Enhanced Social Prescribing Service Report

Social Prescribing Mental Health Team

December 2023

Reporting period: October 2022 - November 2023

The Rainbow Foundation

EXECUTIVE SUMMARY

RAINBOW COVERAGE AND LOCAL CONTEXT

Rainbow Foundation Enhanced Social Prescribers operating in **20 GP Practices** across Wrexham, available to all patients who have a Wrexham GP

27,625 people (20.4%) have a limiting long-term illness in Wrexham

INPUT

£74,000 is the current **contract value** of the Social Prescribing Team (2.28 WTE) covering **20 GP Practices across Wrexham**
This is an average of **£3,700 per GP Practice**

OUTPUTS

3,000 per 100,000 population contacts took place

Two Thirds of all appointments were addressing patients **mental health concerns**, with patients having quicker access to therapies and interventions through accessing the Social Prescribing Team. One Third of all appointments are for concerns such as loneliness, bereavement and financial difficulties.

IMPACT

85.8% of patients reported a **positive improvement in their wellbeing (S)WEMWBS**, after support from the Social Prescribing Team, with an average improvement of 4 points which is statistically significant

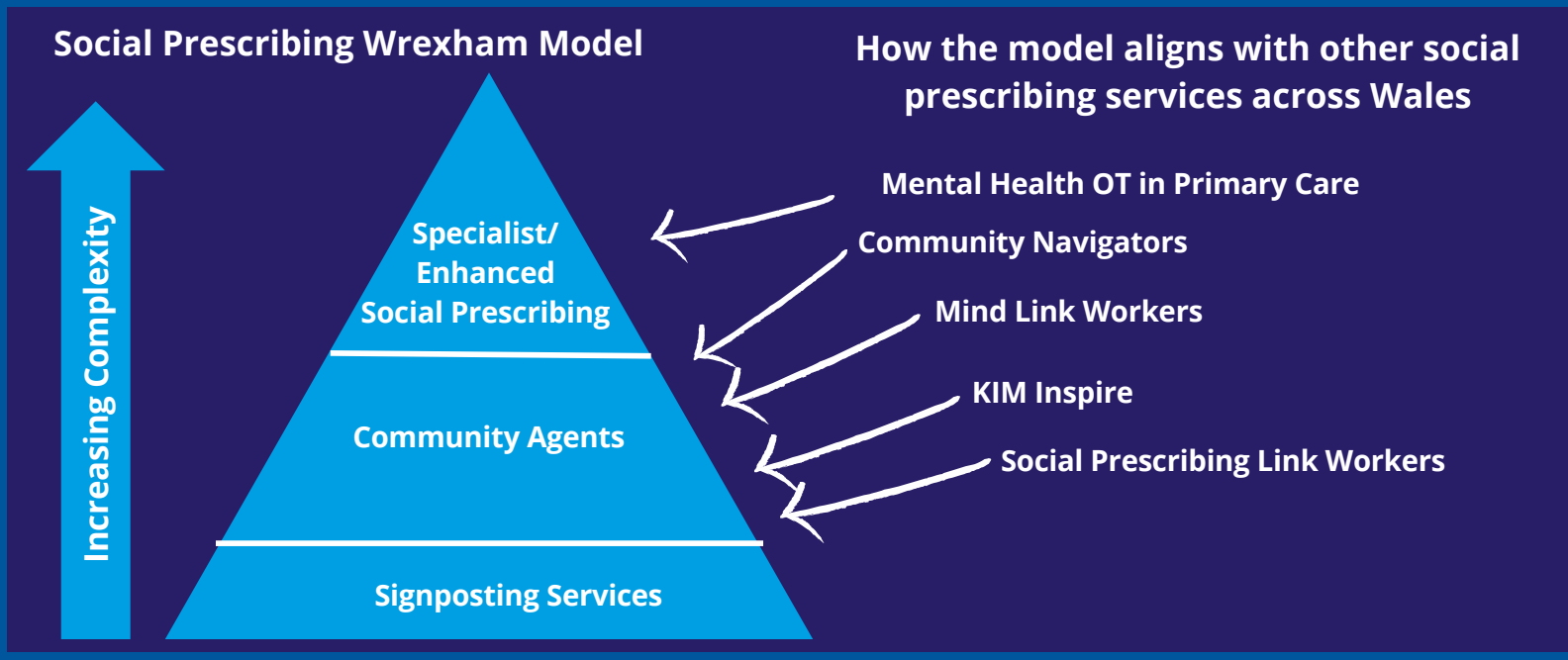
The **Social Return on Investment** for the Rainbow Foundation Social Prescribing Team is **£7.06 for every £1 invested**

3 KEY MESSAGES

about the Rainbow Foundation's Social Prescribing Service

1 COMMUNITY ASSET BASED SOCIAL PRESCRIBING

The Rainbow Foundation Enhanced Social Prescribers provide **mental health support and talking therapy (CBT)** through eight 1:1 sessions working on establishing **what matters** to the patient and health and wellbeing **goal setting**. The patient receives time with a trained Social Prescriber, qualified in mental health and/or talking therapy (Registered Mental Health Nurse or BACP accredited counsellor trained in CBT and mental health) and motivational interviewing.



2 EMPOWERING COMMUNITIES THROUGH USE OF LOCAL ASSETS

In line with the Welsh governments Tackling Loneliness and Isolation in Wales Strategy, The Rainbow Foundation Community Wellbeing Team (Social Prescribers, Community Agents and Volunteer Coordinator) is committed to identifying, working with, and developing new local services and resources that can provide personalised support to individuals, thereby enhancing community resilience and well-being aligned to the five ways to wellbeing. The Rainbow Foundation launched four Bereavement Support Groups across three different locations where people can connect with others. The groups meet monthly in Central Wrexham, Marchwiel and Penycae. The aim is to provide a safe space for people to talk in a supportive way about bereavement and what it means to them.

3 SOCIAL RETURN ON INVESTMENT

£ 1 : £7.06

for every **£1** spent
£7.06 in social value is generated

Social Return on Investment economically measures the good things that happen as charities help people and communities. In other words, it figures out how much good comes from the help charities provide, in economic terms. It is important as it helps us see what real and positive difference is being made to people's lives. It also shows where help provided by charities can be improved. This helps charities know how to use their resources wisely and make the biggest impact on people's lives.

The total funding received to provide the service across 20 GP practices is **£74,000.** This equates to a mean value of **£3,700 per GP Practice area.**

The Social Return on Investment is estimated to be £7.06 for every £1 spent. This means the savings to the wider public sector health and social care system are over 7 times the cost of the service.

The Social Prescribing Service is designed to deliver these quality outcomes.

Improve support in the community

- Reduction in GP attendances
- Reduction in Mental Health Usage
- Reduction in A&E attendances
- Reduction in referrals to secondary care

Reduction in Loneliness and Social Isolation

- Increase in sociability, communication skills and making social connections
- Reduction in loneliness and support to hard to reach people

Health Improvement

- Reduction in symptoms of anxiety and/or depression, and negative mood
- Improvements in mental wellbeing and positive mood
- Reduction in prescriptions
- Improvement in physical health and a healthier lifestyle

This graphic shows the quality outcome measures reviewed and the associated metrics to measure impact and calculate the Social Return on Investment.

The total value of these metrics equates to £522,794 per annum in economic value provided by the Social Prescribers.

SERVICE OFFER

For Patients & Partners that refer:

A direct service based in GP surgeries across Wrexham that supports patients to engage in a 'What Matters to You' conversation to help them improve their health and wellbeing. To promote resilience, improve mental wellbeing, patient knowledge and skills to increase self-help and healthy behaviours and manage long term conditions.

Enhanced Social Prescribing offers a combination of talking therapy, mental health support, goal setting and sign posting to help patients. The team offer a gateway to access other support from health, local government and third sector.

