



# **Social Prescribing in Tower Hamlets: Evaluation of Borough-wide Roll-out**

**1 December 2016 – 31 July 2017**

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## **Acknowledgements**

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## Executive Summary

Tower Hamlets has a history of providing social prescribing in two GP practices, the Bromley-by-Bow Centre and the Mission Practice. In 2016, Tower Hamlets Clinical Commissioning Group funded an 18 month roll-out of social prescribing across the borough with the local GP federation, Tower Hamlets GP Care Group, acting as lead provider organisation. The service is delivered by 10 Social Prescribers (9 WTE) through Tower Hamlet's 8 GP Networks. Each GP practice has a named Social Prescriber.

The evaluation looked at the first 8 months of the roll-out, from 1 December 2016 to 31 July 2017. A range of quantitative and qualitative data sources were used to describe the service during the evaluation period and to assess how well the service met its evaluation objectives, recommending service developments in the short term and an ideal model to work towards in the longer term. The next section summarises these findings.

## Evaluation key findings

### Activity overview:

2,270 referrals were received during the first 8 months of the roll-out. Of these:

- 70% were aged between 30 and 64 and 12% aged over 65 years
- 60% were female and 40% male
- 53% were Asian/Asian British, the majority of whom (90%) were Bangladeshi, reflecting the diversity of the local population
- 52% had at least one long term health condition.

A similar proportion of clients were consulted on the phone and seen face –to-face. Of those who were seen face-to-face, 29% were seen more than once.

### **Evaluation objective 1: To explore the extent to which the programme has embedded itself within the Tower Hamlets primary care system and its impact on the range of services available to users and the impact on those services - objective met**

The extent to which the service has become embedded within primary care is highlighted by the increase in, and sustained high level of, referrals during the first 8 months of the roll-out and the fact that referrals have been received from every practice and from a diverse range of professionals across the primary care system, including from 80% of GPs and GP Registrars. This is supported by the feedback from key stakeholders, which has demonstrated how valued the social prescribing service is locally.

The range of needs Social Prescribers have supported clients with demonstrates how holistic the service is (for example, 24% clients presented with weight management issues,<sup>1</sup> 21% with low level mental health needs, 16% with social isolation, 13% with housing issues and 13% with financial concerns) and the high number of onward referrals and signposts (2,034) to a large range of organisations (333 activities across 279 organisations) in the borough highlights the breadth of

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<sup>1</sup> The high proportion of clients presenting with weight management needs reflects the fact that the two existing schemes acted as a gateway to a previous 'Health Trainer' programme. It is likely that data for the next contract reporting period will present a different weighting of needs.

services available to primary care users through social prescribing. Nearly a quarter (22%) of clients receiving an onward referral or signpost were given 3 or more referrals.

Although there is more work to be done to fully understand the impact the service has had on the voluntary and community sector (VCS), and there are indications that capacity within the sector may be insufficient to cope with rising demand, the high attendance at, and feedback from, the Social Prescribing Forums and Breakfast Events, as well as suggestions made by the VCS for more regular service updates, highlights the willingness of the local VCS to engage with social prescribing, which will continue to strengthen the service offer.

### **Evaluation objective 2: To assess the improvement in health and wellbeing of users of the social prescribing programme - objective met**

Improvements in health and wellbeing have been demonstrated by both service users and referrers. There were improvements in client's main concerns and wellbeing scores, measured using Measure Yourself Concerns and Wellbeing (MYCaW), a validated assessment tool, after their interactions with the social prescribing service (the average improvement for client concerns was 1.5 and 1.39<sup>2</sup> and 0.96 for wellbeing, on a 6-point scale). Service users interviewed were positive about the service and cited being able to talk to someone and voice concerns, appointment length, the support services available in the community and the Social Prescribers themselves as aspects of the service they valued. Feedback shared by key stakeholders involved in delivering or referring into the programme was also positive, for example 99% (177) respondents to the survey of referrers in primary care<sup>3</sup> felt social prescribing brought some benefits to the wellbeing of their patients. Although numbers are unclear, a number of clients have gone onto training, volunteering or employment as a result of consulting with a Social Prescriber, which is known to have a significant impact on health and wellbeing.

### **Evaluation objective 3: To understand the experience of referring into and delivering the programme - objective met**

99% (176) respondents to the referrer survey wanted the service to continue and 98% (175) felt that social prescribing offered some benefit to them in their profession. They cited that it offered a patient-centred approach that supports general practice and makes a significant difference to patient lives. The referral process was felt to be straight-forward, particularly where EMIS could be used and where appointments could be booked directly through reception staff. Wider stakeholders felt that the scheme had been well received by practices and partners across the borough and that there was a discernible impact on the wider primary care system as well as on the experience of patients.

However, the following issues for consideration were raised:

- Some referrers felt that the feedback they received about patients could be improved.
- The current volume of referrals was felt to be too high for the existing service capacity, and with increasingly complex referrals, the level of clinical supervision provided was felt to be insufficient for the Social Prescribers. This is likely to have contributed to high Social Prescriber staff turnover (around 40%) during the initial stages of the borough roll-out.

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<sup>2</sup> In MYCaW clients are asked to describe and score their top two concerns and their general feeling of wellbeing at baseline, and score them again at follow up, conducted at least 12 weeks after their first appointment.

<sup>3</sup> Data from survey of referrers in primary care – 183 responses received from 35 out of 37 practices.

#### **Evaluation objective 4: To assess the extent to which social prescribing can facilitate community development in terms of connecting residents with each other for support - objective partially met**

Despite not having capacity within the current programme to develop this ambition fully across the borough, a few new initiatives for this purpose have been established within two of the networks with pre-existing programmes, for example where activities such as a walking group, a gardening group, informal tea session, a peer-led craft group for wellbeing and a menopause support group have been piloted, and where patients have been referred into the borough time-bank scheme, EastXChange. There is also evidence of residents meeting each other through other programmes prescribed through social prescribing, leading to new social interactions and engagement with different activities.

#### **Evaluation objective 5: To establish the cost savings of the programme within the context of health care and wider public sector budgets – objective partially met**

Evidence from the local programme has shown a demonstrable shift in demand through a 12.3% reduction in GP appointments between the 6 months before and 6 months after patients' appointments with a Social Prescriber (418 fewer appointments in a cohort of 890 patients who had seen a Social Prescriber). This is within the range found in other schemes (average 28%; range 2% to 70%).<sup>4</sup> National research has shown<sup>5</sup> an average reduction both in Accident & Emergency and emergency hospital admissions of 24%, as well as a statistically significant drop in secondary care referrals of 55% at 12 months. National studies have also demonstrated<sup>6</sup> that every £1 invested in social prescribing generates an annual social return on investment of £2.30, which means returns of £864,800 per year for the health and care system in Tower Hamlets.

#### **Evaluation objective 6: To recommend an ideal social prescribing service, including level of funding required - objective met**

The core elements of an ideal social prescribing model for Tower Hamlets were drawn out of the findings of the evaluation, costed at £600,000 per year. These include the following:

- 1) GP practice model of service delivery
- 2) Management resources
- 3) Service capacity and clear line-management for Social Prescribers
- 4) Equitable and competitive pay for Social Prescribers
- 5) Clinical supervision and psychological support for Social Prescribers
- 6) Data recording and reporting tools and processes
- 7) Resource for promotion of the service
- 8) Resource for service development (in addition to management resources).

With the following additional elements to be considered with further funding (not costed):

- 9) Reimbursement for the VCS
- 10) Expansion of the service to new health and social care areas.

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<sup>4</sup> Polley, M et al (2017) A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications, University of Westminster

<sup>5</sup> Ibid.

<sup>6</sup> Ibid.

## **Conclusions**

Social prescribing is valued by professionals and patients across Tower Hamlets and has been shown to fill an important gap in the local health system, in terms of addressing patients' social determinants of health and increasing the awareness of patients of the VCS services available in the borough, supporting them to manage their own health through better use of wider community assets.

The resource involved in developing a new service and the work undertaken and commitment by key stakeholders, in particular the Steering Group and the Social Prescribers themselves, to achieve this goal should not be underestimated. It is also important to recognise the advantages brought to the borough-wide scheme in being able to use the expertise from the two pre-established schemes.

The evaluation has indicated that as well as the many positive aspects of the current programme, there are areas for improvement in service structure and delivery and that at current levels of funding, the service is at capacity, despite the service being still in its infancy at a borough-wide level. These findings have informed a series of recommendations for service development in the short term and also proposals for an ideal future model for the service to work towards.

## **Recommendations**

Based on the findings of the evaluation and the level of need within Tower Hamlets, due to the high impact of the social determinants of health on the local population, this evaluation recommends that the borough-wide service continues and works towards building capacity to deliver the 'ideal model' for social prescribing in Tower Hamlets.

The following service developments are recommended in the short-term, which can be delivered within current resources:

- 1) Improve use of current service capacity
- 2) Standardise service structure and delivery across the borough
- 3) Streamline systems of data capture and reporting and strengthen evidence on patient outcomes
- 4) Continue and strengthen engagement with the VCS.



## 1. Background

As demonstrated by the Marmot Review on health inequalities,<sup>i</sup> there is a close association between socio-economic factors and health outcomes. Other research has shown<sup>ii</sup> that in England, GPs spend nearly a fifth of their consultation time dealing with non-medical issues at a cost of £395 million per annum, equivalent to the salaries of 3,750 full-time GPs. Almost three-quarters of GPs state that the proportion of time they spend dealing with non-health issues as part of consultations has increased.

Residents in Tower Hamlets experience poorer health outcomes than the general population.<sup>7</sup> The reasons for this are the impacts of the social determinants of health: the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. For example, Tower Hamlets has the highest child poverty rate (49%), the lowest life expectancy for men (77.5 years) and the second highest unemployment rate (8.8%) in London.<sup>iii</sup> In deprived areas patients often visit their GP for reasons other than clinical problems as a result of not knowing where to get support for their wider social issues, which have a significant, negative impact on their health. Social Prescribers are link workers, based in GP practices, who support primary care patients with their non-clinical needs and help them to access appropriate support within the local community, for example around volunteering, employment, benefits, housing, debt, parenting and physical activity.

Tower Hamlets has a history of providing social prescribing in two GP practices, the Bromley-by-Bow Centre and the Mission Practice.<sup>8iv</sup> In 2016 Tower Hamlets Clinical Commissioning Group (THCCG)<sup>v</sup> funded the borough-wide roll-out of social prescribing for an 18 month period with the local GP federation, Tower Hamlets GP Care Group (THGPCG),<sup>vi</sup> acting as lead organisation. There are now 6 local primary care providers delivering the scheme.

## 2. Introduction

This evaluation looks at the first 8 months of the borough-wide service, from 1 December 2016 to 31 July 2017. It provides a summary of national and local policy and evidence on social prescribing (**Sections 4 and 5**); an operational overview of the roll-out (**Section 6**); and assesses how it has met its objectives (**Section 7**). It reviews service activity and feedback from key stakeholders to explore questions such as the impact on the health and wellbeing of service users, how embedded the service has become within primary care and return on investment. The evaluation has been undertaken part way through the roll-out in order for the findings to inform commissioning decisions during 2017/18 and service development.

The extended service was able to build on the learning from the two existing schemes. As such, the focus of the evaluation is more on reflections of expanding the scheme across a wider geographical area, than the processes involved in establishing a new social prescribing scheme. Local embedding of the extended service, with 6 different providers, has meant that slightly different delivery models evolved across the borough. In this evaluation the service will be reviewed as a combined, borough-wide service, but, where relevant, local details will be drawn out to inform the proposed model for future delivery of social prescribing in Tower Hamlets.

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<sup>7</sup> For a detailed profile of the population in Tower Hamlets, refer to the borough's Joint Strategic Needs Assessment - [https://www.towerhamlets.gov.uk/ignl/health\\_\\_social\\_care/joint\\_strategic\\_needs\\_assessme/joint\\_strategic\\_needs\\_asses sme.aspx](https://www.towerhamlets.gov.uk/ignl/health__social_care/joint_strategic_needs_assessme/joint_strategic_needs_asses sme.aspx)

<sup>8</sup> Social Prescribing schemes have existed at the Bromley-by-Bow Centre since 2011 and at the Mission Practice since 2013.

### 3. Evaluation objectives and methods

#### 3.1 Objectives

The objectives of the evaluation were agreed by the Social Prescribing Steering Group, which is comprised of experts from Public Health at Tower Hamlets Together, two local GPs, one GP Network Manager from the lead provider (THGPCG), a Social Prescriber from the Mission Practice, a social prescribing development specialist from Bromley-by-Bow Centre, the lead commissioner from THCCG and the Partnership Manager from Tower Hamlets CVS. The objectives reflect the expectations of commissioners of the service, as well as the experience of providers delivering the service and of service users. They ask a broader range of questions than the original aims of the roll-out, which are largely operational, but cover those which are related to service development.<sup>9</sup> The objectives are outlined in Figure 1 below.

The evaluation is structured to answer each of these objectives in turn. In addition to answering the objectives, the evaluation begins with an overview of service activity within the evaluation period to understand referral numbers, the client profile and use of service capacity.

**Figure 1: Evaluation objectives and data used to assess objective achievements**

Evaluation item or objective	Data source
<i>Activity overview (Section 7.1)</i>	<ul style="list-style-type: none"> <li>• Data from case management system on referral numbers over time, client profile (age, sex, ethnicity, long term health conditions, disabilities), use of social prescribing capacity</li> </ul>
<p>1. To explore the extent to which the programme has embedded itself within the Tower Hamlets primary care system, its impact on the range of services available to users and the impact on those services (section 7.2)</p>	<ul style="list-style-type: none"> <li>• Data from case management system on referrals by practice and by professional; client needs; onward signposting and referrals; gaps in support services</li> <li>• Interviews<sup>10</sup> and survey of referrers within primary care<sup>11</sup></li> <li>• Interviews<sup>12</sup> and survey of local voluntary and community sector (VCS) organisation representatives<sup>13</sup></li> <li>• Focus groups with Social Prescribers<sup>14</sup> and Social Prescribers' managers,<sup>15</sup> and interviews with Steering Group members<sup>16</sup></li> <li>• Feedback from clients collected as part of Measuring Yourself Concerns and Wellbeing (MYCaW) follow-ups</li> <li>• Client case studies</li> </ul>

<sup>9</sup> These include the following aims of the roll-out: to identify a model or models that are scalable across the borough; identify what resources a scalable model would require; build local evidence of the benefits; reduce GP attendances.

<sup>10</sup> 5 interviews were conducted with GPs, practice nurses and health care assistants

<sup>11</sup> Survey distributed to all practices within the borough during August 2017; 183 responses received from 35 out of 37 practices; copies of the full survey report available on request.

<sup>12</sup> A group interview conducted with 3 VCS representatives and another with 3 members of the Wellbeing in Tower Hamlets (WITH) Forum

<sup>13</sup> Survey distributed through Tower Hamlets CVS to local VCS organisations during September 2017; 47 respondents from 46 organisations; copies of the full survey report available on request.

<sup>14</sup> Focus group with 8 participants

<sup>15</sup> Focus group with 5 participants

<sup>16</sup> 6 interviews were conducted

Evaluation item or objective	Data source
2. To assess the improvement in health and wellbeing of users of the social prescribing programme ( <b>Section 7.3</b> )	<ul style="list-style-type: none"> <li>• MYCaW scores and feedback</li> <li>• Data from case management system on volunteering and work opportunities taken up</li> <li>• Interviews and survey of referrers within primary care</li> <li>• Focus groups with Social Prescribers and Social Prescribers' managers, and interviews with Steering Group members</li> <li>• Client case studies</li> </ul>
3. To understand the experience of referring into and delivering the programme ( <b>Section 7.4</b> )	<ul style="list-style-type: none"> <li>• Interviews and survey of referrers within primary care</li> <li>• Focus groups with Social Prescribers and Social Prescribers' managers, and interviews with Steering Group members</li> <li>• Feedback from clients as part of MYCaW follow ups</li> </ul>
4. To assess the extent to which social prescribing can facilitate community development in terms of connecting residents with each other for support ( <b>Section 7.5</b> )	<ul style="list-style-type: none"> <li>• Information about social prescribing models across Networks</li> <li>• Client case studies</li> </ul>
5. To establish the cost savings of the programme within the context of health care and wider public sector budgets ( <b>Section 7.6</b> )	<ul style="list-style-type: none"> <li>• Total costs of delivering the scheme</li> <li>• EMIS search to examine changes in primary care use</li> <li>• National research on return on investment, including cost savings within secondary care discussed in here and in <b>Section 5.1</b>.</li> </ul>
6. To recommend an ideal social prescribing model, including level of funding required ( <b>Section 7.7</b> )	<ul style="list-style-type: none"> <li>• Interviews and survey of referrers within primary care</li> <li>• Interviews and survey of local VCS organisation representatives</li> <li>• Focus groups with Social Prescribers and Social Prescribers' managers, and interviews with Steering Group members</li> <li>• Estimated costs</li> </ul>

### 3.2 Methods

This is a mixed-methods evaluation, incorporating quantitative and qualitative elements. How these elements were used to answer the objectives is outlined in Figure 1. For more detail on the evaluation methods and protocol followed, including how consent was sought, refer to **Appendix 1**.

