

The Social Prescribing service
in the London Borough of Waltham Forest
final evaluation report

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Institute for Health and Human Development
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Commissioned by the London Borough of Waltham Forest and the Waltham Forest Clinical Commissioning Group

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The Institute for Health and Human Development employs 23 staff engaged in research and training into the social, economic and cultural determinants of health and well-being. IHHD has attracted funding from UK research councils, charitable trusts, NHS, and the European Commission. We have major programmes of intervention innovation and development including the Well London programme, and an NIHR programme grant developing new models of antenatal care. We have also developed considerable expertise in the evaluation of social prescribing interventions and are key steering group partners of the social prescribing network which lobbies on behalf of over 1,000 members across the UK.

Disclaimer

The views expressed in this report are those of the authors and do not necessarily represent those of Waltham Forest Borough Council or Waltham Forest Clinical Commissioning Group

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1 Executive Summary

Background

Waltham Forest Borough Council and Waltham Forest Clinical Commissioning Group have commissioned the Institute for Health and Human Development based at the University of East London (UEL) to conduct an evaluation of the social prescribing service in Waltham Forest. As agreed in the document submitted to the funder, this final report presents and discusses the results from the evaluation of health outcomes, the process of development of the service and social return on investment for the period between July 2016 and May 2017.

Methodology

The evaluation is based on a mixed methods approach which includes the following:

A prospective cohort study: we captured health and social changes in the population of social prescribing users over a four month period via a telephone survey conducted by researchers from Waltham Forest council. We collected data on health, well-being, quality of life, mental well-being, patient activation, demographic profile and use of health and social services. The information collected by this cohort study also fed into the development of a social return on investment assessment.

Process evaluation: this discusses the key learning to date drawing on data from social prescribing users, social prescribers, community organisations, and healthcare professionals.

Qualitative study of social prescribing participants: a range of qualitative interviews with social prescribing users was also conducted to document experiences with the intervention.

Key Results

In terms of patients' outcomes, social prescribing has had a positive impact on respondents:

- Social prescribing users at follow up (N=48) recorded positive changes in all indicators (mental well-being, health, well-being, quality of life, and patient activation) with the last three of these being statistically significant. Health outcomes improved from a very low starting position, thus more work needs to be done to ensure that users achieve satisfactory levels of health and well-being.
- The Social Return on Investment (SROI) showed that for £1 invested in the social prescribing service in Waltham Forest, the expected return to society could range between £1.09 and £1.92. This is considered a good investment, despite being below the average reported by other studies (£1:£2.3).
- Respondents also reported large improvements in their concerns toward Housing, Practical Support, Work & Finance.
- Although qualitative interviews with users were not so positive, this was mainly related to the lack of CVS offer and long waiting to access CVS services rather than an inherent problem with the rationale for social prescribing.

In terms of the effective functioning of the pathway, some benefits included:

- Good overall relationship with GP practices.
- Some good links with CVS were also established and more links were being built.

Recommendations

However, in considering the future design of the model, it is worth reflecting on the following recommendations and consider the suggested social prescribing model (sec. 7.2 and fig.8):

1. Build further links and invest in the development of the community and voluntary sector (CVS) which are indispensable for the success of any models of social prescribing. The evaluation identified gaps in service provision, lack of funding for delivery, and skills gaps as key issues.
2. The role of social prescribers is key to the success of social prescribers. The evaluation found an inadequate number of social prescribers in relation to the high number of referrals and stakeholders had different views about their role (light touch only phone service versus in-depth face-to-face support). The design of the social prescribing model needs to consider this further.
3. SP has been more effective at tackling practical problems (e.g. work& finance) than mental health problems which require behaviour change. An alternative delivery model may be considered and has been discussed in sec.7.2.
4. The integration with other Better Care Together Programme may be discussed further as there are several challenges with referring patients to self-care pharmacists and/or physician associates.
5. Referral criteria may also be explored further. There were some instances where patients referred presented acute health problems which did not seem suitable for social prescribing support but required instead clinical treatment in secondary care.

2 Introduction

The National Health Service in the UK (NHS) is facing a wide range of challenges, particularly in the context of primary care provision. These include: (i) growing pressure on GP practices which is partly driven by the number of patients who frequently attend their GP surgery with medically unexplained symptoms. About, 20% of patients consult their GPs for problems that are primarily social rather than medical (Torjesen, 2016); (ii) the rising tide of long term conditions growing by 5 million in the next ten years (DH, 2013) despite the 70-80% of people with long term conditions (LTCs) who could be supported to manage their own conditions (DH 2005); (iii) growing health inequalities which result in long-term medical conditions disproportionately affecting people in deprived areas (Marmot et al., 2010; Cawston, 2011; Hutt and Gilmour, 2010).

In an attempt to seek solutions to these problems, the concept of social prescribing holds significant promise. Social prescribing *'enables healthcare professionals to refer patients to a link worker, to co-design a non-clinical social prescription to improve their health and well-being'* (SPN, 2016; p.19).

The NHS Five Year Forward View (NHS,2014) recognises social prescribing as an important model for the future of the NHS and is described by the current Health Secretary as an intervention that helps the NHS to take a *'more holistic view of what it takes to address people's medical problems than it did before'* (GP online, 2014). In addition, social prescribing has the potential to help deliver other government priorities in the field of health such as: the merger of health and social care, developing and delivering health at the community level, and delivering a patient centred approach which supports patients to access community activities thereby empowering the patient to decide what is right for them and their personal circumstances.

In this context, the Institute for Health and Human Development based at the University of East London (UEL) has been commissioned by Waltham Forest Borough Council (WFBC) and Waltham Forest Clinical Commissioning Group (WFCCG) to conduct an evaluation of the social prescribing service in Waltham Forest. This includes health outcomes, qualitative interviews, a process, and an economic evaluation (see methodology section 4).

3 Description of the Social Prescribing Service in Waltham Forest

This section describes the key characteristics of the social prescribing pilot in Waltham Forest and discusses how social prescribing fits into the wider set of health interventions available in the borough. The social prescribing (SP) pilot was officially launched on 14th June 2016 and is scheduled to run for 18 months until the end of Dec 2017. Referrals into the service started in July 2016.

The main aims of the social prescribing pilot scheme¹ are to:

- Facilitate access to a range of support services that will enable individuals to significantly improve their health and wellbeing.
- Increase the role of the CVS (Community and voluntary Sector) in the provision of services and evaluate aspects of the service model prior to wider adoption across the borough.
- Release specialist capacity across the system, so that individuals with the most intense health and social care needs can receive the care they require despite funding constraints.
- Increase 'whole system' efficiency by preventing deterioration in the service user's condition and by reducing duplication of care between organisations and professions.
- Provide 'seamless' care by placing the service user at the centre of decision-making

and designing packages of interventions around their needs irrespective of provider.

The SP pilot includes patient referrals from Healthcare professionals (GP practices and Adult and Social Care department within the council) to two social prescribers based at Waltham Forest Borough Council (WFBC) who are responsible for contacting patients over the phone, discussing their needs and aspirations and recommending a range of solutions available in the statutory or community sector. Healthcare professionals can refer patients with a wide range of health and non-health issues including social and economic concerns.

As part of the referral, a form was filled in by healthcare professionals and sent to social prescribers based at WFBC. The original plan was for Social Prescribers to make three phone calls to each patient: first phone call to understand clients' needs and aspirations, second phone call to enable social prescribers to recommend a package of support from statutory or community organisations and a third phone call after eight weeks to assess the patient progress in accessing support services.

SP is part of the Better Care Together Programme which has been running in Waltham Forest for the last three years or so, and involves the joint working of different partners including LBWF, CCG, NELFT, and CVS to deliver healthcare. In the early years, this programme focussed on the top 3-4% of the most acute cases in the borough who were supported by community matrons with clinical expertise and aimed at stabilising the

¹ Invitation to Quote (ITQ) Social Prescribing Evaluation

patient and avoid potential crisis. The aim of social prescribing is to tackle health issues of population with less severe issues primarily through early intervention, prevention and self-help.

In the wider context of social prescribing pilots across the UK, Waltham Forest SP is unique as it is only delivered over the telephone. Most SP pilots offer face to face sessions with a social prescriber or are a mix of telephone and face to face.

4 Methods

The aims, objectives and study design of the evaluation are described in this section.

4.1 Aims and objectives of the evaluation

The main aims of this evaluation were to assess the following:

- The impact of the social prescribing pilot on the changes in patients' health (outcome evaluation);
- The process of development of the pilot and how it integrates with other local systems (process evaluation)
- Patient satisfaction (service satisfaction)
- The social return on investment, if the programme is continued

The objectives of this evaluation were to collect, and/or analyse a range of information on the following:

- Analyse monitoring information on the social prescribing pathway: sources of referral (e.g. GP surgeries, Adult and Social care), number of patients supported throughout the pathway, number of social prescribers involved, number and types of community support organisations involved;
- Collect patients' information about the health, well-being, quality of life, mental well-being, activation, demographic profile and healthcare service use;
- Perceptions of patients using the service at different levels of involvement in the social prescribing pathway

4.2 Study design

We use a mixed method approach to investigate SP in Waltham Forest including a prospective cohort study, qualitative interviews, a process evaluation and an economic evaluation. The study started in August 2016 and will be completed in May 2017. The methodology for each of these is described below.

Table 1: Summary of Evaluation design

Type of evaluation	Themes	Method of data collection
Cohort study	To capture changes in participants' health outcomes	
	<ul style="list-style-type: none"> Demographic characteristics of participants The key concerns of respondents at baseline and follow up Changes in quality of life, wellbeing, health, mental well-being and levels of activation over a four month period 	<p>Telephone survey with the same population at baseline (Aug – Dec 2016; N=100) and four months follow up (Jan- May 2017; N=48).</p> <ul style="list-style-type: none"> Health related measures: General Health, wellbeing (Measure Yourself Concerns and Wellbeing), quality of life (EQ-5D-3L), mental well-being (Warwick Edinburgh Mental Wellbeing Scale), Patient Activation (Patient Activation Measure). Demographic details: gender, age, ethnicity, living arrangements, employment status and educational level. Service use measures: A&E attendance, GP visits, volunteering, skills training, community activity attendance and use of local council support services. In the follow up we will also be asking questions about the specific use of social prescribing services including the Citizen Advice Bureau, befriending, mental health support, lunch clubs, and transport.
Process evaluation	To capture opinion of stakeholders including participants to inform the future development of the intervention	
	<p>Experience of participants</p> <ul style="list-style-type: none"> Users: experience at different stages of the pathway (HCP, social prescriber, TSO) Unintended effect of intervention Physical health, social networks, emotional well-being Demographic details 	Semi-structured telephone interviews with participants who have been referred by social prescribers and attended community organisations and those who have been referred by social prescribers but did not attend community organisations
	<p>Experience of stakeholders</p> <p>All stakeholders:</p> <ul style="list-style-type: none"> Barriers and enablers Integration in existing health economy Strategies for referrals (social prescribers only) Feedback to HCPs <p>From social prescribers:</p> <ul style="list-style-type: none"> Number of sessions, contact time and details of user referrals Number and details of Did Not Attend (between social prescriber and CVS) 	Focus groups with community organisations and social prescribers; online survey with community organisations and healthcare professionals; 1-2-1 telephone interviews with social prescribers, CCG staff, local authority and community organisations
Economic evaluation	Social return on investment: this measures the return to society from a financial investment into social prescribing	
	Financial analysis of health outcomes and healthcare resource use. Analysis of attribution, drop-off, displacement, and deadweight (sec. 5.3.3 for more details)	From Cohort study: baseline and follow up data on healthcare use (GP, A&E visits), use of services, use of community activities, employment, and volunteering.

4.2.1 *A prospective cohort study*

A prospective cohort study was conducted to to understand key changes to the health and social outcomes of SP users. We collected data from the same population at two points in time using a structured questionnaire, baseline (Aug-Dec 2016) and four months follow up (Jan-May 2017). Key measures collected are reported in

Table 1. Baseline (n=100) and follow up (N=48) data collection was undertaken over the phone by three Waltham Forest Borough Council researchers independently employed from the delivery of the social prescribing service. In most cases, individuals referred by healthcare professionals received a telephone call prior to their contact with social prescribers in order to collect an accurate baseline measure. A small number of participants were sent a postal questionnaire.

