Essex County Council

Evaluation of Social Prescribing Models across Essex

Final Report – September 2017

In association with Chris Dayson

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\*The survey findings relate only to the Basildon and Brentwood; Castle Point and Rochford; Mid Essex; North East Essex (My Social Prescription); and West Essex projects. Cost avoidance calculated using self-reported use of primary, secondary and social care service and the New Economy Manchester Model.

\*\**The survey sample is not representative of the entire population and findings should be treated with caution as only providing an illustration of the types of cost-benefits that might occur more widely as a result of the project in the longer term*

# Executive Summary

## Introduction

This report provides an assessment of the economic and social impact of the pilot Social Prescribing models across Essex completed by RSM PACEC on behalf of Essex County Council (ECC).

ECC required an assessment of how effective the Social Prescribing models were in relation to cost avoidance / cost savings for primary, secondary and social care services as well as the health and wellbeing outcomes for service users. This report provides an overall assessment at programme level, project findings for each locality model are available in individual project reports.

## What is Social Prescribing

Social Prescribing is an overarching term for a project or programme that links patients with non-clinical treatment (social or physical) within their community. Referrals can be made from a range of sources including GPs, primary care professionals and others (e.g. self-referrals or referrals from police or social services) depending on the model being implemented. It aims to reduce the demand on health services, improve community wellbeing and reduce social isolation.[[1]](#footnote-1)

Most Social Prescribing models are based in a healthcare setting where referrals are primarily made by healthcare staff or where a link worker or navigator is based in a primary care setting. However there is an alternative model that is based in a community setting and where referrals are made from the wider system and can involve training staff within organisations to be ‘Social Prescribing Champions’ (SPCs) and make referrals.

Social Prescribing has been developed in a policy environment which places greater emphasis on integrated and preventative healthcare interventions that can reduce pressure on health services. Most recently, the NHS five year forward view (2014) highlighted the need for a greater focus on prevention and wellbeing, patient-centred care, and better integration of services, as well as the role of the third sector in delivering services that promote wellbeing. The General Practice Forward View (2016) also highlighted the role of Social Prescribing in developing better integration across the wider health and care system, noting that Social Prescribing is ‘a key measure by which patients can benefit from wider support’.

## Social Prescribing Models in Essex

A business case was approved in 2015 by the Transformation Challenge Programme Board for funding of £1,310,000[[2]](#footnote-2) for the period 2015/16 – 2016/17 to operate pilot Social Prescribing services across the area. However not all of the funding in the business case was received due to savings required in public health funding and some partners did not contribute the funding originally anticipated. The total income/ funding provided during 2015/16 – 2016/17 was £1,190,942.[[3]](#footnote-3)

Funding was made available from the Transformation Challenge Award (TCA)[[4]](#footnote-4) and Public Health funds. In addition, funding was committed by various statutory partners including two Clinical Commissioning Groups (CCGs)[[5]](#footnote-5), Office of the Police and Crime Commissioner (OPCC) and one local authority.[[6]](#footnote-6)

The overarching objectives for the Social Prescribing projects (as stated in the business case) were to[[7]](#footnote-7):

* improve the health and wellbeing of individuals through early intervention and reduce the dependency on public sector services;
* increase the role and capability of the voluntary and community sector (VCS) in providing support for an individual’s needs and in mobilising communities to support care needs; and
* build a more integrated approach between health and social care and its engagement with the VCS.

ECC funded seven Social Prescribing pilots across Essex and a summary of each model is outlined in the following table.

Table 1:1: Overview of Social Prescribing Models across Essex

| Area | Approach  |
| --- | --- |
| Basildon and Brentwood (Social Prescribing project) | The Basildon, Billericay and Wickford Council for Voluntary Service (BBWCVS) was commissioned by Basildon and Brentwood CCG to pilot an 18-month scheme in GP hubs in Pitsea (four GP practices) and Laindon (two GP practices). The Tile House practice was later added in October 2016 to address the demands/needs of practices within Brentwood. These areas were selected as they had the highest deprivation levels. Individuals are referred by GPs, nurses, clinicians or social care professionals and then meet with a social prescribing navigator. A Personal Plan is developed and patients are signposted to local provision.  |
| Castle Point and Rochford (Ways to Wellness project) | The Castle Point Association of Voluntary Services (CAVS) was commissioned by Castle Point and Rochford CCG to pilot a 24-month scheme in 26 GP practices. Individuals who self-refer or are referred by a GP include patients risk stratified as vulnerable (via care coordination), frequent attenders, carers, and those that are socially isolated. They meet with a Social Prescribing navigator, a Personal Plan is developed and patients are then signposted to local provision.  |
| Mid Essex (Connect Well project) | Chelmsford CVS was commissioned by Mid Essex CCG to implement a ‘whole population approach’ to Social Prescribing that operates at two levels: * Level 1: Social Prescribing Champions facilitate signposting across a number of local organisations.
* Level 2: A team of Social Prescribers, funded by ECC through PROVIDE Essex Lifestyle Team, manage higher level Social Prescribing interventions with more complex and vulnerable people. At level 2 once patients are referred by a SPC they are entitled to a maximum of 6 sessions with a Lifestyle Coach, either face-to-face or via email or telephone, and are provided with assistance with issues such as increasing their self-esteem and becoming more self-sufficient.
 |
| North East Tendring (Mental Health Hub) | Citizens Advice Bureau Tendring was provided with funding by Essex County Council, North East Essex CCG, Office Police and Crime Commissioner and Tendring District Council to provide a mental health hub as a single point for referral (from GPs, police, other parts of CAB, and other stakeholders in the community). The process involves a holistic assessment of the individual’s needs and they are then signposted to relevant services/supports.  |
| North East Colchester (My Social Prescription project) | Colchester Community Voluntary Services (CCVS) was provided with funding by Essex County Council and North East Essex CCG to implement a combined Community Builders and Social Prescribing model. The Social Prescribing model focuses on supporting people with long term health conditions and receives referrals from a number of sources including social workers, clinicians, carers/ family or self-referrals. There are two types of support provided:* Contacts – “quick win conversations” where the requirements are smaller / more focused and are often achieved at the outreach location (i.e. a direct referral on to a volunteer opportunity or a community group where a social prescriber is no longer needed to provide guidance).
* Detailed conversations – SPCs provide more intensive support and develop a set of options with our service users. Following a discussion with a social prescriber, recommendations are made to programmes, volunteers and resources and the service user is provided with contact details and further information.
 |
| West Essex (Smart Life project) | Age UK Essex was commissioned by West Essex CCG to deliver a Social Prescribing project focused on high intensity users of primary, secondary and/or social care services. It covered four GP practices across West Essex and was based on the Age UK model in Cornwall. A Personal Independence Coordinator (PIC) received referrals from doctors, nurses, receptionists, and community staff. Following referral, the PIC had a ‘clinic’ or home visit with the individual and services that already existed locally were identified to form part of the ‘wrap around’ service and a plan was tailored to the specific needs of an individual. Those who required more intensive support participated in a ‘guided conversation’ to identify their goals and were then matched with a Personal Independence Planner (PIP) (volunteer) to support them to achieve these goals.  |
| Southend | Southend Association of Voluntary Services was provided with Transformation Challenge funding by Essex County Council and Southend Public Health funds to deliver a Social Prescribing model that focused on patients with specific long-term conditions and was linked to an existing piece of work delivered by Public Health – PAM (Patient Activation Measures). Patients identified through the PAM met the Social Prescriber to explore their desired outcomes and a personal plan was agreed. Patients were supported and followed up as required to enable them to access these and further services as necessary. Alongside the prescriptions were Quality Awards to develop the quality and capacity of the VCS and a tariff pot to pay for some prescriptions.  |

Across the seven Social Prescribing models:

* 5,461 people were referred to the projects, of whom 5,251 were supported[[8]](#footnote-8) and 2,552 were ‘substantive engagements’ (i.e. received more intensive support); and
* The most common type of services referred to included clubs / leisure activities; community transport; carers services and befriending. Other services provided included volunteering (My Social Prescription); Single Point of Access for occupational therapy, falls team and dietician etc. and adult social care (Smart Life); and housing / financial advice (Basildon and Brentwood Social Prescribing project).

## Methodology

### Methodology Overview

The evaluation methodology involved:

* Desk research - brief review of relevant policy documents, desk review of project management / performance data and analysis of expenditure against budget
* Development of data collection tools – development of a baseline and follow-up survey for patients / clients that received support after 18 July 2016 (date established for commencement of the baseline questionnaire) to gather information on health and wellbeing prior to and after receiving support from the Social Prescribing service
* Consultation / surveys with service users - quantitative data and feedback was obtained from service users (who provided consent) by completion of a survey on joining the project and again three months later
* Interviews with key stakeholders - interviews were carried out with key stakeholders for each project, including partners and those that had made referrals to the project to obtain their feedback on the outcomes and impacts achieved, what has worked well and any areas for development. Detailed findings for each project are included in the individual project reports
* Development of case studies - case studies were developed to highlight impacts on individual service users
* Analysis of cost, economic and social impacts - the impact on primary, secondary and social care service use and the associated cost savings generated were analysed using the Manchester New Economy database
* Development of recommendations for future Social Prescribing models - development of draft and final project and programme reports

### Methodology / Evaluation Challenges

There were a number of challenges to implementing Social Prescribing, namely:

Awareness of the information governance requirements by delivery organisations – it took time to ensure that all delivery organisations complied with ECC information governance requirements in order to ensure data was sent securely.

The time required to get the data collection tools approved – it took time to ensure the data collection tools complied with ECC information governance requirements. As a result the data collection began later than originally anticipated and limited the number of baseline and follow-up surveys that could be completed. This should be considered in plans for the implementation of future models.

The timing of the evaluation / data collection – the evaluation was not commissioned at the start of project delivery and baseline data on health service use was not collected consistently across all projects from the outset. This commenced in July 2016 after RSM PACEC were appointed, however for some projects this was over a year into delivery. As a result a significant number of people supported by the Social Prescribing projects were not able to be included in the survey sample.

Lack of informed consent – only a small proportion of Social Prescribing service users provided consent to be contacted and were included in the survey sample. This was due to a number of issues including:

* not all service users were informed of the evaluation at the outset of their engagement
* reported resourcing issues meant it was not possible to incorporate the baseline survey as part of their initial engagement with the service user
* the vulnerable nature of the client group meant they were often not willing to discuss their health and wellbeing

Inability to engage with some service users – the evaluation team were not able to complete surveys / gather feedback from all service users, specifically for the Southend[[9]](#footnote-9) and Tendring[[10]](#footnote-10) projects. As a result conclusions on outcomes and cost effectiveness / cost avoidance are not reflective of all the Social Prescribing projects funded.

Cost avoidance – the terms of reference for the evaluation requested the identification of cost savings associated with any reduction in the use of primary, secondary or social care services. However:

* Data on health service use was not available – it was not possible to access data on the use of primary, secondary and social care services by those that were referred to the Social Prescribing projects. As a result the findings rely on self-reported use which can be less accurate and variable, for example A+E visits of inpatient hospital admissions may be more accurately reported than GP appointments or prescriptions received
* Data was not collected on the cost to local frontline VCS organisations - the Social Prescribing projects made onward referrals to a number of VCS organisations however the cost to the VCS was not captured; it was therefore not possible to mitigate the cost avoidance values calculated against the cost of delivering support by the VCS

This means there is a challenge in identifying cost savings / cost avoidance in their entirety.

Lack of consistent performance indicators - the Social Prescribing projects were all commissioned independently and used different performance indicators. This meant it was difficult to aggregate project data at a programme level.

## Conclusions and Recommendations

Social Prescribing is still in the early stages of development in Essex and the pilot projects have provided useful evidence and learning that can be used to inform the development of an Essex wide model for 2017/18.

* + 1. **Referrals**

Referral levels in some projects were significantly lower than the targets agreed in individual grant agreements / SLAs. Overall 4,951 ‘referrals in’[[11]](#footnote-11) were made across five Social Prescribing projects.[[12]](#footnote-12) This exceeds their combined target of 3,286, however while some projects exceeded their referral target (Mid Essex and North East (My Social Prescription)) other projects did not (Basildon and Brentwood and Castle Point and Rochford). No referral target was set for West Essex by the CCG however it received 510 referrals.

Obtaining referrals from GPs was a challenge reported by most of the projects. Two key approaches were used to encourage referrals:

* A Personal Independence Planner (PIC) joined Multi-Disciplinary team (MDT) meetings and detailed how Social Prescribing could help clients to the team to encourage referrals of relevant cases. This was used in the West Essex model and staff in these practices noted that they valued this approach. They also noted that they valued the updates provided on those they had referred and felt that having the PIC as part of the MDT meetings ensured there was good communication to find the best solution for patients. This was also highlighted as beneficial by the PIC who stated that being part of the monthly MDT meetings at each surgery “was pivotal to integrating Smart Life into the practices”.
* Use of SystmOne – this was used in the Mid Essex model for the level 2 service. It involved having Social Prescribing integrated into the GP systems therefore allowing them to refer patients quickly and easily. As a result the project successfully increased referrals by 1,252 (of a total 1,491 referrals therefore 84%) via SystmOne.

A review of Social Prescribing referral approaches used elsewhere noted the importance of consulting with GPs / primary care workers and tailoring the approach used to their individual needs. For example, in Doncaster[[13]](#footnote-13) GPs were provided with Social Prescribing ‘prescription pads’ as it was identified that GPs were used to writing medical prescriptions and continuing to use this format for non-medical prescriptions was a simple way get GPs referring the project. In addition, the Rotherham Social Prescribing Pilot[[14]](#footnote-14) successfully used an integrated case management approach where the Social Prescribing Navigator was embedded in case management meetings and referrals were made directly. It was also highlighted by Essex Social Prescribing delivery organisations that a higher number of referrals were received from GP practices that had a ‘GP Champion’ promoting Social Prescribing to other GPs; this was a key feature of the Rotherham Social Prescribing project.

Consultees from the delivery organisations also highlighted that the lower than anticipated number of referrals was a key issue and suggested that:

* Commissioners in the CCGs needed to do more to get Social Prescribing engrained into the everyday work of GPs and primary care staff, this could be ongoing promotion of the benefits of Social Prescribing as well as using incentives to get referrals; and
* A simple and easy referral process was needed, noting that different processes worked in different areas and therefore communication and involvement between delivery organisations and GPs / primary care staff was key in agreeing these processes.

**Recommendation:** We recommend that future Social Prescribing projects / models incorporate a range of GP/ primary care staff referral pathways, and these should be developed in conjunction with the GPs/ primary care staff to understand what works best for them and build on their existing systems / technology.

**Recommendation:** We recommend that consideration is given to how commissioners in the CCGs could become more actively involved to promote Social Prescribing, encourage GPs / primary care staff to make referrals and make potential users aware of the benefits.

* + 1. **Targets / KPIs**

Evaluation of outcomes at a programme level was difficult as the projects did not collect the same performance information. In addition, not all projects had KPIs that related to each of the outcomes to be measured by the evaluation and in some cases the performance measures set were not SMART.[[15]](#footnote-15)

A common set of core KPIs allows for consistency across each area and ensures a focus on the primary outcomes set for the funding (i.e. reduction in use of primary, secondary and social care). It is key that any future funding has outcome measures clearly agreed and evidence collected against these on an ongoing basis. If the primary outcomes change, this should be communicated to all projects and the KPIs changed accordingly. The projects may add to the core KPIs with others that are important to their area.

We understand that work has been completed since the Interim Report in October 2016 by ECC to set consistent targets that include primary, secondary and social care use and it is understood all funded projects for 2017/18 will be required to use KPIs linked to programme objectives.

**Recommendation:** We welcome that future Social Prescribing projects across Essex are expected to use the same core KPIs. These should include the following at minimum:

* Inputs – amount of funding / number of staff/ other resources involved (i.e. volunteers etc.)
* Outputs – number of users referred; sources of referral; numbers who take up the service; number from the target group (i.e. numbers using GPs and hospitals where Social Prescribing may be more relevant support)
* Outcomes – reduction in use of primary/ secondary/ social care (if appropriate); quality of the service provided and health and wellbeing outcomes for those supported (percentage reporting reduced social isolation or percentage reporting increased independence etc. – depending on the target group).
	+ 1. **Monitoring**

A lack of consistent monitoring was identified in the interim Social Prescribing programme report and ECC has carried out work to address the recommendation that a standard monitoring and reporting template should be put in place across all projects. It is understood that all funded projects will now report against (1) a focus on decreasing primary/ secondary and community care costs; and (2) a whole population approach (i.e. changing behaviours to prevent ill-health in the longer term).

**Recommendation:** We welcome the implementation of the recommendation from the interim report and understand that this will be taken forward into the 2017/18 Social Prescribing programme. We recommend that performance against targets is assessed by the CCG / ECC on a monthly basis and mitigating actions to ensure project targets are delivered documented. Ideally performance should be linked to payments.

### Data Collection

Evidence of outcomes and cost avoidance is based on self-reported health service use which can be less reliable and ideally patient-level HSC data would be used to record use of primary, secondary and social care services. This would include patient-level data on number of GP appointments attended; prescriptions received; use of counselling and/or mental health services; inpatient admissions; A + E attendances; outpatient appointments; and support received from a social worker/ social care.

Obtaining informed consent from a representative sample of service users to take part in the evaluation was a key challenge. Processes were not initially in place to obtain consent from service users at the outset of project delivery and as a result not all were invited to take part in the evaluation. Moreover, the time required to develop data collection tools in line with ECC information governance requirements and put in place processes for obtaining consent meant the time period for data collection was shorter than anticipated.

This impacted on the robustness of the data collected and a more representative cohort of survey respondents is needed to provide robust evidence of outcomes. It is also necessary to review if the outcomes reported have been sustained and therefore survey respondents or HSC data should be revisited at 6 and12 months post referral. Follow-up should also be completed to also identify outcomes that may not be apparent in the short term.

**Recommendation:** We recommend that going forward health data on service use is sought and recorded for those referred in order for accurate outcomes to be recorded. Consent should be obtained to access the NHS numbers of Social Prescribing service users, this can then be used to link with data held by the NHS Data Management and Integration Centre on their health service usage before and after engagement with the project. Where applicable an information sharing agreement or protocol between organisations sharing personal identifiable information may be required.[[16]](#footnote-16)

**Recommendation:** We recommend that in order to obtain a robust sample size a request for service users to be part of the evaluation process should be embedded as part of the referral process, so that users are invited to confirm at the outset their willingness to take part in future evaluations.

**Recommendation:** We recommend that given the low response rates and outcome data, further evaluation is required. This should be completed at 6 and 12 months to gather evidence on health service usage and outcomes achieved.

**Recommendation:** We recommend that any delivery organisations for Social Prescribing ECC are made aware of its information governance policy and are required to comply with this as part of their contract/ agreement for funding. This will be of particular importance given the introduction of the General Data Protection Regulation (GDPR) in the UK from May 2018.

* + 1. **Outcomes**
			1. **Primary, secondary and social care**

The RSM PACEC survey results[[17]](#footnote-17) show that between a quarter and a third of users reported reduced use of primary, secondary and social care. Based on self-reported data provided by 136 survey respondents the Social Prescribing projects have had the following impacts:

* Reduced use of primary care – 59% (n=74) of survey respondents (n=125) reported reduced number of hours spent with their GP and 34% (n=46) of survey respondents reported reduced number of prescriptions received
* Reduced use of secondary care – 31% (n=42) respondents of survey reported a reduction in outpatient appointments attended. This compares favorably with the findings from the Rotherham Social Prescribing pilot which reported a reduction of 21% in the number of outpatient appointments[[18]](#footnote-18)
* Reduced use of social care - 25% (n=33) of survey respondents reported reduced hours of support from a social worker

There is also anecdotal evidence from stakeholder consultees (GPs and other healthcare staff) that those they have referred now see their GP less for social / non-medical issues. This was supported by survey findings which highlighted that the greatest reduction reported was in the number of hours they spent with their GP, suggesting that GPs may receive the greater immediate benefit from Social Prescribing. Feedback from a range of consultees highlighted the impact on primary care in their area, for example:

|  |
| --- |
| One GP interviewed for the Basildon and Brentwood Social Prescribing project highlighted that many of the patients they have referred no longer come back to see them for the same issues.It was noted that since referring to the Social Prescribing project they have made fewer referrals to the mental health team. This was particularly in relation to frequent attenders who need social support but have no medical needs (e.g. are socially isolated or need help with financial issues that are impacting on their overall health and wellbeing).As a result they believed the project has helped to reduce the number of unnecessary appointments.- Consultee Interview for the Basildon and Brentwood Social Prescribing Project  |

* + - 1. **Social / health and wellbeing outcomes**

Respondents reported improvements in wellbeing following their referral to the service with over 50% reporting an increase in feelings of satisfaction with life, feelings of life being worthwhile and feelings of happiness while 47% (n=61) reported a decrease in feelings of anxiety. In addition the mean scores for life satisfaction, feelings of life being worthwhile and happiness increased and the mean score for anxiety decreased, however respondents remained within the ‘medium’ wellbeing group and below the ONS averages[[19]](#footnote-19) for each group. In addition there is some evidence of improvement in social connectedness, increased optimism and reduced feelings of depression. Qualitative feedback via service user case studies and stakeholder feedback suggests that the support provided has helped to increase independence and confidence to allow users’ engagement in community activities in which they may not otherwise have participated.

Overall there has not been statistically significant changes in reported social outcomes / wellbeing during the evaluation period (3 months). However the benefits of Social Prescribing may take time to accumulate and in some cases will only be evident in the longer term. In particular, behaviour change and self-care / self-management can take time to embed and where the model involves the training of SPCs the knowledge and learning from the training can take time to translate into referrals.

* + - 1. **Stakeholder feedback**

All consultees were positive about the service being provided and believed that while a range of organisations existed to support different needs, this was fragmented and it was not possible for many of those making referrals (e.g. GPs, social care, police etc.) to be aware of what was available, as result the Social Prescribing projects served as a conduit to fill this gap in the market.

It was suggested that without Social Prescribing, GPs / other referring organisations or individuals would not have the knowledge to signpost those in need of support to the most appropriate organisation.

Stakeholder consultees also suggested that a key element the Social Prescribing projects was the unique and tailored support provided that resulted in the best possible outcome for the people they referred, for example:

|  |
| --- |
| A representative from Rochford & Castle Point District police noted they referred a middle-aged man with financial difficulties who had been reported missing on two occasions to ‘Ways to Wellness’. Thereafter the individual has not been reported to them and the consultee believed this to be a positive sign that he received the support he needed. In addition, while it was stated that they did not have evidence of specific impacts for people they referred, they believed these to be positive, suggesting *“by default the project must be relieving pressure down the line by preventing the “low risk’ cases becoming high risk cases, for example by preventing an individual becoming suicidal due to financial issues that could be resolved with the right form of support”*- Consultee Interview for the Castle Point and Rochford Ways to Wellness Project |

* + 1. **Cost Effectiveness / Cost Avoidance and Cost Effectiveness**

There is evidence to suggest that the Social Prescribing projects have helped to reduce the use of primary, secondary and social care services and resulted in costs avoided to the health service totalling £39,726 (combined net cost avoidance[[20]](#footnote-20) calculated for primary, secondary and social care based on self-reported data provided by 136 patients / service users) over a 3-month period.

A number of positive economic benefits have been estimated:

* Primary care (based on 136 patients / service users[[21]](#footnote-21)) – costs were avoided in relation to hours spent with a GP (£9,478) and prescriptions received (£5,658), however respondents reported an increase in the use of counselling services (£2,238) and mental health support in the community (£14,976). Estimated total cost incurred: £2,078
* Secondary care (based on 136 patients / service users) – costs were avoided in relation to attendance at A+E (£1,080), outpatient attendances (£4,662) and admission to hospital for a planned procedure (£3,614) / for an emergency (£27,105). Estimated total cost avoidance: £36,461
* Social care (based on 134 patients / service users[[22]](#footnote-22)) – costs were avoided in relation to hours spent with a social worker. Estimated total cost avoidance: £5,343
* Quality Adjusted Life Years (QALYs)[[23]](#footnote-23) – based on five Social Prescribing projects[[24]](#footnote-24) an estimated additional 96.56 QALYs at a cost per QALY of £7,892.23 (compared to the NICE threshold of £20,000).[[25]](#footnote-25) If the estimated total QALY gained across five Social Prescribing projects in Essex is converted into a monetary value using the lower NHS threshold of £20,000, the value of the benefits gained amounts to £1.93 million. This means that for every £1 of the £762,074[[26]](#footnote-26) spent supporting vulnerable people, the Social Prescribing projects produced £2.53 of benefits in terms of better health.
* Return on investment – based on 136 patients / service users and an estimated cost avoidance of £39,726; a return on investment of £0.96 - £1.08 pence for every £1 invested is estimated
* Volunteering – In total 195 (active) and 285 (inactive) volunteers and SPCs have been involved in the delivery of the Social Prescribing projects. The New Economy Manchester model attributes a value of £162 to someone taking up a volunteering opportunity. Based on 42 active volunteers (excludes SPCs) this amounts to a value of £6,804 contributed by volunteers

When scaled up to reflect all of those supported by the Social Prescribing projects (**see methodology used in section 8.6**) the following net and gross cost avoidance values are estimated:

* Primary care – potential minimum cost avoidance for primary care usage for all of those supported by the Social Prescribing projects is £256,950 and the maximum is £747,468
* Secondary care – potential minimum cost avoidance for secondary care usage for all of those supported by the Social Prescribing projects is £1,091,272 and the maximum is £1,349,216
* Social care – potential minimum cost avoidance for social care usage for all of those supported by the Social Prescribing projects is £96,708 and the maximum is £211,446.

Therefore, the findings demonstrate that the project has resulted in an estimated cost avoidance for the entire programme is between £1,444,929 and £2,308,128.

* + 1. **Efficiency**

The cost per service user based on total expenditure for five projects[[27]](#footnote-27) (£585,114[[28]](#footnote-28)) and 4,807 people supported is £122, the anticipated cost per service user was £232, suggesting the project has been delivered cost effectively. However there may be other costs associated with the services that supported Social Prescribing service users that could increase the actual cost per participant.

The cost per service user varies significantly according to the project / model implemented and reflects the intensity of the each of the services, specifically:

* those with a higher cost per service user (West Essex, Basildon and Brentwood) spent more time with people on a one to one basis; and
* those with the lowest cost per service user (North East My Social Prescription and Mid Essex) involved signposting or ‘quick conversations’ that result in a direct referral there and then and no further support or time required by a Social Prescribing Navigator.
	+ 1. **Quality**

The evaluation has had a strong focus on collecting available evidence regarding the extent to which the projects reduced the uptake of primary, secondary or social care services. However the quality of the service provided is equally important to determine whether it is helping to improve users’ health and wellbeing. For example, supporting someone in such a way that could prevent suicide is an example of support that is difficult to quantify or measure and the sensitivities around collecting information on the quality of the service provided.

