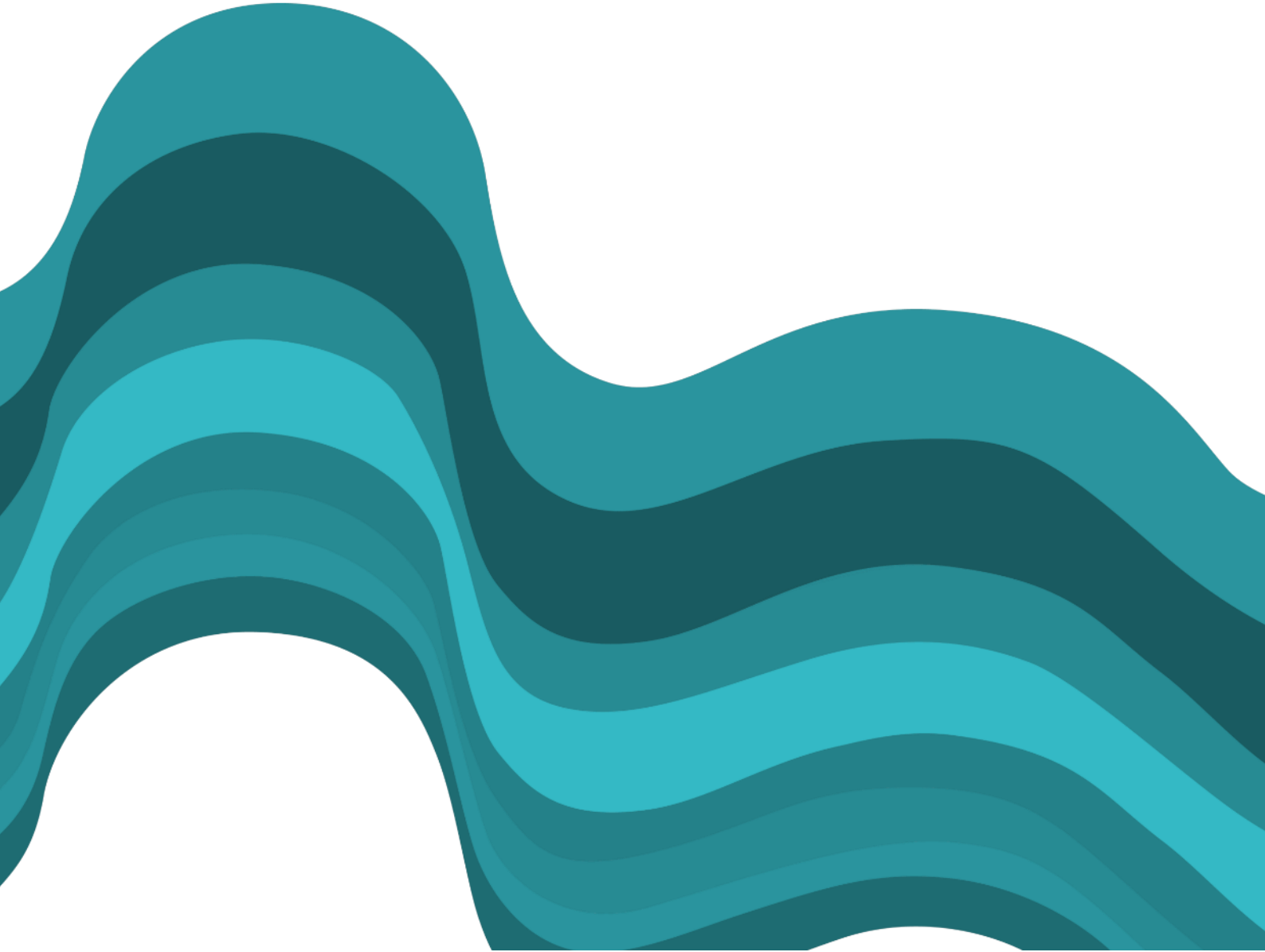
TRITECH Sefydliad Institute

Evaluation Report

Evaluation of the Hywel Dda Arts Referral Pathway

Report Produced on 12th March 2026



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Who We Are

In 2021 the Tritech Institute was launched. We are a team based in a bespoke facility within the Hywel Dda University Health Board comprising of industry-leading engineers, scientists and clinicians.

Our Institute

Here at TriTech Institute, we support the development of healthcare solutions on a local, national, and global level offering designers and manufacturers a single point of access to the NHS through a collaborative and agile approach.

What We Offer

The team's advanced skills in clinical and research design are combined with technical engineering expertise to manage the whole innovative pathway from early unmet need, through to concept design, prototyping, clinical testing, and real-world service evaluations.

Our Services

We provide specific services and solutions for *clinical engineering*, *research and innovation* and *value-based healthcare* and can also support with grant writing and submission.

1. Executive summary

Background: Chronic physical and mental health conditions are an increasingly common challenge for the Welsh population, placing growing pressure on health services across Wales, particularly within primary care. Emerging evidence shows that engagement in the arts and participation in arts-based interventions can improve patient outcomes, and recent policy developments reflect this shift.

Hywel Dda Arts Referral Pathway:

The Hywel Dda Arts Referral Pathway (HARP) was designed for patients with high GP attendance who were living with one or more chronic physical and/or mental health conditions and were considered to be socially isolated.

HARP sought to promote patient wellbeing while decreasing patients' perceived reliance on GP services. Referrals were made via participating GP surgeries. The programme operated across three locations within the Hywel Dda University Health Board area and consisted of eight cohorts, each undertaking a series of eight arts-based sessions. Within these sessions, participants engaged in group arts activities and received information about wider health and wellbeing resources through contributions from external organisations.

Evaluation methods: HARP was evaluated using a mixed-methods approach. Quantitative data on the social and mental wellbeing of service users were collected using two patient-reported outcome measures, both collected at baseline and at the end of the programme, and both analysed descriptively. Qualitative data were collected from interviews and focus groups with service users, arts partners, and some primary care providers. These data were analysed using Thematic Analysis.

Results: 23 service users took part in the HARP programme. Of those, only four had complete data before and after the programme on the two quantitative measures and social and mental wellbeing. Mean differences in scores before and after the programme were minimal. Thematic Analysis of qualitative data identified themes relating to accessibility of the sessions, impact of the sessions on patients and their social wellbeing, and barriers and facilitators to the programme.

