Evaluation of Dundee

Equally Well

Sources of Support:

Social Prescribing in Maryfield

Evaluation Report Four

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many people contributed their time, knowledge, expertise and enthusiasm to the evaluation of equally well in dundee. the evaluation team would like to thank everyone who agreed to be interviewed, took part in focus groups and all the people who gave feedback or shared their views as the test site developed. we would particularly like to thank the sources of support link workers and gps who gave up their time to talk about their experience of the social prescribing pilot. above all, we are grateful to all the people who participated in the project and who contributed by sharing their stories and their own unique journeys.

acknowledgements
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Summary of Sources of Support

Evaluation findings

Social prescribing: woven round the lives of people, where they live, rooted in an analysis of the wider determinants, committed to social justice

This report sets out the findings from the evaluation of Sources of Support (SOS), a pilot social prescribing scheme which forms part of the Dundee Equally Well test site and is set within Maryfield Medical Centre in Stobswell.

1. Aims

“Quite often as a GP, you do realise effectively what you can do is not very much. Life and circumstances and events and all sorts of things affect people’s mental health and all you can do is give them 10 minutes of your time and probably send them away with a prescription” GP interview

The purpose of the social prescribing pilot was to develop, co-ordinate and evaluate a social prescribing scheme in order to:

- Build local evidence of the benefits of social prescribing for patients and health professionals
- Identify the operational issues and solutions in running a practice based scheme
- Gain local support for sustaining and rolling out the scheme

Social prescribing can help provide psychosocial and practical support for people with a wide range of problems and conditions whose needs are not being met within existing services or who may be using services inappropriately. The overall outcome is to improve the mental wellbeing of patients, through supporting them to access non-clinical sources of support within the community. Individual outcome measures include:

- Enhanced skills and behaviours that improve and protect mental wellbeing.
- Increased social contact, support and networks.
- Increased participation in community activities.
- Increased uptake of local services.
- Improved mental wellbeing – Warwick Edinburgh Mental Wellbeing Scale and Work and Social Adjustment Scale.

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1. Friedli L (2011) Briefing on social prescribing for Dundee Equally Well
2. A map of Stobswell is included in Appendix Two
2. Referral routes

“I think it moved me in the right direction. . . she was always sort of reassuring and encouraging. . . when I first began I was quite a . . . I rarely went out, I rarely did anything. It kind of gave me that boost to go and do things with the kids and I was always kind of worried about money. So she put me on to places that didn’t cost too much or were free sort of activities, that sort of thing.” SOS participant.

Key services were identified across Dundee that help address:

- Structural and environmental issues e.g. money/ debt, employment and training, housing support, anti-social behaviour.
- Lifestyle issues e.g. drug and alcohol misuse, physical activity, condition management.
- Social isolation and other psychosocial and emotional needs e.g. counselling, volunteering, adult learning, social activities.
- Family and relationships problems e.g. mediation, children’s services.

3. Activities

“But it was a very, very tough challenge for me. It took me a whole year just to turn round to the person I am today… But I’ve managed to start going back to my workplace. And I’m starting to drive again now” SOS participant

The scheme involves GP referral, followed by contact from a link worker and up to four link worker consultations to assess patient needs and identify appropriate community based information, support and/or activities.

From March 2011 - June 2012, 123 (100%) patients, roughly equal numbers of men and women of all ages, have been referred. 61 (50%) people fully engaged with the scheme; this means they attended at least one consultation. Of the 61 fully engaged people, one third only had one consultation, just under half had two consultations and one in five people had between 3-5 consultations with link workers.

26 people were referred to a community-based activity. All of these 26 (100%) attended this activity, 21 (81%) attended a second activity and 17 (65%) attended a third or fourth activity. In total there were 119 link worker referrals into 47 different community services or groups; a further 36 referrals were made into existing Dundee Healthy Living Initiative (DHLI) groups.

Issues affecting wellbeing reflected on the referral forms by GPs include factors such as social isolation, social phobia, anxiety, low self esteem and low mood affected by circumstances including unemployment, debt, physical and mental health conditions and caring responsibilities.
4. Evaluation findings

“Another young lad was very introverted, and it got him out, doing stuff. That’s great, so he’s doing something positive, so that is good. I don’t know how you evaluate that - tiny changes, but important changes.” GP interview

“Never in a million years did I think I would be going to college so soon and making a lot of friends and for that I can’t thank you enough for everything you done... the other day I met the Lord Provost and got a certificate for doing the adult learning. I was nervous when I had to stand up to get it and get a picture too but I did it!” SOS participant

Most patients found the scheme appropriate to their needs, helpful, flexible, accessible and offering a good variety of activities and support. This included patients with complex and enduring needs who may be difficult to engage and support, as well as patients with no previous history of engagement with any services apart from primary care. Where pre and post intervention data is available for those who have completed the programme (N=16), patients showed a significant (p<0.05) improvement in mental wellbeing and functional ability.

The pilot developed a new approach to meeting complex needs, new cultures and ways of working within primary care and stronger, more effective links between health services and a very large variety of community based services/support. This rich tapestry of information, activities and opportunities was seen by GPs as a valuable local asset for mental health and wellbeing. SOS responded to the wider, socio-economic determinants of mental health, met a wide range of patient needs and was positively evaluated by them. Participation in the scheme resulted in strong, effective partnerships between primary care and link workers, with some evidence of changes of culture and practice, for example G.P. consultations more geared to addressing social needs.

The social prescribing pilot contributed to:

- Engagement (primary care, patients, wide range of service providers).
- Awareness (of what exists in the community to support mental health, of the wider determinants of wellbeing).
- Capacity (enabling primary care to refer patients without having to keep up to date with community based support themselves; partnership between link workers and primary care, partnership between link workers and provider agencies; building community capacity through small incremental steps, as patients were empowered to draw on community based sources of support).
- Behaviour change (some examples of changes in G.P. consultation style to create greater scope for addressing social determinants; patients making changes in their lives e.g. physical activity, social contact, learning new skills, returning to employment).
- Tackling influences (provided an opportunity to improve mental wellbeing through addressing social determinants e.g. financial difficulties, unemployment, lack of education and psycho-social factors e.g. isolation, low self esteem, bereavement).
- Improved wellbeing (most patients who engaged with the scheme valued the experience and showed an improvement in mental wellbeing).
4.1 Contribution of test site

“We have freedom to develop the service as required, which also means you can be flexible, fitting it in...”
Link worker

Developing and evaluating a social prescribing scheme was one of the ‘tests of change’ of the test site. The test site was central to developing Sources of Support and to leading what is essentially a significant service redesign project. This included drawing on the existing evidence base on social prescribing to make the case for new ways of working with and within primary care and for better links between health services and services in the community. It also involved developing monitoring and evaluation systems that recognise and capture the impact on wellbeing of a wide range of socioeconomic and psychosocial factors.

GP interview

GPs were already aware that patients had needs that were not being met, or were not best met, in primary care and that there was ‘lots going on in Dundee’ that might help. However, they faced considerable barriers to acting on that knowledge and signposting patients. The contribution of the test site was to create the conditions for tackling these barriers and putting in place a flexible and accessible route to community groups or activities to improve wellbeing.

The contribution of the test site was also to realise the strategic aspirations of NHS Tayside and the Dundee Partnership in delivering social prescribing in Dundee. The existence of a pilot scheme has helped to keep social prescribing on the strategic agenda and accelerated endeavours to sustain and roll out existing efforts.