4.2.2 Users' experience of the social prescribing service in Waltham Forest

We conducted qualitative interviews with individuals who were referred by their healthcare professionals to the social prescribing service to capture more detailed information about the quality of the service. In order to account for different opinions we attempted to stratify respondents as follows: (i) those who attended at least three sessions whom are defined as having completed SP (15); (ii) those who were referred by SPs but attended no sessions with the community/voluntary or statutory sector (6). In practice, we were able to interview different groups of participants, but not by selecting them beforehand. We selected a random sample of participants, some of whom had not been able to access community organisations and therefore fell into the second group. We completed nine qualitative telephone interviews and collected information about the background of SP users, their experience with healthcare professionals, social prescribers, and community/statutory services. This enabled us to put into context some of the results from the prospective cohort study and provide further information for the development of the service (see sec. 1.1.1 for results and 6.1.2 for discussion). Some 21 interviews were originally planned but in agreement with the commissioner of the evaluation, we stopped at nine interviews because information from an additional respondent was very similar to information received from previous respondents (also called saturation) and decided to concentrate on administering two online surveys to collect further data from community organisations and healthcare professionals.

4.2.3 Process evaluation

The process evaluation collected information about the different stages of implementation of the SP pilot in Waltham Forest. This included information from healthcare professionals to social prescriber and from these to community and statutory services. We also gathered information about referral integration by interviewing stakeholders involved in the setting up, management and implementation of the SP pilot. We conducted semi-structured telephone interviews with stakeholders involved in the strategic development of the pilot, one focus group with social prescribers, one focus group with community organisations, one online survey with healthcare professionals and an online survey with community organisations (see 5.2.4 for results and 6.1.2 for a discussion of results). We completed all the interviews we set out to do, except one interview with a GP. However, in addition to the initial specification, we conducted two online surveys, one with GPs and one with community organisations.

4.2.4 Economic Evaluation

We followed an established and recognised methodology (Cupitt, 2009) to conduct a Social Return on Investment (SROI) analysis (sec. 5.3). This enabled us to illustrate the benefit to society from each £1 invested in the social prescribing pilot. We used a range of published information to estimate the financial values of the following outputs and outcomes: GP consultation rates, A&E attendance, volunteering, employment, mental well-being, quality of life and patient activation measure. As part of the SROI assessment framework, we calculated deadweight, attribution, displacement, and drop off. Finally, we produced a sensitivity analysis which gave us a likely range for the SROI ratio (5.5.2).

5 Results

In this section, we present the results from our quantitative survey with social prescribing users (cohort study), results from our qualitative interviews with SP users and other stakeholders (process evaluation), and results from the assessment of social return on investment (economic evaluation).

5.1 Prospective cohort study

With the cohort study we were able to follow a sample of people over a four month period to assess changes to their demographic profile, health outcomes, activation, and other social aspects such as employment, volunteering, and training.

5.1.1 Descriptive analyses of participant characteristics

The demographic profile described here includes a total of 100 patients at baseline and 48 at follow up, four months later. Changes in health outcomes and other variables draw on baseline and follow up data collected from these 48 patients. Table 1 shows that just over two out five of the baseline respondents (44%) are aged between 45 and 64 and 63% are female (**Table 2**). This trend continued at follow up with even a larger proportion of respondents being in the 45 to 54 years old age group (54%).

Four out 10 respondents were white, and four out 10 lived alone. Most of the respondents (91%) spoke good or fluent English and 49% of them were still in full-time education at age 16. A considerable number of respondents were not in paid employment (65%). More than half of these (33% of total) could not work due to sickness suggesting that some of the most marginalised groups are being referred to the Waltham Forest SP service. The profile of respondents at follow up was mostly similar to baseline, with the exception of work status. At follow up many more respondents were 'unable to work due to sickness' in relation to the baseline sample which had a large proportion of retired.

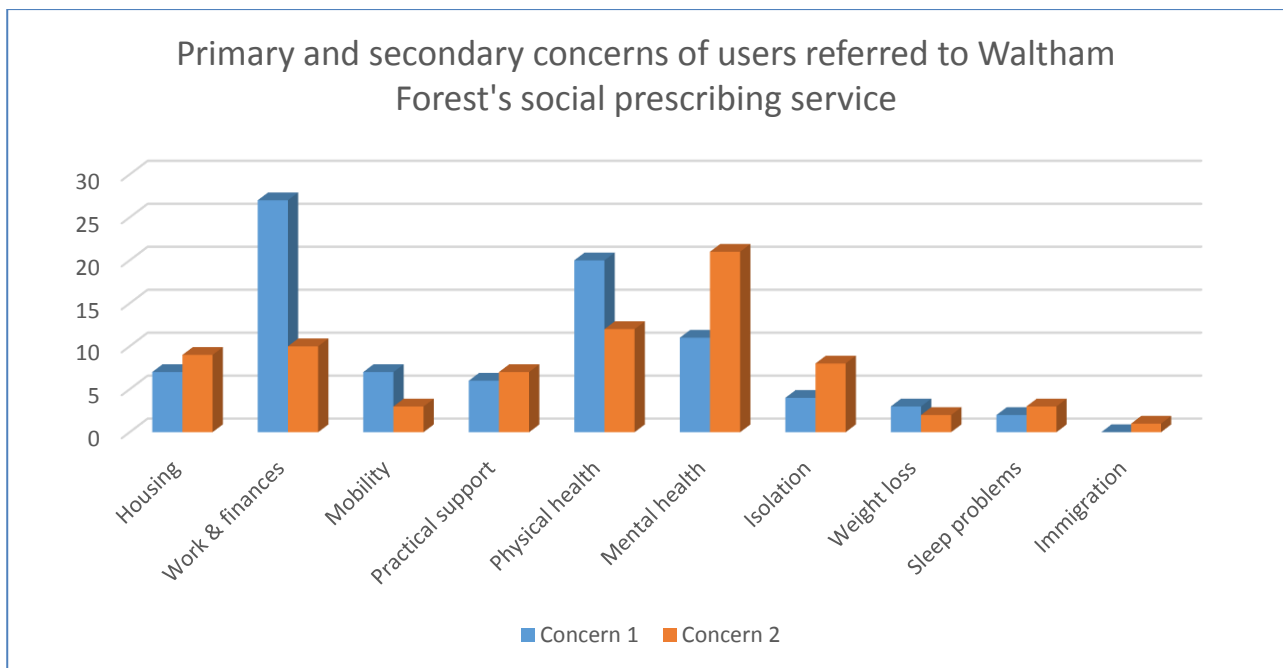
Table 2: Demographic details of SP users at baseline and four months follow up

Profile	Baseline (N=100)	Follow up (N=48)
Age groups (years) %		
18-24	2	2
25-44	31	29
45-64	44	54
>=65	21	13
Unspecified	2	2
Gender %		
Male	34	40
Female	63	58
Unspecified	3	2
Ethnicity %		
White	44	46
Black	19	19
Asian	19	21
Mixed/Other	5	6
Unspecified	13	8
Living arrangements %		
Alone	38	38
With others	59	62
Unspecified	3	0
Language fluency %		
Fluent	72	73
Good	19	17
Below average or poor	7	2
Unspecified	2	8
Work status %		
Employed	14	10
Unemployed and looking for work	20	23
Unable to work due to sickness	33	42
Looking after your family, in education and other	12	12
Retired	21	13
Age left full time education %		
None formal education	2	0
Up to age 16	45	48
Age 17 and upwards	49	48
Still in full-time education and other	4	4

5.1.2 Changes in patient concerns over four months

Baseline evaluation data was collected via a telephone survey from 100 respondents who had used Waltham Forest’s social prescribing service. Some 87 respondents reported their primary concern and 76 their secondary concern at the time of referral. The bar chart below shows that the most common primary concern of users was ‘work or finances’ (including issues to do with benefits). This was followed by problems with physical health and then mental health issues. The most common secondary concern was mental health, with physical health second and work and financial concerns came third.

Figure 1: Presenting concerns of service users



At follow-up 48 service users reported their primary concern and 41 a secondary concern. The biggest improvement for primary concerns was in housing related issues where there was a reported average 2.6 point point improvement of symptoms per individual (Figure 2). This was followed by practical support with a 1.75 reported improvement in symptoms and work and finance with a 1.43 point reported average improvement in symptoms. There were only very small reported improvements in physical and mental health symptoms and the isolation group showed no improvement at all. The data for concern 2 revealed that 'practical support' recorded the biggest improvement in reported severity of 5 points on average per individual (

Figure 3). Mental health showed the second biggest improvement of 2.75 points per individual. This could indicate that the alleviation of primary, more practical concerns like housing and finance, lead to improved mental wellbeing for those individuals.

Figure 2: Improvement in perceived symptoms for concern 1

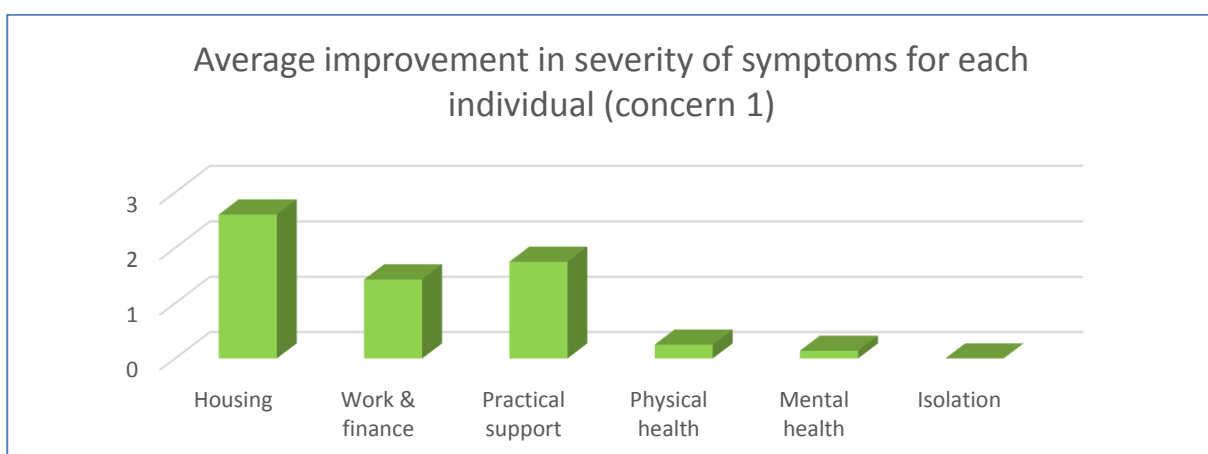
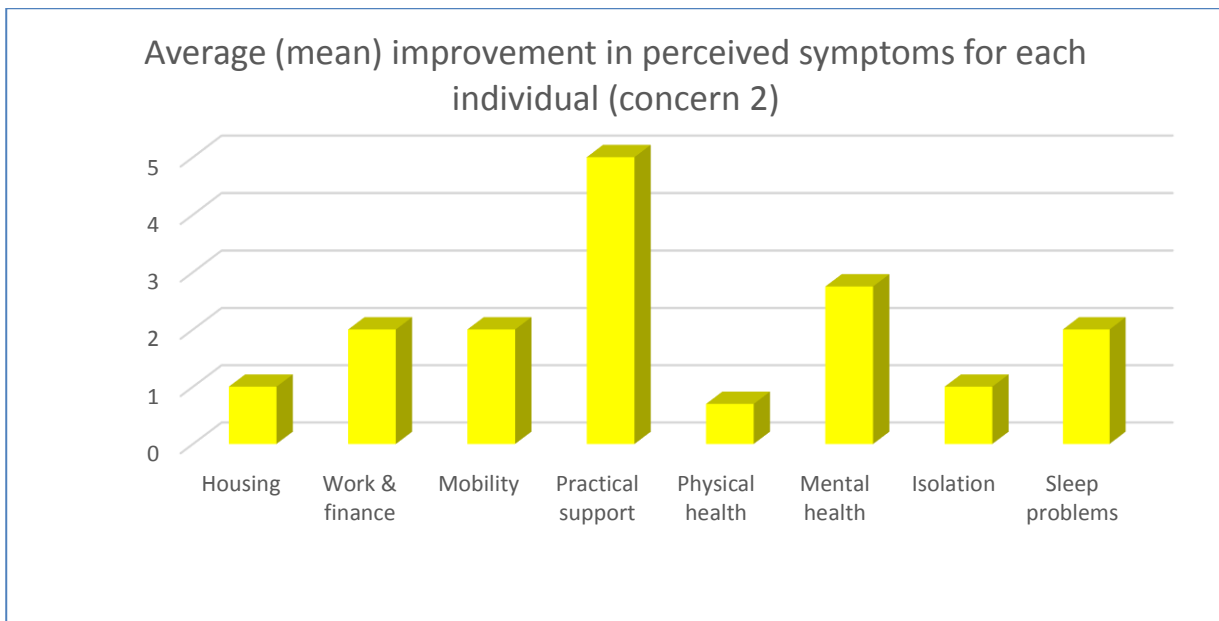


Figure 3: Improvement in perceived symptoms for concern 2



5.1.3 Changes in health outcomes between baseline and follow up

Respondents showed an improvement in all health outcomes including general health, well-being, quality of life and mental well-being (table 2). The most marked improvements were observed in relation to well-being and quality of life.

