

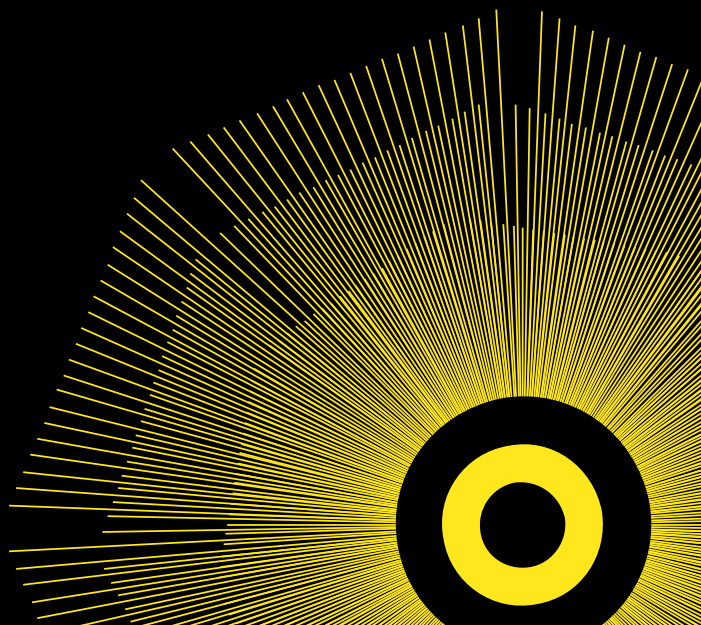
Shine 2014 final report

Social Prescribing: integrating GP and Community Assets for Health

City and Hackney Clinical Commissioning Group and
University of East London

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Part 1: Abstract

Project title: Social Prescribing: integrating GP and Community Assets for Health

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Current health policies are concerned with merging health and social care, effectively managing long-term conditions in the community, reducing social isolation, and at the same time minimising expenditure¹. Social prescribing (SP) is a potential solution to these objectives.

'We are seeing a big growth in social prescriptions where GPs are saying that actually the root cause of this person's problems is isolation and loneliness, so effectively what I'm going to prescribe is that you join a lunch club or something like that to make sure you have company in your life [...] The NHS is taking a more holistic view of what it takes to address people's medical problems than it did before and I do not think that is something we would want to stand in the way of' Jeremy Hunt, Health Secretary².

The term SP encompasses different types of links between primary care and community organisations ranging from an unstructured information service (i.e. leaflet) to a sophisticated holistic approach involving a facilitator³. Building on the latter of these, SP in City and Hackney CCG is one of the most ambitious and innovative in the UK to date:

- (i) Involved a large number of GP practices (23).
- (ii) Set broad inclusion criteria for referral, reflecting the diversity of the people who present to their GPs⁴;
- (iii) Signposted patients to a wide range of services (85 organisations);
- (iv) Had dedicated and trained SP coordinators which supported 737 participants (Feb 2014 - July 2015) for up to eight one hour sessions to co-produce a well-being plan;
- (v) Rigorous evaluation included a control group and economic evaluation – aiming to fill gaps in the existing evidence base^{5 6}.

¹ Department of Health (2010)

² GP online, 10th Dec 2014

³ See Kimberlee (2015) and Brandling and House (2007) for a more detailed discussion

Please see appendix 5 for details of the inclusion criteria for referral and detailed project aims

⁵ Grant et al 2000; Dayson et al 2013

⁶ Kimberlee, 2015; CRD, 2015

The general health and wellbeing of participants surveyed has remained stable over the intervention period. Quantitative analysis showed no statistically significant change in health outcomes between intervention and control groups. However, qualitative interviews (12 out of 15) revealed 'life changing' experiences. The role of the SP coordinator (SPC) was key to this success. The average cost per patient of providing SP is between £225 and £270. Savings may have been realised through a decline in A&E attendance but may have been offset by an increase in General Practice consultation rates during the intervention period.

There is room to increase referrals to SP by GPs. The referral step from SPC to community organisation needs to be developed further, e.g. referral form, to help local organisations feel part of the SP project. Further work is required to establish which patients benefit most from SP and the characteristics community organisations that improve health and wellbeing the most. National collaboration is required to share learning, develop outcome measures, and ensure the potential of SP meets the needs of the NHS.

Part 2: Quality impact: outcomes

23 GP practices in City and Hackney⁷ referred 737 patients to three social prescribing coordinators (SPCs) employed by Family Action (FA)⁸. SPCs assessed individuals' needs and aspirations before connecting patients to appropriate, mainly non-clinical, community services⁹ delivered by 85 statutory and voluntary groups (see Fig 1). The DNA (Did Not Attend) rate at first appointment with the SPC was 11% (Chart 1)¹⁰. Qualitative evidence shows a positive impact due to SP but the quantitative data does not show any statistically significant change due to the intervention. An economic and process evaluation was conducted (see Part 3 and 4).

Fig 1: Community Activities at a Social Prescribing Information stall



Chart 1: Breakdown of consultations provided by SP coordinators to clients

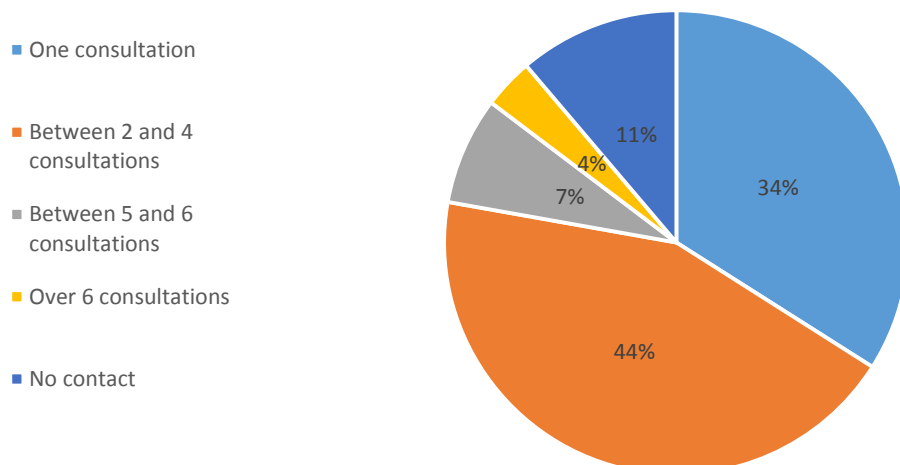
⁷ These 23 practices were from three consortium in City and Hackney – which were selected by the CCG after invitations to participate were circulated prior to the launch of the pilot.

⁸ FA is a Hackney based third sector organisation which run Social Prescribing between Feb 2014 and July 2015

⁹ Lunch clubs, psychological counselling, volunteering, physical activity (e.g. yoga, walking) and specialist support with health, employment and legal issues.

¹⁰ This is better than other social prescribing interventions such as 'Equally Well' which had 36% DNAs at first appointment. Although complete data about attendance of participants to community organisations was not available for the overall period, in the last quarter of the intervention FA reported that about 70% of participants attended community activities.

Breakdown of Consultations (n=624) (Feb 14-Jul 15)



Qualitative interviews with patients: experience with services

Participants (N=15) suffered from a wide range of co-morbidities. The sample was well balanced re gender (female/male), ethnicity (White/non-White), and 66% of respondents were aged 50 or over. About 33% of respondents attended one or two sessions. The selection of respondents was only partially randomised¹¹.

Participants' experience was, overall, positive or extremely positive. *Re-connecting with the world* and *renewed hope for the future* were the two main patient experience themes that emerged. Patients reported suffering from a range of physical and psychological challenges; the most common being *social isolation*, confirming that a key target group for SP was reached.¹² Benefits of SP included becoming involved with organisations on their doorsteps and interacting positively with local people. Several patients spoke of the structure that this gave to their lives and, in the case of those who became volunteers, of a sense of feeling useful again.

"It's done me a world of good, taken me out of the house, given me a routine and given me a sense of purpose and...hope. It's given me back my confidence" (Patient)

Patients' *interaction with SPCs* was key to their progression and experience of SP¹³. Patients spoke positively of being given the time and space to discuss their needs, feeling heard, and the proactive focus of the intervention, e.g. learning new skills. Several patients described 'life-changing' results often relating to employment and social networks¹⁴.

¹¹ Many participants did not reply to initial contact, thus we had to rely on FA selecting participants that may have been more willing to participate.

