Wessex
Academic Health
Science Network

R-Outcomes
MEASURE WHAT MATTERS

Social Prescribing in Wessex
Understanding its impact and supporting spread

Executive Summary

This paper introduces eight different services providing social prescribing in Wessex and describes our work to understand and evaluate the impact they are having, to support their development and spread.

A mixture of quantitative and qualitative evaluation methods have been used to develop a rounded and rich understanding of the impact they are making. This paper summarises the findings to date which include:

- Strong evidence of improvement in how people feel about their health, their confidence to manage it, their wellbeing and their experience of receiving care.
- Further evidence of these improvements from case studies and qualitative interviews.
- Feedback from staff that they are very motivated and committed to the social prescribing role.
- 20-50% reductions in A&E attendances and 32-35% reductions in emergency admissions.
- The potential to deliver economic benefits that are double the investment.

By working with these eight services we have identified a set of design choices that need to be made when developing a social prescribing service. These cover decisions on which part of the population to target and how to identify them, where social prescribing services are based, who should deliver it and at what scale.

Our work has convinced us of the importance of social prescribing and its potential to positively impact on the lives and health of individuals and to shift the pattern of care away from emergency hospital activity.

1. Introduction

Social prescribing is a new model of providing support to people that recognises the importance of the determinants of someone's health – their social, economic and environmental issues. It aims to understand and address people's needs in a holistic way and to support them to take greater control of their own life. There are many different models of social prescribing and most involve a link navigator/ coordinator/ signposter who work with people to understand their situation and goals and help connect them to local sources of support, particularly voluntary services. Individuals are prescribed social support to improve their health and wellbeing – hence the term social prescribing.

This paper introduces eight different services providing social prescribing in Wessex, covering a population of circa 1 million people. It describes the evidence that we have collected, including patient reported outcomes, qualitative interviews, staff reported outcomes, impact on emergency hospital activity and economic benefits. It then sets out a series of design choices and lessons to apply when planning and developing social prescribing services.

Wessex Academic Health Science Network (WAHSN) and R-Outcomes are working together to evaluate and spread best practice in social prescribing. WAHSN is a member led organisation within the NHS that identifies best practice to drive adoption and spread of innovation to improve the public's health. It covers the 2.8 million people that live in Hampshire, Isle of Wight, Dorset and Southern Wiltshire. R-Outcomes work to measure what matters – how patients, carers and staff feel about the care and treatment that they receive and provide- using a unique family of outcome measures that are short, validated and generic to achieve this.

2. A short description of the eight services providing Social Prescribing in Wessex with whom we have worked

Care Navigators in Eastleigh Southern Parishes
Provided by a GP Federation, this is a team of 5 Care Navigators (CN) with one attached to each General Practice. They primarily support older vulnerable patients, with whom they develop a holistic plan covering care coordination and connection with the local voluntary sector. Patients are supported for as long as they need it, which on average is for 6.5 weeks. Half of the patients are referred by the primary care team and half come from telephoning all older people discharged from hospital. The team of five CNs provide a 7-day service, with one CN being on duty at the weekend. Initially pumped primed by CCG, following our evaluation the service has been commissioned.

Care Navigators on the Isle of Wight
The CN's are employed by Age UK IoW and based in General Practices. The majority of the people that they support are over 75 with frailty and long-term health conditions who are referred by primary care teams and other statutory and public services. They provide information and coordinate care to reduce social isolation and improve planned uptake of services. They work with people for up to 6 visits. Originally funded by NHS Vanguard and Big Lottery this is now a business as usual service.

Care Navigators in New Forest
Employed by a GP Federation and based in General Practices with a focus of providing signposting and support for people aged over 70. Provide a short period of active support typically over a 2-4 week period. 60% of referrals come from GPs and the remainder from a wide range of sources in primary care and other local services. Initially pump primed by CCG, the intention is to now commission the service.

Proactive Care Teams in Mid Hampshire
Employed by a GP Federation, the team is made up of Proactive Care Nurses (PCNs) and Care Coordinators (CCs) at a ratio of about 2:1. They provide a blend of holistic care planning and social prescribing for people aged over 70 identified as being at risk of deterioration. PCNs undertake an initial 40 minute home visit and holistic assessment that will involve social prescribing and referral to health and care services. CC's are based in the practice and work with the PCNs to maintain contact with the patient and take the actions to deliver the plan. Patients typically receive two home visits. Initially pumped primed by CCG, following our evaluation the service has been commissioned.