Conclusion: The evaluation found that HARP was widely experienced as a supportive and accessible intervention, offering clear social and confidence building benefits for people facing isolation, anxiety, or long-term health conditions. While some practical and organisational barriers limited the ability

to assess longer term outcomes, the findings highlight valuable learning and identify several actionable opportunities to strengthen future delivery and evaluation of the programme.

Based on the findings of this evaluation, the following recommendations are proposed to support future delivery and evaluation of the HARP programme:

Recommendation 1: Improving GP engagement through simpler referral and clear cues

Consider how the referral process could be optimised to ensure that it is as easy as possible for GPs to refer into HARP in the context of short consultations, a pressurised work environment, and lack of familiarity with arts-based interventions. Additionally, provide materials to increase the visibility and understanding of HARP during consultations. These could include printed and digital prompts, scripts, and brief training sessions focusing on how to frame arts-based interventions to patients.

Recommendation 2: Optimise the referral pathway

Consider how the entire referral pathway could be optimised for service users and staff, ensuring that service users remain supported prior to attending the first session but that resource intensive reminder calls from arts partners are reduced. For example, other professionals, such as community connectors, could bridge the gap between GP referral and attending arts sessions.

Recommendation 3: Enhance programme access and practical delivery

Continue to provide accessible, community centred delivery by maintaining transport funding and making this support even more visible from the point of referral. Proactively engaging with community transport providers at programme startup will further strengthen this approach and help minimise travel related barriers. In addition, offering flexible session times will help ensure that people living with chronic conditions or fluctuating health needs can attend at times that work best for them.

Recommendation 4: Programme delivery adjustments

Continue to allow flexibility in programme delivery where appropriate, including session timing and attendance arrangements, in response to individual service user needs. Such adjustments may help reduce barriers related to health, anxiety, or caring responsibilities and support sustained engagement.

Recommendation 5: Language used to describe evaluation

In future iterations of the programme, consider the language used when describing evaluation activities to Service users. Findings suggest that the term evaluation may carry associations with judgement or assessment for some individuals. Using clearer, more accessible explanations about the purpose of feedback and data collection may support engagement and reduce apprehension.

Recommendation 6: Supporting arts partners with evaluation processes

Provide a training session or guidance for arts partners and others involved in programme delivery e.g. community connectors outlining their role in the evaluation process. This should include the purpose of data collection, including an overview of questionnaires used, and practical guidance on supporting service users to complete outcome measures. Improved clarity may enhance consistency and data quality collected across programme blocks.

Recommendation 7: Questionnaire burden and format

Review the volume and format of questionnaires used with the programme. Where possible, simplifying or streamlining evaluation materials and integrating them more naturally into sessions may reduce burden for service users and support more complete and meaningful responses.

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3. Abbreviations

HDdUHB	Hywel Dda University Health Board
HARP	Hywel Dda Arts Referral Pathway
GP	General Practitioner
SMfHW	Social Model for Health and Wellbeing
SWEMWBS	Short Warwick Edinburgh Mental Wellbeing Scale
SWSWBS	South Wales Social Wellbeing Scale

4. Acknowledgements

This evaluation was made possible through the commitment and collaboration of many individuals and organisations. We would like to acknowledge the work of the multi-disciplinary Creative Prescribing Working Group for their continued feedback and expertise, which helped to shape the HARP programme. We are thankful to the teams at the three participating GP surgeries, Coach & Horses Surgery, Taliesen Surgery, and Tenby Surgery. We extend our sincere thanks to the arts partners and respective freelance artists, Wales Arts Health and Wellbeing Network, People Speak Up, Arts Care Gofal Celf, Span Arts, and Arts4Wellbeing, for their creativity, expertise, and dedication throughout the delivery of HARP. We would like to recognise the work of the healthcare and wellbeing professionals who attended sessions, including smoking and wellbeing practitioners, Be Well service staff, community connectors, and social prescribing and wellbeing practitioners. We are deeply grateful to the service users who took part and thank them for their time and feedback. Finally, we would like to thank and acknowledge the funders of this work, namely the Arts Council of Wales, Arts, Health and Wellbeing Lottery Funding and Hywel Dda Charities.

5. Introduction

Chronic physical and mental health conditions are a common and rising challenge faced by the Wesh population. Recent data from a survey by Public Health Wales indicate a significant decline in physical and mental health in Wales, with 53% reporting worse physical health and 36% reporting worse mental health, in 2024 versus 2023 (NHS Wales, 2025). Additionally, 46% of the population are estimated to live with long-term or chronic conditions (Welsh Parliament, 2025), and 13% of people reported experiencing loneliness (Welsh Government, 2023).

Primary care services in Wales are currently under significant strain (Welsh Government, 2022). Recent data indicate higher levels of GP contact and ongoing workforce pressures. This pressure in primary care also has implications for secondary care services, with evidence for extended waiting times for mental health services (Mind, 2024). Together, these factors highlight the need for alternative approaches that can support wellbeing, reduce reliance on traditional medical services, and help alleviate pressure on primary care (Welsh NHS Confederation (2025).

In response to these challenges, there has been growing interest in holistic, non-pharmacological approaches that support wellbeing, social connection, and patient activation. Arts-based interventions, including arts-on-prescription programmes, have been identified as one way of addressing these wider determinants of health, particularly for individuals living with long-term conditions and social isolation (Fancourt & Finn, 2019).

5.2 Literature review

A recent scoping review of over 3,000 studies provided observational evidence that participation in a wide variety of artforms was associated with benefits to physical and mental health, citing many potential mechanisms for these associations (Fancourt et al., 2023). However, large-scale longitudinal evidence, and potentially causal evidence, is lacking. The report also highlighted barriers to accessing the arts and advocated for greater investment in the sector to promote equitable population health.

Arts-on-prescription and community arts programmes offer a creative outlet for individuals and can address issues such as anxiety, depression, social isolation, and chronic pain (Holt, 2020). Evidence suggests that art programmes are associated with positive physical and mental health outcomes (Jensen et al., 2025), psychological and social benefits (Stickley & Hui, 2012), improvements in confidence (Golden et al., 2023), and increased motivation (Hughes et al., 2019). They also represent a low-cost way to promote mental health and well-being (Uttley et al., 2015). Such programmes aim to

complement, rather than replace, standard medical care by supporting health and well-being through creativity and these findings demonstrate how art interventions foster mental health and social inclusion.