¹² This was a key target group for the CCG

¹³ The same finding was highlighted in a range of other studies (Brandling et al 2010; White, Kinsella and South, 2010),

¹⁴ See appendix 2 for more quotes from qualitative interviews

“Done qualifications at Tesco. The Job Centre really happy with me. Before I was on capacity benefit and I thought I’ll change my life and I have I’m really happy. I do want to work and Job Centre knows that.” (Patient)

“It (social prescribing) gave me the motivation to think I might be ready to go back to work. It helped me deal with my depression, prepared me to go back to work and made me feel useful.” (Patient)

Participants had no knowledge of the term ‘social prescribing’, the provider organisation (FA), or the term ‘well-being/social prescribing coordinator’ but could remember the personal names of SPCs referring them and the types of activities they had been referred to. Most agreed more information, e.g. a leaflet from the GP, would be helpful. Experiences of the referral process were generally good, with no reports of long wait times to see the SPC. Appointment numbers with SPC varied but patients were generally satisfied that they received sufficient input to meet their needs.

Patient reported outcomes: health, well-being, anxiety, depression, active engagement, and quality of life

A control group (six GP practices in City and Hackney) were matched to intervention group (SP respondents).¹⁵ Data was collected at baseline and eight months from both groups.¹⁶

Table 1: Demographic details for intervention and control areas

	Intervention (N=184)(*)	Control (N=302)(**)	Correlations with treatment group
Age	Median 56 (range 18-95)	Median 58 (range 24-83)	P=0.560
Gender	59% female	54% female	P=0.354
Ethnicity			P=0.070
White	49%	58%	
Black	33%	21%	
Asian	9%	8%	
Mixed/Other	9%	13%	

¹⁵ Inclusion criteria in the control group: age group older than 23 and younger than 85 years old suffering from at least one of the following: depression, anxiety, type 2 diabetes. Exclusion criteria: palliative care and housebound

¹⁶ The intervention effectively targeted socially isolated and ethnic diversity of the area is well represented. The control group were well matched (health profile, age, gender), though were more likely to live with others, have higher educational qualifications and be employed.

Living arrangements			P<0.001
Alone	60%	37%	
With others	40%	63%	
Work status			P<0.001
Employed	7%	39%	
Not in paid work	62%	31%	
Retired	30%	30%	
Education			P<0.001
None Formal	6%	3%	
To 16 years	52%	35%	
17 years upwards	42%	62%	

P value < 0.05 is considered as statistically significant; (*) (**) response rates 32% and 10% respectively

Table 2: Change in health profile from baseline to follow up

	Scale	Baseline		8 months Follow up	
Measure		Intervention (N=184)	Control (N=302)	Intervention (N=65)	Control (N= 127)
General health	Very bad to neither Good/very good	79% 21%	59% 41%	85% 15%	58% 42%
Wellbeing past week	6 good as it can be 0 bad as it can be (mean)	2.8	3.6	2.8	3.9
Anxiety (*)	21 extremely anxious 0 not anxious at all (mean)	11.3	8.1	11.2	7.6
Depression (*)	21 extremely anxious 0 not anxious at all (mean)	9.9	6.7	10.1	5.9
Positive and active engagement in life	5 poorly integrated to 20 highly integrated (mean)	13.5	13.7	13.5	14.1
A&E visits in past 3 months (mean)		0.4	0.3	0.3	0.5

(*) Scores between 0-7 in both anxiety and depression scales are considered normal, with 8-10 borderline and 11 or over indicating clinical 'caseness'.

Respondents from the intervention group, in keeping with the CCG target population, showed poor general health and clinical anxiety/depression, although 'wellbeing in the past week' was neither good nor bad (Table 2). Logistic regression analysis showed no statistically significant change in health, well-being, anxiety, depression, or A+E visits due to the SP intervention, even after controlling for age, gender, ethnicity, living arrangement and work status (see appendix 4).

There may be different reasons for such result including:

- (i) Follow up sample size for the intervention (n=65) is small for regression analysis as it represents only 10% of the population that attended social prescribing.
- (ii) Limited information about the type and number of activities people attended. Lack of impact may be due to lack of attendance rather than lack of effectiveness of the intervention.¹⁷
- (iii) There is considerable uncertainty about the 'right' follow up period when considering complex interventions such as SP and issues about the appropriate survey instruments to be used.

The evaluation also examined health related quality of life¹⁸ at baseline and eight months follow up and showed a statistically positive change in both intervention and control groups (Table 3). However, as the control group has also shown a positive change, the positive change in the intervention may not be due to the effect of the intervention but to other reasons.¹⁹

When breaking down the different quality of life components (see appendix 8) 'mobility' improves in the intervention, while worsens in the control. The intervention also recorded a greater improvement in 'usual activities', and 'pain/discomfort' in comparison to the control. An improved ability to engage in physical activities is surprising as most of the literature on social prescribing points to its importance for improving mental rather than physical health.

Table 3: Quality of life (EQ-5D scores)

	EQ-5D score Baseline			EQ-5D score 8 month follow up			Paired t-test p-value (significance between baseline and follow-up)
	N	Mean	SD	N	Mean	SD	
Control group	120	0.606	0.370	120	0.643	0.359	0.067
Intervention group	66	0.342	0.389	66	0.402	0.382	0.058
Unpaired t-test p-value (significance between Control and Intervention)	0.000009			0.000049			

¹⁷ Although in the last quarter of the intervention SPCs reported that about 75% of participants did go on to participate in community activities.

¹⁸ Each of the 5 dimensions (mobility, self-care, usual activities, pain/discomfort and anxiety/depression) to EuroQol are scored on three levels

Part 3: Cost impact

The economic evaluation assessed costs and potential savings due to SP²⁰. The direct cost of the project was calculated by looking at the number of sessions and time spent by SP coordinators with each client. As SP coordinators included people with a background in nursing and social work, a full economic cost for these professions was used to calculate the average cost per patient²¹ as being between £225 and £270 (Table 4). The average cost per patient was multiplied by the number of patients supported to assess the value of social prescribing to City and Hackney CCG. As the CCG has invested £150K and the total cost calculated is £168K (£269.58*624), the investment from the CCG appears cost-effective even though the number of referrals (chart 3) is below what was initially expected.

Table 4: Costs of delivering the intervention £ 2014*

	Average cost per patient	SD	Median	IQR	Min	Max
Nurse	224.62	180.00	187.00	200.00	0.00	1064.00
Social Worker	269.58	215.51	217.25	237.00	0.00	1382.50

* Unit costs 2014 from [1], Curtis L, Unit costs of health and social care 2014.
Community mental health nurse, Curtis 10.2: £74/hour face-to-face contact; £52/hour patient-related, used for non-face-to-face contact time.
Social worker, adult services, Curtis 11.2: £79/hour client-related, used for face-to-face contact and non-face-to-face time.

The average cost per patient does not include indirect costs associated with service delivery from community organisations (although these were not funded by the CCG). On average, SP coordinators referred clients to just over one activity (1.17), although this could range from zero to seven activities in isolated cases. Limited data was available, and no data specified the type of activity clients attended. Thus, it was not possible to examine resources involved. As there was no significant gain in quality of life health in the intervention as compared to control, cost per Quality Adjusted Life Years was not calculated.²²

Mean A&E visits in the last three months at baseline and follow up were analysed in both intervention and control groups (Table 2). There is a decline in mean A&E attendance by 25% in the intervention group compared to an increase in mean A&E visits in the control group by 66%. Savings from decline in A&E attendance in the intervention group are about £1,600 as they only refer to the population of respondents.