The Social Prescribing projects have been collecting feedback from service users through satisfaction surveys as well as case studies which provide more detail and evidence of how the Social Prescribing projects have helped those with more complex needs.

**Recommendation:** We recommend that future projects continue to conduct client satisfaction surveys and collect / develop case studies to demonstrate the quality and value of the service being provided in addition to quantitative measures.

**Recommendation:** We recommend that wider social and health outcomes should be recorded where this is feasible and realistic.

* + 1. **Local infrastructure, relationships and joint working**

The Social Prescribing projects have resulted in the development of infrastructure and support mechanisms, for example:

**Links to other support mechanisms** – the Social Prescribing projects have established relationships and worked with other professionals to promote the projects and increase referrals, for example by attending locality hub MDT meetings. In addition they have participated in a number of wider forums / groups to promote learning from the pilot projects, including participation in the National Social Prescribing Network as well as the Essex Social Prescribing Network and the Regional Social Prescribing Forum.

**VCS infrastructure** – the Social Prescribing projects have been supported by a number of VCS organisations that service users were referred to. These have included a broad range of services and organisations from both the public and third sector.

**Wider infrastructure** – the Social Prescribing projects have worked with and helped to develop community capacity / local assets. Specific examples include:

* Colchester Borough Council / library - My Social Prescription staff have served as steering group committee members and attended workshops to design new look services at Colchester Library, including sharing lessons from the My Social Prescription project. Since August 2015 project staff have facilitated attendance of community projects (including My Social Prescription staff and volunteers, as well as partner voluntary groups) for two mornings a week and provided additional volunteers for one-off events (i.e. New Year, New You and Go Online sessions). The project has also jointly trained hub staff (in excess of 30 people) on My Social Prescription in order to promote referrals into the project.
* Social workers – My Social Prescription hosted Social Care development days/meetings with local social workers that has changed the way in which social workers relate to the voluntary sector, improved their knowledge and created stronger relationships which is reflected in the high number of referrals to the project from social care staff. When new social workers join the team, they now visit with a social prescriber, learn about the VCS and how they can refer into the project.
* Connect Well – the online Connect Well referral system was implemented as part of the Social Prescribing project

**Training of volunteers / Champions** – all of the Social Prescribing projects have used volunteers to support delivery and 424 Connect Well Champions were trained in Social Prescribing, ABCD, Connect Well and Making Every Contact Count during February 2016 – 31 March 2017.

The interim report identified the need to build on the existing shared learning across the provider organisations in order to ensure the outcomes delivered can be maximised. Thereafter ECC increased plans to share learning based on the interim report, including a workshop which agreed key principles and direction of travel for an Essex wide Community Support Network that will align several similar commissioned services. This Network will be reconstituted to share good practice and successful outcomes.

**Recommendation:** We welcome the work planned to increase shared learning and suggest that the plan of work is monitored quarterly, including feedback from those involved to ensure the activities are delivering.

### Summary- Key Model Components

Based on the evidence presented in this report indicative key criteria for successful and effective Social Prescribing models are:

* Simple and easy referral process – processes that can work for a number of different referral sources and avoid too much time being required / invested by those making the referral. For example, for GPs if the referral process is incorporated into their own systems such as SystmOne they are more likely to implement.
* Promotion of the service and its benefits amongst GPs - GP buy in is essential and processes/ resources need to be in place to ensure GPs are aware and updated on how Social Prescribing can support their practice / work. The CCGs are best placed to support this effort in the first instance.
* Output and outcome indicators set are SMART, reflect the target group, and are robustly monitored on a regular basis - there should be consistency between funders on project indicators/ targets and monitoring reports showing progress against these should be sent to funders on a regular basis.
* Use of existing infrastructure / local assets to support delivery - all areas have local assets and it is important that the Social Prescribing providers are linked into these and utilising them where appropriate to support delivery. The development and maintenance of relationship(s) with other voluntary organisations, outreach and referral agencies are all essential to success. Volunteers can be used to support the project, however delivery should not be dependent on their recruitment and continued support, which cannot be guaranteed and can affect the success of project.
* Flexibility to adapt to processes and delivery to meet locality demands / needs - local situations change and providers need to be able to adapt their delivery models whilst staying focused on the outcomes required.

Any future Social Prescribing model must reflect local needs, context and existing resources and services at an area level.

# Background and Evalulation Terms of Reference

## Introduction

In April 2016 RSM PACEC was commissioned by Essex County Council (ECC) to undertake an evaluation of six Social Prescribing Models across Essex. This report evaluates the different models implemented, their performance, socio-economic impact and incorporates perspectives from key stakeholders.

## What is Social Prescribing

Social Prescribing is an overarching term for a project or programme that links patients with non-clinical treatment (social or physical) within their community. Referrals can be made from a range of sources including GPs, primary care professionals and others (e.g. self-referrals or referrals from police or social services) depending on the model being implemented. It aims to reduce the demand on health services, improve community wellbeing and reduce social isolation.[[29]](#footnote-29)

Most Social Prescribing models are based in a healthcare setting where referrals are primarily made by healthcare staff or where a link worker or navigator is based in a primary care setting. However there is an alternative model that is based in a community setting and where referrals are made from the wider system and can involve training staff within organisations to be ‘Social Prescribing Champions’ (SPCs) and make referrals.

The differing approaches implemented across Essex are detailed in section 4.2.

Social Prescribing has been developed in a policy environment which places greater emphasis on integrated and preventative healthcare interventions that can reduce pressure on health services. Most recently, the NHS five year forward view (2014) highlighted the need for a greater focus on prevention and wellbeing, patient-centred care, and better integration of services, as well as the role of the third sector in delivering services that promote wellbeing. The General Practice Forward View (2016) also highlighted the role of Social Prescribing in developing better integration across the wider health and care system, noting that voluntary sector organisations can ‘play an important role in supporting the work of general practice. For example, local models of Social Prescribing can enable GPs to access practical, community-based support for their patients, including access to advice on employment, housing and debt’. It also stated that Social Prescribing is ‘a key measure by which patients can benefit from wider support’.

## Evidence base for Social Prescribing

A report by the Social Prescribing Network[[30]](#footnote-30) states approximately 20% of patients consult their GP for primarily social problems, while other research has highlighted that 40% of health outcomes are attributable to socioeconomic factors[[31]](#footnote-31), highlighting the need for patients to access non-clinical resources to enable them to improve their health and wellbeing.

While there have been several Social Prescribing schemes operating over a number of years (for example the Bromley by Bow Centre Social Prescribing project was established in 1984) and there are currently more than 100 schemes running in the UK[[32]](#footnote-32), the evidence base is still emergent. However there is evidence to suggest that Social Prescribing will be particularly beneficial for certain types of patients and service users.

A NESTA report[[33]](#footnote-33) on services for people powered health[[34]](#footnote-34) states GPs in Social Prescribing pilots were most likely to refer patients with one or more of the following characteristics:

* a history of mental health problems;
* frequent attenders of GP clinics;
* two or more long-term conditions;
* socially isolated;
* untreatable or poorly understood long-term conditions such as irritable bowel syndrome and chronic fatigue syndrome; and
* not benefiting from clinical medicine and drug treatment.

However recent research[[35]](#footnote-35) notes that there remain barriers to engagement, particularly from GPs who are cautious of the quality and sustainability of the services being provided, noting that ‘despite 90% of GPs saying their patients would benefit from social prescribing, and four out of five believing it is something they should have access to, just 16% said they regularly used social prescribing.’

For those that are referred and supported by Social Prescribing interventions, the NESTA report[[36]](#footnote-36) states there is evidence Social Prescribing increases people’s confidence, provides opportunities to build social networks, increases self-efficacy and can increase people’s engagement with weight loss and exercise programmes. The type of outcomes that can be achieved are also evident in the Rotherham Social Prescribing pilot evaluation[[37]](#footnote-37) which found that after 3-4 months 83% of patients had experienced positive change in at least one outcome area relating to wellbeing[[38]](#footnote-38) and it was estimated that the social value of the wellbeing benefits experienced by service users equated to up to £432,000, a social return on investment (SROI) of £2.19 for every £1 invested in the pilot. The evaluation of the Rotherham Social Prescribing pilot also reported that there were reductions in patients’ use of hospital services, including reductions of up to a fifth in the number of outpatient stays, accident and emergency attendances and outpatient appointments. The return on investment (ROI) for the NHS was 50 pence for each pound invested.

However other research has suggested that the benefits of Social Prescribing may take around 18 months to 2 years to accumulate. For example, an evaluation of the Expert Patients Programme (EPP)[[39]](#footnote-39) showed that in the short-term EPP patients did not consult less, but they did show improvement on quality-of-life measures, increased energy and self-efficacy. Habits of seeking help from the NHS do not change quickly. It is not surprising therefore, that cost-effectiveness studies over the short-to medium term do not always show NHS savings and commissioners should be prepared for this.[[40]](#footnote-40)

## Background to Essex County Council Social Prescribing

A business case was approved in 2015 by the Transformation Challenge Programme Board for funding of £1,310,000[[41]](#footnote-41) for the period 2015/16 – 2016/17 to operate pilot Social Prescribing services across the area. However not all of the funding in the business case was received due to savings required in public health funding and some partners did not contribute the funding originally anticipated. The total income/ funding provided during 2015/16 – 2016/17 was £1,190,942.[[42]](#footnote-42)

Funding was made available from the Transformation Challenge Award (TCA)[[43]](#footnote-43) and Public Health funds. In addition, funding was committed by various statutory partners including two Clinical Commissioning Groups (CCGs)[[44]](#footnote-44), Office of the Police and Crime Commissioner (OPCC) and one local authority.[[45]](#footnote-45)

The overarching objectives for the Social Prescribing services (as stated in the business case) were to[[46]](#footnote-46):

* improve the health and wellbeing of individuals through early intervention and reduce the dependency on public sector services;
* increase the role and capability of the voluntary and community sector (VCS) in providing support for an individual’s needs and in mobilising communities to support care needs; and
* build a more integrated approach between health and social care and its engagement with the VCS.

In addition, the business case defined success measures for the programme as:

* Improved health and wellbeing of users;
* Demand on the public sector would be reduced, particularly across health and social care services; and
* Social Prescribing would be embedded within GP Surgeries across Essex.

It also detailed the expected non-fiscal benefits:

* Increased efficiency and effectiveness within GP surgeries: time is released for GPs to spend on the most pressing cases;
* Broader range of community activities and self-care options;
* Increased level of patient wellbeing and happiness;
* Increased number of patients go on to regularly volunteer;
* Increased number of social interactions building stronger social networks; and
* Improved systems between health and community sectors facilitating better communication and improved workforce and working culture.

In addition Partnership Agreements were signed with the CCGs which stated the following characteristics should be present in social prescribing projects across all CCG areas:

* A close operational level relationship with GP practices(s) and social care staff to identify appropriate clients;
* Clear client targeting and recruitment and selection procedures;
* A clearly defined pathway clarifying who is responsible for what activities by organisation at each stage of the pathway;
* Individual tailoring of interventions to support clients’ unique needs based on a personal understanding of the individual and a strong personal yet professional relationship, ensuring that professional boundaries are maintained at all times;
* Recognising the needs of carers. Where the referred patient is a carer, or has a carer, ensuring that personal goals are drawn up either individually for the carer and the cared for or together depending on the needs of the individuals;
* Work with the individual to identify the most appropriate resources available within the community and voluntary sector in order for these goals to be achieved, recognising the range of support that can be provided – including information, advice, benefits checks, falls prevention services, handyman services, community transport services, social activities, health promotion/support groups all with focus on self-care and independence;
* Signposting/Supporting patients to access services, including community organisations and groups, that may help them to self-care or to promote independence. This may include attending with the patients (where possible) until such time as they are able to attend independently (if appropriate);
* Ensure that the patients’ goals are achieved and releasing them from the caseload only when there are suitable community and voluntary sector services in place and when the patient is receiving adequate support from these services;
* Ensure working protocols for all parties meet all patient confidentiality requirements and Caldicott guidelines;
* Ensure secure storage of patient details as per all relevant national legislation and good practice guidance;
* Being supportive of and using, where appropriate, existing projects within the locality, such as Frontline, Community Builders and Social Prescription to better inform development of such services, and their relationship to emerging Social Prescribing programmes; and
* Cooperate with and participate in externally commissioned evaluation by an external academic partner commissioned by ECC.

## Terms of Reference

ECC required an evaluation partner to develop an evaluation methodology and conduct evaluation work which would help decision makers to understand the effectiveness of the Social Prescribing service in terms of impact on services and specifically cashable savings, and medium-term health and wellbeing outcomes for service users. The terms of reference for this evaluation require project and programme reports that set out the primary, secondary and wider outcomes that have been delivered as follows:

Primary outcomes:

* Primary care use by prescription recipients, and savings associated with any reduction (in terms of a reduction in spending on individuals receiving a social prescription)
* Secondary care use and savings associated with any reduction
* Impact on social care use, and savings associated with any reduction

Secondary outcomes:

* Impact on mental wellbeing, social isolation and general health, and patient experience of Social Prescribing
* Estimates of cost to the NHS and Essex County Council of providing the services that people are directed to via social prescriptions
* Whole-system impacts of the SP approach, including impact on SP providers, improving community resilience and capacity, improving inter-organisational relationships and joint working
* The wider impact that a social prescription may have on the families and carers of individuals who receive a prescription

The terms of reference for the evaluation highlight that these outcome targets were agreed with CCGs and provider partners prior to the commencement of the evaluation.

## Purpose of this report

The purpose of this report is to summarise the key findings from each of the pilot Social Prescribing projects at an overall programme level, the detail on each of the individual projects is contained in separate evaluation reports.

# Methodology

## Methodology Stages

The methodology used for the evaluation was agreed with ECC in advance of the project commencing. The evaluators also presented the evaluation methodology to the CCGs/ delivery bodies at the outset. The key stages of work involved:

Stage 1: Desk Research

* Brief review of relevant policy documents to set the context for the evaluation
* Detailed desk review of the project delivery model, aims and objectives, funding, anticipated outcomes, the processes in place to collect monitoring / evaluation data and referrals etc.
* Analysis of progress against targets and expenditure against budget

Stage 2: Development of data collection tools

* A baseline survey was developed for patients / clients that received support after 18 July 2016 (date established for commencement of the baseline questionnaire). This was designed to gather information on health and wellbeing prior to receiving support from the service. A copy of the survey is in Appendix 1
* A follow-up survey was developed to gather information on patients / clients health and wellbeing after receiving support from the service. A copy of the survey is in Appendix 2

All data collection tools were reviewed and approved by Essex County Council and Essex CCGs Information Governance teams.

The survey was developed in the absence of access to actual data on health service use before and after engagement with the Social Prescribing projects. This would have been preferable as often service user self-reporting of health service use can be unreliable, however this was investigated and it was not available within the timescales for the evaluation.

Each survey was developed to collect the quantitative data required to assign cost values using the New Economy Manchester model.[[47]](#footnote-47) This model was used as the business case submitted for TCA funding included estimated cost savings for each project using New Economy Manchester modelling. It was therefore required to be used at the evaluation stage.

While funding was also provided to the Citizens Advice Bureau (CAB) in Tendring to operate a mental health hub, the organisation stated it was not possible to conduct surveys or consultations with services users due to the vulnerable nature of the client group. This meant they often did not provide consent to speak with a third-party organisation, or where consent was given, they did not wish to discuss their experience.

Survey data was not collected for the Southend-on-Sea Social Prescribing project as Southend CCG and Southend Council completed evaluation work for this project in-house. However RSM PACEC completed desk research and focus groups with project participants from Southend-On-Sea and the findings from these are reported on in section 6.5.

Stage 3: Consultation with Service Users

Quantitative data from those who were supported by the project was collected using a survey of service users (who provided consent) on joining the project and again 3 months later. Analysis in section 6.4 focusses on changes between the baseline survey and follow-up survey.

The survey included questions about three types of outcomes relevant to social prescribing:

* Primary, secondary and social care use – as Primary and Secondary coded data was not available for this evaluation, questions were developed to record self-reported use of primary, secondary and social care services in the 3 months prior to engaging with the service and 3 months after
* Personal wellbeing- the 4 measures of personal well-being used by the Office of National Statistics (ONS) were used to measure feelings on satisfaction with life, that things in life are worthwhile, happiness and anxiety
* General health – the EQ-5D scale was used to provide a measure of ‘health related quality of life’. EQ-5D measures five components of health – mobility, self-care, usual activities, pain/ discomfort and anxiety / depression
* Mental health- the Short Warwick Edinburgh Scale is used to monitor mental wellbeing; the shortened version provides a seven-item scale to measure thoughts and feelings from ‘none of the time’ to ‘all of the time’

The follow-up survey also asked questions on satisfaction with the support provided, what worked well and any areas for development.

Stage 4: Interviews with Key Stakeholders

Interviews were carried out with key stakeholders for each project, including partners and those that had made referrals to the project to obtain their feedback on the outcomes and impacts that have been achieved, what has worked well and any areas for development. Detailed findings for each project are included in the individual project reports.

Stage 5: Case Studies

Case studies are included in section 6.5 to highlight how the services provided have impacted on the lives of service users.

Stage 6: Analysis of Costs / Economic and Social Impacts

Analysis of the impacts on primary and secondary care / cost savings generated using the Manchester New Economy database.

Stage 7: Reporting

Development of a draft and final project reports and an overall draft and final programme report.

## Information / Data Governance

All data collected for the evaluation complies with all relevant data protection legislation and thanks is extend to Amy Hamilton from the ECC Governance Team for working with us and the delivery providers in this regard.

Service user contact details were obtained from the delivery organisations[[48]](#footnote-48) through the following process which is in line with ECC Information Governance Principles and Guidelines[[49]](#footnote-49):

* Consent was obtained from the patient / client by the delivery organisation for their information to be shared with RSM PACEC for the purposes of research / evaluation. This was obtained verbally or via the completion of a consent form that follows the template(s) provided in the ECC Information Governance Principles and Guidelines document
* For those that provided consent their contact details were either:
* included in the baseline survey (completed by the delivery organisation), entered onto the online portal and then used by RSM PACEC to complete the follow-up survey[[50]](#footnote-50); or
* their contact details were forwarded to RSM PACEC to complete the baseline survey[[51]](#footnote-51).
* RSM PACEC stored all personal contact information in password protected files within a restricted access folder
* At the start of each telephone call conducted by RSM PACEC the patient / client was asked to confirm their consent to take part in the evaluation and informed that:
* Their personal information had been provided to RSM PACEC by the delivery organisation under their consent;
* The information provided would be treated with confidence;
* This information and the responses in the questionnaire would be securely stored and would not be shared or utilised for any other purpose than which they had given consent;
* The survey was designed to gather information on their health and wellbeing; and
* They did not have to answer all questions if they did not wish to.

All data will be destroyed in a confidential way at the end of the contract with ECC.

**The process has been important in building provider awareness of the importance of complying with information governance processes and the need to ask clients if they are willing to provide consent at the outset of the process, therefore reducing time/ cost required in asking for this at a later date.**

## Report Outline

The following sections present the evidence collected during each stage of the methodology. The remainder of the report is structured as follows:

* Section 4 – Social Prescribing Models
* Section 5 – Indicators
* Section 6 – Performance
* Section 7 – Stakeholder Feedback
* Section 8 – Costs / Cost Avoidance and Cost Effectiveness
* Section 9 – Progress against Interim Recommendations
* Section 10 – Conclusions and Recommendations

# Social Prescribing Models

## Introduction

The following section details the evidence base for Social Prescribing and the current models funded by ECC.

## Essex Social Prescribing Models

ECC funded seven Social Prescribing pilots across Essex and a summary of each is outlined below:

* Basildon and Brentwood - The Basildon, Billericay and Wickford Council for Voluntary Service (BBWCVS) was commissioned by Basildon and Brentwood CCG to pilot an 18-month scheme in GP hubs in Pitsea (four GP practices) and Laindon (two GP practices). The Tile House practice was later added in October 2016 to address the demands/needs of practices within Brentwood. These areas were selected as they had the highest deprivation levels. Individuals are referred by GPs, nurses, clinicians or social care professionals and then meet with a social prescribing navigator. A Personal Plan is developed and patients are signposted to local provision. It is delivered by two full time Social Prescription Navigators; part-time admin support (0.5); and a part time project manager (0.4).
* Castle Point and Rochford - The Castle Point Association of Voluntary Services (CAVS) was commissioned by Castle Point and Rochford CCG to pilot a 24-month scheme in 26 GP practices. Individuals who self-refer or are referred by a GP include patients risk stratified as vulnerable (via care coordination), frequent attenders, carers, and those that are socially isolated. They meet with a social prescribing navigator, a Personal Plan is developed and patients are then signposted to local provision. It is delivered by 3-part time staff and 1 volunteer.
* Mid Essex - Chelmsford CVS was commissioned by Mid Essex CCG to implement a ‘whole population approach’ to Social Prescribing that operates at two levels:
* Level 1: Social Prescribing Champions facilitate signposting across a number of local organisations; and Level 2: A team of Social Prescribers manage higher level Social Prescribing interventions with more complex and vulnerable people.
* At level 2 once patients are referred by a SPC they are entitled to a maximum of 6 sessions with a Lifestyle Coach, either face-to-face or via email or telephone, and are provided with assistance with issues such as increasing their self-esteem and becoming more self-sufficient. This element is commissioned by Essex County Council through PROVIDE.

It is delivered by one contracted Programme Manager, trained SPCs and Lifestyle Coaches (equating to approx. 0.8).

* North East Essex – Mental Health Hub Tendring - Tendring CAB was funded by Essex County Council, North East Essex CCG, Office Police and Crime Commissioner and Tendring District Council to operate a mental health hub that would offer a single point for referral (referrals from GPs, police, other parts of CAB, and other stakeholders in the community, as well as walk-ins). The process involves a holistic assessment of the individual’s needs and they are then signposted to relevant services/supports. It is delivered by 2.0 FTE Hub Assessors / Support Workers.
* North East Essex – Colchester - Colchester Community Voluntary Services (CCVS) was funded by Essex County Council and North East Essex CCG to implement a combined Community Builders and Social Prescribing model. The Social Prescribing model focuses on supporting people with long term health conditions and receives referrals from a number of sources including social workers, clinicians, carers/ family or self-referrals. There are two types of support provided:
* Contacts – “quick win conversations” where the requirements are smaller / more focused and are often achieved at the outreach location (i.e. a direct referral on to a volunteer opportunity or a community group where a social prescriber is no longer needed to provide guidance).
* Detailed conversations – SPCs provide more intensive support and develop a set of options with our service users. Following a discussion with a social prescriber, recommendations are made to programmes, volunteers and resources and the service user is provided with contact details and further information.

It is delivered by 2.5 FTE staff and over approx. 12 volunteers.

* West Essex - Age UK Essex was commissioned by West Essex CCG to deliver a Social Prescribing project focused on high intensity users of primary, secondary and/or social care services. It covers four GP practices across West Essex and is based on the Age UK model in Cornwall. A Personal Independence Coordinator (PIC) receives referrals from doctors, nurses, receptionists, and community staff. Following referral, the PIC will have a ‘clinic’ or home visit with the individual, services that already exist locally will then form part of the ‘wrap around’ and be tailored to the specific needs of an individual. Those who require more intensive support will participate in a ‘guided conversation’ to identify their goals and they will then be matched with a Personal Independence Planner (PIP) (volunteer) to support them to achieve these goals. It is delivered by one full-time PIC and 5 volunteers.
* Southend-On-Sea - Southend Association of Voluntary Services was funded by Essex County Council with Transformation Challenge monies and Southend Public Health to deliver a Social Prescribing model that focused on patients with specific long-term conditions and was linked to an existing piece of work delivered by Public Health – PAM (Patient Activation Measures). Patients identified through the PAM met the Social Prescriber to explore their desired outcomes and a personal plan was agreed. Patients were supported and followed up as required to enable them to access these and further services as necessary. Alongside the prescriptions were Quality Awards to develop the quality and capacity of the VCS and a tariff pot to pay for some prescriptions. It was delivered by one Social Prescribing coordinator.

Therefore it is evident that a number of different models were funded however as this was a pilot programme it provided an opportunity to try new ways of working and identify any lessons learned. The main differences between the Essex Social Prescribing models are outlined in section 4.2.1.

### Differences in the Social Prescribing Models

The models funded through the pilot differ with regard to target groups, referral pathways, the type and format of support provided and the resources used.

Table 4:1: How the Social Prescribing Models Differ

| How they differ | Summary  |
| --- | --- |
| Target Group |  The models target different groups: * **Open to all ages / any conditions:** for example, anyone living in Mid Essex can access Connect Well and be signposted to community providers. Currently this is via a SPC or Social Prescriber based on their potential need and how the community service could improve their health and well-being, and potentially reduce their use of statutory services.
* **Open to all ages with a focus on specific conditions:** models such as Basildon and Brentwood are available to all aged 18+ however with a focus on those with highest need, or Castle Point and Rochford which focus on those that are risk stratified as i) vulnerable/frail ii) pre-frail and at risk of deterioration and / or are frequent attenders at GP practices with no identified medical need. Some projects such as the Tendring Mental Health Hub have a very specific target group (those with mental ill health). In West Essex GPs across the four practices use the same risk profiling tool to identify the top 2% of patients (high intensity users who could be best case managed in community). The North East Essex (My Social Prescription) focused on those with specific conditions like diabetes or chronic kidney disease
* **Focus on people with long term or chronic conditions:** models such as Southend-On-Sea.
 |
| Referrals In | Each of the models accept referrals from GPs / primary care providers (e.g. nurses, clinicians, social care) however in addition some also accept: * self-referral or point of access (Castle Point and Rochford / North East Essex (My Social Prescription) and it is anticipated that in Mid Essex the Connect Well referral route will be developed further to accommodate self-referrals in summer 2017)
* referrals from other community organisations such as police or CAB (North East Essex – Tendring/ Castle Point and Rochford)
 |
| Referrals Out | Each of the models have made a number of onward referrals to a broad range of services and organisations that included both public sector services as well as the third sector. Common services referred to across a number of projects included third groups / clubs / leisure activities; community transport; carers services and befriending. Other services which received high onward referrals by specific projects were volunteering (My Social Prescription); Single Point of Access (for OT, falls team and dietician etc.) and adult social care (Smart Life); and housing / financial advice (Basildon and Brentwood Social Prescribing project). The range of services that received onward referrals indicates the breadth of needs identified and in some cases those referred out were referred to more than one service.  |
| The type of model delivery  | The Social Prescribing models involved the following approaches:* based in a healthcare setting (e.g. where referrals are primarily made by healthcare staff or where a link worker or navigator in based in a primary care setting.
* based in a community setting and where referrals are made from the wider system and can involve training staff within organisations to be ‘Social Prescribing Champions’ (SPCs) and make referrals.
 |
| The type of support provided  | The type of support provided varies across the models and includes:* Meeting with a Social Prescribing Navigator who undertakes a one to one holistic patient assessment, develops a Personal Action Plan and signposts to local provision (Basildon and Brentwood and Castle Point and Rochford)
* Two levels of Social Prescribing (lower level and higher level / more intensive support) based on the needs of the patient / service user
	+ Lower level – this includes access to information / signposting (i.e. Mid Essex / North East Essex)
	+ Higher level - one to one support over a longer period of time (i.e. Basildon and Brentwood / West Essex and Southend)
 |
| Resources used | The differing types of support also use differing resources: * Employed staff (all projects have employed staff however the number of staff varies)
* Volunteers, all of the projects except Mid Essex include volunteers to help deliver the service as well as providing volunteering opportunities for e.g. people with mental ill health
 |
| Monitoring Information / Reports  | * The grant agreements / Service Level Agreement (SLA) set out the monitoring arrangements, however the level of detail on what information is to be recorded varies
* While some projects have monthly monitoring reports that contain data on referrals to the project / source of referrals as well as onward referrals, this is not evident for other projects
 |
| Existing Infrastructure | Each of the projects had access to different existing infrastructure, including:* As part of a wider programme link to a strategic board (Mid Essex and North East Essex (My Social Prescription))
* Staff / volunteers within delivery organisations (all)
* Existing information sources / directories (all)
* Existing relationships with local agencies (all)
 |

Each of the models are at different stages in their development, as while some localities have been delivering services for a year or more others have commenced later. An overview of the timescales for each project is in table 4.2.

