- *Develop a referral mechanism from primary care into community services*

A referral mechanism is now in place in 6 participating surgeries in North Torfaen and has been extended to a further 5 in South Torfaen (with 2 surgeries to be added). There are two main systems of referring, one paper based and one electronic, although there is movement away from the paper based system. The Social Prescribers can access each of the surgeries records with reception staff booking in their appointments. Use of this system has only become more widespread quite recently and early indications are that it reduces the incidence of those that do not attend (DNA's). With access to the patient records, the Social Prescriber can get a good understanding of the background (which wasn't possible from a paper referral) and add notes of action taken.

- *Identify priority needs through analysis of referrals*

We have used the following categories to define and record the primary reason for referral⁷. However, the presenting need identified by the referrer is often not the underlying issue that the individual is looking to resolve. Neither does the data adequately reflect the poor mental health that is often present alongside the presenting need. We have, therefore, found this limiting in our analysis of the referrals and will take steps to improve this in 2017/18. Further data development

⁷http://www.nhsconfed.org/~media/Confederation/Files/Publications/Documents/illness_to_wellness_241011.pdf

is also required to identify need by practice, in particular to compare North and South Torfaen.

The data does highlight what we understand from anecdotal evidence that mental health and social welfare are the most common reasons for referral.

	Jan-Jun 16	Jul-Dec 16	Jan-Feb 17	Total
Healthy Lifestyle (predominantly Mental Health)	50	66	14	130
Family and Early Years	5	10	1	16
Health Protection & Personal Safety	8	15	3	26
Welfare	52	74	26	152
Self-care and Independent Living	21	22	5	48
Work, Learning & Skills	15	21	4	40
Community Development & Leisure	31	30	8	69

- *Provide GP practices with a range of promotional materials on local services*

All surgeries in North Torfaen have provided notice board space and specific information material has been produced and distributed on financial services and welfare reform.

- *Develop an evaluation tool to collect evidence on the value of the service*

This report includes the information we currently monitor although we recognise that there is a need to develop our data collection, recording and analysis. One of the outcomes reported on for Torfaen CBC is the number of patients that have reduced their consultations with primary care following intervention by the Social Prescriber. This has been challenging to collect, although we have some, limited, evidence that there are such cases⁸.

How many?

North Torfaen	Nov 15 – Apr 16	May – Oct 16	Nov 16 – Feb 17⁹	Total
Number of surgery sessions	86	107	67	260
Total number of referrals	136	211	140	487
Numbers attending consultation	72	115	88	275
Numbers resolved by telephone intervention	29	20	28	77
Did not attend	17	34	11	62
Did not engage	8	41	13	62

⁸ Initially we looked at patient records on a sample basis, however, this is time consuming. We followed up with a survey of primary care practitioners referenced later in this report.

⁹ Transitional period during Feb - March with change of post-holder



Number of queries not requiring direct client consultation	10	8	20	38
Face to face reviews / follow ups	Not counted	49	44	93
Telephone reviews / follow ups	Not counted	91	114	205
Number of onward referrals made or services signposted	126	156	108	390

Of 487 referrals, 352 (72%) individuals either attended a consultation or received a telephone intervention and 38 (8%) referrals were resolved by providing information directly to the referrer. Over 80% of those referred were, therefore, engaged in the service. (Bromley by Bow have comparable DNA rates with 24% of referred patients)¹⁰

Referrals by Practice:

Practice (Size)	Jan– Mar 16	Apr-Jun 16	Jul-Sept 16	Oct-Dec 16	Jan-Feb 17	Total
Abersychan (10,561 / 21%)	31	18	38	34	17	138 (30%)
Blaenavon (6,130 / 13%)	7	13	13	18	10	61 (13%)
Churchwood (6,767 / 14%)	6	9	7	6	4	32 (7%)
Mount (11,540 / 23%)	20	18	20	36	18	112 (24%)
Panteg (6,483 / 13%)	14	17	17	8	4	60 (12%)
Trosnant (7,909 / 16%)	9	15	15	18	8	65 (14%)
49,390						468¹¹

Generally, the number of referrals per practice is relative to patient numbers as a percentage of the overall population. However, Abersychan refers significantly more and Churchwood significantly less. Discussions with individual practices over how the service is working for them will take place during the early part of 2017/18.