General Practice consultation rates in both intervention and control areas over a two year period (July 2013-June 2015) were also analysed.²³ (chart 2). Consultations per patient over

²⁰ We kindly acknowledge the advice of Heather Gage, Peter Williams and Clareece Kirby from Surrey University

²¹ Social worker, adult services: 11.2: £79/hour client-related, used for face-to-face contact and non-face-to-face time (Curtis, 2014)

²² An economic evaluation of a referral facilitator (Grant et al 2000) found that the intervention was clinically beneficial but at higher cost

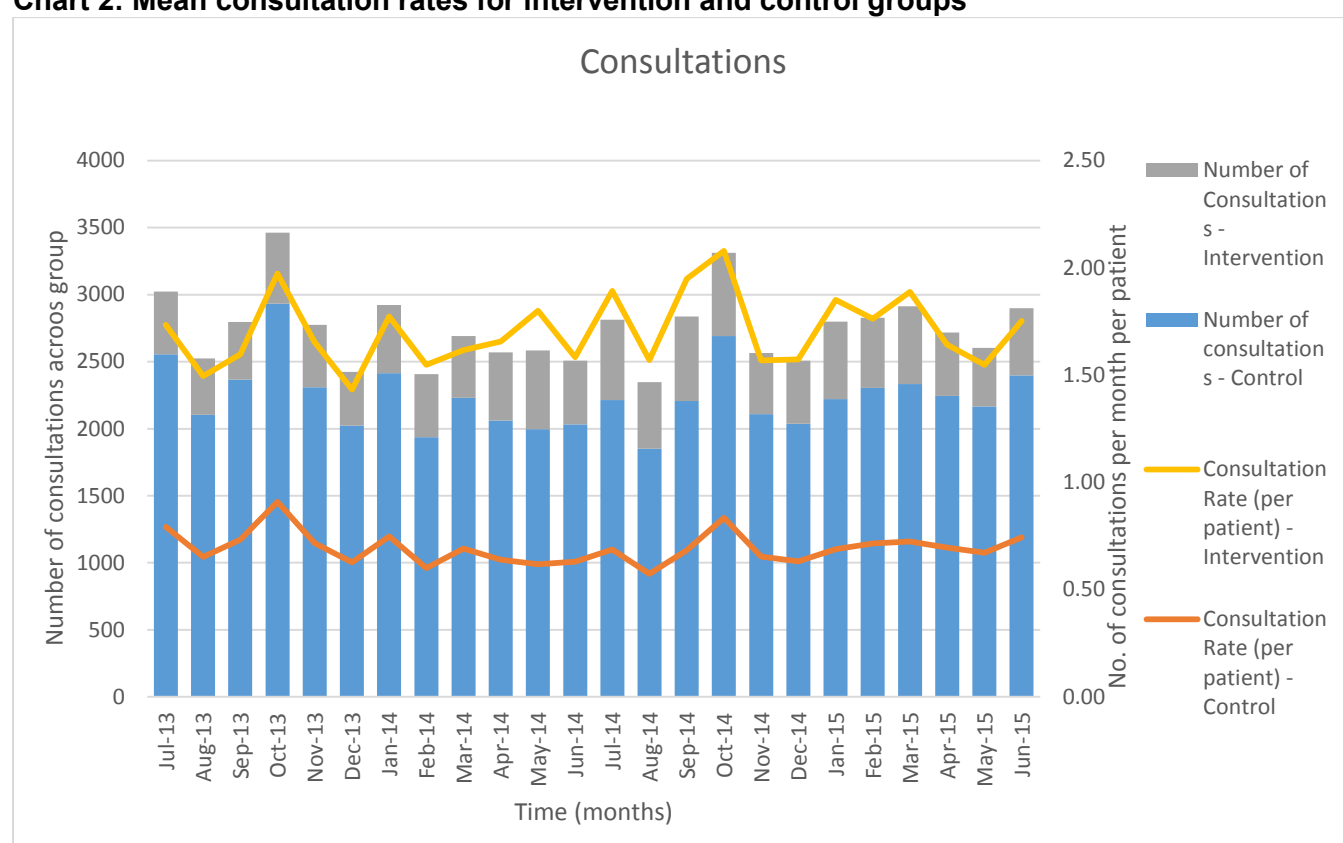
²³ Data for the controls covered 3,235 patients (62,945 consultations). Data from intervention practices (13,344 consultations) covered 498 people who had been referred to SP. Examination of the consultations revealed these included contact with practice management and support staff, including receptionists and secretaries. Since costs of health professionals are "fully loaded" i.e. include allowance for practice overheads and support staff, all consultations recorded for staff who do not provide direct patient care were removed.

the two-year period were higher in the intervention than control group (table 5), consistent with their lower health status²⁴.

Table 5: Consultation rates (Number of consultations per year per patient)

	Consultation rate in Year 1 (July 2013 – June 2014)			Consultation rate in Year 2 (July 2014 – June 2015)			Paired t-test p-value (significance year 1 vs. year 2)
	N	Mean	SD	N	Mean	SD	
Control group	3225	8.36	7.4	3225	8.3	6.68	0.598
Intervention group	498	11.49	8.32	498	12.78	8.17	0.000123

Chart 2: Mean consultation rates for intervention and control groups



Pre and post referral consultation rates were calculated on the 420 patients who had a referral date in the data base (Table 6). There was a significant difference between the consultation rates before and after the date of first referral, with higher consultation rates recorded after.²⁵

Table 6: Consultation rates (per year) per patient of the intervention group

²⁴ Carlisle et al (2002); Worrall et al (1997)

²⁵ As the intervention came into effect in April 2014 and new referrals to FA continued throughout year 2, use of calendar years provided an imprecise measure of the effect of the intervention. In order to explore the impact of treatment more accurately, the date at which each client was referred to FA was identified.

	Consultation rate before referral date			Consultation rate after referral date			Paired t-test p-value (significance between rates before and after referral date)
	N	Mean	SD	N	Mean	SD	
Intervention group	420	12.32	8.03	420	13.21	9.40	0.025

Detailed analysis of General Practice consultation rates is needed to ensure that appointments with SPCs did not contribute to the total number. Moreover, the economic evaluation does not currently take into account other potential benefits generated by the intervention such as clients volunteering, returning to work (contributing as taxpayers and with reduced welfare state support).

Part 4: Learning from your project

The process evaluation has informed this section²⁶. We also produced a benchmark model (see appendix 6) based on the stakeholder meetings and informed by wider literature that could be used more broadly to inform social prescribing in City and Hackney CCG and beyond. The key objectives to implement, refine, and evaluate SP in pilot sites across City and Hackney has been achieved.

Enablers: funding, social prescribing coordinators, stakeholders' buy-in

The concept of SP appeared to resonate with health professionals locally as a potential solution to the challenges faced by their patients and the difficulty of clinicians staying up to date with the range of activities available locally. The Building Health Partnership programme funded a series of community workshops to help design the social prescribing model prior to its launch.²⁷ City and Hackney CCG funding was supplemented by Shine for further evaluation.

The contribution of SPCs was crucial to the success of the intervention. The SPCs skill set and their hour-long appointments meant they were able to accurately assess client's needs as well as referring them onwards. SPCs were also tasked with mapping services locally and engaging volunteers. Co-location of SPCs in practices helped to establish rapport with the clinical team and facilitate GPs directly booking patient appointments. As the project progressed community organisations were able to approach SPCs directly rather than trying to access GPs.

"I tell patients that we have a lady whose job is to link them in with what is going on in the community, and that she is an expert in finding community groups of all kinds [...] Social Prescribing worker [i.e. coordinator] we have is very helpful and patients like her" (General Practitioner).