Table 4:2: Social Prescribing Project Timescales

| Locality  | Project Timescales |
| --- | --- |
| **Basildon and Brentwood** | **1 September 2015 to 1 March 2017**[[52]](#footnote-52) |
| **Castle Point and Rochford** | **February 2016 – March 2018**[[53]](#footnote-53) **(however this report reflects only the funding received for 2016/17)** |
| **North East Essex – Mental Health Hub Tendring** | **April 2015 – 1 March 2017**[[54]](#footnote-54) |
| **North East Essex – Colchester** | **1 January 2015 - March 2017**[[55]](#footnote-55) |
| **Mid Essex** | **July 2015–March 2017**[[56]](#footnote-56) |
| **West Essex** | **December 2014 – 31 November 2016**[[57]](#footnote-57) |
| **Southend-On-Sea** | **June 2015 to September 2016**[[58]](#footnote-58) |

The table above shows that the social prescribing projects in each locality have been delivering services for differing periods of time and therefore it is expected that the outputs and evidence of outcomes may vary.

### Social Prescribing Pathways

Each of the projects involves a specific pathway for referrals; this is similar for the four of the models (Basildon and Brentwood; Ways to Wellness, Smart Life and Southend) with different pathways for My Social Prescription / Tendring and Connect Well.



### Monitoring

In Basildon and Brentwood, Castle Point and Rochford, Mid and West Essex ECC provided funding to the CCG in a section 76 agreement and the CCG commissioned the delivery organisation, while in Southend and North East Essex the grant agreement was direct with ECC.

A review of the contract arrangements show that while each document contains details on the purpose of the project, its objectives and targets and indicates that monitoring reports will be required, the timing and content of these is not specified in each case.

There is scope for greater consistency in the monitoring information that was collected at project level. While projects reported on the information required by their respective CCG / Board the type of information reported was not consistent and in some cases the monitoring reports were not sufficient to assess whether the targets / key performance indicators (KPIs) were on track to be achieved or not as well as expenditure against budget. There are different monitoring / reporting systems available, however a simple approach is the traffic light system that uses red / amber / green indicators to help identify whether targets are met / on track to be met / or are not met. This makes it clearer which areas require focus to get them back on track.

Detail on progress and spend against target / budget as well as monitoring of risk and actions required should be reported by all funded projects to facilitate assessment at a programme level; it is understood that this will be part of the new section 75 agreements with ECC going forward (see section 9).

# Indicators

## Introduction

This section provides an assessment of the indicators used by the pilot Social Prescribing projects and suggested future areas for development.

## Assessment

While the Social Prescribing business case (June 2015) outlines the initial locality specific approaches for each project, it was not possible to provide a detailed intervention logic or rationale for each model as in most cases they were not yet commissioned. In addition the terms of reference for this evaluation (section 2.5) were not covered in the locality contracts/ SLAs as they had not been agreed when the contracts were issued. The following table summarises how the project targets link to the outcomes being measured by the evaluation.

Table 5:1: Locality Models Objectives and Targets

| Locality  | KPIs that link to the evaluation primary outcomes and secondary outcomes. Direct Measurement of: |
| --- | --- |
| Primary care use by service users | Secondary care use | Social care use | Impact on mental wellbeing, social isolation and general health | Patient experience of Social Prescribing |
| Basildon and Brentwood | ✓ |  |  | ✓ | ✓ |
| Castle Point and Rochford  | ✓ |  |  | ✓ | ✓ |
| North East Essex- Tendring | ✓ | ✓ |  | ✓ |  |
| North East Essex - Colchester | ✓ |  |  | ✓ |  |
| Mid Essex[[59]](#footnote-59) | ✓ | ✓ | ✓ | ✓ |  |
| West Essex | ✓ | ✓ |  | ✓ |  |
| Southend |  | ✓ |  | ✓ |  |

The table above shows that not all projects had KPIs linked to primary, secondary and social care use (and associated cost savings), mental wellbeing, social isolation and general health or the patient experience of Social Prescribing.

While six projects had KPIs that measured some primary outcomes and four that measured some secondary outcomes only one had a KPI linked to social care. However some pilot projects included KPIs that incorporated the wider determinants of health (e.g. employment, crime reduction etc.). Examples include:

North East - Tendring:

* reduced poverty;
* avoiding homelessness;
* avoiding benefit sanctions;
* reduced anxiety due to unmanageable debt;
* reduced risk of offending or becoming a victim of crime; and
* avoiding dismissal from employment.

North East – Colchester (expected benefits based on the Manchester New Economy Model):

* All types of crime;
* Anti-social behaviour
* Simple Repossession; and
* Complex Eviction.

While the planned outcomes for the Connect Well Model in Mid Essex includes reduced primary, secondary and social care use as well as improved health and wellbeing, these are not currently measured by the project and current KPIs focus on activity targets. *It is noted that a proposal is currently being developed by Connect Well to obtain NHS assured data that can be used to evidence these outcomes in the future*.

## Conclusion

A detailed intervention logic sets out the required outcomes and then the activities needed to realise these (based on evidence), including any assumptions about how they will do this. This ensures there is a focus on the required outcomes. All Social Prescribing projects / programmes should use an intervention logic and a common set of indicators that include inputs, activities, outputs and outcomes. Indicative indicators for Social Prescribing projects are outlined below.

Table 5:2: Social Prescribing Logic Model – Indicative Example of Typical Indicators

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Inputs  | Activities  | Outputs | Outcomes  | Impacts |
| * Staff time (e.g. Social Prescribing Navigators)
* Volunteers
* Funding
* Existing infrastructure / resources
* GP/ healthcare professional buy-in
* Clear, simple referral process
 | * Project promotion
* Telephone / face to face sessions between the SP Navigator and the service user
* Identification of goals
 | * Number of referrals in / number from the target group
* Number of referrals out
* Number of actions plans completed
* Number of baseline and follow-up surveys completed
* Number of service users that engage in the activity referred to
 | * Reduction in inappropriate use of primary, secondary and social care
* Improved general + mental health and wellbeing
* Reduced social isolation
* Increase self-management of conditions
* Service user satisfaction
* Value for Money (VFM)
 | * Stronger links between primary care and third sector providers
* Increased joint working between sectors
* Improved awareness / value of Social Prescribing as an option for GPs etc.
 |

The pilot Social Prescribing projects were inconsistent in their use of indicators and not all included outcomes, or specifically the outcomes to be measured by this evaluation. All funded projects should have consistent input, output and outcome indicators and it is understood that reporting against the following outcomes is incorporated in the contractual agreements from 2017-18[[60]](#footnote-60):

* decreasing primary/ secondary and community care costs; and
* changing behaviours to prevent ill-health in the longer term.

# Performance

## Introduction

This section provides an overview of the performance of the Social Prescribing projects, the outcomes achieved and illustrative case studies.

## Inputs

The success of any intervention requires the comparison of inputs against outputs and outcomes. The following table details the inputs for each Social Prescribing project in relation to funding, as well as the number of staff, volunteers and referrals. The information in table 6.1 reflects the evidence provided for the seven funded Social Prescribing projects. The number of staff, volunteers and referrals for the Tendring project was not available for this evaluation.

Castle Point and Rochford has a funding period beyond the time period for this evaluation, therefore a pro rata funding figure has been used for this project.

Table 6:1: Funding Provided to Social Prescribing Project by Locality – (2015/16 – 2016/17 – as at 31 March 2017)

|  | Basildon and Brentwood  | Castle Point and Rochford | Mid Essex | NE Essex – Colchester  | NE Essex – Tendring  | West Essex | Southend  | Total  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Funding[[61]](#footnote-61)  | £155,040 | £90,417[[62]](#footnote-62) | £286,485[[63]](#footnote-63) | £159,000 | £200,000 | £230,000 | £70,000 | £1,190,942 |
| Number of staff | * 2 FT SP Navigator
* Admin support (0.5)
* 1 PT project manager (0.4)
 | 3 PT staff | 1 FT project lead0.8 Level 2 Advisors (PROVIDE) | 2.5 FT staff | Not available | 1 FT PIC | 1 FT SP Coordinator | 11 FT staff |
| Number of Volunteers  | 8 volunteers | 11 volunteers | 424 trained SPCs (153 active)[[64]](#footnote-64)one volunteer supporting project administration | * 13 active volunteers
* 11 inactive volunteers
* 1 admin volunteer
 |  | 6 volunteers in a PIP role (3 active) 2017  | 5 volunteers | * 195 (active, including SPCs)
* 285 (inactive, including SPCs)
 |
| Number of Referrals  | 318 | 387 | 1,491 | 2,683 | Not available | 510 | 72 | 5,461 |

Source: Information provided by Basildon and Brentwood CVS; Castle Point Association Voluntary Services; Chelmsford CVS; Colchester CVS; ECC, Age UK Essex, Southend Association Voluntary Services (June 2017)

Table 6.1 shows that in total the Social Prescribing projects have been provided with total funding of £1,190,942, mainly from the TCA and ECC Funding.

Funding in some areas is also provided by other sources, for example the Tendring Mental Health Hub had a contract from the NECCG, an OPCC grant and funds from Tendring District Council. Southend had funds from Southend Public Health. Most projects are being run by only 1-2 people FT/PT people.

## Outputs

The outputs that were recorded by each of the projects relate to the number of referrals in and onward referrals to other support organisations.

The following table details the target and actual number of referrals to each Social Prescribing project.

Table 6:2: Referrals to the Social Prescribing by locality (at 31 March 2017)

|  | Basildon and Brentwood[[65]](#footnote-65)  | Castle Point and Rochford[[66]](#footnote-66) | Mid Essex[[67]](#footnote-67) | NE Essex – My Social Prescription[[68]](#footnote-68)  | West Essex[[69]](#footnote-69) | Southend[[70]](#footnote-70) | Total (excluding West Essex) | *Total (including West Essex)* |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Target number of service users (referrals in) | 875 | 1,127 (pro rata)[[71]](#footnote-71) | 315 (pro rata)[[72]](#footnote-72) | 999 | No Target Set | 75 | 3,391 | *3,391* |
| Actual number of referrals  | 318 | 387 | 1,491 | 2,683 | 510 | 72 | 4,951 | *5,461* |
| **Variance**  | **-557** | **-740** | **1,176** | **1,684** | **N/A** | **-3** | **1,560** | ***N/A*** |

Table 6.2 shows that overall 4,951 referrals in were made across five Social Prescribing projects (Basildon and Brentwood; Castle Point and Rochford; Mid Essex; North East Essex My Social Prescription; and Southend). This exceeds their combined target of 3,391, however while some projects exceeded their referral target (Mid Essex and My Social Prescription) other projects did not meet their target (Basildon and Brentwood and Ways to Wellness).

No referral target was set for West Essex within the CCG contract however it received 510 referrals in total.

Targets have been exceeded in the Mid Essex Connect Well project in part due to the introduction of SystmOne to record referrals from GPs for the Level 2 conversations while My Social Prescription had a range of accessible referral routes into the project (face to face, by phone, by email and online via the Essex Connects and Connect Well Essex databases). Project staff highlighted that this allows people with different experiences and skills to use the information available in their own way. The project has also adapted the referral route to social workers via a specific referral form that allows project staff to understand some of the complexities of the cases they refer. This was also highlighted by a social care representative who noted that “*the project delivers the outcome needed and makes the relevant connection specific to the adult referred*”. It is anticipated that the project will continue to expand its referral routes and widen the stakeholders that can refer to include e.g. Council staff.

Table 6.3 details the number of people that were supported by the Social Prescribing projects. The type of support provided varied according to the model (see section 4.2), specifically:

* Basildon and Brentwood / Castle Point and Rochford – the number supported reflects those supported to develop a person action plan and progress reviewed by a Navigator
* Mid Essex / My Social Prescription and West Essex – the numbers reflect both signposting, referrals and more intensive support. For example, the number of service users reported for My Social Prescription includes ‘contacts’ (“quick win conversations” where the requirements are smaller and more focused and are often achieved there and then on the outreach – i.e. a direct referral on to a volunteer opportunity or a community group where a social prescriber is no longer needed to guide them) as well as “detailed conversations” (more intensive support that involves developing a set of options with service users)

Therefore table 6.3 also outlines those that were ‘substantive engagements’ (i.e. received more intensive support); there were no separate targets set for these engagements.

Table 6:3: Social Prescribing ‘substantive engagements’ Outputs by Locality (at 31 March 2017)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Basildon and Brentwood[[73]](#footnote-73)  | Castle Point and Rochford[[74]](#footnote-74) | Mid Essex[[75]](#footnote-75) | NE Essex – My Social Prescription[[76]](#footnote-76)  | West Essex[[77]](#footnote-77) | Southend[[78]](#footnote-78) | Total  |
| Number of people supported[[79]](#footnote-79) | 301 | 371 | 1,430[[80]](#footnote-80) | 2,640 | 444 | 65 | 5,251 |
| Number of ‘substantive engagements’ | 301 | 371 | 1,244 (level 2) | 563 (detailed conversations | 8 (supported by a PIP) | 65 | 2,552 |

The table above shows that of the 5,251 people supported 2,552 (49%) of these were substantive engagements and table 6.4 shows that of these 2,811 onward referrals were made.

Table 6:4: Social Prescribing Number of Onward Referrals by Locality (at 31 March 2017)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Basildon and Brentwood[[81]](#footnote-81)  | Castle Point and Rochford[[82]](#footnote-82) | Mid Essex[[83]](#footnote-83) | NE Essex – My Social Prescription[[84]](#footnote-84)  | West Essex[[85]](#footnote-85) | Southend | Total  |
| Number of onward referrals | 581 | 713 | 202[[86]](#footnote-86) | 716 | 599 | Not Available  | 2,811 |

## Performance against the Evaluation Terms of Reference

The terms of reference for this assignment require that evidence is sought and analysed with regard to the extent to which the Social Prescribing service has delivered on reduced primary and secondary care usage as well as health and wellbeing impacts, specifically:

* Primary outcomes:
* [Reduced] Primary care use by prescription recipients, and savings associated with any reduction (in terms of a reduction in spending on individuals receiving a social prescription);
* [Reduced] Secondary care use and savings associated with any reduction; and
* Impact on social care use, and savings associated with any reduction.
* Secondary outcomes:
* Impact on mental wellbeing, social isolation and general health, and patient experience of social prescribing;
* Cost [savings] to the NHS and ECC of providing the services that people are directed to via social prescriptions; and
* Whole-system impacts of the SP approach, including impact on SP providers, improving community resilience and capacity, improving inter-organisational relationships and joint working.

RSM PACEC have collected evidence for each outcome by surveying users and comparing baseline results with a follow-up survey, the results of which are detailed in the following sections. The survey was completed with service users in Basildon and Brentwood (Social Prescribing project); Castle Point and Rochford (Ways to Wellness project); Mid Essex (Connect Well project); North East Colchester (My Social Prescription project); and West Essex (Smart Life project). It was not possible to complete a survey with service users in the North East Tendring project or Southend Social Prescribing project.

### Survey Responses

The approach to completing the survey is outlined in section 3.1 and the questionnaires are contained in Appendices 1 and 2.

Overall 276 service users completed a survey at their initial engagement with the project and 136 completed both a survey following their initial engagement and a follow-up survey during the period following engagement. All consenting service users were contacted at a minimum of five times with a request to complete the survey. Progress was communicated at the Network Meeting in January 2017 and thereafter on a weekly basis. The details of who were not contactable / refused to complete the survey with RSM PACEC were communicated to the project leads to follow-up (where appropriate) to increase responses.

The survey sample is not representative of the entire population of Social Prescribing users and findings should be treated with caution. They provide an illustration of the outcomes and impacts that might occur more widely as a result of the project in the longer term.

The evidence is based on service user self-reporting of health service use and therefore can be unreliable. Ideally patient-level health data on usage levels would be used, however this was investigated and was not available within the timescales for this evaluation.

### Primary Outcomes

Service users who completed the baseline and follow-up surveys (n=136) were asked to provide a figure for the number of primary, secondary and social care engagements they had in the past three months. These responses can be compared to provide their perspective on their use of services immediately prior to and following their referral to the project.

Table 6.5 provides an overview of respondent’s reported use of primary services over a 3 month period.

Table 6:5: Reduced use of primary services (over a 3 month period; n=136)

|  | Basildon and Brentwood  | Castle Point and Rochford | Mid Essex | Colchester  | West Essex  | Total |
| --- | --- | --- | --- | --- | --- | --- |
| N | % | N | % | N | % | N | % | N | % | N | % |
| GP hours (n=125) | 45 | 65% | 3 | 21% | 5 | 83% | 9 | 47% | 12 | 71% | 74 | 59% |
| Receiving Prescriptions | 26 | 38% | 5 | 24% | 3 | 50% | 3 | 16% | 9 | 43% | 46 | 34% |
| Counselling services | 4 | 6% | 4 | 19% | 2 | 33% | 1 | 5% | 1 | 5% | 12 | 9% |
| Contact with Mental Health support in the community | 3 | 4% | 1 | 5% | 1 | 17% | 1 | 5% | 3 | 14% | 9 | 7% |

Source: RSM PACEC Survey of Social Prescribing Service Users (2017)

For primary care services it shows:

* GP attendance – 59% of respondents (n=74) reported a reduction in the number of hours spent with their GP and overall the number of reported GP hours reduced by 78.34 hours
* Prescriptions received – 34% (n=46) reported a reduction in the number in the number of prescriptions received and overall the number of reported prescriptions reduced by 138 prescriptions
* Counselling services – 9% (n=12) reported a reduction in in the number of hours of counselling support received however overall the number of hours of counselling received increased by 44.75 hours
* Mental health services in the community – 7% (n=9) reported a reduction in the number of the times they received support however overall the number of times respondents attended mental health services in the community increased by 96 instances. This could potentially be because the projects are uncovering unmet mental health needs and referring to mental health services, however this was not specified in the survey responses.

Due to the small number of respondents the findings above are not representative or statistically significant. The value of the outcome changes above are recorded in section 8.

### Secondary Care Outcomes

Table 6.6 provides an overview of respondent’s reported use of secondary care services over a 3 month period.

Table 6:6: Change in use of secondary care services (over a 3 month period; n=136)

|  | Basildon and Brentwood  | Castle Point and Rochford | Mid Essex | Colchester  | West Essex  | Total |
| --- | --- | --- | --- | --- | --- | --- |
| N | % | N | % | N | % | N | % | N | % | N | % |
| Attendance at A+E | 6 | 9% | 3 | 14% | 0 | 0% | 6 | 32% | 2 | 10% | 17 | 13% |
| Outpatient appointments attended | 23 | 33% | 7 | 33% | 2 | 33% | 1 | 5% | 9 | 43% | 42 | 31% |
| Admittance to hospital – planned procedure  | 4 | 6% | 3 | 14% | 0 | 0% | 4 | 21% | 1 | 5% | 12 | 9% |
| Admittance to hospital – emergency | 3 | 4% | 2 | 10% | 0 | 0% | 2 | 11% | 2 | 10% | 9 | 7% |

Source: RSM PACEC Survey of Social Prescribing Service Users (2017)

For secondary care services it shows:

* Attendance at A+E – 13% (n=17) reported a reduction in attendance at A+E and overall reported attendance at A+E decreased by 10 attendances
* Outpatient appointments attended – 31% (n=42) had reported a reduction in the number of outpatient appointments attended and overall the reported number of outpatient appointments reduced by 54 appointments
* Admittance to hospital (planned procedure) - 9% (n=12) reported reduced admissions to hospital for a planned procedure and overall the number of reported admissions reduced by 2 admissions
* Admittance to hospital (emergency) – 7% (n=9) reported reduced admissions to hospital for an emergency procedure and overall the number of reported admissions reduced by 15 admissions

Due to the small number of respondents the findings above are not representative or statistically significant. The value of the outcome changes above are recorded in section 8.

### Social Care Outcomes

Table 6.7 provides an overview of respondent’s reported use of social care services over a 3 month period:

Table 6:7: Change in use of social care services (over a 3 month period; n=134)

|  | Basildon and Brentwood  | Castle Point and Rochford | Mid Essex | Colchester  | West Essex  | Total |
| --- | --- | --- | --- | --- | --- | --- |
| N | % | N | % | N | % | N | % | N | % | N | % |
| Hours of support received from a social worker | 23 | 33% | 6 | 32% | 0 | 0% | 3 | 16% | 1 | 5% | 33 | 25% |

Source: RSM PACEC Survey of Social Prescribing Service Users (2017)

For social care services the table above shows that 25% (n=33) had reported a reduction in the number of hours spend with a social worker, with the overall number of reported hours reducing by 93.75 hours.

Due to the small number of respondents the findings above are not representative or statistically significant. The value of the outcome changes above are recorded in section 8.

### Personal Wellbeing

Respondents were also asked to provide views on their personal wellbeing three months prior to engagement with the service and three months following. The measures used are based on the ONS four measures of personal well-being: satisfaction with life nowadays, to what extent participants believe the things they do in life are worthwhile, and happiness and anxiety yesterday. In each scenario 0 represented the lowest value, and 10 represented the highest rating. Key findings include:

* Satisfaction with life (n=132) - the average satisfaction rating increased by 0.6 and 50% (n=66) of respondents reported an increase in satisfaction with life
* Feelings of life being worthwhile (n=133) – the average ‘worthwhile’ rating increased by 0.6 and 51% (n=68) of respondents reported an increase in feelings of life being worthwhile
* Feelings of Happiness (n=133) - the average ‘happiness’ rating increased by 0.5 and 51% (n=68) of respondents reported an increase in feelings of happiness
* Feelings of Anxiety (n=131) - the average anxiety rating decreased by 0.2 with 47% (n=61) of respondents reporting a decrease in feelings of anxiety

Overall the findings indicate that at least 47% of respondents experienced a positive change on each of the outcome measures and the average ratings across all respondents improved for each measure.

Comparison of the average baseline and follow-up wellbeing scores with the ONS averages show that while respondents reported an improvement in each area, they were a ‘medium wellbeing’ group at both stages (ONS categorises medium as a score of 5 – 6 for life satisfaction, worthwhile and happiness scores and 4 – 5 for anxiety scores).

Table 6:8: Comparison of Wellbeing Scores with ONS Averages

|  |  |  |  |
| --- | --- | --- | --- |
|  | ONS Average  | Baseline Average  | Follow-up Average  |
| Satisfaction with life | 7.7 out of 10 | 5.0 | 5.6 |
| Feelings of life being worthwhile | 7.9 out of 10 | 5.3 | 5.9 |
| Feelings of Happiness | 7.5 out of 10 | 5.2 | 5.7 |
| Feelings of Anxiety | 2.9 out of 10 | 4.4 | 4.1 |

Source: <https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/jantodec2016> / Source: RSM PACEC Survey of Social Prescribing Service Users (2017)

### General Health

Respondents were asked to provide views on their general health three months prior to engagement with the service and in three months following engagement using EQ-5D components: mobility; self-care; usual activities; pain/discomfort; and anxiety / depression.

The responses show the following self-reported results for each of the five areas over a three month period:

* Mobility – there was a small improvement between baseline and follow-up with a 5% (n=7) increase in respondents stating they have no problems walking about
* Self-Care - there was a small improvement between baseline and follow-up with an 8% (n=10) increase in respondents stating they have no problems with self-care
* Usual Activities - there was a small improvement between baseline and follow-up with a 5% (n=7) increase in respondents stating they have no problems performing their usual activities
* Pain / Discomfort – there was an improvement between baseline and follow-up with a 15% (n=20) increase in respondents stating they have no pain or discomfort
* Anxiety / Depression - there was an improvement between baseline and follow-up with a 15% (n=20) increase in respondents stating they were not anxious or depressed

Respondents were also asked to rate their health on a scale of 1 – 100 where one is indicative of poor health, and one-hundred is indicative of the best possible health. Overall there was a self-reported improvement in general health with a decrease in scores rated less than 50 (decrease of 20%) and an increase in scores rated above 50 (increase of 20%).

### Mental Health

Respondents were asked to rate their perceived quality of mental health based on the short Warwick-Edinburgh scale where “none of the time”, is indicative of poorer mental health, and “all of the time” is indicative of better mental health. The responses show the following self-reported results in areas linked to mental health:

* I’ve been feeling optimistic about the future (n=131) – 21% increase in respondents that felt optimistic all or some of the time
* I’ve been feeling useful (n=130) – 21% increase in respondents that felt useful often or all of the time
* I’ve been feeling relaxed (n=131) – 18% increase in respondent that felt relaxed often or all of the time
* I’ve been dealing with problems well (n=131) – 19% increase in respondents that felt they could deal with problems well often or all of the time
* I’ve been thinking clearly (n=130) – 12% increase in respondents that stated they thought clearly often or all of the time
* I’ve been feeling close to other people (n=131) – 21% increase in respondents that stated they felt close to other people often or all of the time
* I’ve been able to make up my own mind about things (n=129) – 5% increase in respondents that felt able to able to make up their own mind often or all of the time

Respondents were also asked to rate their social contact / interaction with others at baseline and follow-up. Responses indicated that:

* There was no change in the number of people that stated they had as much social contact with people as they would like;
* There was a small increase (10% (n=13)) in the number of people that said they had adequate social contact with people;
* There was a very small increase (1% (n=1)) in the number of people that said they had some social contact with people, but not enough; and
* There was a decrease (-11% (n=14)) in the number of people who felt they had little social contact with people and felt socially isolated

Due to the small number of respondents the findings above are not representative or statistically significant.