Making Connections in North East Hampshire and Farnham
Provided by a partnership of local voluntary organisations, the service developed out of an Age UK pilot for older people in one locality to cover all 5 localities and to support people of any age. Most patients are referred by their GP (65%) or the locality Integrated Care Team (25%). Coordinators undertake guided conversations, complete wellbeing assessments and develop personalised support plans. There is not a time limit for supporting people. The service is funded non-recurrently by an NHS Vanguard.

Local Area Coordinators on the Isle of Wight
Are based in local communities of 10-12,000 and can support all ages and all needs (e.g. mental health, older people, carers, physical disability). They are recruited by members of their local community. Introductions (not referrals) can come from anywhere, professionals, community members or individuals. Support is based upon a conversation about what a 'Good Life' would like, focusing on a person's gifts, skills, interest and experiences. LAC's work to create the conditions for strong communities. They are employed by the Local Authority and funded by a public health grant.

Practice Based Outreach Team in the Tri-Locality (Chandlers Ford, Romsey and Eastleigh)
Employed by a GP Federation, the team provide a blend of holistic care planning, medicines review and social prescribing for older people. The team is made up of a Nurse Specialist and a Community Pharmacist, who undertake the holistic assessments; supported by a team of Assistant Practitioners who support delivery of the plan with patients and carers. The majority of referrals come from GP's and most patients will be visited twice. Initially pumped primed by CCG, following our evaluation the service has been commissioned.

Surgery Signposters in Fareham, Gosport and Havant
This is a volunteer delivered social prescribing service. Gosport Voluntary Action recruit, train and support volunteers to provide a local signposting service. Signposters are attached to a local General Practice and two-thirds of referrals come from primary care with the remainder being self referrals or from a wide range of other local organisations. The service is aimed at people struggling to manage a long term condition, who need support following a diagnosis, are socially isolated or need help with housing and benefits. The service was initially pump primed by WAHSN and is currently funded non-recurrently by an NHS Vanguard.

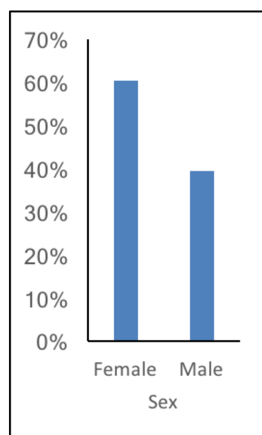
3. Evaluating their impact

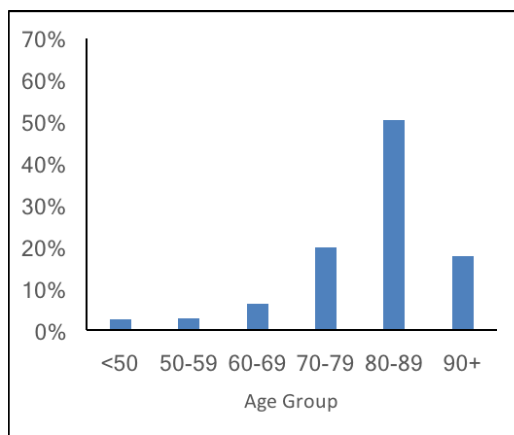
A mixture of quantitative and qualitative methods have been used to evaluate these services, to develop a rounded and rich understanding of the impact that they are making. In this section we summarise the findings from:

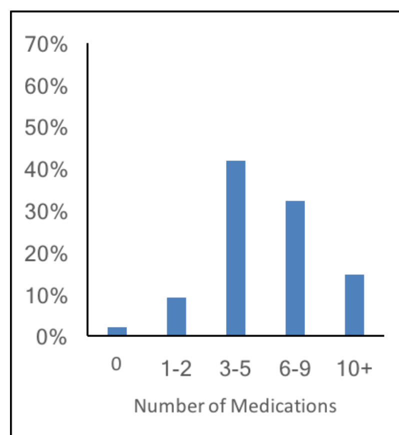
- R-Outcomes for patients/ people
- Qualitative interviews and case studies
- R-Outcomes for staff
- Economic evaluation