5.3 Policy context

The delivery of HARP aligns with key national and regional policy priorities, including the wellbeing of future generations (Wales) act (2015), which emphasises prevention, community cohesion, and improving wellbeing across the life course. At a regional level, HARP supports the heathier mid and west Wales strategy by contributing a social model for health and wellbeing through community-based, preventative approaches that aim to reduce health inequalities.

In addition, the HDdUHB arts and health charter recognises the role of creative practice in supporting holistic, person-centred care. Within this context, HARP represents a practical example of how art-based approaches can be embedded within primary care and wider local health systems to support wellbeing and social inclusion.

5.3.1 The wellbeing of future generations (Wales) act

The Wellbeing of Future Generations (Wales) Act (2015) (Welsh Government, 2015) establishes a legally binding commitment for public bodies, including HDdUHB, to improve the social, economic, environmental, and cultural well-being of Wales. The act sets out seven well-being goals: a prosperous, resilient, healthier, more equal Wales; cohesive communities; vibrant culture and thriving Welsh language; and a globally responsible Wales. These provide a unified purpose for all public bodies.

5.3.2 A healthier mid and west Wales: our future generations living well

The healthier mid and west Wales strategy (Hywel Dda University Health Board, 2018) adopts a whole-system approach, recognising that health and wellbeing are shaped by factors within and outside the health sector. The vision is to shift from reacting to ill-health to prevention and the promotion of wellness, guided by three strategic goals across the life course: starting and developing well, living and working well, and growing older well.

5.3.3 Social model for health and wellbeing

The social model for health and wellbeing (SMfHW) (Hywel Dda University Health Board, 2025) aims to minimise health inequalities by focusing on prevention and empowerment, highlighting shared responsibility across

organisations and individuals. The model principles complement other health board values, principles and objectives, and include strong leadership, community involvement, meaningful collaborations, prevention, and continuous learning.

5.3.4 Hywel Dda University Health Board arts and health charter

The HDdUHB arts and health charter (Hywel Dda University Health Board, 2024) establishes a strategic commitment to integrating the arts into healthcare to support healing, recovery, and overall well-being. It positions creative practice as a key part of holistic, person-centred care, guided by the principles of collaboration, creativity, innovation, inclusivity, safety, sustainability, locality, and person-centredness. The charter ensures that arts programmes are developed with communities and tailored to local needs.

6. Hywel Dda arts referral pathway

6.1 Programme context and aims

HDdUHB is one of seven health boards in Wales. The health board is situated across Carmarthenshire, Ceredigion and Pembrokeshire and supports the local population of approximately 385,615. The health board delivers services across various settings, including GP practices, hospitals, and community care. Compared to other health boards, the population is older, and chronic and mental health conditions are more prevalent. There are also considerable health inequalities in the region, with a 10-year gap in healthy life expectancy between the most and least advantaged members of the community (Hywel Dda University Health Board, 2018).

Hywel Dda Arts Referral Pathway (HARP) directly addresses these challenges and draws on relevant evidence and policy by developing an arts programme to provide access to creative activities and communities across the HDdUHB region. HARP was designed to target people who frequently access GP services and may be living with chronic conditions, mental health needs, and in the context of social isolation.

The programme aimed to improve wellbeing, enhance health outcomes, reduce pressure on clinical services, increase social inclusion, and foster patient activation.

6.2 HARP programme

Service users were referred into the programme via three participating GP surgeries across the HDdUHB region; Coach & Horses Surgery in St Clears, Taliesen Surgery in Lampeter, and Tenby Surgery. Following referral, arts

partners contacted potential participants by telephone to introduce themselves, identify any transport or accessibility needs, and organise subsidised transport for any service users who required it.
Each HARP block consisted of eight two-hour sessions, all of which were delivered in community spaces and led by arts partners. Up to 12 people could be enrolled in each of the groups at any one time. Broadly, sessions involved creative movement-based warm-up and cool-down activities, group discussion activities, and arts activities, such as crochet, collage, and glass painting. Additionally, evaluation activities were completed in sessions two and eight, and some sessions were attended by other professionals, allowing service users to engage with other local health and wellbeing opportunities.

7. Methods

7.1 Quantitative data collection and analysis

The evaluation team aimed to collect data on frequency of patient contact with their GP surgeries, and information about whether participants were socially isolated, and experienced chronic conditions, chronic pain, depression, or anxiety. However, it was not possible to collect all of this information in a systematic way because frequency of GP contact was not reported systematically and social isolation was not coded within GP notes systems. Therefore, the final dataset included information on patient chronic conditions, chronic pain, depression, and anxiety.
Service users completed two patient-reported outcome measures (PROMS), the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) and the South Wales Social Wellbeing Scale (SWSWBS), in the second and final HARP sessions. Both measures were administered using paper-based questionnaires. The Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) is a shortened version of the Warwick-Edinburgh Mental Well-Being Scale (Rempel et al.,2017) and uses seven positively worded statements that focus on mental well-being over the previous 2 weeks. Total scores can range from 7 to 35, and a higher score indicates better mental well-being. The South Wales Social Wellbeing Scale (SWSWBS) is a 14-item scale focusing on individual's social experiences over the previous two weeks. Items are scored using a 5-point Likert scale and total scores can range from 31 and 60. Higher scores indicate better social well-being.
Due to low statistical power, inferential statistical analyses were not conducted. Instead, quantitative data were analysed descriptively using a narrative approach. Only service users with complete data on PROMs were included in the final dataset.

7.2 Qualitative data collection and analysis

Qualitative data were collected from service users, arts partners, and primary care stakeholders. Semi-structured interviews and focus groups were used to explore experiences and perceived impacts of the HARP programme and factors influencing engagement and delivery. Service users provided feedback in the final HARP sessions, arts parters were invited to attend one focus group at the end of the first HARP season and another after the third season, and focus groups and interviews were conducted with relevant stakeholders from each of the participating GP surgeries.

Qualitative were analysed using Thematic Analysis, following the six-phase approach outlined by Braun and Clarke (2006). This involved familiarisation with the data, generation of initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final analytic narrative. An inductive, data-driven approach was adopted, with no a priori hypotheses specified prior to analysis. Initial codes were generated from the data itself. Themes were subsequently reviewed and refined in relation to the evaluation aims to ensure relevance to the objectives of the service evaluation. Theme development was iterative, with ongoing refinement to ensure coherence, internal consistency, and clear distinction between themes.

8. Results

8.1 Quantitative results

GP demographic data indicated a range of diagnosed health conditions among service users attending the HARP programme. Of those referred, nine lived with more than one chronic condition, three lived with chronic pain, eight experienced depression, and six experienced anxiety.