There is no ideal tool for assessing the journey that people make in terms of social prescribing and to measure the impact on their health and wellbeing and other positive changes in their lives, given the broad nature of support Social Prescribers can facilitate access to. On discussion with national experts and the Social Prescribers, it was agreed that MYCaW was the best available tool to help make this assessment locally, in conjunction with service activity data and stakeholder feedback.

## 4. Policy context

### 4.1 National policy

Social prescribing was highlighted in the 2006 White Paper *Our health our care our say*<sup>vii</sup> as a mechanism for promoting health, independence and access to local services. The objectives of social prescribing also support the principles set out in subsequent NHS policy documents, including the *NHS five year forward view*,<sup>viii</sup> which encourages a focus on prevention and wellbeing, patient-centred care, and better integration of services, as well as highlighting the role of the VCS in delivering services that promote wellbeing. The subsequent *Next steps on the NHS forward view*<sup>ix</sup> document stated how the NHS “will work collaboratively with the voluntary sector and primary care to design a common approach to social prescribing”. The *General practice forward view*<sup>x</sup> has also emphasised the role of voluntary sector organisations in efforts to reduce pressure on GP services, including through social prescribing specifically.

There is an increasing amount of guidance on social prescribing available for commissioners and stakeholders in the NHS and local government, as well as a Social Prescribing Network<sup>xi</sup> set up to provide support and share practice on social prescribing at a local and national level. Over 100 schemes are now in place nationally. In June 2016, NHS England appointed a national clinical champion for social prescribing to advocate for schemes and share lessons from successful social prescribing projects, as well as appointing a social prescribing development manager with a small team. A fund of £4M from the Department of Health’s Wellbeing Fund will be allocated to successful new and expanding social prescribing projects in 2018.

### 4.2 Local policy

In the consultation for the London Mayor’s Health Inequalities Strategy,<sup>xii</sup> the Mayor stated that he would like more people to have the power to act on the things that affect their health. This includes more people having access to groups, places and networks that make their community a healthy place. Social prescribing is cited as a way to refer people to community-based services. The Mayor’s key ambition is to support the most disadvantaged Londoners to benefit from social prescribing to improve their health and wellbeing.

Social prescribing also supports the delivery of other local priorities, outlined in the East London Health and Care Partnership’s plan<sup>17, xiii</sup>, the Tower Hamlets Together Population Health Strategy<sup>xiv</sup> and the Tower Hamlets Health and Wellbeing Strategy.<sup>xv</sup>

## 5. Evidence base for social prescribing including associated reduction in healthcare service use

### 5.1 National evidence

The evidence base for social prescribing has grown with the increase in the number of schemes established across the UK. A recent review of community referral schemes (social prescribing),<sup>xvi</sup> based on 42 studies, identified the following, wide-ranging benefits of social prescribing:

- Increase in self-esteem and confidence, sense of control and empowerment
- Improvements in psychological or mental wellbeing, and positive mood

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<sup>17</sup> Tower Hamlets, Sustainability and Transformation Plan work

- Reduction in symptoms of anxiety and/or depression, and negative mood
- Improvements in physical health and a healthier lifestyle
- Increases in sociability, communication skills and making connections
- Reduction in social isolation and loneliness, support for hard-to-reach people
- Improvements in motivation and meaning in life, provided hope and optimism about the future
- Acquisition of learning, new interests and skills, including artistic skills
- GPs provided with a range of options to complement medical care using a more holistic approach
- Reduction in number of visits to a GP, referring health professional and primary or secondary care services.

Reduction in use of primary and secondary care services was the subject of another recent review, which looked specifically at the impact of social prescribing on healthcare demand.<sup>xvii</sup> This review found that demand on GP services reduced by an average of 28% (range 2% to 70%) among evaluated schemes. Furthermore it showed an average reduction in Accident & Emergency attendances of 24% (range 8% to 27%) and an average reduction in emergency hospital admissions of 24% (range 6% to 34%). One study reported in the review also found a statistically significant drop in secondary care referrals of 55% at 12 months and 64% at 18 months. The broader, social return on investment of social prescribing was found to be £2.3 per £1 invested in the first year.

## 5.2 Evidence from pre-existing local schemes

These national findings are supported by the findings of previous evaluations of local schemes in Tower Hamlets. Of the 172 people interviewed about social prescribing as part of the 2015 evaluation of social prescribing at the Mission Practice, 75% said that working with the Social Prescriber improved their feelings of mental wellbeing and confidence, while their reported levels of poor or very poor health reduced from 53% to 13%. The same evaluation also demonstrated a 6.1% reduction in visits to the GP by those who took part in the social prescribing scheme three months after their initial referral.<sup>xviii</sup>

An evaluation of the Bromley-by-Bow Social Prescribing scheme in 2013<sup>xix</sup> also showed a high level of benefit to patients: 71% of people interviewed about social prescribing (n=28) felt the service had helped to make some or a significant improvement to their lives and 75% stated that the issue for which they were referred was partially or fully resolved. 68% of people felt they probably/ definitely would not have accessed the relevant support service if they had not been referred via the Social Prescriber. Additionally 50% of interviewees felt a bit or a lot healthier as a result of the service, 54% rated their mental health as a bit or a lot better than before they were referred, 79% felt confident a bit or a lot more of the time and 32% felt their ability to perform their usual activities had got a bit or a lot better. In addition, 36% had made new friends, 25% had lost weight, 25% had started eating more healthily, 18% had become more active in the community, 18% had started to look after their health more, and 32% had become more physically active since they were referred.

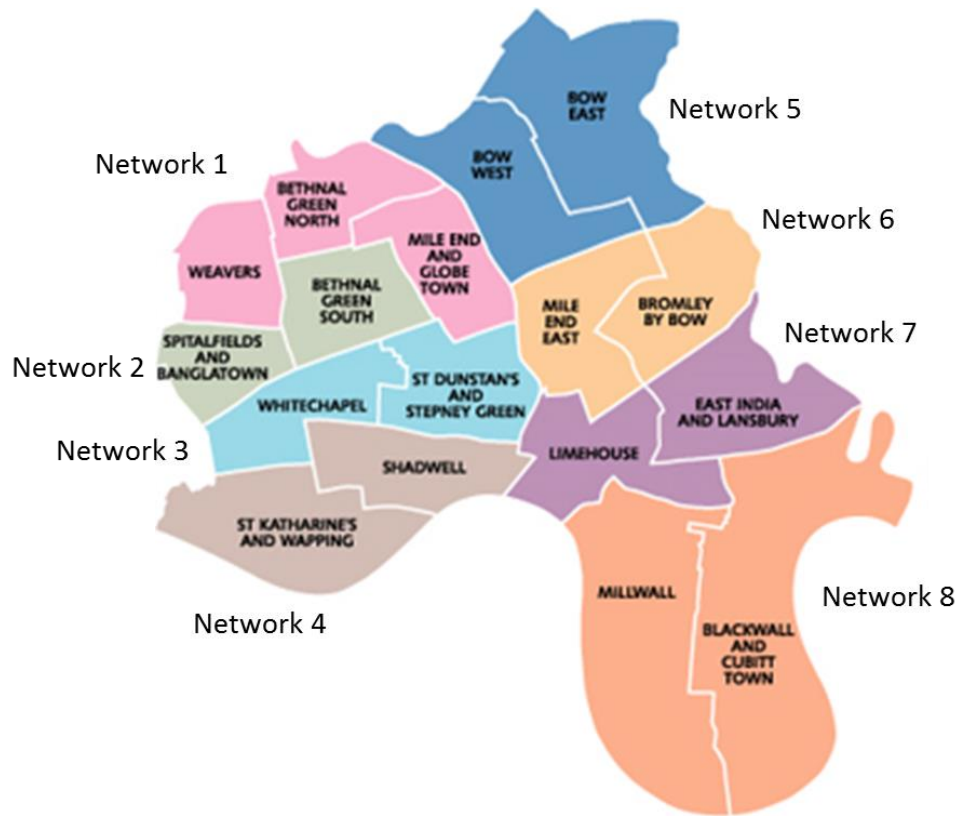
## 6. Overview of the service

The borough roll-out built on the structure and service delivery models for social prescribing which were developed in the two pre-existing schemes.

There are 37 GP practices in Tower Hamlets, arranged in 8 GP Networks (refer to Figure 2 for a map of the Networks). There are currently 6 providers delivering the social prescribing service, each covering one GP Network, with the exception of Networks 3 and 4, and Networks 7 and 8 which share a provider. There is a Social Prescriber linked to each of the borough's GP practices.

Whilst the initial establishment of a localised model, with multiple providers, led to some differences in the way the service operated across the GP Networks, over time these differences have become less so, as Social Prescribers and their Networks have learnt from the pre-existing services and each other. There do, however, remain some differences, which are outlined in this section.

**Figure 2: Map showing the GP Networks in Tower Hamlets**



## 6.1 Staffing

There are 10 Social Prescribers in post (equivalent to 9 working time equivalent (WTE)).<sup>18</sup> There is 1 Social Prescriber in each of the GP Networks, with an extra part-time Social Prescriber in Networks 1 and 6. This geographical distribution facilitates the embedding of the service within the local primary care infrastructure and is important for ensuring that Social Prescribers build their knowledge of, and engagement with, support services within the local community. Social Prescribers are allocated physical space for administrative work and to see patients in the majority of practices.

Social Prescribers are line managed by the Network Manager in their GP Network. The multi-agency strategic Steering Group oversees service delivery, providing expertise and project management, driving and overseeing service developments, including around data recording, helping to rectify any operational issues and supporting service evaluation (refer to **Section 3.1** for the membership of the group). The Steering Group is an integral part of the service. Additional one-off capacity to support this evaluation was provided by researchers at UCL, a local GP and an Engagement Manager from THCCG, whilst on placement at Tower Hamlets Together.

<sup>18</sup> The service has additional support from 1 Macmillan-specific Social Prescriber, who works borough-wide with people living with and beyond cancer. It should be noted, however, that the Macmillan social prescribing service is not funded as part of the borough programme, and is not covered by this evaluation.

From June 2018, capacity within the Steering Group will be reduced, with the loss of the two representatives from Public Health at Tower Hamlets Together. The lack of on-going evaluation capability and reduced capacity on the Steering Group needs to be considered within future service planning.

## **6.2 Training and support**

All of the Social Prescribers are required to undertake the following training as part of their contract:

- Motivational Interviewing
- Making Every Contact Count (MECC)<sup>xx</sup>
- Information Governance
- Basic Life Support
- Safeguarding.

They have also been trained in MYCaW (a validated tool used within the service to assess changes in wellbeing). Some Social Prescribers have also undertaken further training to support them in their roles, including Mental Health First Aid and EMIS (the primary care case management system).

In addition to line-management support, some of the Social Prescribers receive supervision and/or psychological support to support them in managing their more complex cases, funded by their individual Networks. There is currently variety in how this is provided across Networks, for example whether this is provided on a routine or adhoc basis. Its value is recognised and work is being undertaken to ensure that there is routine provision for all Social Prescribers.

## **6.3 Referral criteria**

The social prescribing service has a broad service referral criteria, with the only restrictions being clients who are registered with a Tower Hamlets GP, have expressed a non-clinical support need and age: all of the Networks accept referrals from those aged 18 and over, with Network 1 also seeing clients aged 16-18. Social Prescribers do, however, support parents with issues related to their children.

## **6.4 Referral process**

The referral process differs slightly across the different GP Networks. Where Social Prescribers have access to EMIS<sup>19</sup>, referrals generally come via EMIS, otherwise hard copy referral forms are used. Self-referrals are also accepted and can be made over the phone, via email, or via reception staff.

## **6.5 Consent**

Consent is sought by the referrer to make patient referrals to Social Prescribers. Where Social Prescribers have access to EMIS, consent is sought from patients for Social Prescribers to access patient information on EMIS relevant to the management of their case, following agreed information governance protocols. Social Prescribers also seek consent from patients to feedback details of their consultation to the referrer.

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<sup>19</sup> Social Prescribers have access to EMIS in 6 out of the 8 Networks.

## 6.6 How Social Prescribers work with clients

Client consultations are conducted either on the telephone or in face-to-face appointments, depending on need. Some Social Prescribers do more of their consultations on the telephone and others do more face-to-face appointments. During the initial consultation, where possible, Social Prescribers use MYCaW to facilitate clients to articulate their top two concerns and their feelings of general wellbeing (refer to **Section 7.3.1** for further discussion of MYCaW).<sup>20</sup> These and any other needs are discussed during the course of the consultation and referrals or sign-posts are made to organisations which can support those needs. The majority of these support organisations are in the voluntary and community sector or informal support groups, although some referrals are made to statutory organisations. To ensure clients can make the most of onward referrals and sign-posting Social Prescribers use a range of motivational interviewing, goal-setting and coaching skills in their discussions with clients.

In five of the Networks, in exceptional circumstances, Social Prescribers accompany clients to services. Similarly, in three Networks, where felt necessary on an individual client basis, Social Prescribers offer home visits, for example for those who are housebound. Refer to **Appendix 2** for a flow chart describing a typical client pathway through the social prescribing service.

Face-to-face sessions with clients generally last around 30 minutes, but one Network spends an average of 60 minutes with each client. Most Networks place no restriction on the number of consultations a client may have with a Social Prescriber, but two apply a guide to the maximum number, ranging from 4 to 6. Refer to **Section 7.1.3.1** for further discussion of number of consultations clients have.

It is recommended that further work is undertaken to understand the reasons behind the variance, such as time spent with clients, across Networks, so that the best practice can be shared to develop the service.

## 6.7 Feedback to referrers

Feedback is given to referrers in a number of ways. Where Social Prescribers use EMIS for their case management, the referring health professional can review the consultation notes directly without additional feedback being required. In some Networks, or where GP's have specifically requested it, feedback may be emailed or sent in a letter. Other means of feedback include as part of a monthly report on referrals received and verbal feedback given at clinical meetings.

## 6.8 Data recording

In Networks where the Social Prescribers have access to EMIS, EMIS is used for the majority of case management notes. Other Networks use a bespoke, secure Excel spreadsheet for data recording, based on Bromley-by-Bow Centre's data recording tool. Currently, even where Social Prescribers have EMIS access, Excel is used for capturing additional case management information for contractual reporting purposes. Stakeholders consulted for the evaluation highlighted the value of Social Prescribers having access to EMIS (refer to **Section 7.4.1.**) and facilitating access for Social

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<sup>20</sup> It should be noted, however, that during the time period covered by this evaluation not all Networks used MYCaW and that MYCaW is not used with every client. If the client is 'in crisis' then the Social Prescriber may make the decision that MYCaW is not appropriate as part of that consultation. There is also variety in the protocols followed for MYCaW across the Networks, with some only using MYCaW when seeing clients face to face.



Prescribers in all Networks is recognised by the Steering Group as important service development and is built into the ideal service model described in **Section 7.7.2**.

