



University of the
West of England

BRISTOL

Kimberlee, R. (2016) *Gloucestershire clinical commissioning groups social prescribing service: Evaluation report*. Project Report. UWE. Available from: <http://eprints.uwe.ac.uk/30293>

We recommend you cite the published version.

The publisher's URL is:

<http://eprints.uwe.ac.uk/30293/>

Refereed: No

(no note)

Disclaimer

UWE has obtained warranties from all depositors as to their title in the material deposited and as to their right to deposit such material.

UWE makes no representation or warranties of commercial utility, title, or fitness for a particular purpose or any other warranty, express or implied in respect of any material deposited.

UWE makes no representation that the use of the materials will not infringe any patent, copyright, trademark or other property or proprietary rights.

UWE accepts no liability for any infringement of intellectual property rights in any material deposited but will remove such material from public view pending investigation in the event of an allegation of any such infringement.

PLEASE SCROLL DOWN FOR TEXT.

Gloucestershire Clinical Commissioning Group's Social Prescribing Service: Evaluation Report



Dr. Richard H. Kimberlee
November 2016

'We need to empower general practice by breaking down the barriers with other sectors, whether social care, community care or mental health providers, so that social prescribing becomes as normal a part of your job as medical prescribing is today' (Jeremy Hunt speaking to GPs, 2015)ⁱ

'I went in to get a letter about me not driving anymore and wanting too. The GP said to me I have got a man who can help you with that and everything else and since then he has helped me with so many things I don't know what I would have done. I have my driving licence sorted, I have got help with caring for my husband and I now have a new circle of friends' (A social prescribing patient)

'She has helped to reduce the need to go to hospital sometimes because patients know where to turn to instead of the GP or A&E when it wasn't a medical concern'. (A Practice Manager)

Front page photograph: A social prescription pill box designed by Joe Magee.
Supported Dr. Opher from the Walnut Tree practice and funded with support from the Barnwood Trust.
<http://www.periphery.co.uk/joyN>
JoyN © Joe Magee

Acknowledgments

I would like to acknowledge the kind support shown to me by all the staff delivering the social prescribing service in Gloucestershire. In particular the two co-ordinator teams in the Forest of Dean and Gloucester led by Gary Deighton and Ian Preston. They provided access to their teams and facilitated interviews with some of the beneficiaries of their service. I would like to thank Helen Edwards for managing the collection and collation of secondary data for this analysis and providing access to GP practices and social prescribing hubs. Jem Sweet, from VCS Alliance, for organising a survey of their members who have patients referred to them. Additionally, I would also like to thank and praise the GPs across Gloucestershire who I have met who are at the forefront of developing a cultural change in primary care. I have benefitted from advice and support of the Social Prescribing Network of the UK and Ireland who are exploring and developing practical tools and knowledge to help support the organic development of social prescribing for the benefit of all: patients and practitioners alike.

Contents

| | |
|--|-----|
| Acknowledgements | p3 |
| Contents | p4 |
| Abbreviations | p5 |
| Executive summary | p6 |
| Background | p11 |
| Social Prescribing | p11 |
| Why social prescribing now? | p11 |
| Social Prescribing in Gloucestershire | p15 |
| Aims of the evaluation | p16 |
| Data Collection | |
| CCG monitoring Tool | p18 |
| Impact of Social Prescribing | |
| Evidence from the first evaluation of two social prescribing pilots in Gloucestershire | p19 |
| Demographic profile of the patients referred to social prescribing | p19 |
| Referral | p20 |
| Social prescribing | p22 |
| Links to the Voluntary and Community Sector (VCS) | p23 |
| Impact of the social prescribing service in Gloucestershire | p26 |
| More impact and innovation | p33 |
| Realising the value of social prescribing | p34 |
| Refining the service | p40 |
| References | p42 |
| Appendix 1: Difference between patient numbers recorded on the database and those that are recoded | p46 |
| Appendix 2: Organizations referred to by the hub co-ordinators | p47 |
| Appendix 3: Details of Gloucestershire VCS Alliance survey | p53 |
| Appendix 4: Footnotes | p54 |

Abbreviations

| | |
|--------|--|
| CCG | Clinical Commissioning Group |
| CGP | College of General Practitioners |
| DoH | Department of Health |
| EQ-5L | Euro Quality of Life Scale |
| GCCG | Gloucestershire Clinical Commissioning Group |
| GP | General Practice |
| GVCSA | Gloucestershire VCS Alliance |
| ICT | Integrated Care Teams |
| MYMOP | Measure Yourself Medical Outcome Profile |
| NHS | National Health Service |
| PSSRU | Personal Social Services Research Unit |
| RCT | Randomised Control Trial |
| SPN | Social Prescribing Network (of United Kingdom and Ireland) |
| SROI | Social Return on Investment |
| VCS | Voluntary and Community Sector |
| WEMWBS | Warwick Edinburgh Mental Wellbeing Scale |

Executive Summary

Background

There are increasing numbers of people presenting to GP practices. In 1995 patients visited GPs on average 3.9x a year; this had increased to 5.5x a year in 2012. GP attendances have climbed from 17.8m in 2004-5 to 24m in 2012-13 (Campbell 2013:4). The DoH and NHS England have not routinely collected data on activity levels in general practice since 2008-09; but modelling attendance data from 2009 means that it is believed that there were 37m GP consultations in England in 2014-15 (National Audit Office, 2015).

According to the former Chair of the UK's College of General Practitioners (CGP) there is now a crisis in general practice (Gerada, 2013). As patient contacts grow exponentially; GPs are increasingly aware that up to 20% of their appointments are for non-medical reasons (Citizens Advice, 2016) costing the NHS £395 per year.

The Social Prescribing Network (SPN) have reviewed over 400 different social prescribing projects (Polley, 2016). In their presentation to the Health Select Committee in March 2016 they revealed that 49% of these projects were identified as having some CCG financial involvement. Of which 14% were CCG and public health/local authority partnerships. Sole CCG funded social prescribing projects can be found within and across: Wakefield, Hertfordshire, Rotherham, Bradford, Lewisham, Hackney and City, Bradford, Camden and Sheffield CCGs.

Gloucestershire CCG's social prescribing service reflects a growing trend around the country of local health professionals developing local, organic, initiatives to manage the increase in demand for primary care services.

The overall vision within Gloucestershire Clinical Commissioning Group's (GCCG) five year operating plan is to enable and deliver a cultural shift from a reactive, disease-focused fragmented model of care towards one that is more proactive, holistic and preventative.

The social prescribing service in Gloucestershire is delivered through a hub coordination model. There are six hubs across the county with a social prescribing service available to all GP Practices. The hub coordinator role was skilfully built into existing roles operating in a similar field (e.g. Local Area Coordinators, Care Coordinators, Healthy Lifestyles teams and/or third sector partners).

The patients and the service

The social prescribing services database contained information on all patients who had received the service up until August 2016. The amount of data collected, inputted and the reported varied from hub to hub with some co-ordinators collecting complete sets of information on patients referred; while other areas were less complete. At the time of analysis there were records for 2047 patients who had been referred to receive the social prescribing service.

