Key Outcomes

- Almost 200 people were referred to the East Hertfordshire Social Prescribing Service (EHSPS) between January 2018 and January 2019.
- The EHSPS demonstrated a positive effect on the wellbeing and social connectedness of the service users.
- The evaluation of the EHSPS showed that there was a statistically significant improvement in mental wellbeing and a statistically significant reduction in social isolation for the service users.
- The wellbeing valuation analysis showed that the East Hertfordshire Social Prescribing Service provided a cost effective way of creating a positive social impact on the service users.

Introduction

Social isolation has been shown to have an impact on physical and mental wellbeing\(^1\) and mortality\(^2\). Social prescribing services attempt to address this issue as they are considered to work well with people who have long term health conditions, feel socially isolated, require support for mental health or have social needs affecting their wellbeing\(^3\).

Social prescribing can be described as a link service between primary care and non-clinical services which enables patients to be referred to services to address their social, emotional or practical needs\(^3\). These services can include the creative arts, physical activity, volunteering and befriending services or practical support such as debt and legal advice\(^4\). Link workers within a social prescribing service work together with service users to explore and develop personal plans using the link worker’s knowledge of local partnerships and services.

As part of the new NHS Long Term Plan, social prescribing is expected to play an important part in personalising care\(^3\). As well as having a positive impact on individuals, social prescribing services can benefit community groups and the health and care system. Previous research and evaluations have suggested that social prescribing services can improve both service users’ wellbeing and feelings of social connectedness\(^5\)\(^6\)\(^7\). However, a systematic review of fifteen social prescribing evaluations found evidence for long-term effectiveness of social prescribing is limited and highlighted that many of the existing studies had a high risk of bias\(^8\). Therefore it important to continue to evaluate social prescribing services to add to the knowledgebase.
Pressures on GP surgeries are growing due to shortages of GPs and it is suggested that approximately 20% of all GP appointments are the result of social welfare issues such as housing problems, debt, issues with benefits and difficulties accessing community care. Therefore these appointments are considered to be an inappropriate use of GP time and more suited to social prescribing services.

Research on approaches to social prescribing has revealed that there are several different models of social prescribing in which four distinctive types have been identified. These are: social prescribing as sign posting; social prescribing light; social prescribing medium and social prescribing holistic. However, the sign posting model is described as a complementary approach to social prescribing by NHS England and not a social prescribing model in itself. The most common form of social prescribing is the Social Prescribing Light model which the East Herts Social Prescribing Service (EHSPS) most closely resembles.

**Description of the service**

For this evaluation, the EHSPS targeted patients aged 50+ who were suffering from social isolation, loneliness or mild depression. Referrals were made from five GP surgeries, an integrated care team and local pharmacies in the Stort Valley and Villages CCG locality. A total of 198 referrals were made between 15th January 2018 and 14th January 2019.

After being referred by their GP, patients attended a triage appointment with the Social Prescribing Co-ordinator to assess their needs and suitability for the service. If they met the requirements for the service, they were booked onto an initial 45 minute appointment held at one of the GP surgeries. Patients who were unable to leave their home easily were offered a home visit. Within the initial appointment, the Social Prescribing Co-ordinator helped the patient/service user to identify suitable social prescriptions within the community for their personal needs and set up a start date for them to attend.
The types of interventions that service users were referred to included:

- Day centres
- Physical activity classes
- Health walks
- Social groups
- Learning programmes
- Befriending services
- Meals
- Lunch clubs
- Transport support
- Financial support
- Mental health support
- Bereavement support

After the first attendance to a community activity or service, the link worker contacted the service user either via a face to face visit or a telephone call to find out how the patient got on. The service user was then followed up 12 weeks after the initial appointment to find out how the community group/service had made an impact on their wellbeing. Figure 1 below shows the East Herts Social Prescribing pathway:
Aims and objectives of the EHSPS

The aim of the East Hertfordshire social prescribing service project was to support at least 180 East Hertfordshire residents a year by improving their wellbeing and helping them to re-engage with others to reduce social isolation.

The objectives of the EHSPS service were:

1. To reduce the average Campaign to End Loneliness (CtEL) score of service users by at least one point.
2. To determine if there was a statistically significant reduction in the average CtEL score of the service users 12 weeks after the initial one to one appointment with the social prescribing co-ordinator.
3. To increase the average service user’s wellbeing score by at least two points using the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS).
4. To determine if there was a statistically significant improvement in the average wellbeing score (SWEMWBS) of the service users 12 weeks after the initial one to one appointment with the social prescribing officer.
5. To determine if there was a positive wellbeing valuation by applying the SWEMWBS results to the mental health social values calculator produced by HACT.