Offering support such as:

- Talking Therapy sessions
- Cognitive Behaviour Therapy
- Lifestyle Coaching/Goal Setting
- Pain Management/Sleep Hygiene
- Sign posting and referrals to other agencies, health services, charities, or community groups
- Advance Care Planning
- Carers Support
- Bereavement Support
- Access to Wrexham Community Agents outreach service
- Access to The Rainbow Foundation: Meals on Wheels, Day Opportunities, Domiciliary Care, Community Groups/Support, and transportation
- Wider access to services and support across Wrexham

Social Prescribers help people with:

Mental Wellbeing (including depression, anxiety, and trauma)

Grief	Loneliness	Long Term Conditions & Pain Management
Employment Difficulties	Chronic Illness	Relationship Challenges
Adverse Childhood Experiences	Healthier Lifestyles	Money Worries

To the staff: The Rainbow Foundation operates with a team-based approach.

Providing

Induction & Training

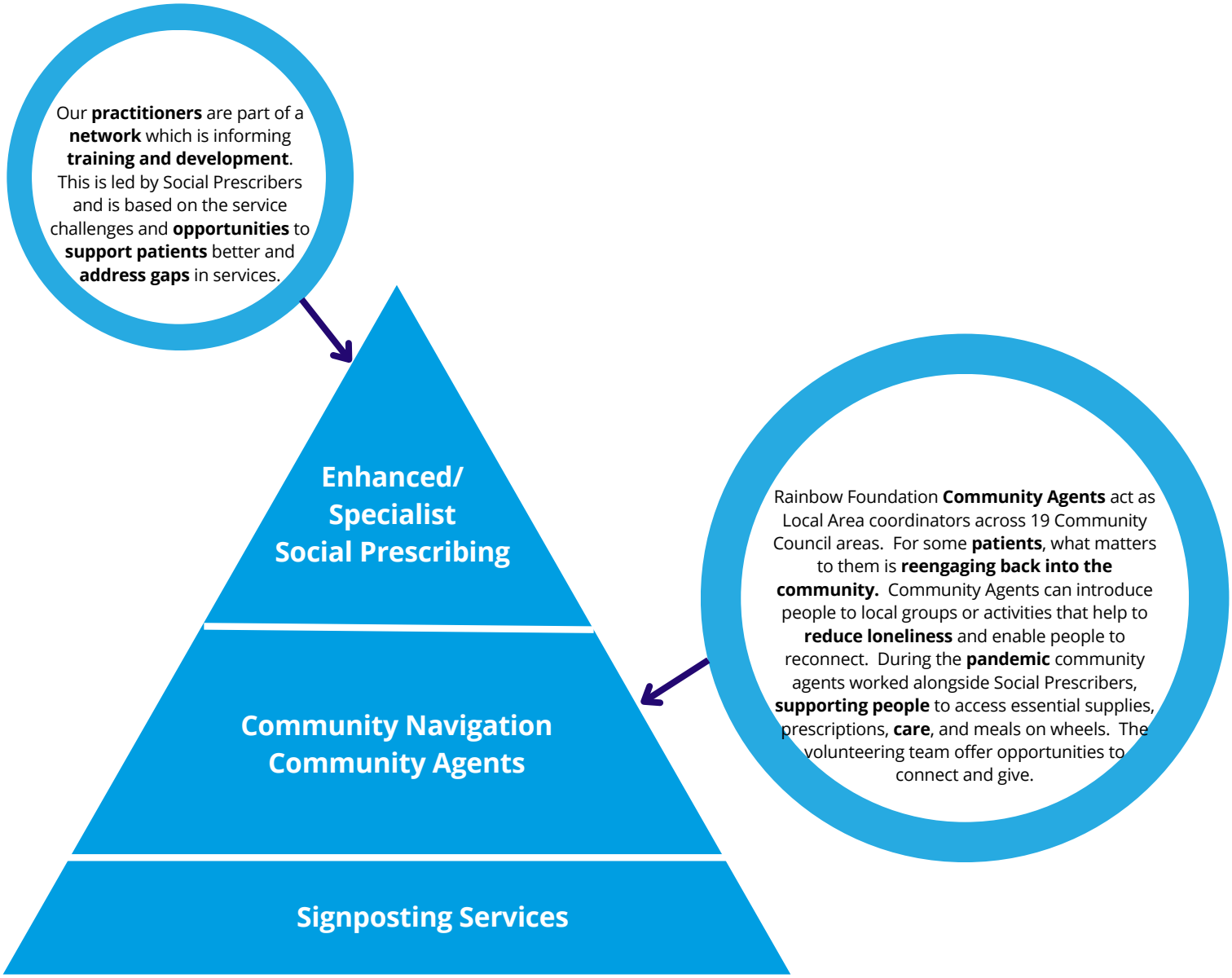
- Social Prescribing Toolkit
- Staff Handbook – includes lone working, confidentiality, safeguarding
- Mental Health First Aider / Safeguarding / Suicide Awareness / Motivational Interviewing / Coaching / Cognitive Behavioural Therapy (accredited)
- Social Security Benefits and Debt Management
- Follow 5 Ways to Wellbeing
- Shadowing and mentoring opportunities
- Use of approved websites, applications and library to support advice and patient self learning
- Standardised approach to casework addressing 'what matters'
- Shared Case Management System
- Community Sector Directory (acknowledge limitations)
- Commitment to rolling programme of training and development for SP's to upskill, aligned to wider public health agenda

Management and Support

- Adopting a Quality Advice Framework (Advice Quality Standard)
- Casefile Audits - quality of advice, support and process followed
- Clinical Supervision – safe space to offload and talk through difficult cases
- Peer support – support and share learning

SOCIAL VALUE

The **Enhanced Social Prescribing** Service is built on the **principals** of Social Value, and considers the **social, economic and environmental wellbeing** of Wrexham as a whole and at a local area level.



Many of the people referred to the Enhanced Social Prescribing Service by social care, housing organisations and other third sector organisations are people who would have accessed their GP and primary care services for support. Wrexham's social prescribing model operates across Wrexham and provides a comprehensive social prescribing programme. The Enhanced Social Prescribing Team (working with Community Agents) in this way means that people with non-medical needs are supported and the demand moved from primary care to social prescribing and the third sector.