## 6.9 Promotion of the programme

The borough roll-out has been promoted in a number of ways within GP practices and the local community:

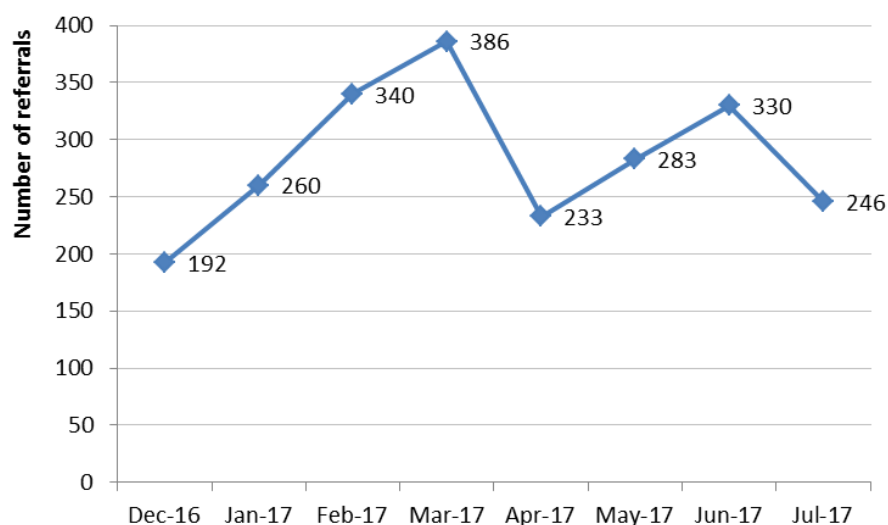
- A social prescribing leaflet – hard and electronic copies are available
- Floor-ceiling banners in GP waiting rooms
- Social Prescribers and Steering Group members attending protected learning time (PLT) events and practice meetings
- Steering Group members representing the programme at senior level meetings
- Regular Social Prescribing Forums and Breakfast Events for Social Prescribers to meet with VCS organisations, and exchange service information.

## 7 Evaluation results

### 7.1 Activity overview

#### 7.1.1 Number of referrals to social prescribing

**Figure 3: Number of referrals per month to social prescribing, 1 December 2016 – 31 July 2017**



Note: The peak in referrals in February and March reflects an increase in referrals in Network 6 generated as part of a short pilot to use new patient checks as a way to direct people to social prescribing.

There were 2,270 referrals made to social prescribing in Tower Hamlets between 1 December 2016 – 31 July 2017. Comparisons made with other schemes nationally, indicate that it is already one of the programmes with the highest referral numbers for its size and budget. This equates to an average of 8.2 referrals per Network per week, with a range across individual Networks from 4 to 15. These differences across GP Networks can be explained by a multitude of factors, including how embedded the service is (existing schemes have amongst the highest referral numbers), differences in capacity across Networks (variety in staff WTE and periods with vacant posts) and different strategies for processing referrals (for example, in some Networks referrers book clients directly into appointment slots placing an automatic limit on referral numbers within a given time period; in others, referrals

come to the Social Prescriber directly to process). It is important that any learning from the variance across the Networks and areas of 'best practice' are captured to inform service development.

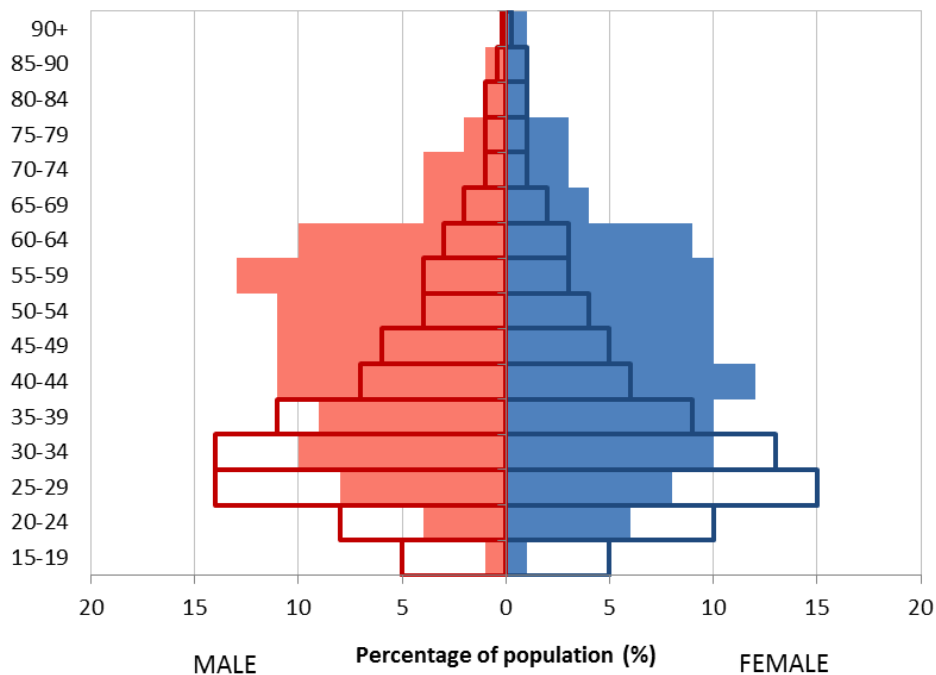
Figure 3 shows a general increase in referrals over time, although there is some fluctuation in the number of referrals received each month. The peak in referrals in February and March reflects an increase in referrals in Network 6 generated as part of a short pilot to use new patient checks as a way to direct people to social prescribing.

The sustained high referral numbers and general increase for a new programme demonstrates the progress that has been made embedding the service within the primary care system. (This is discussed further in **Section 7.2.1**) The high referral numbers have, however, contributed to high staff turnover of Social Prescribers within the programme (about 40%). This is something which should be explored to ensure that with any expansion of the scheme referral numbers are kept to manageable levels for the service capacity.

## 7.1.2 Client profile

### 7.1.2.1 Age and gender of clients

**Figure 4: Breakdown of clients referred by age and sex (solid colours) compared to Tower Hamlets population (outline), 1 December 2016 – 31 July 2017**



Note this does not include 51 records where age unknown/recorded as younger than age 15.  
 Source: client ages and sex from Social Prescribing database; comparison data from 2014-based subnational population projections for 2017 for Tower Hamlets<sup>21</sup>

Figure 4 shows that clients from a wide age range have accessed the service. The majority of clients were aged between 30 and 64 years (70%, 1,605) and 12 % (295) were aged over 65. 60% (1,359) referrals were female and 40% (904) were male (7 unknown gender). Compared to the population of Tower Hamlets as a whole, the population aged between 40 and 64 was largely over-represented

<sup>21</sup><https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2>

and the population under 40 under-represented in the cohort of clients accessing social prescribing. These findings correlate with what we know about primary care service users: higher consultation numbers for women and an increasing number of consultations with age (after childhood).<sup>xxi</sup>

### 7.1.2.2 Ethnicity of clients

**Figure 5: Proportion of clients belonging to different ethnic groups, compared to Tower Hamlets as a whole 1 December 2016 – 31 July 2017, where ethnicity recorded**

Ethnicities	Numbers of clients	% clients	Tower Hamlets comparison
Bangladeshi/Bangladeshi British	990	48%	32%
Asian/Asian British: all other	117	5%	9%
White	479	23%	45%
Black/Black British	248	12%	7%
Mixed ethnicity	152	7%	4%
Other ethnicities	92	4%	2%
<b>TOTAL</b>	<b>2270</b>		

Source: client ethnicity from Social Prescribing database; comparison from 2011 Census data for Tower Hamlets.<sup>22</sup>

Where ethnicity was recorded, over half of clients were recorded as being Asian/Asian British (53%, 1,107), with the majority of these (90%, 990) being Bangladeshi. As Figure 5 shows, the Bangladeshi population were over-represented in the social prescribing cohort and the White population under-represented compared to Tower Hamlets population as a whole. Data on the deprivation of clients is not currently collected as part of the programme, but it is likely that the ethnic breakdown of social prescribing clients reflects higher social needs amongst some ethnic groups, including the Bangladeshi population, and thus an appropriate use of the current service. In addition, several of the Social Prescribers speak some of the community languages, for example Bengali, a feature of the service which is likely to attract Bengali-speaking clients. That being said, these data are based on small numbers so cannot necessarily be taken as an indicator that the service is not reaching a population representative of the general Tower Hamlets population.

### 7.1.2.3 Clients with long term health conditions (LTHC) and disabilities

52% (1,180) clients are recorded as having at least one long term health condition (Figure 6)<sup>23</sup> and 17% (390) clients have multiple long term conditions. Due to issues with data recording<sup>24</sup> this is likely to underestimate the number of long term health conditions amongst the client cohort. In comparison, 23% of the population in England have a long term condition.<sup>xxii</sup> The higher proportion of LTHC amongst the cohort of patients accessing social prescribing reflects the relationship between the social determinants of health and LTHCs, for example having a LTHC can be both a symptom and a cause of deprivation. Furthermore, patients with chronic physical illness and mild to moderate depression and anxiety are a cohort which the social prescribing service was intended to work with, as part of the initial service specification and according to the data from this evaluation this is happening in practice.

<sup>22</sup> [https://www.nomisweb.co.uk/census/2011/DC2101EW/view/1946157257?rows=c\\_ethpuk11&cols=c\\_sex](https://www.nomisweb.co.uk/census/2011/DC2101EW/view/1946157257?rows=c_ethpuk11&cols=c_sex)

<sup>23</sup> The range across Networks was 21% to 81%.

<sup>24</sup> In Networks using EMIS, this data was extracted directly from the primary care system. Where Networks are not on EMIS, data on LTHC is only recorded where it is entered on the referral form, in connection to the reason for referral/ comes up in a conversation with a client.

**Figure 6: Breakdown of clients with long term conditions, 1 December 2016 – 31 July 2017**

Long term health condition identified		Number	Percentage of all referrals
Multiple LTHC (including mental and physical health conditions)		390	17.2%
Patients with singular LTHC	Depression/ Anxiety/ Dementia/ other mental health	272	12.0%
	Cardiovascular Disease/ Stroke/ Hypertension	152	6.7%
	Diabetes	145	6.4%
	Chronic Obstructive Pulmonary Disease /Asthma/ other respiratory disease	87	3.8%
	Other e.g. epilepsy	61	2.7%
	Chronic pain/ Arthritis	46	2.0%
	Cancer	8	0.4%
	Learning disability	8	0.4%
	Hypothyroidism	6	0.3%
	Chronic Kidney Disease	5	0.2%
<b>TOTAL WITH LTHC</b>		<b>1180</b>	<b>52.0%</b>
<b>TOTAL REFERRALS</b>		<b>2270</b>	

139 (6%) clients are recorded as having a disability. Again, due to issues with data recording, this is likely to underestimate the number of people with a disability who access social prescribing services. The most common recorded disability amongst this cohort was having a learning disability.

### 7.1.3 Service capacity

#### 7.1.3.1 Types of client engagement

Social Prescribers receive two types of referral: direct referrals and social prescribing referrals. The direct referrals are where the referrer indicates which service the client requires and the Social Prescriber makes the onward referral without directly contacting the patient. These clients use service capacity, but a limited amount. The second type of referral makes up the majority and in these instances the Social Prescriber phones the patient and either conducts the consultation with the patient on the phone or books a face to face appointment, depending on patient need.

**Figure 7: Levels of client engagement, clients referred 1 December 2016 – 31 July 2017**

Types of engagement	Numbers	%
Direct referral	198	9%
Phone advice only and signposting/referral (from one to multiple calls)	916	40%
Seen 1x face-to -ace	535	24%
Seen more than 1x face-to-face	239	11%
Seen face-to-face and accompanied to service	43	2%
Did not attend or engage (DNA)	339	15%
<b>Total</b>	<b>2270</b>	

As Figure 7 shows, during the first 8 months of the roll-out, 9% (198) of referrals were direct referrals. A slightly higher proportion of clients were consulted on the phone (40%, 916) than seen

face to face (36%, 817). As discussed in **Section 6.6**, Networks differ in the proportion of consultations they do on the phone and face-to-face. Face-to-face consultations use significantly more social prescribing capacity than phone consultations. The most time-intensive work is with clients who require multiple appointments (239, 11% clients) and those who are both seen face to face and accompanied to services (43, 2%).

It should be noted that this data represents a snapshot, based on the appointments of clients who were referred and seen between the 1 December 2016 and 31 July. It does not capture the appointments of other clients during that time period, where the patient was referred at an earlier date, nor follow the clients referred between these dates over a longer time period. It also captures the ‘highest’ level intervention the client had during the time period, i.e. if a client was consulted both on the phone and face-to-face, only the face-to-face contact would be captured. The data cannot be used to estimate the capacity burden in terms of time spent with clients. The level of intervention does not capture the additional preparation and follow up time Social Prescribers spend on each client case, in terms of for example, referrer liaison and onward referrals.

15% of referrals were unavailable for follow up or did not turn up for appointments or did not want to engage with the service. Social Prescribers have a policy of making at least two attempts at contact and leaving messages before clients are classed as a ‘DNA’, although the specific number of contact attempts and media used to make contact with clients who do not attend appointments or are uncontactable on the phone (email, text, letter etc.) varies across Networks. This highlights that even where clients do not attend, they still impact on service capacity. Comparative data from GP and secondary care appointments nationally indicates that this DNA rate is relatively high.<sup>25</sup> Since DNAs still use Social Prescribing capacity, it is important to understand, where possible, the reason behind DNAs and whether there is any learning around the appropriateness of referrals which could be fed into service development.

Of the 817 people seen face-to-face, 29% were seen more than once. There is a range in the complexity of the needs of clients, which is reflected in the number of appointments some clients require. As the data indicates some clients only require a single appointment. The reasons for this range from the Social Prescriber being able to resolve the client’s issue in single session to the client not being ready to access further support or not feeling that social prescribing was appropriate for them.

**Figure 8: Numbers of appointments for clients with >1 appointment, 1 December 2016 – 31 July 2017 (based on data from 2 Networks)**

No. of appointments	No. of clients in 2 Networks	% of clients	Estimated number of clients for whole scheme
2	51	54%	129
3	24	25%	60
4	10	11%	26
5	5	5%	12
>5	5	5%	12
<b>TOTAL CLIENTS</b>	<b>95</b>		<b>239</b>

<sup>25</sup> One report based on 5 CCGs estimated that the DNA rate for GP appointments was between 3.5% and 5% <https://www.gponline.com/10m-gp-appointments-lost-dnas-year-warns-gpc/article/1424483> and a report from the Health and Social Care Information Centre from 2013 showed the DNA rate for hospital outpatient appointments in England was 8.1% <http://content.digital.nhs.uk/article/4801/One-in-50-outpatients-who-miss-an-appointment-fail-to-attend-three-or-more-further-appointments-within-three-months>

Data was available from 2 Networks to show how many appointments clients who had more than one appointment had (Figure 8). 95 clients across these two Networks had 282 appointments between them, and nearly half (46%) had three or more appointments. This again shows the resource required to support some of the Social Prescribers' more complex clients.

### 7.1.3.2 Language of clients and use of interpreters

29 different languages were spoken across the clients referred to social prescribing. Where English was not the first language, Figure 9 shows that the next two most common spoken languages were Sylheti (22%) and Bengali (15%), reflecting the ethnic breakdown of the client group seen by Social Prescribers, indicated in Figure 5. These potential language barriers are challenges that may not be faced to the same extent in social prescribing schemes in other parts of the country, with a less diverse population.

**Figure 9: Breakdown of first languages of clients, where recorded and spoken by than more than 10 clients, 1 December 2016 – 31 July 2017**

Language	Number of clients	% of clients
English	829	57%
Sylheti	318	22%
Bengali	215	15%
Somali	26	2%
Turkish	12	1%
Arabic	11	1%
Other	50	3%

Data on interpreter need is extracted from EMIS. On EMIS 262 social prescribing clients are recorded as requiring an interpreter, which in many cases means additional time is required for client sessions and impacts on the quality of the therapeutic conversation. Four of the Social Prescribers speak relevant community languages, which helps alleviate these challenges. In other instances Social Prescribers use Language Line for telephone interpreter support with clients.

### 7.1.4 Activity summary

#### Referral numbers

- 2,270 referrals were made to social prescribing during the first 8 months of the borough roll-out.

#### Client profile

- 60% clients were female and 40% male.
- 70% clients were aged between 30 and 64 years and 12% were aged over 65.
- 53% clients were Asian/Asian British, the majority of whom (90%) were Bangladeshi.
- 52% clients are recorded as having at least one long term health condition, with 17% having multiple conditions.
- 6% clients are recorded as having a disability.