Evaluation method

To measure service user wellbeing, the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS)\textsuperscript{10} was chosen due to its popularity, validity and reliability. National data from 2011 was also available to enable the comparison of the baseline and follow up data to the general population. To measure the social connectedness or feelings of social isolation of the service users, the Campaign to End Loneliness measurement tool (CtEL)\textsuperscript{11} was chosen because it has been tested for reliability and validity and did not use the word lonely within the questions.

A patient centred questionnaire Measure Yourself Concerns and Wellbeing (MYCaW)\textsuperscript{12} was also selected to identify specific concerns raised by service users and to determine if there were any common concerns among the service users.

Baseline data was collected at the first one to one appointment and the follow up data was collected twelve weeks after the first appointment. Both datasets for each measure were checked for normality and the interquartile range was calculated to look for outliers in the data. Outliers were removed from the CtEL datasets. A paired sample t-test was carried out on the SWEMWBS data and the CtEL datasets to determine if the changes between the initial appointment and the 12 week follow up were statistically significant.
Wellbeing valuation provides a way of understanding how improvements in mental wellbeing can lead to a positive social impact on people. The approach taken by HACT provides a way to place a monetary value on improvements of wellbeing by calculating the amount of money it would take to provide an alternative way to improve wellbeing and life satisfaction\textsuperscript{13}. To calculate the wellbeing valuation of the EHSPS, the SWEMWBS improvement values for each service user were matched to HACTs Mental Health Social Value Calculator (Version 1) to determine the average score per service user. This value was then multiplied by the number of service users who attended the first appointment between 15th January 2018 and 14th January 2019 and the overheads of the service deducted.

**Results**

Between 15\textsuperscript{th} January 2018 and 14\textsuperscript{th} January 2019, 198 people were referred to the EHSPS service and completed the triage. After the triage, 133 people attended the initial appointment putting the uptake of the service at 67%. Reasons for not attending the initial appointment included: inappropriate referrals; service declined by the patient; patient did not attend; unable to contact; duplicate referral; referred to another service; patient deceased.

Of those who attended the initial appointment, 65% of service users were female and 35% were male. The average age of the service user was 75, with the youngest being 29 and the oldest being 95. The majority of service users were aged over 50. However, exceptions were made for 10 service users who were under 50 years old. The average number of social prescriptions was two per service user.

Overall 125 service users completed the baseline questionnaires and 65 had completed the follow up questionnaires by the time of this evaluation report nine months into the service. Therefore, a total of 65 records were included in the analysis of the SWEMWBS and CtEL data. It was not always appropriate to ask some patients to respond to the baseline and follow up questionnaires due to ill health or mental health issues such as dementia or bereavement.

Both the mean and median scores for the loneliness measure (CtEL) were reduced by one point which met the first objective.

Comparing the SWEMWBS data to the 2011 National data set collected in the Health Survey for England, the starting score was 22 and the 12 week score was 24. Both of these scores were classed as below average. However, a paired samples t-test carried out on the baseline ($M = 22.14, SE = 0.66$) and follow up data ($M = 24.34, SE = 0.61, t(64) = -4.15, p < 0.01, r = 0.46$) showed that there was a statistically significant improvement in wellbeing.

A paired samples t-test carried out on the CtEL data between the baseline ($M = 3.87, SE = 0.31$) and follow up data ($M = 2.89, SE = 0.28, t(62) = 3.90, p < 0.01, r = 0.46$) showed that there was a significant reduction in loneliness.
Due to a poor response rate, caused by the questions confusing many of the elderly residents, the data from the MYCaW questionnaire was not deemed suitable for analysis and was therefore excluded from this evaluation.

The results from the HACT wellbeing valuation analysis showed that for this pilot, the average value per person completing the 12 weeks with the EHSPS was £1,778.80 minus overheads. The staffing and the grant costs for the service came to £39,810. Appointment rooms were provided by the GP surgeries and telephone costs were covered by the GP surgeries. Therefore, the overall wellbeing valuation, including the estimated return on investment and NHS cost savings achieved, for this pilot was £196,770 for the 133 people that attended the first appointment (assuming they completed the full 12 weeks).