Table 3: SP users' change in health profile at baseline and follow up

Measure	Scale	Baseline (N=100)		Follow up (N=48)	
		Mean (SD)	Min; Max	Mean (SD)	Min; Max
General health	Very bad to very good (on scale of 1 to 5)	2.4(1.0)	1; 5	2.5 (1.1)	1; 5
Well-being	As bad as it could be to as good as it could be (on scale of 0-6)	1.5 (1.3)	0; 6	2.0 (1.6)	0; 6
Quality of life ¹	EQ5D single index value (1 as the best health state)	0.3 (0.3)	-0.5; 0.9	0.5 (0.4)	-0.2; 0.9
Mental Well-being	WEMWB 7-item metric score (on scale of 7 to 35)	18.3 (3.9)	7; 29.3	19.2 (3.1)	11.3; 25.0

¹ A detailed breakdown by EQ-5D dimensions and PAM levels are shown in Table 5 and

Figure 4.

Table 4 (treatment effect) shows that improvements in well-being and quality of life are statistically significant, particularly in terms of ‘well-being’ with an average four points score increase. Furthermore, respondents experienced a statistically significantly reduction in GP visits (3 times less compared to baseline), but slightly increased their A&E visits over four months. Data about GP and A&E visits have been included in the social return on investment analysis (sec. 5.4). We were not able to control for any confounders such as gender, age, employment status, educational level as the sample size at follow up is too small and did not produce any statistically significant results.

Table 4: Treatment effect of social prescribing

Measure	Effect of SP		
	N	Net change ⁶ Coef. (95%CI)	Significance P value
General health	48	0.17 (-0.35; 0.69)	0.513
Well-being	36	4.09 (3.10; 5.10)	<0.001
Quality of life (index score)	45	0.16 (0.04; 0.30)	0.013
Mental Well-being	42	1.43 (-0.38; 3.23)	0.118
Patient Activation score	45	4.46 (-0.90; 9.83)	0.101
Patient activation level	45	0.7 (0.15; 1.32)	0.015
GP visits	32	-3.09 (-5.61; -0.57)	0.018
A&E visits	37	0.48 (0.04; 0.93)	0.033

⁶ Net change refers to the difference in the average score between baseline and follow-up.

More detailed analysis shows that improvements in dimensions of quality of life are particularly noticeable in terms of the respondents’ ability to perform ‘usual activities’ and reduction of feelings of ‘anxiety or depression’.

Table 5: Change in quality of life

EQ-5D dimension ²	Baseline (N=100)	Follow up (N=48)
Mobility %		
I have no problems in walking about	36	42
I have some problems in walking about	58	56
I am confined to bed	4	2
Self-care %		
I have no problems with self-care	53	56
I have some problems washing or dressing myself	41	44
I am unable to wash or dress myself	4	0
Usual activities %		
I have no problems with performing my usual activities	18	46

I have some problems with performing my usual activities	64	50
I am unable to perform my usual activities	17	4
Pain / Discomfort %		
I have no pain or discomfort	18	40
I have moderate pain or discomfort	49	29
I have extreme pain or discomfort	31	29
Anxiety / Depression %		
I am not anxious or depressed	11	19
I am moderately anxious or depressed	56	58
I am extremely anxious or depressed	32	19

Mental well-being (Table 3) was measured through the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) which is a validated scale of 7 items used for the measurement of mental wellbeing of the population aged 13 to 74. It comprises of seven positively worded statements and participants are asked to answer each mental wellbeing statement in the previous two weeks. Mental wellbeing refers here to positive states of being, thinking, behaving and feeling and is a good indicator of how people and populations are able to function and thrive (Putz et al 2012). Follow up analysis shows an improvement in mental well-being from 18.3 to 19.2 but this improvement is modest and not statistically significant.

5.1.4 Levels of Patient activation

The patient activation measure (PAM) is concerned with assessing the patient's knowledge, skills and confidence for managing their health and health care (Hibbard and Gilbert, 2014). Higher levels of patient activation are associated with greater attendance to screenings and check-ups, and higher engagement in healthy behaviours like taking exercise (Tabrizi et al 2010). Moreover, higher levels of activation have also been associated with positive clinical outcomes for people suffering from depression, post-traumatic stress disorder, anxiety and schizophrenia (e.g. Cabassa et al 2013). Thus the higher the PAM score the better. The PAM can be divided in four levels:

Level 1: the respondent may still believe that their nurse or doctor will 'fix' them.

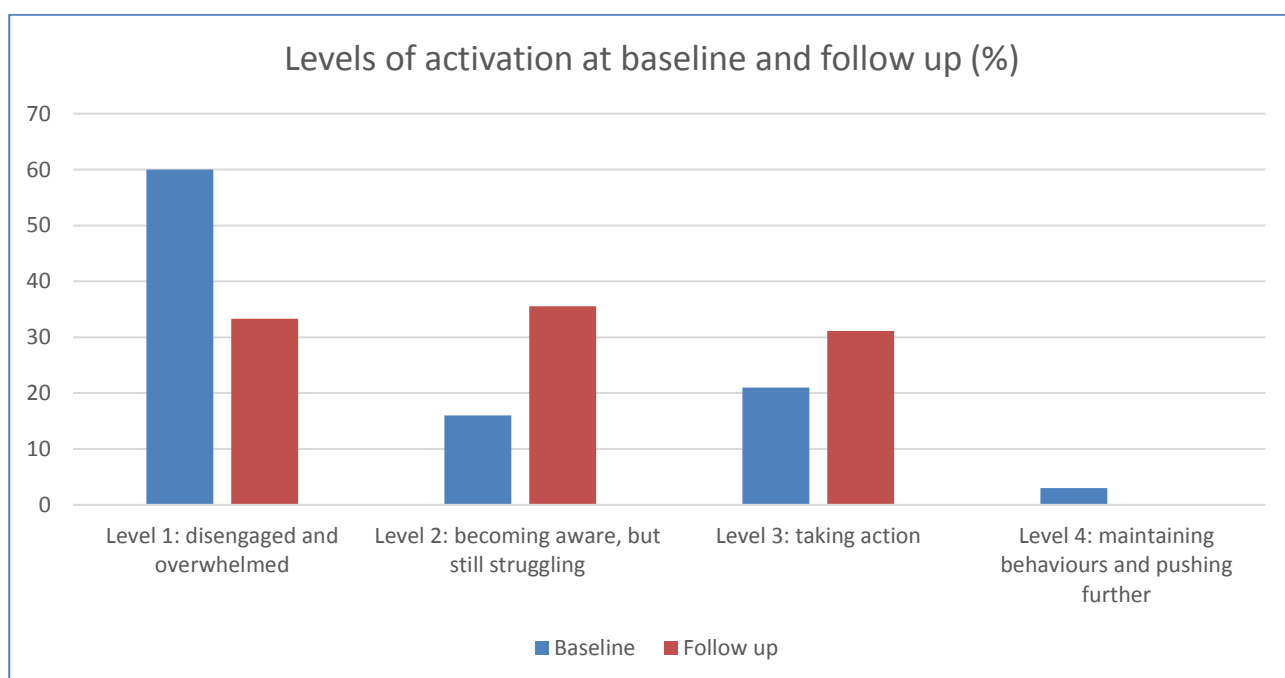
Level 2: the respondent may understand that they must be involved in their healthcare, but lack the knowledge and confidence to take care of their conditions.

Level 3: the respondent is beginning to gain confidence to take on self-management behaviours and need to experience small successes to build a sense of self-efficacy and increase activation.

Level 4: the respondent has the confidence and skills to manage their health, but may need help with maintaining their progress during stressful times.

Figure 4 shows the level of patient activation at baseline (N=96) and follow up (N=45). Although none of the respondents reached level 4 at follow up, almost 30% of respondents moved up from level 1 into level 2 and Level 3 and this change is statistically significant (see Table 4). About 10% of respondents to both baseline and follow up experienced a two-level increase and another 10% a one-level increase in their PAM.

Figure 4: Levels of Patient Activation at baseline and follow up (%)



5.2 Process evaluation

The process evaluation had the following aims:

- To use monitoring data to build a picture of the pilot in terms of referral numbers throughout the pathway, types of referral sources (e.g. GP practices), and types of community support organisations involved.
- To gather information about referral integration by interviewing stakeholders involved in the strategic development and delivery of the pilot.
- To assess the strengths and weaknesses of the pilot by collecting views from different types of users including social prescribing coordinators, public health officials at the London Borough of Waltham Forest and other stakeholders involved in the strategic development of the pilot.

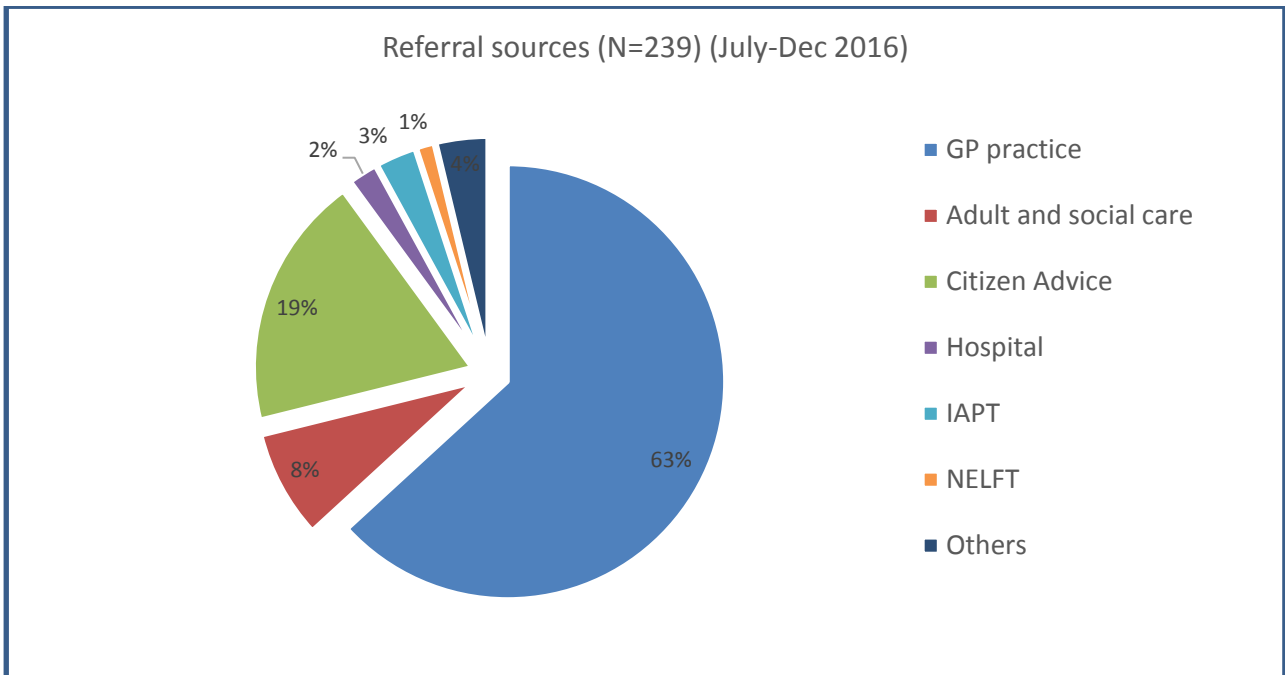
5.2.1 Number, source and reasons for referrals

The current referral target for the period between July 2016 and December 2017 is 650 referrals to social prescribers. From July 2016 to end of June 2017 (one year), the service received 600 referrals, thus the target set is set to be exceeded as the average number of referrals per month to social prescribers is 86 people. This target was revised down from 1,300 which was considered overoptimistic as designed for a high volume, low contact types of service. In practice, this was not feasible as most patients required a much higher level of assistance than initially envisaged.

We do not have data related to the period from Jan to May 2017, so the following data are drawn from the interim report presented in Jan 2017 and concerning the period June to Dec. 2016. This shows that social prescribers were able to contact 69% of all patients referred. Of the 248 referrals received by social prescribers, 69% had been contacted until Dec 2016 (172 people). Following at least four attempts to contacting these, about 73% (126 people) were referred onto additional services. The remaining group (27%) was not referred as the service was either not suitable, users did not want it or they could not be reached. On average, 14 people per month were contacted through the Waltham Forest SP telephone service.