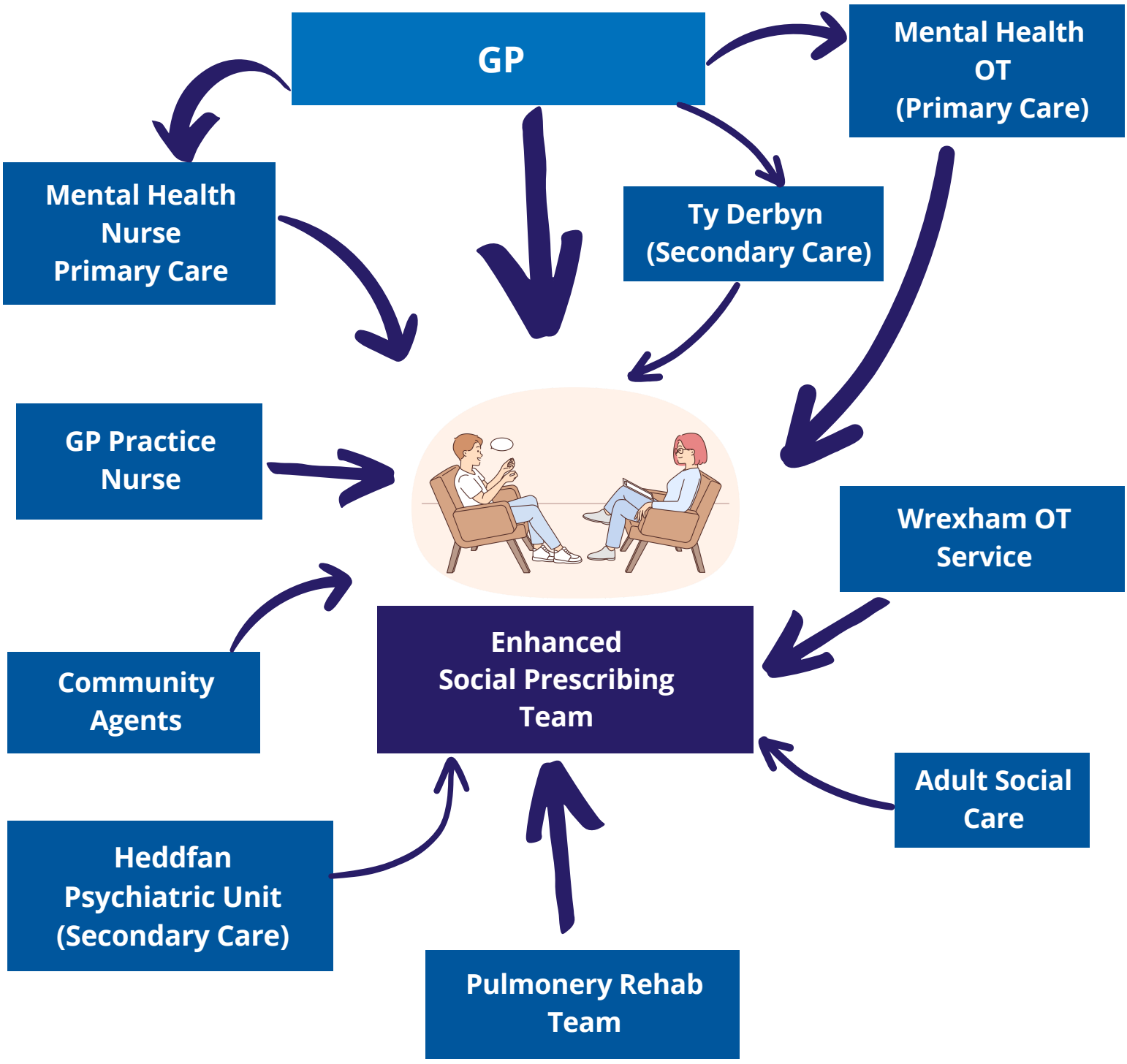
Service Outputs

- A consistent practical approach to Social Prescribing for referring healthcare professionals, local authorities, community groups and third sector.
- A confidential accessible service for patients to receive the support and care they need with behavioural change and positive improvements to their welling.

REFERRAL ROUTES

Who refers to the Social Prescribing Team:

The diagram below shows the professionals who refer to the service. A range of professionals across health and social care refer patients for support. Patients can also self-refer into the service.



PATIENT PATHWAY

Patient Referred to Enhanced Social Prescribing Service

Talking Therapy Process

Session One
What Matters To Me
(S)WEMWBS

Session Two
Action Plan Developed

Session Three
Progress Assessment & Goal Setting

Session Four
Progress assessment plan and activation

Session Five
Progress assessment plan and activation

Session Six
Progress assessment plan and activation

Session Seven
Progress assessment plan and activation

Session Eight
(last session)
Review Progress
&
(S)WEMWBS

NICE National Institute for Health and Care Excellence

Behaviour Change:
Individual approaches

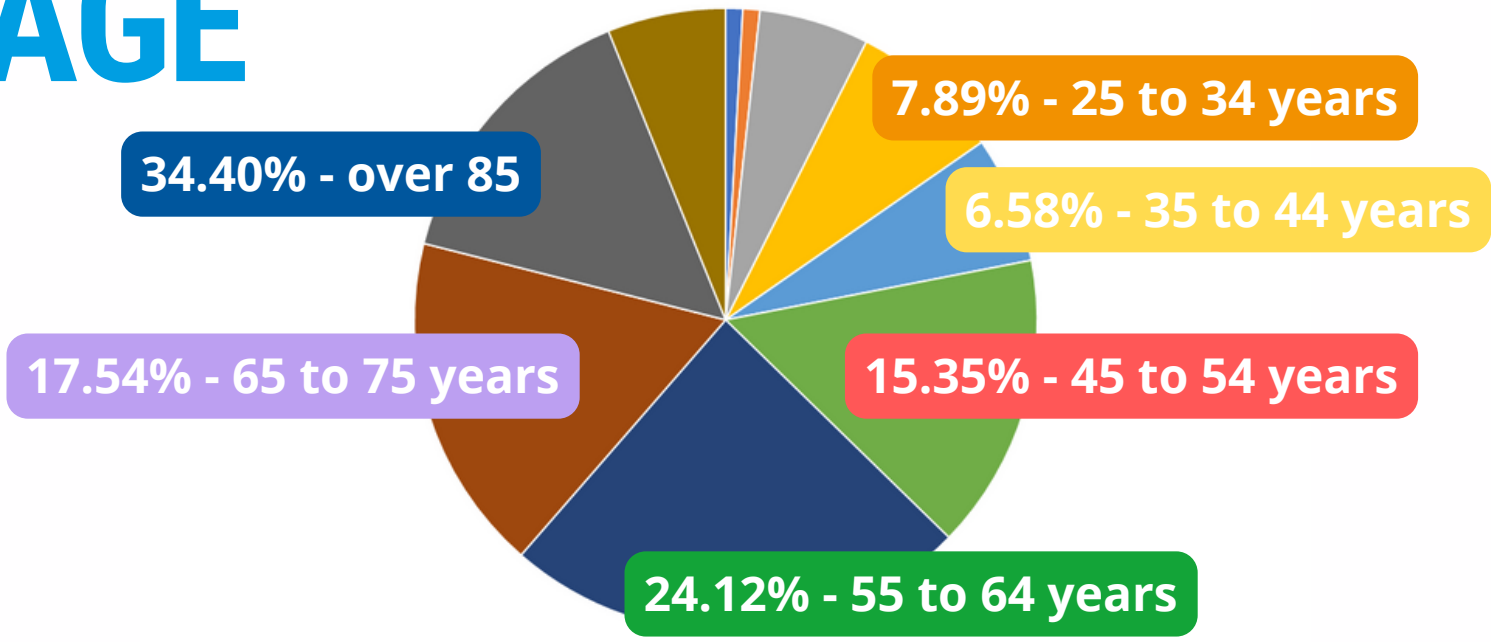
Patients are reviewed regularly and are discharged at a point that is right for them. The number of sessions required is dependant on the needs of the patient.

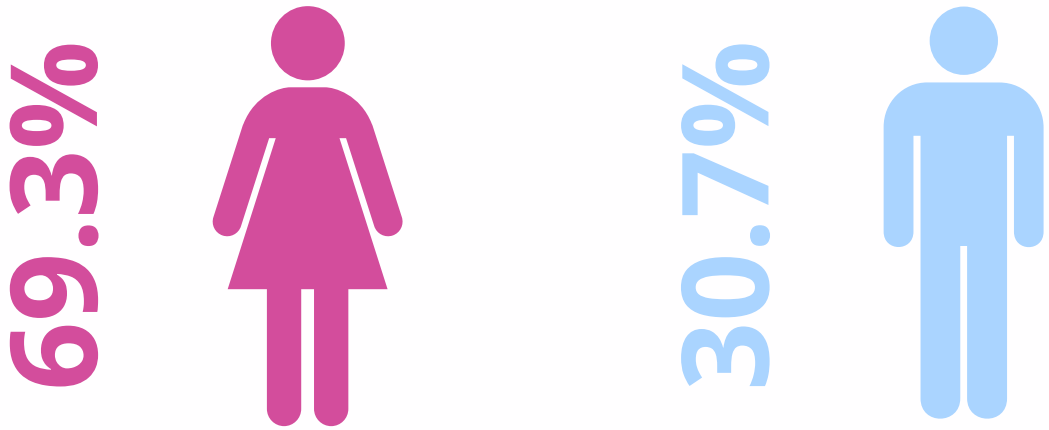
Patients are given information on discharge as to how to access the service again with a new matter either by self-referral via Social Prescribing Team email or through their GP Surgery.