It was estimated that at least 700 hours of direct service user contact time was required for 200 service users completing the programme with an 85% completion rate.

**Feedback from Referrers to the Service**

The GP surgeries referring into the EHSPS were contacted to provide feedback on the service. Below are two examples from one GP surgery showing how the EHSPS had had an impact on GP appointments:

- **Patient A** - In 2018 at the beginning of the year she was ringing constantly requesting home visits and appointments. Prior to your intervention there were 23 contacts between Jan - Sept. Since September there have only been 4 appointments and she is supported by Age UK befriending service.

- **Patient B** - In 2016 she had 14 appointments, 2017, 9 appointments and in the first 3 months of 2018, 5 appointments. Since the social prescribing intervention in April she has had 1 appointment and that was a medication review requested by the GP.

A patient case study can be found in the appendices at the end of this report.

**Discussion**

The results of this evaluation indicate that the EHSPS has had a positive effect on the wellbeing and social connectedness of the service users. All five objectives set at the beginning of the evaluation were met. Overall the results are in line with other social prescribing studies which had similar objectives and used the same measures. For example, three studies assessed by Bickerdike et al.\(^8\) found positive results for participant wellbeing using the WEMWBS measure which aligns with the results of this evaluation. However, only one of the studies tested for statistical significance and all the studies had low numbers of participants. Woodall et al.\(^6\) reported significantly statistical improvements for both their WEMWBS and the CtEL measures which aligns with the findings for wellbeing and social
connectedness in the present evaluation. In addition, Woodall et al.⁶ carried out 26 semi-structured interviews with service users to understand how the service had improved wellbeing and social connectedness for their service users. Semi-structured interviews could be a useful addition to any further evaluation of the EHSPS.

The MYCAW questionnaire, which had a qualitative element, was used with the service users for one month. However, it was reported by the Social Prescribing Co-ordinator that service users felt thrown by the questions and their general response was that they were okay. They did not relate to the process of identifying specific concerns or being able to quantify wellbeing with the wellbeing question. It was felt that the SWEMWBS questionnaire was easier to relate to in terms of understanding and measuring wellbeing.

Overall, the completion rate of the baseline questionnaires was good considering that it was not always appropriate to ask some patients to respond to the questionnaires due to ill health or mental health issues. The completion rate for the follow up questionnaires was also good considering that it only included the first nine months of the programme. The number of referrals increased month-by-month throughout the year and patients referred from late October would not have provided their follow up data by the time of starting this report. In addition, one of the GP surgeries was slow to start referring and their first appropriate referral was not made until August 2018. Other reasons for incomplete follow-up data were due inappropriateness of sensitive questions to some of the service users, still waiting for a response from the follow up letter or the service user had deceased.

In terms of quality, the uptake of the service was similar compared to other social prescribing services⁸. However, this was a small scale intervention and there was no long term follow up. Therefore, although short term findings suggest it had a positive impact on the service users, we do not know if this will be sustained. There was no control group due to limited resources for this evaluation. However, this is a limitation of many social prescribing evaluations. A control group would require some service users to be prepared to complete the measures at baseline and follow up and yet not received the service which they may not be happy with. Confirmation that service users attended their referral was not collected from the community service or activity. Instead, attendance was based on self-reporting by the service user.

Finally, this evaluation was not able to show the impact of the service on inappropriate GP appointments as gaining access to GP data is challenging due to data protection regulations. In addition, there was no qualitative element to this evaluation so it is not known if there were any barriers to the update of social prescriptions or if there was a lack of suitable prescriptions for some service users as found in the study by Wildman et al.⁷.
Conclusion

Overall, the East Herts Social Prescribing Service pilot has shown promising outcomes in terms of mental wellbeing and social connectedness for the service users. It has also shown positive results in terms of wellbeing valuation. However, it is difficult to know what the longer-term effect for supported patients referred to the service will be. This is because data has not been collected beyond the 12 week follow up with patients.

Recommendations

Going forward with the service it would be useful to carry out some qualitative interviews to find out more about how this service improves wellbeing and social connectedness and if there are any barriers to accessing appropriate services. To determine the longer term effects of this service it would be helpful to include further follow up data collections (e.g. 6 months after their final appointment) from the service users to determine if their levels of wellbeing and social connectedness are sustained.

In terms of process evaluation, it would be beneficial to build in checks to confirm if a service user attends their social prescriptions(s) and to track the social prescriptions referred to determine which services are the most popular. This will enable the EHSPS to predict future demand of services and to help these services seek appropriate funding.