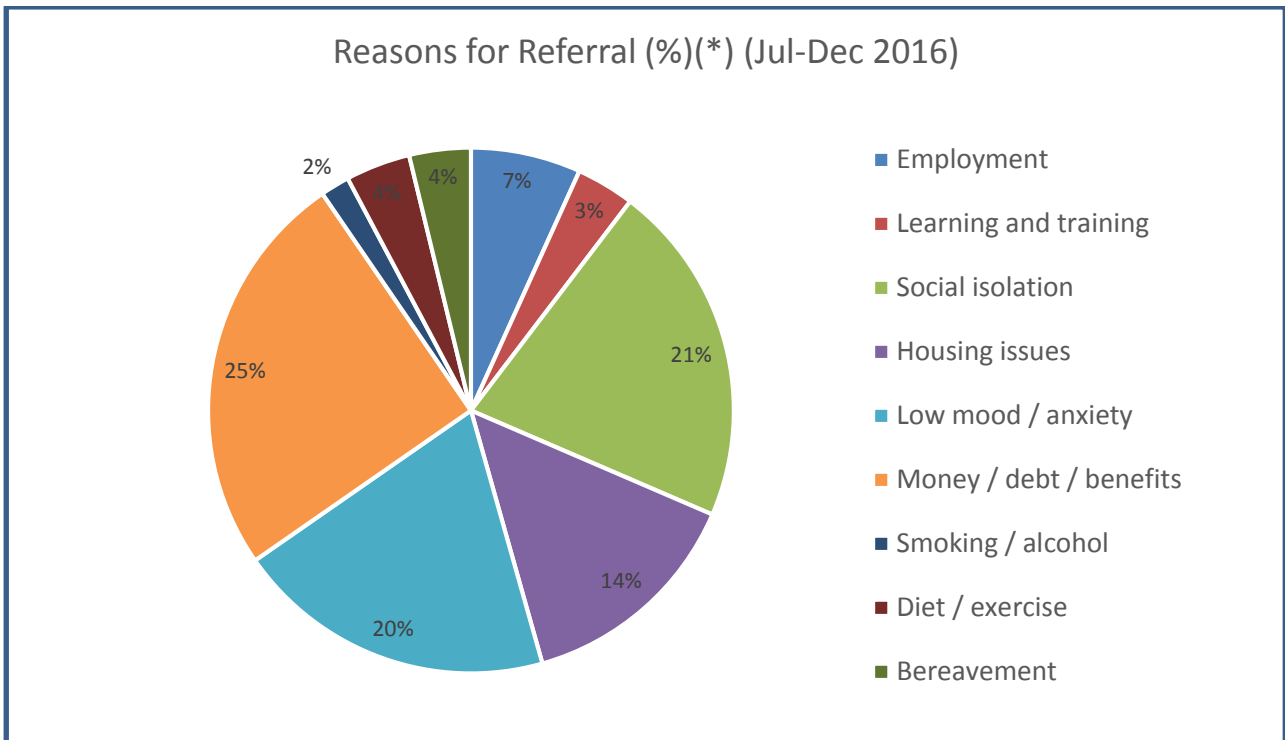
Most of the referrals to social prescribers came through GP practices (63%) followed by citizen advice (19%), and adult and social care (8%). Given that the reasons for referral (Figure 5) are predominantly driven by concerns with money/debt/benefit, housing, and social isolation, individuals referred by GP practices are likely to be known to adult and social care and therefore are a key target for the intervention over and above the health component of social prescribing. This will be confirmed through further analysis and available in the final report.

Figure 5: Referral sources



The analysis of reasons for referral (**Figure 5**) also shows that most referrals have taken place for reasons related to a social rather than health concerns, despite considerable mental health problems with 20% of the referrals due to low mood and anxiety.

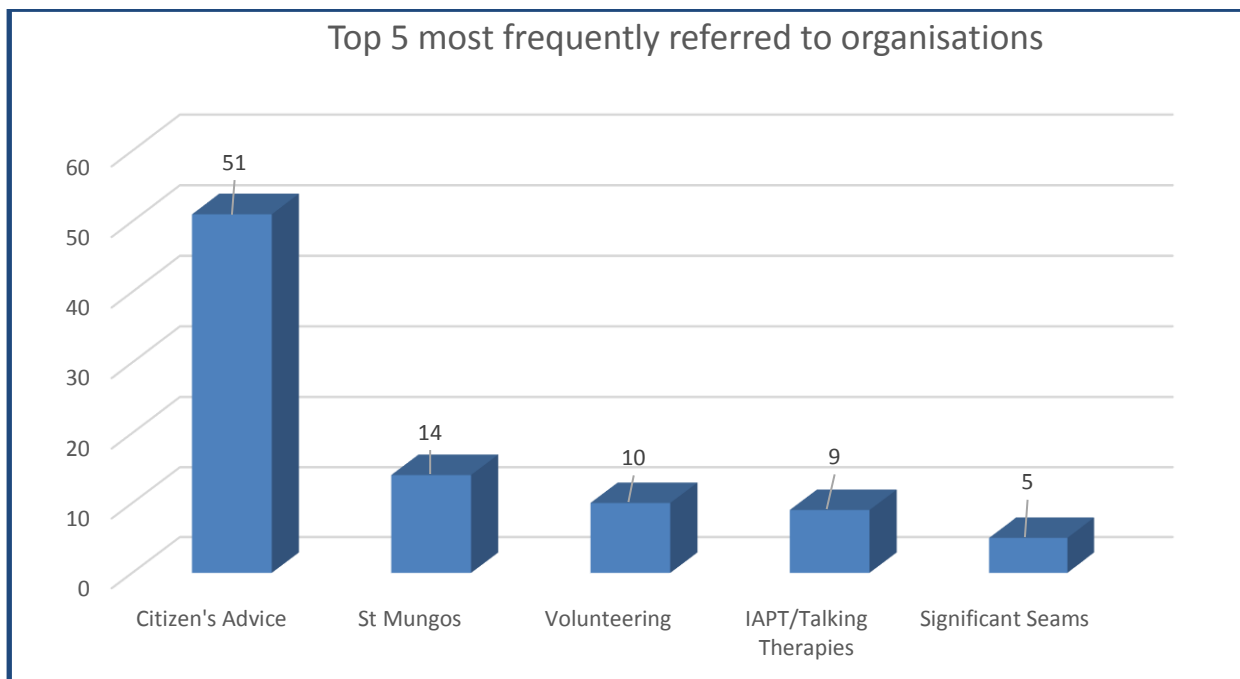
Figure 6: Reasons for referral from healthcare professional to social prescriber



(*) please note that more than one reason for referral may have been included. Number of responses 502

Over the period (July to Dec 2016), some 126 people were referred to 158 activities delivered by a total of 47 statutory and voluntary organisations. These included a wide range of different services, the top five of which were citizen’s advice (money, benefit, or employment), housing/homeless, mobility, volunteering and mental health. The top support organisations involved in the assistance of social prescribing users included Citizen’s Advice (32%), St Mungo’s (9%), Talking Therapies (IAPT) (6%) and Significant Seams (3%).

Figure 7: top 5 most frequently referred to services by social prescribers



5.2.2 Use of social prescribing community services

When follow up data was collected as part of the cohort study, SP users were asked to name the services they attended in the previous four months, their rate of attendance, and whether they had been referred to such services as a result of social prescribing. It is useful to provide a broad understanding of whether participants who were referred by the social prescribers actually attended activities in the community or statutory sector. However, please note that this data does not reflect the total number of social prescribing referrals, but only of those who responded to both baseline and follow up survey (=43). There were also some inconsistencies in data collection, thus the data in Table 6 should be interpreted with caution.

About 88% of respondents to follow up data collection (N=43) were referred by the social prescribing pilot to a total of 62 community or statutory services delivered by Citizen Advice Bureau, Talking Therapies (i.e. IAPT), St Mungo’s, McMillan Cancer Services, and others. Some respondents were referred to more than one service. More than one out of three (35%; n=17) attended the community activities they had been referred to, particularly Citizen Advice Bureau (76% of attendees). Of the remaining number, about 10% were new referrals, leaving 55% of respondents who were referred but did not attend.

Table 6: number of respondents referred and attending community activities (N=49)(*)

Types of services	Referrals	Attending
Citizen Advice Bureau	23	13
Support at Home	0	n/a
Talking Therapies	11	1
Lunch/social clubs	0	n/a
St Mungo's	10	n/a
Others	19	3
Total	63	17

(*) this only analyses the number of respondents who were referred and attended community organisations. It does not represent the total number of people who were referred as part of social prescribing.

5.2.3 Views from Social Prescribing users: qualitative interviews

Qualitative interviews with users had the following aims:

- to understand their experience of the social prescribing service and the strengths and weaknesses of the pilot from users' perspectives;
- to explore users' background to understand further how to assist them more effectively in the future

Nine participants took part in qualitative telephone interviews describing their experiences of the service. The number of participants interviewed was fewer than originally planned due to difficulties making contact with them and a request to divert resources into the development of two online surveys. Almost all of the respondents were unsure what social prescribing was and needed some prompting to relate it to the calls they had received from the Waltham Forest social prescribing team.

Participant 1 (Afro-Caribbean, middle-aged, female) was very unhappy with her experience of

the social prescribing service, her initial concerns had been regarding physical problems although homelessness was also an issue. She had been referred onto an organisation and was expecting to hear back from them but had heard nothing for 8 weeks.

Participant 2, (White British, middle-aged, female) was helped by a lady (she couldn't remember names) to apply for free prescription charges. While she was pleased with the help she had received in sourcing and filling out the form, she was unclear as to whether this support was as a result of the social prescribing service or a separate interaction with a health professional.

Participant 3, (White British, middle-aged, male) was looking for support with financial concerns and felt social prescribing was generally a good idea but would have liked more information about it. He said he had been waiting for 2 months for a follow-up call from the SP service and had yet to progress to the final stage of the process (ie referral to community support or activity).

Participant 4, (White, middle-aged, male) was referred to the service to help with stress and anxiety. He found talking on the phone quite difficult and did not want to be referred on at the time. He would have liked more information about SP and felt that talking to someone properly, face-to-face would have helped. He also would have liked some support going to the referral organisation for the first time. He thinks SP is generally a good idea and wished he could have taken up the referral, he now feels as though he needs to 'grin and bear it' until he has the confidence to take first steps on his own.

'I (the call from the social prescriber) helped me at the time...but I need to actually see someone and sit and have a chat and explain my life and situation and then maybe they can put me on to someone who can help me out.'

It's confidence that I've lost...I feel like I'm useless.'

'I would try it (social prescribing) again in future and would recommend it to others.'

Participant 5, (South American, elderly, female) she was lonely and wanted some support with finances and day-to-day life. While she was happy to use the phone, rather than face-to-face, she didn't feel like the service had helped her and found the process very frustrating.

'Why bother me if they can't help me?'

Participant 6, (Eastern European, middle-aged, female) presented with housing, unemployment

and health issues. Could not get a coherent response to her experiences of the SP service but she was very unhappy about the health service in general.

'System is like the Gestapo - here to make you suffer.'

Participant 7, (White British, elderly, female) was referred for anxiety. Found the first contact with the SP team 'pleasant' and was referred to talking therapies. However, she could not attend because her anxiety prevented her from leaving the house and decided that talking about her problems would only make things worse. She thought SP could help others but she would have preferred a consultation with a counsellor. She is also looking into online therapy solutions independently.

'I don't think it was for me personally but it could well help other people.'

Participant 8, (British, middle-aged, female) needed help with housing issues and also her daughter who is depressed. She had one call from the SP team and was expecting another but had not heard anything in the last three months. She thought social prescribers might have been able to help her but because she has not heard from them or been referred she doesn't feel as though she has got anywhere.

Participant 9, (Bangladeshi, late thirties, female) was referred to SP for help with her son's benefits. The SP team made an appointment for

her with CAB, who she'd tried unsuccessfully to contact herself. A year later, the issue has been resolved and she was very happy with her experience of the social prescribing service.

'It (the SP service) was actually quite good.'

'If I was on my own I would have to call and call and ask for help and I don't know who to go to. If someone (the social prescriber) didn't call me I would be struggling, you know, if they hadn't called there would be so much stress about where to go.'

5.2.4 Interviews with stakeholders

This section explores the strengths, challenges and lessons learnt by stakeholders involved in the development and implementation of the social prescribing pilot in the borough. We interviewed a mix of stakeholders including social prescribers, commissioners, healthcare professionals and community organisations delivering SP. We report the results from stakeholders below and discuss these in section 6.1.2.

Interviews and focus group with social prescribers

Social prescribers could really see the importance of providing a social prescribing service in the borough and were acutely aware of its potential to effectively support people to change their behaviour but also in finding ways to solve their complex problems. Social prescribers reported that there are advantages in providing a phone-based service as some people find it easier to

disclose personal information than through face-to-face meetings due to the more informal means of communication. However, social prescribers were also aware of the importance of offering a face-to-face service particularly to those who present with more complex life situations and who are from marginalised and vulnerable groups.