On being referred the social prescribing co-ordinators complete a registration form which enables the CCG to get an understanding of the demographic profile of the patients referred to the service. Comparison with read codes for social prescribing suggests that there are generally more patients on the social prescribing data base than are known and recorded through the GCCG's read codes.

Having 2047 patients referred to the service means that Gloucestershire's social prescribing service is one of the largest in the country in terms of referral numbers. The majority of patients referred to social prescribing service are female (60.2% n=1,138). A third of patients are aged 75+ and a median age range is 56-65. 29.2% (n=597) of patients self report that they are disabled (Gloucestershire, 15.4% report a limiting long-term illness).

GPs (88%, n= 1802) are the largest referral source to social prescribing. 8.5% (n=174) have come from Integrated Care Teams (ICTs) and the rest from either: community nurses, social workers or a community hospital.

There are 629,835 patients registered with GP practices. Referral rates for social prescribing (patient/1000 patients registered at the practice) vary across the county's districts (co-ordinator hubs) from 1.07 to 4.14. The average referral rate is 3.27/1000. Referral rates vary between GP practices. Mean referral rate per practice was 20.3. With a range of referral rate per practice of: 0 to 151. There is tendency for larger GP practices (number of patients on their list) to refer more patients to social prescribing. There was a medium positive correlation between practice size and referral rate ($r=+3.20$, $n=83$, $p<0.01$).

There was also variation in terms of the number referrals made by GPs within practices. Excluding those practices that have not referred anyone to social prescribing the referral rate per GP in practices varies from 0.14 to 30.20 referrals per partner. The mean referral rate is 5.3 referrals per partner.

Reasons for a referral varied: for 48% (n=886) of patients it was for mental health and wellbeing, 35% (n=647) for benefits, housing or environmental advice, 16% (n=288) for generic health and fitness, 15% (n=279) for carers support, 14% (n=254) for social isolation, 6% (n=116) for memory loss and 4% (n=75) for some other reason e.g. falls prevention.

Of those referred and identified on the database (n=2047) social prescribing was given and received by 81% (n=1651) of patients, 9% (n=177) declined the offer, 8% (n=170) were uncontactable, 0.8% (n=16) disengaged with the service, 0.6% (n=13) either died or moved out of the area. 1% (n=19) of referrals were identified as an inappropriate referral to the service.

Co-ordinators' time with a patient once referred also varies. For things like inappropriate referrals the case will be live for one day only. However the mean time a case is live is 103 days. The longest recorded live case was 280 days.

The average amount of recorded contact made by a prescriber with a patient was 5. One patient received 37 contacts from their co-ordinator. Contact was predominantly undertaken in GP practices but there is evidence of home visits and telephone contact.

The social prescribers made 2476 onward referrals. Of patients who received the service the prescribers referred/signposted the patient on to an average of 2.3 different organizations. Some patients did not receive any onward referral (15%, n =154) whereas 5 patients were referred to 12 different organizations.

Gloucestershire VCS Alliance (GVCSA) ran a short survey about social prescribing with their affiliates from June-August 2016. 49 different organisations had responded to the survey. All but one organization said they were interested in receiving referrals. Responses were largely very positive. Most respondents said they were happy with social prescribing and report that they have been able to build good relationships with their local co-ordinator/GP. They report that this has helped to raise awareness of their organization's work and mission.

There were over 234 different organizations and individuals that the co-ordinators referred too. Age UK, the Barnwood Trust, Citizens Advice and Carers Gloucestershire received most referrals.

Impact

The primary outcome measure was improvement in patient wellbeing. If we look at the matched before and after sub sample we find that there was a statistically significant increase in reported short WEMWBS scores from baseline (M =18.51, SD 6.1) to follow up (M=22.37, SD 5.9) $t(398) = -16.21$. The mean increase in mental health scores was 3.83 with a 95% confidence level of -4.291 to -3.363. The eta squared statistic 0.39 indicated a large effect size.

Interpretation of hospital admission and attendance data is difficult. Partly because the six month time frame allowed for this evaluation is quite small. Other studies exploring the impact of social prescribing tend to adopt a time frame of 12 months.

However scrutiny of the data suggests that those patients who were referred to social prescribing had lower emergency admissions rates after six months than those patients who refused the service or were uncontactable. There is a 23% decline in A and E admissions in the six months after compared to the six months before. Not only is it lower but it is contrary to an increase in emergency admissions in patients who refused to engage with the social prescribing service.

Looking at the mean attendance cost/patient of emergency admissions to A and E we can see the cost imposed by social prescribing patients attending actually increased slightly (2.5%) despite the decrease in attendance by 23%. This is against a backdrop of an overall increase in costs of 42% for all patients in the sample.

Looking at primary care data there is a clear reduction in the number of patient encounters with GP services. The data available is limited. Partially because it only looks at 44 GP practices and not the 82 referral sources identified on the social prescribing data base. It looks at the patient records of 1,147 different patients who have been referred to the social prescribing service. GP appointments declined by 21% in the six months after referral to a

social prescribing co-ordinator compared to six months before. The number of GP home visits declined by 26% and the number of GP telephone calls by 6%.

It is clear that different attempts have been made to measure the cost effectiveness of social prescribing e.g. cost consequence analysis (Roslyn et al, 2001), cost benefit analysis (Dayson et al, 2014) and Social Return on Investment (SROI) (Kimberlee, 2016) amongst others. Comparison between studies is very difficult because a lot of the studies will actually monetise different things.

Exploring SROI approaches the SPN have collated several studies and have discovered that social prescribing studies show that for every £1 invested there is a SOCIAL return on investment of between £1.20 and £3.10 in the first year. So these benefits go to various stakeholders, including the health service.

The cost of the social prescribing service in Gloucestershire represents a £480,819 investment. In Gloucestershire the unit cost per patient referred to the social prescribing service is £234.88/patient. This is similar to the £245.60/patient unit cost for the Hackney and City scheme (Bertotti, 2014) and £301/patient unit cost of the Rotherham scheme (Dayson, 2014).

Looking at the 12 month modelled savings to the health service we see in Gloucestershire there is a return on investment of 43p for every £1 spent on the social prescribing service. Additional modelling reflecting other studies suggests that the cost of recouping the investment for health services is likely to take at least two and half years. However this may be an underestimate because not all impacts have been documented by the service and valorised (e.g. outpatient referrals, elective surgery rates, prescription rates).

Most evaluations also look at social savings in addition to savings to the health service. We have looked at the impact the service as had on suicide prevention, improvement in wellbeing, enhanced volunteering and savings from a return to work. Adding the 12 months savings to the health service with the estimated (social) savings we believe that in the first year there is a £1.69 (health £0.43, social £1.26) return on investment for every £1 spent by GCCG on the social prescribing service. This return on investment is probably an under estimation because the social prescribing service are yet to develop a rigorous and consistent way of counting impact across the six hubs.

Refining the service

This report makes several suggestions on how to improve the service and highlights that the popularity of the initiative has seen the service receive requests from secondary care to make referrals. It might be worthwhile trialling secondary care referral in one hub to see if additional cost savings can be made.