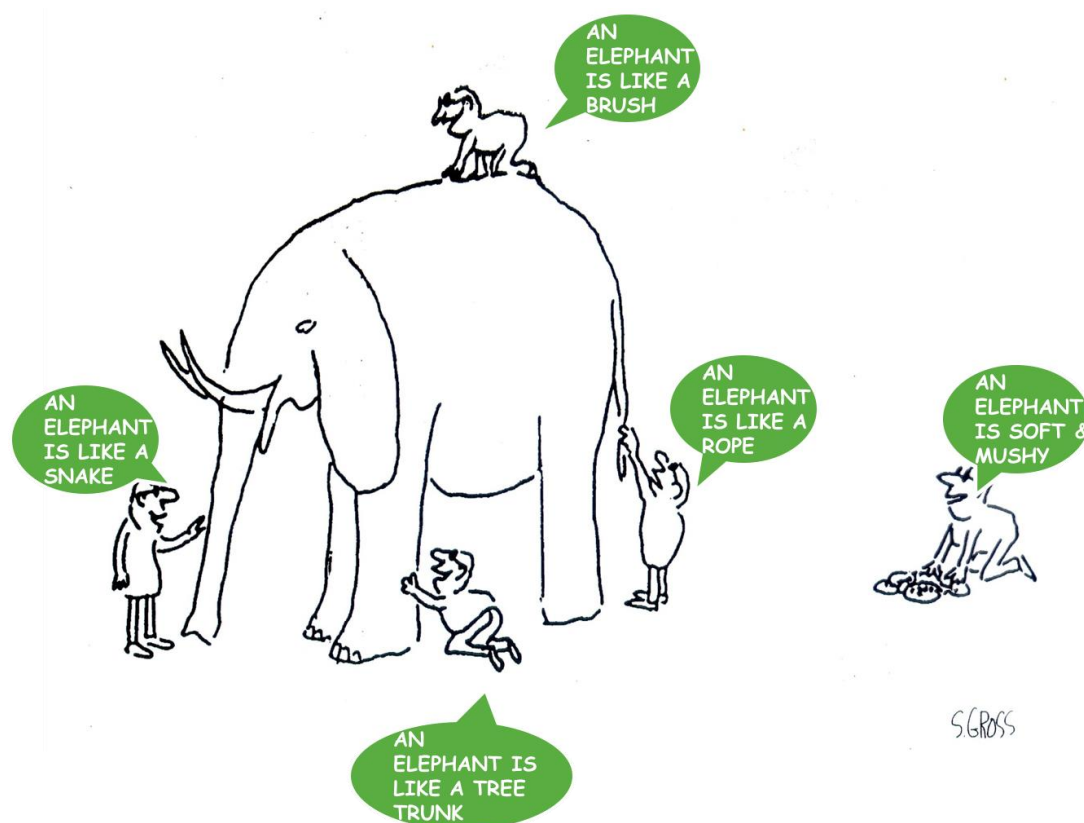
The relationship between FA and most community organisations was a positive feature of the intervention. Evidence from interviews with community organisations showed that clients had been referred appropriately by SPCs and had accurate expectations of the service available. Most referrals were managed by about 10 organisations, but a total of 85 organisations participated to social prescribing showing an attention towards the variety of support provision as well as clients' needs and choices, particularly in terms of geographic proximity. The structure of the project – which included quarterly steering group meetings and learning events – meant that a range of partners could share emerging learning.

²⁶ Interviews were conducted with social prescribing coordinators (6), GPs (2), staff from City and Hackney CCG (4) and community organisations (3). Two learning events were also held (July 2014 and March 2015) with key stakeholders including commissioners, voluntary sector service providers, practice nurses, GPs, volunteers and patients to discuss the progress of social prescribing, identify strengths, weaknesses and priorities for the future. Two GP online surveys were also completed; the first by 52 people (Sep 2013); the second (Apr 2015) by 26 people.

²⁷ http://www.socialenterprise.org.uk/uploads/editor/files/Health_Partnership_Hackney_04.pdf

Challenges and Solutions: referral numbers, branding, involvement of third sector

The capturing learning events highlighted the different perspectives people had about SP (see elephant analogy below). For example, GPs were not so aware of what happened once patients were signposted on to community organisations. Likewise some community organisations were not aware that people were visiting them as a result of SP – particularly as for most activities there was no standardised referral form they were often drop in. There were also culture differences that were subtle but important for appreciating the complexity of the pathway: GPs referred to 'patients', SPCs to 'clients', and some voluntary organisations to 'people.' Awareness of these different perspectives is important when trying to establish referral pathways amongst professional groups that have not worked with each other before.



Gross S (1980) 'An elephant is soft and mushy: cartoons by S. Gross', Dodd, Mead

It was a challenge to involve the community and voluntary sector after the initial consultation in the SP pathway given there was little direct funding to support them. Participants to learning events reported that in most cases this led to limited sense of belonging to the SP pathway and limited monitoring of community activities. Although challenging to administer, alternatives may include a 'payment by result' strategy as developed by Newham Community Prescribing Scheme (Bertotti et al, 2014), which could make community organisations more accountable, sustainable and facilitate monitoring of the intervention.

Two of the SPCs left after the first year, which affected continuity. There were also three successive management teams involved from the CCG – though good working relationships have been consolidated quickly thanks to the steering group.

GP referral rates have been inconsistent (see chart 3) and concentrated in a number of GP practices²⁸. SP referral numbers could be increased.²⁹ Lack of time within busy consultations, forgetting about the availability of the service, and scepticism about patients effectively attending community activities once referred were reasons GPs cited as barriers to referral. SP was also set up during a time of unprecedented national and local reorganisation. Strategies to improve referrals involved; feedback letters sent to clinicians by the SP Coordinators, GP education events, encouraging SPC attendance of clinical meetings, information stalls within practice reception areas, and insertion of a 'pop up alert'³⁰ ('Consider referral to Social Prescribing Service?') into the electronic records at one practice for patients with a history of anxiety or depression.

"The terrible thing is that I referred five but I should have referred about 15 times that. Although I am very enthusiastic about it, it is hard to keep in front of your mind, and that's the challenge!" (General Practitioner)

Chronic disease templates within electronic records could include prompts for GPs to refer to SP coordinators. Maximising the potential of centralised databases such as www.hackneyicare.org are important to ensure that a robust and up to date directory of community activities, accessible to health professionals and patients, reflects the knowledge that SPCs develop in their role. Widening referrers to SP, e.g. pharmacists, physiotherapists, psychologists, might help increase numbers. Self-referral is also an option to consider. Though these options potentially risks diluting potential of social prescribing as a tool within the GP consultation. Outcomes need to be fed back to clinicians so they learn what happens to their patients.

There is scope to consolidate the 'brand' of social prescribing.³¹ Patients might be more aware of being referred to SP and hence facilitate evaluation. An information leaflet for patients at the point of referral would help. Referral forms to community organisations would also make community organisations when a patient had been referred onwards via SP. As further services emerge locally, there is a greater challenge to ensure that duplication is minimised – currently in City and Hackney a number of organisations are setting out to act as navigators and to carry out 'social prescribing.'

²⁸ This is confirmed by other studies (Brandling et al, 2011)

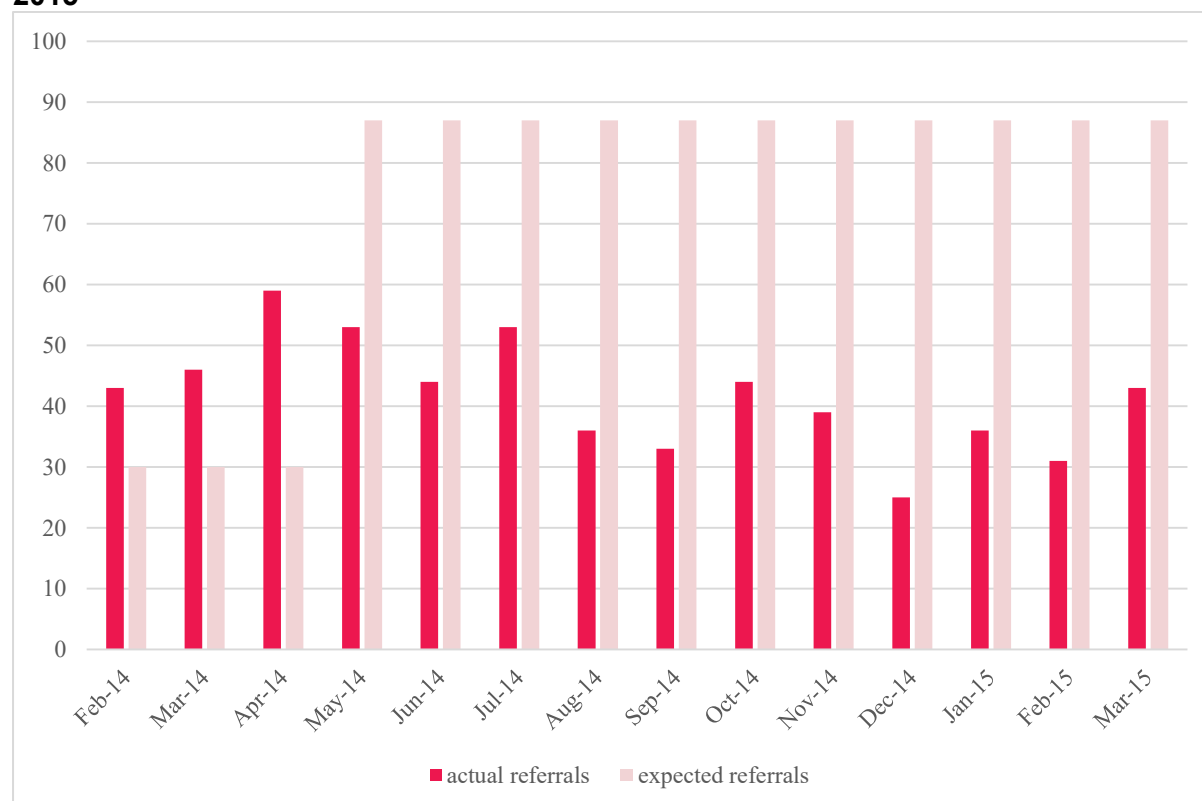
²⁹ As confirmed by some literature (Grant et al 2000; Friedli, Vincent and Woodhouse, 2007), and our own evaluation (online surveys with GPs, monitoring data and qualitative interviews) the potential for GP referral has not been maximised.