Work load was identified as one of the most relevant issues by the two social prescribers. Their job role involved contacting patients referred by healthcare professionals, finding relevant activities locally, connecting with the CVS, doing follow up calls, overseeing the telephone evaluation data collection, organising regular SP network and training meetings, feeding back to referrers, writing briefing reports and communication updates, and presenting to a wide group of stakeholders (including all the admin associated with these processes.) Maintaining a high and regular profile within the surgeries was found to help with referral numbers but this was hard to achieve with only two social prescribers.

More than the anticipated three calls are being made to many individuals because people want to talk in detail about their issues or they present with more than one (often complex) issue. Patients are often not given enough information from referrers about what the social prescribing service involves (a telephone only signposting service) and the SP team then has to manage unrealistic expectations. For example, they expect social prescribers to solve their patient's

housing problems or to provide an immediate befriending service for those who are frail, often housebound and socially isolated.

'Managing the expectations of GPs – they think you know everything that is going on out there. They think you can solve their patient's problem with housing.'

'Social isolation is the number one problem– people want a befriending service-there is only one and waiting list is 6 months for housebound.'

Social isolation is one area where there are inadequate resources available in the community as there is not enough befriending support available across the borough. This is a particular problem for those with specific language and cultural requirements. Other gaps in provision include services for the hard of hearing or those who speak little or no English. The comprehensive directory of services and voluntary organisations is still a work in progress so often referrers are unaware of other similar organisations nearby. In order to facilitate appropriate referrals in a context of limited community services available, social prescribers spend a significant amount of time trying to develop networks with and between community organisations.

'Introducing the voluntary sector to each other takes up time not allocated for. There is no directory of services.' 'I have been making it happen. I'm what a voluntary sector unit should be doing.'

Focus group, interviews and an online survey with the community and voluntary sector

Three people participated to the focus group that was conducted by a UEL researcher in early 2017. Participants felt that the social prescribing has considerable potential in terms of providing 'holistic' health care that joins up the community sector with primary care. Social prescribing is seen as a good way to provide residents with additional care options via the community sector. The current link with social prescribers was generally working well and it was of major help, particularly in referrals to the Citizen Advisory Bureau (CAB). In this case, social prescribing was seen as an important service to 'filter' relevant cases as most people need help with many disparate problems all happening at the same time. These include social isolation, housing, employment and mental health issues. The social prescriber was seen as useful for advising people where they can access help with their many disparate issues.

For one of the respondents, previous pathways had broken down and social prescribing was replacing these with a service that increases collaboration between the community sector and the council and, in the future, with the CCG.

One of the respondents pointed out that the community sector has traditionally found it difficult to establish links with GP practices directly. Social prescribing provides a vehicle for the council and the CCG to encourage GP practices to refer patients to the voluntary sector

via social prescribers which enables them to set up and develop links between primary care and the community sector.

However, respondents highlighted some key challenges with the current model of social prescribing including the lack of resources, skills capacity of each organisation and the capacity of the sector as a whole. As one of the respondents pointed out:

‘There is no money in the community sector. It is great that SP refers people to us but there are not enough people, we won’t be able to offer any services. [...]There is a real expectation that the community sector somehow kind of just can expand infinitely to take on someone else’s strategy and aims’.

The lack of resources had a tangible impact on one of the respondent’s organisation who highlighted the fact that in the current funding climate they rely on social prescribers to contact and accompany SP service users to activities. As social prescribers are not providing this service, all the referrals to their organisations have not led to any user attending their activities and receiving support.

An additional challenge respondents agreed upon was the set of skills required by local authorities and CCGs to apply for funding and work in partnership. Partnership working was welcomed by respondents but a combination of lack of time and skills seemed to prevent them from making

effective use of available opportunities. One of the respondents called for more training in equipping voluntary organisations with the skills and knowledge to apply for funding.

‘And there is not training that actually say oh let’s give organisations training on the key elements of partnership, no much capacity building. More hand holding and support.’

Finally, a third important challenge highlighted by a respondent was the need for the sector to include mid-range organisations and increase the variety of its offer. Respondents pointed out that on the one hand large voluntary organisations such as AGEUK operate in the borough, and on the other there are a sufficient number of grassroots organisations but not much in between. Furthermore, there are only limited specialist services such as mental health services, and other organisations have left the borough as funding is limited. The lack of specialist advice was also a problem in relation to CAB assistance where referrals significantly outnumbered the capacity on offer and the work of experts in housing and employment advice would be welcome.

Online survey with community organisations:

there were only 6 responses from community organisations at the time of writing but they represented a diverse range of support including: Talking Therapies, physical activities, housing and financial advice. All had received referrals from the social prescribing service and 5 out of 6 said these had been straightforward. One

organisation, however, complained that referrers had consistently failed to provide the information required for their referral form, creating extra work for them. Suggested improvements to the service included improved communication with GPs and better links with other organisations in the community. Signposting and professional referral received the most endorsement in terms of the role of the social prescriber; but one-to-one coaching and buddying also received votes. Three organisations cross-referred users to other organisations, whilst two did not. Four of the six organisations provided some sort of feedback. 4 of the organisations felt that social prescribing contributed to stronger links with the NHS and other organisations, 3 felt that it improved their attendance numbers. Concerns were expressed however, at the lack of extra funding for community organisations as a result.

Key themes emerging from interviews with other stakeholders

Some commissioners, and healthcare professionals were also interviewed to provide views about the strengths and challenges of social prescribing including the vision for its future. Overall, stakeholders pointed to a number of strengths of social prescribing. A clear emphasis was placed on the need to re-direct people to non-health resources, as a way to address social determinants of health. Social prescribing was also seen by respondents as a way to include the voluntary sector as an 'asset' in an effort towards improving the health and wellbeing of residents in the borough. Social prescribing offers the voluntary sector an

opportunity to promote itself and offer services that respond more effectively to the needs of residents:

'Age UK are set up to literally treat everybody in the same way. If you are 60 years old, you turn up at Age UK, you are offered the same service. Social prescribing will help realise that some 60 years old behave differently and need something different from other 60 years old as there are a range of services available to choose from.'

Apart from being an advantage for voluntary organisations, social prescribing is also an opportunity for users of the service to reflect on what their needs and aspirations are alongside a social prescriber who can support them to choose from a range of services.

An additional important strength for the development of social prescribing was identified by respondents as the commitment of social prescribers whom were seen as extremely motivated and effective in delivering the service and building the capacity of the voluntary sector to receive referrals, establish links between organisations and provide training. This resulted in new links set up with the voluntary sector and a small but increasingly widening support offer.

Respondents also reported on a number of challenges including crucially the lack of capacity and resources of the voluntary sector, the lack of resource in the health and social care system as a

whole, and the higher than expected need of residents referred. Respondents mentioned that these challenges need to be seen as part of the learning associated with developing social prescribing as a new intervention. Any assessment of social prescribing should also be seen in the context of the wider sets of health interventions put in place in the borough through the Better Care Together Programme. As social prescribing was implemented more quickly than other interventions, the overall pathway and choice for residents referred by GP practices and other sources was not optimally utilised. Thus, an overall assessment of social prescribing needs to take into account of the fact that other interventions are not yet fully functional.

Respondents highlighted the higher than expected rate of referral, high number of people with acute needs and the number of unmet needs. As SP users have greater needs, more time was spent to support them which led to the inability to support other residents and the accumulation of a backlog. One respondent pointed out that if other interventions such as Living Well Waltham Forest had been active, the backlog would have been partly addressed. The respondent continued by observing that social prescribers were never intended to support people with acute needs and a revision of the current service model is necessary.

Regardless of these particular issues, all respondents agreed on the current inability of the voluntary sector to provide an appropriate non-clinical pathway for residents in the borough.

Such inability was due to historical underinvestment in the sector, but also a lack of council's belief in the potential of the sector.

'It is not clear how really interested the council is in supporting the voluntary sector. In other councils you have very strong strategies on how you are going to develop the voluntary sector. But here, to be honest, my impression is that it is not one of their strengths.'

And again,

'A lot of diagnostic work has been done in the last two years which has reached the same conclusion [that current size of the voluntary sector is not adequate].'

The voluntary sector also needs to be more creative in trying to find funding from other sources beyond local authorities. There has been an overreliance on local authority funding in the past. It was suggested that apart from providing more resources, the council could help further with business support and training provision which for some respondents has currently started to take place.

'There is a plan to have regular dialogue sessions, to undertake more co-production work and service design solutions with the voluntary sector. There things are happening now, we ask the CVS sector to co-design our service model, but they

would not have happened at the time when SP first went live.'

One respondent highlighted the need for greater clarity in policy development.

'We want the voluntary sector to deliver services, but we withdraw funding to them. A case of 'cognitive dissonance'.'

Respondents felt that the future for social prescribing is uncertain. There are many competing demands particularly in relation to funding acute services in the CCG but politically both CCGs and local authorities, and the latter in particular, can see the benefits of social prescribing especially in relation to addressing the social determinants of health.

One respondent clarified that social prescribing cannot request substantial new resources to be made available but needs to make use of existing resources in the system.

'The only really credible basis for a business case for SP in this borough which has many competing demands is if we are successful in weaving the frontline SP activity, team of frontline Social prescribers using existing resources'.

On this basis, the future of social prescribing was seen as a clearer design of how social prescribing fits into the overall local health system. Social prescribers were seen as having a very strong understanding of the services available in the

borough with excellent information at their fingertips primarily in the form of an integrated directory, operating a light touch signposting role and referring them to different frontline services depending on their needs. The respondent pointed out that the involvement of social prescribers in a signposting light touch role would ensure a high volume service and hence justify the investment.

'The idea of the social prescriber is to devise a care of package and support for that residents which will do the job. Motivate the patient to access care and support, to follow up on whether the resident has indeed made use of the care and support.'

In order to achieve smooth functioning and support as many people as possible in the right way, one respondent discussed the provision of a 'universal training' which would be made available to a spectrum of people working on the frontline in the delivery of social prescribing and its referral to community organisations.

Online surveys with health professionals and community organisations: at the time of writing the report, 11 responses had been received from health care professionals via an online service evaluation survey. Respondents represented a variety of roles including a GP, social worker, nurses, physiotherapist, psychotherapist and administrator. Half of the respondents claimed to know quite well or very well what support was available in the community. However 10% (one

respondent) said they had no knowledge at all. A large proportion of respondents (80%) had referred to the service and nearly 90% said the process was straightforward. One commented, however, that it took a long time for the social prescribing team to contact the service user and they had to do a lot of chasing. Reasons for not referring were given as being uncertain about the service and forgetting that the service exists.

The vast majority of healthcare professionals (90%) reported that one of the most beneficial

aspects of social prescribing was its contribution to tackle social isolation. This was followed by improved mental health (50% of respondents) and housing (40%). 7 out of 11 respondents felt that support with social issues was the most beneficial aspect of social prescribing for clinicians although 2 felt it did not benefit them at all. 70% wanted to see the social prescribing service continue in Waltham Forest suggesting improvements to the service such as more information for service users and improving feedback channels for all involved.

5.3 Economic evaluation and use of services: Social Return on Investment

The Social Return on Investment analysis (SROI) is a staged process that considers the inputs, outputs and outcomes from the intervention and produces a financial assessment of the return to society given the initial investment (Cupitt, 2009). We make use of an established SROI analysis which accounts for displacement, attribution, deadweight, and drop off to generate a range of values in which SROI is likely to fall into.

5.3.1 Mapping inputs

The first part of the social return on investment considers the inputs which include the costs associated with setting up and running the intervention in Waltham Forest, whilst the final assessment will be available in the final report, after the collection of follow up data. The cost of running the SP intervention in Waltham Forest has been set to £128,000 for the first 12 month period April 2016 to end of March 2017. This is the cost to Waltham Forest council to run social prescribing including the cost of salaries, training and overheads. This does not include the cost to GP practices or community organisations supporting participants.

5.3.2 Mapping outputs and outcomes

Quantitative data have been used to inform this SROI. Baseline and four month follow up data from social prescribing users has been collected as part of the cohort study (sec 4.2.1). Judgement has been made about what is measurable with the best approximation and what is in line with the aims of the evaluation. SROI assessments do not require the use of a control group as is the case for most economic evaluations. However, it does use a range of other strategies to establish the correct impact (sec.5.3.3 and 5.4.3) which include deadweight, attribution, displacement, drop off, and a sensitivity analysis accounting for different

options. We added a further element called net benefit calculation which accounts for the financial value of worsening health outcomes on respondents.