#### Use of capacity

- 40% clients were consulted over the phone.
- 37% clients had face-to-face appointments.
- 15% referrals did not attend/engage with the service.

Data on the service activity has also indicated the following issue for consideration:

- The high referral numbers have contributed to high staff turnover amongst Social Prescribers within the first 8 months of the roll-out (about 40%), which has affected service delivery. It is important that the reasons behind staff turnover are looked at to inform service development. It is recognised that staff support has not been optimal during the roll-out of the borough-wide service, and that the role of a Social Prescriber is complex and they have been seeing increasingly complex cases.
- It is important that the variation in referral numbers and ways the different Networks manage their referrals is investigated to inform ideal weekly referral numbers, to ensure that the scheme is able to grow sustainably and not overburden staff.
- It is important to understand, where possible, the reason behind patients not attending appointments and capture any learning around the appropriateness of referrals which could be fed into service development.

## **7.2 Objective 1: To explore the extent to which the programme has embedded itself within the Tower Hamlets primary care system, its impact on the range of services available to users and the impact on those services**

### **7.2.1 Embedding social prescribing within primary care**

In this section, referral data from the social prescribing case management system, alongside feedback received in surveys, interviews and focus groups with key stakeholders and client case studies will be used to demonstrate how the programme has embedded itself within the Tower Hamlets primary care system.

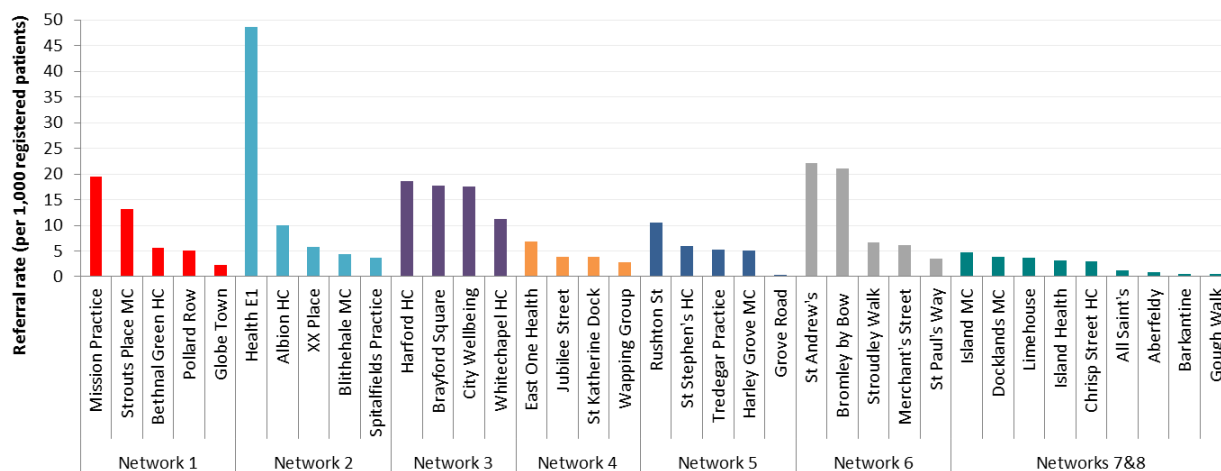
#### **7.2.1.1 Referrals by practice**

The extent to which social prescribing has been embedded uniformly across the borough can be shown using data on referrals by practice. Figure 10 shows that referrals have been made to Social Prescribing from every GP practice in the borough, even if to-date some have only made a small number of referrals (one practice only had 1 referral). Referral rates range from 1 to 49 per 1,000 registered patients, although as the graph shows the referral rate of 49 per 1,000 at Health E1 is an outlier, which reflects the complex patient profile of this practice<sup>26</sup> and how Social Prescribing fills a valuable gap in the overall support available for these patients. Perhaps unsurprisingly, some of the practices (but not exclusively) with the largest referral rates are in areas where social prescribing has been established for a number of years: Mission Practice in Network 1 and St Andrew's and Bromley-by-Bow in Network 6. Social prescribing in these practices has benefited from sustained levels of funding over a number of years and the stability this has provided has contributed to their success in embedding the service. Longer term funding of the borough-wide programme is required to build on the progress made in other practices and facilitate further embedding.

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<sup>26</sup> Health E1 is a practice for homeless patients, a population with many social needs appropriate for social prescribing

**Figure 10: Referral rates to social prescribing per GP practice, 1 December 2016 – 31 July 2017 (rates per 1,000 registered patients)**



Note: the practice was unrecorded in 18 cases.

Source: monthly referral figures from Social Prescribing database and practice population data provided by the GP Care Group.

The high referral numbers in some practices shows how successful the schemes have been in embedding themselves within the primary care system but the variation across practices highlights where the programme is still in its infancy and requires further work to build referral numbers.

If all practices referred at the rate of the practices with pre-existing schemes of 19/1,000<sup>27</sup> the 8 month referral number would be 6,144, increasing to 9,216 over the course of a year, compared to the 2,270 over 8 months and 3,405 annually at the current referral rate. This is an important issue to consider when looking at future capacity required for the service.

### 7.2.1.2 Referrals by profession

The extent to which Social Prescribing has been embedded across the primary care system as a whole can be shown using data on referrals by professional group. Referrals to social prescribing are encouraged from all professionals within primary care and individuals can also self-refer. During the first 8 months of the roll-out, over 415 different staff members within primary care referred clients to the service, 225 of which were GPs. There are currently 283 GPs and GP Registrars working in Tower Hamlets<sup>28</sup>, indicating that as many as 80% may have referred into Social Prescribing, which highlights the reach of the service across the borough.

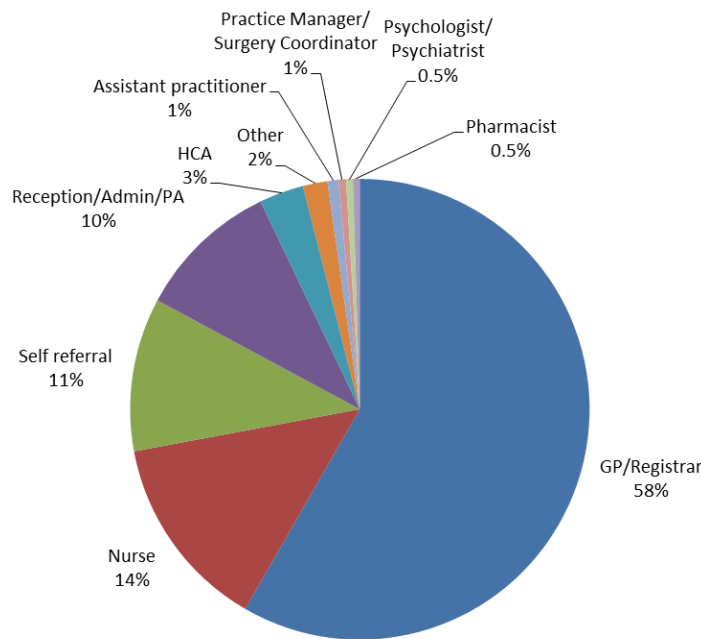
As Figure 11 shows, referrals came from a range of different professionals, with the majority coming from GPs (1,213, 58%) but, for example, 209 (10%) were from reception and administrative staff. These findings are important, since they indicate that there is awareness of and use of the social prescribing across the primary care system. The fact that referrals have come from staff other than GPs, in particular reception and administrative staff, is significant, since if patients' social needs are identified earlier or elsewhere in the patient pathway, it helps to reduce demand on GP capacity, allowing GPs to focus on patients' clinical needs.

<sup>27</sup> The real range for these practices was 19 – 22/1,000 but the lower rate was used for the modelling. It should also be noted that two of the new schemes achieved these practice referral rates.

<sup>28</sup> Data provided by the Tower Hamlets Community Education Provider Network



**Figure 11: Proportion of referrals received by profession, 1 December 2016 – 31 July 2017**



Note: the profession was unrecorded in 190 cases.

### 7.2.1.3 Stakeholder feedback

#### Social Prescribers as part of the local support system

Stakeholders who took part in the interviews and focus groups felt that Tower Hamlets was somewhat familiar with social prescribing, due to the pre-existing schemes. Furthermore, most stakeholders remarked upon a vibrant community and voluntary sector which provided opportunities for the scheme and had enabled its embedding into the local system. Additionally, with a greater national focus on social prescribing coupled with the need to address a myriad of issues in primary care, most stakeholders thought social prescribing ostensibly had a role to play in local service transformation.

*One GP said: '(I)wonder now how we managed without it - feel it's at the beginnings and has huge potential - also in helping us form links/conduits with local community/voluntary sector.'*

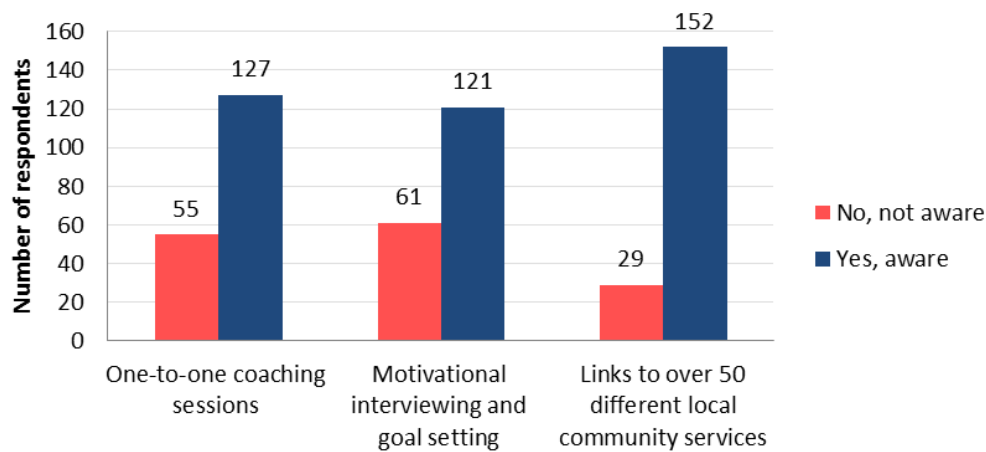
#### Awareness about the social prescribing service

The majority of respondents (77%, 140) to a survey conducted with referrers within primary care<sup>29</sup> had referred to the social prescribing service. Of the group who had not referred 7 were GPs. The main reasons for GPs not referring were a lack of information about what the service offers/who is appropriate to refer and lack of time within the appointment to discuss this with their patients. One was a new starter who was yet to become familiar with the service.

As shown in Figure 12, the majority of respondents (66%, 121) were aware of the services offered by the Social Prescribers. However, a number were not aware of all aspects of the service.

<sup>29</sup> 183 responses received from 35 out of 37 practices.

**Figure 12: Responses to question asking about awareness of services social prescribing offers**



The survey asked whether respondents were aware of the social prescribing patient leaflet, describing the service. 70% (127) had seen the leaflet with 31% (56) stating that they use it in clinical practice.

Survey respondents suggested that a directory of services be developed and made accessible to all. This would allow clinicians to be constantly updated with what services the social prescribing team are referring into. Potentially the clinicians could refer less complex patients directly using this resource or signpost clients to the directory to self-refer to reduce the demand for social prescribing appointments, allowing higher need patients to be seen quicker. They felt it could also be used as a resource for referrers to explain to patients what the social prescribing service can offer, which could help facilitate new referrals and improve their quality. There are some existing public directories of the local service offer which could be shared for this purpose. There is also work underway within Tower Hamlets Together to develop a ‘public facing portal’ which will bring together and supplement existing directories of local services.

A need to increase awareness of social prescribing was also raised within the focus groups and interviews conducted with key stakeholders. Social Prescribers raised the point that they are not always known to individual GPs but felt this was as a result of them spending, in most cases, just a few hours a week in any one practice. Only two Social Prescribers could claim to be ‘resident’ in their place of work and part of the surgery team – both of these were part of the schemes that had preceded the borough roll-out. Of the five clinicians who were interviewed, only one was aware that Social prescribers were physically based in practices. Some clinicians referred to meetings they had attended in the past outlining the scheme but felt regular ongoing information sharing or further meetings would be useful.

*‘But I think because here at this practice, we started with just me being employed here, a lot of supervision, clinical lead, and we feel very strongly that I’m kind of part of the team here, so it’s very different to many other GP surgeries.’ Social Prescriber*

These findings highlight that further work is need to fully embed knowledge about the social prescribing service across all staff groups within primary care and that regular updates are required to ensure key members of staff are not missed through staff turnover, and to act as an aide memoire, whilst being mindful of service capacity.

## Challenging established mindsets

Clinicians interviewed mentioned that the greatest challenge to embedding the service was changing their own and their colleagues' mindsets. Inevitably this required a culture change amongst clinicians, seeing the whole patient and not just the clinical need. Interviewees suggested some clinicians were more accustomed to 'relinquishing control' and enabling the social needs of patients to be met by other professionals such as Social Prescribers. However, most clinicians believed that the change in mindset related to familiarity and that colleagues would become accustomed to referring into the scheme as social prescribing continues to embed itself into the primary care infrastructure.

## 7.2.2 The impact of social prescribing on the range of services available within primary care

In this section, data on client needs and onward signposting and referral from the social prescribing case management system, alongside feedback received in surveys, interviews and focus groups with key stakeholders, MYCaW follow ups and client case studies will be used to demonstrate the impact the programme has had on the range of services available through primary care as a result of social prescribing.

### 7.2.2.1 Meeting clients' holistic wellbeing needs

Client needs are identified through a combination of the referral process, for example on the referral form, and during the Social Prescriber's consultation with the client. It is these needs which are addressed through the Social Prescriber's interaction with the client and their onward signposting and referrals. Figure 13 highlights the range of needs people are supported with and how broad the service is.

**Figure 13: Breakdown of clients' presenting needs, 1 December 2016 – 31 July 2017**

Needs	Number of clients presenting with needs	% of clients
<i>(Exercise*)</i>	774	34%
<i>(Weight Management*)</i>	547	24%
Anxiety/stress/depression/low mood	480	21%
<i>(Healthy eating*)</i>	392	17%
Social isolation	370	16%
Learning/training/employment	285	13%
Money/debt/benefits	298	13%
Housing issues	285	13%
Smoking, drugs, alcohol and other addictive behaviours	70	3%
Other needs - where need specified (see <b>Appendix 3</b> )	122	5%
Other needs - unspecified	218	10%
<b>TOTAL NEEDS</b>	<b>3841</b>	
<b>TOTAL CLIENTS (DENOMINATOR)</b>	<b>2270</b>	

\* The data is skewed towards physical activity, healthy eating and weight management, which reflects the fact that the two existing schemes acted as a gateway to a previous 'Health Trainer' programme. It is likely that data for the next contract reporting period will present a different weighting of needs.

*“Talking about my concerns was important, and having access to services that could help me reach my goal. I gained information that helped me.”* Service user

The need presented by the most clients was support with exercise (774, 34% clients), followed by weight management (547, 24%). 41% (936) clients presented with one or a combination of physical activity, healthy eating or weight management needs. This reflects the fact that the two existing schemes acted as a gateway to a previous ‘Health Trainer’ programme. A large proportion of clients, however, also presented with mental health needs (480, 21%) and for reasons of social isolation (370, 16%). Many clients presented with multiple needs. 340 ‘other’ needs were identified by clients. Some of the more frequent ‘other’ needs included carer support, support with IT skills, help with the tasks of daily living and domestic violence support (see **Appendix 3** for a breakdown of ‘other needs’). Data on clients’ most pressing issues are discussed as part of the data collected by MYCaW, in **Section 7.3.1**.

### **7.2.2.2 Onward sign-posting and referral and engagement with the VCS**

In the first 8 months of the roll-out, Social Prescribers made 2,034 onward referrals and sign-posts to 333 services and activities across 279 organisations. The Tower Hamlets CVS website lists 283 member organisations currently, although there are many more services in existence locally.<sup>xxiii</sup> These data show the value of the Social Prescriber role as a link worker and the breadth of additional services available to users of primary care through the social prescribing service. Clients are referred and sign-posted to a myriad of types of services, with a range of referral mechanisms, from those with established referral pathways to more adhoc services and programmes without clear contact details, which require more resource to identify and navigate the local service offer on behalf of clients. Building relationships with staff in local organisations and understanding the local offer is a central aspect of the Social Prescriber role.