### Service User Satisfaction

Respondents provided positive feedback on the support provided with 80% (n=106) of 132 respondents stating they were quite or very satisfied with the service, examples of qualitative feedback from respondents includes:

“*It is a brilliant support which works well as part of an integrated health service. Really grateful, wouldn't be able to do anything without it*” [respondent from My Social Prescription]

“*The service was second to none and everything worked well and was worthwhile. In my opinion the best service I've ever had*” [respondent from Ways to Wellness]

“*I like the fact that I am listened to and not just put to bed*” [respondent from Smart Life]

In addition, 93% of 123 respondents stated they would recommend the project to others.

### Additionality

Overall 55% (n=59) of 107 respondents[[87]](#footnote-87) indicated that they probably or definitely would not have received the same support in the absence of the project, indicating that any benefits reported, or lack of deterioration in health and wellbeing can at least in part be attributed to the support provided. This is supported by additional qualitative feedback provided by respondents which highlighted that in many situations they would not have sourced any other support with one respondent noting that “*[in the absence of the project] I would have done myself in. Suicide! I think the service is second to none, it is fantastic and brilliant*” [respondent from Ways to Wellness].

The remaining respondents stated:

* Would have received support, with same result (12%; n=13)
* Would have received support, but would have taken longer to receive (3%; n=3)
* Would have received support, but not as much (6%; n=6)
* Would have received support, but would have taken longer and would not have received as much support (2%, n=2)

However while 22% (n=24) stated ‘other’ and 22% (n=24) stated that they would still have received support, when asked to explain / indicate where they could have received support in the absence of the project 42 respondents provided a response. These included they did not know where they would have received support (40%, n=17); would have paid for support privately (26%, n=11); would have sought support from another organisation in the third sector (10%, n=4) would have gone to their GP (10%, n=4) or sought support from family / friends (10%, n=4) or social services (5%, n=2).

Therefore while the outcomes reported in this section assumes 100% additionality, these benefits may only be 55% additional as 45% respondents believed they could have received similar support elsewhere / in another way.

### Impact on community resilience and capacity

#### Volunteers

In total 195 (active) and 285 (inactive) volunteers and SPCs have been involved in the delivery of the Social Prescribing projects during 2015/16 – 2016/17. The purpose of volunteers varied between the models, for example:

* Basildon and Brentwood – supported project delivery by making client appointments, preparing confirmation of appointment letters assisting with client telephone evaluations, and accompanied Navigators on home visits / providing support to clients including weekly telephone calls and accompanying them to local walking groups etc.
* Castle Point and Rochford - dealt with telephone enquiries / dealt with enquiries from the public at outreach sites
* North East Essex (My Social Prescription) – trained Social Prescribers / Champions to support delivery of the My Social Prescription project as well as in Mid Essex / for other public sector partners to meet with clients and make referrals to other organisations via Connect Well
* West Essex – it was intended that volunteer PIPs would support those referred to the project and identified as requiring more intensive support to identify and help them to achieve personal goals. However the project found it difficult to recruit and retain volunteers.

Each of the projects provided bespoke training for volunteers specific to the individual project. This included training in areas such as:

* customer care;
* communication skills;
* supporting patients with mental health needs;
* safeguarding / mental health awareness; and
* social prescribing as a methodology and specific information and guidance relating to the individual project.

In some cases volunteers have subsequently progressed to employment and have reported improvements in confidence and health and well-being.

The Mid Essex model, by adapting a whole population approach utilised resources differently to the other models, with a focus on training those who connect with people during their day job in public facing roles to implement empowered signposting across a number of local organisations. In total 424 Connect Well Champions were trained in social prescribing, ABCD, Connect Well and Making Every Contact Count during February 2016 – 31 March 2017 and of these 153 are active. Feedback from stakeholders (section 7) indicates that the training of SPCs has been beneficial, further research is required to assess the impact of the training provided on the knowledge / understanding of staff, how they have used this and the impact it has had on their day to day interactions with potential Social Prescribing users.

Examples of volunteer feedback / case studies are outlined below:

Case Study One

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| “I was involved with Basildon CVS both as a client and volunteer for about 6 months last year (2016). My experience in both categories was excellent. As a client I was treated with respect, friendliness and encouragement. My mentor was supportive, enabling me to identify key targets and identify a forward path. As a volunteer I was given training and agreed targets. The management staff and colleagues were professional, supportive and friendly. They enabled me both to support other people and to identify short term targets within a long term plan. In short my time with CVS was both happy and helpful. I would not hesitate to recommend the service” |

Source: BBWCVS (May 2017)

Case Study Two

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| “Because of illness I had been unable to work for a number of years and I considered volunteering. I started volunteering with the Social Prescription team in August 2016. I really enjoy the work and the people I work with. After being a volunteer for a while I saw a job vacancy which I thought looked interesting and I applied. In the past I would not have had the confidence to even consider applying and it is only as a result of the confidence I have gained during my time with the CVS that I applied for the job. I was successful and now work part time but I still volunteer at the CVS because I enjoy it so much and feel like I am making a difference.” |

Source: BBWCVS (May 2017)

Case Study Three

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| “When I started volunteering in November 2016 I had been unemployed for around 5 years. My self-confidence was very low, and I was beginning to give up hope of ever finding suitable employment. However on the advice of my work coach at the job centre, I decided to try volunteer work.It changed my life! I have really enjoyed my time as a recruitment/SP volunteer, and truly believe that working here has increased my self-confidence more than I could have imagined. The people are all lovely, the work is interesting and varied, and having a routine has helped me to believe in myself again. It has made a big difference to my attitude. Being able to tell prospective employers that I am currently doing voluntary work instead of using the word “unemployed” made me feel that I was doing something worthwhile. I will always remember my time here fondly and be grateful to BBWCVS for making me feel like a valued member of the team” |

Source: BBWCVS (May 2017)

#### Community/ Voluntary Sector

Each of the projects has developed links / relationships with a variety of organisations and individuals in the VCS. In total 2,811 onward referrals have been made by five of the projects[[88]](#footnote-88) to a range of public sector and VCS organisations.

Feedback from VCS organisations that have received referrals from Social Prescribing projects has been positive and indicates that they have been able to develop a good working relationship with the staff in their local Social Prescribing project. It was felt that without the Social Prescribing project the individuals referred to them would not been aware of the support available and that the referrals they received have been appropriate for their service.

The different models have worked with the wider community and voluntary sector in a number of different ways, including:

* By having accessible referral routes into the project - feedback from VCS consultees also highlighted that those projects with multiple referral routes helped to effectively engage community members. For example, the My Social Prescription project accepts referrals from a number of routes: face to face, by phone, by email and online via the Essex Connects and Connect Well Essex databases. Project staff highlighted that this allows people with different experiences and skills to use the information available in their own way. The project has also adapted a referral route to social workers via a specific referral form that allows project staff to understand some of the complexities of the cases they refer. This was also highlighted by a social care representative who noted that “*the project delivers the outcome needed and makes the relevant connection specific to the adult referred*”.
* Working with the wider community to codesign the project – in the Mid Essex model the development of Connect Well started in late spring/early summer 2014 with discussion of the Mid Essex locality Health and Wellbeing priorities that are shared across the three localities / districts. A mapping exercise was carried out during summer 2014 and the first workshop was held in September 2014 to explore how social prescribing could help address the perceived disconnect between the public and the activities and also between commissioners and providers.

However feedback from project delivery organisations has highlighted that in some instances the VCS organisations referred to did not have sufficient resources to meet the demand created by the Social Prescribing projects. For example one delivery organisation reported “*we have seen limited capacity amongst some organisations, the loss of others entirely or the emergence of new projects with more capacity…. our biggest area of concern was befriending where we found disparity in the services offered and great demands on resources*”. In addition, delivery organisations highlighted that sustainability of services could potentially be an issue in the future.

## Qualitative Findings / Case Studies

Case Study One – Reduced Social Isolation (My Social Prescription)

The My Social Prescription project received a high number of referrals and engagement from social care teams. The following case study details the experience of one referral from a social worker perspective

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| ‘I have worked with [MSP] in relation to a case, the gentleman was socially isolated and had limited support networks. MSP was a very positive and engaging process as it was based on a strengths/asset based approach. [Staff] and the MSP approach was person centred which enabled the gentleman to identify what resources he currently had and how these could be built upon. He was able to reflect on life experiences and how he could connect to local groups in the community, to offer his skills and knowledge and in return be able to engage in volunteering from which he would gain fulfilment, structure to his day and a sense of purpose and identity. [Team member] supported the gentlemen to look at volunteering opportunities where his skills could be utilised and with the volunteering application process. The gentleman lacked self-confidence, however the [team member] was responsive and sensitive in her approach. She explained MSP and each part of the process, answering all his questions fully.[Team Member] linked in with the volunteering placement and provided a named link person, this enabled the gentleman to have a planned meet and greet before starting his volunteering. He was able to questions and familiarise himself with the people and environment reducing any anxieties.The gentleman is now ready to start volunteering and is positive about the benefits this will bring to his wellbeing.It is my experience that MSP through its utilisation of community resources enables people to make choices which can have a direct impact on their quality life, in addition it has the potential to reduce the pressures felt by already stretched public services.’ |

Source: CCVS

Case Study Two – Reduced Anxiety / Improved Self-Esteem (Ways to Wellness)

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| The Ways to Wellness scheme was contacted by a young lady who was extremely anxious, had very low self-esteem and was experiencing self-harm and suicidal thoughts. It was quickly established that she had visited her GP two weeks previously and was awaiting an appointment at the Mental Health Unit the following week. Whilst engaging with the client, she was very panicky and made it very clear that she could not cope with waiting for the appointment as her feelings of self-harming and suicide were overwhelming her. Details of a local Counselling service was discussed as well as alternative therapies and the client said that she had considered trying Meditation. The discussion was concluded with the team member stating they would contact the counselling service on her behalf, find out about courses she could register with at the Recovery College and source local Meditation classes. The CAVS team member followed up with the GP who contacted the local counselling service and an appointment was made within 48 hours. A follow up was made with the client a few days later. She confirmed that she had attended the counselling session which had been beneficial and was intending to continue with these for the foreseeable future. She had been assessed by the Mental Health Unit and support was being put in place. She had also booked a Meditation class and stated that since speaking with CAVS, she had felt that there were options open to her and she felt privileged that someone had taken the time to listen to her. If she had not spoken to the team member that day she felt very fearful of what could have happened and felt that this conversation “saved her life”.  |

Source: Ways to Wellness

Case Study Three – Increased Confidence (Smart Life)

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| The client is a 71 year old widow who lives alone with Parkinson’s Disease; she had attended surgery with her daughter in law in a wheelchair and had no support or advice since diagnosis. She had physical needs, however no mental health support was identified. In addition her family, as her main carers, were also seeking support and she was referred by her GP. She was seen at one of the first clinics held in Thaxted surgery. Actions taken following meeting with PIC included:* Referral to Adult Social Care (ASC) for urgent care needs assessment.
* Referral back to GP for wheelchair referral.
* Referral to ASC for bath chair and commode - both items received.
* Referral to Age UK Essex Information & Advice for Age UK Attendance Allowance guide to be sent to daughter in law to help with completion of the attendance allowance form - now in receipt of attendance allowance.

As a result of engagement with the PIC, the client received a wheelchair specific for her needs, attendance allowance so she could afford to pay for outside help, and aids to help her with personal care. |

Source: Age UK Essex

Case Study Four – Reduced Social Isolation (Southend on Sea Social Prescribing Pilot)

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| The client was signposted to Social Prescribing via a self-management course which had been recommended by her doctor. She had recently moved out of London following retirement and was struggling to adjust to the new environment. She said she did not know where to go to get help for medical and loneliness-related problems and ended up going to the doctor. Mary got involved in Social Prescribing in order to improve her overall wellbeing and the range of activities she undertook. She found herself becoming more isolated and with less reason to leave the house or take positive steps to maintain a healthy life. As a result of her involvement in Social Prescribing, she became involved in a very wide range of social, educational, cultural and health-related activities. These included swimming and stretching classes at the nearby gym to provide exercise. Additionally, Mary was signposted by her Social Prescribing co-ordinator and the SAVS team to other local services. These included getting involved with singing in a local choir, links to historical associations and heritage society, carrying out archival work and original historical research and recovering manuscripts on local music in the area. Mary said that her emotional health and wellbeing-related mental problems had stabilised or subsided. She had a regular routine throughout the week as well as a calendar containing social, health-related and cultural events on a regular basis. “I find that these activities give me structure. You have diary dates and you can actually do stuff. Don’t just get stuck in a groove that can last weeks and months if you don’t short-circuit it. It’s really helped me to develop a social life.”She said the most important part of Social Prescribing was the social and activity-based structure of diary dates and activities. She said that, when trying to be proactive in the past, she shied away from engaging, and fell into ‘a groove’ which could last weeks or even months. The support of Social Prescribing peers, SAVS staff and new friends from social activities had given her a sense of purpose, community belonging and fresh confidence. She said she had built a social life on the basis of the interactions which had occurred as a result of Social Prescribing. Mary reported major changes in social and emotional wellbeing, saying she had made new friends and looked forward to the future ‘for the first time in a long time’. “Social Prescribing really helped me to develop a social life. Life is definitely better now than when I arrived in Southend. Life would have been far less fulfilling [in the absence of the service]. It really contributes to my mental state and overall sense of balance.”Mary believed that problems which were fundamentally social – i.e. feeling depressed through loneliness – had been addressed through Social Prescribing. Previously, she would have visited her doctor or been signposted on to a range of medical professionals to receive medication or treatment for loneliness-related conditions such as depression. In addition to social and emotional wellbeing and community engagement she also reported anecdotal improvements in physical health from involvement in gym swimming and ‘social exercise’. |

Source: Developed based on evidence collected via focus group sessions carried out by PACEC in September 2016

Case Study Five – Improved physical health (Connect Well)

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| The client is a 76 year old male who lives on his own in Maldon District. He has rheumatoid arthritis due to a strong immune system and takes immunosuppressants which is also possibly affecting his thyroid function but does not consider himself to have a disability. They were referred to Provide’s Essex Lifestyle Service through the Harbour Project at Maldon using Connect Well the Social Prescribing website and referrals were made for advice on diet and exercise due to concerns over his weight.They met with Provide advisors at least twice at St Peter’s Hospital in Maldon where he received advice on eating a balanced diet. The support from Provide also included accessing the Mid Essex Exercise referral scheme where he was also given a letter to take to the local leisure centre for a free trial leisure pass and then a reduced rate of entry, noting that “*they are the two main things which have helped*.”Feedback from the client indicates that their expectations about Provide have been met, noting “Yes, it’s helped maintain it (physical health) at a level, so I’ve managed to lose some weight and maintain that.” The biggest impact Provide has had on his life is to maintain him in his home and allow him to continue to live independently, noting that “*if I became housebound and more confined then there would be problems*.” |

Source: Connect Well

Case Study Six – Multiple Needs (Basildon and Brentwood)

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| The client had a number of issues on referral to the Basildon and Brentwood Social Prescribing service, specifically:* Employment and Support Allowance (ESA) being stopped;
* Numerous anti-depressant prescribed;
* Awaiting Mental Health Assessment;
* Lost contact with family after father’s death recently;
* Evidence of historical physical and mental abuse;
* Suffers from insomnia;
* Self-medicates with alcohol; and
* Debt from unpaid utility bill.

Actions taken following a meeting with the Social Prescribing Navigator include:* Offered to accompany client at next Job Centre visit;
* Offered bereavement counselling;
* Offered entry-level exercise: Fitness in Mind Programme/Local Community Walk;
* Offered sign-posting to Synergy for support with alcohol; and
* Referred to charitable debt counselling service to address outstanding debt.

As a result of the support provided a number of outcomes have been achieved including: * Medication reviewed by hospital and sleeping slightly improved;
* Attending weekly counselling sessions;
* Additional support gained from job centre staff;
* Attended introduction to Yoga in Brentwood;
* Attending drop-in befriending service locally, and now involved in helping out in the tea-bar weekly at the group; and
* Considering attending alcohol support group.

Qualitative feedback from the client included that their feeling of self-worth has increased as they felt useful and helpful. |

Source: BBWCVS

## Conclusion

The Social Prescribing projects have adapted a number of approaches to generate referrals and those projects that have utilised a number of outreach locations, pro-actively developed partnerships with other voluntary organisations and referral agencies and have had a number of accessible routes for referrals have exceeded their referral targets. In total 4,951 ‘referrals in’ were received across five Social Prescribing projects (Basildon and Brentwood; Castle Point and Rochford; Mid Essex; North East Essex My Social Prescription; and Southend), exceeding their combined target of 3,391 by 1,560.

Based on self-reported data provided by 136 service users via the RSM PACEC survey, the Social Prescribing projects have had an impact on use of primary, secondary and social care services and resulted in improved personal / mental wellbeing and general health. Specifically:

* Reduced use of primary care – 59% (n=74) of survey respondents (n=125) reported reduced number of hours spent with their GP and 34% (n=46) of survey respondents reported reduced number of prescriptions received
* Reduced use of secondary care – 31% (n=42) of survey respondents reported a reduction in the number of outpatient appointments they attended and 13% (n=17) of survey respondents reported reduced attendance at A+E
* Reduced use of social care - 25% (n=33) of survey respondents reported reduced hours of support from a social worker
* Personal wellbeing – at least 47% of respondents experienced a positive change on each of the outcome measures and the average ratings across all respondents improved for each measure
* General health – greatest improvement was in relation to feelings of pain / discomfort (15% (n=20) increase in survey respondents reporting no pain or discomfort at follow-up) and feelings of anxiety / depression (15% (n=20) increase in respondents stating they were not anxious or depressed at follow-up)
* Mental health – greatest improvements were in relation to feeling optimistic about the future; feeling useful and feeling close to other people (21% increase in survey respondents reporting they felt this way often or all of the time at follow-up)

In addition, qualitative data and feedback from stakeholders suggests the project has had a positive impact on quality of life and in addressing specific / individual needs of those referred to the Social Prescribing projects. However it is recognised that some projects are supporting those with multiple, complex needs and / or long-term conditions and therefore changes to health care usage within a short time period may not be possible.

# Stakeholder Feedback

## Introduction

This section details feedback from key stakeholders in relation what worked well / areas for development, the impacts of the projects and shared learning.

## Worked Well

Organisations / individuals that made referrals to the project as well as representatives from organisations that received referrals from the projects stated that they were satisfied with the service being provided and the elements noted as working well by consultees and the project staff were:

* Referral process – this was highlighted as being important by stakeholders across each of the projects. While the referral process varied between the models however, two key elements highlighted were:
* In those models where patients were referred to the project for support - consultees felt the processes worked well as it was simple to make referrals and these were followed up quickly by project staff, with consultees noting that being able to make referrals by email ‘avoids overcomplicating the process’ and while there are categories to be able to provide sufficient detail, it does not deter referrals by requiring excessive time and effort
* In the population wide model (Mid Essex) consultees highlighted that the referral process for SPCs via the online portal was simple, quick and easy to use, allowing SPCs to make direct referrals via a simple form without ‘reams of forms….[which] saves time’; the interim report also noted that the online system is a ‘core asset of the model’
* Flexibility – the ability to adapt and amend project delivery or approaches was noted as an important feature of most of the projects, this included:
* finding the best approach to supporting someone who did not wish to consent for their details to be forwarded for an onward referral (Basildon and Brentwood) or if a home visit is required (West Essex);
* continual codesign and PDSA, this was highlighted as a strength of the Mid Essex model as it means it can adapt to future locality demands / needs. The impact of this is evident in the adaption of SystmOne as a referral route for primary care in response to a lack of engagement from GP practices; and
* approach to accepting referrals – three of the projects (Castle Point and Rochford, North East Essex My Social Prescription and West Essex) were flexible in their approach to accepting referrals (by phone, email/letter, via Frontline etc.).
* Enables referring organisations to offer a wide range of supports to their clients –consultees highlighted that while they were aware of support organisations that existed, they would not know which of the 200-300 to refer to. Therefore the Social Prescribing project acts as a conduit that they can refer to and which can make an appropriate and informed onward referral. In addition it was noted by one consultee that made referrals to the Ways to Wellness project that even if they did know which organisation to refer to, each may have different referral processes or forms to be completed etc.; however once referred to Ways to Wellness they take on this part of the process, thereby eliminating time for the referring organisation
* The skills/ personal attributes of the Social Prescribing staff/ Navigator - all consultees in those models that directly support patients / service users noted that the skills and personal qualities of those delivering the service was fundamental to the model, in particular one consultee stated that it was important for anyone in these roles to be able to listen to and understand the needs of the person referred “which is a different approach to only having five minutes and two questions” during a GP visit

## Areas for Development

While key stakeholders were positive about the Social Prescribing project, the most common areas highlighted as considerations for any future projects included:

* Referral numbers – low referral numbers were highlighted as a key issue by consultees across the projects and consideration should be given as to how to get more organisations to refer relevant people, in particular:
* Need for greater awareness amongst GPs: for those projects that were linked to specific practices staff highlighted that some GPs were not referring as they are not fully aware of the benefits of social prescribing and / or do not consider the project when meeting with a patient. It was suggested that greater promotion at commissioner level is needed in order to ‘ingrain’ social prescribing as an option for support. One stakeholder highlighted that communication with GPs is a key part of increasing referrals, noting that as GPs are struggling to meet demand working with the social prescribing project should be a key mechanism to reduce this.
* Need for greater referrals by SPCs: in Mid Essex consultees noted that it has taken time for referrals to increase and there is scope for these to be increased further. Those consulted highlighted that they are seeking to do this within their organisation by providing reminders to staff (in email updates etc.) and, in the case of one organization, by exploring embedding use of the system into performance reviews. This is key to ensuring that the investment in training champions is worthwhile and this needs close monitoring.
* Need for greater awareness amongst patients – for those projects that were linked to specific practices staff noted that patients are not fully aware of what social prescribing is/ can offer them and the term ‘prescription’ often means they believe it is another form of medication, and as a result they can often be reluctant to engage
* Need for greater buy-in from GPs – one stakeholder indicated that most patients will want to see their GP as this is what they have always done and may not trust a new initiative; therefore GPs need to “ramp up intensity on the message that social prescribing is a good thing for them”.
* Volunteers – consultees highlighted two key issues in relation to volunteers:
* Recruitment: this was a significant issue for the West Essex project and it was not able to recruit the anticipated number of volunteers that have met the required criteria (overall 27 people were interviews and of these 6 volunteer PIPs were appointed). Consultees believed that this may in part be due to the job requirements exceeding those that would be expected from voluntary role; and
* Need for ‘befriender’ volunteers – project staff from two of the projects highlighted that some of those referred to the service experienced social isolation and while they are referred to local social groups and clubs, however many lack the confidence to attend on their own and the recruitment of volunteers to carry out a befriending role would be beneficial.
* Need to manage relationships on an on-going basis - the model relies on relationships and the collaboration / commitment of core stakeholder organisations. For the model to be a success requires the close management of relationships to maintain shared ownership of model, which can be challenging when budgets are being cut and when organisations also change structure and staff.

## Impacts

Consultees highlighted perceived impacts across three key areas: primary/secondary care; project beneficiaries; and on the services provided by GP practices.

Impact on primary / secondary care – consultees noted that the projects have helped to educate people on when it is appropriate to visit their GP / attend A+E and when it is not. It was suggested by one consultee interviewed for the West Essex Smart Life project that those referred more have more “*confidence in managing their condition and are less panicked; meaning they are not attending A+E and instead using other resources or approaches (e.g. relaxation techniques)*”. Knowledge in how to use health services more appropriately was highlighted as a key benefit of the project.

In addition, feedback from a range of consultees highlighted the impact on primary care in their area:

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| One GP interviewed for the Basildon and Brentwood Social Prescribing project highlighted that many of the patients they have referred no longer come back to see them for the same issues and since referring to the social prescribing project they have made fewer referrals to the mental health team; this is particularly relevant for frequent attenders who need social support but have no medical needs (e.g. are socially isolated, need help with weight management or financial issues that are impacting on their overall health and wellbeing), and has helped to reduce the number of unnecessary appointments.- Consultee Interview for the Basildon and Brentwood Social Prescribing Project  |

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| One consultee who is a reablement advice coordinator highlighted that their clients have often been in hospital for a long or short time and when they return home can be socially isolated, have lost confidence or need support to access groups. It was believed that without the Social Prescribing project the clients they referred would have gone to their GP, noting that “*Social Prescribing is filling a niche in the market; providing someone who is aware of what is available to support our clients, without this they would have sought this from their GP*” - Consultee Interview for the Castle Point and Rochford Ways to Wellness Project  |

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| One consultee who provides a befriending service noting *“without this support [clients] would repeat their old ways and go back to their GP or phone an ambulance for conversation”*. It was noted that there is a continuing need for the service, believing that Social Prescribing can continue to support people to be rehabilitated in their home- Consultee Interview for the Castle Point and Rochford Ways to Wellness Project  |

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| One consultee who is an Occupational Therapist highlighted that their patients are often socially isolated and / or experience mental ill health, however My Social Prescription is able to link them with activities / support organisations that increase their motivation and confidence to engage in community activities. It was suggested that without this support the mental health of some of those referred could have deteriorated and that since referring people to the project they “*have not had to work with people they have referred on as their needs have been met elsewhere*”. It was also noted that the project is effectively addressing ‘lower level need’ and if the right support is provided at this level it can prevent issues escalating to when a statutory organisation or support may be needed. - Consultee Interview for the North East Essex My Social Prescription Project  |

* Impact on project beneficiaries – all consultees suggested that a key element of the My Social Prescription project is the unique and tailored support it provides that results in the best possible outcome for the people they refer and felt the support provided helped to address a wide range of needs:

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| Consultees that referred to the Smart Life project felt the tailored support provided had helped to address a wide range of needs (e.g. social isolation, financial problems etc.), with one consultee noting “*they feel valued as a patient and no longer isolated or lost with their condition – they feel activated, supported and more like a partner in their own care*”- Consultee Interview for the West Essex Smart Life Project  |

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| It was noted that many social issues are identified in GP consultations, for example one stakeholder highlighted that a patient with anxiety asked for a pill to be prescribed, however during the GP consultation it was identified they were not sleeping due to social issues (debt / housing problems) and did not require medication; they were referred to the social prescribing project that linked them with an organisation that could help with this issue. Overall practice staff indicated that the project has had a positive impact with one noting that the project had been “*very beneficial [and] patients have reported improvements*”.- Consultee Interview for the Basildon and Brentwood Social Prescribing Project |

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| A representative from Rochford & Castle Point District police noted they referred a middle-aged man with financial difficulties who had been reported missing on two occasions to Ways to Wellness. Thereafter the individual has not been reported to them and the consultee believed this to be a positive sign that he received the support he needed. In addition, it was stated that while they did not have evidence of specific impacts for their referrals, they believed these to be positive, suggesting *“by default the project must be relieving pressure down the line by preventing the “low risk’ cases becoming high risk cases, for example by preventing an individual becoming suicidal due to financial issues that could be resolved with the right form of support”*- Consultee Interview for the Castle Point and Rochford Ways to Wellness Project |

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| Helped to improve the support they can provide to people they see on a daily basis as part of their ‘day job’, with feedback from one Housing Association highlighting that “*the tool enables my team to connect people with the services that are out there* *[which in turn] has helped residents to sustain their tenancies….and stop people falling into crisis*”- Consultee Interview for the Mid Essex Connect Well Project |

* Provides an additional service to the GP practices it is aligned with – GP consultees for the Smart Life project stated that the PIP has integrated well into the six practices and provides extra support that is not otherwise available, suggesting that “*if someone had diabetes they can see a diabetes nurse, without Smart Life there is no one to help people that may be frequent attenders due to panicking or worry about their condition*”.