SERVICE REFERRALS & DEMOGRAPHICS

CLIENT

AGE





Complex Cases:
Most clients present with a mental health and wellbeing need and have a long term condition

SERVICE OUTPUTS

The Social Prescribing service has:

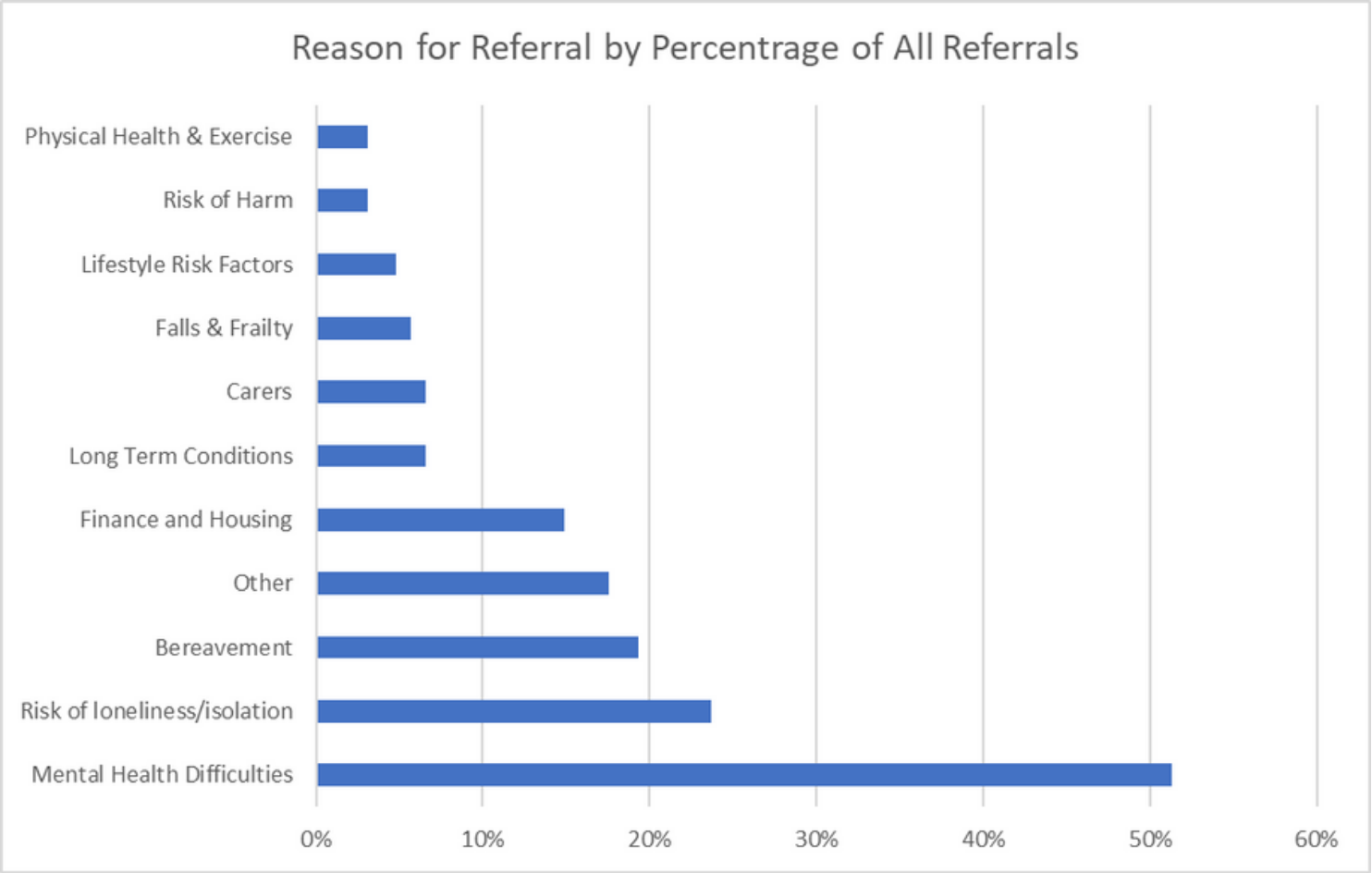
MADE OVER **2,000** **CONTACTS** WITH PEOPLE ACROSS **WREXHAM**

OVER **1,000** **APPOINTMENTS** **SESSIONS SUPPORTING IMPROVEMENTS TO MENTAL HEALTH**

SUPPORTED OVER **500** **CLIENTS WITH** SOCIAL PRESCRIPTIONS & SIGNPOSTING

REFERRALS

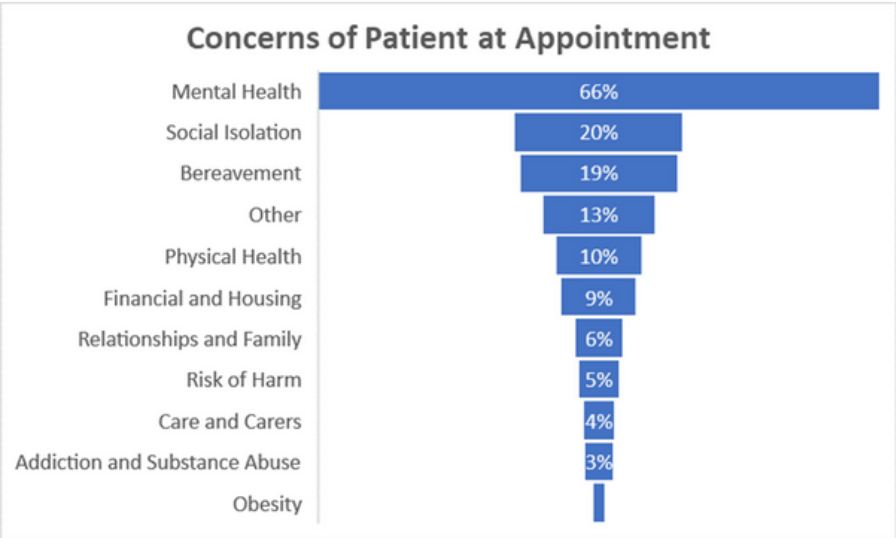
All GP practices in Wrexham refer to the service. The chart below highlights reasons for referral. Most clients are referred due to mental health difficulties, and these range from anxiety, depression (clinical and able self-motivate), low self-esteem and stress management.