For both PROMS measures, the dataset was incomplete, with only four participants completing both PROMs before and after the programme. As shown in figures 1 and 2 trends in SWEMWEBS and SWSWBS scores indicated no meaningful difference in mental or social wellbeing before and after the programme. Reported SWEMWBS scores were marginally higher and reported SWSWBS were marginally lower after the programme compared to baseline. Given the high proportion of missing data and small sample size, these findings should be interpreted with caution and are indicative rather than conclusive.

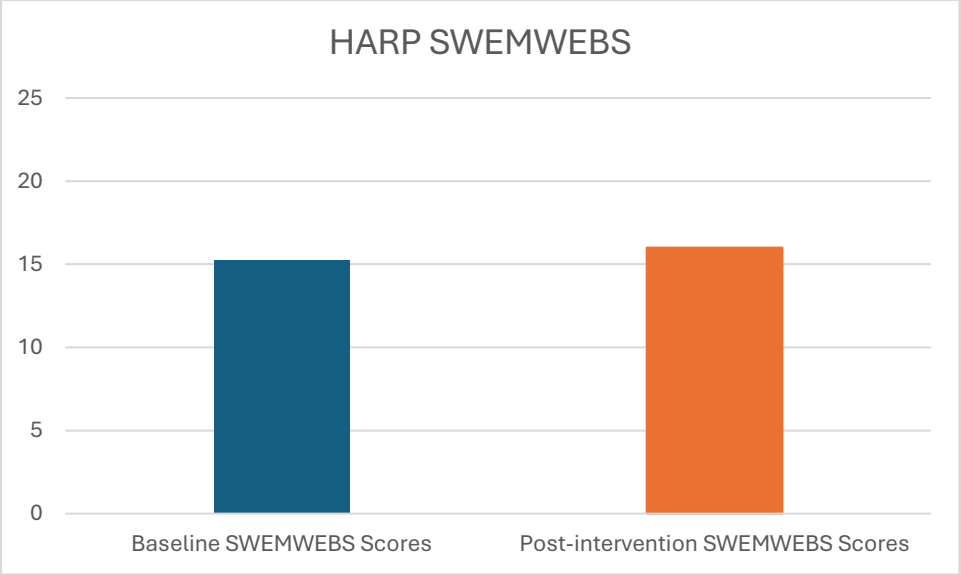

Figure 1. Mean SWEMWBS scores before and after HARP.

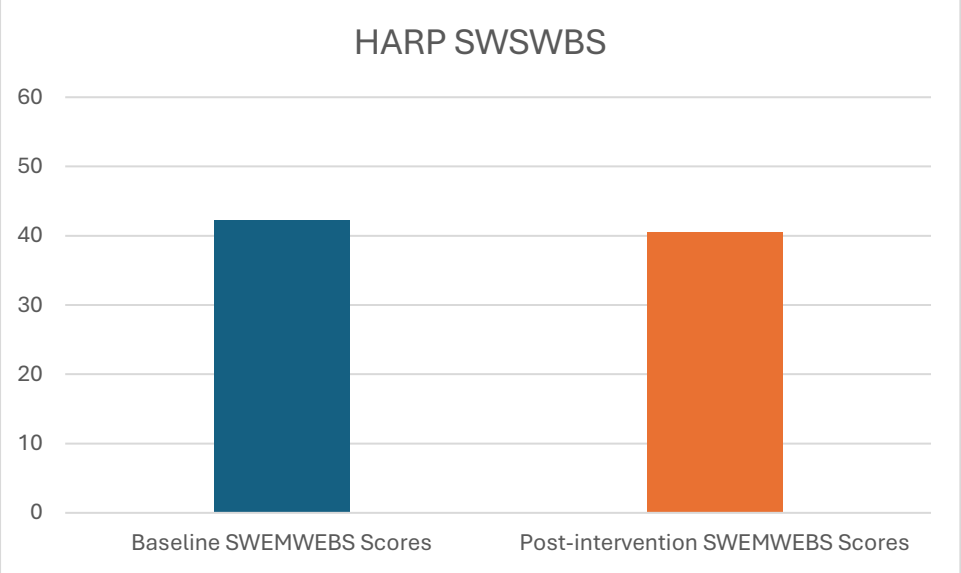

Figure 2 Mean SWSWBS scores before and after HARP.

8.2 Qualitative results

Qualitative results from service users, arts partners, and primary care stakeholders are synthesis below. Reflections from programme organisers can also be found in Appendix 1.

8.2.1 Service user and arts partner feedback

As depicted in figure 3, six overarching themes were identified through thematic analysis of qualitative data collected from service users and arts partners. These included the social impact of HARP, enablers to engagement, transport and location, barriers for arts partners evaluation, and programme delivery and adaptation.

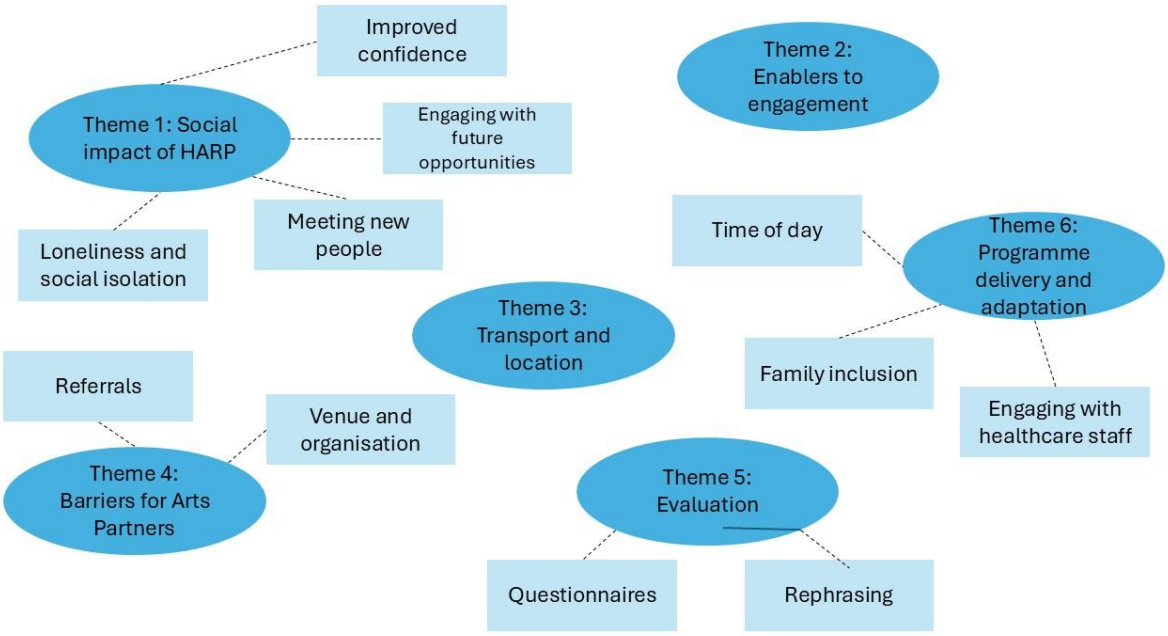

Figure 3 Thematic map of themes identified during Thematic Analysis of HARP data.