The NHS shared planning guidance 16/17 – 20/21 outlines a new approach to help ensure that health and care services are planned by place rather than around individual institutions. Every NHS organization is producing a Sustainability and Transformation Plans for the future

showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision.

NHS Forward View encourages CCGs to include social prescribing in their suite of plans from 2017 forward. And the SPN has been lobbying NHS England to encourage CCGs to consider investing a £1 per patient into social prescribing initiatives. Gloucestershire like other CCGs have started on that journey to develop a more proactive, holistic and preventative model of care.

Background

Social Prescribing

The overall vision within Gloucestershire Clinical Commissioning Group's (GCCG) five year operating plan is to enable and deliver a cultural shift from a reactive, disease-focused fragmented model of care towards one that is more proactive, holistic and preventative. As part of this change GCCG has commissioned a county wide social prescribing service that is aimed at having a social prescribing co-ordinator attached to every GP practice.

But what is social prescribing? There is no clearly agreed definition. In fact it is a phenomena seen as too complex to actually define (Friedli, 2007:11-12). Nevertheless there are some key features which general practitioners and researchers may recognise. In general social prescribing is a structured way of linking patients with non-medical needs to sources of support within their community (Scottish Development Centre for Mental Health, 2013:12). The opportunities provided by social prescribing may include: arts; creativity; physical activity; learning new skills; volunteering; mutual aid; befriending; and self-help, as well as support for a wide range of problems including: mental health, employment; benefits; housing; debt; legal advice; and parenting problems.

The aim of social prescription is to identify people in the primary care setting, who either do not have health needs or whose health needs need to be better managed and who would benefit from the range of voluntary and community sector services which are already available to them in the local community.

But in doing so social prescribing is also providing a route to reduce social exclusion, both for disadvantaged, isolated and vulnerable populations in general, and for people with enduring mental health problems in particular (Evans, et al., 2011). And locally, in Bristol, for example, Age UK will be commissioning social prescribing initiatives to address social isolation in people aged over 55 years of age.

Given the broad nature of social prescribing it is not surprising that there is no single model of delivery. The Social Prescribing Network (SPN) in their review of over 400 affiliated social prescribing projects have identified six distinct delivery models (Polley, 2016):

- GP to practice-based SP (link person) to community
- GP to community-based SP (link worker)
- GP direct to community activity
- GP to community-type activities in GP practice
- GP in centre to other services in same centre
- Care coordinator or key worker to activities

The most common model tends to be for the GP to refer an identified patient to a facilitator or co-ordinator who then works with the patient to identify needs or issues that may undermine patient wellbeing. The co-ordinator may have different names: social prescriber, health worker, community navigator, engagement worker etc. But the intention remains the

same. The social prescriber can then refer onwards or draw on community resources to address patient needs. Some projects might even draw on a volunteer to offer personal support for the patient in actually taking up social opportunities.

In recent reviews of social prescribing practices in one CCG it is clear that degree of engagement of the co-ordinator with the referred patient can vary across initiatives; from simple signposting through to more holistic engagement with patients (Brandling and House, 2007, Kimberlee, 2013). Holistic social prescribing initiatives interventions aim to address all patient needs in a holistic way (anything from loneliness through to domestic violence). This is done through co-production, identification of need and action; thus the patient and the prescriber seek to achieve the promotion of self-management. There are no time limits to the relationship and links cease only on the achievement of improved well-being.

The promotion of patient self-management and resilience is often crucial to social prescribing. It endeavours to ensure that the patients have the skills to look after themselves. In some ways it has parallels with the House of Care model developed and tested by the Year of Care programme in 2011/2 by Diabetes UK and the Department of Health (DoH). This was piloted on more than 3000 practitioners and 60 trainers working in 26 communities around England (Coulter, 2013). This programme was about developing personalised care planning. It involves clinicians and patients working together using a collaborative process of shared decision-making to agree goals, identify patient support needs to develop and implement action plans and monitor their progress. In the programme the intervention is a continuous process, and not a one-off, bolt on event (Coulter, 2013).

Why social prescribing now?

Around the country social prescribing projects are being developed and commissioned. Over 400 different social prescribing projects (Polley, 2016) have affiliated to the SPN since its launch in January 2016. In a review of 94 projects for a SPN presentation to the Health Select Committee in March 2016; 49% of these projects were identified as having some CCG financial involvement. Of which 14% were CCG and public health/local authority partnerships. Sole CCG funded social prescribing projects can be found within and across: Wakefield, Hertfordshire, Rotherham, Bradford, Lewisham, Hackney and City, Bradford, Camden and Sheffield CCGs.

In the South West of England CCGs have also supported some individual pilot social prescribing initiatives in individual practices e.g. Devon CCG has funded a social prescribing service at a Cullompton practice since 2007 (Dixon, 2016). While other social prescribing initiatives have been commissioned by local authorities including: Bath and North East Somerset; South Gloucestershire and North West Somerset. These have usually commissioned a service from a third sector organization or not for profit organization to deliver their social prescribing service rather than use in-house staff.

But why commission social prescribing now? There are distinct pressures leading health sector commissioners to consider social prescribing. These are:

- the increasing pressure on GP services
- the growing burden (and cost) of mental health
- the growing burden of long term conditions
- a growing aging population
- a reduction in universal welfare provision

There is mounting evidence to suggest that primary care services are under increasing strain. GP surgeries are facing an increase in the numbers of patients attending their surgeries. Patients are additionally presenting with increasingly complex needs and in reality GPs are not necessarily equipped to handle all the social and psychological burdens they present. The service itself is also changing. It has come a long way from a model where patients were examined in their own living room. GPs now usually practice in stand-alone surgeries or healthy living centres which offer an ever broadening range of services. Which services they develop and offer can vary across GP practices. But these changes and pressures coupled with complex reforms have led Clare Gerada the former Chair of the UK's College of General Practitioners (CGP) to conclude that general practice is now in crisis (Gerada, 2013). Survey work commissioned by Gerada and undertaken by the Kings Fund revealed that:

- 85% of GPs believed their service was in crisis
- nearly, 50% thought they could no longer guarantee safe patient care
- 50% felt their job had got more stressful
- most GPs were conducting 40-60 patient consultations each day and working 11 hour days in their consulting room;
- and most GPs predicted that patients will have to wait longer for an appointment in the future.

(Gerada, 2013, Accessed 8th October 2016)

More recent research of 1000 GPs undertaken in February 2016 suggest that GPs are spending nearly a fifth of their consultation time dealing with non-medical issues at a cost of £395 million, according to Citizens Advice (2016). This represents more than 5% of the NHS England budget for general practice and equivalent to the salaries of 3,750 full-time GPs (Citizens Advice, 2016). Additionally, three-quarters of GPs say that the proportion of time they spend dealing with non-health issues as part of consultations has increased over the past year! And 92% of GPs report that their patients had raised issues about personal relationship problems with them in the past month.

And there are increasing numbers of people presenting to GP practices. In 1995 patients visited GPs on average 3.9x a year; this had increased to 5.5x a year in 2012. GP attendances have climbed from 17.8m in 2004-5 to 24m in 2012-13 (Campbell 2013:4). The DoH and NHS England have not routinely collected data on activity levels in general practice since 2008-09 but modelling attendance data from 2009 means that it is believed that 37m consultations were conducted in 2014-15 (National Audit Office, 2015).