4.2 Transferable learning

“One year on, positive findings from SOS, both for patients and for primary care, tend to corroborate what is known from much larger, longer-term evaluations in the research literature. Some specific findings from the local scheme may be particularly relevant to implementing social prescribing in disadvantaged areas and to developing a model that successfully engages patients with complex needs.

Key lessons from the scheme include:

- Social prescribing is new and unfamiliar – for patients and for primary care – communication support is needed.
- GPs are more likely to refer patients when the primary care culture supports holistic, psycho-social approaches and may require a shift in consultation style.
- The link worker role is essential if the scheme is to support disadvantaged patients.
- High levels of persistence, support and flexibility are needed to engage patients with complex needs and enable them to overcome barriers to accessing support: this requires highly skilled link workers.
- Successfully matching patient needs depends on the availability of a wide range of good quality, flexible, community based services.
- Emerging outcomes e.g. improved mental wellbeing, increased social contact, greater participation – have cost benefits, suggesting the cost effectiveness potential of social prescribing.
For GPs, the way in which link workers approached their role was seen as crucial and distinguished social prescribing from any other service available for vulnerable patients. Key elements of this included speed of follow up, persistence, flexibility, understanding barriers patients face and local expertise.

The link workers felt that the freedom to provide a flexible service, based on their experience of what worked for people with complex needs, was fundamental to ensuring that vulnerable patients could engage with the scheme. Like the GPs, they saw this commitment to providing a service designed around the patients’ needs as a distinguishing and essential characteristic of the social prescribing pilot.

### 4.3 Sustainability

“I think it would help anybody, people losing jobs, people not well, generally with society at the moment with money problems, that doesn’t help people... I think there’s a big need out there”  
SOS participant

The scheme depends on significant interdependencies to facilitate appropriate referral, patient engagement, signposting and supported access to community based support. Predominantly this involves Maryfield Medical Centre staff, DHLI Link Workers, Equally Well Lead Officer, and local organisations that comprise the referral pathways. The partnerships and protocols are now well established, operational issues have been readily addressed and there is strong support within primary care for roll out.

Many of the tools which have been developed, such as referral forms, patient database, and outcomes framework, have the potential to be used on a much bigger scale. Other contributions include changes to Dundee City Council’s website to make more explicit and easy to access the range of support options available for people to improve their mental health and wellbeing.

It is likely that further local evaluation will continue to show benefits for those involved to corroborate what we know from much larger, longer-term evaluations in other parts of the country. Local evaluation will also help highlight issues associated with non-engagement and tell us how best to go about promoting and branding social prescribing.

The operational and strategic support that the pilot scheme has engendered is testimony to the calculated risk that the test site took in setting up a short term initiative. Social prescribing remains a priority for health equity in the new SOA and Healthy Dundee has made roll out of social prescribing one of its key aims in the coming year, along with rolling out across Dundee the test site approach as a whole.
5. Conclusion

“The most helpful thing was just all this learning stuff. . . as I say, if I hadn’t seen her [link worker] then I wouldn’t have done this. . .” SOS participant.

Half of the patients referred into the SOS scheme fully engaged and all those referred to a community-based activity attended at least one activity. Those people who engaged did so consistently and showed significant benefits. Overall, the pilot was successful in its aim of building local evidence of the benefits of social prescribing for both patients and health professionals. Operational issues were quickly resolved and strong, positive partnerships built between primary care and link workers, as well as between link workers and provider agencies.

The availability of the scheme addressed existing concerns of GPs about unmet need and provided a trusted route for meeting the psycho-social needs of vulnerable patients. Participation in SOS also influenced G.P. consultation style and has the potential to generate wider interest and debate about partnerships for addressing the social determinants of mental health and wellbeing and reducing inequalities.

Above all, the test site has been successful in gaining support at the highest level for the roll out of the test site approach and the social prescribing pilot. These two interventions, (along with the enhancement of the Dundee Healthy Living Initiative), have been agreed by all partners as key methodologies that can support redirection of resources to ‘preventative spend’ and reductions in failure demand. This strategic achievement has resulted in over £200,000 being awarded to the test site to support changes in ways of working in Dundee’s Community Regeneration Areas and to implement social prescribing in two further GP Practices and across other settings.
1. Introduction

This report sets out the findings from the evaluation of Sources of Support, a social prescribing scheme within Maryfield Medical Centre, which forms part of the Dundee Equally Well test site. It includes background information on the aims, context and approach of Equally Well in Dundee (sections 1-6). The social prescribing scheme evaluation is covered in sections 7-8.

2. Equally Well background

The Dundee test site is one of eight national demonstration sites sponsored by the Scottish Government as part of the implementation of Equally Well. The Dundee test site focused on the Equally Well priority of addressing:

**the high economic, social health burden imposed by mental illness and the corresponding requirement to improve mental wellbeing.**

Working in Stobswell, a disadvantaged community in Dundee, it aimed to test new ways of working, predominantly in public services, to tackle health inequalities and improve community mental wellbeing. The test site has taken a determinants approach, acting as a catalyst for change. Improving mental wellbeing is seen as a long term outcome which can only be achieved if the influences on wellbeing are addressed.

3. Aims of Test Site

The test site hypothesis is:

*That through a process of engagement, awareness raising and capacity building, services and the community can change to better address factors affecting mental wellbeing.*

The test site has aimed to improve community mental wellbeing through a process of:

- Community and service provider engagement.
- Increased understanding of mental wellbeing in its broadest sense.
- Building community and service capacity to support mental wellbeing.
- Identifying and supporting changes that will make a difference.

The test site further focused on finding answers to the following questions:

- How does the test site facilitate the service, community and partnership response?
- What difference does this make to mental wellbeing and its determinants?

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3 A full list of evaluation reports for the Dundee Equally Well test site is included in appendix one
4. Mental health and wellbeing

The test site developed the following plain-speak definition of mental wellbeing:

*Mental wellbeing is how we feel, think and behave. It is affected by lots of things, such as where we live, whether we feel useful and valued, and the kinds of relationships we have with others. Mental wellbeing is important for everyone.*

This definition explicitly highlights key determinants of wellbeing – the circumstances of people’s lives, how people are treated and the quality of relationships – and was used as the basis for a wide range of conversations about mental wellbeing with local communities, services and other stakeholders. It was also included on contact cards for people who had any queries about the test-site and these were handed out during outreach activities.

5. The test site approach

The test site was guided by a set of ‘simple rules’, endorsed by the Equally Well Core Group (figure 1).

**Figure 1: Simple Rules**

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<th>Core Group level</th>
<th>Community level</th>
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<tr>
<td>Think mental health inequalities as well as mental health</td>
<td>Work in partnership</td>
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<tr>
<td>Take into account the wider determinants of mental wellbeing</td>
<td>Involve the community and frontline staff at every stage</td>
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<tr>
<td>Build changes into existing processes and structures</td>
<td>See people as assets</td>
</tr>
<tr>
<td>Think sustainability and transferability</td>
<td>De-jargonise</td>
</tr>
<tr>
<td>Measure progress in ways that make sense to the community</td>
<td>Work in groups</td>
</tr>
<tr>
<td>Make evidence informed decisions</td>
<td>Think of creative solutions to complex problems</td>
</tr>
<tr>
<td>Reflect and learn</td>
<td>Reflect and learn</td>
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The test site worked across three levels; locally, strategically and nationally. Its philosophy was reflected in these ‘simple rules’ as well as in Dundee traditions of social justice, community development and partnership working. Working towards the key aims of improving mental wellbeing and reducing health inequalities involved recognising explicitly the link between these outcomes and addressing deprivation and disadvantage.
6. Evaluation of the test site’s approach

The framework for evaluating the test site is based on a Contribution Analysis (CA) theory of change (Figure 2). CA describes a process of engagement, raising awareness, and capacity building, which leads to changes in behaviours and practice. These changes will impact on the determinants of mental wellbeing (identified through the test site community consultation) and lead to improvements in community mental wellbeing over the long term. The test site is perceived as having direct control over the engagement and awareness stages of the change process, direct influence over capacity building and changes in behaviours, and indirect influence on determinants and longer term outcomes.