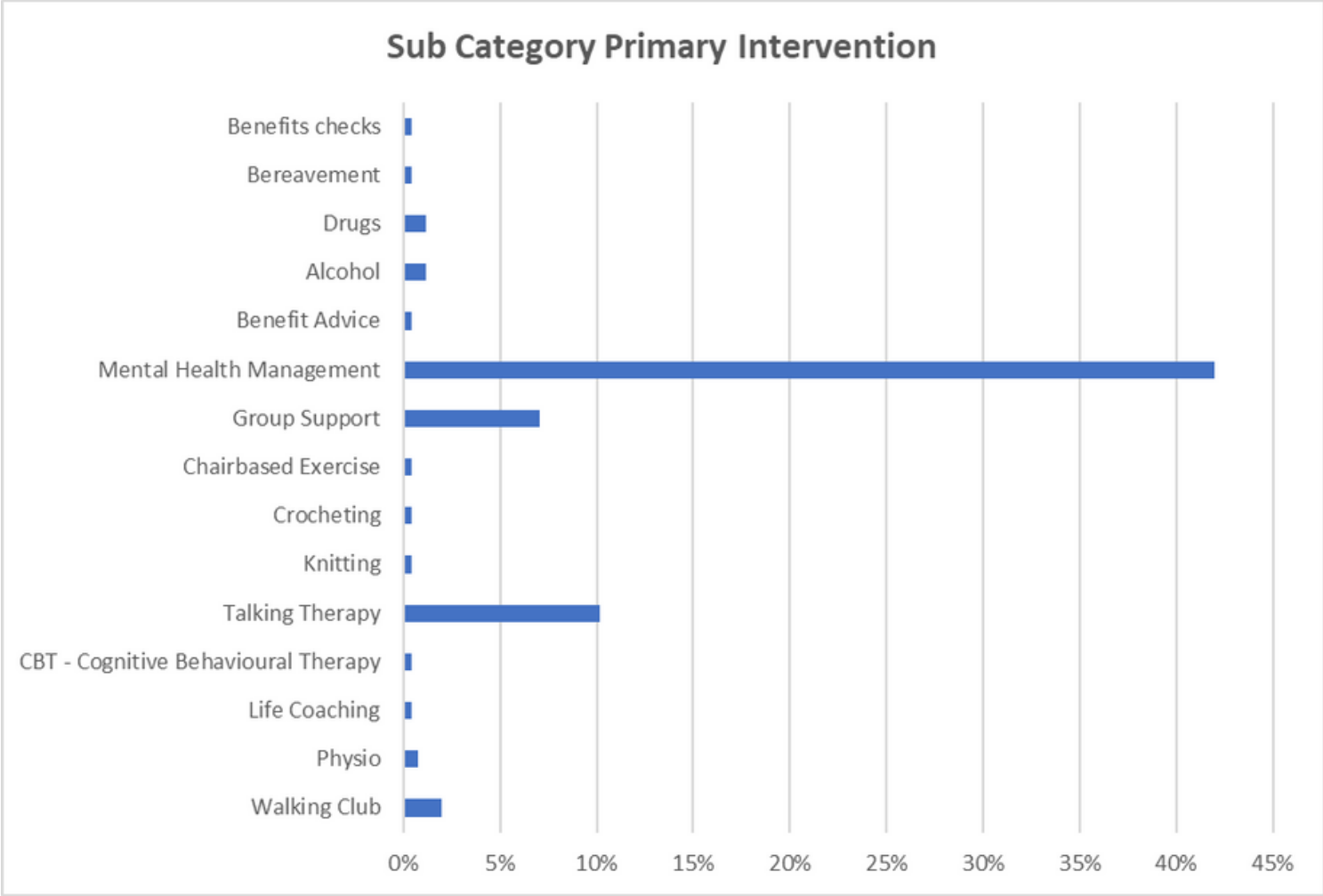
APPOINTMENTS

When asked the question "What Matters Most" people share more than the original referral reason, with the social prescribers. The chart below shows the categories of concerns raised at appointments.

Two thirds of all appointments are addressing people's mental health concerns. Many people suffer with a range of conditions from low motivation, low self-esteem, stress, anxiety, through to tier 1 mental health needs. Most patients present with 2 or more concerns.



PRIMARY INTERVENTIONS



The sub categorisation shows that most interventions were support with achieving better mental health. By supporting people to care for their own mental health in the community, it reduces likelihood of referral to secondary care, reduces risk of harm, and likelihood of anxiety conditions such as panic attacks as people learn coping strategies. This information further demonstrates the need for mental health support for people within our communities and has a positive impact on diverting patients with a non-acute or chronic clinical physical need from primary care.

PRESCRIPTIONS

The Enhanced Social Prescribing Service has access to a range of services within the community, provided by the third sector, health and social care. In 2023, the following prescriptions where made. Adopting this community-centric approach can help provide more appropriate and effective ways of engaging people and improving their health and wellbeing. In the diagram below, the larger the font size of the prescription, the higher the number of prescriptions made.

Community Agents
Coping Skills - Anxiety
Protective Factors
Single Point of Access - Wrexham Social Services
Advanced Brighter Futures
Active Futures
Citizens Advice
Mindful Meditation
GP Surgery - Wrexham
Compassion
Self Care
Relaxation Techniques
Positive Affirmations
What is anxiety?

NEWCIS: Carer Assessment
Wrexham Community Mental Health Team
Bereavement Support Group
Telecare
AVOW
Dan 24/7
Depression
Wrexham Food Bank
Daily Exercise
National Trust Erddig
Unhelpful thinking habits
Domestic Abuse Safety Unit
Falls Prevention Service
CALL Helpline
Beyond Our Control
Rainbow Day Opportunities
Volunteering through AVOW

NHS Sleep Guidance
Challenging Negative Throughts
Problem goal framework
Social Anxiety
Parabl - talking therapies
Nightingale House Hospice
Thought Journal
Welfare Rights
The Pain Tool Kit NHS
Stepping Stones North Wales
The silver line
Age UK
NEWCIS: Carer Groups Drop-ins
Age UK Shropshire
Mind Wrexham
Counselling - Drug and Alcohol Service
StepChange
Cruse Bereavement Wales
Men's Advice Line
Breathworks
CAB
Ramblers

Attendance Allowance Applications
Rainbow Lunch Club - Penley
Rainbow Lunch Club - Marchwiel
Knit, Natter and Crochet
Carers Trust Cheshire West
Housing Options Team
STOPP
The Parrot
Thoughts Recording Sheet - Anger
Samaritans
The Elms
Project 65
U3A
Blue Badge
Menopause Support Group
Meals on Wheels
Changing Habits for Life
Vision Support
Falls Prevention Class

IMPACT OF SERVICE

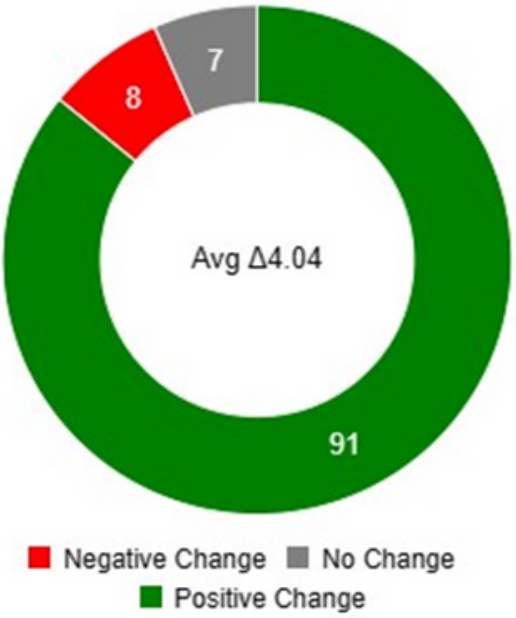
WELLBEING SCORE

The social prescribers use the SWEMWBS (Short Warwick-Edinburgh Mental Wellbeing Scale) which is a self-reported questionnaire designed to measure mental well-being.

The average increase across all patients was 4.04 points, which is higher than the 1-3 points which is statistically significant.

85.8% of clients reported an improvement in their mental well-being with an average increase of 4.04 points. 14% of clients have more complex needs and their journey does not end, some require acute mental health support, others have an acute need relating to long term condition or physical health need and require further support, which includes working with community agents.

SWEMWBS is responsive to change at individual and group level. At individual level a **change** of between **1 and 3 points** meets thresholds for **statistically important change in wellbeing**.



SWEMWBS Score Definition

17 or less	probable depression
18-20	possible depression
21-27	average mental wellbeing
28-35	high mental wellbeing

The SWEMWBS scoring supports the social prescribing team with;

Holistic assessment: allow the Social Prescribers to gain an understanding of aspects of the patient's life satisfaction and emotional state

Tailored interventions: Results can help the social prescriber to tailor social prescriptions and interventions to address specific areas of concern

Outcome measurement: changes to the SWEMWBS over time helps indicate the effectiveness of prescriptions, and evaluate impact interventions is having on the well-being of individuals

Communication: Using the questionnaire as a basis for conversation, at a point when the patient feels comfortable to be open with the social prescriber, helps identify and prioritize aspects which may require attention

Empowerment: Completing the SWEMWBS empowers the individual by increasing awareness in their wellbeing and demonstrates the impact their active participation in the prescriptions has had on improving their health and wellbeing.

SERVICE APPROACH

BEHAVIOURAL CHANGE: INDIVIDUAL APPROACHES

The Enhanced Social Prescribing Service follows the 2018 NICE Guidelines Behavioural Change: Individual Approaches. The guidelines outline best practice when supporting behavioural change.