³⁰ However, this needs to be specific enough in order not to lose its applicability (see Brandling et al, 2011).

³¹ For example a number of different terms were used during this project, e.g. 'social prescribing coordinator' and 'well-being coordinator' to describe the same role

The design of key performance indicators (KPIS) for FA by the CCG was a challenge as evidence from similar projects elsewhere was limited.³² Such data on KPIS could be shared between CCGs to allow realistic targets, e.g. for referral numbers, to be set for start up SP projects. Learning needs to be shared nationally as further SP projects emerge. The challenge remains to find out which patients benefit most from referral to SP and which types of community activities most improve health and wellbeing.

Chart 3: Number of actual versus expected referrals over the period Feb 2014 and Jan 2015



³² Although in the first quarter targets were met, referrals averaged about 50% of set target in the following quarters, thus the number appear to be low. On reflection, the initial target was too high and did not account for the inconsistent number of GP referrals (see chart 3), and the number of sessions provided by SP coordinators.

Part 5: Plans for sustainability and spread

Sustainability beyond the funding period

We are making a strong case to continue the funding, which is secured until April 2016. In the short term the project plans to roll out to other GP sites in City and Hackney, with some additional funding. As CCGs and local authorities are both facing substantial cuts, the future of social prescribing is likely to rest on a closer collaboration between these coalescing around a set of agreed criteria and objectives perhaps using the Health and Well-being boards as a negotiating mechanism.

CCG funding would be ideal – but it would also be useful to work with partners who like the concept of social prescribing and are keen to see the model evolve (appendix 7). There is great potential to develop the City and Hackney service – given its population approach in a diverse range of GP practices – so that other parts of the country could readily import it.

As many different small interventions are operating in Hackney in different health areas and pathways, we are considering the design of a ‘universal point of access’ which would reduce duplications and maximise investment in the local health economy. However, this is likely to need substantial initial investment to align different partners and interests, thus we seek partners to direct social prescribing towards the implementation of this model.

We are exploring the platform for the www.hackneyicare.org website to see whether additional funding might allow a more easily navigable format for health and voluntary sector users. It would be useful to capture the knowledge the SPCs are gathering so that it can be shared. A readily accessible database with client feedback, and clinician feedback might be useful social network

In collaboration with UEL, we are also planning to apply for additional dissemination funding from the Health Foundation to make use of online media, build a website to act as an online forum and evaluation data repository. This will bring together both practitioners and researchers to discuss different models, good practice, challenges for the implementation of social prescribing and methods for evaluating its impact. Alongside this, we would like to use the funding from the Health Foundation to generate a short movie to capture the experience of some social prescribing clients and other stakeholders including GP practices and use that for further dissemination.

Conferences and awards

- Abstract article accepted for the Royal College of General Practitioners Conference (Glasgow, October 2015)
- We are planning a journal publication on a comparison between models of social prescribing to highlight good practice and review existing literature on impact of social prescribing schemes.
- We are planning a journal publication reporting on the impact of social prescribing in City and Hackney

Funding applications

Hackney and City CCG and University of East London are hoping to apply for funding from the National Institute for Health Research to conduct a Randomised Controlled Trial on the effectiveness and cost-effectiveness of social prescribing initiatives. Comparable initiatives need to be identified.

Appendix 2: Resources from the project

Qualitative interviews with social prescribing clients: main themes

Re-connecting with the world

"Before I do nothing I was in bad place. I come out of myself and talk to people."

"I do coffee morning as volunteer and meals for elderly. I work with elderly with dementia I've been challenging myself and people really nice, I have problems and didn't think there were nice people in the world but I was wrong."

"I do volunteer work, I've been loving it and enjoying it and meeting people."

"The experience has been lovely I been making friends I walk down street now and every time I see people they say hello to me now, before they never say hello to me. I didn't do nothing before."

"Best thing has been meeting new people and making friends. My mobile full up with names and numbers of friends before it was just family and doctor's number. I was really depressed before but now really happy. Before I have nothing to do, now every day I wake I think 'yes volunteer work!' or 'meeting friends!'"

"With me I enjoy talking to people once the conversation starts it's easy."

"Well there is plenty going on, you don't have to sit indoors like I did all those years. Until a year ago you know. There's people you can go to you've only got to speak to your doctor."

"Said to doctor going mad sitting indoors. Met woman in doctor's surgery talked about getting out of the house a bit more."

"Last summer was the best one I've had since my surgery because I've got somewhere to go..... It's better to sit with company sometimes than sit by yourself."

"With the people I'm with now I think I've got what I wanted."

Renewed hope for the future

"Done qualifications at Tesco. The Job Centre really happy with me. Before I was on capacity benefit and I thought I'll change my life and I have I'm really happy. I do want to work and Job Centre knows that."

"We spoke about me volunteering and that was the best part for me because I felt like I had purpose."

"Teamed me up with an old boy with Alzheimer's and we go and do a bit of gardening in our local park in winter we do cooking it gets me out. Before that I was just sitting indoors doing my medical procedures."

"The depression had taken so much from me and that (volunteering) was giving me something back. It allowed me to keep my hand in so when I was ready and able to go back to work I wouldn't have been not working been since 2012."

"I've got references and skills that are current. And being able to help somebody else. It got me out of the house."

"That gave me the motivation to think 'I think I might be ready to go back to work. It helped me deal with my depression, prepared me to go back to work and made me feel useful."

"It gave me hope, it gave me a sense of purpose, it gave me an avenue for dealing with what was going on for me without feeling like I was being a burden to someone."

Feeling empowered

"We went through a list of places...I said to her St Luke's but I didn't think I could get in there. But she managed to make a meeting with the girl who does the gardening."

"I've been invited to attend groups discussing social prescribing... for me that gave me information but I felt really good as well because I felt like I was at work!"

"I could go in say a bit about how I was feeling and there was things I could do as well."

The experience of the social prescribing pathway

"You feel able to offload if you need to, discuss your fears - it's about not being so hard on myself and validating myself."

"I'd say do it because it's changed my life for the better."

"She (social prescribing co-ordinator) understands – she speaks my language. She understood me and I understood her. She's a lovely lady."

"It's done me a world of good; taken me out of the house, given me a routine and given me a sense of purpose and...hope. It's given me back my confidence."

"We (social prescribing co-ordinator) had good talks, I was suicidal at the time, I was emotional and run down I don't know anyone but she was very helpful to talk to."

"It's (social prescribing) is about the time that you're given, the freedom that you're given and the practical tools that you're given at the end."

"I would say it's worth going for it (social prescribing) if they were in the same situation I was in like, there's nothing worse than being by yourself. Even on days when I feel a bit off peak I can go round there no-one's going to force me to do anything leave me sitting there if I just want to sit down have a chat there's someone there to chat to there's always someone there to chat to, there's always someone in there, it's nice just to go in and watch a bit life go past sometimes. Before that I weren't going nowhere I was lucky if I'd go to the shop to get some milk."

"I can't say anything bad about it (SP) because it has been good."

"It's lovely!"

Main Themes: Social Prescribing Co-ordinators

Working with clients

"It's Collaborative work. Not about me telling you how to live your life or what to do. Just two heads are better than one."

"I think it's having a very honest dialogue. Some people have an expectation that we're going to fund them to do a course. I always make it very clear it's about the goals they want to set for themselves. This is often the first time they've had to generate ideas for themselves, used to being told what to do by the GP. Tell me what to do! Well what do you want to do? That's quite a big thing, I think, for some people."

"Instead of focusing on what someone can't do, look at what has gone well and the skills they have. A large no of people I work with go towards the volunteering route because it is about giving something that helps your self-esteem and your sense of purpose."

Empowering clients

"I've had a client who I recommended help us with our service. She was taking and now she's giving."

"A client with MS, we looked for a society for her, found one in Walthamstow and now she's a founder member of one in Hackney. She's getting support and she's supporting other people."