Figure 2: Mapping a theory of change (adapted from Wimbush 2009)

Evaluation questions:

- What strategies and resources are used by the test site to engage and influence stakeholders, build community/service capacity, change behaviour/practice and tackle influences on mental wellbeing?
- How successful are the test site strategies in achieving influence: at local, strategic and national level?
- Is there any evidence that local services and the community are working differently?
- Do these changes result in improvements likely to influence mental wellbeing?
- What are the lessons from the development and implementation of the test site that are transferable?
- Are the achievements of the test site sustainable?


7. Wimbush E and Mulherin T (2010) A Results-Based Performance Framework for Dundee Equally Well Test Site and StobsWELLbeing
Edinburgh: University of Edinburgh Business School
7. Evaluation of Social Prescribing Outcomes

The following sections describe the background, aims, activities and evaluation findings of the social prescribing scheme.

7.1 Social prescribing: background and context

Social prescribing links primary care patients with non-medical sources of support within the community (Scottish Development Centre for Mental Health 2007; Friedli et al 2009). Research suggests that a high percentage of GP consultations concern social factors, notably in areas of deprivation, where GPs have a higher number of consultations and more out of hours calls (Vedsted et al 2005; Popay et al 2007).

Social prescribing can help provide psychosocial support for people whose needs are not being met within existing primary care services or who may be using services inappropriately.

Developing and implementing social prescribing was a specific aspiration set out in NHS Tayside’s Health Equity Strategy: Communities in Control. The strategy recognises the importance of factors such as community resilience, co-production, good mental health and wellbeing, social capital, ease of access, and addressing the wider determinants of health. In addition, Dundee Partnership’s Single Outcome Agreement stated implementing social prescribing as one of the top priorities for health equity in Dundee.

In order to support the realisation of these plans and aspirations, one of the tests of change of the test site was to develop and evaluate a social prescribing scheme. The development of the scheme took over a year, with the initial 6 months devoted to strategic discussions with senior partners about future sustainability of social prescribing, investigation of existing schemes across the country and identification of a Medical Practice in which to base the scheme. The latter 6 months were spent on establishing and supporting a working group involving staff from Discover Opportunities, Dundee Healthy Living Initiative, Maryfield Medical Centre and the Equally Well test site. This group, led by the Equally Well Lead Officer, developed the scheme specification, outcomes, referral processes, inclusion/exclusion criteria, consultation and feedback forms, and other practical issues, such as identification of potentially relevant community groups, services and activities.

The scheme, Sources of Support (SOS) was set up within the Maryfield Medical Centre. Originally planned to run from March 2011 for a 4 month period, it was subsequently extended until June 2012. SOS was funded within existing resources and uses Dundee Healthy Living Initiative (DHLI) as the delivery mechanism.

Social prescribing can provide a framework for:

- Developing alternative responses to mental distress and expanding treatment options.
- Recognition of the wider socio-economic influences on mental health outcomes.
- Improving access to services, activities and opportunities that support wellbeing.

Social prescribing for mental health and wellbeing has shown a range of positive outcomes including:

- Reduction in symptoms (e.g. anxiety, depression).
- Social benefits (inclusion, participation, access to new networks).
- Uptake of activities that promote mental and physical health (physical activity, arts and creativity, learning, volunteering).
- Practical and material benefits (resolving problems with debt, benefits, housing).
- Skills (linking people to opportunities for training, routes to employment).
- Quality of life (reducing isolation, loneliness, lack of confidence and self esteem)

(Friedli et al 2009)

Social prescribing can also contribute to reduced frequent attendance at primary care, which is often a result of people’s wider social, emotional and practical needs not being met, as well as reductions in unplanned admissions and use of other secondary care services. The evidence suggests that the role of social prescribing in improving access to sources of social support, especially for people who are most likely to be isolated or excluded, may be of particular importance (Holt-Lunstadt et al 2010; Knapp et al 2011b).

7.2 SOS Aims and objectives

“I was quite intrigued by a few things – talking about how people’s wellbeing is affected by very simple things e.g. speaking to a neighbour, going to your local shop, speaking to the shop keeper, made a big difference in people’s perceived mental health. I thought, quite often as a GP, you do realise effectively what you can do is not very much. Life and circumstances and events and all sorts of things affect people’s mental health and all you can do is give them 10 minutes of your time and probably send them away with a prescription. Sometimes this works but often it is putting your finger in the dyke”

GP interview

The aim of SOS was to establish whether and how a social prescribing scheme might work in Dundee. Given the existing evidence base on the mental health benefits of, for example, exercise on prescription, bibliotherapy, arts on prescription and other community based activities and sources of support (SDCMH 2007; Friedli et al 2009), the overall aim was not to demonstrate that social prescribing can be effective. Rather, the purpose of the pilot was to develop, co-ordinate and evaluate a social prescribing scheme in order to:

- Build local evidence of the benefits of social prescribing for patients and health professionals
- Identify the operational issues and solutions in running a practice based scheme
- Gain local support for sustaining and rolling out the scheme
Outcome Measures

The overall outcome is to improve the mental wellbeing of patients referred to the scheme, through supporting them to access non-clinical sources of support within the community. In terms of individual outcome measures, these are:

• Enhanced skills and behaviours that improve and protect mental wellbeing.
• Increased social contact, support and networks.
• Increased participation in community activities.
• Increased uptake of local services.
• Improved mental wellbeing.

7.3 Description of activities

“She disengaged mid way through and was hard to get hold of but the end outcome for her was she was successfully referred to an organisation where she is now fully involved.” Link Worker

The scheme was open to Maryfield Medical Centre patients, with referrals taken from GPs and latterly Health Visitors. Link workers then contact the patient to arrange an initial consultation, followed by up to three further consultations, depending on complexity of social and support needs and levels of distress.

The scheme aims to be as inclusive as possible, whilst taking care not to act as a substitute for other forms of healthcare provision, and accepts patients who meet some or all of the following criteria:

• Poor mental wellbeing affected by their social circumstances e.g. socially isolated, recently bereaved, lone parents, low income.
• Mild to moderate depression and anxiety.
• Long term physical/mental conditions.
• Frequent attenders in primary care.

The following patients are excluded from the scheme:

• People experiencing acute episodes of psychosis.
• People with primary issues of drug or alcohol misuse.

The link worker consultations are aimed at exploring the psychosocial needs of patients. Depending on patient need, link workers facilitate access to a range of local sources of support, activities and opportunities in the community.

Since the scheme began in March 2011, 123 (100%) patients have been referred.
7.4 Process

Maryfield Medical Centre practice staff identifies suitable patients for participation in the scheme and completes a prescription for those patients. Link Workers contact patients, arrange consultations and co-ordinate access to local sources of support. This includes:

- Assessing whether referral into the scheme has been appropriate.
- Assisting the patient to identify their needs and sources of support.
- Liaising with referral agencies to investigate services and activities.
- Providing support and assistance for the patient to access these services.
- Ensuring appropriate feedback loops.