Ensure the content, scale and intensity of each intervention is proportionate to the level of social, economic or environmental disadvantage someone faces and the support they need (proportionate universalism)

Employers should ensure staff are aware of the importance of being supportive, motivating people and showing them empathy

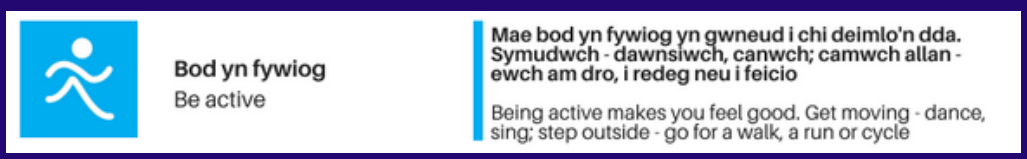
Ensure behaviour change interventions aim to both initiate and maintain change. Interventions should include techniques to address relapse and recognise that it is common

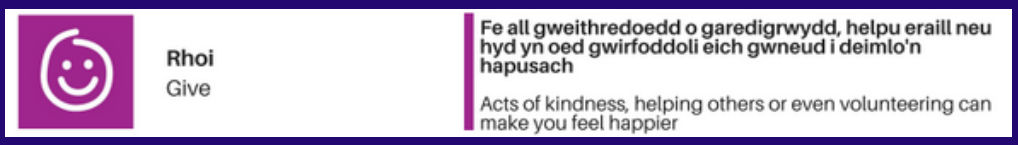
A quality assurance process is in place to assess whether the intervention was delivered as planned (intervention fidelity), achieves the target behaviour change and health and wellbeing outcomes, and reduces health inequalities. (The frequency of quality assurance checks should be specified.)

Base behaviour change interventions and programmes on evidence of effectiveness

FIVE WAYS TO WELLBEING

The Social Prescribing Team have adopted the 5 Ways to Wellbeing. These are a set of practical actions aimed at improving our mental health and wellbeing. They were developed by the New Economics Foundation from evidence gathered in the Foresight Mental Capital and Wellbeing Project (2008).





Be Active

Take Notice

Connect

CASE STUDY

Relationship Issues and Homelessness

A few words about Chris

Chris is 32 years old; he had recently separated with his partner of one year and was homeless. Chris referred himself to the Rainbow Foundation Social Prescribers, he had previously been prescribed anti-depressants by his GP and felt his depression was not under control. Chris was sleeping in his van, after the relationship had broken down, he moved out of the home he shared with her.

WHAT WE DID

The Social Prescriber worked with Chris over the course of the sessions to look at:

- his feelings, thoughts, and emotions during and between each session to improved his understanding of what had happened
- Chris was assessed using the suicide identifying checklist to ensure he was kept safe
- the Social Prescriber helped Chris understand what housing support was available to him
- the Social Prescriber worked with Chris on a sleep routine and healthy eating pattern and exercise that would help with his anxiety and showed him how keeping a journal to process thought patterns would benefit him.

Outcome for Chris

Chris's mental health improved by 7.6 SWEMWBS points from 14.75 (probable depression) to 22.35 (average mental wellbeing). Chris felt considerably better and told us that having someone who could listen, advise and signpost was helpful and felt less lonely and more confident for his future.

Take Notice

Keep Learning

Be Active

Connect

Give

CASE STUDY

Poor Metal Health and High Anxiety

A few words about Dan

Dan is 33-year-old and was referred by his GP. Dan described himself as an anxious person, his anxiety had increased since his dog passed away in August 2022. He reported that his sleep had deteriorated since then. Dan has been registered deaf since aged 18 months, his mum works nights shifts and his dog gave him a feeling of safety as he used to alert him during the night of any noises. This feeling of safety had gone since the death of his dog.

WHAT MATTERED TO DAN AND WHAT WE DID

The Social Prescriber worked with Dan over the course of the sessions to look at:

- his feelings and thoughts. Dan described himself as an introvert, feeling safe in his environment of 'gaming'. Dan was supported to widen social connections based on past hobbies.
- negative automatic thoughts, unhelpful thinking styles and cognitive restructuring. The Social Prescriber worked with Dan on CBT, and tools and techniques to cope with unhelpful thinking patterns.
- Dan was referred to the NERS programme (as requested by his GP) for help with weight management
- Dan was referred to the F2F confidence building course and for help with interview techniques and job search support session. The Social Prescriber focused on confidence building to support Dan seek employment.

Outcome for Dan

Dan reported improvement in mood and was much more optimistic for the future. On (S)WEMWBS Dan initially scored 15.84 indicating probable depression after 6 sessions of support and hard work by Dan to put in place actions identified in the goal setting, **Dan's score increased to 24.11 an increase of 9 points**, now indicating average mental wellbeing. Dan's appearance changed he lost weight and had a haircut for the first time in a very long time, and was taking pride in his appearance. Dan developed the confidence to look for employment.

A few words about Catherine

Catherine is 73-year-old and recently moved to a new village following the sudden death of her partner. Catherine does not drive and had no friends or family nearby.

WHAT WE DID

Catherine was referred to the Rainbow Foundation Bereavement Support Group in Marchwiel, and reported how beneficial she was finding it to talk through her grief since her partner died.

As Catherine worked through the stages of grief, she was referred to the Rainbow Foundation monthly lunch club and the weekly shopping trips to a supermarket. As her confidence grew, and she felt able to be more socially active, the Social Prescriber referred her to a local club giving Catherine an opportunity to meet new people and have a regular activity she enjoyed.

Catherine was put in contact with the local Women's Institute, and she became part of the WI monthly meetings as well as participating in regular trips and a book club.