## Shared Learning

Workshops with delivery bodies and CCGs have shown that there is significant commitment and enthusiasm for Social Prescribing. This is evident through the sharing of information and learnings in areas such as recruitment of participants, achieving healthcare professional / key stakeholder buy-in and links to other services (i.e. Community Agents, Active Essex, Healthy Lifestyle Service, Dementia Care, Books on Prescription etc.)

In addition, some of the delivery organisations are members of the National Social Prescribing Network.[[89]](#footnote-89) They in turn provide information on events or learnings from other Social Prescribing Networks to the Essex group.

Staff feedback suggests new relationships are being developed (e.g. between health, social care and the third sector) as part of a wider cultural change, for example some delivery staff are working alongside social care on forums and committees supported by local strategic partnerships or undertake joint training and as a result are getting referrals from social care staff.

In addition there is evidence of relationships and joint working between the different Social Prescribing projects and stakeholders. For example, feedback from the Mid Essex project highlighted that CVSs meet regularly in Mid and Colchester. Moreover, CVSs across Essex have a formal network and there is a national network where CVSs and VCS from all parts of the country have the opportunity to share learning by COIN network and at conference.

Examples of learning that has been shared / gained by the project includes:

* Engaging in the social prescribing network has been useful to assess how other areas models vary and where there may be learning from that, for example the Castle Point and Rochford project is currently working on dedicated time in GP surgeries to increase the referrals from GPs;
* Engagement with relevant partners in the community to encourage partnership working and cross referral across schemes; and
* Feedback project staff highlighted that through their Social Prescribing project they have identified more sources of support from community groups that they would not have otherwise known about however identify when looking for the most appropriate client support.

## Conclusion

Interviews with key stakeholders for each project highlighted a number of key findings associated with the process of delivering the projects as well as the impacts being achieved. These include:

GP referrals – getting GPs / primary care to make referrals has been an issue across each of the projects however this has had a greater impact on those that have GP practices as their main source of referrals. This has also been identified in other research / evaluations and a recent report[[90]](#footnote-90) noted that all primary care services (i.e. not just the GP) need to support and encourage patients to engage with Social Prescribing ‘*so that the patient [is] in no doubt of its importance as an alternative source of support*.’

Development and maintenance of relationships - stakeholders highlighted that all models rely on the skills / attributes of those involved and that relationships, collaboration and commitment of core stakeholder organisations is fundamental for success.

Flexibility – consultees noted that flexibility was important in the referral process as well was as adapting / amending its approach to getting referrals or in meeting individual needs of service users where required.

Impact on primary / secondary care – consultees believed that the projects have helped to reduce inappropriate use of primary and secondary services by supporting people to manage their own conditions (where appropriate) and by acting as an effective conduit to the most suitable form of support. It was suggested that this was ‘filling a niche in the market’ as without Social Prescribing, GPs / other referring organisations or individuals would not have the knowledge to signpost those in need of support to the most appropriate organisation.

Impact on service users – some consultees had limited knowledge of the impact on service users however those that were able to comment felt that the Social Prescribing projects have provided tailored support to address individual needs.

# Costs / Cost Avoidance and Cost Effectiveness

## Introduction

This section summarises the financial performance of the Project against its budget, the value for money achieved and assessment of cost avoidance.

## Project Budget / Spend

Table 8.1 outlines the overall expenditure against the budget for the period 2015/16 – 2016/17.

Table 8:1: Expenditure against Pro Rata Funding (2015/16 – 2016/17)

| Locality  | Funding (£) | Expenditure  | Variance  |
| --- | --- | --- | --- |
| Basildon and Brentwood  | £155,040 | £112,575 | -£42,465 |
| Castle Point and Rochford | £90,417 | £73,130.70 | -£17,286 |
| Mid Essex | £286,485 (includes ECC commissioning funds for Provide to supply Level 2 conversations) | £217,593(includes ECC commissioning funds for Provide to supply Level 2 conversations) | -£68,892 |
| NE Essex – Colchester | £159,000 | £159,000 | £0 |
| NE Essex – Tendring | £200,000 | £199,000 | £1,000 |
| West Essex | £230,000 | £199,776 | -£30,224 |
| Southend | £70,000 | £54,000 | -£16,000 |
| **Total** | **£1,190,942** | **£1,015,075** | **-£175,867** |

Source: Funding: Social Prescription Cash flow v0 6; provided by ECC to PACEC July 2016/ information provided by Age UK Essex and ECC. Spend: Information provided by delivery organisations (May / June 2017)

Table 8.1 shows that at 31 March 2016 there has been an overall underspend of £175,867; this is due to a variety of reasons at project level including:

* Basildon and Brentwood – underspend due to delays in mobilisation/ project start which resulted in recruitment delays. In addition, savings were able to be made in categories such as volunteer expenses as while initially it was expected a team of up to 30 volunteers would be recruited to support patients, this was overestimated and not required to deliver the project, resulting in less e.g. training expenses. The project also saved on IT development costs by being able to use a pre-existing database of organisations. These funds will be carried forward to 2017/18.
* Castle Point - underspend was intentional as it was anticipated that if the scheme were successful the second year would require a higher level of investment to meet increasing demand / level of workload. It was noted by the delivery organisation that plans are in place to ensure there is no underspend at the end of the two-year term as the organisation is currently reviewing resource for the immediate future to meet both the current levels of referrals and anticipated up take of the service.
* Mid Essex – underspend of £68,892 which has been allocated but not yet spent as the project is waiting for work to be completed and will be carried forward to 2017/18.
* West Essex - the contract issued to the delivery organisation by the CCG was for £199k and therefore £30,224k has been carried forward for use by the delivery organisation in 2017/18.
* Southend – part of the funding (£20,000) was used to establish a ‘tariff pot’ to help fund the services provided by 10 VCS organisations however this was not used as much as originally anticipated due to the initial lack of patients taking up the Social Prescription offer; the agreed tariffs varied considerably in price as some of the organisations were run purely by volunteers and thus the costs were low; -the prescriptions were much broader than originally anticipated with many being referred to other organisations other than the ten identified who were not paid for their services; and some of the more highly motivated patients purely needed support to create simply lifestyle changes that didn’t necessitate a paid for service. It is anticipated that the funds will be carried forward to 2017/18 to undertake Social Prescription activities linked to the new localities structure that is being set up in Southend.[[91]](#footnote-91)

Table 8.2 details expenditure on set up and business as usual / project delivery for five of the seven projects (this information was not available for North East Essex Tendring or Southend). Business as usual / delivery costs refers to the cost of delivering the project after the initial costs associated with implementation.

Table 8:2: Expenditure for set up and project delivery for five projects (2015/16 – 2016/17)

|  |  |  |
| --- | --- | --- |
| Set up Costs | Business as Usual / Delivery Costs  | Total Expenditure (Five Projects) |
| £289,689 | £472,386 | £762,075 |

Source: Provided by delivery organisations to RSM PACEC (May 2017)

Table 8.2 shows that set up costs account for 37% of expenditure with the remaining 63% relating to business as usual / project delivery costs.

## Value for Money

Across five projects[[92]](#footnote-92) 4,951 referrals were received and 4,807 people supported with either a lower and / or higher level of support (see section 6.3). Tables 8.3 and 8.4 detail the anticipated and actual cost per service user based on total project costs (set up and business as usual / delivery costs) and business as usual / delivery costs only.

Note:

* This does not include the funding or expenditure figures for the Tendring Mental Health Hub project as participant numbers were not available for this evaluation.
* This does not include the funding or expenditure figures for the West Essex Smart Life project as it did not have referral targets and therefore cannot be included in the anticipated vs actual cost per participant analysis.
* Expenditure for Southend includes the amount allocated to the Social Prescription element (£22,815)**[[93]](#footnote-93)**. Southend was not included in the business as usual analysis as this breakdown was not available
* It also does not include costs associated with the services that Social Prescribing service users were referred out to which may be substantial.

These show that:

* Total project costs (set up and business as usual / delivery costs) – the cost per service based on total project costs and 4,807 people supported (for five projects) is £122 compared to an anticipated cost per service user of £232; and
* Business as usual / delivery costs only – the cost per service user based on business as usual costs of £305,470 and 4,742 people supported (for four projects) is £64

Table 8:3: Cost per service user – based on total budget and expenditure for five projects (2015/16 – 2016/17)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Total budget (£)**  | **Anticipated number of service users**  | **Anticipated cost per service user** | **Total expenditure (£) – at 31 March 2017** | **Number of service users at 31 March 2017** | **Actual cost per service user** |
| £760,942 | 3,286 | £232 | £585,114 | 4,807 | £122 |

Source: Budget: Social Prescription Cash flow v0 6; provided by ECC to RSM PACEC July 2016; Expenditure and service users: Provided by delivery organisation to RSM PACEC (May/ June 2017)

Table 8:4: Cost per service user – based on business as usual (business as usual) costs only for four projects (2015/16 – 2016/17)

|  |  |  |
| --- | --- | --- |
| **Actual Costs (£) – at 31 March 2017** | **Number of service users – at 31 March 2017** | **Actual cost per service user** |
| £305,470 | 4,742 | £64 |

Source: Provided by delivery organisation to RSM PACEC (May/ June 2017)

Tables 8.5 and 8.6 detail the cost per service user based on total project expenditure as well as business as usual / project delivery costs at 31 March 2017. These show that the projects with the higher cost per service user (West Essex; Basildon and Brentwood; Southend and Castle Point and Rochford) are also those that involve more intensive / one to one support.

Table 8:5: Cost per service user per project – total expenditure (2015/16 – 2016/17)

| Locality  | Total Expenditure  | Total Service Users | Cost per Service User  |
| --- | --- | --- | --- |
| Basildon and Brentwood  | £112,575 | 301 | £374 |
| Castle Point and Rochford | £73,130 | 371 | £197 |
| Mid Essex | £217,593 | 1430 | £152 |
| NE Essex – Colchester | £159,000 | 2640 | £60 |
| West Essex | £199,776 | 444 | £450 |
| Southend | £22,815[[94]](#footnote-94) | 65 | £351 |
| **Total** | **£784,889** | **5,251** | **£149** |

Source: Provided by delivery organisation to RSM PACEC (May/ June 2017)

Table 8:6: Cost per service user business as usual costs only per project (2015/16 – 2016/17)

| Locality  | Business as Usual / Delivery Costs Only  | Total Service Users | Cost per Service User  |
| --- | --- | --- | --- |
| Basildon and Brentwood  | £107,755 | 301 | £358 |
| Castle Point and Rochford | £55,067 | 371 | £148 |
| Mid Essex | £12,648[[95]](#footnote-95) | 1,430 | £9 |
| NE Essex – Colchester | £130,000 | 2,640 | £49 |
| West Essex | £166,916 | 444 | £376 |
| Southend | Not available | - | - |
| **Total** | **£472,386** | **£5,186** | **£91** |

Source: Provided by delivery organisation to RSM PACEC (May/ June 2017)

In addition to cost per service user the overall programme has also provided VFM in the following ways:

* Training of volunteers / volunteer time in delivering the Social Prescribing projects – in total 195 (active) and 285 (inactive) volunteers and SPCs have been involved in the delivery of the Social Prescribing projects. Of the 195 active volunteers 153 are SPCs and 42 volunteers. The New Economy Manchester model attributes a value of £162 to someone taking up a volunteering opportunity. Based on 42 active volunteers this amounts to a value of £6,804.
* Volunteer placement in other organisations - in addition to placement within Social Prescribing project volunteer roles, individuals have also been placed in volunteering roles within other community groups.
* In kind contributions – for example:
* Organisations that have allowed staff to attend training for SPCs;
* Organisations that were involved in the codesign process for Mid Essex; and
* Organisations that are board members of the Living Safe and Well Board and / or the Connect Well operation sub group.
* Integration within the community – staff in each of the projects have conducted outreach at a number of venues. This is a more prominent feature in those projects that receive referrals from more sources / other than GP practices, with contacts taking place at GP surgeries, libraries and one-off events, as well as the training provided to Champions in a number of organisations. The high number of self-referrals in a number of projects suggested this has resulted in a wider awareness of Social Prescribing in the local community. In addition, in those models where staff have been linked more closely with GP practices (e.g. Basildon and Brentwood and West Essex) feedback from practice staff highlighted that good communication and relationships with staff delivering the project (and in the West Essex project having the PIC as part of the Multi-Disciplinary Team meetings) has helped to increase awareness of Social Prescribing and what it can offer, however it was also noted that due to competing demands any new initiative will always take time to embed/ be picked up on
* Provides an integrated service – by acting as a conduit CAVS inter-refers to other third sector and statutory organisations as appropriate and where specific specialisms and skills are needed to support individuals. It is was noted that while the scheme is designed to prevent crisis, where they engage with clients in ‘extreme’ situation (i.e. potential suicide) staff know who to go to in a professional capacity to ensure that a client is supported appropriately.
* Additional funding leveraged – in addition to TCA and Public Health monies an additional £155,040 was leveraged from CCGs, OPCC and district councils (see section 8.2)

## Cost Avoidance

The following section outlines the cost-benefits for primary, secondary and social care that is the focus of this evaluation. The types of costs considered are those directly relating to the use of primary, secondary and social care services to address the requirements of the evaluation terms of reference, specifically:

* Hours spent with the GP;
* Prescriptions for medication received;
* Hours of counselling services received;
* Attendance at Mental Health support in the community;
* Attendance at A+E;
* Outpatient appointments attended;
* Admittance to hospital;
* Hours of support received from a social worker; and
* Social Worker Support.

Methodology

Data from the RSM PACEC survey on reduced use of primary, secondary and social care services was costed using the 2015/16 fiscal values from the New Economy Manchester Unit Cost Database.[[96]](#footnote-96) These values represent national costs derived from government reports and academic studies and are available for analysts to use to apply Cost Benefit Analysis to projects and programmes. The values are used to support the cost benefit analysis model developed with assistance from a Technical Advisory Group (joint group of analysts from Central Government and Greater Manchester).

The NET cost avoidance values were established by calculating the difference between the activity reported at baseline and follow-up which was then multiplied by the fiscal value associated with that activity. For example, the difference in reported number of hours spent with the GP at baseline and follow-up was multiplied by the fiscal value for GP cost per hour. This takes into account both reductions and increases in service use reported to provide a net cost avoidance value.

As noted in section 6.4 the survey sample is not representative of the entire population and findings should be treated with caution as only providing an illustration of the types of cost-benefits that might occur more widely as a result of the project in the longer term. In addition, the data relates to 3 months before and after referral due to time constraints for the purpose of evaluation and ideally data would be collected at 12 months to be more robust and reliable.

The survey findings relate only to the Basildon and Brentwood; Castle Point and Rochford; Mid Essex; North East Essex (My Social Prescription); and West Essex projects. Therefore any scaled up / estimated data is based on the total number of people supported for each of these projects (which excludes Southend and Tendring).

For the purposes of calculating cost avoidance values only ‘substantive engagements’ have been included– that is people who were referred and had an assessment with a Social Prescribing advisor and took-up some kind of referral activity to ensure that there is a chance of some impact occurring.

### Cost Avoidance Values – Based on RSM PACEC Survey Data

#### Primary Care - Cost Avoidance Values

An overview of the cost avoidance values for primary care as a result of the Social Prescribing projects is outlined in table 8.7. The cost avoidance values are based on self-reported service use by 136 survey respondents (125 respondents in relation to hours spent with a GP).

Table 8:7: Primary Care - Total Cost Avoidance (Net[[97]](#footnote-97)) (over a 3 month period (based on 136 survey respondents))

|  | Basildon and Brentwood | Castle Point and Rochford | Mid Essex | NE Essex Colchester  | West Essex  | Total  |
| --- | --- | --- | --- | --- | --- | --- |
| Hours spent with the GP[[98]](#footnote-98) (n=125) | -£3,862 | £545 | -£847 | -£4,386 | -£928 | -£9,478 |
| Prescriptions for medication received[[99]](#footnote-99) | -£1,435 | £82 | -£82 | -£574 | -£3,649 | -£5,658 |
| Hours of counselling services received[[100]](#footnote-100) | £3,350 | -£1,325 | -£150 | -£137.50 | +£500 | +£2,238 |
| Attendance at Mental Health support in the community[[101]](#footnote-101) | £7,956 | £624 | £0 | £5,148 | £1,248 | +£14,976 |
| **Total** | **+£6,009** | **-£74** | **-£1,079** | **+£51** | **-£2,829** | **+£2,078** |

Table 8.7 shows that potentially costs have been avoided in three of the four primary care services. Specifically:

* GP attendance - in the 3 months since engagement there was a cost reduction of £9,478
* Prescriptions – in the 3 months since engagement there was a cost reduction of £5,658
* Use of counselling services- in the 3 months since engagement there was a cost incurred of £2,238
* Attendance at Mental Health support in the community - in the 3 months since engagement there was a cost incurred of £14,976. However it is possible that the Social Prescribing projects were uncovering unmet mental health needs and referring to mental health services, therefore while it represents a cost incurred it could be a positive outcome for service users in the longer term (see section 6.4.5 – 6.4.7 which indicates improved personal and mental wellbeing in the same period).

As a result there is a total cost incurred of £2,078, based on 136 respondents this equates to a cost incurred of £15 per service user.

#### Secondary Care - Cost Avoidance Values

An overview of the cost avoidance values for secondary care as a result of the Social Prescribing projects is outlined in table 8.8. The cost avoidance values are based on self-reported service use by 136 survey respondents.

Table 8:8: Secondary Care - Total Cost Avoidance (Net[[102]](#footnote-102)) (over a 3 month period (based on 136 survey respondents))

|  | Basildon and Brentwood | Castle Point and Rochford | Mid Essex | NE Essex Colchester  | West Essex  | Total |
| --- | --- | --- | --- | --- | --- | --- |
| Attendance at A+E[[103]](#footnote-103) | -£218 | -£426 | £0 | -£436 | £0 | -£1,080 |
| Outpatient appointments attended[[104]](#footnote-104) | -£4,329 | N/A | -£666 | +£333 | -£1,332 | -£4,662 |
| Admittance to hospital – planned procedure[[105]](#footnote-105)  | 0 | +£3,614 | £0 | -£5,421 | -£1,807 | -£3,614 |
| Admittance to hospital – emergency[[106]](#footnote-106) | -£21,684 | N/A | £0 | -£3,614 | -£1,807 | -£27,105 |
| **Total** | **-£26,231** | **+£3,188** | **+£666** | **-£9,138** | **-£4,946** | **-£36,461** |

Table 8.8 shows that potentially costs have been avoided in each of the four secondary care services. Specifically:

* Attendance at A+E – in the 3 month since engagement there was a cost reduction of £1,080
* Outpatient appointments attended - in the 3 month since engagement there was a cost reduction of £4,662
* Admittance to hospital (planned procedure) - in the 3 month since engagement there was a cost reduction of £3,614
* Admittance to hospital (emergency) - in the 3 month since engagement there was a cost reduction of £27,105

As a result there is a total cost avoidance of £36,461, based on 136 respondents this equates to a cost avoidance of £268 per service user.

#### Social Care - Cost Avoidance Values

An overview of the cost avoidance values for social care as a result of My Social Prescription is outlined in table 8.9. The cost avoidance values are based on self-reported service use by 134 survey respondents.

Table 8:9: Social Care - Total Cost Avoidance (Net[[107]](#footnote-107)) (over a 3 month period (based on 134 survey respondents))

|  | Basildon and Brentwood | Castle Point and Rochford | Mid Essex | NE Essex Colchester  | West Essex  | Total  |
| --- | --- | --- | --- | --- | --- | --- |
| Hours of support have you received from a social worker | -£741 | -£6,042 | 0 | -£698 | +£2,138 | -£5,343 |

Table 8.9 shows that there has been a cost avoidance of -£5,343 in relation to social care, based on 134 respondents this equates to a cost of -£40 per service user.

#### Total Cost Avoidance

The total cost avoidance for primary, secondary and social care as a result of the Social Prescribing projects is -£39,726 and the estimated cost avoidance per service user (based on 136 survey respondents) is £292.

Table 8:10: Estimated total cost avoidance (over a 3 month period (based on 136 survey respondents))

|  |  |
| --- | --- |
| Cost avoidance (net) – survey findings  | Cost avoidance per service user (net) |
| -£39,726 | -£292 |

## Estimated Cost Avoidance for Entire Programme

In order to estimate the cost avoidance for the entire programme the cost avoidance figures from the survey findings have been scaled up using two approaches:

Net Cost Avoidance:

Net savings have been calculated using the following approach:

* Net cost avoidance for all survey respondents (this takes into account those that reported a reduction and an increase);
* Divided by the number of people that responded to the survey question to get the ‘cost avoidance per person’;
* This figure was multiplied by the total number of people supported by the project to estimate the cost avoidance for the entire project / per service area;
* The total figure for each project was added to estimate the total net cost avoidance per service area at programme level.

Gross Cost Avoidance:

Gross savings have been calculated using the following approach:

* Total cost avoidance for those that reported a reduction (not taking into account those that reported any increase);
* Divided by the number of people that reported a reduction to get the ‘cost avoidance per person’;
* Using the percentage of respondents that reported reduction the equivalent number for the total number of people supported was calculated (e.g. if 9% of respondents reported a reduction in GP hours, 9% of the total number of people supported was calculated to estimate the potential number of people who could have experienced a reduction);
* This figure was multiplied by the ‘cost avoidance per person’ to estimate the cost avoidance for the entire project / per service area;
* The total figure for each project was added to estimate a total cost avoidance per service area at programme level.

Both analysis assumes that the cost outcomes identified for the baseline and follow-up sample are representative of the project as a whole.

Both analysis are presented in the following section to illustrate the potential minimum cost avoidance values (net values) and maximum cost avoidance values (gross values).

The survey findings relate only to the Basildon and Brentwood; Castle Point and Rochford; Mid Essex; North East Essex (My Social Prescription); and West Essex projects. Therefore any scaled up / estimated data is based on the total number of people supported for each of these projects (which excludes Southend).

### Primary Care – Estimated / Scaled Up Cost Avoidance Values

An overview of the estimated cost avoidance values for primary care as a result of the Social Prescribing projects is outlined in tables 8.11 and 8.12. The cost avoidance values are based on self-reported service use by 136 survey respondents (125 respondents in relation to hours spent with a GP) that have been scaled up to reflect the entire project.

Table 8:11: Primary Care - Total Cost Avoidance (Net) (over a 3 month period (based on 136 survey respondents and scaled up for 2923 people supported))

|  |  |
| --- | --- |
| Outcome area | Cost Avoidance  |
| GP hours  | -£332,241 |
| Receiving Prescriptions | -£115,971 |
| Counselling services | -£33,397 |
| Contact with Mental Health support in the community | £224,660 |
| **Total** | **-£256,949** |

Table 8:12: Primary Care - Total Cost Avoidance (Gross) (over a 3 month period (based on 136 survey respondents and scaled up for 2923 people supported))

|  |  |
| --- | --- |
| Outcome area | Cost Avoidance |
| GP hours  | -£407,162 |
| Receiving Prescriptions | -£187,532 |
| Counselling services | -£83,907 |
| Contact with Mental Health support in the community | -£68,866 |
| **Total** | **-£747,467** |

The tables above show that the potential minimum cost avoidance for primary care usage for all of those supported by the Social Prescribing projects is £256,949 and the maximum is £747,467.

### Secondary Care – Estimated / Scaled Up Cost Avoidance Values

An overview of the cost avoidance values for secondary care as a result of the Social Prescribing projects is outlined in tables 8.13 and 8.14. The cost avoidance values are based on self-reported service use by 136 survey respondents that have been scaled up to reflect the entire project.

Table 8:13: Secondary Care - Total Cost Avoidance (Net) (over a 3 month period (based on 136 survey respondents and scaled up for 2923 people supported))

|  |  |
| --- | --- |
| Outcome area | Cost Avoidance |
| Attendance at A+E | -£17,722 |
| Outpatient appointments attended | -£251,742 |
| Admittance to hospital – planned procedure  | -£198,838 |
| Admittance to hospital – emergency | -£622,970 |
| **Total** | **-£1,091,272** |

Table 8:14: Secondary Care - Total Cost Avoidance (Gross) (over a 3 month period (based on 136 survey respondents and scaled up for 2923 people supported))

|  |  |
| --- | --- |
| Outcome area | Cost Avoidance |
| Attendance at A+E | -£46,915 |
| Outpatient appointments attended | -£352,714 |
| Admittance to hospital – planned procedure  | -£536,343 |
| Admittance to hospital – emergency | -£413,243 |
| **Total** | **-£1,349,215** |

The tables above show that the potential minimum cost avoidance for secondary care usage for all of those supported by the Social Prescribing projects is £1,091,272 and the maximum is £1,349,215.

### Social Care – Estimated / Scaled Up Cost Avoidance Values

An overview of the cost avoidance values for social care as a result of the Social Prescribing projects is outlined in tables 8.15 and 8.16. The cost avoidance values are based on self-reported service use by 136 survey respondents that have been scaled up to reflect the entire project.