Key services were identified across Dundee that address:

- Structural and environmental issues e.g. money/ debt, employment and training, housing support, anti-social behaviour.
- Lifestyle issues e.g. drug and alcohol misuse, physical activity, condition management.
- Social isolation and other psychosocial needs e.g. counselling, adult learning, social support services.
- Family and relationships problems e.g. mediation, children’s services.

The scheme depends on significant interdependencies to facilitate appropriate referral, engagement, signposting and supported access. Predominantly this involves Maryfield Medical Centre staff, DHLI Link Workers, Equally Well Lead Officer, and local organisations that comprise the referral pathways.

7.5 Evaluation Methods

Evaluation of SOS is based on:

- Data from GP prescriptions (patient demography and reasons for referral) (N=123).
- Pre and post intervention measures completed by patients (N=16).
- Link worker notes and reflections.
- Interviews with a purposive sample of patients who had completed the scheme (N=12).
- Semi-structured face to face interviews with GPs (N=2) and link workers (N=3).

The following scales were used pre and post participation in the scheme:

- WEMWBS – Warwick-Edinburgh Mental Well-being Scale, a 7 item scale assessing positive mental wellbeing.9
- WSAS - Work Social Adjustment Scale to assess functional impairment.

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7.6 Evaluation findings from SOS

“For those that engaged, definitely, some great success stories; people’s lives have definitely been changed by exposure to the scheme. Small numbers, but quite a huge thing for the individual.” GP interview

Referral and engagement

Since March 2011, 123 (100%) patients, roughly equal numbers of men and women of all ages, have been referred (figure 3)

- 61 (50%) have engaged fully (attended consultations).
- 18 (15%) have partially engaged (telephone contact but no consultation).
- 44 (35%) have not engaged (no contact).

Of the 61 who have fully engaged
- Sex: 26 male, 35 female.
- Age: median age was 44.

44 patients were discharged as they did not engage with the scheme:
- No contact.............16 (36%).
- Multiple DNA’s.... 28 (64%).
- Of the 44, 17 were male, 27 female.
- Age: median age was 36.

Issues affecting wellbeing reflected on the GP referral forms include factors such as social isolation, social phobia, anxiety, low self esteem and low mood affected by circumstances including unemployment, debt, physical and mental health conditions and caring responsibilities.

Figure 3: Engagement with Sources of Support scheme
Eighteen (15%) patients engaged partially; they did not attend consultations but were in telephone contact. Just over a third of people referred (N=44) did not engage. This is despite significant efforts by the link workers to make contact and set up appointments. Further investigation will be required to establish why people have not engaged with the scheme but early reflections and data tell us the following:

- Most people can be contacted eventually but this requires a persistent mixture of telephone calls, letters, and reminders.
- Non-engagers both cancel appointments and DNA.
- Building relationships over the phone can help, but does not guarantee, attendance.
- The term "social prescribing" is not always understood by clients (and is difficult for referring GPs to explain) and this may affect response/uptake rate.

**Link worker consultation**

Of the 61 fully engaged people, one third only had one consultation, just under half had two consultations and one in five people had between 3-5 consultations with link workers (figure 4). The scheme has been successful in engaging young males, a particularly difficult group to involve.

**Figure 4: Number of link worker consultations**

[Diagram showing the number of consultations (n=61) with percentages for 1, 2, 3, 4, and 5 consultations]

**Participation in activities**

26 people were recorded as being referred to a community-based activity. All of these 26 (100%) attended this activity, 21 (81%) attended a second activity and 13 (50%) attended a third activity. 4 (15%) people attended a forth activity. In total there were 119 link worker referrals into 47 different community services or groups; a further 36 referrals were made into existing Dundee Healthy Living Initiative (DHLI) groups. Referrals covered a very wide range of activities, information and support, including financial advice, adult learning, physical activity, sports and leisure, relaxation, cookery, counselling and addiction services, support for carers, domestic violence and returning to employment. The wide variety meant that no individual agency was overloaded and also generated awareness of the scheme with a large number of local services across all sectors.
Overview (figure 5)
Half of the people referred into the scheme fully engaged with the link workers. Of those, two out of three people attended more than one consultation with the link workers. Moreover, all the people referred to a community-based activity attended at least one activity. Four out of five people attended at least two activities. This demonstrates that people who engage with the scheme once, tend to do so consistently.

Of the sixteen people who have fully completed the programme, their pre-and-post scores indicate a significant ($p<0.05$) improvement in mental wellbeing and functional ability.

Figure 5: Overview of Sources of Support: Social Prescribing Pilot

The scheme aims to fill the gaps in psychosocial and practical support for people with a wide range of problems and conditions affecting their wellbeing. The target group, therefore, includes people with complex and enduring needs who may be difficult to engage and support. Despite these challenges, early indications are that for those people who have engaged, the social prescribing scheme has been "life changing".
“You do see a change – she couldn’t look you in the eye, now she’s going to literacy classes”.

“Some people really, really benefit – they are more in control of money, of their benefits, they can challenge systems...” Link worker interviews

The pilot developed a new approach to meeting complex needs, new cultures and ways of working within primary care and stronger, more effective links between health services and an extensive variety of community based services/support. This rich tapestry of information, activities and opportunities was seen by GPs as a valuable local asset for mental health and wellbeing and enabled the social prescribing scheme to respond to the wider, socio-economic determinants of mental health and meet a wide range of patient needs.

The social prescribing pilot contributed to (figure 6)

- Engagement (primary care, patients, over thirty different service providers).
- Awareness (of what exists in the community to support mental health, of the wider determinants of wellbeing).
- Capacity (enabling primary care to refer patients without having to keep up to date with community based support themselves; partnership between link workers and primary care, partnership between link workers and provider agencies; built community capacity through small incremental steps, as patients were empowered to draw on community based sources of support).
- Behaviour change (some examples of changes in consultation style to create greater scope for addressing social determinants; patients making changes in their lives e.g. physical activity, social contact, learning new skills, gaining financial control).
- Tackling influences (provided an opportunity to improve mental wellbeing through addressing social determinants e.g. financial difficulties, unemployment, lack of education and psycho-social factors e.g. isolation, low self esteem, bereavement).
- Improved wellbeing (most patients who engaged with the scheme valued the experience and showed an improvement in mental wellbeing).

Figure 6: Impact of social prescribing pilot - results chain

<table>
<thead>
<tr>
<th>Engagement</th>
<th>Awareness</th>
<th>Capacity</th>
<th>Behaviour</th>
<th>Addressing</th>
<th>Improved</th>
</tr>
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7.6.1 Sources of Support: the patient experience

“Talking to someone on a one-to-one basis has really helped me; it’s given me the motivation to look at my life and the changes that I can make. It’s given me that extra push, taking things one step at a time - I’m moving myself forward.”

Sixty one patients, or half of those referred, had at least one link worker consultation, with twenty six of those going on to take part in one or more activities. Those patients who attended a link worker consultation tended to do so consistently, rather than dropping out and for some patients, the consultation with the link
worker may have fulfilled their needs. All the people referred to a community-based activity attended at least one activity. Four out of five people attended at least two activities.

Most patients reported that they benefitted from the scheme and found it appropriate to their needs, helpful, flexible, accessible and offering a good variety of activities and support. This included patients with complex and enduring needs who may be difficult to engage and support, as well as patients with no previous history of engagement with any services apart from primary care.