The key aggregate demographic features of the patients or people supported by these services are:

Mostly female **aged over 80** **taking a lot of medications**





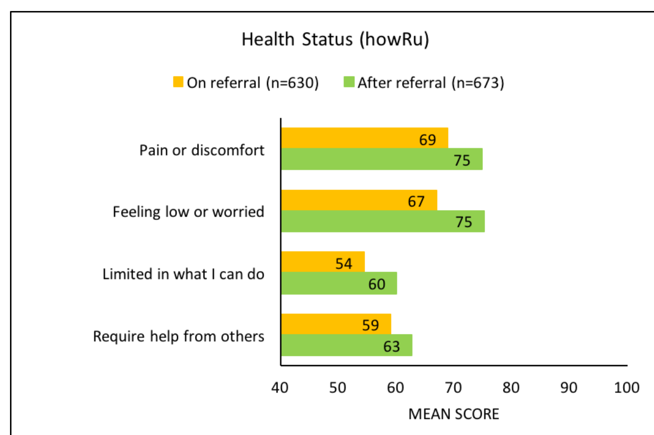


3.1 R-Outcomes for patients/people

All of the services have collected R-Outcomes from the patients/ people they have supported. Outcomes are recorded when people first access the service and then again once they have been supported.

The aim is to look for evidence of an improvement in how they respond. Free text comments are also collected.

The following four charts set out the aggregate findings for four R-Outcome measures. Each is scored out of 100 and the longer the bar/ higher the score the better the outcome.

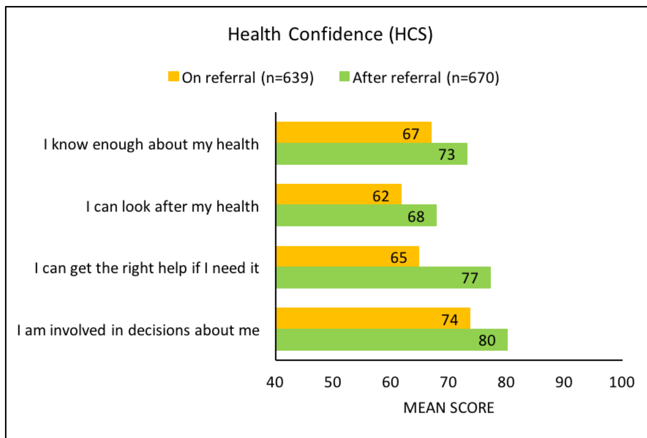


Improved Health Status

People record how they feel physically and mentally and how much they can do in terms of loss of function and independence. It has been validated against other measures including SF12 and EQ-5D.

People report an improvement in all questions for health status. The largest increase is feeling less low or worried after they have been supported by the service – reflecting the empathetic and person centered approach that they take.

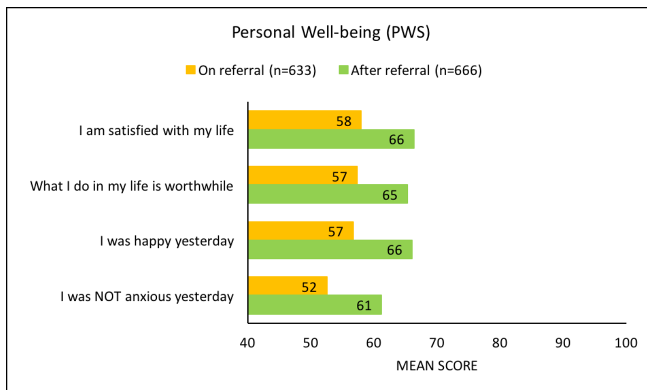
R-Outcomes MEASURE WHAT MATTERS



Increased Health Confidence

This score monitor's people's confidence in their ability to manage their own health and engage with health care providers. This measure is closely associated with the concepts of empowerment, perceived self-efficacy, activation and engagement.