8.2.1.1 Theme 1 Social impact of HARP

8.2.1.1.1 Loneliness and social isolation

Participants described experiences of loneliness and social isolation prior to attending the programme, with some reporting limited opportunities for social contact. Attendance at HARP was described as providing structure and purpose, offering a reason to leave the house and engage in activity outside of existing routines, *"These sessions have helped me in, you know, with getting out the house", (CE003, Lampeter)*. For some service users, this was perceived as a meaningful change, particularly where isolation had been an ongoing challenge.

8.2.1.1.2 Meeting new people

Participants described opportunities to meet new people and form social connections as a valued aspect of attending the programme. For some service users, participation provided a supported context in which to interact with others, particularly where social contact had previously been limited. Attending sessions was described as offering a reason to leave the house and engage with other outside of usual routine, which participants felt helped reduce feelings of isolation. One participant described how they had previously avoided social contact stating:

I don't really know anyone and don't really go out. I've got no friends here […]. I don't see anybody apart from people that are helping me, cause, I've just been afraid to be social, (CA003, St Clears).

Others described attending HARP as an opportunity to connect with people in a manageable way, describing it as *"…a way of meeting other people rather than being in my own bubble a bit" (CA008, St Clears).*

8.2.1.1.3 Improved confidence

Service users described initial feelings of nervousness or anxiety prior to attending the programme, particularly in relation to participating in group activities. Some participants described feeling *"…. a bit nervous" prior to the first session (CE003, Lampeter)* or lacking confidence in speaking within a group, noting that *"I don't feel like I am very good at speaking up in front of other people so much" (CE002, Lampeter)*.

Following engagement with the programme, service users described feeling more comfortable participating in sessions and engaging in activities such as leaving the house, taking part in art-based activities, and speaking within a group setting. Attendance at HARP was described as supporting increased confidence through gradual exposure to group participation within a supportive and non-judgemental environment, with one participant describing how *"we just clicked with [the arts facilitators] and totally relaxed" (CE001, Lampeter)*.

Participants also described arts activities as being presented in an accessible way, with artists supporting engagement in tasks that had previously felt difficult. This approach appeared to contribute to increased confidence by enabling participation without pressure or expectation of artistic skills, as one service user explained:

They can make something that looks quite complicated, down to something to be able to do, and I'm not that artistic. (CA009, St Clears).

For some service users, participation in group settings had previously been experienced as challenging; however, engagement with the programme appeared to support increased confidence in managing these situations over time.

8.2.1.1.4 Engaging with future opportunities

Some service users described reflecting on future engagement with creative or community-based activities following their participation in the programme. These reflections included renewed interest in previous hobbies, consideration of volunteering, or exploring additional arts-based or social groups.

For some participants, involvement in HARP appeared to prompt re-engagement with creative activities that had previously lapsed, with one Service User describing how they had *"taken back up my crocheting and stuff like that" following participation (CA009, S3)*. Others described interest in becoming involved in future programmes in a more active or supportive capacity, including volunteering, expressing a desire *"to be involved in other ways…like I said before… I'd love to volunteer to help out" (CA009, S3)*.

Participants also described considering engagement in other community-based arts or social groups beyond the programme. For some this included interest in activities that were distinct from formal therapeutic settings, with one participant describing how *"I might sign up for doing some, a weekly art group that's not a therapy group to learn new skills and meet people as a social" (CA008, St Clears)*.

8.2.1.2 Theme 2 Enablers to engagement

Service users identified several factors that supported their engagement with the HARP programme. Central to this was the role of the arts partners and the structure of the sessions, which were described as creating a supportive and manageable environment.

Service users regularly described arts partners as compassionate, dedicated, and non-judgemental. This approach was described as important in fostering trust and enabling participants feel comfortable sharing experiences related to their health and wellbeing.

You know, [the artist facilitating the sessions] is a lovely person, a good combination; they work well together. What's special is that there's no judgment, (CA008, St Clears).

I think it would probably be the empathy that [the artist facilitating the sessions] showed me when I talked about my condition and about my mental health and stuff, (CE002, Lampeter).

The small-group format of sessions was also described as supporting engagement. Groups of around ten people were perceived as more manageable and less intimidating than larger group settings. One participant noted that *"I wouldn't enjoy it if it were a massive group, because I can't cope with big crowds" (CA003, St Clears),* highlighting how group size influenced willingness to attend.

8.2.1.3 Theme 3 Transport and location

Service users identified transport as a potential barrier to attending the HARP programme. Participants described challenges related to limited public transport in rural areas, resulting in unsuitable timetables that may not align with the HARP programme. Some participants also reported anxiety associated with travelling, stating "*I don't drive, you see, so I can't get public transport because my anxiety goes through the roof." (CA003, St Clears).* Others explained how the financial costs of alternative transport could have been difficult to manage, but that the programme funding included transport support "*So they found funding for me to get a taxi from home back to here…That's £15 each way." (CE004, Lampeter)*.

On the other hand, for some participants, the local delivery of the sessions eased any barriers to transport "*It's just down the road from me, it makes it a lot easier, so I don't have to go very far." (CA005, St Clears)*, thus increasing the accessibility to the programme. These findings highlight the role of community-based delivery in reducing transport related anxiety and perceived barriers to engagement.

8.2.1.4 Theme 4 Barriers for arts partners

Arts partners described several challenges associated with delivering the HARP programme. These barriers related primarily to referral processes and organisational factors, which were perceived as influencing engagement and continuity of delivery.