"The model is the strength – it changes people's lives."

Interviews with community organisations: main themes

Confusion about role in pathway

“...I didn’t know if it was OK to refer an individual on. Did I need to send them back to FA? But now I know that it’s OK that’s great. I can actually give them some support round that and that’s great.”

“Can we link to other organisations so we can refer on? We’ve had other companies come in and deliver interventions we don’t offer and weren’t involved with SP but we got them involved.”

Communication and feedback

“What would help would be if I knew who FA were referring so that I can keep track of them and maybe either like monitor their usage and feed that back to them. I have info but not feeding back to FA.”

Nominee: Tai La

**Tai La's Evergreen Club, Chinese Vietnamese Community
Hackney, London**

Tai La has lived in Hackney for 30 years and is an active member of the Chinese Vietnamese community.

She was referred to the Public Health Team through the Borough's GP Social Prescribing Pilot. Her Wellbeing Co-ordinator established that, since the closure of the local community centre where she had arranged social activities, she was at risk of becoming 'socially isolated'.

Hackney Council in partnership with Hackney Homes offered Tai La the use of New Kingshold's under-used community centre where in July 2014 she held a taster event for Ballroom Dancing funded by the council. Thanks to her hard work over 40 members of the community attended (see picture).

A weekly Ballroom Dance Class has now been funded that regularly attracts 20+ residents.



Tai La also set up a Ping Pong & Badminton Club and organised a Christmas Party in which she cooked for over 40 residents.

Having adopted the centre as the new hub for her community, Tai La works tirelessly supporting local residents, who benefit from the social, physical and mental stimulus of attending weekly activities.

Nominated by:

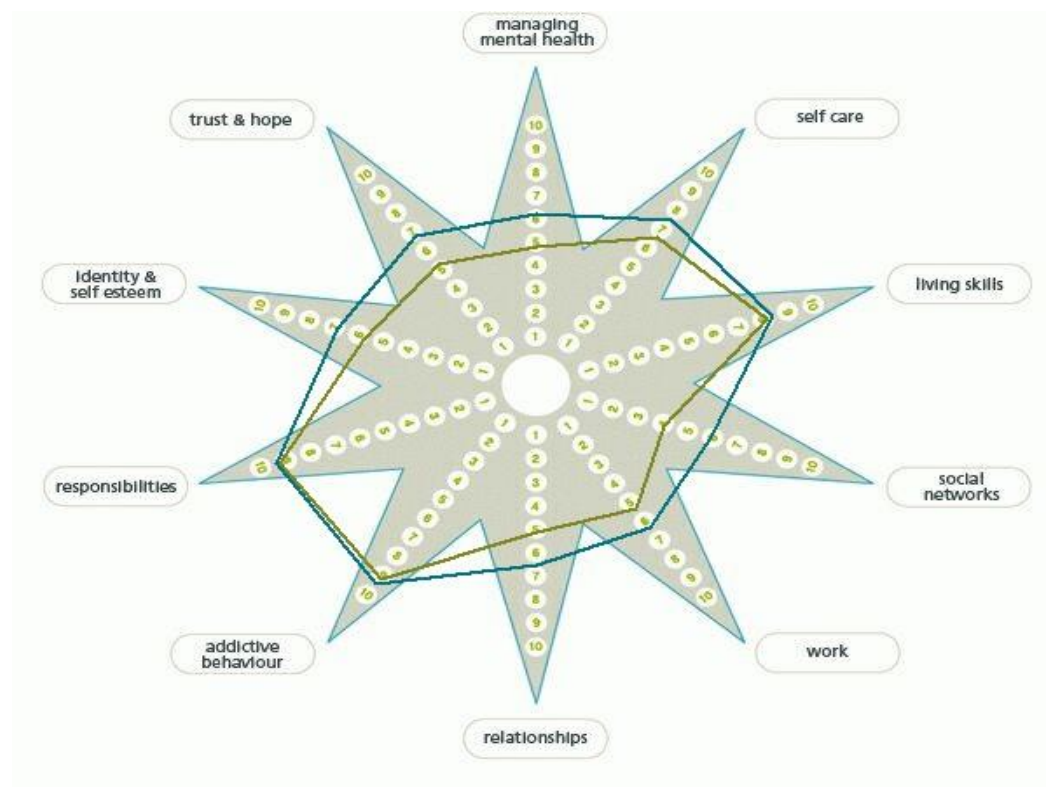
Meg Hillier MP
Hackney South & Shoreditch

Appendix 3: Evidence from FA

Evidence of intervention impact come from data collected by FA on a range of different outcomes (see chart below). This evidence has *not* been independently evaluated so should only be regarded as illustrative of other dimensions of the impact social prescribing may

have on clients. Some 96% of people (N=53) who completed the pre (green line) and post (blue line) intervention recovery star (see chart below) showed an *improvement in at least one of the measures* with major improvements in social networks, trust/hope and managing mental health.

Chart: Wellbeing outcomes star for clients attending social prescribing



Appendix 4 : Logistic regression and methodological details

Table 4 – Treatment effect (Analysis of outcome variables between groups)

	Regression on outcome differences (between baseline and follow-up) against treatment group (Coef.; p value)	With controlled variables (age, sex, ethnicity, work status and living arrangement) (Coef.; p value)
General health score	-0.029; 0.838	0.127; 0.472
Wellbeing (past week) (range 0-6)	-0.089; 0.714	-0.013; 0.966
HADS Anxiety score (range 0-21)	-0.542; 0.409	-0.119; 0.892
HADS Depression score (0-21)	0.679; 0.283	0.857; 0.289

HADS score (0-41)	0.232; 0.845	0.906; 0.557
Social integration score (0-20)	0.023; 0.963	-0.073; 0.905

Logistic regressions was conducted to identify the relations between treatment effect (group) and control variables. P values were recorded to highlight the significance of the relations. It was found that except age and gender, all other control variables are significantly correlated with treatment. Analysis was completed to investigate if the treatment had any effect on the health outcomes. Derived variables recording the difference between baseline and follow-up scores were generated for each set of outcome variables. A simple linear regression model was used first on each outcome difference against treatment. The model was then adjusted by control variables, including age, gender, ethnicity, living arrangement and work status. All outcome variables (general health score, wellbeing at past week, HADS anxiety score, HADS depression score, HADS score, social interaction score, number of regular activities, A&E visits in past 3 months) were analysed using the above techniques individually

Appendix 5: referral form & project aims

SOCIAL PRESCRIBING

REFERRAL FORM

City & Hackney Social Prescribing
Well Being Coordinator
Ability Plaza
Unit 6, Arbutus Street
London
E8 4DT
[Tel: 020 7249 8109](tel:02072498109)
Fax: 020 3119 0077

Patient surname Patient forename Age Date of Birth Patient address	Referring GP Surgery Address
	NHS Number:
	Home Telephone Number
	Mobile Number
Language Advocate Needed Yes <input type="checkbox"/> / No <input type="checkbox"/>	
Language:	Date of Referral:

Reason(s) for referral (please tick):

- ☐ Socially isolated ☐
- ☐ Frequent attenders to GP/A+E ☐
- ☐ Presenting with a social problem ☐
- ☐ Mild-moderate mental health problems ☐
- ☐ Keen to participate in non-clinical activities but not aware of what's happening locally ☐
- ☐ Other (please specify) ☐.....

Relevant Medical Conditions

Other Relevant Information, e.g. carries and EpiPen/other care agencies involved

I have obtained consent for sharing the above medical information Yes ☐ / No ☐

Please tick to indicate that you have entered Reed Code 8TO9 "Referral to social prescribing service" on Emis ☐

I confirm that this patient does not meet any of the exclusion criteria ([see Key Information sheet attached](#)) ☐

PLEASE FAX THIS REFERRAL TO 020 3119 0077
The Client Will Then Be Contact Directly to Arrange an Appointment

Key Information for Referrers

Individuals will be offered an appointment with a Social Prescribing Coordinator who will conduct an in-depth needs assessment and then facilitate activate participation in local community based services, e.g. lunch clubs, gardening groups, benefits advice, exercise groups.