And what patients are presenting with is often more complex. Patients with multiple health problems are rapidly becoming the norm not the exception, and the NHS is not set up to treat them properly, according to a study carried out in Scotland. Examining a dataset of 314 medical practices representing 1.75 million patients, data on 40 morbidities were extracted. Although multiple morbidities were recognised as being more common among older people, the team found that there were more in absolute terms in those under 65—210, 500 versus 194, 966 in people over 65. By the age of 50, half the population had at least one morbidity and by 65 most had more than two. People living in deprived areas were more likely to experience multi-morbidity, even though the population of such areas was on average younger. Young and middle aged people in the most deprived areas had rates of multi-morbidity equivalent to those of people 10 to 15 years older in the most affluent areas. More than a third of those with multi-morbidity had a mental health problem, with women more likely than men to combine a mental and a physical health disorder (Hawkes, 2012:345).

With the increase in attendance GPs are perceived to be having a reduced impact in terms of effective diagnosis of mental health conditions. It was recognised only a while ago that GPs only diagnose between a fifth and a half of the psycho-social issues that patients present with in surgeries (Gulbrandson, et al 1997). However, psychosocial problems are increasingly common in primary care consultations. The recent NHS Adult Psychiatric Morbidity Survey (2016) shows that 24.7% of all adult women in the West Country experienced some sort of common mental disorder in the week before they were surveyed as did more than a quarter (25.5%) of men aged 16-59 living alone with no children.

With an aging population the burden on primary care is only going to increase and it is anticipated that consultation rates will rise by 5% over the next 20 years. GPs also perceive that their patients are demanding better services and expect more. In particular younger patients are seen as less likely to grin and bear their ailments compared to older generations according to Sam Everington, CCG commissioner in Tower Hamlets CCG (Beavers, 2013).

And unlike other health services primary care has no waiting list or referral criteria—they are forced to deal with the here and now in all its ramifications on a daily basis (Hardy, 2013:347); including social problems. The most common social problems elicited by the GPs were difficulties relating to welfare benefits and housing (Popay et al, 2007a). It is not always easy for patients to distinguish between medical and social problems, and hence both types of problems may be brought to a GP consultation (Cawston, 2011). However GPs have limited responses to the social issues often presented in surgeries. If they did refer on it was often without a supportive framework to achieve a successful outcome (Brandling and House, 2009).

With pressures on GPs growing CCGs and GPs are advocating and developing new approaches to developing their service delivery. This fresh approach includes social prescribing. Dr Sam Everington, Chairman of Tower Hamlets CCG, has argued that GPs need assistance to manage their workload (Beavers, 2013:5) and believes that GPs should be offered more incentives to develop partnerships to make their services work more effectively. The former Chair of the CGP recently argued that GPs need all providers of

health and social care, within a geographically aligned area to come together to pool resources (Gerada, 2013). This includes making use of third sector organizations according to a retired GP from Bethnal Green Health Centre writing in the BMJ who argued it requires commissioners and GPs to undertake a:

a radical rethink on service provision, with perhaps less emphasis on classification and more on collaborative working practices (Hardy, 2013:347)

Part of this push to encourage primary care services to develop collaborative working is the realization that the burden of managing long-term conditions calls for a holistic approach. There are 15 million people in the UK living with a long-term condition. Typically this can include people who are repeat attendees in surgeries for which social prescribing is increasingly seen as a potential solution. There are also over 3 million adults of working age who are not in work and receiving incapacity benefits in the UK, and poor mental health was the most significant reason for their incapacity (ESN, 2011:25). According to the World Health Organization (WHO) by 2020 depression will be a leading cause of disability globally, second only to ischemic heart disease (Dewa and McDaid, 2011). Recent Kings Fund Caring Research has led to a call for GPs to be more proactive and preventive in their approach. Improving care for people with long-term conditions is seen as involving a shift away from a reactive, disease-focused, fragmented model of care towards one that is more proactive, holistic and preventive, in which people with long-term conditions are encouraged to play a central role in managing their own care (Coulter, 2013:2).

Social Prescribing in Gloucestershire

Gloucestershire is facing some important health challenges mirroring the trends noted for the UK above. The number of older people in Gloucestershire is predicted to increase by 70% (an increase of 78,000) by 2035, the number of people living with diabetes and stroke is projected to increase by approximately 34%, and Coronary Heart Disease (CHD) 50%. The impact on the NHS and Social Care of supporting people with long term conditions is significant with approximately 70% of the health and social care costs being spent on long term conditions (Edwards, 2016).

The social prescribing service was launched by Gloucestershire Clinical Commissioning Group in 2014 in 2 pilot areas. The initiative was supported under the Prime Minister's Challenge Fund. Initially social prescribing was aimed at patient groups who were perceived as frequent attenders in primary care. These were vulnerable and at risk groups and people with long term conditions.

Following the development of two social prescribing pilots GCCG decided that the social prescribing service should be rolled out across Gloucestershire in a consistent manner. A hub coordination model was advised with coordinators based in GP Practices to meet people face to face. The hub coordinator role was built into existing roles operating in a

similar field (e.g Local Area Coordinators, Care Coordinators, Healthy Lifestyles teams or third sector partners). This had the benefit of building on and utilising existing good knowledge of local provision. The role was seen as allowing enough time for an element of handholding, one-to-one support - e.g. time to support those patients with the most complex needs if required. But the intention was that the model going forward should be a mixture of formal referral and signposting. This would involve formal referral to larger third sector partners with paid staff who could then potentially act as case workers and informal signposting to a range of smaller, community level organisations and groups. In essence a social prescribing medium project (Kimberlee, 2015).

From March 2016 patients in all 81 practices in Gloucestershire were able to have access to social prescribing. The service accepted referrals from GP practice staff (including practice managers), staff in 21 Integrated Community Teams (ICT) and staff in community hospitals.

The high level aims of GCCG's social prescribing initiative were to:

- Ensure individuals are able to make informed choices to manage their self-care and wellbeing needs,
- Communicate effectively to enable individuals to assess their needs, and develop and gain confidence to self-care,
- Support and enable individuals to access appropriate information to manage their self-care needs (aligns to The Care Act),
- Advise individuals how to access support networks,
- Support and enable positive risk management and risk taking to maximise independence and choice,
- Support the health and social care workforce to ensure that they have the skills and competences to become co-producers in health and promote self-care,
- Reduce use of statutory services, where appropriate.

From witnessing the social prescribing service in GCCG it is clear that the co-ordinators are clear about their remit and they fully address the tasks they are set. They have grown their service organically without any explicit direction from the CCG. And they have developed it with considerable passion and commitment. Patients referred frequently get a lot more than simple signposting and that their social prescribing is not just light or medium but can verge on the holistic (Kimberlee, 2013); particularly those who have a lot of needs and co-morbidities.

Aims of the evaluation

The overarching aim of this evaluation is:

To evaluate the effectiveness of the expanded Social Prescribing pilot across Gloucestershire.