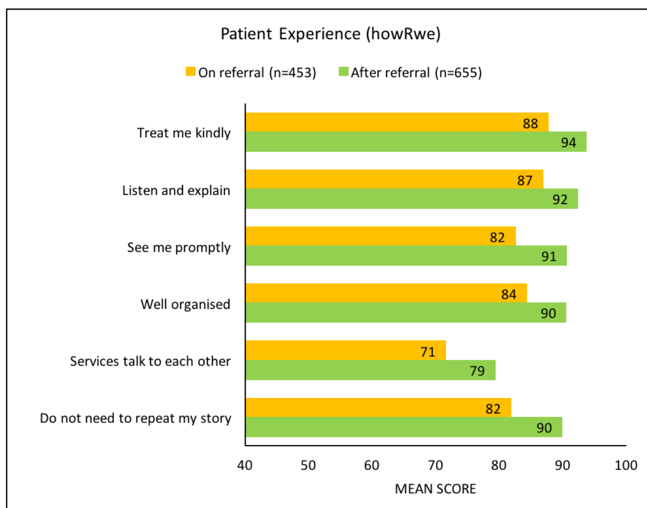
People report an improved confidence in managing their own health. The largest increase is in feeling that they can get the right help if they need it.



Improved Wellbeing

This is a short generic measure of happiness or subjective wellbeing and is closely based on the Office of National Statistics personal wellbeing questions used in the Annual Population Survey.

From a low starting point, people report significant improvements in all questions relating to their wellbeing. The greatest improvement is in life satisfaction.



Improved experience of services

This measures people's experience and perception of their care, covering the quality of the interaction with professionals and how well the service is organised. The last two questions were added for these services to understand their impact on integrating care.

The starting point is relatively high, but people's experience still improves across the board. The lowest score on referral is that services don't talk to each other, and this improves significantly.

Social prescribing services operate at a human level – getting to know and understand people to support them to make a difference to their life and their health. Understanding the impact the service makes from their perspective is therefore very important and the R-Outcomes measures allow us to do this for large numbers of people.

Taken together, these self-reported outcome measures tell a good story about the impact of social prescribing services on individuals. What stands out is that the greatest improvements are in the things that are hard to measure objectively, but that we know are important – such as people's sense of their wellbeing and their confidence in their relationship with the services that are there to help them. This is what social prescribing aims to do and these measures provide evidence that it works.

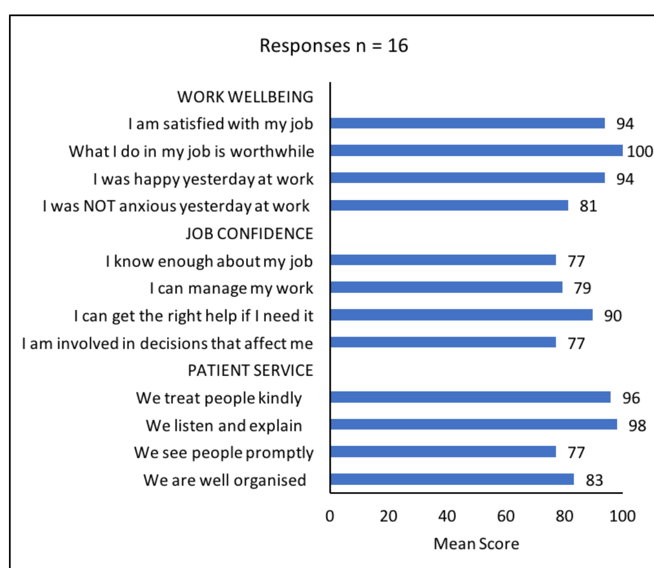
3.2 Qualitative interviews and case studies

Each of the services regularly collected case studies that recorded what the service does and the difference it made. Case studies can be used to help explain and describe the service to others and identify areas for further development. We analyse them for themes that demonstrate their impact and triangulate these with the R-Outcomes findings. We often supplement the case studies by arranging for experienced researchers to undertake qualitative interviews with clients, carers, staff or stakeholders. Here is a summary of the key themes from interviews with twelve people supported by one of the services:

Theme	Quotes
Communication Is greatly improved, a central point of contact, feedback and more time to listen	"I am now aware of the process and who to contact which makes life much easier" "She gave regular updates and kept the carer informed and alerted to any issues"
Continuity of care Is improved by greater accessibility and frequency of contact by phone or visiting	"She said the day you can't manage you are to ring me and I'll arrange for someone to come out or I'll come out"
Holistic Addressing a wide range of needs, including those of carers	"I wasn't sure I could cope in this house on my own. She has got me absolutely everything I could need" "She looked at the needs of my wife too and asked 'what can we do for you?'"
Improved relationships Between patients, carers and professionals	"She had a nice manner. She didn't treat me as though I were senile"
Wellbeing	"This service is a lifesaver and has made a huge difference to our lives" "She is one of the best people I have ever met, who can come to you and not make you feel bad about yourself"

3.3 R-Outcomes for Staff

All of the services recognise the importance of their staff and many of them use the R-Outcomes staff measures to understand these. The following chart sets out the results from a recent survey of a team of social prescribers that had a 100% completion rate. Once again, each measure is scored out of 100 and the higher the score the better.