Table 8:15: Social Care - Total Cost Avoidance (Net) (over a 3 month period (based on 136 survey respondents and scaled up for 2923 people supported))

|  |  |
| --- | --- |
| Outcome area | Cost Avoidance |
| Hours of support received from a social worker | -£96,708 |
| **Total** | **-£96,708** |

Table 8:16: Social Care - Total Cost Avoidance (Gross) (over a 3 month period (based on 136 survey respondents and scaled up for 2923 people supported))

|  |  |
| --- | --- |
| Outcome area | Cost Avoidance |
| Hours of support received from a social worker | -£211,446 |
| **Total** | **-£211,446** |

The tables above show that the potential minimum cost avoidance for social care usage for all of those supported by the Social Prescribing projects is £96,708 and the maximum is £211,446.

Therefore the total potential minimum cost avoidance for all of those supported by the Social Prescribing projects is £1,444,929 and the maximum is £2,308,128.

## Cost Effectiveness

### Understanding the cost-effectiveness of Social Prescribing in Essex

The National Institute for Health and Care Excellence (NICE) guidelines on the methods to be used in the economic evaluation of health interventions preference cost utility analyses (CUAs). In CUA, the consequences of interventions are measured in Quality Adjusted Life Years (QALYs) which combine length of life with a utility value for health related quality of life (HRQL). The evaluation questionnaire captured data on respondent's health related quality of life (HRQL) using the EQ5D tool. This enables an assessment of the cost-effectiveness (CUA) of the Social Prescribing projects from a health perspective via HRQL and QALYs. The following sections present analysis of the HRQL of survey respondents and use this to produce a simple estimated CUA for the Social Prescribing projects in Essex.

### An overview of the HRQL of Social Prescribing beneficiaries

Table 8.17 provides an overview of the average (mean) HRQL scores at baseline and follow-up for the full survey sample. Figures are also provided for 25th, 50th and 75th percentiles. It shows that, at baseline, the mean HRQL score was 0.489, and that this increased to 0.592 at follow-up. This means that there was an overall improvement in the mean HRQL score for the Social Prescribing beneficiaries of 0.103 between baseline and follow-up. Importantly, the percentile scores show that the largest improvement in the mean HRQL occurred within the 25th percentile, indicating that it was the ‘least healthy’ Social Prescribing beneficiaries whose health improved the most. This is further evidenced by the fact that at baseline 43 beneficiaries had an HRQL score of less than 0.5 and that this reduced to 28 at follow-up.

Table 8:17: Baseline and follow-up HRQL scores for the full evaluation sample

|  |  |  |  |
| --- | --- | --- | --- |
|  | Baseline | Follow-up | Change |
| Sample mean | 0.489 | 0.592 | 0.103 |
| 25th Percentile | 0.124 | 0.5160 | 0.392 |
| 50th Percentile | 0.620 | 0.6890 | 0.069 |
| 75th Percentile | 0.727 | 0.8480 | 0.121 |

Table 8.18 provides a breakdown of the mean HRQL scores and the number of additional QALYs for five of the Social Prescribing services which participated in the survey. It shows some variation at a project level:

* Basildon and Brentwood - mean HRQL increased from 0.432 at baseline to 0.628 at follow-up
* Castle Point and Rochford - there was no change in HRQL between baseline and follow-up (0.517)
* Mid Essex - there was a small increase in mean HRQL from 0.723 to 0.774, although overall HRQL was considerably higher than for the other projects
* North East Essex - mean HRQL reduced slightly from 0.579 at baseline to 0.532 at follow-up
* West Essex - mean HRQL increased from 0.487 at baseline to 0.560 at follow-up

Table 8:18: Baseline and follow-up HRQL scores for each service

|  | Baseline | Follow-up | Change | Additional QALYs |
| --- | --- | --- | --- | --- |
| *Survey* | *All beneficiaries* |
| Basildon and Brentwood | 0.432 | 0.628 | 0.196 | 13.524 | 58.996 |
| Castle Point and Rochford | 0.517 | 0.517 | 0.000 | 0 | 0 |
| Mid Essex | 0.723 | 0.774 | 0.051 | 0.306 | 63.444 |
| North East Essex | 0.579 | 0.532 | -0.047 | -0.893 | -26.461 |
| West Essex | 0.487 | 0.560 | 0.073 | 1.533 | 0.584 |

### A cost utility analysis of the Social Prescribing Service

The NHS values a QALY at between £20,000 and £30,000. This is the threshold for cost-effectiveness recommended by NICE. Taking the lower threshold value, this means that a £100,000 intervention can be considered cost-effective if it generates five additional QALYs.

The HRQL data from the evaluation survey can be used to estimate the overall cost utility of five Social Prescribing projects. This is summarised in table 8.19 below which indicates that five Social Prescribing projects in Essex are estimated to have led to an additional 96.56 QALYs at a cost per QALY of £7,892.23.

Table 8:19: An overview of the cost utility (cost per QALY) of Social Prescribing (for five Social Prescribing projects)

|  |  |
| --- | --- |
|  | All beneficiaries |
| **Inputs** |
| Total annual Social Prescribing expenditure | £762,074  |
| Total no of beneficiaries\* | 2,487 |
| Expenditure per beneficiary\* | £306.42 |
| **Outcomes** |
| Est total additional QALYs | 96.56\*\* |
| Est cost per QALY | £7,892.23 |

\*Refers to the number of 'substantive engagements' for the five Social Prescribing projects that were included in the service user survey

\*\*This figure is weighted at a project level to reflect the change in mean HRQL and the actual number of beneficiaries per project

If the estimated total QALY gained across the five Social Prescribing projects is converted into a monetary value using the lower NHS threshold of £20,000, then **the value of the benefits gained amounts to £1.93 million.** This means that **for every £1 of the £762,074[[108]](#footnote-108)** spent supporting vulnerable people, the Social Prescribing projects produced **£2.53 of benefits** in terms of better health.

Therefore Social Prescribing in Essex **appears to be a cost-effective intervention** when the cost per QALY of £7,892.23 is compared to the NICE threshold of £20,000. However, in interpreting these findings it is important to recognise that data only provides an indication of short term benefits. The changes in HRQL were measured after approximately three months following first engagement with Social Prescribing and as such it is not possible to conclude on the extent to which these changes have been sustained over a longer period (i.e. 12 months or more), or how much of the change is due to a Social Prescribing 'effect' or a combination of wider social and physical factors.

## Return on Investment

The cost avoided values for primary and secondary care can be compared with the costs of delivering the Social Prescribing projects to provide an estimate of the return on investment provided.

**Note** – input costs relate to the cost of supporting the 136 service users from the survey cohort only.[[109]](#footnote-109)

Table 8:20: Estimated return on investment – set up and business as usual costs

|  |  |  |
| --- | --- | --- |
| Input Costs (set up and business as usual) | Benefits (primary, secondary and social care) | ROI |
| £41,452 | -£39,726 | -0.96 |

Table 8:21: Estimated return on investment – business as usual costs only

|  |  |  |
| --- | --- | --- |
| Input Costs (business as usual ONLY) | Benefits (primary, secondary and social care) | ROI |
| £36,702  | -£39,726 | -1.08 |

This demonstrates that the estimated cost avoidance during 2015/16 – 2016/17 (based on self-reported findings at a 3 month interval from 136 service users) was £39,726 compared to total input costs of £41,452 (set up and business as usual) / business as usual costs only of £36,702. This translates to:

* Set up and business as usual costs - a return on investment of 0.96 for every pound invested; or
* Business as usual costs a return on investment of 1.08 for every pound invested

Both compare favourably with other Social Prescribing projects, for example in the Rotherham Social Prescribing pilot there was an estimated return on investment of 0.26 in year one and 0.73 in year two.[[110]](#footnote-110)

However it is important to note that the figures are based on extremely low responses and do not provide an accurate reflection of the likely service user and cost-benefits of the model over a longer time period.

## Conclusion

Overall the Social Prescribing programme has underspent by £175,867; this is due to a variety of reasons at project level including delays in project mobilisation / project start dates and subsequent recruitment delays; savings on e.g. volunteer expenses and by using existing infrastructure to help deliver the project(s), as well as intentional underspend in some areas to allow higher level of investment in the second year of delivery.[[111]](#footnote-111) It is planned that the underspend will be carried forward into the 2017/18 financial year.

There is some evidence that the Social Prescribing projects have helped to reduce use of primary, secondary and social care services and result in costs avoided to the health service totalling £39,726 in a three month period for the survey cohort. A number of other positive economic benefits have been estimated:

* Primary care – costs avoided in relation to time spent with a GP, prescriptions received and hours of counselling services received totaling £15,136; however due to respondents reporting an increase in the number of hours of counselling received or attendance at mental health support in the there is a cost incurred to primary care of £2,078
* Secondary care – costs avoided in relation to attendance at A+E, outpatient appointments attended and admissions to hospital for a planned or emergency procedure totaling £36,461
* Social care - costs avoided in relation to hours of support received from a social worker attended totaling £5,343
* Quality Adjusted Life Years (QALYs)[[112]](#footnote-112) - based on five Social Prescribing projects[[113]](#footnote-113) an estimated additional 96.56 QALYs at a cost per QALY of £7,892.23 (compared to the NICE threshold of £20,000)[[114]](#footnote-114)
* Return on investment – based on estimated cost avoidance of £39,726; a return on investment of £0.96 - £1.08 pence for every £1 invested is estimated
* Volunteering – the estimated value of volunteering to the pilot is £6,804

Overall the greatest cost avoidance reported has been in secondary care and specifically in relation to reduced hospital admissions (estimated cost avoidance of £27,105). However primary care, and specifically GPs, have also benefitted with an estimated cost avoidance of £9,478.

Estimated cost avoidance for the entire programme

When scaled up to reflect all of those supported by the Social Prescribing projects (**see methodology used in section 8.6**) the following net and gross cost avoidance values are estimated:

* Primary care – potential minimum cost avoidance for primary care usage for all of those supported by the Social Prescribing projects is £256,950 and the maximum is £747,468
* Secondary care – potential minimum cost avoidance for secondary care usage for all of those supported by the Social Prescribing projects is £1,091,272 and the maximum is £1,349,216
* Social care – potential minimum cost avoidance for social care usage for all of those supported by the Social Prescribing projects is £96,708 and the maximum is £211,446.

Therefore the estimated cost avoidance for the entire programme is between £1,444,929 and £2,308,128.

# Progress against Interim Report Recommendations

## Introduction

This section outlines progress against the interim report recommendations (October 2016).

## Progress

A number of recommendations were made in the interim report in relation to project aims, objectives and targets, monitoring and shared learning. Actions taken on each of these is detailed below.

Table 9:1: Progress against Interim Report Recommendations

| Recommendation / Area for Development | Progress / Work Completed to Date |
| --- | --- |
| **Project Aims and Objectives and Targets** |
| There is a need to be clear on the aims for Social Prescribing that relate to the funding provided. At present there are two different sets of aims: (1) a focus on decreasing primary/ secondary and community care costs and (2) a whole population approach (i.e. changing behaviours to prevent ill-health in the longer term). | It was agreed with each project that both sets of outcomes must be reported against and agreed metrics are now in the contractual agreement from 2017-18. |
| Each project should ensure evidence against the primary and secondary outcomes (where relevant to their project) are available to support the final evaluation | This was agreed with 5 of the 7 schemes and has been included in the final evaluation report; it has also been confirmed by ECC that this evidence against these outcomes will be integral to future reporting. |
| Key Performance Indicators (KPIs) - there needs to be a common set of KPIs that link to the outcomes and used by all funded through the Essex CC programme for Social Prescribing. | A common set of KPIs has been agreed and will cover all 6 of the projects in Essex (the Southend project has been terminated).  |
| **Performance** |
| Delivery Targets – the delivery targets for the last 6 months to March 2017 should be reconsidered as the initial targets set in the business case were somewhat unrealistic and set at the time when the locality Social Prescribing models unclear. Each locality should project revised targets for the next 6 months and agree these with Essex County Council by mid-November 2016. These should also take into account the individual / varying characteristics of the cohort in each locality | Future targets have now been revised to reflect the approach in each locality. |
| Demonstrating Value for Money – cost per participant is one measure to demonstrate value for money however each locality should consider other ways in which they could demonstrate this for the final evaluation | The current varied data collection system has been revised to provide a more consistent approach. Additionally, the findings in the interim report were further investigated, revealing a lack of co-ordination between agencies, lack of trust and poor penetration in the marketing of this ‘service’. Low referrals from GP services were deemed unacceptable, especially where only a few GP practices were enrolled onto the local scheme. The Mid Essex population-wide approach, which provides an opportunity to train SPCs across a wider range of partner agencies, has been more successful in increasing effective signposting, advice and support.Wider social and health outcomes should be recorded where this is feasible and realistic.  |
| Service user feedback – service users should be asked to sign up to be part of the evaluation process at the outset and to agree to be contacted by either in house staff or external evaluators for this specific purpose. | This proved very challenging and must be embedded as part of the referral process, moving forward. |
| **Monitoring** |
| Monitoring – a standard monitoring and reporting template should be put in place across all projects to allow for reporting at programme level. At minimum this should include fortnightly figures relating to:* Participant / Service Users (new and cumulative to date)
* Project spend (cumulative to date)
* Number of volunteers (new and cumulative to date)
* Number of service users that have provided consent to complete a baseline survey (and number completed for those delivery organisations that are completing these)
 | A standard monitoring dataset was agreed and included in the new contractual agreements (see attached Appendix 3). |
| **Shared Learning** |  |
| There is need to build on the existing shared learning across the delivery bodies in order to ensure the outcomes delivered over the remaining 5-6 months can be maximised. | The Social Prescribing Network has enabled some of this, starting with a Workshop which agreed key principles and direction of travel.A new model for delivering the Social Prescribing Programme was agreed and was rolled out from April 2017, with a single point of referral for participating agencies.Additionally, following publication of the final report, the Essex Social Prescribing Network will be reconstituted to share good practice and successful outcomes (good news story-book) and will endeavour to share good practice in Essex with other areas within the Regional Social Prescribing Forum.  |

Source: RSM PACEC (2016) Evaluation of Social Prescribing Models Across Essex: Interim Evaluation / Information provided to RSM PACEC by ECC (June 2017)

## Summary

The development of the Social Prescribing pilot models has enabled a range of approaches to be tried and tested and has resulted in learning that is now being used to help inform the future development of a local model. Going forward, the Essex Social Prescribing model will have a single point of access for GPs and involve a whole population approach / ‘wrap around’ service. The West Essex Care Navigation Partnership was launched on 1st April 2017[[115]](#footnote-115) which has started this approach. It is expected that the approach will provide a greater return on investment as when looking at cost per case ‘population wide’ approaches have a lower cost per case compared to those dependent on GP referrals (see section 8.4). It is evident that the key recommendations from the interim report have been used to inform the metrics and processes to support its implementation and ensure there are consistent processes for systematic data collection going forward, as while Social Prescribing is wider than only stopping people going into hospital, new models will need to collect evidence of the impact on primary and secondary care in order to demonstrate a return on investment for commissioners.

# Conclusions and Recommendations

## Introduction

This report provides an assessment of the economic and social impact of the pilot Social Prescribing models across Essex during the period March 2015 – March 2017.[[116]](#footnote-116) It builds on an earlier interim evaluation report which identified strengths and key areas for development during the remaining months of the programme.

Social Prescribing is still in the early stages of development in Essex and the pilot projects have provided useful evidence and learning that can be used to inform the development of an Essex wide model for 2017/18.

## Referrals

Referral levels in some projects were significantly lower than the targets agreed in individual grant agreements / SLAs. Overall 4,951 ‘referrals in’[[117]](#footnote-117) were made across five Social Prescribing projects.[[118]](#footnote-118) This exceeds their combined target of 3,286, however while some projects exceeded their referral target (Mid Essex and North East (My Social Prescription)) other projects did not (Basildon and Brentwood and Castle Point and Rochford). No referral target was set for West Essex by the CCG however it received 510 referrals.

Obtaining referrals from GPs was a challenge reported by most of the projects. Two key approaches were used to encourage referrals:

* A Personal Independence Planner (PIC) joined Multi-Disciplinary team (MDT) meetings and detailed how Social Prescribing could help clients to the team to encourage referrals of relevant cases. This was used in the West Essex model and staff in these practices noted that they valued this approach. They also noted that they valued the updates provided on those they had referred and felt that having the PIC as part of the MDT meetings ensured there was good communication to find the best solution for patients. This was also highlighted as beneficial by the PIC who stated that being part of the monthly MDT meetings at each surgery “was pivotal to integrating Smart Life into the practices”.
* Use of SystmOne – this was used in the Mid Essex model for the level 2 service. It involved having Social Prescribing integrated into the GP systems therefore allowing them to refer patients quickly and easily. As a result the project successfully increased referrals by 1,252 (of a total 1,491 referrals therefore 84%) via SystmOne.

A review of Social Prescribing referral approaches used elsewhere noted the importance of consulting with GPs / primary care workers and tailoring the approach used to their individual needs. For example, in Doncaster[[119]](#footnote-119) GPs were provided with Social Prescribing ‘prescription pads’ as it was identified that GPs were used to writing medical prescriptions and continuing to use this format for non-medical prescriptions was a simple way get GPs referring the project. In addition, the Rotherham Social Prescribing Pilot[[120]](#footnote-120) successfully used an integrated case management approach where the Social Prescribing Navigator was embedded in case management meetings and referrals were made directly. It was also highlighted by Essex Social Prescribing delivery organisations that a higher number of referrals were received from GP practices that had a ‘GP Champion’ promoting Social Prescribing to other GPs; this was a key feature of the Rotherham Social Prescribing project.

Consultees from the delivery organisations also highlighted that the lower than anticipated number of referrals was a key issue and suggested that:

* Commissioners in the CCGs needed to do more to get Social Prescribing engrained into the everyday work of GPs and primary care staff, this could be ongoing promotion of the benefits of Social Prescribing as well as using incentives to get referrals; and
* A simple and easy referral process was needed, noting that different processes worked in different areas and therefore communication and involvement between delivery organisations and GPs / primary care staff was key in agreeing these processes.

**Recommendation:** We recommend that future Social Prescribing projects / models incorporate a range of GP/ primary care staff referral pathways, and these should be developed in conjunction with the GPs/ primary care staff to understand what works best for them and build on their existing systems / technology.

**Recommendation:** We recommend that consideration is given to how commissioners in the CCGs could become more actively involved to promote Social Prescribing, encourage GPs / primary care staff to make referrals and make potential users aware of the benefits.

## Targets / KPIs

Evaluation of outcomes at a programme level was difficult as the projects did not collect the same performance information. In addition, not all projects had KPIs that related to each of the outcomes to be measured by the evaluation and in some cases the performance measures set were not SMART.[[121]](#footnote-121)

A common set of core KPIs allows for consistency across each area and ensures a focus on the primary outcomes set for the funding (i.e. reduction in use of primary, secondary and social care). It is key that any future funding has outcome measures clearly agreed and evidence collected against these on an ongoing basis. If the primary outcomes change, this should be communicated to all projects and the KPIs changed accordingly. The projects may add to the core KPIs with others that are important to their area.

We understand that work has been completed since the Interim Report in October 2016 by ECC to set consistent targets that include primary, secondary and social care use and it is understood all funded projects for 2017/18 will be required to use KPIs linked to programme objectives.

**Recommendation:** We welcome that future Social Prescribing projects across Essex are expected to use the same core KPIs. These should include the following at minimum:

* Inputs – amount of funding / number of staff/ other resources involved (i.e. volunteers etc.)
* Outputs – number of users referred; sources of referral; numbers who take up the service; number from the target group (i.e. numbers using GPs and hospitals where Social Prescribing may be more relevant support)
* Outcomes – reduction in use of primary/ secondary/ social care (if appropriate); quality of the service provided and health and wellbeing outcomes for those supported (percentage reporting reduced social isolation or percentage reporting increased independence etc. – depending on the target group).

## Monitoring

A lack of consistent monitoring was identified in the interim Social Prescribing programme report and ECC has carried out work to address the recommendation that a standard monitoring and reporting template should be put in place across all projects. It is understood that all funded projects will now report against (1) a focus on decreasing primary/ secondary and community care costs; and (2) a whole population approach (i.e. changing behaviours to prevent ill-health in the longer term).

**Recommendation:** We welcome the implementation of the recommendation from the interim report and understand that this will be taken forward into the 2017/18 Social Prescribing programme. We recommend that performance against targets is assessed by the CCG / ECC on a monthly basis and mitigating actions to ensure project targets are delivered documented. Ideally performance should be linked to payments.

## Data Collection

Evidence of outcomes and cost avoidance is based on self-reported health service use which can be less reliable and ideally patient-level HSC data would be used to record use of primary, secondary and social care services. This would include patient-level data on number of GP appointments attended; prescriptions received; use of counselling and/or mental health services; inpatient admissions; A + E attendances; outpatient appointments; and support received from a social worker/ social care.

Obtaining informed consent from a representative sample of service users to take part in the evaluation was a key challenge. Processes were not initially in place to obtain consent from service users at the outset of project delivery and as a result not all were invited to take part in the evaluation. Moreover, the time required to develop data collection tools in line with ECC information governance requirements and put in place processes for obtaining consent meant the time period for data collection was shorter than anticipated.

This impacted on the robustness of the data collected and a more representative cohort of survey respondents is needed to provide robust evidence of outcomes. It is also necessary to review if the outcomes reported have been sustained and therefore survey respondents or HSC data should be revisited at 6 and12 months post referral. Follow-up should also be completed to also identify outcomes that may not be apparent in the short term.

**Recommendation:** We recommend that going forward health data on service use is sought and recorded for those referred in order for accurate outcomes to be recorded. Consent should be obtained to access the NHS numbers of Social Prescribing service users, this can then be used to link with data held by the NHS Data Management and Integration Centre on their health service usage before and after engagement with the project. Where applicable an information sharing agreement or protocol between organisations sharing personal identifiable information may be required.[[122]](#footnote-122)

**Recommendation:** We recommend that in order to obtain a robust sample size a request for service users to be part of the evaluation process should be embedded as part of the referral process, so that users are invited to confirm at the outset their willingness to take part in future evaluations.

**Recommendation:** We recommend that given the low response rates and outcome data, further evaluation is required. This should be completed at 6 and 12 months to gather evidence on health service usage and outcomes achieved.

**Recommendation:** We recommend that any delivery organisations for Social Prescribing ECC are made aware of its information governance policy and are required to comply with this as part of their contract/ agreement for funding. This will be of particular importance given the introduction of the General Data Protection Regulation (GDPR) in the UK from May 2018.

## Outcomes

### Primary, secondary and social care

The RSM PACEC survey results[[123]](#footnote-123) show that between a quarter and a third of users reported reduced use of primary, secondary and social care. Based on self-reported data provided by 136 survey respondents the Social Prescribing projects have had the following impacts:

* Reduced use of primary care – 59% (n=74) of survey respondents (n=125) reported reduced number of hours spent with their GP and 34% (n=46) of survey respondents reported reduced number of prescriptions received
* Reduced use of secondary care – 31% (n=42) respondents of survey reported a reduction in outpatient appointments attended. This compares favorably with the findings from the Rotherham Social Prescribing pilot which reported a reduction of 21% in the number of outpatient appointments[[124]](#footnote-124)
* Reduced use of social care - 25% (n=33) of survey respondents reported reduced hours of support from a social worker

There is also anecdotal evidence from stakeholder consultees (GPs and other healthcare staff) that those they have referred now see their GP less for social / non-medical issues. This was supported by survey findings which highlighted that the greatest reduction reported was in the number of hours they spent with their GP, suggesting that GPs may receive the greater immediate benefit from Social Prescribing. Feedback from a range of consultees highlighted the impact on primary care in their area, for example:

|  |
| --- |
| One GP interviewed for the Basildon and Brentwood Social Prescribing project highlighted that many of the patients they have referred no longer come back to see them for the same issues.It was noted that since referring to the Social Prescribing project they have made fewer referrals to the mental health team. This was particularly in relation to frequent attenders who need social support but have no medical needs (e.g. are socially isolated or need help with financial issues that are impacting on their overall health and wellbeing).As a result they believed the project has helped to reduce the number of unnecessary appointments.- Consultee Interview for the Basildon and Brentwood Social Prescribing Project  |

### Social / health and wellbeing outcomes

Respondents reported improvements in wellbeing following their referral to the service with over 50% reporting an increase in feelings of satisfaction with life, feelings of life being worthwhile and feelings of happiness while 47% (n=61) reported a decrease in feelings of anxiety. In addition the mean scores for life satisfaction, feelings of life being worthwhile and happiness increased and the mean score for anxiety decreased, however respondents remained within the ‘medium’ wellbeing group and below the ONS averages[[125]](#footnote-125) for each group. In addition there is some evidence of improvement in social connectedness, increased optimism and reduced feelings of depression. Qualitative feedback via service user case studies and stakeholder feedback suggests that the support provided has helped to increase independence and confidence to allow users’ engagement in community activities in which they may not otherwise have participated.

Overall there has not been statistically significant changes in reported social outcomes / wellbeing during the evaluation period (3 months). However the benefits of Social Prescribing may take time to accumulate and in some cases will only be evident in the longer term. In particular, behaviour change and self-care / self-management can take time to embed and where the model involves the training of SPCs the knowledge and learning from the training can take time to translate into referrals.

### Stakeholder feedback

All consultees were positive about the service being provided and believed that while a range of organisations existed to support different needs, this was fragmented and it was not possible for many of those making referrals (e.g. GPs, social care, police etc.) to be aware of what was available, as result the Social Prescribing projects served as a conduit to fill this gap in the market.

It was suggested that without Social Prescribing, GPs / other referring organisations or individuals would not have the knowledge to signpost those in need of support to the most appropriate organisation.

Stakeholder consultees also suggested that a key element the Social Prescribing projects was the unique and tailored support provided that resulted in the best possible outcome for the people they referred, for example:

|  |
| --- |
| A representative from Rochford & Castle Point District police noted they referred a middle-aged man with financial difficulties who had been reported missing on two occasions to ‘Ways to Wellness’. Thereafter the individual has not been reported to them and the consultee believed this to be a positive sign that he received the support he needed. In addition, while it was stated that they did not have evidence of specific impacts for people they referred, they believed these to be positive, suggesting *“by default the project must be relieving pressure down the line by preventing the “low risk’ cases becoming high risk cases, for example by preventing an individual becoming suicidal due to financial issues that could be resolved with the right form of support”*- Consultee Interview for the Castle Point and Rochford Ways to Wellness Project |

## Cost Effectiveness / Cost Avoidance and Cost Effectiveness

There is evidence to suggest that the Social Prescribing projects have helped to reduce the use of primary, secondary and social care services and resulted in costs avoided to the health service totalling £39,726 (combined net cost avoidance[[126]](#footnote-126) calculated for primary, secondary and social care based on self-reported data provided by 136 patients / service users) over a 3 month period.