With subsidiary objectives to:

- Assess whether people receiving a social prescription in Gloucestershire improve their mental wellbeing (using short WEMWBS);
- Assess whether people receiving a social prescription have reduced the number of visits they make to primary care;
- Assess the use of outpatient, hospitals, social care and day care services by the patients referred to social prescribing, before and after referral;
- Assess the impact of the social prescribing services on third sector partners;
- Assess health professional views on the social prescribing pilot, paying particular attention to the views of and impact on GPs, ICTs and Community Hospitals.
- Undertake a cost analysis of the social prescribing service;
- Assess if there are outcome variations depending on if the patient received additional one-to-one support beyond the initial appointment;
- Assess if there is an outcome variation based on sign-posting versus referral to an organisation.

Data Collection

CCG monitoring Tool

The key data source to assessing impact of the social prescribing service is the information collected by the co-ordinators at the first appointment with the coordinator and subsequent appointments (if required). The information was recorded and inputted by the co-ordinators at the six different hubs and added to an Excel spreadsheet locally. This information was sent to GCCG where it was anonymised and forwarded to the researcher. The data collected by the co-ordinators included:

- Age
- Gender
- Ethnicity
- GP practice
- Self report disability
- Referral reason
- Agencies involved
- Organization of referral
- Signposted organization
- Contact date
- Completion date

Additionally the short Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) was used to measure any changes in mental wellbeing for patients given a social prescription. It was intended that the patients should complete WEMWBS on the initial appointment and then complete a follow-up test 12 weeks later. Several hubs also forwarded notes on patient pathways and other outcomes (e.g. employment gained) and included this in their reports. Some co-ordinators also usefully recorded the number of contacts made and time spent with a patient.

In addition interviews and focus groups were undertaken with stakeholders and patients in two different districts: Forest of Dean and Gloucester. In all the evaluation engaged with 13 patients, 5 GPs, 6 representatives of third sector organizations and the 6 co-ordinator teams. Two of the teams were visited twice.

Impact of Social Prescribing

Evidence from the first evaluation of two social prescribing pilots in Gloucestershire

A report from an earlier evaluation of the two pilot social prescribing initiatives was written in March 2015. Despite there being significant difficulties in collecting feedback from patients, and with data only available from the Forest of Dean and South Cotswold hubs; monitoring information revealed that social isolation (54%) and mental health and wellbeing (53%) were the most common primary reasons for referral; although a wide range of non-medical referral reasons were seen including: benefit advice, housing advice and employment advice. Most patients referred were in the 81 to 90 age category (23%). There was some evidence for an overall reduction in primary care visits following the instigation of the pilot. And there were also recorded improvements in WEMWBS. Although there was no evidence that there was a reduction in prescription rates.

Demographic profile of the patients referred to social prescribing

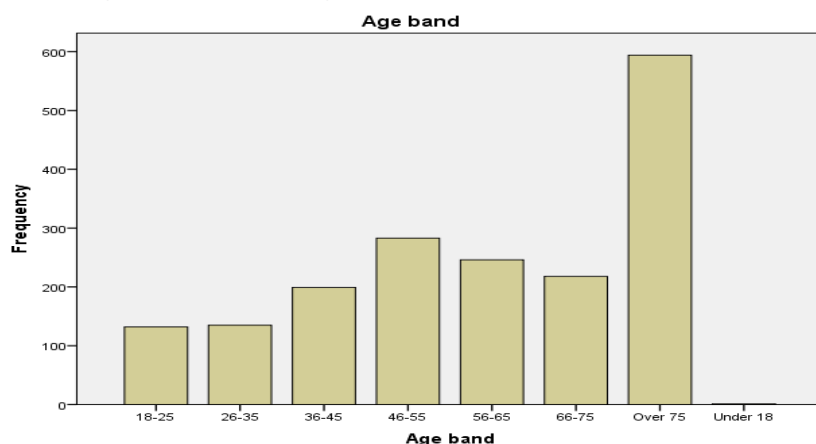
Looking at the enhanced database the evaluator was able to look at data collected from the pilots up to August 2016. The amount of data collected, inputted and then reported varied from district to district with some co-ordinators collecting complete sets of information on patients referred; while other areas were less complete. At the time of analysis there were records for 2047 patients who had been referred to receive the social prescribing service.

On being referred the social prescribing co-ordinators complete a registration form which enables the CCG to get an understanding of the demographic profile of the patients referred to the service. Comparison with read codes for social prescribing suggests that there are generally more patients on the social prescribing data base than are known and recorded through the GCCG's official dataset (See Appendix 1).

Having 2047 patients referred to the service means that Gloucestershire's social prescribing service is one of the largest in the country in terms of referral numbers. CCG wide evaluations across an equivalent time period in the City and Hackney service evaluation included 737 patients (Bertotti et. al, 2014) and 1,607 patients in Rotherham (Dayson et al, 2014).

The majority of patients referred to the GCCG social prescribing service are female (60.2% n=1,138), ~~with~~ With a third of patients aged 75+. Because of the unequal age brackets used to codify age (fixed at the start of the evaluation) it is difficult to determine the spread of ages beyond 75. However the median age range is 56-65.

Table 1: Age band of referred patients



Data on the ethnic background of patients is extremely limited. One district did not collect any data, while the rest had a lot of not known responses. Where ethnic identity of the patients (n=1,086) are known: 94.4% have a self-defined white British identity (Gloucestershire, 95%)ⁱⁱ, 4.4% white other (Gloucestershire, 2.4%) and 1.1% are BME or of mixed race identity (Gloucestershire, 2.8%). It would seem that there is a small under representation of white British people and BME and mixed race patients referred to the service.

29.2% (n=597) self report that they are disabled (Gloucestershire, 15.4% report a limiting long-term illness)ⁱⁱⁱ. Of these 41% (n=259) report a physical disability, 28% (n=177) mental health problems, 20% (n=177) are living with a long term condition, 4% (n=26) reported learning difficulties, 2% (n=15) a visual impairment, 2% (n=11) a hearing impairment and 2% (n=15) some other disability.

Referral

On referring health professionals completed a referral form ticking an appropriate reason for the referral:

- Social isolation
- General health and fitness
- Benefits / housing / environment
- Caring responsibilities
- Memory problems
- Other (please state)

Examining the referral information on the database GPs (88%, n= 1802) are the largest referral source to social prescribing. 8.5% (n=174) have come from ICTs and the rest from either: community nurses, a social worker or a community hospital. Even though GPs are the largest recorded referrer it is possible that some of their referrals are actually from a practice manager. The evaluator is aware that practice managers and front of house staff were beginning to triage to social prescription without the necessity of involving the GP.

There are 83 different referral agencies. The overwhelming majority are GP surgeries. As of May 2016 only 5 of the known 84 GP practices had not made a referral. Other referring agencies include ICTs particularly in the Stroud and Berkeley Vale District. One surgery in the South Cotswold area referred the largest number of patients (n=151).

There are 629,835 patients registered with GP practices. Referral rates for social prescribing (patient/1000 patients registered at the practice) vary across the county's districts (co-ordinator hubs) from 1.07 to 4.14/1000. The average referral rate is 3.27/1000.