*“I felt isolated and a burden but I feel on the road to positive changes. Most important is the one person to contact that puts you in touch with all the other organisations.”* Service user

*‘It complements and reinforces patient care, making their experience and outcomes much better’* GP

Figure 14 shows the top 20 organisations which were referred into. It should be noted that the data is skewed by a high number of referrals to the ‘Health Trainer’ programme. Since this programme is no longer operational is likely that future service data will present a different weighting of organisations referred and signposted to. It should also be noted that referral to a single organisation hides the fact that in many instances these organisations provide multiple services that will help support that client.

In some instances the consultation with a Social Prescriber will not result in an onward referral, for example in cases where social prescribing is not appropriate, the client’s issue has already been resolved, there is no service available which could meet the client’s specific needs (discussed further in **Section 7.2.2.3**) or the Social Prescriber can support the client’s needs without onward referral, for example when the client only needs support through coaching and motivational-interviewing techniques. Where clients receive a referral or are sign-posted to support services, nearly a quarter (22%) receive 3 or more service referrals (Figure 15).

**Figure 14: Top 20 organisations referred into, 1 December 2016 – 31 July 2017**

Organisation/Programme <sup>30</sup>	Description of service	No. of referrals
(Health Trainers*)	Support and motivation to help adults to live a healthier lifestyle	388
Bromley-by-Bow Centre activities (except Health Trainers & Fit for Life)	Centre offers a wide range of services including: social advice on housing, debt management and finances; IT support and training; management of energy bills; local skills exchange; employment/ volunteer advice; health, wellbeing and lifestyle support	318
Fit for life	Exercise, weight management and healthy eating for patients with BMI >30	202
Limehouse Project	Community centre providing support for learning and skills development, help with employment and social welfare, legal advice and finances	58
St Hilda's Centre	Community centre offering predominantly services for women and older people	53
Goodmoves sessions	Structured lifestyle programme for people with long term conditions	32
Compass Wellbeing	Primary care psychology services	29
Idea Store activities	Educational community centres; libraries	29
Social services		26
Inspire	Mental health, recovery and wellbeing services	23
LINK AGE+	Working with over 50's to improve social networks and activity	21
DWP	Department of work and pensions – benefit information and guidance	20
Tower Hamlets Legal Advice Centre	Legal advice for housing, welfare, employment, and family law	19
Tower Hamlets Housing	Support with homelessness and housing	18
Groundwork	Energy saving support for vulnerable tenants	18
CHT team	Community health service – access to district nursing, PT/OT, ARCARE and other community based teams	17
Island Advice Centre	Provides welfare, finance, housing and legal advice	17
Age UK	Charity that offers advice and befriending services for elderly patients	16
Better Leisure Centres	Providing leisure facilities for local residents run by the local authority	16
Toynbee Hall	Community venue and provides free legal advice	14
Young at Heart	Physical activity and socialising for over 50s	14

\* The data is skewed towards the 'Health Trainer' programme since the pre-existing programmes acted as a gateway to this programme. Since this service is no longer operational is likely that data for the next contract reporting period will present a different weighting of organisations referred and signposted to.

<sup>30</sup> Note that Health Trainers and Fit for Life are not organisations but are identifiable programmes.

**Figure 15: Breakdown of number of referrals made per client, where a referral was made, 1 December 2016 – 31 July 2017**

Number of services	% clients
1	66%
2	11%
3 or more	22%

The importance of Social Prescribers as link workers is also demonstrated by feedback received from the referrer survey in primary care. If Social Prescribing did not exist, only half (86, 52%) of respondents would try to take on some of the support themselves by finding appropriate organisations to refer clients into and 48 (29%) would steer away from opening up holistic conversations because they do not feel they have the knowledge/ confidence to refer to appropriate organisations. Given the range and diverse nature of the VCS and other services which Social Prescribers access, and the standard GP consultation time of 10 minutes, it is likely that even if other professionals were able to engage with patients about their social needs the support provided would be significantly more limited than that provided through social prescribing.

Uptake data was not captured as part of the evaluation. Evidence on the benefit of onward referrals can be seen in the case studies presented below and in **Sections 7.3.2, 7.3.4 and 7.5** and by the feedback captured as part of MYCaW follow up assessments in **Section 7.4.3**. Consideration should be given as to how uptake data could be collected as part of future monitoring of the service.

**Case study 1: Impact of social prescribing on the range of services available to users**

27 year old male living in a hostel where he felt staff were racially abusing him. He was having epileptic fits 4 to 5 times a week and was struggling to stay in his room as found he was hurting himself during his fits. He had Post-traumatic Stress Disorder (PTSD), depression and felt socially isolated. He was finding it hard to care for his mother with bi-polar disorder as well as look after himself. He was passionate about starting a career working young people, to guide them in making the right decisions.

Through social prescribing, the client was referred to three services. An advice centre has helped him secure a larger room in the hostel which will keep him safe in the case of a fit. They have also helped him apply for Personal Independence Payment (PIP). He has enrolled in a Level 3 IT skills course and Level 2 Health and Social Care course at a local college, and is also accessing mental health and housing support from the college’s in-house student support scheme. A mental health charity is helping him get carers support for his mother and have offered him respite support as needed.

The client said *“Having the right support helped me make the right decisions and feel confident to take the right steps. I feel like my life is worthwhile now.”*

**Case study 2: Impact of social prescribing on the range of services available to users**

45 year old male with a severe mental health condition, who felt that playing a musical instrument really helped him to manage his condition more than taking medication. He used to play in a park, as his neighbours did not like him playing at home but it was getting cold with the change in seasons.

The Social Prescriber spoke to the client on the phone and his request was very clear cut: he needed a new place to practice. The Social Prescriber emailed contacts with access to space, and got three

positive responses, which were forwarded to the client. The client has started playing in a local church where he is welcome to practice any time.

Building up knowledge of the range of support available on a local and borough basis takes time and is vital to an effective social prescribing service. It is supported by the fact that Social Prescribers are aligned to GP Networks, with specific catchment areas, and their on-going liaison work with individual services, as well regular Social Prescribing Forums and networking Breakfast Events, which allow Social Prescribers and VCS organisations to learn collectively about, and keep up to date with, each other's work. Feedback collected on the day from VCS attendees at these forums has been very positive,<sup>31</sup> with participants valuing the opportunity to 'share and learn,' and gain a better understanding of social prescribing.

The majority of respondents to the survey conducted with VCS organisations for this evaluation<sup>32</sup> (74%) had heard of social prescribing and 64% had received referrals. 47% had attended at least one Social Prescribing Breakfast Event and 25% had attended one of the Social Prescribing Forums.<sup>33</sup> These data, however, do suggest that more work is needed to ensure that all organisations are aware of the social prescribing service. Similarly, VCS representatives who were interviewed as part of the evaluation suggested that some Social Prescribers were not yet fully aware of the extent of the range of services available in the borough, with patients being referred to services which were not always in close proximity to their home. This was reaffirmed by Network Managers who believed that some of the Social Prescribers had to 'build their knowledge base on local services and create their own links and networks', which takes time.

Respondents to the VCS survey were asked about how communications about social prescribing could be improved. Suggestions included using online communications such as twitter, email or web based newsletters, which could be circulated via the networks. Some respondents also suggested that receiving more regular communications about social prescribing would be useful.

### **7.2.2.3 Gaps in support services**

The success of social prescribing relies on a thriving voluntary and community sector into which to signpost and refer clients for support and a detailed awareness on the part of the Social Prescribers as to the full range of support services available within the community.

Capturing unmet needs of service users is important to inform future commissioning decisions in the borough. For example, understanding whether the services clients need do not exist, whether there are long waiting lists or services are full, instances where funding from services has been withdrawn and services where the cost of accessing support is prohibitive. These are discussed as part of the regular service monitoring meetings between the commissioner and lead provider. Examples of gaps reported by Social Prescribers during the first 8 months of the roll-out include social welfare support, particularly during the roll-out of Universal Credit, indoor exercise classes for people with disabilities, befriending activities for people with mental health issues, affordable 'handymen' services, and localised support for older Bengali women. This information shows that despite the

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<sup>31</sup> For instance data from 30 feedback forms showed that participants rated the relevance of the events for them as 4.5 on average (with ratings being, 5 = Excellent, 4 = Very good, 3 = Fairly good, 2 = Mildly good, 1 = Not good at all) and gave an average score of 8.8 on a scale of 1-10 (with 10 being extremely likely) for how likely they would be to recommend the event to a colleague.

<sup>32</sup> 47 responses were received from 46 organisations

<sup>33</sup> Social Prescribing Forums are borough-wide but the networking breakfasts are local to each Network area, allowing more local conversations.

breadth of support available in the local community through social prescribing, there are some limits to the support Social Prescriber’s are able to refer and sign-post clients to.

### 7.2.3 The impact of social prescribing on the services clients are referred to

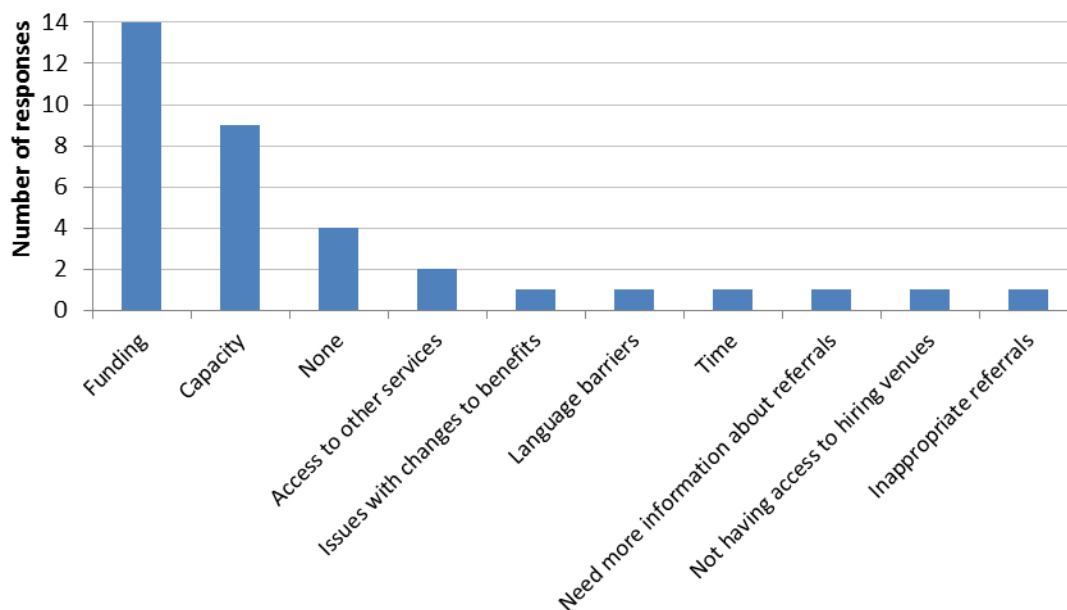
In this section, responses received from a survey conducted with the VCS and focus groups with key stakeholders will be used to assess the impact the programme has had on the services clients are signposted and referred to.

#### 7.2.3.1 Issues raised in delivering services to referred clients

VCS organisations were asked to comment on issues they had experienced in delivering services to clients referred via social prescribing. Only 8 instances were cited, the most frequent being that clients had not attended appointments, insufficient funding or capacity and clients not meeting the service criteria. Where clients had not met the service criteria this had been fed back to the social prescribing team.

Figure 16 shows wider issues that affect local VCS organisations’ capacity to deliver services in general.

**Figure 16: Factors which might affect organisations’ capacity to deliver their services**



Feedback received from the interviews and focus groups with key stakeholders involved in delivering the programme suggested that capacity amongst the VCS was insufficient to cope with rising demand. Moreover, the VCS expressed a concern that referrals were skewed to a small number of providers who were subsequently struggling to meet demand with limited financial and human resource and there was reliance upon individual goodwill. Indeed, they suggested that their services should be sufficiently reimbursed by the programme to maintain the quality of provision.

*‘...a few people that said they have run out of capacity, they’ve run out of ... funds. In Tower Hamlets there is such a vibrant community and voluntary sector.....But I’m also really aware of the fact that why should... As health care gets overburdened why should we then over burden*



*the voluntary sector as well? So things like Rotherham Community and Voluntary sector have money per referral, you know that would be the ideal actually. Can we afford to do that?’*  
Steering Group Member

#### **7.2.4 Summary of evaluation objective 1 achievements**

Evaluation objective 1 - To explore the extent to which the programme has embedded itself within the Tower Hamlets primary care system, its impact on the range of services available to users and the impact on those services

The evaluation has shown that the service has met objective 1. The extent to which the service has become embedded within primary care has been highlighted by the increase in, and sustained high level of, referrals during the first 8 months of the roll-out (2,270) and the fact that referrals have been received from every practice and from a diverse range of professionals across the primary care system, including from 80% of GPs and GP Registrars. This is supported by the feedback from key stakeholders, which has demonstrated how valued the social prescribing service is locally. The range of needs Social Prescribers have supported clients with demonstrates how holistic the service is and the high number of onward referrals and signposts to a large range of organisations in the borough (2,034 referrals to 333 services and activities across 279 organisations) highlights the breadth of services available to primary care users through social prescribing. The high attendance at, and feedback from, the Social Prescribing Forums and Breakfast Events, as well as suggestions made for more regular service updates, highlights the willingness of the local VCS to engage with social prescribing, which will continue to strengthen the service offer.

The findings have, however, also indicated the following issues for consideration:

- There is variety in referral rates across practices and some practices have only made a small number of referrals to social prescribing to-date
- If all practices referred at the rate of practices with pre-existing schemes the overall annual borough referral numbers would be 2.7 times higher than the numbers predicted at current referral rates
- There is a need to increase awareness of the services offered by social prescribing across professionals within primary care, taking consideration of service capacity
- There is a need to increase awareness of the social prescribing service within the VCS, taking consideration of service capacity
- It is important that Social Prescribers are supported to keep up to date with the range of local services on offer to support clients
- Despite having a thriving third sector within the borough, there remain gaps in local provision to meet all the needs of social prescribing clients
- Capacity within the VCS was raised as an issue, particularly with any increase in referrals and a perception that high referral numbers may be centred on a few services
- There was a suggestion that VCS services, particularly those receiving high numbers of referrals from Social Prescribers, should be sufficiently reimbursed to maintain the quantity of provision
- Consideration should be given as to how uptake data from onward referrals could be captured as part of future evaluations of the service.

### 7.3 Objective 2: To assess the improvement in health and wellbeing of users of the social prescribing programme

In this section, MYCaW baseline and follow up data, feedback from key stakeholders, data on clients supported into volunteering and employment and client case studies will be used to demonstrate the improvement in health and wellbeing of users of the social prescribing programme.

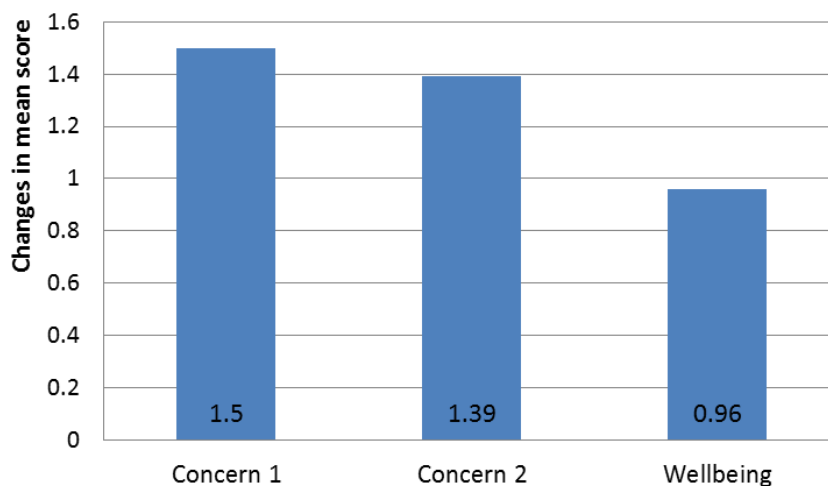
#### 7.3.1 Changes in Measure Yourself Concerns and Wellbeing (MYCaW) scores

MYCaW<sup>xxiv</sup>, a validated tool that assesses changes in wellbeing, has been used in 6 of the Networks to collect baseline data on patients' concerns and perceptions of their general wellbeing. During their first contact with the Social Prescriber, clients are asked to name their two main concerns and score these on a scale of 0-6 (with 0 being 'not bothering me at all' up to 6 'bothers me greatly'), as well as score their general feeling of wellbeing.<sup>34</sup> At follow up, patients are asked to score their two main concerns and feelings of wellbeing again. These are used to calculate the average change in scores.