Analysis of GP consultation rates

A total of 32 SP users provided baseline and follow up data on the number of visits to GP in the four months prior to data collection. SP users recorded, on average, 2.25 fewer GP consultations four months after interventions in relation to four months prior to the intervention for a total of 72 fewer consultations and a saving to GPs of nearly £7,776. These only examine 32 completed cases. As fully functional social prescribing pilot support about 235 patients over a four month period (700 in one year), projections of savings in terms of GP costs could amount to nearly £20K over a four month period and £60K over a year. It is important to note that the calculation of these savings is only based on the cost of GP's time rather than the GP practice as a whole (e.g. receptionist) or other costs (e.g. prescriptions), thus this is probably a gross underestimate of real cost benefit. On the other hand, there is no comparison group so it is difficult to estimate whether these benefits would have occurred anyway.

Analysis of A&E attendance

A total of 37 SP users provided baseline and follow up data on the number of visits to A&E in the four months prior to data collection. Mean A&E attendance at follow up was much higher than baseline (from an average of 0.27 to 0.62 visits). As the cost for A&E was calculated as £138 per patient per episode (DH, 2016), this evaluation estimates a cost increase of £5,382 due to increased A&E attendance. We included different scenarios in the sensitivity analysis to account for attribution of A&E increase to the intervention.

Volunteering

SP users were asked whether and often they had volunteered in the three months prior to baseline and follow up data collection. At follow up they were asked if that was due to the referral from social prescribers. 13 SP users responded this question (n=50), two of whom started volunteering as a result of social prescribing, one respondent on a weekly basis, the other on a monthly basis. We estimate that each volunteer spent two hours volunteering each time they attended. In the three months prior to follow up data collection, their volunteering contribution is worth £292 to the organisations they supported. This was calculated at the living wage (£9.75 per hour in London). This is only for the period of data collection, so this data is likely to be significantly underestimated.

Employment

SP users were asked whether they found employment in the three months prior to follow up data collection. Three respondents had found employment. From a return on investment perspective, employment generates two types of benefit: a reduced burden on the Inland Revenue and an increased tax

payment. Assuming that all three respondents will be in full time employment for at least one year, the reduced burden on the Inland Revenue was calculated at £11,422 and the tax generated from a job paid at the living wage was £5,590. The total accrued was £17,012.

Mental well-being

SP users were asked to complete the short version of the Warwick Edinburgh Mental Well-being Scale (SWEMWBS). This asks seven questions about aspects of the mental well-being. In order to place a financial value on the outcomes from this tool, we compared it to the cost of low intensity IAPT treatment (Radhakrishnan et al 2013) which places a financial value of £493 per low intensity IAPT treatment. 39 users responded this question at baseline and follow up, 24 (61%) of whom showed a benefit in the overall score, 14 experienced a decline in mental well-being over the period. We calculated the net benefit i.e. those who received benefits minus those who experiencing a decline in mental well-being (total £4,930).

Patient Activation Measure

SP users were asked 13 questions about their level of activation at baseline and follow up through the Patient Activation Measure (PAM). Hibbard (2014) found that the annual cost differential between those high in Level 1 and those in Level 4 is £1,562 per patient. Following examination of the changes in PAM. We calculated net savings of £8,591.

Quality of life

We calculated how many respondents experienced changes in the five dimensions of quality of life drawing on the EQ-5D tool. We assessed positive and negative changes in mobility, usual activities, self-care, pain/discomfort and anxiety/depression and used established guidance from other SROI evaluations to cost each of these dimensions (Table 7).

Table 7: Outputs and outcomes created by the social prescribing pilot in Waltham Forest

Outcome	Data source	Net change	Proxy and source	Value (£) (net benefit over 12 months **)
Changes in GP consultation rates	Cohort study	72 fewer consultations	£36 per consultation with General Practitioner (Curtis and Burns, 2016)	£7,776
Changes in A&E attendance	Cohort study	13 more A&E visits	£138 per patient per episode (DH, 2016)	-£5,382 (*)
Changes in Volunteering	Cohort study	2 volunteered	Living wage in London (£9.75 per hour), 2 hours per session per week	£292

Change in employment	Cohort study	3 found employment	Reduced burden to Inland Revenue (3,807.20 per person per year) https://www.gov.uk/jobseekersallowance/whatyoullget Tax generated: living wage per hour in London (£9.75) https://www.livingwage.org.uk/calculation	£11,422+ £5590=17,012
Mental well-being	Cohort study: SWEMWBS	10 improved MWB	Cost per low intensity IAPT treatment is £493 (Radhakrishnan et al 2013)	£4,930
Level of Activation	Cohort study: (PAM)	22	£1,562 per patient annual cost differential between those high in Level 1 and those in Level 4 (Hibbard, 2014)	£8,591
Mobility	Cohort study: (EQ-5D, quality of life)	48 (net benefit change is 3)	£3 per session, once per week. https://www.better.org.uk/leisure-centre/london/waltham-forest/peter-may-sports-centre/memberships	£468
Usual activities		48 (net benefit change is 17)	Cost of social club membership and attendance at activities (£2 per session). Once per week	£1,768
Self-care		48 (net benefit change is 3)	£480 per person managing yourself and person effectiveness training course	£1,440
Pain/discomfort		48 (net benefit change is 9)	Average annual prescription per person in England (£142) https://www.nuffieldtrust.org.uk/chart/annual-prescribing-spend-per-person-in-the-uk	£1,278
Anxiety/depression		48 (net benefit change is 15)	£45 per hour counselling (Curtis and Burns, 2016)	£675

(*) minus indicate an increased cost from baseline; (**) we calculated net benefits i.e. discounted respondents who saw their health or wellbeing decline over the period.

5.3.3 Establishing impact

In evaluating the Social Return on Investment is important to consider the effect of a number of elements including deadweight, displacement, attribution, drop-off, and net benefit calculation. Considering these elements helps to provide a more realistic and accurate assessment of SROI.

Deadweight measures how much of the activity would have happened anyway. As most respondents had a very low level of activation at baseline and they required significant support to act upon their health and social issues, we estimate the deadweight to be nil.

Attribution measures how much of the outcome was caused by the contribution of other organisations or people. Social prescribing is made of three key components including a referral source (e.g. GPs), the support work of social prescribers and the support work of community organisations. It is extremely

difficult to disentangle the contribution of each of these. In this SROI, we concentrate primarily on the work of social prescribers but we discount for the impact due to the work of community organisations. Our cohort study showed that only about 17 people attended community activities and 13 of these went to Citizen Advice Bureau (CAB) for reasons concerning mainly housing and employment. As a result, we accounted for the contribution of CAB by discounting the employment impact of social prescribing by 10% and the mental well-being and anxiety/depression by 5%.

Displacement measures what activities or services are displaced by the project. Interviews with stakeholders revealed that social prescribing has been the only type of initiative available. Efforts to set up other similar initiatives which may have been displaced by social prescribing have taken longer and only recently been put in motion. As a result, we estimated a zero displacement. The work of social prescribers is primarily driven by the need to create a ‘non-existing’ link between primary care and the community sector therefore we estimated a nil displacement effect.

Drop-off measures the decline in the outcome over time. The magnitude of the outcome generally reduces over time. It is generally calculated if the outcome lasts for more than one year and the annual rate of discount applied after this period is 3.5% (HM Treasury, 2003).

Net benefit calculation: In this SROI we introduced a new element called ‘Net benefit calculation’. We have not observed this element in previous SROI on social prescribing and other areas (e.g. homelessness). We include it here as part of the evaluation and below in the sensitivity analysis. When exploring changes in mental wellbeing, quality of life and other health and social indicators, some SP users experienced positive changes i.e. they improved their quality of life or mental well-being, whilst others experienced a decline in the same indicators. We feel that if we attribute positive results to the effect of social prescribing, we also have to attribute negative results to the effect of social prescribing. So the financial values produced in this SROI account for net benefits (positive minus negative outcomes).

5.4 Calculating the Social Return on Investment

5.4.1 Establishing the present value (PV)

During the SROI calculation, the ‘time value of money’ is usually recognised. This concept is based on the idea that people prefer to receive money today as future payments are uncertain and alternative investment may be more convenient (Cupitt, 2009). In order to account for this, Table 7 shows the Present Value (PV) of estimated financial benefits has been discounted over the period of five years using a basic rate (r) of 3.5% (Treasury, 2003).

Table 8: Value of impact over five years

Year	1	2	3	4	5
Impact					

Present value =	Impact in year $1/(1+r)$	Impact in year $2/(1+r)^2$	Impact in year $3/(1+r)^3$	Impact in year $4/(1+r)^4$	Impact in year $5/(1+r)^5$
Present value for each year	£35,619.86	£33,210.78	£30,964.64	£28,870.42	£26,917.83

The total present value of social prescribing is £155,583.52 (the sum of third row Table 8).

5.4.2 Calculating the Social Return on Investment (SROI) ratio

The SROI ratio makes a comparison between the invested inputs and the financial value of the proposed outcome. The financial value of the former was calculated as £153,755 whilst the latter was obtained £155,583.52.

Thus, the net SROI = £155,583.52 : £ 128,000
= **£1.22** : **£1**

This ratio is the result of the financial calculation of SROI and the assumptions described 5.3.3 (deadweight, attrition, displacement, drop off and negative impact). However, good practice in SROI analysis dictates the selection of a range of values in which the ratio may fall into depending on a number of hypothesis. This range is examined in the section below (5.4.3).

5.4.3 Sensitivity analysis

The sensitivity analysis explores how SROI would change when assumptions about the impact of social prescribing are changed. It produces a range of possible ratios within which is realistic to expect SROI to fall into. We considered the following scenarios:

Elimination of negative impacts cost assessment: As we considered positive health changes to respondents as due to the impact of social prescribing, we considered fair to discount the negative health outcomes as also due to lack of an impact of social prescribing. As a result we discounted the financial value due to negative health changes to respondents. However, SROI assessments do not place a financial value on negative health outcomes so we present here the SROI without such negative impacts. The added benefit in terms of SROI are £16,330 which lead to a SROI ratio of £1 invested, a return of £1.92.

Lowering attribution: from data collected via our survey instrument, we were able to ask respondents whether their attendance to community activities was due to the referral from social prescribing or had taken place independently. In order to account for this, we added 10% of all HH outcomes as attributed to outside unaccounted factors. This changes the SROI to £1:£1.09.

Lowering drop-offs: the estimated duration of outcomes may have been underestimated. For example, some health benefits will continue well beyond the five years period (e.g. mental health). In order to account for this, some of the drop off outcomes have been lowered by 10%. The resulting SROI is then the following: £1:£1.34.

5.4.4 Analysis of SROI

Following the sensitivity analysis which takes into account of a range of additional factors influencing the value of outputs and outcomes, it is possible to generate a range within which the social return on investment for social prescribing in Waltham Forest is likely to fall. The SROI is likely to range between £1.09 to £1.92, thus **for £1 invested in social prescribing, our social return on investment is likely to range between £1.09 (£0.09 higher than the initial investment) and £1.92 (£0.92 higher than the initial investment)**. This calculation is open to some limitations which are explored in the discussion section (6.1.3).

6 Discussion

6.1 Summary of the main findings

This section discusses the main findings in light of the four key aims of the evaluation

6.1.1 *The impact of the social prescribing pilot on the changes in patients' health and social outcomes*

The majority of respondents in the sample were women (63%), only 21% were aged 65 or over, and from ethnically mixed background (44% white). A substantial proportion of the people in the sample lived alone (38%), were not in paid employment (65%), and unable to work due to sickness (33%). The make up of this population is slightly different from other social prescribing pilot which tend to target an older population (e.g. Kimberlee, 2016; Bertotti et al 2015), and have a large proportion of people in working age who are not in paid employment primarily because they are unable to work due to sickness.

Given the large proportion of people who are not in employment and experiencing physical and/or mental health issues, it is not surprising that work and finances were their main concern, followed by physical and mental health. When looking at the changes that occurred during the evaluation period, most of the improvement in the concerns of respondents was related to housing, practical support and work/finance. In terms of their second concern, respondents reported the largest improvements in 'practical support' and 'mental health'. This shows that on average the intervention has somewhat helped respondents to address their housing, work/finance but has been less effective in relation to addressing mental and physical health problems.

Another important finding of this evaluation is that respondents experienced positive changes in all health measures (general health, well-being, quality of life and mental well-being) and activation (patient activation measure) between baseline and four months follow up. Changes in well-being, quality of life and patient activation were also statistically significant which is particularly relevant given the short follow up of four months. It is reasonable to expect further improvements over a longer period as well-being and quality of life improvements can only generally be detected over a longer period (e.g. 1-2 years).

Yet, it is also important to note that these positive benefits come from a very low starting position and seem to be only marginal, at least in relation to this follow up period. For example, mean changes in mental well-being between 18.3 and 19.2 is well below the mean of 24 (out of 35) that represent the average mental well-being of the UK (HSE, 2011) and other social prescribing pilots (Weld et al, 2015; Bertotti et al 2014) but in line with another pilot (Brandling et al 2011).