Patient interviews (N=12) found a good level of satisfaction with SOS and where pre and post intervention data is available (Figure 5), patients showed an improvement in mental wellbeing and life circumstances (e.g. getting out more, meeting people, learning new skills, reconnecting with employment, participating in sports and leisure activities).

“[The scheme] was very good actually. I never actually realised that it was a pilot thing… I thought it had been going on for years.”

“It was better than I thought it would be… I wasn’t expecting… I didn’t think much would change but a few tips she gave me helped… far more than any of the pills they’ve been prescribing me…”

“I thought the scheme was excellent.”

“Before I got attacked I used to be really sociable but since the attack there’s distrust issues and just… But slowly but surely, I go to badminton and the people are good there so… for that space of time that I’m there, I feel better… Yeah it is helping… it makes you feel a lot better yeah.”

SOS participant interviews

After being discharged from the scheme, all but one of the interviewed patients reported that they would recommend the scheme to other people.

“I loved it and I would wish that everybody would try it… I would definitely recommend it.”

“I think so yeah [recommending the scheme], if they were sort of in a rut and that, aye…”

“It was good to go and talk to someone outwith the whole situation. She referred me to quite a few places to do with my situation and whatnot… I would recommend it to anybody.”

Not every patient was immediately convinced by the scheme; some were sceptical to begin with but gradually came to value the support they were receiving. In particular, some clients found it difficult to talk about their problems – an issue one GP recognised:

“Some patients say they are simply not very good at speaking, ‘I don’t like talking about my problems to strangers’. I say: ‘this isn’t traditional counselling – simply looking where you are now, what things are out there that would sit well with your interests or complement your life.’ Certainly SOS has made it easier to get patients to understand what it is.” GP interview

The link workers were able to help patients to open up and the clients appreciated this.
“It was scary to start with having to go and open up to somebody a bit... It takes a couple of sessions to really feel trust...”

The scheme also helped to raise awareness of the variety of support opportunities that are available in the local community:

“If I hadn’t of seen [the link worker] then I wouldn’t have got involved with [a service and service provider]. So she definitely helped me with that.”

“Every case is unique and individual – some people are ready and others need a lot of support - it’s a real mix. Some people just don’t know what’s out there. Really varies.” Link Worker interview

Link workers were strongly proactive in looking for activities that matched client preferences. At the same time, people felt that they had not been pressured to get engaged with any activity, which they appreciated:

“It was very relaxed, you know, there was no pressure for me to do anything; that’s what I liked about it. There was no sort of... you must do this, you must do that... I mean I think... everyone’s circumstances are different and needs are different so it was kind of tailored to my own needs... on a sort of personal basis I suppose... It wasn’t just a rigid... a rigid structure that must be followed it was a very open.”

Highly tailored support also helped clients to access and make the most of activities. Some patients initially needed support to attend activities but were subsequently confident to continue on their own and managed to do so:

“Actually [link worker] contacted the majority of [activities] for me and helped us along kind of thing. Rather than just saying here’s an organisation contact them they’ll be good for you. She actually did it and got the first appointment set up... I would have took the information but I don’t think I would have had... not the nerve but... the confidence to follow it through so it was good that [link worker] did the first one and... yeah, I could do this now.”

“I think it moved me in the right direction... And... she was always sort of reassuring and encouraging I was... when I first began I was quite a... I rarely went out, I rarely did anything. It kind of gave me that boost to go and do things with the kids and I was always kind of worried about money. So she put me on to places that didn’t cost too much or were free sort of activities that sort of thing.” (AI)

SOS participant interviews
Not all interventions were successful, of course. Some patients remarked on relapses or their dissatisfaction/lack of interest in individual activities or services. However, the diversity of services on offer enabled patients to try a range of activities until they found a service they felt comfortable with and so minimised potential feelings of failure:

“I went to [specific service]. Then I got quite annoyed with [service provider] because he was trying to tell me what to do. . . I went to [another service], they are not targeting. . . they’ve not got the right audience. . . I went there [a third service]. . . I kind of disliked it as well because I was the outsider. . . but [this service] has been fine and it is actually quite good having all these people around.”

Even where clients did not find an activity helpful, they enjoyed meeting other people or getting out of the house:

“To be honest, it didn’t work fully for me but I was ok trying it. . . because I think a little bit of me maybe wants to make some friends cause I don’t really have any. . . and it is because I’ve had quite a bad past with it and that so, yeah.”

One participant was grateful for the service, had his house insulated as a result of talking to the link worker, but felt unable to engage with any activities:

“I can’t attend them because I have a lot of bowel problems and reflux, and I don’t sleep well, and really the idea is great but really would be too much for me because it takes me all my time to do what I’ve got to do.

Others found the scheme helpful but felt at the same time that they were only at the beginning of their recovery:

“Because of what I was going through last year and that was depressing and that, things weren’t looking too good for me. . . Em. . . And. . . and being honest, I was suicidal last year. . . but even going in, even talking to [link worker] for they few times that I did see her and that she was really good. . . Yeah. . . she was really good, I was able to talk to her, I mean I was under counselling as well. . . I moved on slightly but it is hard and difficult”

Whether they were still on the road to recovery or were feeling better, participants highlighted the comforting knowledge that they could contact the link worker again at any time and re-engage with the scheme.

“I’ve even got [Link Worker’s] card from her and she said anytime that I needed to talk just to phone her so that in itself is kind of like a wee back up thing that I’ve got if I need it kind of thing. . . ” (AH)
Participating in the scheme helped some patients to start or renew their efforts to make changes in their lives, often in the face of profound difficulties. This could include learning more about the problems they were facing, as well as finding out about activities and how to join them.

“But it was a very, very tough challenge for me. It took me a whole year just to turn round to the person I am today. . . But I’ve managed to start going back to my workplace now. And I’m starting to drive again now.”

What emerges in the patient feedback is the importance of the combination of link worker consultations and the diversity of community-based activities and opportunities on offer:

“The most helpful was just all this learning stuff. . . as I say, if I hadn’t seen her [link worker] then I wouldn’t have done this. . .”

As indicated, the link worker played a significant role in enabling patients to make changes that could contribute to improved wellbeing:

“She got me to the gym. . . got myself out of myself. . . I mean, I’m working now, I’ve got a job. I feel better.”

Some patients who initially needed support to attend activities were subsequently confident to continue on their own and managed to do so.

Evaluation of SOS provides preliminary evidence of a significant increase in wellbeing and functioning (WEMWBS and Work and Social Adjustment Scale) for those who completed the programme. It is too soon to assess whether the improvements in mental wellbeing will be sustained or whether other positive outcomes for participants – for example increased social contact/support/networks and increased participation in community activities - will be maintained. However, the levels of patient satisfaction and the success of the scheme in linking vulnerable people with information, activities and support that met their needs are notable.

7.6.2 Sources of Support: the primary care experience

“I think health can be very insular and there’s a lot of stuff sitting out in the community that could be utilised that isn’t utilised. Health services should be part of the whole health agenda, rather than be separate from it. . . A whole area based approach which I do feel is essential because we can’t cure people because a lot of their ills aren’t illnesses – they are dis-ease rather than disease.” GP interviews

The pilot was successful in engaging the interest and commitment of primary care, particularly as the scheme progressed. GPs involved felt the scheme was filling a gap, meeting needs and increasing options available to patients. The two GPs who most regularly referred to the scheme welcomed the opportunity to draw on a wider range of resources to support their patients: ‘GP practices should be the hub of social networking, of holistic therapy’ and felt social prescribing provided a route to addressing wider social and economic influences on health and wellbeing.
“So many of people you see - it’s life circumstances, dis-ease – I’ve always reckoned instead of giving people Prozac, perhaps just give them £20 a month.”