A number of positive economic benefits have been estimated:

* Primary care (based on 136 patients / service users[[127]](#footnote-127)) – costs were avoided in relation to hours spent with a GP (£9,478) and prescriptions received (£5,658), however respondents reported an increase in the use of counselling services (£2,238) and mental health support in the community (£14,976). Estimated total cost incurred: £2,078
* Secondary care (based on 136 patients / service users) – costs were avoided in relation to attendance at A+E (£1,080), outpatient attendances (£4,662) and admission to hospital for a planned procedure (£3,614) / for an emergency (£27,105). Estimated total cost avoidance: £36,461
* Social care (based on 134 patients / service users[[128]](#footnote-128)) – costs were avoided in relation to hours spent with a social worker. Estimated total cost avoidance: £5,343
* Quality Adjusted Life Years (QALYs)[[129]](#footnote-129) - based on five Social Prescribing projects[[130]](#footnote-130) an estimated additional 96.56 QALYs at a cost per QALY of £7,892.23 (compared to the NICE threshold of £20,000).[[131]](#footnote-131) If the estimated total QALY gained across five Social Prescribing projects in Essex is converted into a monetary value using the lower NHS threshold of £20,000, the value of the benefits gained amounts to £1.93 million. This means that for every £1 of the £762,074[[132]](#footnote-132) spent supporting vulnerable people, the Social Prescribing projects produced £2.53 of benefits in terms of better health.
* Return on investment – based on 136 patients / service users and an estimated cost avoidance of £39,726; a return on investment of £0.96 - £1.08 pence for every £1 invested is estimated
* Volunteering – In total 195 (active) and 285 (inactive) volunteers and SPCs have been involved in the delivery of the Social Prescribing projects. The New Economy Manchester model attributes a value of £162 to someone taking up a volunteering opportunity. Based on 42 active volunteers (excludes SPCs) this amounts to a value of £6,804 contributed by volunteers

When scaled up to reflect all of those supported by the Social Prescribing projects (**see methodology used in section 8.6**) the following net and gross cost avoidance values are estimated:

* Primary care – potential minimum cost avoidance for primary care usage for all of those supported by the Social Prescribing projects is £256,950 and the maximum is £747,468
* Secondary care – potential minimum cost avoidance for secondary care usage for all of those supported by the Social Prescribing projects is £1,091,272 and the maximum is £1,349,216
* Social care – potential minimum cost avoidance for social care usage for all of those supported by the Social Prescribing projects is £96,708 and the maximum is £211,446.

Therefore the findings demonstrate that the project has resulted in an estimated cost avoidance for the entire programme is between £1,444,929 and £2,308,128.

## Efficiency

The cost per service user based on total expenditure for five projects[[133]](#footnote-133) (£585,114[[134]](#footnote-134)) and 4,807 people supported is £122, the anticipated cost per service user was £232, suggesting the project has been delivered cost effectively. However there may be other costs associated with the services that supported Social Prescribing service users that could increase the actual cost per participant.

The cost per service user varies significantly according to the project / model implemented and reflects the intensity of the each of the services, specifically:

* those with a higher cost per service user (West Essex, Basildon and Brentwood) spent more time with people on a one to one basis; and
* those with the lowest cost per service user (North East My Social Prescription and Mid Essex) involved signposting or ‘quick conversations’ that result in a direct referral there and then and no further support or time required by a Social Prescribing Navigator.

## Quality

The evaluation has had a strong focus on collecting available evidence regarding the extent to which the projects reduced the uptake of primary, secondary or social care services. However the quality of the service provided is equally important to determine whether it is helping to improve users’ health and wellbeing. For example, supporting someone in such a way that could prevent suicide is an example of support that is difficult to quantify or measure and the sensitivities around collecting information on the quality of the service provided. The Social Prescribing projects have been collecting feedback from service users through satisfaction surveys as well as case studies which provide more detail and evidence of how the Social Prescribing projects have helped those with more complex needs.

**Recommendation:** We recommend that future projects continue to conduct client satisfaction surveys and collect / develop case studies to demonstrate the quality and value of the service being provided in addition to quantitative measures.

**Recommendation:** We recommend that wider social and health outcomes should be recorded where this is feasible and realistic.

## Local infrastructure, relationships and joint working

The Social Prescribing projects have resulted in the development of infrastructure and support mechanisms, for example:

**Links to other support mechanisms** – the Social Prescribing projects have established relationships and worked with other professionals to promote the projects and increase referrals, for example by attending locality hub MDT meetings. In addition they have participated in a number of wider forums / groups to promote learning from the pilot projects, including participation in the National Social Prescribing Network as well as the Essex Social Prescribing Network and the Regional Social Prescribing Forum.

**VCS infrastructure** – the Social Prescribing projects have been supported by a number of VCS organisations that service users were referred to. These have included a broad range of services and organisations from both the public and third sector.

**Wider infrastructure** – the Social Prescribing projects have worked with and helped to develop community capacity / local assets. Specific examples include:

* Colchester Borough Council / library - My Social Prescription staff have served as steering group committee members and attended workshops to design new look services at Colchester Library, including sharing lessons from the My Social Prescription project. Since August 2015 project staff have facilitated attendance of community projects (including My Social Prescription staff and volunteers, as well as partner voluntary groups) for two mornings a week and provided additional volunteers for one-off events (i.e. New Year, New You and Go Online sessions). The project has also jointly trained hub staff (in excess of 30 people) on My Social Prescription in order to promote referrals into the project.
* Social workers – My Social Prescription hosted Social Care development days/meetings with local social workers that has changed the way in which social workers relate to the voluntary sector, improved their knowledge and created stronger relationships which is reflected in the high number of referrals to the project from social care staff. When new social workers join the team, they now visit with a social prescriber, learn about the VCS and how they can refer into the project.
* Connect Well – the online Connect Well referral system was implemented as part of the Social Prescribing project

**Training of volunteers / Champions** – all of the Social Prescribing projects have used volunteers to support delivery and 424 Connect Well Champions were trained in Social Prescribing, ABCD, Connect Well and Making Every Contact Count during February 2016 – 31 March 2017.

The interim report identified the need to build on the existing shared learning across the provider organisations in order to ensure the outcomes delivered can be maximised. Thereafter ECC increased plans to share learning based on the interim report, including a workshop which agreed key principles and direction of travel for an Essex wide Community Support Network that will align several similar commissioned services. This Network will be reconstituted to share good practice and successful outcomes.

**Recommendation:** We welcome the work planned to increase shared learning and suggest that the plan of work is monitored quarterly, including feedback from those involved to ensure the activities are delivering.

## Summary- Key Model Components

Based on the evidence presented in this report indicative key criteria for successful and effective Social Prescribing models are:

* Simple and easy referral process – processes that can work for a number of different referral sources and avoid too much time being required / invested by those making the referral. For example, for GPs if the referral process is incorporated into their own systems such as SystmOne they are more likely to implement.
* Promotion of the service and its benefits amongst GPs - GP buy in is essential and processes/ resources need to be in place to ensure GPs are aware and updated on how Social Prescribing can support their practice / work. The CCGs are best placed to support this effort in the first instance.
* Output and outcome indicators set are SMART, reflect the target group, and are robustly monitored on a regular basis - there should be consistency between funders on project indicators/ targets and monitoring reports showing progress against these should be sent to funders on a regular basis.
* Use of existing infrastructure / local assets to support delivery - all areas have local assets and it is important that the Social Prescribing providers are linked into these and utilising them where appropriate to support delivery. The development and maintenance of relationship(s) with other voluntary organisations, outreach and referral agencies are all essential to success. Volunteers can be used to support the project, however delivery should not be dependent on their recruitment and continued support, which cannot be guaranteed and can affect the success of project.
* Flexibility to adapt to processes and delivery to meet locality demands / needs - local situations change and providers need to be able to adapt their delivery models whilst staying focused on the outcomes required.

Any future Social Prescribing model must reflect local needs, context and existing resources and services at an area level.

APPENDIX 1: SERVICE USER BASELINE QUESTIONNAIRE

**Purpose of Survey:**

**RSM PACEC have been appointed by Essex County Council to undertake a review of six Social Prescribing Models across Essex. As part of this process we are conducting two surveys – one with service users when they first receive support and one three months later to capture feedback on their experience of the service and impact of the support provided. The baseline survey is designed to gather information on health and wellbeing prior to receiving support from the service.**

**Who this survey is for:**

**This survey is for clients that have started one of the Social Prescribing services in July 2016. Please note that respondents do not have to answer all questions if they do not wish to. This questionnaire will be used in conversation with the service user and will not be posted or emailed.**

**How your responses will be used:**

**This survey is confidential. The information provided will be treated with confidence and used for the purposes of this research only.**

**Note: This questionnaire should only be completed with clients / service users that have provided consent for their contact details and personal information to be shared for evaluation purposes. This should be confirmed before the questionnaire is completed.**

**Note (to be read out to data subject before questionnaire is conducted): Your personal information has been provided to us by [*refer to name of organisation that provided the contact details*] under your consent. This information and the responses in this questionnaire will be securely stored and will not be shared or utilised for any other purpose than which you have given consent.**

****Background Information****

|  | **Individual Patient Details** |
| --- | --- |
|  | PACEC Patient / Client Reference (*this should follow the format: Area; Navigator or Staff Initials; and Number)[[135]](#footnote-135)* *For example: BBJK1* **REQUIRED** |  |
| Name |  |
| Date started on the Social Prescribing Service  |  |
| Referral Agent (e.g. GP / self-referral)  |  |
|  | **Please confirm which service you have been supported by:** *Tick one* |
|  | Basildon and Brentwood (Social Prescriber in GP Hub) | **[ ]**  |
| Castle Point and Rochford (Social Prescriber in GP Hub) | **[ ]**  |
| North East Essex - Colchester (My Social Prescription - Social Prescription in CVS) | **[ ]**  |
| North East Essex - Tendring (Mental Health Hub) | **[ ]**  |
| Mid Essex (Community Builders / Social Prescribing Champions and intensive support by PROVIDE) | **[ ]**  |
| West Essex (Social Prescriber in GP Hub - Personal Independence Planners) | **[ ]**  |

|  | **Which ethnic group do you belong to?** *Choose one ethnic group that best describes your ethnic group or background* |
| --- | --- |
|  | White: |
| English / Welsh / Scottish / Northern Irish / British | **[ ]**  |
| Irish | **[ ]**  |
| Gypsy or Irish Traveller | **[ ]**  |
| Other White | **[ ]**  |
| Mixed/multiple ethnic group: |
| White and Black Caribbean | **[ ]**  |
| White and Black African | **[ ]**  |
| White and Asian | **[ ]**  |
| Other Mixed | **[ ]**  |
| Asian/Asian British: |
| Indian | **[ ]**  |
| Pakistani | **[ ]**  |
| Bangladeshi | **[ ]**  |
| Chinese | **[ ]**  |
| Other Asian | **[ ]**  |
| Black/African/Caribbean/Black British: |
| African | **[ ]**  |
| Caribbean | **[ ]**  |
| Other Black | **[ ]**  |
| Other ethnic group: |
| Arab | **[ ]**  |
| Any other ethnic group | **[ ]**  |
| **Do not wish to disclose** | **[ ]**  |

|  |  |
| --- | --- |
|  | **Are you a Carer?** *Tick one* |
|  | Yes | **[ ]**  |
| No | **[ ]**  |
| **Do not wish to disclose** | **[ ]**  |

|  |  |
| --- | --- |
|  | **Do you have any long-standing illness, health problem, condition or disability?** *Tick one* |
|  | Yes | **[ ]  (go to Q6)** |
| No | **[ ]  (go to Q7)** |
| **Do not wish to disclose** | **[ ]  (go to Q7)** |

|  |  |
| --- | --- |
|  | **If yes, tick all that apply**  |
|  | Tiredness / Fatigue  | **[ ]**  |
| Pain  | **[ ]**  |
| Insomnia  | **[ ]**  |
| Anxiety / Nerves  | **[ ]**  |
| Depression  | **[ ]**  |
| Diabetes  | **[ ]**  |
| Breathing problems (e.g. chronic bronchitis, asthma or emphysema)  | **[ ]**  |
| High blood pressure  | **[ ]**  |
| Heart disease  | **[ ]**  |
| Osteoarthritis  | **[ ]**  |
| Stroke  | **[ ]**  |
| Cancer  | **[ ]**  |
| Other\* | **[ ]**  |
| \*Other (*please state)*  |

****Personal Wellbeing****[[136]](#footnote-136)

|  | **Please rate on a scale of 0 to 10, where 0 is “not at all” and 10 is “completely” how satisfied are you with your life nowadays?** *Tick one*  |
| --- | --- |
|  | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |

|  | **Please rate on a scale of 0 to 10, where 0 is “not at all” and 10 is “completely” to what extent do you feel the things you do in your life are worthwhile?** *Tick one*  |
| --- | --- |
|  | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |

|  | **Please rate on a scale of 0 to 10, where 0 is “not at all” and 10 is “completely” how happy did you feel yesterday?** *Tick one*  |
| --- | --- |
|  | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |

|  | **Please rate on a scale of 0 to 10, where 0 is “not at all” and 10 is “completely” how anxious did you feel yesterday?** *Tick one*  |
| --- | --- |
|  | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |

****Health and Wellbeing Outcomes****

Primary Outcomes

|  | **Primary care - In the last 3 MONTHS** *(please insert a figure in the boxes below)* |
| --- | --- |
|  | How many **hours** have you spent with your GP |  |
| How many **prescriptions** for medication have you received from your GP |  |
| How many **hours** of Counselling services have you received  |  |
| How many **times** have you attended Mental Health support in the community |  |

|  | **Hospital / Secondary Care - In the last 3 MONTHS** *(please insert a figure in the boxes below)* |
| --- | --- |
|  | How **often** have you attended A&E  |  |
| How **many** outpatient appointments have you attended[[137]](#footnote-137) |  |
| How many **times** have you been admitted to hospital: |
| For a planned procedure |  |
| As an emergency (i.e. unplanned) |  |

|  | **Social care - In the last 3 MONTHS** *(please insert a figure in the boxes below)* |
| --- | --- |
|  | How many **hours** of support have you received from a social worker? |  |

Secondary Outcomes

General Health

|  | **Below are some simple questions about your health in general. By ticking one answer in each group below, please indicate which statements best describe your own health state TODAY[[138]](#footnote-138)**  |
| --- | --- |
|  | **Mobility** | **Please Tick One** |
| I have no problems in walking about | **[ ]**  |
| I have some problems in walking about | **[ ]**  |
| I am confined to a bed | **[ ]**  |
| **Self-Care** | **Please Tick One** |
| I have no problems with self-care | **[ ]**  |
| I have some problems washing or dressing myself | **[ ]**  |
| I am unable to wash or dress myself | **[ ]**  |
| **Usual Activities**  | **Please Tick One** |
| I have no problems with performing my usual activities (e.g. work, study, housework, family or leisure activities) | **[ ]**  |
| I some problems with performing my usual activities | **[ ]**  |
| I am unable to perform my usual activities | **[ ]**  |
| **Pain / Discomfort** | **Please Tick One** |
| I have no pain or discomfort  | **[ ]**  |
| I have moderate pain or discomfort  | **[ ]**  |
| I have extreme pain or discomfort  | **[ ]**  |
| **Anxiety / Depression**  | **Please Tick One** |
| I am not anxious or depressed | **[ ]**  |
| I am moderately anxious or depressed | **[ ]**  |
| I am extremely anxious or depressed | **[ ]**  |

Mental Health[[139]](#footnote-139)

|  | **Below are some statements about feelings and thoughts. Please tick the box that best describes your experience over the last 3 months:** *Tick one on each row* |
| --- | --- |
|  | **Statements** | **None of the time** | **Rarely** | **Some of the time** | **Often** | **All of the time** |
| I’ve been feeling optimistic about the future | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| I’ve been feeling useful | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| I’ve been feeling relaxed | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| I’ve been dealing with problems well | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| I’ve been thinking clearly | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| I’ve been feeling close to other people | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| I’ve been able to make up my own mind about things | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |

|  |  |
| --- | --- |
|  | **Thinking about how much contact you have had with people you like in the last 3 months, which of the following statements best describes your social situation:[[140]](#footnote-140)** |
|  | I have as much social contact as I want with people I like | **[ ]**  |
| I have adequate social contact with people | **[ ]**  |
| I have some social contact with people, but not enough | **[ ]**  |
| I have little social contact with people and feel socially isolated | **[ ]**  |

Your Health Today[[141]](#footnote-141)

|  | **We would like to know how good or bad your health is TODAY. The scale is numbered 1 to 100. 100 means the BEST health you can imagine, while 1 means the WORST health you can imagine. Please write a number between 1 and 100 in the box provided below to indicate how your health is TODAY** |
| --- | --- |
|  | Your Health Today = |  |

APPENDIX 2: SERVICE USER Follow-Up QUESTIONNAIRE

**Purpose of Survey:**

**PACEC have been appointed by Essex County Council to undertake a review of six Social Prescribing Models across Essex. As part of this process we are conducting two surveys – one with service users when they first receive support and one later to capture feedback on their experience of the service and impact of the support provided. You had previously spoken with us when you first joined the project, this survey is designed to gather information on your health and wellbeing after receiving support from the service. This survey is for clients that have started one of the Social Prescribing services in July 2016. Please note that respondents do not have to answer all questions if they do not wish to. This questionnaire will be used in conversation with the service user and will not be posted or emailed.**

**How your responses will be used:**

**This survey is confidential. The information provided will be treated with confidence and used for the purposes of this research only.**

**Note: This questionnaire should only be completed with clients / service users that have provided consent for their contact details and personal information to be shared for evaluation purposes. This should be confirmed before the questionnaire is completed.**

**Note (to be read out to data subject before questionnaire is conducted): Your personal information has been provided to us by [*refer to name of organisation that provided the contact details*] under your consent. This information and the responses in this questionnaire will be securely stored and will not be shared or utilised for any other purpose than which you have given consent.**

****Background Information****

|  |  |
| --- | --- |
|  | **Individual Patient Details** |
|  | PACEC Patient / Client Reference (*this should follow the format: Area; Navigator or Staff Initials; and Number)[[142]](#footnote-142)* **REQUIRED – NOTE THIS SHOULD RELATE TO THE NUMBER FROM THE BASELINE SURVEY** |  |
| Name |  |
| Date started on the Social Prescribing Service  |  |
| Referral Agent (e.g. GP / self-referral)  |  |
| 1.
 | **Please confirm which service you have been supported by:** *Tick one* |
|  | Basildon and Brentwood (Social Prescriber in GP Hub) | **[ ]**  |
| Castle Point and Rochford (Social Prescriber in GP Hub) | **[ ]**  |
| North East Essex - Colchester (My Social Prescription - Social Prescription in CVS) | **[ ]**  |
| North East Essex - Tendring (Mental Health Hub) | **[ ]**  |
| Mid Essex (Community Builders / Social Prescribing Champions and intensive support by PROVIDE) | **[ ]**  |
| West Essex (Social Prescriber in GP Hub - Personal Independence Planners) | **[ ]**  |

|  | **Which ethnic group do you belong to?** *Choose one ethnic group that best describes your ethnic group or background* |
| --- | --- |
|  | White: |
| English / Welsh / Scottish / Northern Irish / British | **[ ]**  |
| Irish | **[ ]**  |
| Gypsy or Irish Traveller | **[ ]**  |
| Other White | **[ ]**  |
| Mixed/multiple ethnic group: |
| White and Black Caribbean | **[ ]**  |
| White and Black African | **[ ]**  |
| White and Asian | **[ ]**  |
| Other Mixed | **[ ]**  |
| Asian/Asian British: |
| Indian | **[ ]**  |
| Pakistani | **[ ]**  |
| Bangladeshi | **[ ]**  |
| Chinese | **[ ]**  |
| Other Asian | **[ ]**  |
| Black/African/Caribbean/Black British: |
| African | **[ ]**  |
| Caribbean | **[ ]**  |
| Other Black | **[ ]**  |
| Other ethnic group: |
| Arab | **[ ]**  |
| Any other ethnic group | **[ ]**  |
| **Do not wish to disclose** | **[ ]**  |

|  |  |
| --- | --- |
|  | **Are you a Carer?** *Tick one* |
|  | Yes | **[ ]**  |
| No | **[ ]**  |
| **Do not wish to disclose** | **[ ]**  |

|  |  |
| --- | --- |
|  | **Do you have any long-standing illness, health problem, condition or disability?** *Tick one* |
|  | Yes | **[ ]  (go to Q6)** |
| No | **[ ]  (go to Q7)** |
| **Do not wish to disclose** | **[ ]  (go to Q7)** |

|  |  |
| --- | --- |
|  | **If yes, tick all that apply**  |
|  | Tiredness / Fatigue  | **[ ]**  |
| Pain  | **[ ]**  |
| Insomnia  | **[ ]**  |
| Anxiety / Nerves  | **[ ]**  |
| Depression  | **[ ]**  |
| Diabetes  | **[ ]**  |
| Breathing problems (e.g. chronic bronchitis, asthma or emphysema)  | **[ ]**  |
| High blood pressure  | **[ ]**  |
| Heart disease  | **[ ]**  |
| Osteoarthritis  | **[ ]**  |
| Stroke  | **[ ]**  |
| Cancer  | **[ ]**  |
| Other\* | **[ ]**  |
| \*Other (*please state)*  |

****Personal Wellbeing****[[143]](#footnote-143)

|  | **Please rate on a scale of 0 to 10, where 0 is “not at all” and 10 is “completely” how satisfied are you with your life nowadays?** *Tick one*  |
| --- | --- |
|  | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |

|  | **Please rate on a scale of 0 to 10, where 0 is “not at all” and 10 is “completely” to what extent do you feel the things you do in your life are worthwhile?** *Tick one*  |
| --- | --- |
|  | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |

|  | **Please rate on a scale of 0 to 10, where 0 is “not at all” and 10 is “completely” how happy did you feel yesterday?** *Tick one*  |
| --- | --- |
|  | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |

|  | **Please rate on a scale of 0 to 10, where 0 is “not at all” and 10 is “completely” how anxious did you feel yesterday?** *Tick one*  |
| --- | --- |
|  | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |

****Health and Wellbeing Outcomes****

Primary Outcomes

|  | **Primary care - In the last 3 MONTHS** *(please insert a figure in the boxes below)* |
| --- | --- |
|  | How many **hours** have you spent with your GP |  |
| How many **prescriptions** for medication have you received from your GP |  |
| How many **hours** of Counselling services have you received  |  |
| How many **times** have you attended Mental Health support in the community |  |

|  | **Hospital / Secondary Care - In the last 3 MONTHS** *(please insert a figure in the boxes below)* |
| --- | --- |
|  | How **often** have you attended A&E  |  |
| How **many** outpatient appointments have you attended[[144]](#footnote-144) |  |
| How many **times** have you been admitted to hospital: |
| For a planned procedure |  |
| As an emergency (i.e. unplanned) |  |

|  | **Social care - In the last 3 MONTHS** *(please insert a figure in the boxes below)* |
| --- | --- |
|  | How many **hours** of support have you received from a social worker? |  |

Secondary Outcomes

General Health

|  | **Below are some simple questions about your health in general. By ticking one answer in each group below, please indicate which statements best describe your own health state TODAY[[145]](#footnote-145)**  |
| --- | --- |
|  | **Mobility** | **Please Tick One** |
| I have no problems in walking about | **[ ]**  |
| I have some problems in walking about | **[ ]**  |
| I am confined to a bed | **[ ]**  |
| **Self-Care** | **Please Tick One** |
| I have no problems with self-care | **[ ]**  |
| I have some problems washing or dressing myself | **[ ]**  |
| I am unable to wash or dress myself | **[ ]**  |
| **Usual Activities**  | **Please Tick One** |
| I have no problems with performing my usual activities (e.g. work, study, housework, family or leisure activities) | **[ ]**  |
| I some problems with performing my usual activities | **[ ]**  |
| I am unable to perform my usual activities | **[ ]**  |
| **Pain / Discomfort** | **Please Tick One** |
| I have no pain or discomfort  | **[ ]**  |
| I have moderate pain or discomfort  | **[ ]**  |
| I have extreme pain or discomfort  | **[ ]**  |
| **Anxiety / Depression**  | **Please Tick One** |
| I am not anxious or depressed | **[ ]**  |
| I am moderately anxious or depressed | **[ ]**  |
| I am extremely anxious or depressed | **[ ]**  |

Mental Health[[146]](#footnote-146)

|  | **Below are some statements about feelings and thoughts. Please tick the box that best describes your experience over the last 3 months:** *Tick one on each row* |
| --- | --- |
|  | **Statements** | **None of the time** | **Rarely** | **Some of the time** | **Often** | **All of the time** |
| I’ve been feeling optimistic about the future | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| I’ve been feeling useful | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| I’ve been feeling relaxed | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| I’ve been dealing with problems well | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| I’ve been thinking clearly | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| I’ve been feeling close to other people | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| I’ve been able to make up my own mind about things | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |

|  |  |
| --- | --- |
|  | **Thinking about how much contact you have had with people you like in the last 3 months, which of the following statements best describes your social situation:[[147]](#footnote-147)** |
|  | I have as much social contact as I want with people I like | **[ ]**  |
| I have adequate social contact with people | **[ ]**  |
| I have some social contact with people, but not enough | **[ ]**  |
| I have little social contact with people and feel socially isolated | **[ ]**  |

Your Health Today[[148]](#footnote-148)

|  | **We would like to know how good or bad your health is TODAY. The scale is numbered 1 to 100. 100 means the BEST health you can imagine, while 1 means the WORST health you can imagine. Please write a number between 1 and 100 in the box provided below to indicate how your health is TODAY** |
| --- | --- |
|  | Your Health Today = |  |

Counterfactual / Satisfaction

|  | **How satisfied are you with the support you have received from the project?***Tick one*  |
| --- | --- |
|  | Very satisfied | Quite satisfied | Satisfied | Dissatisfied |
| **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |

|  |  |
| --- | --- |
|  | **In the absence of the Social Prescribing project would you have been able to receive support from elsewhere?** *Tick one* |
|  | Would have received support, with same result | **[ ]**  | **Go to Q20** |
| Would have received support, but would have taken longer to receive | **[ ]**  | **Go to Q20** |
| Would have received support, but not as much | **[ ]**  | **Go to Q20** |
| Would have received support, but would have taken longer and would not have received as much support | **[ ]**  | **Go to Q20** |
| Probably would not have received support | **[ ]**  | **Go to Q21** |
| Definitely would have not received support | **[ ]**  | **Go to Q21** |
| Other\* | **[ ]**  | **Go to Q20** |
| \*Other (please specify):       |

|  |  |
| --- | --- |
|  | If the Social Prescribing Project had not been available how would you have received support? Include details of where support would have been accessed |
|  |  |

|  |  |
| --- | --- |
|  | What elements of the project have worked well / best for you? |
|  |  |

|  |  |
| --- | --- |
|  | What elements of the project could be improved upon? |
|  |  |

|  |  |
| --- | --- |
|  | Is there any other type of support that you would like to have received? |
|  |  |

|  |  |
| --- | --- |
|  | Would you recommend the project others? *Tick one* |
|  | Yes | [ ]   |
| No | [ ]   |

Appendix 3: Social Prescribing s76 addendum revised KPIs

Following discussions,and under the ’variations’ section to this Agreement as provided for in Clause 5 and Schedule 6, **THE PARTIES AGREE** tothe following:

|  |  |
| --- | --- |
|  | **Amendment to Key Performance Indicators and Information Provision** Below is a list of key pieces of information required to inform the reporting of the social prescribing programme. We have categorised these into two groups [1] Essential and [2] Desirable.**[1] Essential reporting information:*** Final targets (as applicable, if these were revised since October 2016);
* Number of referrals to the project by source;
* Number that declined the service;
* Number of participants / service users;
* Number of onward referrals, by type of service referred to;
* Number of volunteers and number of volunteer hours spent on the project;
* Total spend from project start to date (reporting must show cumulative totals) – detailing Revenue; Overheads; Programme Costs; Capital spend and reasons for any underspend / overspend;
* The cost per participant.