8.2.1.4.1 Referrals

Arts Partners reported challenges in securing referrals to the programme, particularly in relation to engagement with GPs. Participants described GP time pressures as a key barrier to referral, noting difficulties in ensuring that the programme was fully understood and prioritised within busy primary care settings. One arts partner reflected that *"…it was quite challenging to get the doctors to really understand and take it on board because they're so busy" (AP1).*

These challenges were reflected in periods of reduced referrals to the programme, with one arts partner describing how *"For block 3, referrals slowed up a bit for…for those sessions" (AP2)*. In response, arts partners described adopting proactive strategies to support engagement, including personalised invitations and follow-up contact with service users. One arts partner described how *"one of the things that we kept doing was the personal invitation" and "so each individual got a referral…We sent handwritten personal card with the with the contact numbers, contact names, place a venue and also welcoming them" (AP6).*

However, arts partners also described the resource-intense nature of this approach. One participant reported that when an arts partner was unable to provide reminder calls due to leave, some service users did not attend sessions, which was perceived as contributing to missed engagement opportunities.

Arts partners also described making pragmatic adjustments to referral processes to reduce barriers for service users. In some case, this involved adapting referral procedures to enable arts partners to complete referrals directly, particularly where service users had been unable to do so themselves. One arts partner described how *"She forgot to go and get her referral. I said, well, don't worry. Because by that time, we'd slightly changed the process, and I could make the referral for her" (AP1).*
These findings suggest that proactive and flexible referral processes were perceived as important in supporting engagement with the programme, while also highlighting the reliance on arts partner capacity to sustain this level of support.

8.2.1.4.2 Venue and organisational factors

One arts partner described challenges related to venue use and organisational arrangements during one season of their provision. These included last-minute room changes and inconsistencies in staff preparedness, which were perceived as disruptive to programme delivery. They described how *"…we did have a few issues, didn't we? With them changing the rooms without telling us" (AP1).* To address this, arts partners emphasised the importance of clear communication, consistent room allocation, and ensuring that relevant staff were provided with adequate information about the programme. These issues were overcome in the second HARP season, when the sessions were run in a different location.

8.2.1.5 Theme 5 Evaluation

Arts Partners reflected on challenges associated with the evaluation component of the HARP programme, particularly in relation to the format of questionnaires and how the evaluation was introduced to service users. These factors were perceived as influencing engagement with evaluation activities. engagement beyond the structured sessions.

8.2.1.5.1 Questionnaires

Arts partners described the volume and repetitive nature of questionnaires as challenging for some service users. This was perceived as contributing to feelings of overwhelm and, in some cases incomplete or inattentive responses. One arts partner noted that service users *"… had to deal with so much paperwork" (AP3).*

In response, arts partners described adapting the way questionnaires were presented in an effort to make them more accessible. One participant described embedding the questionnaires with participant journals, noting that "*we got round the, the Edinburgh Warwick stuff by just putting it in the journals and that worked" (AP6).* These adaptions were described as pragmatic responses to perceived challenges, rather than systemic changes to the evaluation process.

8.2.1.5.2 Rephrasing the term evaluation

Arts partners described that service users appeared hesitant to engage with the evaluation component of the programme, which was perceived to be linked to the terminology used. In particular, the term evaluation was described as having associations with judgement or assessment, which some arts partners felt may have contributed to anxiety or reluctance among service users. One arts partner reflected that *"the word evaluation is just frightening off our participants I felt and I could even sense that on the one the phone calls" (AP4),* and that when they framed interviews as 'having a chat' with health board staff, service users were more comfortable engaging with the evaluation.

This suggests that when the arts partners described the evaluation as an opportunity to provide their opinion service users responded more positively. Future versions of the HARP programme may need to reevaluate the terminology used around the evaluation. Additionally, having arts partners explain to service users the importance of the evaluation can help increase

understanding and engagement this could improve the quality of the data collected.

8.2.1.6 Theme 6 Programme delivery and adaptation

Arts partners described a range of practical challenges encountered during delivery of the HARP programme and outlined adjustments made in response to barriers affecting service users' engagement and attendance. These adjustments were described as responsive and pragmatic, shaped by observed service user needs during programme delivery.

8.2.1.6.1 Time of day

Arts partners identified the timing of sessions as a barrier for some service users, particularly those living with chronic health conditions that affected sleep, energy levels, or medication routines. Early session start times were described as difficult for some individuals to manage. One arts partner reflected that difficulties with sleep and medication schedules meant that attending a session for "*10:00am was incredibly difficult" (AP1).*

In response, arts partners described adjusting session times later in the day in order to improve accessibility. For example, one arts partner noted that they *"moved it to the afternoon to see how that works and we did hear that from other referrals as well." (AP1).* These adjustments were described as responsive to service user needs and aimed at reducing barriers related to attendance.

8.2.1.6.2 Family inclusion

Arts partners also described instances where flexibility around attendance enabled service users to bring spouses or family members to sessions. This was described as a change from earlier programme blocks and was associated with individual circumstances, particularly anxiety. One arts partner noted *"People brought their spouses with them, which is something that hadn't happened in the earlier blocks, but for reasons such as anxiety." (AP4).*

Allowing family members to attend was described as a flexible response to individual circumstances, supporting engagement where anxiety was identified as a barrier to attendance.

8.2.1.6.3 Engaging with healthcare staff

Healthcare and other support service professionals attended a number of sessions to talk about other health and wellbeing opportunities or to carry out

evaluation activities. arts partners observed that service users appeared more comfortable during those sessions when the healthcare professionals participated in the arts activities alongside them and became part of the group. This was described as reducing perceived hierarchy and creating a more equal and informative group environment. One arts partner reflected that when healthcare professionals joined in the same activities and conversations, they were perceived as *"just another human being within that room. And I think it really worked for the participants to see that" (AP6).*

This observation suggests that shared participation by health professionals may support service user comfort and engagement by reducing perceived power differences within group settings. However, this was based on arts partners' observations rather than direct service user accounts.

8.2.5 Primary care stakeholder feedback

The analysis of primary care stakeholder discussions identified three interconnected themes that together illuminate how the HARP programme was perceived and implemented across sites. These themes reflect stakeholders' views on HARP as a valuable addition to patient support, the barriers that constrained referral and uptake, and the particular considerations involved in introducing a non-standard, arts-based intervention into routine primary care practice.