Social prescribing staff report a high level of wellbeing at work – very satisfied with their job, and top marks for feeling that their job is worthwhile.

Staff scored their confidence in delivering their role scores less highly – perhaps reflecting it is complexity and evolution. They report that they can get help when they need it.

Very high scores were reported for the level of personal service and empathy that they provide, but less good for the organisation of the service.

A number of the services collect these staff outcomes quarterly to understand how they change as the service develops.

Free text comments are also recorded that help the service understand their staff perspective.

3.4 Economic evaluation

All of these services had a key objective to reduce the use of emergency hospital activity. Each service started on non-recurrent funding and success with this objective was seen as key to the service being commissioned recurrently. Reduced use of emergency hospital services potentially releases resource that the Commissioner can re-direct to social prescribing.

We analysed the health records of the people supported by the service to see if there has been a change in the number of A&E attendances and emergency admissions to hospital – comparing the 120 days before referral with the 120 days after. A period of 120 days was chosen to recognise that it is often a recent deterioration in circumstance that can lead to a person being referred to or accessing a social prescribing service. The tables below summarise the results for two of the services that we have worked with

Mid Hampshire Healthcare Proactive Care Team
Analysis of 1757 patient records

	No 120 days before referral	No. 120 days after referral	Reduction
A&E attendances	670	462	-31%
Emergency admissions	494	334	-32%

Eastleigh Southern Parishes Care Navigators
Analysis of 183 patient records

	No 120 days before referral	No. 120 days after referral	Reduction
A&E attendances	94	47	-50%
Emergency admissions	63	43	-32%

The reduction in emergency hospital activity following support is impressive. We have done this analysis for other social prescribing services which has found a range of 20%-50% reduction in A&E and 32%-35% reduction in emergency admissions in the 90 or 120 days following referral. We model these reductions to calculate the potential annual value for commissioners using tariff costs. Our model assumed that the reduction observed over 120 days was not maintained at the same level for the rest of the year and that activity rates begin to rise again.

We are working to test these assumptions by looking at health care use over a longer period following support. This generates the following potential values of the reduced hospital activity and potential returns on investment if those savings were realised:

	Potential annual tariff savings	Potential return on investment
Mid Hampshire Healthcare	£2,715,000	222%
Eastleigh Southern Parishes	£627,000	225%

There are limitations to the analysis undertaken so far. Nevertheless, even with a large margin for error the activity and economic evidence for social prescribing looks strong.

This provides early evidence that social prescribing services have the potential to save more than they cost and that it may be a good commissioning decision to commission them recurrently on that basis. This is what has happened with both of these services

4. Social Prescribing Design Choices

The eight services providing social prescribing in Wessex are all different. By working with each of them we have identified a set of choices that need to be made when designing and developing a social prescribing service.

Which population?

Who do we want to target and access the service? The majority of the services target older people, typically over 80 years old, to help them better manage their health as they acquire long term conditions, or struggle to care for their partner, suffer bereavement or experience deterioration in their quality of life such as loneliness and isolation. However, we have found that those that set out with a clear age policy are likely to soon find people who are younger that they can help just as much. There is a move towards services being needs rather than age based. For example, Local Area Coordinators (LAC) on the Isle of Wight support a much younger demographic with an average age of 51.

How should people access the service?

Referrals from GPs and primary care are the most common way that people access these services. Where this works well, a social prescriber linked to a particular practice will be well known in the community and part of an integrated team. They will take referrals from GPs, from multi-disciplinary team meetings and from anyone who has a concern about someone, including reception staff. It is common to receive referrals from an extended range of sources such as community nurses, social workers and voluntary groups and some services target and encourage these wider relationships. LACs describe these as 'introductions' rather than referrals and they can come from anywhere, including people introducing themselves. Self referral is rare.