GPs are encouraged to consider referring the following groups of patients:

- **Socially isolated**
- **Frequent attenders to GP/A+E**
- **Presenting with a social problem**
- **Mild-moderate mental health problems**
- **Keen to participate in non-clinical activities but not aware of what's happening locally**

The three consortia involved in the initial phase of the project:

Rainbow & Sunshine (who are also **recruiting diabetic patients**)

South West (who are focussing on **isolated over 50s**)

Well (who are focussing on **isolated over 50s**)

Please do not refer if the patient is:

- **A threat to themselves or others**
- **In a crisis situation**
- **Already got a care plan in action from another organisation**
- **Any uncontrolled mental health issues or addictions**
- **Unsuitable for group related activities**
- **Housebound**

Further details of organisations operating locally in the community and voluntary sector can be found at I-Care (www.hackneyicare.org.uk), which is accessible to all GP consortia in City and Hackney.

Wider Context

Social Prescribing is an innovative project, which aims to reduce health inequalities by improving the social capital ('the links that bind and connect people within and between communities'³³) in City and Hackney. The project is being evaluated by QMW Dept of General Practice and Primary Care.

If you have any comments, questions or suggestions please do not hesitate to contact Sandra Cater as we are aiming to actively improve the service in light of any feedback.

*'Some patients say they are simply not very good at speaking. I say: 'this isn't traditional counselling – simply looking at where you are now, what things are out there that would sit well with your interests to compliment your life.'*³⁴(GP, Social Prescribing

³³ Marmot Review: Healthy Lives. Health Society

³⁴ Friedli et al Sept 2012, Dundee

PROJECT AIMS

- reduce social isolation
- enable individuals to feel more in control, manage their Long Term Condition better and improve self- confidence
- improve health and well-being
- improve awareness in primary care of community activities available to patients
- increase numbers accessing community activities
- support individuals to visit the GP or hospital less

Appendix 6: Social Prescribing Benchmark table

This results from literature review and learning events with stakeholders in City and Hackney

Key elements	Ideal Social Prescribing	Happening at the moment (April 2015)	Gaps with ideal social prescribing	Indicators/measurement
KEY COMPONENTS				
Effective partnership between all stakeholders	<ul style="list-style-type: none"> • New and improved relationships between primary care and community organisations are being created and sustained in the long term • <u>Operational level</u>: strong & effective partnership between GPs, Social Prescribing (SP) coordinators and community/statutory organisations. Shared short-term objectives (increased referrals) and long-term objectives (improved patients outcomes) • <u>Strategic level</u>: collaboration between Clinical Commissioning Groups and local /county authorities via health and well-being boards or other policy networks. Long rather than short-term strategies. • Networks with funding/commissioning organisations are built with potential engagement and involvement of private sector investment (e.g. corporate social responsibility) • Ownership of social prescribing is shared across the health pathway (from GPs to community/statutory organisations and patients) • Volunteers and volunteer/community organisations are active stakeholders in the partnership • Local expertise of third sector organisations valued and considered on an equal footing with medical and clinical expertise 	<ul style="list-style-type: none"> • SP coordinators have developed good working relationships with GPs and are embedded in surgeries • SP co-ordinators are working well with community/statutory organisations and continue to develop new relationships within the community. • Patient/clients are feeling heard and supported throughout the Social Prescribing pathway 	<ul style="list-style-type: none"> • At the strategic level short-term, SP is still seen as a short-term strategy in its pilot stage. Recurrent funding are sought to fund it • Community/statutory organisations feel less sense of ownership across the SP pathway than GPs and SP co-ordinators • Volunteers are currently under-utilised • Patients' steering group needs to be set up for future projects. 	<ul style="list-style-type: none"> • Number of referrals from primary care to coordinators • Operational level: regular meetings involving all stakeholders to make sure of compliance with action plan • Formal agreements between CCGs and LAs supporting the development of SP • Joined up resources invested from both CCGs and LAs • Health and Well-being board is aware and committed to SP • Regular steering group involving patients and evidence of how decisions have been included in evaluation of SP • Interviews with stakeholders for the qualitative evaluation of the study

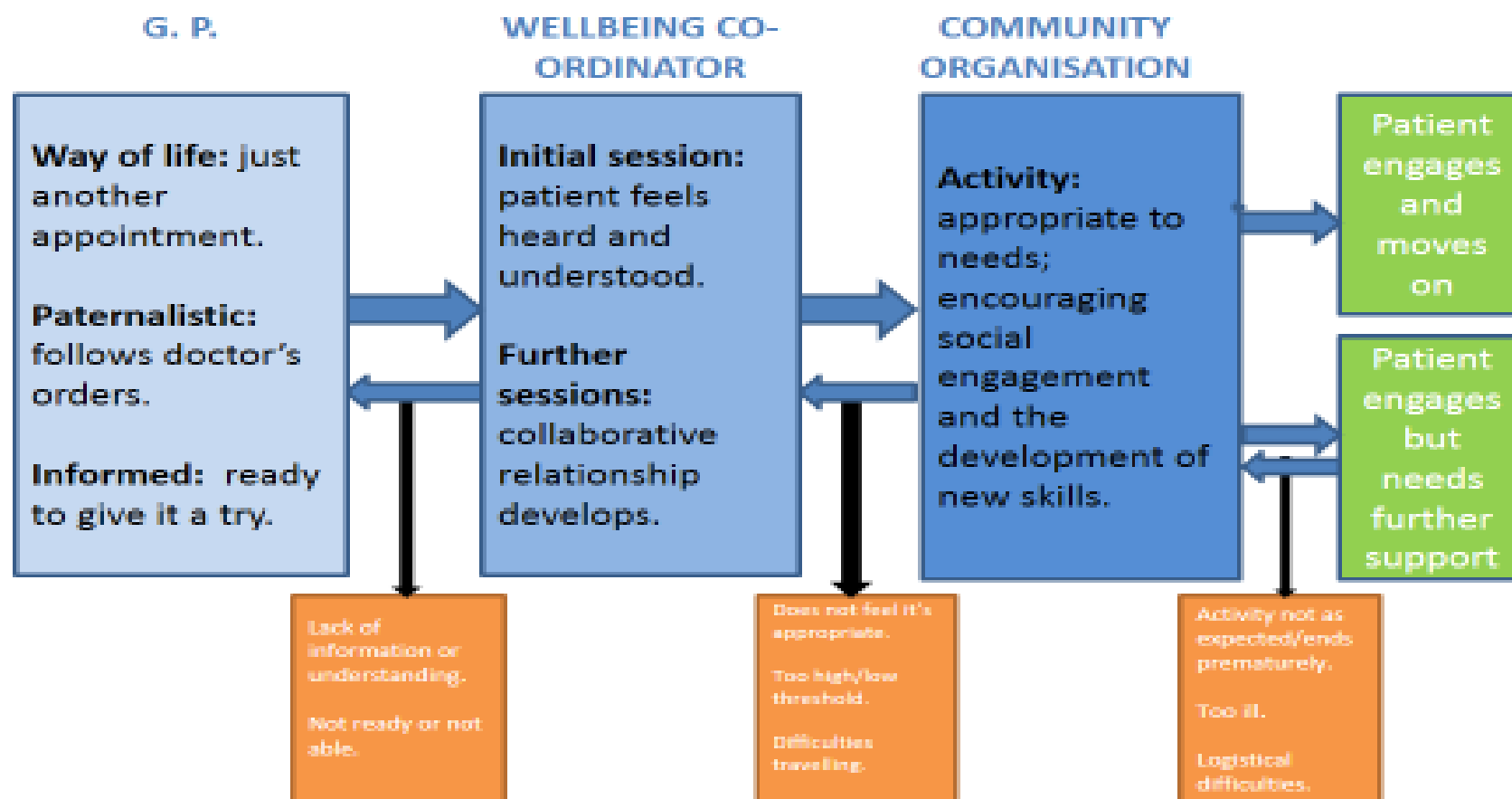
	<ul style="list-style-type: none"> • Patients are accurately represented 			
Communication	<ul style="list-style-type: none"> • High awareness of the information about SP for everyone, which is easy to access and share, (patient leaflets, information boards, videos, hard copy of services available in the borough) • Mixed formats (video, internet, leaflets/brochures) • Clarity on how to access • Branding: patients may not know that they have been referred as part of social prescribing • Database of community organisations is regularly updated • Information sharing between stakeholders (e.g. health of patients referred) is key (Warmald & Ingle, 2004) • Clear roles and responsibilities • Patients are aware of Social Prescribing when being referred • Consistent definition of the interventions and roles involved in the Social Prescribing pathway with relation to other projects 	<ul style="list-style-type: none"> • I-care database with community services is available • Steering group meetings invite a number of stakeholders • SP Coordinators and community organisations are aware of their roles and responsibilities. • Promotion of SP brand improved with posters in surgeries. • New EMIS flagging alert to encourage GP referrals 	<ul style="list-style-type: none"> • 'I-care' database is not yet updated • Lack of standardised feedback loop keeping track of client progression. GPs in particular receiving no information regarding patients' outcomes • Uneven participation of GP practices. Most referrals came from 6-7 practices. Need to communicate and persuade others to refer more. • SP branding unclear to patient/clients who are requesting a leaflet to take home from initial GP consultation. More resources need to be spent promoting the intervention • Need for SP coordinators to promote further to GPs (e.g. GP practice clinical meetings, consortia meetings) 	<ul style="list-style-type: none"> • Survey of patients' knowledge of social prescribing. However, danger of patients confusing social prescribing with other NHS schemes, consultations and appointments. • Interviews/ focus groups with key stakeholders to collect information about roles and responsibilities
Sustainability	<ul style="list-style-type: none"> • Resources are found to ensure long-term sustainability of social prescribing • Joined responsibility of local authority and CCG • Money follows the patient: delivery organisations are paid in reason of the number and quality of sessions provided and depending on the outputs/outcomes achieved (Newham CCG) • Volunteers are actively engaged in the delivery of SP to ensure sustainability • Sustainability key in other SP projects (Lee et al, 2009) 	<ul style="list-style-type: none"> • Small charge of free services available from community organisations • Service delivery depends upon existing resources secured by organisations via other means than the CCG. • Some but limited involvement of volunteers • Plans for a tear-off prescription for patient and possible funding to follow patient? 	<ul style="list-style-type: none"> • Plan for City and Hackney is to make the case for sustainability once evidence from evaluation is clearer • Commitment of resources for delivery is limited • Greater involvement of volunteers could have cost saving implications • Community organisations which have had positive impact on SP clients already disappearing due to lack of continued funding 	<ul style="list-style-type: none"> • Number of trained volunteers engaged in delivery of SP • Long term commitment of funding and other resources allocated to community organisations via CCG and other commissioning bodies. • Amount of funding from Public Health (Local authority) • Economic evaluation of interventions