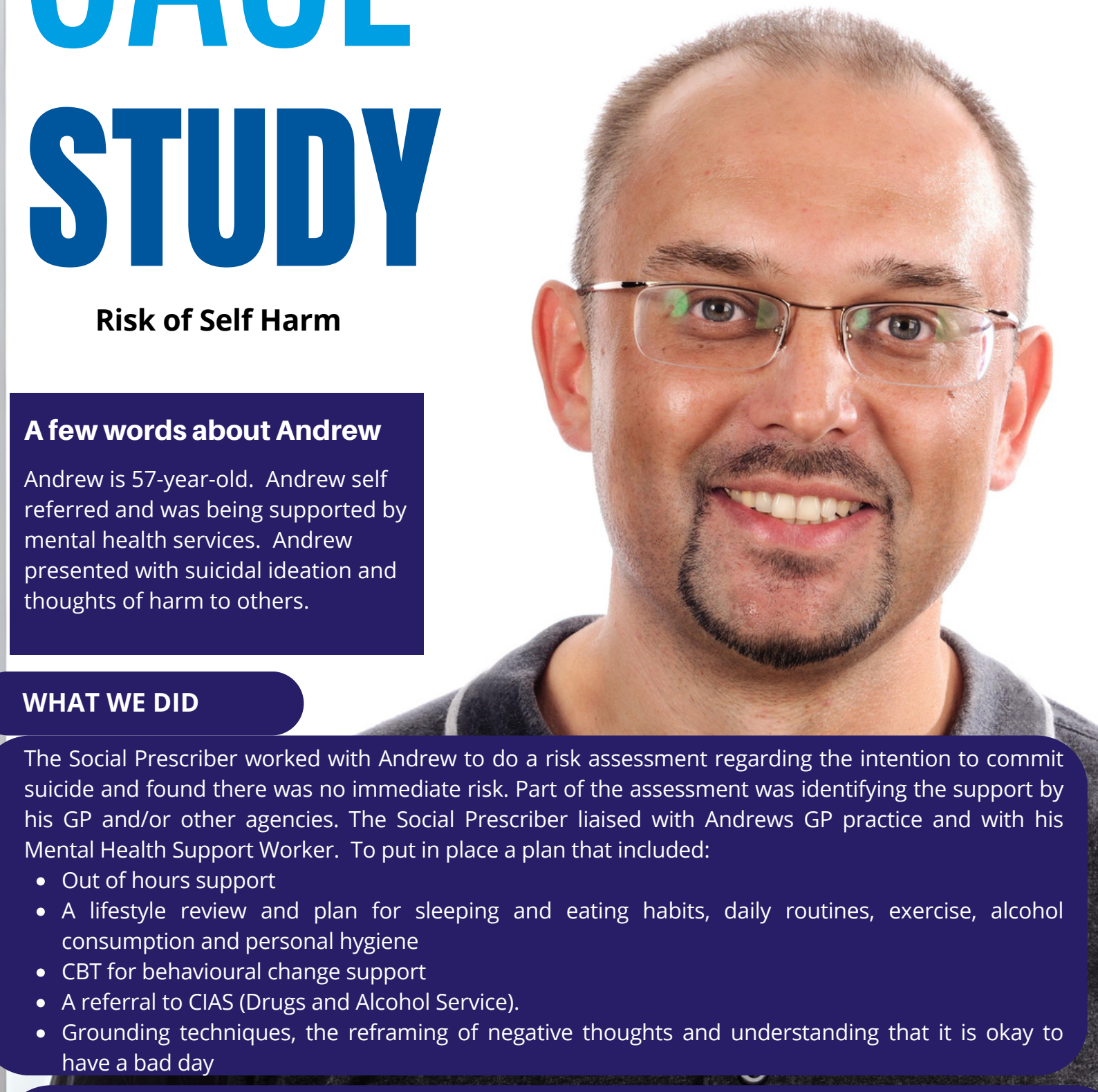
Outcome for Catherine

Catherine wellbeing score increased from 19 (possible depression) to 25 (average mental health). Catherine has reported feeling much more confident and part of the community. She is managing her grief well, and actively participates in several clubs which she was introduced to by the Social Prescribing Team. Catherine now knows she can self-refer to the Social Prescribing Team when she has felt she has needed some additional help for her needs.

CASE STUDY

Take Notice | Connect | Be Active

Risk of Self Harm



A few words about Andrew

Andrew is 57-year-old. Andrew self referred and was being supported by mental health services. Andrew presented with suicidal ideation and thoughts of harm to others.

WHAT WE DID

The Social Prescriber worked with Andrew to do a risk assessment regarding the intention to commit suicide and found there was no immediate risk. Part of the assessment was identifying the support by his GP and/or other agencies. The Social Prescriber liaised with Andrews GP practice and with his Mental Health Support Worker. To put in place a plan that included:

- Out of hours support
- A lifestyle review and plan for sleeping and eating habits, daily routines, exercise, alcohol consumption and personal hygiene
- CBT for behavioural change support
- A referral to CIAS (Drugs and Alcohol Service).
- Grounding techniques, the reframing of negative thoughts and understanding that it is okay to have a bad day

Outcome for Andrew

Andrews wellbeing score increased by 8 points. His original score was 7 probable depression and after 8 sessions moved up to a score of 15, a movement of 8 points. Andrew was a complex case however the improvement through being supported by Social Prescriber, meant for Andrew he was able to go on holiday with his partner and joined community activity groups to socialise and meet new people. Something Andrew would not have thought possible before engaging in the Social Prescribing Service. He gradually over time demonstrated an increased positive mindset.

Keep Learning | Be Active | Connect | Give

CASE STUDY

Family Carer Support

A few words about Jane

Jane is 62-year-old she lives with her parents and is their main carer. Jane's father had been diagnosed with Dementia and was suffering with memory loss and changes in mood. Jane's mum was recovering from recent stomach cancer surgery.

WHAT WE DID

The Social Prescriber gave Jane space to talk through her feelings and needs. Jane was encouraged and supported to look after her own wellbeing. Self-care information was identified and shared, and wellbeing information given. Jane worked on her sleep hygiene and breathing techniques for stress management.

Jane was signposted to Dementia connect, Newcis, the befriending service, and local care services, for support in caring for her parents. The Social Prescriber helped Jane with accessing the falls team as both Jane's parents had recently fallen.

Jane was signposted to citizens advise and welfare rights to ensure all the correct benefits were being claimed.

The Social Prescriber arranged regular phone calls for support and to give Jane the time to talk though feelings. Jane was helped with techniques to help her communicate with her dad given his memory loss, such as reminiscence therapy.

Outcome for Jane

Jane's (S)WEMWBS score improved from 22 points (average mental health) to 28 points (high mental health). Jane felt very grateful for the support, time and information given, and the organizations that were shared to help and support at home. Jane reported feeling better able to cope with home circumstances and caring responsibilities. Jane felt more positive about moving forward and the future.

Take Notice

Connect

Domestic Abuse

CASE STUDY

A few words about Lucy

Lucy is 51 years old and was separating from her husband. Lucy's marriage was a coercive controlled and financially abusive relationship, and Lucy was suffering from the trauma experienced within the relationship.

WHAT WE DID

The social prescribing sessions allowed Lucy to have time to talk through the home situation and divorce. Helping Lucy identify her needs in terms of mental health, wellbeing, sleeping, eating and general health, and develop a plan to work on improving each area. Lucy was supported with;

- talking therapy to deal with the trauma
- a sleep hygiene plan and breathing techniques for anxiety and panic.
- Lucy discussed her social support and network, and coproduced a plan of groups in the area that Lucy could join. The Social Prescriber followed up with other groups of interest as Lucy's self-confidence improved.
- the social prescriber supplied food bank vouchers, and signposted Lucy to local organizations that could advise and assist on income issues Lucy was facing, such as Welfare rights and citizens advice.
- work around self-esteem, confidence and entering the workforce again.

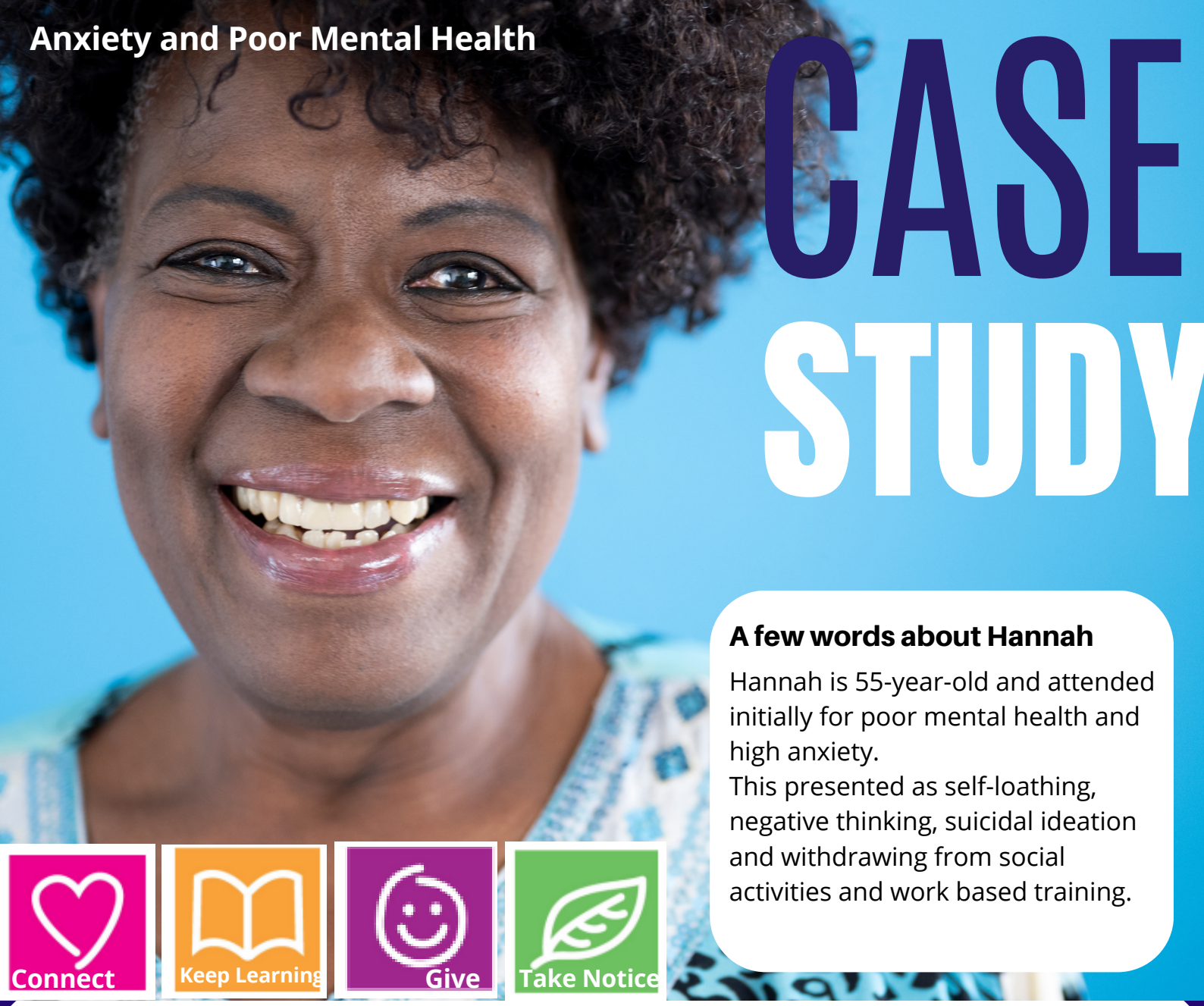
Outcome for Lucy

By the end of the course of sessions with the social prescriber. Lucy had applied for a new job as she was feeling more confident. She began meeting with friends again and had made exercising regularly part of her routine. Lucy reported she was feeling better in herself and sleeping better.