In relation to levels of patient activation, statistically significant improvements were detected with considerable changes in level of activation from level 1 to level 2 and 3, although none to level 4. This means that almost 30% of the respondents moved from being 'disengaged and overwhelmed' to becoming 'aware, but still struggling' (19%) and 'taking action' (11%), although none of the respondents were able to reach the level 4 status of 'maintaining behaviour and pushing further'.

In summary, these results should only be seen as a step toward a satisfactory health and well-being status rather than an end in itself. It appears that social prescribing is able to support people's circumstances but such support needs to be maintained over time in order to create the basis for long lasting, more permanent health gains. From the point of view of perceived changes in participants' concerns, a 'triage' style model of social prescribing and referral which focuses more on supporting respondents with complex psychological issues would be more effective than the current telephone system which, on its own, is unable to provide the required in-depth conversations between social prescribers and patients needed for effective referral to psychological and physical health support in the community or statutory sectors. Furthermore, health and patient activation gains could be further reinforced by expanding the links and offer of the CVS organisations operating in the borough.

6.1.2 Development of the pilot and integration into wider health economy

The referral target of 650 referrals to social prescribers is very likely to be exceeded within the set timescale (July 2016 - Dec 2017) as the current number of referrals received was 600 at the end of June 2017. However, this does not represent the number of people who have been actually supported by the intervention but only the number of referrals to social prescribers from various sources, primarily GP practices. We suggest that a target number of people assisted by the social prescribers and referred on is set by the commissioners in consultation with social prescribers. This depends upon the specific model used i.e. more or less intense support provided face to face or by telephone only. An economic evidence review by Polley et al. (2017) shows that on average one social prescriber managed to provide in-depth support for 167 users over a 12 month period which makes 14 patients per month. This includes constant contact with GP practices and other referral sources to ensure a continuous flow of referrals, in-depth user support (at least 2-3 consultations) as well as establishing and maintaining contacts with community and statutory services for correct referral.

Social prescribers were seen as key to the effective development of social prescribing. With the exception of some users, most other stakeholders (commissioners, healthcare professionals and community organisations) had an overwhelming positive opinion towards social prescribers. Social prescribers were highly regarded due to their person-centered skills, their vast knowledge of the community and voluntary sector and their ability to connect community groups with others in the local area. Their extensive

knowledge of local community projects is such that other frontline professionals and support organisations request social prescribers to provide information on existing current services for their own clients.

However, the appropriate role for a social prescriber was contested. It ranged substantially from an in-depth referral support role to a much light touch signposting role. For example, some respondents from community organisations felt that the social prescriber should in some circumstances (e.g. lack of mobility, specific mental health issues) visit patients' homes and accompany them to community activities, at least the first time. In their opinion, community organisations do not have enough capacity to visit the homes of people referred through social prescribing. There are examples from across other areas of the UK (e.g. Rotherham; Wigan; Calderdale) that have included home visits in their social prescribing model (Dayson and Bashir, 2014; Windle et al., 2016) and evidence that this has increased take up from one fifth to half of clients (Windle et al., 2016). However, other stakeholders warned about the cost involved in funding such model and emphasised an approach based on social prescribers as covering a primarily signposting role. This role would be delivered only over the phone, make use of an integrated directory of services, and the sharing of care records which would enable social prescribers to check the situation of each resident in other care settings. In the future, social prescribers would then be able to refer patients to Living Well Waltham Forest, as well as self-care pharmacists and physician associates or CVS directly, depending on the needs of each patient referred. Thus, the future role of social prescribers is seen as one of signposting a high volume of patients.

The majority of social prescribing users (seven out of nine) did not feel they had been helped by the service, either because they were still waiting to be contacted by a community organisation at the time of interview or had not received a referral from social prescribers. Some respondents were somewhat incoherent in their responses. This reflects the level of need and the complex interaction between social and health issues, particularly concerns with housing and finance alongside physical and mental health problems. Such mix of complex needs leads users to have a range of appointments with public sector support services and difficulties in remembering clearly who has helped them. As a result, almost all respondents were unsure about what social prescribing was. Although this problem has been highlighted by other evaluations of social prescribing (Bertotti et al. 2014; Brandling et al., 2011), in Waltham Forest this problem appears to be more pronounced as the service is only delivered over the phone, whilst most other social prescribing services are delivered face to face, providing users more space to remember the names and faces of social prescribers.

Despite an overall negative opinion about the support received from the service, two respondents felt positive about their referral on to support in the community at the time of the call, but this had not been enough to overcome the psychological barriers they were experiencing and they had failed to attend. These

patients felt they would have benefitted from a face-to-face model of social prescribing and possibly someone to accompany them to their first appointment. Several other patients were also 'too high threshold' for social prescribing and needed more intensive support than the service could provide, suggesting the need for a more defined set of referral criteria. This also impacted negatively on patients when they became increasingly frustrated by the inability of the service to solve specific issues with housing, for example.

Extent of referral integration: the integration of the social prescribing pathway in Waltham Forest depends upon the relationship between three key stakeholders: social prescribers, healthcare professionals and the community and voluntary sector (CVS). Only one of healthcare professionals surveyed (n=11) encountered any problems in referring patients to social prescribers. Moreover, there are no issues of low referrals, rather there are too many referrals to social prescribers and the latter cannot cope with it. Thus, the relationship between social prescribers and healthcare professionals seem to work well overall. However, one of the issues that was identified at this stage of the pathway was the excessively high health needs of some patients referred. In this case, patients needed to be referred to clinical treatment rather than social prescribing. In collaboration with GP practices, social prescribers could therefore develop clearer criteria that would avoid the referral of patients with acute health conditions and/or change the social prescribing delivery model to accommodate for people with such conditions.

The integration between social prescribing and the community and voluntary sector (CVS) was very poor at the beginning of the project and still insufficient at the end of the project, despite the dedication of social prescribers to building links with the CVS to ensure collaboration in receiving referrals and increasing referral options available to SP users. Commissioners, social prescribers, and community sector respondents agreed that the capacity of the community and voluntary sector (CVS) in the borough needs to be improved significantly. Social prescribers found it difficult to find appropriate services for some of the clients because of the gap in provision in the community sector, particularly in relation to befriending for those with specific language or cultural requirements and services for the hard of hearing. This was echoed by responses from social prescriber users who complained about the lack of service availability with clear implications for the success of social prescribing. The current lack of capacity of the CVS sector was highlighted as an historical problem due to lack of investment over a number of years which could be now bridged by investing in greater links with existing organisations through developing training opportunities as well as commissioning services. Stakeholders across the spectrum reported that other councils in London have a more developed strategy to support the role of the voluntary sector, although some respondents reported that the attitude toward the voluntary sector is changing. Social prescribers started to create links between CVS and the social prescribing service, but more needs to be done through funding and training

opportunities as there are skill gaps in the capacity of each organisation, and the capacity of the sector as a whole.

In addition to the lack of CVS capacity and funding, social prescribers were unable to cope with the large number of referrals from healthcare professionals because of the lack of an adequate supporting infrastructure at the time of delivery of social prescribing. Other initiatives (e.g. Living Well Waltham Forest) were not operational at the time social prescribing was launched and this limited somewhat the options of social prescribers. One stakeholder pointed out that the planned introduction of Living Well Waltham Forest as well as the involvement of self-care pharmacists and physician associates will help to integrate social prescribing with other independently funded health interventions and thus maximise the returns to social prescribing.

6.1.3 The social return on investment (economic evaluation)

The Social Return on Investment (SROI) is likely to range between £1.09 and £1.92, thus for £1 invested in social prescribing, our social return on investment is likely to range between £1.09 (£0.09 higher than the initial investment) and £1.92 (£0.92 higher than the initial investment). This range is lower than the average SROI for the sector which was calculated by Polley et al. (2017) at £2.3 for each £1 pound invested. This can be due to several reasons:

- If monitoring data had been collected for the all period to June, the SROI might have been substantially more accurate and potentially higher. For example, more accurate data on the number of people in employment as a result of social prescribing would have had a substantial impact on the SROI. Employment often contributes to the SROI both in terms of tax revenue increases and welfare benefits savings (e.g. job seekers' allowance).
- It is important to note that this SROI is based on data on 48 respondents, 10% of the total number of people referred over the period. This makes the current SROI a large underestimate of the total but shows that even at this low level of responses the SROI is likely to be a good investment as even in the worst case scenario (£1:£1.09), the loss is minimal.
- There are economies of scale effects due to the inclusion into the SROI calculation of a larger sample of respondents. This means that SROI tends to be higher when the intervention covers a higher number of users. Thus, if social prescribing were to be extended the ratio would increase, the larger the investment, the larger the return.
- There are only four months between baseline and follow up data collection. Within this period, some outcomes such as mental health, patient activation, employment may not have yet materialised. This is likely to lead to an underestimation of the SROI.

In conclusion, the SROI ratio seems to be acceptable for what is a pilot project subject to revision. More accurate data collection in the future may enable to obtain a higher SROI ratio, particularly in terms of

collecting data on potential number of social prescribing users taking up employment and volunteering and other outcomes of use of healthcare services (e.g. medicine use).

6.2 Limitations of the evaluation

This evaluation has a range of important limitations as follows:

- (i) The absence of a control group is a problem in this evaluation and all the evaluations of social prescribing except one (Grant et al. 2000). It is difficult to attribute change in health outcomes to the effect of the intervention without an appropriate control group to compare results to. This is even a more important problem in evaluations of social prescribing as most participants experience very acute health problems and therefore are more likely than average to improve over time even without the support from the service (e.g. regression to the mean). The use of randomised controlled trials (RCT) is judged as the most rigorous way to assess the effectiveness of a health intervention. However, just on step down from the RCT on the scale of rigour, a matched controlled group design could be used to assess effectiveness (Craig et al., 2012). This is easier to develop as it follows policy cycles and often much less costly than an RCT.
- (ii) The follow up sample size for the intervention (n=49) is small for regression analysis, thus we were not able to carry out further analysis on the whether age, gender, ethnicity, employment status and education level affect results.
- (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. A four month follow up period may underestimate the impact of some health outcomes which may appear much later. Thus, although this evaluation found positive statistically significant changes in some health outcomes, these are likely to be higher in the future. The impact of social prescribing may have been underestimated.

7 Conclusion

The Waltham Forest Social Prescribing Service has had a positive and in some cases statistically significant impact on health changes, particularly in terms of well-being, quality of life and patient activation.

However, health outcomes improved from a very low starting position and much more support needs to be provided to users in order to help them to reach a satisfactory level of health and well-being. Respondents also reported large improvements in their concerns toward Housing, Practical Support, Work & Finance.

Although qualitative interviews with users were not so positive, this was mainly related to the lack of Community and Voluntary Sector (CVS) offer and long waiting times rather than an aversion to the idea of social prescribing. The Social Return On Investment (SROI) showed that for £1 invested in the social prescribing service in Waltham Forest, the expected return to society could be between £1.09 and £1.92. This is below the average of other SROI evaluations (£1:£2.3) but it is important to recognise that this is a pilot and even this lower return would justify the investment.

Thus, there is little doubt that social prescribing has had a positive impact on participants at an acceptable cost, despite the issues with a lack of integration, funding and capacity in the community and voluntary sector, and the lack of support that was planned to come from other initiatives such as Living Well Waltham Forest. However, in considering how to design the model going forward, it is worth reflecting on the following recommendations which may be useful in designing a robust and effective social prescribing model.

7.1 Key recommendations

1. No model of social prescribing is likely to work unless the CVS is well connected with social prescribing and people have an adequate range of services they can choose from and be referred to. Building further links and investing in the development of the community and voluntary sector (CVS) is therefore a priority. Funding for service delivery is a priority for the sector but other aspects are also important. Various stakeholders identified important gaps in service provision (e.g. befriending) and capacity issues that could be partly addressed by training in building skills within the sector (e.g. skills to apply for funding other than local authority funding). Lastly, CVS organisations should be encouraged to refer to each other. This would benefit patients and build links between organisations for mutual support.
2. The current number of social prescribers appears to be inadequate in relation to the number of referrals received. A change in the current model is required to maximise the chances that social prescribers can sufficiently 'activate' people referred so that they take up referrals. Targets for social prescribers should be based on the number of people assisted and referred to CVS or other services rather than on referrals received by healthcare professionals. Social prescribers could make use of

MYCAW to identify and monitor the type and level of concerns patients have. This would ensure that the service is person-centred and responds directly to the needs and aspirations of the patient. It would also help to assess needs of each patient and refer accordingly (see point 3 below and sec. 7.2 for a suggested model).