[**2] Desirable information to support local outcomes:*** 1-pager case studies;
* Any other qualitative feedback from service users that has been collected;
* Any feedback on what has / has not worked with the SP model in your area with regard to target groups, referral pathways, the type and format of support provided and the resources utilised;
* Any evidence of shared learning through the project (e.g. participating in networks or working with other Social Prescribing projects).

**This information is required on a monthly basis on the first day of the month.**  |

Signed ……………………………………… for XXXX CCG

 ……………………………………… Position

 ……………………………………… Date

Signed ……………………………………… for Essex County Council

 ……………………………………… Position

 ……………………………………… Date

1. Idox (2017) Social Prescribing [↑](#footnote-ref-1)
2. Transformation Challenge Award of £650,000 and £660,000 of partnership funding from various statutory sector partners [↑](#footnote-ref-2)
3. This includes ECC commissioning funds for Provide to supply Level 2 conversations in Mid Essex (net figure of £16,485 based on: 1309 referrals x £15 (hourly rate including FCR elements) = £19635; however Provide’s staff accessed 21 training places at £150 per place which equates to a costed benefit of £3150 = net figure of £16,485 [↑](#footnote-ref-3)
4. The Transformation Challenge Award is a challenge fund which makes £120 million grant (£15 million in 2014 to 2015 and £105 million in 2015 to 2016) and a £200 million facility to use the capital receipts from asset sales flexibly to support transformation, available to support local authorities re-engineer their business practices and redesign service delivery [↑](#footnote-ref-4)
5. Basildon and Brentwood; North East Essex; [↑](#footnote-ref-5)
6. North East Essex (Tendring District Council) [↑](#footnote-ref-6)
7. Social Prescription Business Case (June 2015) [↑](#footnote-ref-7)
8. Referrals minus those that declined support [↑](#footnote-ref-8)
9. The Southend project completed an in house evaluation and was almost complete when RSM PACEC were appointed [↑](#footnote-ref-9)
10. It was not possible to conduct surveys or consultations with service users due to the vulnerable nature of the client group. This meant they often did not provide consent to speak with a third party organisation, or where consent was given, they did not wish to discuss their experience [↑](#footnote-ref-10)
11. A ‘referral in’ refers to a referral made to a Social Prescribing project [↑](#footnote-ref-11)
12. Basildon and Brentwood; Castle Point and Rochford; Mid Essex; and North East Essex My Social Prescription. West Essex has been excluded as it did not have a referral target [↑](#footnote-ref-12)
13. Dayson, Chris; Bennet, Ellen (2016) Evaluation of the Doncaster Social Prescribing Service: Understanding outcomes and impact [↑](#footnote-ref-13)
14. Dayson, Chris; Bashir, Nadia (2014) The social and economic impact of the Rotherham Social Prescribing Pilot [↑](#footnote-ref-14)
15. Smart, Measurable, Achievable, Realistic and Timebound [↑](#footnote-ref-15)
16. <https://www.england.nhs.uk/wp-content/uploads/2016/12/information-sharing-policy-v2-1.pdf> [↑](#footnote-ref-16)
17. As the data is based on a small number of responses it may not necessarily be a true reflection of the entire programme. In addition, the evidence is based on service user self-reporting of health service use and therefore can be unreliable. [↑](#footnote-ref-17)
18. Rotherham only reported on secondary care reductions (not able to include the same sentence / conclusion for GP hours or social care etc.); Rotherham had higher reductions in A+E attendances. [↑](#footnote-ref-18)
19. ONS categorises medium as a score of 5 – 6 for life satisfaction, worthwhile and happiness scores and 4 – 5 for anxiety scores [↑](#footnote-ref-19)
20. The NET cost avoidance values were established by calculating the difference between the activity reported at baseline and follow-up which was then multiplied by the fiscal value associated with that activity. For example, the difference in reported number of hours spent with the GP at baseline and follow-up was multiplied by the fiscal value for GP cost per hour. This takes into account both reductions and increases in service use reported to provide a net cost avoidance value. [↑](#footnote-ref-20)
21. For GP hours this is based on 125 respondents as 11 respondents did not provide the number of hours they spent with their GP [↑](#footnote-ref-21)
22. Two respondents did not provide the number of hours they spent with their GP [↑](#footnote-ref-22)
23. QALYs combine length of life with a utility value for health related quality of life (HRQL) [↑](#footnote-ref-23)
24. Relates to the five Social Prescribing that were included in the service user survey. The survey was completed with service users in Basildon and Brentwood (Social Prescribing project); Castle Point and Rochford (Ways to Wellness project); Mid Essex (Connect Well project); North East Colchester (My Social Prescription project); and West Essex (Smart Life project) [↑](#footnote-ref-24)
25. The NHS values a QALY at between £20,000 and £30,000. This is the threshold for cost-effectiveness recommended by NICE. Taking the lower threshold value, this means that a £100,000 intervention can be considered cost-effective if it generates five additional QALYs [↑](#footnote-ref-25)
26. Relates to the five Social Prescribing that were included in the service user survey [↑](#footnote-ref-26)
27. Basildon and Brentwood; Castle Point and Rochford; Mid Essex; North East Essex My Social Prescription and Southend. West Essex has not been excluded as no referral target was set; Tendring has been excluded as participant numbers were not available for this evaluation [↑](#footnote-ref-27)
28. Total expenditure for the Southend project was £54k; of this £8,370 which was the cost of the Quality for Health licences/ information from SAVS indicates that a least 50% of the time and resources were spent on the Quality for Health/VCS capacity building element of the project. Therefore the amount allocated to the Social Prescription element is £22,815 [↑](#footnote-ref-28)
29. Idox (2017) Social Prescribing [↑](#footnote-ref-29)
30. Report of the Annual Social Prescribing Network Conference (2016) [↑](#footnote-ref-30)
31. Kinsella, Sarah (2015) Social Prescribing: A Review of the Evidence [↑](#footnote-ref-31)
32. Idox (2017) Social Prescribing [↑](#footnote-ref-32)
33. NESTA (2013) More than medicine: new services for people powered health [↑](#footnote-ref-33)
34. People powered health refers to integrating and promoting community-based services into health and social care; the research refers to three specific elements to achieve this: Social Prescribing, signposting and community-based services [↑](#footnote-ref-34)
35. Idox (2017) Social Prescribing [↑](#footnote-ref-35)
36. NESTA (2013) More than medicine: new services for people powered health [↑](#footnote-ref-36)
37. Centre for Regional Economic and Social Research (CRESR) (2016) Evaluation of the Rotherham Mental

Health Social Prescribing Pilot [↑](#footnote-ref-37)
38. Feeling positive; lifestyle; looking after yourself; managing symptoms; work, volunteering and other opportunities; money; where you live and family / friends. [↑](#footnote-ref-38)
39. Richardson G, Kennedy A, Reeves D, Bower P, Lee V, Middleton E, Gardner C, Gately C, Rogers A. ‘Cost effectiveness of the Expert Patients Programme (EPP) for patients with chronic conditions’ J Epidemiol Community Health 2008;62:361-367 doi:10.1136/jech.2006.057430. The Expert Patients Programme (EPP) aims to deliver self-care support by developing peoples’ self-care skills, confidence and motivation to take more effective control over their long-term conditions [↑](#footnote-ref-39)
40. Brandling, J and House, William ‘Social prescribing in general practice: adding meaning to medicine’ Br J Gen Pract. 2009 June 1; 59(563): 454–456 [↑](#footnote-ref-40)
41. Transformation Challenge Award of £650,000 and £660,000 of partnership funding from various statutory sector partners [↑](#footnote-ref-41)
42. This includes ECC commissioning funds for Provide to supply Level 2 conversations in Mid Essex (net figure of £16,485 based on: 1309 referrals x £15 (hourly rate including FCR elements) = £19635; however Provide’s staff accessed 21 training places at £150 per place which equates to a costed benefit of £3150 = net figure of £16,485 [↑](#footnote-ref-42)
43. The Transformation Challenge Award is a challenge fund which makes £120 million grant (£15 million in 2014 to 2015 and £105 million in 2015 to 2016) and a £200 million facility to use the capital receipts from asset sales flexibly to support transformation, available to support local authorities re-engineer their business practices and redesign service delivery [↑](#footnote-ref-43)
44. Basildon and Brentwood; North East Essex; [↑](#footnote-ref-44)
45. North East Essex (Tendring District Council) [↑](#footnote-ref-45)
46. Social Prescription Business Case (June 2015) [↑](#footnote-ref-46)
47. New Economy research helps agencies to identify the costs and benefits of new ways of working. Manchester New Economy has developed a Cost Benefit Analysis (CBA) model that can identify the fiscal, economic, and social value of project outcomes, and specify which public agency sees this benefit. [↑](#footnote-ref-47)
48. Basildon, Billericay and Wickford Council for Voluntary Service (BBWCVS); Castle Point Association for Voluntary Services (CAVS); Provide; Colchester Community Voluntary Services (CCVS) (now Community 360); and Age UK Essex [↑](#footnote-ref-48)
49. Social Prescribing Evaluation- Information Governance principles, Guidance and Consent process [↑](#footnote-ref-49)
50. Basildon and Brentwood; Mid Essex; and West Essex [↑](#footnote-ref-50)
51. Castle Point and Rochford; and North East Essex – Colchester [↑](#footnote-ref-51)
52. Memorandum of Understanding between Basildon CCG and BBWVCS (September 2015) [↑](#footnote-ref-52)
53. Grant Agreement from CCG: Social Prescribing and Early Intervention for Adults Project (February 2016) [↑](#footnote-ref-53)
54. Grant Agreement between ECC and CAB Tendring (31 July 2015) [↑](#footnote-ref-54)
55. Dates provided by CCVS to PACEC September 2016 [↑](#footnote-ref-55)
56. Start and end dates: mobilisation period was complete in March 2015 however the project did not go live until July 2015 (Mid Essex ‘High Level Critical Path’ provided by Connect Well to RSM July 2016). [↑](#footnote-ref-56)
57. Dates provided to PACEC from Age UK Essex September 2016. [↑](#footnote-ref-57)
58. Southend Association of Voluntary Services (SAVS) (2016) Social Prescribing in Southend on Sea: Learning from the pilot [↑](#footnote-ref-58)
59. Mid Essex Social Prescribing Project: An Overview (2015) / information provided by Connect Well Lead Programme Manager to RSM PACEC (June 2017) [↑](#footnote-ref-59)
60. Information provided by ECC to RSM PACEC (June 2017) [↑](#footnote-ref-60)
61. TCA and ECC Funding. Funding in some areas is also provided by other sources, for example the CCG, an OPCC grant and funds from the District Council [↑](#footnote-ref-61)
62. Pro Rata: Project is provided with £5,416.67 per month = £70,416.71 (13 months February 2016– 31 March 2017) plus £20,000 mobilisation fee = £90,416.71 [↑](#footnote-ref-62)
63. This also includes ECC commissioning funds for Provide to supply Level 2 conversations in Mid Essex (net figure of £16,485 based on: 1309 referrals x £15 (hourly rate including FCR elements) = £19635; however Provide’s staff accessed 21 training places at £150 per place which equates to a costed benefit of £3150 = net figure of £16,485 [↑](#footnote-ref-63)
64. In addition, 32 0rganisations have provided ‘in kind’ support by allowing staff to attend training for Social Prescribing Champions, providing training rooms and training resources and in some circumstances allowing staff to become trainers to maintain the model delivery for future staff [↑](#footnote-ref-64)
65. Information provided by BBWCVS to RSM PACEC (June 2017); actual referrals: CCG monitoring report (March 2017) [↑](#footnote-ref-65)
66. Grant agreement between Castle Point and Rochford CCG and CAVS (February 2016); actual referrals: CCG monitoring report (March 2017) [↑](#footnote-ref-66)
67. Information provided by Connect Well Lead Programme Manager to RSM PACEC (June 2017) [↑](#footnote-ref-67)
68. Grant Agreement between ECC and CCVS (July 2015); actual referrals: Information provided by CCVS/Community 360 to RSM PACEC (June 2017) [↑](#footnote-ref-68)
69. Information provided by Age UK Essex to RSM PACEC (June 2017) [↑](#footnote-ref-69)
70. SAVS (May 2017) Social Prescribing in Southend on Sea: Learning from the pilot [↑](#footnote-ref-70)
71. Target 2016/17: 1,040 referrals; target 2017/18: 1,040 referrals. Pro rata = 1,040 + 1 month (1,040/12\*1 = 87) = 1,127 [↑](#footnote-ref-71)
72. Annual Target: 270; 270/12 = 22.5 per month x 14 months of project delivery = 315 [↑](#footnote-ref-72)
73. CCG monitoring report (March 2017) [↑](#footnote-ref-73)
74. CCG monitoring report (March 2017) [↑](#footnote-ref-74)
75. Information provided by Connect Well Lead Programme Manager to RSM PACEC (June 2017) [↑](#footnote-ref-75)
76. Information provided by CCVS/Community 360 to RSM PACEC (June 2017) [↑](#footnote-ref-76)
77. Information provided by Age UK Essex to RSM PACEC (June 2017) [↑](#footnote-ref-77)
78. SAVS (May 2017) Social Prescribing in Southend on Sea: Learning from the pilot [↑](#footnote-ref-78)
79. Referrals minus those that declined support [↑](#footnote-ref-79)
80. 186 to level 1 support and 1,305 to level 2 support; people declined support at level 2; data on those that declined the service at level 1 is not collected, therefore it is assumed that all who were referred were supported [↑](#footnote-ref-80)
81. CCG monitoring report (March 2017) [↑](#footnote-ref-81)
82. CCG monitoring report (March 2017) [↑](#footnote-ref-82)
83. Information provided by Connect Well Lead Programme Manager to RSM PACEC (June 2017) [↑](#footnote-ref-83)
84. Information provided by CCVS/Community 360 to RSM PACEC (June 2017) – based on a sample of the onward destinations of 563 service users that was analysed by Community 360 using data from ‘detailed conversations’. This found that they were referred to 716 voluntary activities during January 2015 – 31 March 2017 [↑](#footnote-ref-84)
85. Information provided by Age UK Essex to RSM PACEC (June 2017) [↑](#footnote-ref-85)
86. Of the 1305 referrals made to the higher level social prescribing in Mid Essex there were 202 recorded onward referrals to other organisations either during or after their (health coaching intervention) with individuals. This means that they either required ongoing or extra support after/alongside their six sessions (max) with Essex Lifestyle Service or through the health coaching work other opportunities for support were identified as SMART goals were set with the individuals [↑](#footnote-ref-86)
87. 29 respondents did not answer this question [↑](#footnote-ref-87)
88. Information was not available for Tendring and Southend projects [↑](#footnote-ref-88)
89. The aim of the National Social Prescribing Network, which was borne out of a Wellcome Trust-funded research project, is to bring together the Social Prescribing stakeholders who have been making innovations in their local area, and creating a way of enabling strategic collaboration and sharing of best practice [↑](#footnote-ref-89)
90. Dayson, Chris and Moss, Bronwen (2017) The Rotherham Social Prescribing Service for People with Long-term Conditions: A GP Perspective [↑](#footnote-ref-90)
91. SAVS (May 2017) Social Prescribing in Southend on Sea: Learning from the pilot [↑](#footnote-ref-91)
92. Basildon and Brentwood; Castle Point and Rochford; Mid Essex; North East Essex My Social Prescription and Southend. West Essex has not been included as no referral target was set [↑](#footnote-ref-92)
93. Total expenditure for the Southend project was £54k; of this £8,370 was the cost of the Quality for Health licences/ information from SAVS indicates that a least 50% of the time and resources were spent on the Quality for Health/VCS capacity building element of the project. Therefore the amount allocated to the Social Prescription element is £22,815 [↑](#footnote-ref-93)
94. Total expenditure for the Southend project was £54k; of this £8,370 which was the cost of the Quality for Health licences/ information from SAVS indicates that a least 50% of the time and resources were spent on the Quality for Health/VCS capacity building element of the project. Therefore the amount allocated to the Social Prescription element is £22,815 [↑](#footnote-ref-94)
95. Note – in the Mid Essex model it is anticipated that the business as usual costs will increase over time and the project set up costs reduce. It is anticipated that there will be approx. 20% of project costs that will be ongoing development costs. This includes ECC commissioning funds for Provide to supply Level 2 conversations in Mid Essex (net figure of £16,485 based on: 1309 referrals x £15 (hourly rate including FCR elements) = £19635; however Provide’s staff accessed 21 training places at £150 per place which equates to a costed benefit of £3150 = net figure of £16,485 [↑](#footnote-ref-95)
96. <http://www.neweconomymanchester.com/our-work/research-evaluation-cost-benefit-analysis/cost-benefit-analysis/unit-cost-database> [↑](#footnote-ref-96)
97. Includes those that reported an increase and decrease in primary care service use to calculate the net cost avoidance [↑](#footnote-ref-97)
98. Based on New Economy Manchester Code HE20.0 (GP - cost per hour, General Medical Services activity - £121) x number of reduced hours [↑](#footnote-ref-98)
99. Based on New Economy Manchester Code HE21.0 (GP - prescription costs per consultation = £41) x the number of reduced prescriptions [↑](#footnote-ref-99)
100. Based on New Economy Manchester Code HE19.0 (Counselling services in primary medical care, cost per hour = £50) x the number of change in hours [↑](#footnote-ref-100)
101. Based on New Economy Manchester Code HE16.0 (Mental health community provision - average cost per contact = £156) x change in the number of visits [↑](#footnote-ref-101)
102. Includes those that reported an increase and decrease in secondary care service use to calculate the net cost avoidance [↑](#footnote-ref-102)
103. Based on New Economy Manchester Code HE4.0 ((A&E attendance (all scenarios)) - £109) x number of reduced visits [↑](#footnote-ref-103)
104. Based on New Economy Manchester Code HE8.0 (Hospital outpatients - average cost per outpatient attendance - £111) x number of reduced appointments [↑](#footnote-ref-104)
105. Based on New Economy Manchester Code HE7.0 (Hospital outpatients - average cost per outpatient attendance - £111) x number of admissions [↑](#footnote-ref-105)
106. Based on New Economy Manchester Code HE7.0 (Hospital inpatients - average cost per episode (elective and non-elective admissions) - £1,807) x number of admissions [↑](#footnote-ref-106)
107. Includes those that reported an increase and decrease in social care service use to calculate the net cost avoidance [↑](#footnote-ref-107)
108. Relates to the five Social Prescribing that were included in the service user survey [↑](#footnote-ref-108)
109. Cost per service user for each area multiplied by the number of survey respondents for that area; the cost for each area was added together to calculate the input costs for the survey cohort [↑](#footnote-ref-109)
110. CRESR (2014) The Social and Economic Impact of the Rotherham Social Prescribing Pilot [↑](#footnote-ref-110)
111. Relates to Castle Point and Rochford and it has been confirmed by CAVS that plans are in place to ensure there is no underspend at the end of the two year term as the organisation is currently reviewing resource for the immediate future to meet both the current levels of referrals and anticipated up take of the service. [↑](#footnote-ref-111)
112. QALYs combine length of life with a utility value for health related quality of life (HRQL) [↑](#footnote-ref-112)
113. Relates to the five Social Prescribing that were included in the service user survey. The survey was completed with service users in Basildon and Brentwood (Social Prescribing project); Castle Point and Rochford (Ways to Wellness project); Mid Essex (Connect Well project); North East Colchester (My Social Prescription project); and West Essex (Smart Life project) [↑](#footnote-ref-113)
114. The NHS values a QALY at between £20,000 and £30,000. This is the threshold for cost-effectiveness recommended by NICE. Taking the lower threshold value, this means that a £100,000 intervention can be considered cost-effective if it generates five additional QALYs [↑](#footnote-ref-114)
115. In West Essex the partners are Age UK Essex, Community Agents and Provide's Essex Lifestyle Service. It is intended to support any non-clinical issue for anyone over the age of 16 years. The majority of referrals for older people (60+) will be triaged to Community Agents and Smart Life will see people under 60 years. All referrals go to one single point of access - Provide - who triage the referral and send to the appropriate service provider. [↑](#footnote-ref-115)
116. Social Prescription Business Case (June 2015) [↑](#footnote-ref-116)
117. A ‘referral in’ refers to a referral made to a Social Prescribing project [↑](#footnote-ref-117)
118. Basildon and Brentwood; Castle Point and Rochford; Mid Essex; and North East Essex My Social Prescription. West Essex has been excluded as it did not have a referral target [↑](#footnote-ref-118)
119. Dayson, Chris; Bennet, Ellen (2016) Evaluation of the Doncaster Social Prescribing Service: Understanding outcomes and impact [↑](#footnote-ref-119)
120. Dayson, Chris; Bashir, Nadia (2014) The social and economic impact of the Rotherham Social Prescribing Pilot [↑](#footnote-ref-120)
121. Smart, Measurable, Achievable, Realistic and Timebound [↑](#footnote-ref-121)
122. <https://www.england.nhs.uk/wp-content/uploads/2016/12/information-sharing-policy-v2-1.pdf> [↑](#footnote-ref-122)
123. As the data is based on a small number of responses it may not necessarily be a true reflection of the entire programme. In addition, the evidence is based on service user self-reporting of health service use and therefore can be unreliable. [↑](#footnote-ref-123)
124. Rotherham only reported on secondary care reductions (not able to include the same sentence / conclusion for GP hours or social care etc.); Rotherham had higher reductions in A+E attendances. [↑](#footnote-ref-124)
125. ONS categorises medium as a score of 5 – 6 for life satisfaction, worthwhile and happiness scores and 4 – 5 for anxiety scores [↑](#footnote-ref-125)
126. The NET cost avoidance values were established by calculating the difference between the activity reported at baseline and follow-up which was then multiplied by the fiscal value associated with that activity. For example, the difference in reported number of hours spent with the GP at baseline and follow-up was multiplied by the fiscal value for GP cost per hour. This takes into account both reductions and increases in service use reported to provide a net cost avoidance value. [↑](#footnote-ref-126)
127. For GP hours this is based on 125 respondents as 11 respondents did not provide the number of hours they spent with their GP [↑](#footnote-ref-127)
128. Two respondents did not provide the number of hours they spent with their GP [↑](#footnote-ref-128)
129. QALYs combine length of life with a utility value for health related quality of life (HRQL) [↑](#footnote-ref-129)
130. Relates to the five Social Prescribing that were included in the service user survey. The survey was completed with service users in Basildon and Brentwood (Social Prescribing project); Castle Point and Rochford (Ways to Wellness project); Mid Essex (Connect Well project); North East Colchester (My Social Prescription project); and West Essex (Smart Life project) [↑](#footnote-ref-130)
131. The NHS values a QALY at between £20,000 and £30,000. This is the threshold for cost-effectiveness recommended by NICE. Taking the lower threshold value, this means that a £100,000 intervention can be considered cost-effective if it generates five additional QALYs [↑](#footnote-ref-131)
132. Relates to the five Social Prescribing that were included in the service user survey [↑](#footnote-ref-132)
133. Basildon and Brentwood; Castle Point and Rochford; Mid Essex; North East Essex My Social Prescription and Southend. West Essex has not been excluded as no referral target was set; Tendring has been excluded as participant numbers were not available for this evaluation [↑](#footnote-ref-133)
134. Total expenditure for the Southend project was £54k; of this £8,370 which was the cost of the Quality for Health licences/ information from SAVS indicates that a least 50% of the time and resources were spent on the Quality for Health/VCS capacity building element of the project. Therefore the amount allocated to the Social Prescription element is £22,815 [↑](#footnote-ref-134)
135. Area Code: Basildon and Brentwood: BB; Castle Point and Rochford: CPR; North East Essex: NE; Mid Essex: ME and West Essex: WE [↑](#footnote-ref-135)
136. Based on the 4 measures of personal well-being used by the ONS [↑](#footnote-ref-136)
137. We acknowledge that these would usually be appropriate and planned use of care [↑](#footnote-ref-137)
138. Based on the EQ5DL Questionnaire [↑](#footnote-ref-138)
139. Based on the Short Warwick Edinburgh Scale [↑](#footnote-ref-139)
140. Based on measure 1.18i/ii from the PHOF and 1i from the ASC OF. Drawn from the Adult Social Care Survey/Personal Social Services Survey of Adult Carers in England. [↑](#footnote-ref-140)
141. Based on the EQ5DL Questionnaire [↑](#footnote-ref-141)
142. Area Code: Basildon and Brentwood: BB; Castle Point and Rochford: CPR; North East Essex: NE; Mid Essex: ME and West Essex: WE [↑](#footnote-ref-142)
143. Based on the 4 measures of personal well-being used by the ONS [↑](#footnote-ref-143)
144. We acknowledge that these would usually be appropriate and planned use of care [↑](#footnote-ref-144)
145. Based on the EQ5DL Questionnaire [↑](#footnote-ref-145)
146. Based on the Short Warwick Edinburgh Scale [↑](#footnote-ref-146)
147. Based on measure 1.18i/ii from the PHOF and 1i from the ASC OF. Drawn from the Adult Social Care Survey/Personal Social Services Survey of Adult Carers in England. [↑](#footnote-ref-147)
148. Based on the EQ5DL Questionnaire [↑](#footnote-ref-148)