Lucy's (S)WEMWBS score had improved from 19 points (possible depression) to 26 points (high mental health) .

Anxiety and Poor Mental Health

CASE STUDY



A few words about Hannah

Hannah is 55-year-old and attended initially for poor mental health and high anxiety.
This presented as self-loathing, negative thinking, suicidal ideation and withdrawing from social activities and work based training.

WHAT WE DID

Hannah was experiencing an 'Existential Crisis' and had begun to question her relationships, values, and beliefs. The Social Prescriber worked with Hannah to;

- do a risk assessment, regarding the client's intention to commit suicide, there was no immediate risk or intent. Support out of hours was identified
- A lifestyle review looked at sleep, eating habits, daily routines, exercise, alcohol consumption and personal hygiene.
- Referral to Stepping Stones and Kim Inspire.
- undertake talking therapies working on encouraging behaviour change and for the patient to set achievable goals and evaluating her 'Protective Factors'.
- work on grounding techniques, for anxiety, the reframing of negative thoughts, healthy relationships and understanding that it is okay to have a bad day.
- Hannah was sign posted to several activity groups including arts, support groups, volunteering, and social groups.

Outcome for Hannah

Initially Hannah scored 15 indicating probable depression on SWEMWBS. After 8 sessions with the Social Prescriber Hannah scored 21, a movement of 6 points. Moving into average mental wellbeing and she had made positive changes to her lifestyle and thinking habits.

INNOVATIONS
IN COMMUNITY ASSET DEVELOPMENT

The Social Prescribing Team have identified trends in referrals, and gaps in service provision, to better support people in their communities. This has led to the introduction of a number of innovations in the community, using the third sector and volunteers to implement community assets that have been shown to have high engagement, usage and reported to be valued by the local communities they serve.

Below are some examples of Innovations developed by The Rainbow Foundation to tackle loneliness, anxiety and depression in the community and help people feel a sense of community and help improve their feelings of self worth.

Menopause Group:
The Hot Ladies is a support group for ladies of menopause age and over. They meet the last Monday of every month from 6:30pm – 8pm at the Rainbow Centre, Penley. Ladies come together for fun, support and lots of laughter with other people who understand the challenges of the menopause.

Carers Support:
The Carers support service helps people in the local area, identify areas of need based on their individual circumstances. Carers are referred to relevant services for respite help, as well as services such as falls prevention, if their loved one is at risk of falls.

Active Futures:
The Active Futures programme supporting people with MSK conditions, pain management and frailty, has three principals, improving independence in old age by 1) Exercising regularly, 2) Peer support with exercising and 3) wellbeing support and education. The exercise classes are risk positive and take place in a safe environment and include education on preventing falls and ageing healthy.

GP PRACTICE FEEDBACK

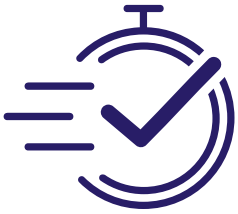
In January/February 2024, The Rainbow Foundation conducted a survey of the GP Practices, who have access to and use the Enhanced Social Prescribing Service. The survey was completed by GPs, Practice Managers, Allied Health Professionals, Nursing and administrative staff.

82% Often or sometimes refer to the Enhanced Social Prescribing Service.

89% Strongly agreed or agreed with the statement: "I can think of patients, whose lives improved, by the Social Prescriber and the practice team working together."

61% Strongly agreed or agreed with the statement: "As a result of the Social Prescribing Service, I feel closer to the community, and have found some patients are becoming less reliant on me and more engaged with the wider services."

61% Strongly agreed or agreed with the statement: "My practice would benefit from more hours of Enhanced Social Prescribing time to further reduce the demand to see GPs/Practice Nurses."



There were a number of comments received from colleagues in primary care.

"This is an excellent service , provided by an excellent provider, and we would very much like it to continue."

"I do feel the service is valuable and appreciated by staff and patients. There have been some patients where I have had some close contact with the social prescriber as we look to provide person centred care between OT and social prescriber input. Thank you for all you do. "

"Excellent service with such approachable, helpful team thank you."

"Social prescribers provide a vital service for our patient population."

"The service provided give support to our patients and is very well organised and patients do ask to speak to [Enhanced Social Prescriber] who comes to the surgery."

"A brilliant service for those that need it."

"Excellent service provided."

CAPACITY AND DEMAND

Capacity and demand analysis is crucial to manage a services efficiency, resource utilisation and will therefore have an impact on service quality performance. As well as the day-to-day operational management, capacity and demand is used strategically to plan for future demand trends and reduce waiting lists.

The capacity and demand analysis of the Social Prescribing Team has shown that at any one time there are approximately 18 patients waiting for a first appointment. Each patient is offered a maximum of eight 50 minute sessions.

The Service is currently provided by 2.28 FTE/WTE members of staff across the 20 GP practices, supporting the GP-registered adult population of Wrexham.

Capacity Gap:

Total capacity	Total demand (and clear waiting list)	GAP
2501	2708	-207

The capacity calculated as the number of hours available in a 12-month period, for the number of appointments slots each Social Prescriber has in practice. The capacity value above is the number of hours available given each patient is offered up to 8 appointments as support.

The demand is calculated from the number of new referrals, and the number of appointments and all contacts (including non-face to face) with patients. The Social Prescribers waiting list is included in the demand calculation. The number above is the number of hours of demand for the service. The total capacity gap is currently 207 hours, which includes clearing the waiting list and improving the time to first contact with social prescribers.

There is a need for additional resource within the Social Prescribing Team to reduce the length of time people are waiting to access the service and to reduce the waiting list so people are seen more timely for their health care need.

BENEFITS OF THE SERVICE DELIVERY MODEL

The following benefits have been identified on reviewing evidence-based case studies within the current Rainbow Foundation Service Model:

1

Comprehensive Social Prescribing Offer Addressing Mental Health

This holistic health planning approach ensures that all aspects of physical and mental health are considered when planning a care plan based on the needs of the individual. There are reports from patients that caring for their physical health and wellbeing is helpful in managing an already difficult condition. Giving people a sense of ownership and autonomy where they otherwise feel their health is outside their control.

2

Reduction in Primary Care Demand

Social Prescribers and Community Agents have reported that clients on their caseloads have avoided booking appointments in primary care, as they know there is another alternative for help. There are patients, who have been discharged from the Social Prescribing Team, who have re-referred themselves back into the service, if they need to do so, as they know they need help with a non-medical matter. Before the introduction of Social Prescribing, these patients would have booked appointments in Primary Care. This ultimately frees capacity in primary care for patients with medical care needs. Social Prescribing has demonstrated that the emotional wellbeing of people increases as patients actively engage in new healthy habits and participate in exercise and hobbies that promote health and well-being. There is evidence that the socio-economic impact of this is reduction in demand for primary care as there is less reliance on medication and increased ability to self care.

3

Reduction in Mental Health and Secondary Care Demand

The addition of the Enhanced Social Prescribing Service adds to mental health pathway across Wrexham. This service takes demand from specialist mental health teams, by freeing capacity, helping support demand management in secondary and tertiary care services.