3. SP has been more effective in tackling practical problems (Work & Finance) than low and medium mental health problems and issues of social isolation/loneliness. This requires further consideration as to the best social prescribing model to be implemented. One option would be to consider the use of face to face in-depth consultations with social prescribers for those requiring mental health and social isolation/loneliness support as this group needs to be supported to address the barriers (both physical and psychological) that often stand in the way of behaviour change. Evidence shows that behaviour change requires the social prescriber spending time to listen and motivate patients to take sustained action to improve their health. This cannot be done over the phone as individuals need to establish a rapport. Options could include the involvement of volunteers for some aspects of this support eg. accompanying the patient to their first session, but in-depth consultation requires people with motivational and coaching as well as social skills of empathy and a significant knowledge of services available in the borough both CVS and statutory.
4. The integration of the service into other Better Care Together Programme should be discussed further. In particular, there is a danger that the use of self-care pharmacists and physician associates may prolong the pathway and leading patients to be 'lost in the system'. Current evidence shows that a non-clinical approach to patient needs that prioritises skills such as the ability to listen empathically and build a collaborative relationship is of primary importance. This would potentially be lost if pharmacists and physicians were to be involved in supporting patients as their training is primarily clinical and their knowledge of CVS organisations available in their locality is not likely to be of high standard.
5. Some referrals experienced acute health and mental health problems that are not suitable for social prescribing which is primarily designed to improve levels of self-care and self-management. There is a risk that some individuals experiencing acute health problems are not properly diagnosed which could adversely impact their health. As a result, thresholds for referral criteria should be clarified further so that healthcare professionals can refer appropriately.

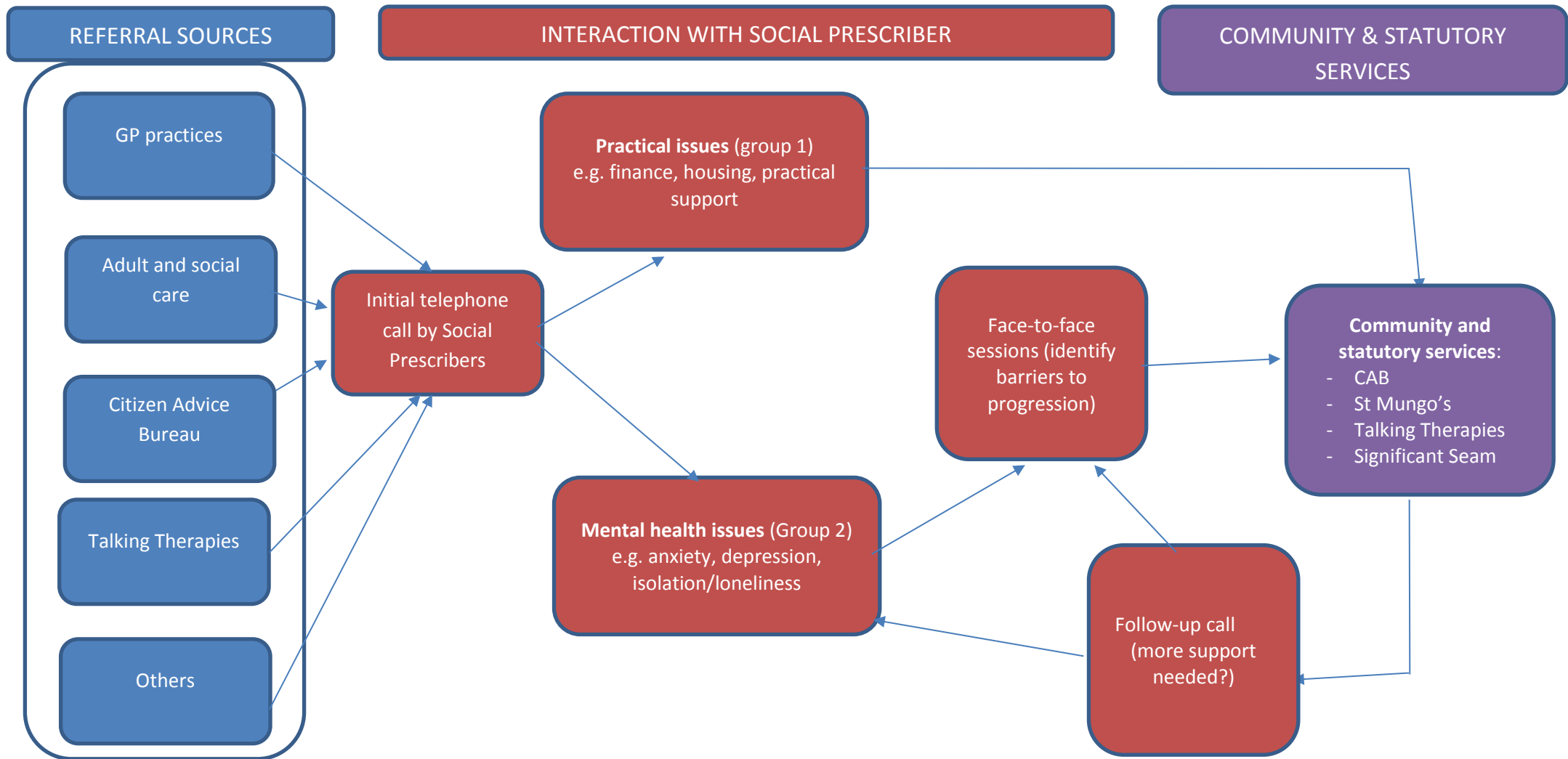
7.2 An alternative social prescribing model

In order to build on the recommendations in sec. 7.1, we have designed an alternative social prescribing model that may aid further discussions between the funders of this report and other stakeholders. This evaluation identified that two broad groups of social prescribing users are referred to the service by healthcare professionals (see 5.1.2).

The first (group 1) faces practical issues (finance, housing and other practical support), the second (group 2) faces mild to moderate mental health issues (including isolation). In many cases, people may present with more than one issue so the SP model needs to be designed in a way that can support both of these groups. Following referral, an initial phone call by a social prescriber can establish patient's primary and secondary concerns and refer them accordingly. The MYCAW is a person-centred tool that enables social prescribers to group different types of health and non-health concerns into categories that can be used to make sense of broader issues. The key concerns of each individual can then be addressed in a person-centred way whilst monitoring referral over time. MYCAW is particularly useful in determining when mental health issues are the primary concern, requiring a more intensive approach, or a secondary concern related to problems such as finance or housing. In this situation mental health may improve anyway, as a result of successfully addressing the primary concern.

The evaluation of SP in Waltham Forest has shown that social prescribers can support patients with practical issues (group 1) over the phone and refer them directly to community and support services (e.g. CAB) with no further need for immediate contact. However, the role of the social prescriber may involve a follow up phone call to ensure that the patient has received help and assist with potential other problems that may require further referral to other CVS organisations or statutory sector. If patients who have been helped with their practical issues still experience other problems (isolation/loneliness, or mild to moderate mental health problems), a more in-depth service should be proposed involving a face-to-face consultation service (e.g. up to four consultations) accompanied by home visits, where necessary. Equally, if during the first telephone conversation, the patient reveals to the social prescriber that the primary concern is about poor mental health and/or social isolation/loneliness (group 2), the patient should be referred to more intensive face to face support. Evidence shows that a face-to-face consultation is more effective at activating the user and improves outcomes and likelihood of attendance to community and statutory services. Both social prescribers and the more in-depth consultation service would require people with a specific set of skills including motivational and coaching training, empathic listening skills, and significant knowledge of the range and quality of CVS organisations available in the borough. Home visits could be carried out by volunteers (e.g. befrienders, buddying) managed by social prescribers or an externally contracted CVS organisations.

Figure 8: Suggested model of social prescribing for Waltham Forest



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9 Appendices

9.1 Treatment effect analytical method

The method explained in Netuveli et al. (2008) is used to analysis the treatment effect of SP on those continuous scores here. We first correct Y2 (score at follow up) for regression to the mean (RTM) effect using the method of Naranjo and McKean (2001): $Y2 = Y2 - ((1 - \rho)(Y1 - \mu))$ where Y2 is the corrected measurement at follow up, ρ is the correlation between Y1 and Y2 and μ is the common average for Y for both time points. In the second step we consider the change is real only if it is outside the 95% confidence interval of Y1. In regression based analyses, correction for RTM is easily achieved by including Y2 in the regression equation.

9.2 Findings from qualitative interviews

Table 9: Findings from qualitative interviews

User concern (at time of interview)	Process	Outcome	Demographics
Homeless	Referred by GP. SP referred her on to an organisation that could help. She was expecting to hear back from them but has heard nothing for 8 weeks.	Very unhappy with service. Doesn't feel she has been helped.	45-54yrs Caribbean Female Lives with others Unable to work (long term sickness) Left education age 16
Financial help with prescription charges. Depression/anxiety/OCD.	Referred by nurse? Sarah from CAB? Had trouble filling out form – unclear whether questionnaire or prescription form! Thinks questionnaire was part of application for prescription charges.	Helped her to get form to claim for prescription charges. Unclear whether help actually came through social prescribing. Waiting to hear back about application – could take 3 to 4 months. Story not very coherent.	45-54yrs Female Lives with others White British Looks after home/family Left education age 16
Didn't want to say.	Referred by GP (he thinks!) Happy to talk on phone. Had one call so far but no follow-up 6 weeks later. Waiting for next call, haven't been referred on anywhere yet.	Nothing's come of it yet. Not sure whether SP suits him or not, needs more information.	45-54yrs Male Lives alone White British Unable to work (long tem sickness) Left education age 16
Lost confidence, stress and anxiety.	Referred by a doctor at hospital. Would have liked more info. A week between referral and first call. Had two calls. Would have preferred face-to-face, phone quite difficult. Didn't want referral at time. Thinks maybe he should have let them refer him on after all.	Felt SP could help him. Relieved anxiety and stress by having someone to talk to (SP). Felt good after call but then things went back to normal. Face-to-face would have been a lot better for him. Someone to check out the organisation with him would have helped. Decided he'd rather deal with it himself and would 'grin and bear it'. Found it helpful to certain extent but really he wanted to talk properly to someone face-to-face. Would try SP again in future. Would recommend SP to others.	55-64yrs Male Lives alone White British Unable to work (long term sickness) Left education age 12 or less

		Thinks he can get back on his feet by himself –the SP helped by giving him confidence to take those steps.	
Pension credit taken away. Very worried. Lonely – wants to know someone has her back.	Doesn't remember much about process. Two calls, she thinks. Preferred to speak over the phone but they couldn't help her so it was a waste of time.	They don't help. Very frustrating. Would take a lot to change service for better. Would like some support from people to help her with day to day life. Asked about her pain 'yes or no' questions. Felt like another number to tick off. Doesn't expect to hear from SP again. They listen and go. She nearly put phone down on them. Asked about illness but didn't say they could do anything about it.	75-84yrs Female Lives alone South American Retired from paid work Left education age 16
Housing/ can't work/ health?	'System is like the Gestapo – here to kill you.' 'System here to make you suffer.' 'Neglected and exploited by the government'. A social worker has helped her.	Very unhappy about NHS, government and system in general Could not get coherent response about SP experience.	45-54yrs Female Alone Lithuanian Unable to work (long term sickness) Left education at 19yrs
Anxiety	Referred by social worker. Received some info on SP. A week between referral and first call. Phone contact was fine. SP was pleasant. Referred to talking therapy but didn't attend. Decided later that she didn't want to attend. More useful if someone could have come to her home (counsellor).	Didn't help her personally but could benefit others. Thinks it would be helpful for others but anxiety prevents her getting out. Involved travelling about which is not something she could do. Can only go as far as local shops – people don't seem to understand. All outside, only wants to stay in. Found an online therapy solution by herself.	65-74yrs old Female Lives alone White British Unable to work (long term sickness) Left education at 16yrs
Problem with getting daughter into school. Housing. Daughter depressed and self-harming.	Referred by GP. Just one call from SP. Didn't mind using phone. Was expecting them to call again but hasn't heard anything in 3 months. No referral. Has tried standard housing routes but no joy because she's not homeless.	It helped to talk on the phone. Thought they might have been able to help but they haven't called back. Doesn't feel like she's got anywhere.	45-54yrs Female Lives with others British Looking after home/family Left education age 20 or over
Son's benefits reduced/stopped.	Tried unsuccessfully to contact CAB herself. SP made appointment with CAB for her. Can't remember who referred her. 3 calls in total from SP. Phone contact worked for her.	Issue resolved (although took 1 year). Happy with SP service. Would recommend to others.	35-44yrs Female Lives with others Bangladeshi Unable to work (long term sickness) Left education age 16

9.3 Waltham Forest Social Prescribing Pathway (July 2016- Dec 2016)