8.2.5.1 Theme 1 A valuable addition to the support offered to patients

Across all three sites, primary care stakeholders described HARP as a meaningful addition to the options available for patients with complex needs. Clinicians emphasised how often they see individuals living with anxiety, depression, chronic pain, or social isolation, and how limited their options can feel in routine practice. In this context, HARP was regarded as a welcome alternative. One staff member described how impactful the intervention had been for a particularly vulnerable individual, saying that it "*really kind of saved her at a point of crisis because she had somewhere to sort of link in" (PC3).*

Stakeholders also highlighted the value of the social connections that emerged within groups. One stakeholder recounted attending a session and witnessing two anxious women building a small but meaningful relationship, describing how one participant offered the other a lift home so she would not have to leave early, and how this everyday act demonstrated *"how powerful [it was] for*

them to build that connection when they've both got really poor mental health and anxiety" (PC1). These stories strengthened clinicians' confidence that the programme was not only appropriate, but also capable of creating the kinds of relational and emotional improvements that traditional clinical services can struggle to provide.

8.2.5.2 Theme 2 Barriers to referral

Despite widespread support, staff described structural, practical, and cultural challenges that limited referral numbers. A central issue was the pace and pressure of general practice. Several clinicians noted that even positive intentions were undermined by the realities of short appointments and heavy clinical workload. One doctor admitted simply, *"I'd forgotten it was available actually," (PC1)* explaining that this was not due to a lack of interest, but because of the number of competing services they must keep in mind.

Beyond the challenge of remembering the programme, some clinicians felt uneasy about how to introduce a non-medical intervention in a medical consultation. One GP described the apprehension that referrals sometimes generated, saying that the difficulty lay largely in "*us changing the mindset," and that they occasionally felt "a bit uncomfortable approaching it, not knowing how [patients are] going to take it on" (PC2).* Although no patients were reported to have reacted negatively, the anticipation of possible discomfort acted as an early barrier.

Practical considerations also played a role. Several clinicians argued that the reliance on GP-led referral constrained reach and suggested that self-referral would remove unnecessary bottlenecks. One GP explained that *"if it could be self-referral… that would be a useful step," emphasising that this would allow motivated patients to access the programme without waiting for a consultation (PC2).*

Other barriers related to patient circumstances. Some staff noted that daytime sessions prevented working adults from attending, even when these individuals would have benefited. Childcare challenges were also noted, particularly for younger women, whom staff identified as a group both interested in and well-suited to the provision. One practitioner described how some women *"had young children that didn't have childcare… and weren't able to attend but*

would like to" (PC1). These reflections showed that even motivated patients can face access challenges unrelated to the referral process itself.

8.2.5.3 Theme 3 Considerations around a non-standard intervention

Introducing an arts-based option within primary care required a shift in expectations for both staff and patients. Several participants reflected that HARP sits outside the typical repertoire of medical interventions, and that integrating it into practice therefore requires time, familiarity, and cultural adjustment. One clinician described the evolution of confidence in offering the intervention, explaining that *"once you do [suggest it], it's normally more that I feel a bit uncomfortable… But nobody so far has kind of stormed out…," which helped to alleviate initial concerns (PC2).*

Participants also viewed the early stage of the programme as a critical factor. Some referenced other comparable programmes that took years to embed, with one participant emphasising that the process of normalising new forms of care is inherently gradual.

There was also concern that premature withdrawal of funding would undermine this slow but important process of cultural embedding. Staff noted that just as clinicians were becoming more comfortable with the model, and as patients were beginning to hear about the programme through word-of-mouth and return for second seasons, the pilot period was already ending. Staff from one practice described the extent to which patients valued the programme, recalling that one woman was *"really upset that the funding was ending and threatened to come with placards" (PC3).* Experiences like this reinforced the sense that HARP is meeting a real gap in provision and that sustaining it over time is essential for it to achieve its potential.

9. Recommendations

Based on the findings of this evaluation, the following recommendations are proposed to support future delivery and evaluation of the HARP programme. These recommendations are intended to inform service development and implementation in subsequent iterations of the programme.

Recommendation 1: Improving GP engagement through simpler referral and clear cues

Consider how the referral process could be optimised to ensure that it is as easy as possible for GPs to refer into HARP in the context of short consultations, a pressurised work environment, and lack of familiarity with arts-based interventions. Additionally, provide materials to increase the visibility and understanding of HARP during consultations. These could include printed and digital prompts, scripts, and brief training sessions focusing on how to frame arts-based interventions to patients.

Recommendation 2: Optimise the referral pathway

Consider how the entire referral pathway could be optimised for service users and staff, ensuring that service users remain supported prior to attending the first session but that resource-intensive reminder calls from arts partners are reduced. For example, other professionals, such as community connectors, could bridge the gap between GP referral and attending arts sessions.

Recommendation 3: Enhance programme access and practical delivery

Continue to provide accessible, community centred delivery by maintaining transport funding and making this support even more visible from the point of referral. Proactively engaging with community transport providers at programme startup will further strengthen this approach and help minimise travel related barriers. In addition, offering flexible session times will help ensure that people living with chronic conditions or fluctuating health needs can attend at times that work best for them.

Recommendation 4: Programme delivery adjustments

Continue to allow flexibility in programme delivery where appropriate, including session timing and attendance arrangements, in response to individual service user needs. Such adjustments may help reduce barriers related to health, anxiety, or caring responsibilities and support sustained engagement.

Recommendation 5: Language used to describe evaluation

In future iterations of the programme, consider the language used when describing evaluation activities to service users. Findings suggest that the term evaluation may carry associations with judgement or assessment for some individuals. Using clearer, more accessible explanations about the purpose of

feedback and data collection may support engagement and reduce apprehension.

Recommendation 6: Supporting arts partners with evaluation processes

Provide a training session or guidance for arts partners and others involved in programme delivery e.g. community connectors outlining their role in the evaluation process. This should include the purpose of data collection, including an overview of questionnaires used, and practical guidance on supporting service users to complete outcome measures. Improved clarity may enhance consistency and data quality collected across programme blocks.

Recommendation 7: Questionnaire burden and format

Review the volume and format of questionnaires used with the programme. Where possible, simplifying or streamlining evaluation materials and integrating them more naturally into sessions may reduce burden for Service users and support more complete and meaningful responses.

10. Conclusion

This service evaluation examined the experiences of key stakeholders involved in the HARP programme, focusing on engagement, accessibility, and programme delivery. Findings indicate that HARP was perceived as a supportive and acceptable intervention, particularly for individuals experiencing social isolation, anxiety, or long-term health conditions. Participants reported perceived social and confidence-related benefits, while arts partners emphasised the importance of flexibility and responsiveness in enabling effective engagement.