As part of the evaluation, follow up calls were conducted in 4 of the Networks where it had been 12 weeks since the baseline data was collected. There is not currently a routine follow up process for MYCaW established within the borough. Responses were collected from 37 clients who had a baseline assessment.<sup>35</sup>

When analysing changes in MYCaW scores, an average change of 1.5-2.0 in concerns scores and a 0.5-1.0 change in wellbeing scores, in a positive direction, are interpreted as a good outcome.<sup>xxv</sup> Figure 17 shows that this was achieved for the clients' first concern score and the general wellbeing score.

Figure 17: Changes in mean score for MYCaW (n=37)

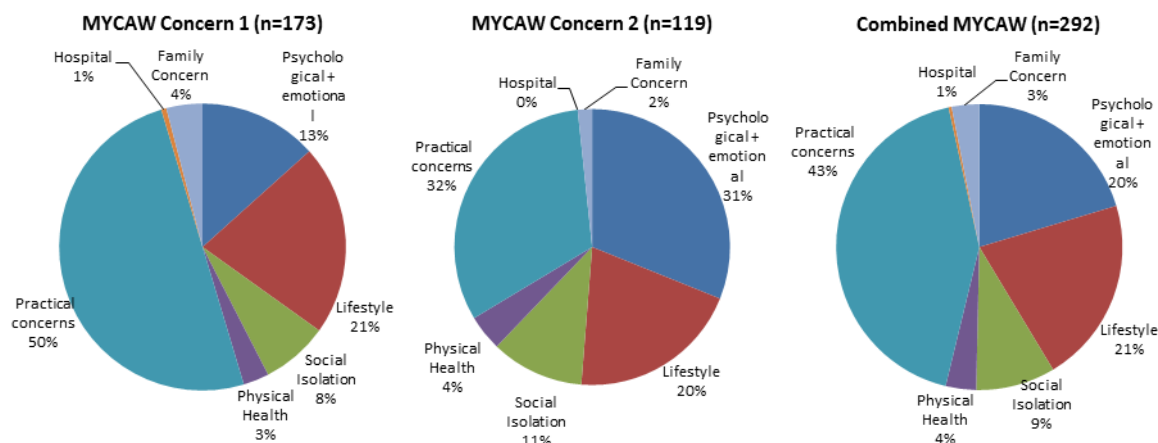


<sup>34</sup> It should be noted that baseline data collection is not always appropriate on an individual case basis, for example when a client is 'in crisis'.

<sup>35</sup> The different Networks followed different protocols for the number of attempts they made to contact clients at follow up and the denominator for the number of people called was not available for the evaluation from all Networks. As such it is not possible to calculate a response rate. 7 responses were from Network 5; 13 from Network 6; and 17 from Networks 7&8.

The charts in Figure 18 highlight the types of concern clients shared as part of their MYCaW baseline interviews. Baseline data was available from 173 clients across 5 Networks. The concerns have been grouped into categories to identify what the main areas of concern were. A key for these categories is presented in Figure 19. The graphs clearly show that the greatest concerns are ‘practical’ in nature, for example concerns over debt, work, housing etc. These data complement the data on client needs shown in **Section 7.2.2.1**.

**Figure 18: Overview of top two client concerns at MYCaW baseline interviews**



**Figure 19: Key to categories of client concerns**

Categories	Concern Stated
Practical concerns	Debt/ work/ housing/ training/ benefits/ learning English
Lifestyle	Weight/exercise/ diet
Psychological + emotional	Depression/ anxiety
Social isolation	Isolated/ wishes to go out more
Physical health	Management of health issue
Family concern	Concerns about family/carers
Hospital	Practical concerns about hospital treatment or appointments

### 7.3.2 Feedback from clients on the impact of the service on their health and wellbeing

At the end of the MYCaW follow up conversations, clients were asked additional questions about their experience of social prescribing and the impact of the service on their health and wellbeing, following an interview guide developed for the evaluation. The service feedback is outlined in **Section 7.4.3** but the following quotes from service users highlight some of the impacts on health and wellbeing shared by those interviewed:

*"I have been looking forward to life for the first time in my life"*

*"The service has been brilliant - you've really help [sic] me a lot. God must have sent you to me. You have helped and pushed me, you won't understand how much you have helped. Since I have spoken to you, I have had no weed or alcohol too"*

*"Talking to someone helps you re-evaluate things. Great service that should be advertised more to patients"*

### **Case study 3: Impact of social prescribing on health and wellbeing**

39 year old female was seeing a counsellor but did not find cognitive behavioural therapy (CBT) helpful. She was very stressed about her husband's gambling problem and her child with autism and relieved her stress by over-eating. Although she has started to eat more healthily and exercise more this had not helped her over-eating.

Through social prescribing she was referred to four activities. The Social Prescriber accompanied<sup>36</sup> her to her first gambling counselling support session, as she was reluctant to attend. She is now attending sessions with her husband and feels their relationship has improved because they are dealing with the problem together. The Social Prescriber accompanied her to an Idea Store to borrow self-help books to help with her eating. The Idea Store has given her space to spend some time reading and she feels that she can now understand her condition better and is more confident to tackle her over-eating. Her referral to a mental health charity has helped her access support for the care of her son and they are also providing her with respite. She has also started going out for walks, which has helped her give her a break and clear her head to make the right decisions.

The client said *"I feel confident that I can feel better and sort out my problem. Couldn't have done it on my own. It's like I am getting my family back."*

### **Case study 4: Impact of social prescribing on health and wellbeing**

67 year old male with a speech impediment, which led him to be shy and not make eye contact with others, was referred to the service by his psychologist. He was single and socially isolated, and had both anxiety and depression. He wanted the opportunity to make friends and take part in activities with others but was scared of being rejected and bullied, which had happened when he was younger. He needed his confidence building and to feel reassured.

The Social Prescriber visited him during one of his psychology sessions. She suggested attending a gardening group, where many of the participants were socially isolated, vulnerable and/or had mental health problems. Although the psychologist was concerned that the client would not show up, he met the Social Prescriber as arranged at the surgery and they went together to the gardening group.<sup>37</sup> At first he was shy but the other participants were very welcoming and made him feel at ease. He wanted to stay on with the group after the Social Prescriber left. The client now attends the gardening group regularly, independently. As a result he wants to attend more classes and do more volunteering, and there has been a noticeable change in his confidence: he holds his head high and chats to everyone.

### **Case study 5: Impact of social prescribing on health and wellbeing, and managing a long term condition**

A 56 year old male who had recently given up his job due to the progression of his Parkinson's was referred to the service. He wanted to do more exercise to keep himself fit. The Social Prescriber referred him to a neurological support group and 'Dancing with Parkinson's', as well as four other exercise classes, including the local leisure centre's over 50s exercise programme, disability swimming, walking football and weightlifting for older men.

<sup>36</sup> As discussed in **Section 6.6**, it should be noted that clients are only accompanied to services on an exceptional basis where there is a clear need for this to be necessary.

<sup>37</sup> As discussed in **Section 6.6**, it should be noted that clients are only accompanied to services on an exceptional basis where there is a clear need for this to be necessary.

When, during his third appointment, the client explained that he couldn't afford the few pounds for some of these sessions, the Social Prescriber discovered that he was living from his overdraft and hadn't applied for benefits. She referred him to a local foodbank in walking distance from his house, so he would be able to carry the food himself. They helped him apply for ESA and PIP, and the Social Prescriber applied for a council crisis grant for him, which was awarded. She also referred him to a local charity to help him apply for a bus pass.

As a result of the intervention the client does exercise about 3 times a week and is a consistent weekly attender at 'Dancing with Parkinson's', to help keep as fit as possible. He doesn't need his overdraft any longer as his benefits are sorted and have been back paid to the day he had to give up his job.

### **7.3.3 Feedback from key stakeholders on the impact of the service on their patients' health and wellbeing**

Many of the stakeholders who were interviewed or took part in focus groups suggested that social prescribing filled an important gap in the local health system, in terms of addressing patients' social determinants of health. Furthermore, it was thought that the scheme increased the awareness of patients of the VCS services available in the borough, supporting them to manage their own health through better use of wider community assets. Clinicians were encouraged by the fact that the scheme provided a means of enabling them to help address the underlying social issues that many of their patients presented with, which they believed had an adverse effect on an individual's health and wellbeing. They believed that addressing these social issues through the scheme had improved their patients' psychological health given that the patients they referred were socially isolated or suffering with mental health problems. They also referred patients with employment and housing issues, suggesting that stability in a patient's personal life improved their outlook and wellbeing.

*'I've also referred ... a very elderly patient who needed a bed and can't afford one.... I wanted someone to take him to the second hand shop and I got some feedback that they've arranged for someone to deliver him a new bed .... He had COPD and diabetes and he wanted a bed that he could sleep on downstairs and when I recently saw him it's as if a weight has been lifted from his shoulders.'* GP

*'One patient who comes in really stressed and suicidal every week, ended up being up in the morning, 9 o'clock, going to work in the gardens and doing a horticultural course. So yeah, really life changing....there's been positive feedback from patients to us and, you see them more confident in managing their health too.'* GP

Social Prescribers felt that they provided a unique service in primary care by effectively removing time bound appointments, with some Social Prescribers spending up to one hour in their first consultation with patients and in a minority of cases also accompanying patients on initial visits to the service they had been referred into, where there is capacity (although some Social Prescribers do this in their own time). The time Social Prescribers had to discuss issues was thought to provide high levels of satisfaction to patients.

These findings were supported by the referrer survey, where 99% respondents felt that social prescribing brought benefits to the wellbeing of their patients and 80% respondents felt that patients respond well to the idea of social prescribing (agreed/strongly agreed). Only 1% disagreed. When asked to comment on the benefits for patients, respondents stated the following reasons:

- Improves patient wellbeing

- Approaches patients holistically
- Meets patients' needs appropriately
- Tackles social issues
- Good signposting and discovering new services
- Single point of access to many interventions
- Provides community connections
- Gives adequate time to patients
- Environment where patients feel safe.

*'Not to all but to some it is completely life-changing.'* GP

*'It's an amazing service that can make a massive difference to people's lives and health'* Practice Nurse

*Empowers patients and gives them time and space to address their "life" concerns which inevitably affect their health.* GP

When asked about the consequences of the social prescribing service being withdrawn, 76% (125) of survey respondents believed it would affect the ability of their patients to engage with their health and 78% (129) believed that it would affect the ability of their patients to address the social determinants of health.

### **7.3.4 Evidence of volunteering or work opportunities taken up**

Being in good employment is protective of health. Conversely, unemployment contributes to poor health. Getting people into work is therefore of critical importance for health and wellbeing and for reducing health inequalities.<sup>xxvi</sup> Social prescribing has been identified as a key facilitator for supporting people into employment locally.<sup>xxvii</sup>

As Figure 13 shows, 13% (285) of clients present to social prescribing with learning, training and/or employment support needs. Whilst many of these clients are then referred or signposted to appropriate support within the community, data is not routinely recorded as to whether clients who want to go on to take up volunteering opportunities or find employment following their interaction with the social prescribing team. In many cases this is likely to be a long-term process, as clients often present with multiple issues, and require a degree of support before being ready to find the right employment support services. There is, however, evidence of this happening, as demonstrated by case studies 6 and 7 below and case study 8 in **Section 7.5**.

#### **Case study 6: Supporting people to volunteer**

35 year old female with a history of depression. She wanted to get involved with local volunteering projects to help create some structure in her life but she struggled to be around too many people. The Social Prescriber referred the client to a local nature reserve as they have a very quiet space that is not open to public. She began to engage with them but they were not in need of volunteers until the beginning of the summer so the Social Prescriber suggested that she could volunteer in the surgery garden in the meantime. She has now been coming every week and has been a big part of the new garden design. Someone from a local city farm has been helping out with the design too and the client has now begun to volunteer with city farm's gardening group after making this contact in the surgery garden.

The client said: *'I've enjoyed seeing you on regular basis and seeing gradual growth of garden'*

### **Case study 7: Supporting people to get into employment**

A 36 year old female who suffers from long-term anxiety with depression was referred to the service. Due to being a perfectionist, she gets stuck easily and has low self-esteem, feeling other people her age have achieved more than her. She had previously received support from the Social Prescriber at the end of 2016 but returned in 2017 after finishing her studies for support with her search for a job. They discussed a range of opportunities, including becoming a volunteer at a local charity supporting struggling mothers. They agreed that it would be good for the client to do something practical for others, to build up her confidence. She applied to do the training, which will commence soon. They also looked at dog walking, affordable yoga and other ways to improve the client's wellbeing. The Social Prescriber referred her to a local charity which provides training and employment opportunities for people with mental health support needs, and when she read about a vacancy for a local part-time job she forwarded it to her client.

The client applied for the job and now works there part-time. The Social Prescriber crossed path her client once again at one of the Social Prescribing Networking Events, which she attended in a professional capacity in her new role.

### **7.3.5 Summary of evaluation objective 2 achievements**

Evaluation objective 2 - To assess the improvement in health and wellbeing of users of the social prescribing programme.

The evaluation has shown that the service has met objective 2. The extent to which the service has improved users health and wellbeing has been demonstrated by the improvements shown in concern and wellbeing scores after clients' interactions with the social prescribing service (the average improvement for client concerns was 1.5 and 1.39 and 0.96 for wellbeing, on a 6-point scale) as well as the feedback shared by key stakeholders involved in delivering or referring into the programme and clients themselves. Although numbers are unclear, a number of clients have gone onto training, volunteering or employment as a result of consulting with a Social Prescriber, which is known to have a significant impact on health and wellbeing.

The findings have, however, also indicated the following issues for consideration:

- MYCaW baseline data has not been collected universally and a process has not yet been established to ascertain the methodology and number of MYCaW follow ups which would be needed to assess the effectiveness of the service, whilst not adding to the administrative burden on Social Prescribers. Some client follow up is needed to help demonstrate improvements in the health and wellbeing of service users. Capacity to conduct an agreed number of MYCaW follow ups should be built into future service design.
- It would be helpful for a standard set of questions to be developed, building on the interview guide developed for the evaluation, and used in a systematic way, for all MYCaW follow ups to maximise our understanding of the impact of the service on users.

### **7.4 Objective 3: To understand the experience of referring into and delivering the programme**

In this section data collected from surveys, interviews and focus groups will be used to understand the impacts of the programme on the work of key stakeholders.

## **7.4.1 Stakeholders' experiences of referring into the programme**

### **7.4.1.1 The referral process**

98% of respondents to the survey of referrers felt that the referral process was straight forward. Many commented how easy the process was, particularly in Networks where they are able to refer by entering a code into EMIS or asking the reception team to book appointments directly.

Of those GPs who had referred into the service, only one GP stated that the referral process had not been straight forward, but commented that their issue had been rectified.

### **7.4.1.2 Feedback on clients referred**

The majority of respondents to the referrer survey (82%, 124) were happy with the feedback they received about the clients they referred. Where referrers were not happy, they cited that they had not heard regarding patient attendance or outcomes. Feedback was seen positively when referrers could look at the consultation outcomes directly through the Social Prescriber's consultation notes on EMIS.

Issues with feedback were also raised during the interviews with referrers as an area for improvement. They felt that Social Prescribers ought to provide some feedback on their consultations with patients and felt any omissions were in part due to not all Social Prescribers having access to EMIS. Clinicians reported sometimes receiving feedback via the patients themselves.

### **7.4.1.3 Continuation and expansion of the service**

99% of respondents to the referrer survey wanted social prescribing to continue, commenting that it was a much needed service with no alternative service for patients to be referred to. They felt that it offers a patient-centred approach that supports general practice and makes a significant difference to patient's lives.