As the Social Prescribing Co-ordinator works within GP surgeries it would useful to find a way to demonstrate a reduction in inappropriate use of GP appointments by exploring data sharing options.
References


Appendix

East Herts SPS Case Study: Mrs M: Lady aged 87

Date of Referral: May 2018

Source of Referral to EHSPS: GP working out of South Street Surgery, Bishops Stortford.

The issue

Mrs M lives alone and she has recently lost her husband. Her niece can only visit occasionally as she does not live close by. Mrs M has no other living family. As a result, Mrs M felt lonely, depressed, anxious and lacked the confidence to leave her home. For Mrs M small problems would easily expand into big problems. She was phoning her niece at least once a day with minor issues regarding her house and she would regularly contact her GP and the Ambulance Service about minor issues such as headaches/migraines. Mrs M was also continuously contacting her neighbours about small problems. Although her neighbours were initially willing to support her, they felt that they were put under undue strain and eventually found the situation difficult to handle. In response, they often made out they were not at home when Mrs M knocked on their door.

Referral process

The East Hertfordshire Social Prescribing Service (EHSPS) accepted the referral in line with the guidelines they provide to health professionals. The EHSPS co-ordinator phoned Mrs M within a day of receiving the GP referral form and arranged a convenient date and time to visit her at home. The visit took place seven working days after this phone call and lasted an hour.

Action Plan by EHSPS

In the initial meeting, the East Herts social prescribing co-ordinator and Mrs M jointly discussed a wide variety of potential community/social groups and services that Mrs M could consider. She was keen on several of these. However, due to her lack of confidence leaving her home, and the restricted transport options in her area, it made attending the most suitable social groups more limiting. Therefore, it was agreed that the social prescribing co-ordinator would contact HertsHelp. The aim was firstly to provide Mrs M with support that would build up her confidence walking and leaving her home.
Mrs M agreed that the East Herts social prescribing co-ordinator could pass her contact details to the following support groups; SilverLine, Apton Road Day Centre, and Age UK Befriending Service, and for the East Herts social prescribing co-ordinator to request that they make contact to offer further help. EHSPS task of contacting all these organisations was undertaken between 1-3 days.

**Outcomes**

**EHSPS initial meeting with client and niece**
As a result of the EHSPS intervention, Mrs M has now been contacted by several additional support services who the East Herts social prescribing co-ordinator contacted on her behalf. Mrs M has been contacted by SilverLine and she now has a regular ‘pen friend’ arranged by this charity. HertsHelp have been able to take Mrs M to the shops. However, due to their own current inhouse restrictions, they were only able offer her two sessions.

**EHSPS eight-week follow-up appointment with niece**
Mrs M’s niece has reported that Mrs M is now confident to go out on her own and gets a taxi to her hairdressers regularly rather than a home appointment. She also happily takes a taxi to local shops to select her own food shopping.

Now that Mrs M has gained the confidence to leave her home and she would like to join Apton Road Day Centre. The East Herts social prescribing co-ordinator has provided details of CVS Uttlesford Community Car Scheme who state that they already take residents from the same village as Mrs M to the centre regularly.

Her niece now rarely receives a call from Mrs M. However, she is happy to phone Mrs M just to have a quick chat and make sure she is ok. She is pleased that she continues to improve her overall wellbeing and social engagement.

**EHSPS ten-week follow-up phone conversation with client**
Mrs M was contacted by the East Herts social prescribing co-ordinator by phone to discuss how she was getting on. The East Herts social prescriber used standard wellbeing tools to measure the changes in Mrs M’s mental wellbeing and feelings of social isolation (SWEMWBS and Campaign to End Loneliness measurement tool). Both tools showed that Mrs M feels there has been a positive improvement in her wellbeing and a reduction in her social isolation.
Benefits to others

**NHS:** Mrs M has now stopped frequently phoning her surgery or calling out her GP and the ambulance service. It is estimated that an Ambulance call out is approximately £600 a visit, a GP’s surgery appointment and/or home visit is approximately £85-£100 per visit, and a Nurse Practitioner is £40 per session, added onto this is the surgery administration costs for the frequent phone calls.

**Close Family Members:** Mrs M’s improvements have greatly reduced the emotional strain and time commitment endured by her niece.

**The Neighbours:** Neighbourly rapport is now back on an even keel.

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