¹⁰ http://www.bbbc.org.uk/data/files/Knowledge_HUB_SP/MEEBBB_Social_Prescribing_report_-_final_Jul_2016.pdf

¹¹ This figure is different from table above as does not count referrals received in Nov and Dec 2016; there is also a data anomaly in that the numbers in the monthly reports don't tally. Improved electronic systems should avoid this in future



Where do we refer to¹²?

41% of onward referrals are to organisations that support with financial and housing issues and 17% are to mental wellbeing services. However, 9% of referrals were made to Torfaen Floating Support which provides support for housing related needs, including mental health.



Other onward referrals are wide ranging from leisure services including community based art classes to weight management and carers support

So what?

“It means we can deal with the patients’ medical problems and treatment – rather than social problems, which I can do little about”

Between October and November 2016 we conducted a survey of primary care practitioners to gain feedback on the service. There were 16 responses, all of which were positive about the service and 11 of whom said that it had reduced, and made more appropriate, primary care consultations. One respondent gave 3 examples of reduced consultations: *“agoraphobic house bound patient needing basic help to empty bins and start engaging with primary mental health care services for first time;*

¹² Note: there is a data anomaly with our record of onward referrals showing as 390, but when broken down by agency only 347 are counted. The % are based on of the 347.



Housing issues; Access to children being blocked by ex-partner” and another “recalled two or three people who were happy to be referred onto an appointment....rather than further review with myself as part of the Primary Care Mental Health Service (PCHMS)”. The survey highlighted the added value of the intervention to PCMHS whose responses reflected the need to resolve social issues to improve the chances of the success of mental health interventions.

“A client who was having financial problems so needed to resolve this first prior to depression”

4. What have we learned?

- Our participation in the Public Health Wales led ‘learning in action collaborative’ for co-production projects has enabled us to access funding and support for learning activities. As part of this, facilitated by a consultant, we have developed a ‘*Theory of Change*’ which provides us with a **strategic action plan** for the development of social prescribing and an integrated wellbeing network.
- At the **project delivery** level, there have been a number of lessons learned, in particular in relation to the levels of vulnerability of referred patients, which have prompted a review of service delivery.

John attended the appointment on the Thursday and was due to return to court the following Tuesday expecting to be evicted. His Employment Support Allowance (ESA) had been stopped 4 months previously and he was in significant arrears. By working with the Housing Solutions team and Bron Afon the eviction was adjourned. Unfortunately John experienced a psychotic episode a few weeks later and was admitted to hospital. He has now been allocated a support worker and there are regular case conferences between agencies working towards a long-term solution

- Developing strong **partnerships** is important in order to escalate a referral to a priority level. Once a patient has confided in the Social Prescriber they are looking for a fairly quick response, especially when they are in crisis; whilst we cannot influence waiting lists or referral criteria, good relationships with partners will assist in accessing appropriate support in a timely manner.
- One off sessions are often not enough and **significant follow up** is required, whether this is direct contact with the patient or with the services being referred onto. The service has developed flexibly to accommodate this but this easily fills the non-surgery time and raises questions for workload and capacity. There are challenges moving on the patient to the appropriate service meaning that the Social Prescribers do more to support than the service was initially designed to do. Many individuals would benefit from ‘lead’ or ‘support’ workers to help them to navigate services.

- **Monitoring outcomes** can be challenging, particularly in relation to evidencing the reduced demand on primary care

5. What happens next?

The project is funded until 31st October 2017 in North Torfaen and 31st December 2017 in South Torfaen with some tentative discussions around how we can ensure that recurrent funding is secured.

The transition from Communities First will have an impact on the types of services that the Social Prescribers refer into and this impact will need to be understood and responded to over the next 12 months.

Opportunities for development including strengthening links with specific parts of the primary care system, but also secondary care, e.g. chronic pain / physiotherapy and mental health. However, this is dependent on increasing resource.

The following key actions are a priority for 2017/18:

- Identify and secure funding to commission a formal evaluation
- Continue to develop and improve monitoring systems
- Review the person specification and job description
- Develop new marketing materials to encourage patients to self-refer
- Provide training to reception staff to empower them to sign-post directly to the service.
- Strengthen key relationships, in particular, with housing support services and social care
- Identify opportunities to create additional resource to further support primary care and extend model to secondary care

“Appreciate it Lynn – I have not had support like this before – thank you”

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