*'This service is so innovative and I think the direction the health service needs to go in order to be more sustainable cost effective (as it considers the actual person and not blankets them with a generic treatment). It also links many different aspects social, financial, cultural which can become heavy burdens for our patient.'* Practice Nurse

*'I think this service is a vital part of caring for the overall well-being of our patients'* GP

When asked about ways that the service could be improved, some suggested the expansion of the service, for example through accepting referrals from community health teams, mental health services and urgent care.

### **7.4.1.4 Benefits of social prescribing for professionals in primary care**

98% of respondents to the referrer survey felt that social prescribing offered some benefit to them in their profession. The benefits cited can be grouped into the following themes:

- Allows Health Care Professionals (HCP) to approach patients holistically
- Gives primary care staff extra tools and referral pathway



- Allows primary care staff to use time appropriately
- Allows focus on medical issues
- Increases knowledge of alternative services
- Reduces appointments/inappropriate appointments (Discussed in more detail in **Section 7.6.2**)
- Relieves administrative pressure
- Increased HCP awareness of social issues
- Provides an extra safety net.

*'Don't think that I could continue as a GP in Tower Hamlets without it. GP*

*'It gives me, as a doctor, a better perspective on the impacts of health on people's lives and of their lives on health!' GP*

*'My dealings with patients, particularly those that are vulnerable, has shown me that there is a need to support patients non-clinically. Often these patients don't know who to turn to for help so they end up making an appointment to see a GP, when their problems are not medical.'* Practice Manager

*'As front of house this is something we can inform patients about in a friendly way.'* Receptionist

*'Feel that we are handing patient over to colleague who is up to date on local options something we struggle to keep up to date with/often unknown - I feel it reduces possible re-attendances and often helps speed up consultations.'* GP

## **7.4.2 Stakeholders' experiences of delivering the programme**

The clinicians who were interviewed and the Social Prescribers who took part in the focus groups reported a positive experience of the service which was, in part, due to the positive experience of service users: an important motivating factor cited by Social Prescribers was a sense of personal reward through witnessing the positive impact of the scheme on the lives of their clients and clinicians believed that the programme had made a dramatic change to the lives of their patients, improving their physical and mental health and general wellbeing.

### **7.4.2.1 Social Prescriber capacity and support**

Whilst the stakeholder experience of delivering the programme was largely positive, there were some concerns expressed by the Social Prescribers and others about their personal capacity. It was thought by most stakeholders that the volume of referrals into the scheme was possibly too high for the existing capacity of the Social Prescribers. Furthermore, Social Prescribers often had patients on their caseload with complex health and social care problems and complex navigation for onward referral, for which they had a degree of clinical and emotional responsibility but very little support in terms of clinical supervision. Social Prescribers also felt that they were often burdened by administrative tasks which may detract from the focus of their role. The issue of limited capacity was compounded by the perception amongst most steering group members that the Social Prescribers had not received enough support from the system in terms of administration and supervision, although periodic peer support meetings were felt to be useful for peer support. For instance the engagement with the VCS and practices, such as setting up Social Prescribing Forums and attending protected learning time (PLT) meetings at GP practices has been led by the Social Prescribers rather than centrally arranged.

*'... there is huge demand for the SP services and workload is quite high as we deal with very complex cases that need a lot of follow up with services and clients. Time is spent case managing with no protected time to engage with the services that are referred into.'* Social Prescriber

Increasing service capacity was also mentioned as an area for improvement within the referrer survey. Respondents asked for an increase in staff numbers to allow for greater availability of Social Prescribers to engage at a practice level, e.g. attending practice meetings.

### **7.4.3 Feedback from patients on the social prescribing service**

During MYCaW follow up calls with 37 clients from 4 Networks, they were asked what they felt the most important aspect of the time they spent with the Social Prescriber was. The following feedback was received:

- Amazing/excellent/great/professional service
- Being able to talk to someone and voice or share concerns
- Appropriate services available
- Staff are very knowledgeable and good at their job
- The time allocated to the appointment
- Meeting with kind and caring people.

Overall the comments were very positive about the service and people wished for it to continue. Where in a few instances negative comments were made, the most common was that patients had thought that they would have been contacted again for follow up but this never happened. A very small number thought that the service did not provide the help that they needed. This highlights a need to ensure that patients are clear about what the social prescribing service can deliver and how to access further support if necessary.

Patients were also asked about the outcomes of their interactions with the service. People reported various positive outcomes and no negative outcomes. Patients reported being referred for emergency fund grants; to complete qualifications to return to work; going to training and social groups; starting volunteering; managing their debt; to name a few examples. In a few cases clients fed back that although they were given all the information required about a service they did not contact the service themselves for various reasons. In these instances, some individuals felt that if they had had some sort of follow up that they might have accessed these services.

### **7.4.4 Summary of evaluation objective 3 achievements**

Evaluation objective 3 - To understand the experience of referring into and delivering the programme
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The evaluation has met objective 3. The majority (98%) of referrers felt that social prescribing offered benefit to them in their profession and wanted the service to continue. The referral process was felt to be straight-forward, particularly where EMIS could be used and where appointments could be booked directly through reception staff. Wider stakeholders felt that the scheme had been well received by practices and partners across the borough and that there was a discernible impact on the wider primary care system as well as on the experience of patients.

The findings have, however, also indicated the following issues for consideration:

- Referrer feedback appears to be currently insufficient in some cases. Improved communication was felt to be facilitated by use of EMIS and not all Social Prescribers have access to EMIS

- The current volume of referrals was felt to be too high for the existing capacity of the Social Prescribers
- Social Prescribers are receiving increasing numbers of referrals of complex and vulnerable patients without sufficient supervision to manage them
- The programme is currently felt to be quite administratively heavy with little administrative support
- The service should look to increase capacity, to allow greater engagement at a practice level and in the future consider accepting referrals from other areas such as mental health services, community health teams and urgent care
- Not all service users access the services that they are referred to, for a number of reasons, for example not being ready to seek further support or competing life issues. Conversations with service users indicated that in some instances if they had, had further engagement with Social Prescribers over time, they may have attended. Whilst a balance needs to be struck with social prescribing capacity, it is important that clients receive the support they need to access local services, and that they are clear about the social prescribing process and how to access further support if necessary.

## **7.5 Objective 4: To assess the extent to which social prescribing facilitates community development in terms of connecting residents with each other for support**

There has not been capacity within the initial roll-out of the borough-wide programme to develop the ambition across the borough of doing more to connect residents with each other for support. Despite this, a few initiatives have been established within two of the networks with pre-existing programmes, for example where activities such as a walking group, a gardening group, informal tea session, a peer-led craft group for wellbeing and a menopause support group have been piloted, and where patients have been referred into the borough time-bank scheme, EastXChange. Many of these initiatives were set up by Social Prescribers who identified a need from discussions with their clients and identified willing volunteers to co-host the initiative. Due to capacity and dependency on Social Prescriber input, not all the groups have been able to continue. The Walking Group continues at Mission Practice, with a dedicated group of around 5-8 people and has been successful in making connections between residents. The Social Prescriber was also successful in obtaining funding from London Borough of Tower Hamlets Public Health Department to support the menopause support group, which is now hosted by Popular Harca charity and increases in popularity.

As demonstrated by Case Studies 6 (**Section 7.3.4**) and 8 (below), there is also evidence of residents meeting each other through the programmes prescribed through social prescribing, leading to new social interactions and engagement with different activities. To develop this ambition more formally would require a significant increase in Social Prescriber capacity or a different model of social prescribing, for example building in a peer support element.

### **Case study 8: Supporting residents to connect with each other**

A 48 year old female who struggled with her job due to health issues and a lack of enjoyment, was referred to the service. She was single and her family had passed away and, although she had friends, she felt lonely, particularly at the weekend. The Social Prescriber informed her about the local volunteering centre, the national careers service, a local darts session at the leisure centre and connected her with a disability employment advisor, who helped her through the process of giving up her job. The Social Prescriber introduced her as a potential volunteer to two local services and introduced her to another patient to become exercise buddies.

While being off-sick, she started to meet with the other patient - they enjoy walking together and socialising. With the help of the Disability Employment Advisor, she felt supported when she left her job on health grounds. The client volunteered with a local charity, helping monthly at a tea club for the elderly at a local community centre – which she loved. The client returned at a later date to the Social Prescriber as she wanted to do more volunteering. Knowing a local sheltered housing organisation could probably do with more activities, the Social Prescriber connected her with the organisation’s Community Investment Coordinator. Once the paperwork was sorted, she started leading activities there as well. As a result, she is gaining work experience in a setting that she would like to do paid work in, in the future.

### **7.5.1 Summary of evaluation objective 4 achievements**

Evaluation objective 4 - To assess the extent to which social prescribing facilitates community development in terms of connecting residents with each other for support

Although due to capacity, the service has not fully met Objective 4, there is evidence of innovative work being piloted in some areas in the borough, which could be built on borough-wide in due course.

## **7.6 Objective 5: To establish the cost savings of the programme within the context of health care and wider public sector budgets**

This section outlines the cost of delivering the current programme and uses published evidence and local data on changes in GP appointments to demonstrate how the programme contributes return on investment and cost savings to public sector budgets.

### **7.6.1 Cost of delivering the programme**

The current scheme in 2017/18 is delivered within a budget of £376,000. The majority of the funds come from THCCG, with additional contributions from individual GP Networks and in-kind support from other partners, covering Steering Group staff time spent on service development and evaluation, and evaluation contributions from academics at University College London. From 2018/19 the borough service will have a budget of £240,000. This evaluation has indicated that £240,000 is not sufficient to deliver a tenable service given what we know about current demand, capacity and support required for staff. **Section 7.7.2** estimates that the cost of an ideal social prescribing model for Tower Hamlets, based on the findings of the evaluation, is £600,000.

It is important to recognise that the borough roll-out has been able to achieve the outcomes it has, within the existing budget, due to being able to build on the foundations laid by, and reputation of, the two pre-existing schemes, which gave it a head start in terms of embedding within the primary care infrastructure.

### **7.6.2 Changes in health care use as a result of social prescribing**

Data analysed from GP Network 1, where Social Prescribing has been running for a number of years, has shown a 12.3% reduction in GP appointments between the 6 months before and 6 months after patients’ appointments with a Social Prescriber (based on data from 890 patients, whose

appointments reduced from 3,388 to 2,970.)<sup>38</sup> This is within the range of other national programmes (2% to 70%) discussed in **Section 5**.<sup>xxviii</sup> If this reduction in one network was applied to the expected referrals received across the whole borough over a 12 month period (3,405), based on the current service model, around 1,566 GP appointments would be avoided. This represents a potential shift in demand worth £70,483 per annum (based on an approximate cost of £45 per GP appointment).

That the service had led to a reduction in GP attendance for patients using the service was also a reflection shared by clinicians who took part in the focus groups and respondents to the referrer survey.

GP appointments are one element of reductions in healthcare service use brought by social prescribing. **Section 5** also demonstrates that there is the potential for social prescribing to reduce emergency and elective appointments in secondary care but this has not been possible to calculate locally for the purpose of this evaluation.

Additional evidence, not quoted earlier, is provided by the Joseph Rowntree Foundation, who have estimated annual per capita costs of £846 to the NHS from out-of-work claimants. An evaluation of one social prescribing programme showed that 17% of beneficiaries who at baseline described themselves as looking for work found employment during their social prescribing intervention.<sup>xxix</sup> If we apply this proportion to the cohort looking for work covered by the evaluation, this would result in annual savings of £61,555 to the NHS (both primary and secondary care).<sup>39</sup>

### **7.6.3 Applying evidence of broader return on investment for social prescribing**

Return on investment for social prescribing is broader than savings to the NHS. National research and evaluation from other programmes has demonstrated a social return on investment of £2.30 for every £1 spent in the first year on social prescribing.<sup>xxx</sup> This means that our current programme (£376,000) delivers a social return on investment of £864,800 each year.

National evidence in this area is growing with the work of the Social Prescribing Network and the increasing number of programmes being established and members of the Steering Group interviewed acknowledged the importance of keeping abreast of any developments to strengthen the data on return on investment we are able to show within the local programme.

### **7.6.4 Summary of evaluation objective 5 achievements**

Evaluation objective 5 - To establish the costs savings of the programme within the context of health care and wider public sector budgets.

The evaluation has partially met objective 5. Evidence from the local programme has shown a demonstrable shift in demand through a 12.3% reduction in GP appointments. National research has shown<sup>40</sup> an average reduction both in Accident & Emergency and emergency hospital admissions of 24%, as well as a statistically significant drop in secondary care referrals of 55% at 12 months

<sup>38</sup> This data was run on 15 September 2017. It includes clients seen during the borough roll-out (up to mid-March 2017) and prior to the borough-wide scheme starting – mid-March being the cut off to allow for 6 months to have passed since their social prescribing referral.

<sup>39</sup> 285 people expressed that they were looking for work or training, an annual figure of 428.

<sup>40</sup> Polley, M et al (2017) A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications, University of Westminster

following social prescribing interventions. National studies have also demonstrated<sup>41</sup> that every £1 invested in social prescribing generates an annual social return on investment of £2.30, which means returns of £864,800 per year for the health and care system in Tower Hamlets.

The findings have, however, also indicated the following issues for consideration:

- Due to the length of the borough scheme at the time of the evaluation it was not possible to analyse GP appointment data on a borough-wide basis. This should be done routinely, as the scheme becomes more established and has been in place for long enough to collect longitudinal data.
- Over time it is important to identify other ways to demonstrate return on investment within the programme, learning from work in other areas nationally, including exploring data around the impacts of social prescribing on secondary care usage.

## **7.7 Objective 6: To recommend an ideal social prescribing model, including level of funding required**

Evidence from throughout the evaluation, and in particular the qualitative evidence, has been used to develop the ideas below as to what an ideal social prescribing model for Tower Hamlet should look like.

### **7.7.1 Suggestions from interviews and focus groups with key stakeholders**

As outlined in **Section 6**, there are currently some differences in the service delivery model in different parts of the borough. Now the programme is more embedded, learning from the roll-out indicates that there is a need for greater standardisation in roles and responsibilities, training and support across the borough, to provide an equitable service and improved support for Social Prescribers. This will help with service capacity and delivery, as well as recruitment and retention.

A more centralised approach would enhance referrer liaison and awareness through better communication and information sharing to catalyse a shift in the culture and mindset of clinicians, encouraging them to embed social prescribing into their everyday practice. There may, however, be some local tailoring required to ensure the programme takes into account requirements at an individual practice level.

The universal provision of clinicians' supervision for Social Prescribers in practices was felt to be necessary. It was felt that this would relieve some of the emotional responsibility Social Prescribers experience and assist them in overcoming the challenges associated with more complex cases. Having a senior Social Prescriber acting as an advisor for others in the borough and providing peer support was also recognised as invaluable.

It was suggested that an additional resource such as a project coordinator role would enable a more standardised borough wide approach. This would limit the variation that currently exists in certain aspects for example recruitment (generic job descriptions) and supervision.

Having a triage function was also raised as an option to consider, to ensure appropriate referrals are made to social prescribing and to better manage service capacity, but with the caveat that should any such system be developed it should ensure that clients did not have to engage with multiple professionals and repeat their story.

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<sup>41</sup> Ibid.

## 7.7.2 Drawing together core elements of an ideal future model

The findings from the evaluation point to the following being core elements of an ideal social prescribing model for Tower Hamlets, with some ideas suggested for how they might be realised. Developing such a model for Tower Hamlets has been costed at £600,000 per year.

### 1) **Practice-based model of service delivery:**

- Having a named Social Prescriber linked to each GP practice, facilitates the embedding of the service within the local primary care infrastructure and is important for ensuring that Social Prescribers build their knowledge of, and engagement with, support services within the local community. It also ensures the service is equitable in terms of access.

### 2) **Management resources built into the programme:**

- Strategic support to identify and drive changes needed to develop the service, bringing in local expertise and clinical support, building on work currently undertaken by the Steering Group.
- A Project Manager (0.8 WTE, Band 8a, Agenda for Change (AfC)<sup>42</sup> equivalent) and a Project Support Officer (1 WTE, Band 4/5, AfC equivalent) to operationalise service developments and lead the day-to-day running of the service, including SLA monitoring and acting as the main link with commissioners, and to support data collection and reporting. The Project Manager would line manage a Senior Social Prescriber (see below).