As the scheme continued, a wider range of primary care practitioners were drawn in:

“It took a long time for other people in the practice to come round to it – now the others are doing it – we get health visitors into it. . . a lot of it is that professional attitudes need to change - your remit is health - you can narrow it down if you want to. All of us in the practice are quite good at the whole person approach. It’s getting over the closed ranks of professions sometimes. . .” GP interviews

Both GPs felt that engaging patients in the scheme was a barrier, partly because social prescribing is a new concept and can be difficult to explain:

“I find the main barrier is actually patients themselves. They still, similar to me, to begin with, don’t really understand the idea of social prescribing. Because it’s quite difficult to explain.”

“What’s difficult is getting people to engage. I find it hard explaining what it’s about. I haven’t come up with a nice easy phrase to say what it is. Partly because it’s so completely different from what we tend to do. . .” GP interviews

In some cases, a further barrier to engagement was patient concern that social prescribing could be similar to other projects seen to represent a potential threat to welfare entitlement, although the SOS scheme has no direct outcomes related to employment or getting people off State Benefits.

“Now there is a big drive to get people off benefits – rightly or wrongly – so they are reluctant to go anywhere where it says Job Centre Plus. I think they (patients) saw a little bit of a similarity between social prescribing and Discover Opportunities and that put the brakes on. They like their issues in a way dealt with through the traditional medical route, to know ‘you’re on my side’, ‘it’s confidential, they’ll not try to take me off my benefits’ . . . that’s the reason for reluctance for some patients.” GP interviews

Interviewed GPs felt that more patients than were currently being referred would probably benefit from the scheme and that there was a need for greater awareness and understanding of social prescribing – both from professionals and patients.

“I think what would really help is a publicity campaign trying to educate the community about what social prescribing is and that would really pave the way for a GP in a consultation to open up that discussion. Everybody knows about cholesterol, so it’s easy to start discussions about cardiovascular risk factors. It would help if it (social prescribing) wasn’t totally new, a never heard of concept.” GP interviews

Once patients had been referred, the way in which link workers engaged with patients was seen as crucial:

“They seem to get on patients’ wave lengths which is quite challenging – because they are very varied. They persist – they keep phoning patients, which is great. It takes time, to keep phoning.”

“Some people tell us they have benefitted from the places they were referred to; other people it seems just liked going through the options with the link worker.” GP interviews
Participation in the social prescribing pilot had a very significant impact on primary care’s awareness of and confidence in non medical, community based sources of support. GPs were already aware that there was ‘lots going on in Dundee’ but faced considerable barriers to acting on that knowledge and signposting patients. These included the difficulty of gaining and maintaining up to date information and the time involved, lack of knowledge and confidence that specific services/groups were competent, reliable and of good quality, and not knowing enough about a service or activity to be confident that it would meet a particular patient’s needs.

“There used to be a magazine – that was only resource I had – with a list of different places where people with mental health problems could get support – I would often pick something – and refer – and it was a huge faff, or ended up being useless.”

“This is another problem you have with all these organisations – short term funding. By the time you find out about them, they are three quarters through their funding and you refer patients and it’s ‘actually we’re winding up now.’ To avoid these kinds of disappointments is important because for my patients, disappointments are probably one of the things that are a repetitive feature of their lives.”

GP interviews

As the scheme developed, GPs also expanded their ideas about which kind of patients would benefit and became more aware of the range of activities available:

“I’m also getting more of an idea of what patients to refer. Initially I was quite restrictive – but I’m widening it out a bit – some of the feedback – you see that it’s maybe not just the patient who has clinical depression but also the patient who is isolated, had money problems, just lost their job or found out their son has drug addiction. These sorts of issues that I wouldn’t have previously referred.”

“I’ve been quite impressed at the number of things that the girls (Link workers) are linked to, and what’s going on - opportunities, volunteering, cooking for men – the number of people I’ve had laughing at me when I’ve suggested that – and not the patients actually. . .” GP interviews

The level of detailed knowledge that the link workers have about what’s available in Dundee and their skill in matching referred patients to appropriate options was seen as a key strength of the scheme:

“I watched Secret Millionaire – it was in Dundee – I found out that literally a stone’s throw from the practice was this place called Boomerang for elderly people – a day time club – I had no idea that existed. So I thought ‘hmm, I wonder what else is out there that is really very good that I don’t know about?’ And this is where the link workers are such a great resource. Other organisations have tried to do a little bit of that – but I think they weren’t as expert at knowing everything that is out there. The link workers have the time, to pick up on patients’ aspirations, but also they have the expertise.” GP interview

The growing engagement of primary care, positive feedback from patients and/or from link workers and growing awareness of the scope of the scheme and what was available for patients all contributed to building a new capacity for meeting the mental health and wellbeing needs of patients. This capacity was rooted in the strength of the relationship between primary care and the link workers, and the growing
confidence that link workers inspired in GPs, and in the consequent opening up of ideas about what might help patients:

“When you look at the (referral) list, it’s massive – some of it is really surprising. In one of the first feedbacks, most referrals had gone to the men’s cooking group – something I wouldn’t in a million years know about, think about, refer anybody to, you know, as a doctor, but I can see that’s a good thing. . . By having found out that, you can start to think of different patients.”

For GPs, the way in which link workers approached their role was seen as crucial and distinguished social prescribing from any other service available for vulnerable patients. Key elements of this included:

- The speed with which link workers followed up a referral (within a maximum of two weeks and generally much more quickly),
- The persistence of the link workers in establishing contact/arranging to meet patients
- Flexibility around appointments and understanding the barriers some patients faced in attending
- Local expertise which enabled link workers to identify a range of support or activity options that were appealing to patients and met their needs
- Commitment to supporting patients to overcome barriers to accessing support
- Capacity to relate to patients

“With link workers, they commit to see patients within a week or maximum 2 weeks of referral. You build a patient up, they agree. If it doesn’t happen, then they lose interest. That’s the strength of the way it works at the moment, no other organisation has that. You would generally experience lengthy waiting time. To have an organisation see a patient in a very short space of time, committed to identify something for the patient, that’s great.”

“I don’t know if we’ve been particularly lucky with link workers but they do seem to have connected with patients, which surprises me, because quite often you get people who are just poles apart, so they’ve obviously got good skills to manage that.” GP interviews

The link workers felt that the freedom to provide a flexible service, based on their experience of what worked for people with complex needs, was fundamental to ensuring that vulnerable patients could engage with the scheme. Like the GPs, they saw this commitment to providing a service designed around the patients’ needs as a distinguishing and essential characteristic of the social prescribing pilot:

“We have freedom to develop the service as required, which also means you can be flexible, fitting it in. . .”

“We make a real effort to try and get that person there in the first place. So you would maybe phone, make a call, maybe leave a message, maybe send a letter, you would keep trying, and once you get hold of them you’d say, ‘I’ll remind you, text you on the day to remind you of your appointment’ Because people forget, because their lives aren’t straightforward. That wee prompt the night before that gets them in the door. We make the time to do that, do the little extras things to get them there that maybe another service wouldn’t do.”
“We work together to do that, you might get somebody with chronic depression, has difficulty getting up in the morning, so you would phone them up and give them other options, to look at all the options, to reduce any barriers – they might have to pick their kids up for 3 o’clock – work to reduce any barriers before the person even attends.” Link Worker interviews

For the link workers, it has been a gradual process of building a relationship with the Maryfield practice and establishing lines of communication:

“Communicating with the practice, we’ve got better relationships. It’s easier to speak to the practice now, we know who to contact. Say I know that one GP is free on Wednesday afternoon until about 3 o’clock when patients come in. I know if I’m really worried, I know she’s free and I can knock on the door.”