Referral rates vary between GP practices. Mean referral rate per practice was 20.3. With a range of referral rate per practice of: 0 to 151. There is tendency for larger GP practices (number of patients on their list) to refer more patients to social prescribing. There was a medium positive correlation between practice size and referral rate ($r=+3.20$, $n=83$, $p<0.01$).

There was also variation in terms of the number referrals made by GPs within practices. Excluding those practices that have not referred anyone to social prescribing the referral rate per GP in practices varies from 0.14 to 30.20 referrals per partner. The mean referral rate is 5.3 referrals per partner.

Referrers were asked to identify a reason for referral. In 39% (n=710) of referrals there were multiple reasons for the referral. Adding these referrals to those patients who were referred for a single reason we see the following referral reasons (n=1830): 48% (n=886) mental health and wellbeing, 35% (n=647) for benefits, housing or environmental advice, 16% (n=288) for generic health and fitness, 15% (n=279) for carers support, 14% (n=254) for social isolation, 6% (n=116) for memory loss and 4% (n=75) for some other reason e.g. falls prevention. This level of referral for mental health is similar to other social prescribing projects e.g. Newcastle (ERS, 2013). 0.5% (n=11) referrals were received by social prescribers for which no reason was specified on the referral form. Thus the majority of patients who are referred are referred because they have a mental health and wellbeing need, which is different to the initial pilot where social isolation was seen as the predominant reason for referral.

However it is clear that there is variability in GP referral. There are clear referral criteria outlined on the referral form but it is the perception of some practice managers that reasons for referral in their practice may differ.

Our GPs have referred to SP at some point either because patients have brought up a social matter themselves, or the GP has deduced a social need. (A Practice Manager)

Social prescribing

Of those referred and identified on the database (n=2047) social prescribing was given and received by 81% (n=1651) of patients, 9% (n=177) declined the offer, 8% (n=170) were uncontactable, 0.8% (n=16) disengaged with the service, 0.6% (n=13) either died or moved out of the area. 1% (n=19) of referrals were identified as an inappropriate referral to the service.

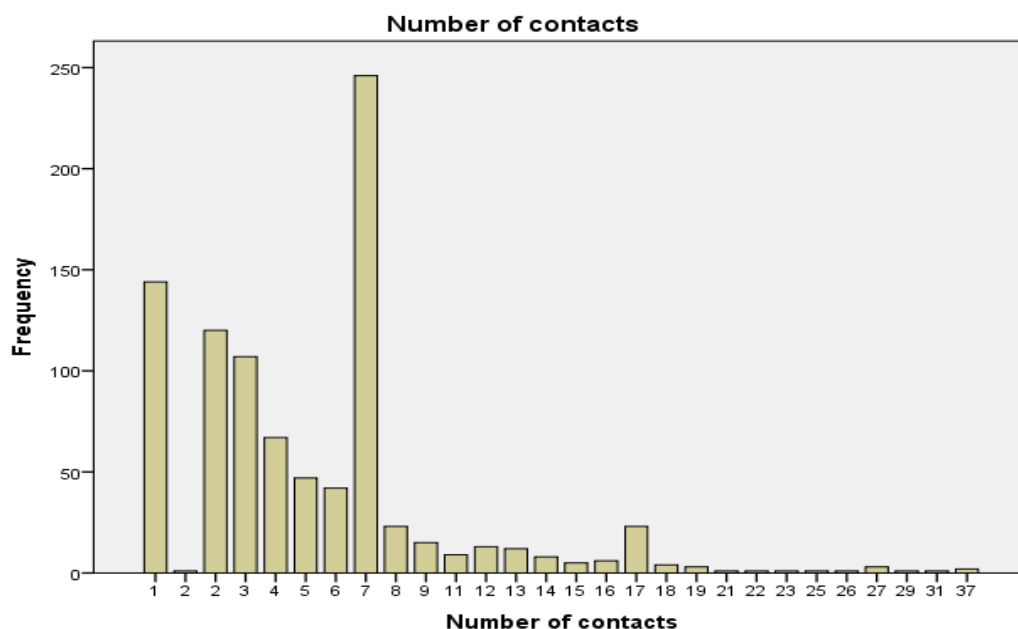
Acceptance of a social prescribing service ranged between 80-92% in all of the districts. However in one district the acceptance rate was as low 60%. Men and women accept the social prescription at similar levels. But people who were younger (18-25 and 26-35 groups) had higher levels of declining or disengaging with the service and/or being uncontactable.

Prescribers link to patients vary. Each case can be very different requiring different challenges. Most patients receive information, advice and guidance. But many other prescribers go beyond what is perhaps anticipated by GCCG. Thus the co-ordinators have been extraordinary innovative and undertaken a range of activities including: accompanying patients with low confidence to activity classes and self-help groups, become involved in advocacy, liaised with family members, co-ordinated quotations for building projects, identified communities of interest to patients and helped to direct patients into volunteering and employment opportunities.

Co-ordinators time with a patient once referred varies. For things like inappropriate referrals the case will be live for one day only. However the mean time a case is live is 103 days. The longest recorded live case was 280 days.

District teams were asked to calculate the amount of time they spent with a client at their hub. This was done fairly effectively in five of the districts. In the other districts there are only partial or no records of contact. The average amount of recorded contact made by a prescriber with a patient was 5. One patient received 37 contacts from their co-ordinator. Contact was predominantly undertaken in GP practices but there is evidence of home visits and telephone contact.

Table 2: Number of contacts



There is evidence to suggest that co-ordinators stuck to the GP Executive Group guidance on contact where they agreed that the co-ordinator would have a minimum of three concurrent separate attempts to contact those referred before signing off a referral as ‘unable to contact’. However, interviews with co-ordinators suggest that some co-ordinators go the extra mile and can try five or six times with a patient referred.

The social prescribers made 2476 onward referrals. Of patients who received the service the prescribers referred/signposted the patient on to an average of 2.3 different organizations. Some patients did not receive any onward referral (15%, n =154) whereas 5 patients were referred to 12 different organizations.

Links to the Voluntary and Community Sector (VCS)

Social prescribing often strengthens links between health care providers and third sector service providers, particularly to organisations that are concerned with delivering social care and advocacy. In these services there are potential solutions: to the wider determinants of mental health, for example, leisure, welfare, education, culture, employment and the environment (Scottish Development Centre for Mental Health, 2003:5). But it has long been acknowledged that these links between primary health care services and the third sector still remain underdeveloped and that that they actually require considerable time and patience to develop and evolve (South et al, 2008:310).

The co-ordinators in the districts have patiently built strong and enduring links with a variety of organizations and individuals attached to the VCS sector. In Appendix 2 there is a list of 234 different organizations, individuals and services that patients have been referred to in the course of the time they have been with the social prescribing service. Most of these activities and services have been provided by the VCS. However some are provided by the statutory sector (e.g. the fire service) and some are private concerns (e.g. some care homes).

An important issue often raised by patients is the challenges that isolation poses for their health and wellbeing. We are aware of over 50 different organizations to which referred patients have been further referred to undertake voluntary work. These include a variety of different types of organizations including an: animal shelter, Badgervale Court, befriending projects, an edible garden project, a foodbank, Macmillan, community transport, World Jungle, Roses Theatre in Tewkesbury and Volunteer Gloucestershire.