However, limitations relating to referral pathways, transport, and engagement with the evaluation measures restrict the ability to draw firm conclusions about programme effectiveness or longer-term outcomes. Future iterations would benefit from stronger referral pathways, clearer communication about evaluation requirements, and continued attention to practical barriers affecting attendance.

Overall, this evaluation provides valuable insight into how HARP was experienced in practice and identifies pragmatic considerations to inform future delivery and evaluation of the programme.

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Appendix 1: Reflections from programme organisers

Challenge	Adaptations already implemented / proposed	Next steps
Low referral numbers from primary care - **Limited GP time even when supportive** - **Lack of confidence in changing medical conversation into social one** - **Lack of understanding/experience in some Surgery staff** - **Lack of capacity right across the system**	• Developed GP-facing materials (leaflets/guides); exploration of EMIS compatibility while keeping low-burden, paper-friendly options.	• Extend referral acceptance to GP Team. • Run short, in-practice "micro-briefings" and demos to GP teams; use **referral champion charts / friendly competition** across practices to nudge behaviour. • Present at **Locality Leads**, cluster and collaborative meetings; target GP-specific communications for national attention.
Low patient take-up from those referred (ranging from 30-60%) although this is inline with average take up rates for social prescribing for people with complex needs	• Behaviourally informed **Patient Packs** developed to provide more info. • Arts partners provided reassurance and welcome through phone calls, invitations and meeting at the door and weekly reminder phone calls.	• Co-design approach with previous cohorts to refine info/consent and remove friction. • Introduce "**warm handover**" via Community Connectors / care navigators for first session.
Fixed referral windows (due to funding constraints) create barriers and missed opportunities	• Move from fixed term windows to a **continuous rolling programme** so patients can join at point of need and in line with usual referral patterns.	• Operationalise rolling intake with simple triage and periodic "onboarding" sessions to protect artist capacity and group cohesion.
8-week provision too short to show change / build habits	• Proposal to extend to **16-week blocks** (aligned with NERS), acknowledging many participants naturally stay longer.	• Pilot 16-week cycles within the rolling model; define a light-touch "healthy ending" protocol with onward signposting and support from Community Connectors.
Artists unsure about onward pathways and "healthy endings" into community provision	• Identify **artist training needs** (endings, signposting, evaluation basics).	• Run an **Artist Training Workshop** covering: safe endings, local assets

		mapping, brief data capture, and safeguarding refreshers.
Time needed to build a shared multi-disciplinary approach / culture change	• Broader governance refresh (new Chair; ToR update) to align with HB structures and embed arts & lived experience voices.	• Establish a **Creative Prescriber Leadership Role** to coordinate referrals, partnerships, evaluation, and scale-up planning for 12 months.
Evaluation Difficulties: PROMs burden, consent complexity, and mismatch for vulnerable participants (although we now understand that average PROM response rates in Wales for SP hover around 40-50%)	Discussed and explored new possible evaluation model.	• Co-produce simplified information sheets and consent; include simple PREMs ("what did you like/not like?"). • **Trial PAM (Patient Activation Measure)** and brief baseline questions (activation, wellbeing, loneliness) at referral, not in sessions; consider a **Most Significant Change** strand and invite decision makers to score stories. • Adapt language – talking about conversations rather than evaluation • Moved evaluation from Artist responsibility to Community Connector
Difficult to quantify social isolation (not coded like other needs by GP surgeries); limited visibility of health inequalities impact	• Discussed creating **deprivation baseline** using postcode-derived measures and simple referral questions.	• **Target practices in the most deprived quintile** (e.g., 20four7/Deep End Cymru lens); embed a standard deprivation field at referral to evidence inequality impact.
Unclear position of HARP within wider social prescribing & prevention landscape	• Dialogue with Primary Care Academy and TriTech; explore health pathway write-up and alignment.	• Publish a **HARP Health Pathway** (TriTech/Primary Care Academy) clarifying eligibility, flow, data points, and onward routes; ensure prevention narrative is explicit.

Fragmented operational processes (DPIA, IG, procurement timelines)	• DPIA/IG work underway; four arts partners appointed via RfT	• Create a **repeatable implementation pack** (DPIA template, referral flow, comms, data map, partner MOUs) to speed new site onboarding.
Difficulties with procurement – which takes up a lot of time in short 1 year projects where funds are insecure so project set up time is required.	• Allow for at least 3 months of set up time for the programme from point of funding confirmed before referrals open to allow time for procurement and then planning by commissioned arts partners.	• Develop new **Arts and Health Procurement Framework** in partnership with Procurement colleagues to ease procurement challenges in a way that is more suited to working with the arts sector.
Difficulties in identifying GP surgeries to work with in a fair, equitable and accessible way whilst resources remain too small for full roll out.		Consider identifying GP surgeries based on: 20four7 model – identify those within 20% most deprived area Those with interested GPs and active social prescribing Those who are Health Board Managed Practices to make data agreement easier.
Capacity & sustainability (funding, workforce, leadership)	• Funding agreed for new A&H Project Manager; exploring SROI research; volunteer role description signed off to build future workforce.	• Take evaluation to **Value & Sustainability Group** and **Strategy & Planning Committee** with a clear **value model** and workforce plan; prepare to engage clusters as commissioning vehicles (prevention).
Variable practice readiness; rurality and engagement challenges in high-need areas	• Use a phased **place-based roll-out**: start with willing/high-need practices with community assets, then spread using peer practice advocacy.	• Focus emerging on Pembroke Dock/Milford Haven; leverage **Deep End Cymru** style networks; identify proactive cluster leads.

Kindness & relationship-centred care valued but not measured	• Proposal to develop a **kindness KPI** (e.g., PREM questions) aligned to "Safe, Accessible, Kind."	• Add 2–3 **Kindness PREM items** (felt listened to; felt welcomed; felt safe) to post-session feedback; report alongside activation and attendance.
Comms & advocacy opportunities underused	• Invitations to present HARP at national events (NCC H/WAHWN; Social Model Summit).	• Systematically **harvest and package stories** (co-produced vignettes + data points) for locality leads, clusters, RCGP SIG for Creative Health, and HEIW channels. • Publish HARP on internet – to provide reassurance of robust Hywel Dda programme. Develop short video clips and advocacy. Work with Cluster and GP surgery websites.

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