“I feel we’re more part of the practice, what’s going on.”

“I know the practice are happy with what we’re doing, it’s just my personal preference – I still don’t think GPs know our names – I know the reception staff and the practice nurse do, but I don’t think some of the GPs do.” Link worker interviews

For one GP, involvement in the scheme had a marked impact on his consultation style, which he felt had to change to open up a discussion with the patient about the possibilities of social prescribing:

“I found by now it’s probably embedded in my consultation style but it had to change, my consultation had to move away from this sort of biomedical model of depression and go more for a sort of social model and see the patient a bit more in the wider family and community to smoothly lead on to something like social prescribing. Because social prescribing didn’t sit well at all with the bio-medical model of the patient.
Talk about appetite or sleep leads quite smoothly to anti depressants and sleeping tablets but doesn’t move to social prescribing – you know it really jarred. So I had to change my consultation style to enable me to open up a discussion about social prescribing and if the patient was interested. One of the reasons I find it easier now – I had to learn that – so that was a challenge at the beginning.”

The scheme is not currently evaluating GP consultation rates of patients before and after engagement with the SOS scheme, but there was a perception that patients referred to social prescribing were subsequently seen less often in primary care.

“I would say anecdotally, we do see patients we’ve referred to social prescribing less, but that’s - I’m not seeing much of them anymore – my gut feeling – or they think it’s such a stupid idea they never come back to me!”

“In the longer term maybe it’s going to reduce our workload. . .” GP interviews

Overall, the pilot was successful in its aim of building local evidence of the benefits of social prescribing for both patients and health professionals. Emerging operational issues were quickly resolved and strong, positive partnerships built between primary care and link workers, as well as between link workers and provider agencies. The availability of the scheme addressed existing concerns of GPs about unmet need and provided a trusted route for meeting the psycho-social needs of vulnerable patients. Participation in SOS also influenced G.P. consultation style and has the potential to generate wider interest and debate about partnerships for addressing the social determinants of mental health and wellbeing and reducing inequalities.
7.6.3 Contribution of test site

“It’s not medical needs. These are the unmet need of patients we see before us who we’re powerless to do anything about except prescribing.” GP interview

One of the tests of change of the test site was to develop and evaluate a social prescribing scheme. The test site was central to developing Sources of Support and to leading what is essentially a significant service redesign project, alongside the raft of other local actions that formed Equally Well. This included drawing on the existing evidence base on social prescribing to make the case for new ways of working with and within primary care and for better links between health services and services in the community. It also involved the development of monitoring and evaluation systems that recognise and capture the impact on wellbeing of a wide range of socioeconomic and psychosocial factors.

GP interview

All those involved in the SOS pilot - primary care, link workers and patients - felt that the scheme provided considerable benefits. The apparent success of the scheme, even at this early stage, suggests that it is meeting unmet psycho-social needs for a significant number of vulnerable patients—nearly half of those referred—in an area of high deprivation. These needs included factors such as social isolation, social...
phobia, anxiety, low self esteem and low mood affected by circumstances including unemployment, debt, physical and mental health conditions, and caring responsibilities.

Key lessons from the scheme include:

• Social prescribing is new and unfamiliar – for patients and for primary care – communication support is essential.
• GPs are more likely to refer patients when the primary care culture supports holistic, psycho-social approaches.
• The link worker role is essential.
• High levels of persistence, support and flexibility are needed to engage patients with complex needs and this requires highly skilled link workers.
• Successfully matching patient needs depends on availability of a wide range of good quality community based services.
• Emerging outcomes – improved mental wellbeing, increased social contact, greater participation – have cost benefits, suggesting the cost effectiveness potential of social prescribing.

Particular features of the scheme that seem to work well are the skills and in depth local knowledge of the link workers, as well as the highly flexible nature of the service they provide for patients. The SOS link workers have considerable skills in counselling techniques, motivational interviewing and person-centred problem solving. They are also experienced in dealing with people with complex mental health, wellbeing and lifestyle issues. These skills were highly valued by GPs, contributed centrally to the positive experience of the scheme reported by patients and may explain why once fully engaged, patients rarely dropped out.

“They try and accommodate people when you arrange to have meetings if they don’t come along or whatever, don’t get there – you know you say that’s alright, you didn’t manage it that time, we’ll look at how you could manage it the next time – because they beat themselves up enough, you don’t want to be telling them off – that’s what they’re used to, people being quite rigid, I think the thing that is good about it is we’re really quite flexible with people. We adapt to their needs so they don’t have to fit into our schedule.” Link Worker interview

This level of flexibility, the degree of liaison required with providers and the amount of research needed to ensure that information on local support was constantly maintained, updated and extended meant that the major problem for link workers was the amount of time needed to deliver a high quality service, particularly as the link worker role is fitted around other commitments.

“Nobody came to fill in my role as a nurse (in substantive post) – saying that, I could never see me saying to a client, right Mondays and Tuesdays is when I do my social prescribing so could you just phone me those days rather than any other day of the week but maybe dedicated time would help.”

What was also apparent, however, was that some community based providers could not adapt their services or their criteria to match the level of flexibility needed.
“The other frustrating thing, and sometimes you feel disappointed, when you feel there’s not enough stuff out there for people or you feel that agencies are letting you down a bit because when you get someone through the door, people don’t fit into their criteria.”

“He doesn’t want services to come into the home. They said ‘we’ve got a project, but we provide care in the home. We’ll provide a telephone assessment.’ I said ‘he won’t respond well to that.’ I spoke to them for about half an hour explaining – all he wants is to meet up for a cup of tea and a chat and being out of his environment for a while. They said ‘that’s such a shame, he would fit perfectly into this.’ Whereas that’s not what he wants – he doesn’t want people to come into his house. That’s just one example. . .”

Link worker interviews

More broadly, the pilot demonstrated a need for services that meet the support needs identified, notably more befriending and more services for people experiencing anxiety, as well as counselling.

“It’s showing there are gaps, going to a group is a major thing, so there’s a need for more befriending, more help for anxiety, more generic befriending, not just for people with a diagnosis.”

“There’s not any generic befriending, you have to fit into a criteria.” Link Worker interviews

Other learning relates to the need to increase public awareness of social prescribing:

“I would like some form of words to explain it, so if it rolls out, professionals have to be given some way to speak about it – also people need to be more aware of it, there has to be some publicity. Sometimes it’s great, people have said ‘can I go to it’ but a lot of practices have TV screens so it needs to go on to TV screens because patients are expecting a prescription.” GP interview

Making the economic case

Although the evaluation of the scheme was not designed to assess cost effectiveness, some of the emerging outcomes have potential cost benefits. The research literature suggests that social prescribing, notably through reducing isolation and strengthening social networks, has considerable cost effectiveness potential and can contribute to making more effective use of limited resources. Economic modelling for programmes directly relevant to social prescribing (including community navigators, referral to debt or benefits advice, befriending and Timebanks) have shown good levels of cost effectiveness, based on a range of indicators e.g. reduced GP visits, improved mental wellbeing, quality of life and employment (Knapp et al 2010; Department of Health 2010a; Friedli and Parsonage 2009).
Other emerging evidence suggests that the availability of social prescribing reduces GP referrals to secondary care, perhaps partly through reducing medically unexplained symptoms. Although social prescribing referrals for people with complex needs can involve high levels of initial support from link workers, as has been the case with SOS, long term savings might include reductions in:

- Frequent GP attendance
- Prescriptions
- Outpatient consultations
- Inpatient treatment /bed days
- A&E Care
- Unplanned admissions

Even very slight reductions in these areas involve quite considerable cost benefits, in addition to the quality of life benefits for individuals and their families.