Gloucestershire VCS Alliance (GVCSA) ran a short survey about social prescribing with their affiliates from June-August 2016. 49 different organisations had responded to the survey. All but one organization said they were interested in receiving referrals. The linked questionnaire was sent to formally constituted organisations irrespective of size and deliberately excluded very local voluntary run services, such as choirs and book clubs. Interestingly only 31 of the responding organizations said they had actually received a social prescribing referral. Responses were largely very positive. Most respondents said they were happy with social prescribing and report that they have been able to build good relationships with their local co-ordinator/GP. They report that this has helped to raise awareness of their organization's work and mission. Regular liaison and networking have worked well for a majority of organizations who often praise the positive attitude of the co-ordinators they link with.

In their responses to the survey there were many reflections that suggested that the social prescribing service has helped to raise their own organization's profile with local GPs. They believe that without the social prescribing service GPs would not be aware of the support and local knowledge they make available to local patients. There were also quite a few positive comments suggesting that they thought social prescribing was working well.

I've been impressed by the commitment and knowledge of the prescribers I've met. (VCS organization)

We have worked closely with the social prescribing team to link to local organisations and make them aware of initiatives that we organise. I believe we have a good working relationship which has mutually beneficial outcomes. (VCS organization)

However there are a few organizations that have signed up to have referrals from the scheme but had not seen anything happen; they seem to have found it difficult to get on the

co-ordinators' radar. And despite limited funding many organizations welcomed the opportunity to expand their work with social prescribing referrals and develop their volunteering opportunities.

The majority of our referrals have come from the Forest of Dean and Cheltenham. In these areas the two schemes work alongside each other to great effect. We would like to see more referrals from the rest of the county. (VCS organization)

I have heard positive feedback about social prescribing, I hope our service will benefit from referrals in the future. (VCS organization)

There were over 234 different organizations and individuals that the co-ordinators referred too. Age UK, the Barnwood Trust, Citizens Advice, Carers Gloucestershire received most referrals. The range and number of organizations reflects the geographical size of the county compared to smaller urban projects like the City and Hackney social prescribing service that referred on to 85 statutory and voluntary groups and community services (Bertotti et al, 2015).

The CCG has a stated intent to engage with the VCS in support of the strategic aims set out in: *Joining Up Your Care 2014-19* (Gloucestershire CCG, 2014). A key joint piece of work underway between the CCG and the VCS Alliance is the development of a Kite Mark for social prescribing with the aim of providing a greater degree of assurance to primary care colleagues. This has enabled the successful documenting of affiliate organizations to deliver social prescribing.

Impact of the social prescribing service in Gloucestershire

In all the interviews I have undertaken for the evaluation I have only come across positivity for the social prescribing initiative and the co-ordinators who deliver the programme.

*Having ***** here....it has been brilliant as our Social Prescriber in helping our patients and reducing GP involvement for several. Things like contact numbers and paperwork and then following up with patients. Helping organise needs in their own homes. She has helped to reduce need to go to hospital sometimes because patients know where to turn to instead of GP or A&E when it wasn't a medical concern.
(Practice Manager)*

For many patients the social prescribing service is the only service they can turn to because they perceive that access to other services is proving too challenging. It is clear to them that the social prescribing service is stepping into service provision gaps where they as quite vulnerable patients are receiving no support. Locally, waiting times to vital services from initial GP referrals have got longer. In one district it is estimated that a post referral wait for adult social care could be up to 3 – 4 weeks and for the mental health team 4 – 5 months. In the absence of support patients can easily spiral into crisis.

The primary outcome measure selected by GCCG and used by the co-ordinators is the short (WEMWBS). This is a measure of wellbeing. WEMWBS is a useful tool for measuring the impact of a service or intervention on mental wellbeing. In its full form it is a 14 positively worded item scale with five response categories. It covers most aspects of positive mental health (positive thoughts and feelings) currently in the literature, including both hedonic and eudaimonic perspectives. The short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) has also been validated and can be used with adults and children aged 13 plus. It has been used in other evaluations of social prescribing services including Newcastle (ERS, 2013) where the prescribing is similarly carried out by a link worker.

However it proved quite a challenging tool to use and it was not popular with either co-ordinators or patients. There are some reports on the database that some patients refused to engage with the tool and others did not understand the tool or felt they could not complete it because of competence. This was particularly true if patients were frail or the carer thought they lacked the competency.

Nevertheless 41% (n=844) of patients completed WEMWBS at baseline. Scores on the scale ranged from 7 through to 34 producing an almost perfect natural distribution curve (mean = 18.52, median = 18, mode = 18).

The table below shows the distribution of scores across the three 'well-being' domains: 'low', 'moderate' and 'high' mental well-being – as defined in the North West Public Health Observatory study (2009). Modelled to an English population the data suggests that those

referred to the social prescribing project in Gloucestershire have very low levels of reported personal wellbeing.

Table 4: Baseline WEMWBS scores of social prescribing patients

| | Mean WEMWBS score | Low well-being | Moderate well-being | High well-being | Base |
|----------------------------------|-------------------|----------------|---------------------|-----------------|--------|
| England population* | 28 | 16.8% | 62.8% | 20.4% | 18,500 |
| GCCG Social Prescribing baseline | 18 | 79% | 20.5% | 0.5% | 844 |

*North West Mental Wellbeing Survey 2009

19.4% (n=399) matched baseline and follow up WEMWBS scores were available in August 2016. This is quite an achievement given the remoteness of patients after cases are no longer live. Similar follow up studies with social prescribing interventions achieved only 11% using the demanding MYMOP and EQ-5L of wellbeing (Bertotti et al 2014).

We need to be careful about the interpretation of the follow up responses because they are dissimilar to the baseline profile of the overall sample. Although the age and gender profile is similar, data provided by follow up were obtained from only five of the hubs.

It was intended that follow-up should be 12 weeks after commencement on the programme. However the severity of the challenges posed by those patients who were referred meant duration of engagement with the service was often greater than initially planned. Thus instead of the anticipated 84 days until completion of a case and administration of follow-up WEMWBS the mean duration time to completion (where known) was in fact 103 days. In many cases we don't actually know the follow-up completion date; in fact completion dates were recorded for only (n=199) cases. So time effects could undermine the overall impact of the intervention in terms of assessing and attributing impact on personal well-being.

If we look at this matched sub sample there was a statistically significant increase in reported short WEMWBS scores from baseline (M =18.51, SD 6.1) to follow up (M=22.37, SD 5.9) $t(398) = -16.21$. The mean increase in mental health scores was 3.83 with a 95% confidence level of -4.291 to -3.363. The eta squared statistic 0.39 indicated a large effect size. This replicates the findings from the initial evaluation.