### 3) **Increased service capacity and changes to line-management for Social Prescribers:**

- A senior Social Prescriber (team leader, Band 7, AfC equivalent), to line manage the other Social Prescribers, foster a team dynamic and offer peer support, working closely with the Project Manager around service issues.
- 10 Social Prescribers (WTE, Band 5, AfC equivalent)<sup>43</sup> to ensure full coverage of all practices in the borough and to mitigate against breaks in service provision due to holiday, sickness absence and vacancies, providing short-term capacity during times of high demand.

### 4) **Social Prescribers' salaries:**

- Social Prescribers on equitable and competitive pay related to the challenging nature of their role (i.e. AfC Band 5 equivalent).

### 5) **Clinical supervision and psychological support for Social Prescribers:**

- A named clinician in each practice for Social Prescribers needing support with the management of particular individual clients.
- Access to psychological support to provide mentoring on a one-to-one or group basis.

### 6) **Streamlined data recording and reporting tools and processes:**

- All Social Prescribers having full access to EMIS.
- A centralised approach to data capture and reporting.

### 7) **Resource for promotion of the service:**

- Updating existing marketing materials to ensure they continue to reflect current service provision, ensure appropriate referrals to the service, and raise awareness of the

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<sup>42</sup> Agenda for Change is the national pay system for all NHS staff, with the exception of doctors, dentists and most senior managers.

<sup>43</sup> The 10 Social Prescribers currently working within the service are not all 1.0 WTE so this represents an increase in capacity.

programme across all professional groups working within primary care and patients.

- Regular engagement with VCS – building on work already undertaken, for example individual engagement between Social Prescribers and local organisations, Social Prescribing Forums and Networking Breakfasts, for mutual information sharing and to maximise the service offer through social prescribing.
- Regular engagement with referrers – building on work already undertaken, for example through attending practice meetings, PLTs and staff inductions, to promote the service, maintain and build on current levels of referrals, and ensure their appropriateness, and facilitate further the embedding of the service across practices.

8) **Resource for service development** (in addition to points covered under 2) above):

- Capacity for long term patient follow-up – strengthen the follow-up data collected as part of the current programme and consider how uptake data could be captured to understand the journeys clients take after Social Prescribers make onward referrals, as part of future evaluations or services audits.
- Capacity to conduct robust service evaluations and adhoc research as appropriate.
- Capacity to build on the innovative work being piloted in some areas in the borough in connecting residents with each other for support.

9) **Reimbursement for the VCS** - A longer term addition to this model would be to develop a system to reimburse the VCS for the work they do to support clients referred on from social prescribing. This would have additional resource implications, beyond the £600,000 stated above.

10) **Expansion of the service to new healthcare areas** – Another longer term addition, outside of the costed model, would be to increase capacity within the service to enable referrals from other areas such as mental health services, community health teams, urgent care and social care.

The evaluation has shown that there is variety currently in the way the service is delivered across the borough, for example in the length of appointments, the number of times clients are seen and the number of referrals received. Some of these differences have evolved as the service has received increasing numbers of referrals. It is important that additional learning around this variety is captured to inform service development and establish a realistic number of referrals which can be managed within service capacity. Changes to data management systems which are in development will go some way to freeing up capacity but it is important to understand further where there may be best practice in terms of managing caseloads to ensure that the service can be expanded without overburdening the Social Prescribers.

### **7.7.3 Summary of evaluation objective 6 achievements**

Evaluation objective 6 - To recommend an ideal social prescribing model, including level of funding required
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The evaluation has met objective 6 and developed a costed model for an ideal social prescribing service in Tower Hamlets.

The findings have, however, also indicated the following issues for consideration:

- That there is further work required to understand the different service models currently operating across the Networks and learn from ‘best practice’, for example to establish workable caseload numbers for an established capacity.



## 8 Conclusions

Within a short period of time, the borough-wide roll-out has successfully begun to embed itself within primary care, receiving a high level of referrals from many different professionals across the patient pathway and some referrals from all practices in the borough. Comparisons with other areas indicates it is already one of the schemes nationally with the highest referral numbers for its size and budget. The resource involved in developing a new service and the work undertaken and commitment by key stakeholders, in particular the Steering Group and the Social Prescribers themselves, to achieve this goal should not be underestimated. It is also important to recognise the advantages brought to the borough-wide scheme in being able to use the expertise from the two pre-established schemes.

Social prescribing is a service which is valued by professionals and patients across Tower Hamlets and has shown to be of benefit both to service users and the primary care system as a whole, improving the health and wellbeing of patients and increasing the range of services they access, through successful engagement with the local voluntary and community sector.

The success of social prescribing relies on the strength of relationships between Social Prescribers and primary care staff and the voluntary and community sector. This takes time to develop and relies on stability within the service, requiring a longer-term funding commitment. The evaluation has indicated that there are areas for improvement in service structure and delivery and that at current levels of funding, the service is at capacity, despite the service being still in its infancy at a borough-wide level. These findings have informed a series of recommendations for service development (**Section 9**) and also proposals for an ideal future model (**Section 7.7**) for the service to work towards.

## 9 Recommendations

Based on the findings of the evaluation and the level of need within Tower Hamlets, due to the high impact of the social determinants of health on the local population, this evaluation recommends that the borough-wide service continues and works towards building capacity to deliver the 'ideal model' for social prescribing in Tower Hamlets, outlined in **Section 7.7**.

The following service developments are recommended in the short-term, which can be delivered within current resources:

### 1) Improve use of current service capacity

- Establish a way to manage the current referral numbers and increase in complex cases within existing capacity, for example through the use of waiting lists; looking at referral 'appropriateness;' identifying where direct referrals could be managed through the general primary care system without triage through the Social Prescriber; and minimising the time Social Prescribers spend on administrative tasks, such as data recording and reporting.
- Undertake further work to understand the reasons behind the variance in models of service delivery across the borough, such as appointment length and the way caseloads are managed, so that the 'best practice' across Networks can be shared to develop the service and identify an ideal weekly referral number for a given capacity.
- Reflect on the reasons behind the high staff turnover amongst Social Prescribers during the initial roll-out, to inform service developments.

- Look at the reasons behind clients not attending appointments to identify any areas where the DNA rate could be reduced.
- Share links of existing public directories of the local service offer with referrers, which could be used for direct referrals or signposting for the social needs of less complex patients and to explain to patients what the social prescribing service can offer.

## **2) Standardise service structure and delivery across the borough**

- Continue the work started by the Steering Group to standardise the roles, responsibilities, types of referrals, training and support, including administrative support and clinical supervision, and service promotion for social prescribing across the borough.
- Explore how to strengthen project management support for Social Prescribing, within existing capacity.
- Consider whether the current marketing of the service is fit for purpose and fully explains the service on offer – for example to ensure referrals are appropriate and help reduce the DNA rate.
- Ensure a consistent approach to feedback to referrers and that referrers are kept informed if clients do not engage or are not able to be contacted.
- Ensure adequate physical space for administration and face-to-face appointments for Social Prescribers in all GP practices.

## **3) Streamline systems of data capture and reporting and strengthen evidence on patient outcomes**

- Continue the work started by the Steering Group to streamline data collection tools to ensure recording and reporting systems are consistent across the borough, that they optimise data quality and minimise use of Social Prescriber capacity. Investigate appropriate use of new technology in this area.
- Ensure all Social Prescribers have full access to EMIS, following strict data access protocols, for the purpose of case management.
- Develop a protocol and process for MYCaW baseline and follow ups to ensure a uniform approach across the borough (whether as a central function or on a Network basis) and that the MYCaW follow up conversations are used to collect additional outcome information in a standardised way.
- Build analysis of change in health service use, such as GP appointment data, into routine data reporting requirements.
- Continue to keep abreast of developments in the National Social Prescribing Network, including any return on investment tools, which could be applied locally.

## **4) Continue and strengthen engagement with the VCS**

- Where possible within existing capacity, strengthen engagement with the VCS on a borough wide and individual Network basis to ensure all possible opportunities to support clients within the community are fully realised and that individual services are not overburdened with referrals – for example through raising awareness of the social prescribing service with the VCS and vice versa, such as through continuation of the Social Prescribing Forums and Breakfast Events.
- Continue to capture and share information on gaps in current service provision to support clients, to identify any alternative pathways of support and inform future commissioning decisions.

## 10 Appendices

### Appendix 1: Overview of the protocol followed for the quantitative and qualitative elements of the evaluation

#### Quantitative data collection and analysis

A snapshot of the case management system used by Social Prescribers showing referrals made between 1 December 2016 to 31 July 2017 was used for the main quantitative data analysis. The data was anonymised at the source by each Network and only non-identifiable data was shared with the evaluation team.<sup>44</sup>

The only exception to this was MYCaW baseline data. Permission was sought from patients to conduct MYCaW follow ups in each Network when the baseline data was connected. Minimal patient identifiable data (name, telephone number and MYCaW baseline data) was shared with the evaluation team using secure methods and stored following data protection protocols. MYCaW follow up calls were conducted by two members of the evaluation team and two of the Social Prescribers, who called their own patients. The data was analysed anonymously and key themes were drawn out, following the guidance set out in *Qualitative analysis guidelines for MYCaW*, or presented as unattributed quotes.<sup>xxxix</sup>

Quantitative data was also collected as part of two surveys which were conducted for the purpose of the evaluation, one with referrers in primary care and the other with VCS organisations. The surveys took place in August and September 2017, respectively. Participants were given the option to provide their names in both surveys if they wanted further information about the service. The responses to the surveys were analysed anonymously and presented as aggregate findings or unattributed quotes in the evaluation report.

#### Qualitative data collection and analysis

Participants were purposefully selected for the qualitative part of the evaluation, and comprised the key stakeholders of the social prescribing programme. Their recruitment was facilitated by partners from across the GP networks. Interviews and focus groups were conducted by three members of the evaluation team at UCL and transcribed and analysed using a thematic framework approach. This method was also used to analyse the qualitative questions in the referrer and VCS surveys by members of the wider evaluation team. Case studies were shared by individual Social Prescribers, who had sought prior consent from their clients to use their stories.

Surveys, focus group and interview guides were designed and agreed upon by the evaluation team, with questions based on the current academic and policy evidence base for social prescribing as well as on information and experience provided by members of the Steering Group.

Participation in the interviews and focus groups was voluntary and participants were made aware of their right to withdraw throughout the process. Verbal informed consent was sought from participants before they took part. The anonymity of participants was maintained at all times during the research process, and sensitive and/or confidential discussions were not disclosed. The interviews and focus groups were transcribed by hand, rather than recorded. In order to ensure participants' anonymity, all data was anonymised at the stage of transcription and separated from identifying information. Pseudonyms were used in transcriptions where necessary. If, for any reason,

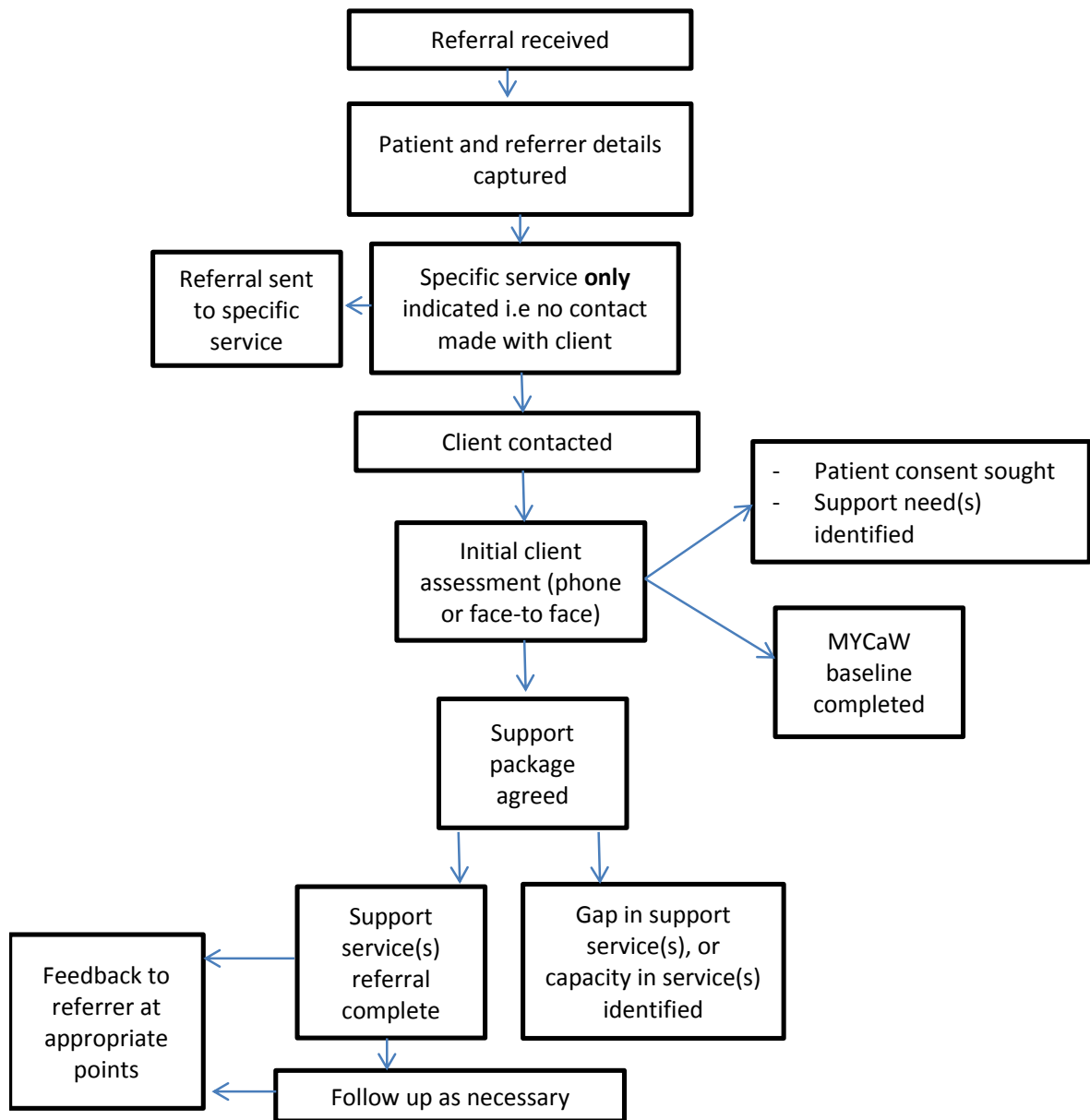
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<sup>44</sup> The evaluation team comprised members of the Steering Group, 3 researchers from UCL and a GP and Engagement Manager from THCCG, on placement in Public Health at Tower Hamlets Together.

participants were unavoidably identifiable in any of the interview data, the evaluation team sought further consent from them that the data might still be used for analysis in its current state or whether further means of anonymization were required before reaching an agreement regarding its inclusion in the final study. Key themes from this research and unattributed quotes were incorporated throughout the body of the report.

Interviews and focus groups took place between August and October 2017.

**Appendix 2: Flow chart showing client journey through social prescribing**



**Appendix 3: Breakdown of other needs, where need was specified 1 December 2016 – 31 July 2017**

<b>Category of 'other' need</b>	
Access to child	Home maintenance
Acupuncture	Immigration support
Advice worker	IT Skills
Anger management	Language support
Bed bugs	Mental health other
Befriending	Mobility help
Befriending service	Needs letter
Bereavement	NHS choices
Carer support	Occupational therapist
Child Maintenance	Pain management
Counselling	Parenting support
Day centre	Pre-diabetes programme
Diabetes management	Reduced gym
Domestic violence	Relationship problems
Fit for Life	Self-harm
Fuel poverty	Social activities
Goodmoves	Social crisis fund
Growth hormone	Social services
Health trainer	Support with taking inhaler
Health Trainers	Support worker
Healthy lifestyle advice	Transport support
Help with tasks of daily living	

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[https://www.towerhamlets.gov.uk/ignl/health\\_social\\_care/health\\_and\\_wellbeing\\_board/latest\\_news.aspx](https://www.towerhamlets.gov.uk/ignl/health_social_care/health_and_wellbeing_board/latest_news.aspx)
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