A modest contribution to improving outcomes for those who are most vulnerable and thereby contributing to narrowing the health gap, would also add to the cost effectiveness case (Department of Health 2010b). In addition, when some of the most excluded and vulnerable people overcome barriers and obstacles to participate in social activities or to access mainstream services from which they previously felt excluded, the whole community benefits. There is a multiplier effect: fewer people are left out – more people are involved. Part of the value of social prescribing may therefore also lie in its contribution to community capacity building; in other words, impacts can be at an individual, family and community level.

7.6.5 Sustainability/legacy

Sustainability has been a central theme concerning all aspects of the test site’s work. However, the issue of sustainability for the pilot social prescribing scheme was not able to be resolved prior to the scheme’s establishment. Despite its inclusion in key strategic documents, social prescribing did not have a dedicated or indicative budget aligned to it. Rather, it was seen as the direction that services and partners would aspire to travel in. The opportunity provided by the test site to implement a pilot scheme that would provide local evidence of benefits, and valuable learning, was seen as too good to miss. Indeed, the operational and strategic support that the pilot scheme has engendered is testimony to the calculated risk that the test site took in setting up a short term initiative. Social prescribing remains a priority for health equity in the new SOA and Healthy Dundee has made roll out of social prescribing one of its key aims in the coming year, along with rolling out across Dundee the test site approach as a whole.

For both link workers and primary care, the major concern about sustainability and future roll out of the scheme related to the perceived difficulty of maintaining the quality of the service:

“I’d be scared - for social prescribing to work as a roll out, people have to invest the time and flexibility – I think there’s too much in the NHS, if people DNA, don’t turn up, then no one phones them, two times and you’re out – that’s our biggest fear.”

“The huge thing that has to stay there is, it’s designed around the client; people don’t fit into tick boxes, but an awful lot of things expect that”  Link worker interviews
“It’s working. Every time something gets bigger there’s a risk as well. I suppose if it rolls out, you get more workers, there’s a risk that calibre goes down. You could get wrong people – don’t know how they get to be good, trained up like this but if they do roll out. . .”  GP interview

In terms of operational issues, the scheme is constantly evolving and been able to address and resolve administrative and other challenges efficiently. Many of the tools which have been developed, such as referral forms, patient database, and outcomes framework, have the potential to be used on a much bigger scale. The sustainability of the pilot therefore rests on the identification of funding to support roll out, together with ongoing efforts to promote social prescribing, both to patients and to primary care:

“Roll out – would be very worthwhile. The issues will be similar to what I encountered – a steep learning curve. The question is if GPs will be wanting to go down that line or not. Within the practice now there are a larger number of referrals but probably half of doctors don’t refer. Probably because they stop at the early stage. . . they fall back on the bio-medical model.”  GP interview

The potential for sustainability may also be linked to growing awareness, including within NHS Tayside’s Health Equity Strategy, of the contribution to health outcomes made by social engagement, participation, mutuality, social support and social integration. There is now robust evidence for the contribution of both social support and social integration to health. The magnitude of these factors is comparable with quitting smoking and exceeds many other risk factors for mortality (e.g. obesity, physical inactivity and alcohol) (Holt-Lunstadt et al 2010).
8. Conclusions

“It’s interesting: a third didn’t engage – half of 60 – disengaged. The remainder benefitted quite considerably. That’s also savings on drugs, savings on benefits. GP consultations and what you can’t measure actually, a person that now feels they are doing something with their life, which is probably quite priceless.” GP interview

Overall, the pilot was successful in its aim of building local evidence of the benefits of social prescribing for both patients and health professionals. The pilot involved developing a new approach to meeting complex needs, new cultures and ways of working within primary care and stronger, more effective links between health services and an extensive variety of community based services/support. This rich tapestry of information, activities and opportunities was seen by GPs as a valuable local asset for mental health and wellbeing and enabled the social prescribing scheme to respond to the wider, socio-economic determinants of mental health and meet a wide range of patient needs.

For GPs, the way in which link workers approached their role was seen as crucial and distinguished social prescribing from any other service available for vulnerable patients. The scheme demonstrated the importance of persistence, flexibility and highly tailored support in engaging and meeting the needs of vulnerable patients. Where this is provided, patients are much more likely to remain engaged.

The social prescribing pilot contributed to:

- Engagement (primary care, patients, over forty five different service providers).
- Awareness (of what exists in the community to support mental health, of the wider determinants of wellbeing).
- Capacity (enabling primary care to refer patients without having to keep up to date with community based support themselves; partnership between link workers and primary care, partnership between link workers and provider agencies; built community capacity through small incremental steps, as patients were empowered to draw on community based sources of support).
- Behaviour change (some examples of changes in consultation style to create greater scope for addressing social determinants; patients making changes in their lives e.g. physical activity, social contact, learning new skills, gaining financial control).
- Tackling influences (provided an opportunity to improve mental wellbeing through addressing social determinants e.g. financial difficulties, unemployment, lack of education and psycho-social factors e.g. isolation, low self esteem, bereavement).
- Improved wellbeing (most patients who engaged with the scheme valued the experience and showed an improvement in mental wellbeing).

There is a growing level of support within primary care for rolling out social prescribing. This might be enhanced by growing evidence of the effectiveness and potential cost benefits of social approaches, that by improving wellbeing also influence a broader range of health outcomes. Other outcomes of interest might include generating additional resources from within a community (e.g. community members taking on the organisation of a project or activity) and making better use of the totality of resources within a community.
to meet needs, as well as offering people a wider range of options for coping with and overcoming problems.

The success of the test site in gaining support at the highest level for the roll out of the test site approach and the social prescribing pilot is also a notable achievement. These two interventions, (along with the enhancement of the Dundee Healthy Living Initiative), have been agreed by all partners as key methodologies that can support redirection of resources to ‘preventative spend’ and reductions in failure demand. This has resulted in over £200,000 being awarded to the test site to support changes in ways of working in Dundee's Community Regeneration Areas and to implement social prescribing in two further GP Practices and across other settings.
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Appendix One

Equally Well Evaluation Reports
Dundee: Dundee Healthy Living Initiative
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Structure of the Equally Well test site

**Strategic influence**
- Dundee Partnership
- Healthy Dundee
- Dundee CHP
- NHS Tayside
- Fairness Strategy
- Education and Early Years Development Service
- Stepped Care/Matched Care Group
- Towards a Mentally Flourishing Dundee Network
- Dundee Mental Well-being Network

**National influence**
- Scottish Government
- Equally Well National Learning Network
- Health Scotland

**0.7 fte EW Lead Officer**

**1 fte EW Development Worker**

**Local influence and actions**
- Social prescribing, mental health literacy programme, StobsWELLbeing Group, Maryfield LCPP, Picnics in the Park, Outreach programme, community engagement events, logic modelling service support, community support
Appendix two: Map of Stobswell