Who should run the service and where should it be based?

Of the eight services in Wessex, four are run by GP Federations, three by voluntary organisations and one by public health. There is some evidence that the GP Federation run services receive more referrals and can be busier. The voluntary organisations believe that they are often better placed to understand and access support options from the community. All of the services apart from the LACs are primarily based in General Practice. The LAC service is run by public health and based within the broader community.

Who should do it?

The majority of people providing these services are non-clinical staff. As these services have set themselves up they have recruited very good people from a range of backgrounds. They are typically looking for people with experience of direct contact with clients, that have empathy and a commitment to make a difference, can develop a detailed understanding of the services available, can deal with complexity and work well in teams. Once in post, people appear to stay and commit to the role – the main retention problems result from the uncertainty of fixed term contacts. Two of the services combine clinical and non-clinical roles to good effect to also provide clinical review and care planning.

It is less clear how effective it is when the service is provided by volunteers. The Making Connections service originally planned to partner paid coordinators, to undertake the guided conversation, and volunteers to support the resulting actions. However, they were unable to recruit enough volunteers so changed their model.

At what scale?

There is a range in the scale of investment and workforce across these eight services. The Eastleigh Southern Parishes (ESPN) Care Navigators and Mid Hampshire Healthcare (MHH) Proactive Care Teams have approximately 1 member of staff per 10,000 people. There are half as many Care Navigators in the New Forest, and whilst they have a positive impact for their patients, the economic benefit was around two-thirds less than in ESPN and MHH. On the Isle of Wight there are 1 Care Navigator and 1 LAC per 15,000 population (or one social prescriber per 7,500). Making Connections have one Coordinator per 37,000 population and whilst they deliver improvement, compared with the larger scale services the economic benefit is less and people can wait longer once referred. For Surgery Signposters there are 19 trained volunteers working across 5 practices, supported by one paid member of staff to train and manage them. Only ESPN provide a seven day service – the 5 Care Navigators work a rota with one of them on duty each weekend to support patients that need them and support discharge from hospital. The amount of cover for annual and sick leave is variable – and this is important if the service is to become mainstream.

How long are people supported for?

There appear to be two broad camps. For some services the aim is to 'walk with' the person for as long as they are needed and for others it is to provide a set piece of intensive support over a few weeks/ couple of visits. Both approaches can be very effective in improving R-Outcomes and reducing emergency activity and we are currently looking at whether these improvements last longer in one than the other. As a rule, the longer term model tends to support people with higher levels of need.

Engagement with General Practice

We have seen wide variation in how General Practice engages with social prescribing services. At its best the social prescriber is seen as part of the primary care team, has a base in the practice, attends multi-disciplinary meetings to review patients and accesses and inputs to patients' electronic health records. A minority of practices doesn't engage with social prescribing and doesn't refer patients. However, this is changing as more evidence about the impact of these services is known. It is important that our health systems set the expectation that all people should have the opportunity to benefit from social prescribing initiatives.

Active ingredients for success

We have started to work with services to identify the 'Active Ingredients' that were present for them and that enabled them to make the impacts identified in our evaluatioin. This helps develop and share the learning on how new models of care can spread. For the Making Connections service the Active Ingredients that support their model were identified as:

- Co-design with stakeholders and partners was essential
- Having the time to develop the relationship with the client though guided conversations.
- Having General Practices bought in.
- Being part of the Multi-Disciplinary Team as an equal player is essential.
- Having good local knowledge and connections with a wide range of voluntary and statutory organisations and services

5. Conclusions

Our work with these eight social prescribing services in Wessex has convinced us of their importance and their potential to positively impact on the lives and health of individuals, and to shift the pattern of care away from emergency hospital activity.

They are all still relatively new and still developing. Through measuring and evaluating their outcomes we want to understand the different impacts made by the different approaches being taken. This paper describes what we have found so far, and we will continue to work with the services in the coming year to deepen our understanding and share what works. It is hoped that our learning will support the spread of social prescribing to enable more individuals to benefit from the opportunities offered by this model of care.

All of them started with non-recurrent funds. The good news is that because of the evidence of what they achieve, four are now commissioned services.

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