Patients engagement	<ul style="list-style-type: none"> • Patients steering group to advice on development of social prescribing • Person-centred approach: patients have an active voice and co-produce their health plan with SP coordinators • Patient/clients actively involved in development of the project. 	<ul style="list-style-type: none"> • Patients choose the type of classes/activities they are referred to compatibly with what is available in their local area • Patients engaged and report positively on their experience of the scheme 	<ul style="list-style-type: none"> • No patient steering group exists • Positive experience of interaction with Well-being Co-ordinator is key to patient/client progression through SP pathway 	<ul style="list-style-type: none"> • Regular steering group involving patients and evidence of how decisions have been included in evaluation of SP
Data management and monitoring	<ul style="list-style-type: none"> • There is a clear structure of ethos, principles and responsibilities shared by all the stakeholders • The information about the SP and community services are shared on the other websites such as CCG, GP sites, FA site. • Standardized measures employed to evaluate the health and behaviour changes demonstrating the outcomes in a long term • Service User's Card implemented enabling easier data collection. Electronic cards could be given to each participant to enable tracking their use of community organisations (smart card). 	<ul style="list-style-type: none"> • I-care database exists • SP coordinators identify and keep regular contact with most organisations active on the ground • Some cost-effectiveness data collected • Data collected by some community organisations regarding participants who attended the activities • SP coordinators are collecting some data about participants' progression 	<ul style="list-style-type: none"> • 'I- care' database still not updated • Limited data on cost effectiveness • No standardised process of data collection or feedback regarding patient progression 	<ul style="list-style-type: none"> • Economic evaluation • Monitoring through a 'smart card' given to each patient would improve quality of data capture and reduce evaluation costs • See other rows • Need to select carefully period for follow up and tool to be used to measure the impact of social prescribing. What are we measuring?
KEY STAKEHOLDERS				
Primary care (mainly GP practices)	<ul style="list-style-type: none"> • GP practices are aware of SP (Gidlow et al, 2005) • The vast majority of GPs approve of SP and refer patients accordingly • Primary care professionals recognise a more balanced relationship between bio-medical model and social prescribing • Patients are referred by health practitioners, nurses, physiotherapists, psychologists and other qualified health care staff 	<ul style="list-style-type: none"> • GP awareness of SP increased; new flagging system on EMIS introduced 	<ul style="list-style-type: none"> • Low referral numbers still a problem • Referrals patchy across GP surgeries • Well-being co-ordinators report a number of inappropriate referrals 	<ul style="list-style-type: none"> • Survey of GP and other healthcare professionals to measure awareness of Social prescribing (via education events) • Measurement of GP referrals, OOH and use of emergency services at various points in time • GP are regularly informed of

	<ul style="list-style-type: none"> • Number of GP referrals, OOH and use of emergency services declines over time • Expanded GP capacity with increased 			the development of Social Prescribing in order to increase awareness and buy-in (e.g. good practice case studies)
Well-being coordinators	<ul style="list-style-type: none"> • Awareness of services available in the community • Ability to match patients with services available • Ability to understand the needs of patients (patient centred process) • Volunteers are active part in the delivery of SP with potential to ensure sustainability of services • Minimise the number of drop outs • Patients are empowered and have a 'voice' in the services they are referred to • Well-being Coordinators recruited on the basis of acknowledged expertise in their role as a key component of the intervention. 	<ul style="list-style-type: none"> • Well-being coordinators are enthusiastic, professional and effective • Work effectively to identify needs and facilitating the referral process • Patient/clients report feeling heard by well-being coordinators and this stage of the pathway seen as therapeutic in its own right. • Effective signposting to available activities 	<ul style="list-style-type: none"> • Volunteers need to be more engaged in service delivery (e.g. helping patients). Consider expanding volunteers' roles and responsibilities • Relationship between well-being-coordinator and patient/client key to both patient's progression and overall patient's experience 	<ul style="list-style-type: none"> • Number of referrals to community services over the number of referrals from GP practices • Interviews with patients to collect views about well-being coordinators and patients' choice • Focus groups with well-being coordinators to collect info about their views about process. • Interviews with volunteers
Service delivery from community/statutory organisations	<ul style="list-style-type: none"> • Services meet the needs and aspirations of patients • Easy access to services • Funding follow patients (funding provided by partnership between the CCG and local authority). Ambition is to deliver services that are free to patients • Wide range of services for a wide range of age groups • Volunteers are engaged and acting as a link between patients and community organisations; volunteers supporting & encouraging patients at the start of SP • Services are local to patients and based within their communities encouraging social networks to develop further. 	<ul style="list-style-type: none"> • Community organisations do not have a plan for referrals • Community organisations do serve a population of over 50s. • Charge for services is often small or free • Patients/clients report positively on experiences with community organisations 	<ul style="list-style-type: none"> • Need for greater engagement of volunteers into helping patients • Successful community projects ending because of lack of funding • Community organisations don't feel part of SP pathway/project 	<ul style="list-style-type: none"> • Number and engagement of volunteers • Quality of training for volunteers • Number of people referred, where and how often attended • Interviews with case study organisations to understand their barriers and quality of services delivered

Appendix 7: Social Prescribing Pathway

Social Prescribing Pathway



Appendix 8: Quality of life (EQ5D) questions

Please tick which statements best describe your own health state today

1. Mobility Please tick (✓) one [aQLmobl]

I have no problems in walking about ☐

I have some problems in walking about ☐

I am confined to bed ☐

2. Self-care Please tick (✓) one [aQLself]

I have no problems with self-care ☐

I have some problems washing or dressing myself ☐

I am unable to wash or dress myself ☐

3. Usual activities such as work, study, housework family or leisure [aQLusac]

Please tick (✓) one

I have no problems with performing my usual activities ☐

I have some problems with performing my usual activities ☐

I am unable to perform my usual activities ☐

4. Pain/Discomfort Please tick (✓) one [aQLpain]

I have no pain or discomfort ☐

I have moderate pain or discomfort ☐

I have extreme pain or discomfort ☐

5. Anxiety/Depression Please tick (✓) one [aQLanxi]

I am not anxious or depressed ☐

I am moderately anxious or depressed ☐

I am extremely anxious or depressed ☐

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