Table 5: Baseline and Follow-up WEMWBSs scores of social prescribing patients

| | Mean WEMWBS score | Low well-being | Moderate well-being | High well-being | Base |
|----------------------------------|-------------------|----------------|---------------------|-----------------|--------|
| England population* | 28 | 16.8% | 62.8% | 20.4% | 18,500 |
| CCG Social Prescribing baseline | 19 | 79% | 20.5% | 0.5% | 844 |
| CCG Social Prescribing follow up | 22 | 60% | 38% | 2% | 399 |

*North West Mental Wellbeing Survey 2009

The above table reveals a shift in reported wellbeing in this sample. This is not the only evidence recorded for improved wellbeing. Our interviews with patients in two of the districts reveal high levels of improved wellbeing stemming from engagement with the social prescribing project in Gloucestershire. Both of the districts were able to get follow up WEMWBS responses.

While it is impossible to be precise about how much change in WEMWBS is considered 'meaningful', best estimates range from 3 to 8 WEMWBS points difference between 'before' and 'after' time points as being significant and indicative of change. So if a participant's score increased by 3 to 8 points during the project, WEMWBS would be demonstrating that mental wellbeing meaningfully improved over the course of the project. At a group level a 'statistically significant' change will depend on the number of participants completing WEMWBS, with a greater the sample size, the smaller the difference likely to be detected (Putz et al, 2012).

Improvement in wellbeing is important because in improving a person's sense of wellbeing health outcomes are also directly improved (DoH, 2014). This is supported by some of the data we were able to collect from and secondary care. Examining the data on secondary care we find further evidence on impact in terms of emergency admissions and emergency attendance six months prior to referral to social prescribing and six months after. These are based on data from five districts. We find some small decreases in burden.

Table 6: Mean number of emergency admissions and attendances per patient to A and E six months before referral and six months after (n=2047).

| | Six months prior to referral to social prescribing service | Six months after referral to social prescribing service |
|--|--|---|
| Mean number of emergency admissions per patient | 0.16 | 0.15 |
| Mean number of emergency attendance per patient at A and E | 0.37 | 0.33 |

Interpretation of hospital admission and attendance data is difficult. Partly because the time frame examined here is quite small. Other studies exploring the impact of social prescribing tend to adopt a time frame of 12 months rather than six months. Secondly looking at subsets in the data we find that some of the sample sizes are quite small so the trends discussed here should be seen as more as indicative of a trend that would require further examination, particularly over 12 months which would be the normal time frame to use in an evaluation.

However greater scrutiny of the data suggests that those patients who were referred to social prescribing and actually took up the service had lower emergency admissions rates after six months than those patients who refused the service or were uncontactable, died or were an inappropriate referral. Not only is it lower but there is a perceptible decline contrary to an increase in emergency admissions in the other categories. There is a 23% decline in A and E admissions in the six months after compared to the six months before. This compares favourably with the Rotherham findings (Dayson et al, 2014) of a decline of 21%. And it is also against the general trend of a monthly increase of admissions in 2016-17 of 14,200 compared to the previous year (Kings Fund, 2016).

Table 7: Mean number of emergency admissions per patient to A and E

| | Six months prior to referral to social prescribing service | Six months after referral to social prescribing service |
|---------------------------------------|---|--|
| Accepted service (n=1651) | 0.13 | 0.10 |
| Declined service (n=177) | 0.30 | 0.43 |
| No contact (n=170) | 0.35 | 0.50 |
| Disengaged with Service (n=16) | 0.00 | 0.00 |
| Died (n=6) | 1.00 | 2.00 |
| Inappropriate referral (n=19) | 0.80 | 0.20 |

Looking at the mean attendance cost/patient of emergency admissions to A and E we can see the cost imposed by social prescribing patients attending actually increased slightly (2.5%) despite the decrease in attendance 23%. This is against a backdrop of an overall increase in costs of 42% for all patients in the sample.

Table 8: mean cost/patient of emergency admissions per patient to A and E

| | Six months prior to referral to social prescribing service | Six months after referral to social prescribing service |
|---|--|---|
| Accepted service (n=1651) | £187.81 | £192.58 |
| Declined service (n=177) | £631.80 | £559.65 |
| No contact (n=170) | £389.52 | £1,304.20 |
| Disengaged with Service (n=16) | 0 | 0 |
| Died (n=6) | £3,103.50 | £4,404.00 |
| Inappropriate referral (n=19) | £520.80 | £779.20 |
| Total costs of all patients (n=2047) | £172,773 | £207,831 |

The table below shows that the mean number of emergency attendance per patient to A and E remained static for those patients who accepted a social prescription referral. But there were different trends in costs for the other types of patients referred by GPs. Other studies that have looked at mean emergency attendance visits at baseline and follow up have shown a greater decline (25% in Bertotti, 2015) in comparison to a control sample. In Rotherham it reduced by 20% (Dayson et al, 2014).

Table 9: Mean number of emergency attendance per patient to A and E

| | Six months prior to referral to social prescribing service | Six months after referral to social prescribing service |
|---------------------------------------|--|---|
| Accepted service (n=1651) | 0.26 | 0.26 |
| Declined service (n=177) | 0.87 | 0.80 |
| No contact (n=170) | 1.06 | 0.65 |
| Disengaged with Service (n=16) | 0.40 | 1.00 |
| Died (n=6) | 1.00 | 1.50 |
| Inappropriate referral (n=19) | 0.80 | 0.50 |

The following table explores the costs associated with the mean number of emergency attendances per patient to A and E. This increased by 0.4% for those patients who accepted a social prescription referral. This increase is against on overall decline of 4.6% for the whole sample.

Table 10: mean cost/patient of emergency attendance per patient to A and E

| | Six months prior to referral to social prescribing service | Six months after referral to social prescribing service |
|---------------------------------------|--|---|
| Accepted service (n=1651) | £33.88 | £35.42 |
| Declined service (n=177) | £118.71 | £111.52 |
| No contact (n=170) | £125.76 | £97.82 |
| Disengaged with Service (n=16) | £54.60 | £110.00 |
| Died (n=6) | £165.50 | £213.50 |
| Inappropriate referral (n=19) | £288.16 | £70.00 |
| Total costs | £35,663 | £34,016 |

Fixation on these key indicators actually masks a lot of other medical impacts that are not recorded on the database or the notes. For example social prescribers have been able to pick up on medical issues that the patient may have been too embarrassed to share with a GP. This includes issues like alcohol dependency. In one district they claim that 40% of their referred patients discussed their problem of alcohol dependency with their co-ordinator.

In Bromley by Bow GPs report witnessing falls in consultation rates for some patients, particularly the frequent attenders and socially isolated. They record better health outcomes and reduced consultation rates among patients referred similar self-care programmes (Roberts, 2016).

Beyond direct impact on known indicators of health and wellbeing there have been important impacts in many other sectors e.g. the social and in particular the development of community capacity. There has been tremendous innovation shown by the co-ordinators in expanding and developing onward referral services. Some former social prescribers have gone on to set up their own wellbeing groups and activities having enjoyed the benefits of their social prescribing service. This includes a new knitting group in Gloucester and a new art club. The co-ordinators have worked hard to provide and develop new services where a gap has emerged. This includes making links with three new private gyms to kick start and negotiate a deal on Exercise on Referral.

New links have been made with other health service providers other than GPs. This includes having referrals from Health Visitors and District Nurses. This can be a particular important source of referral particularly for those patients who have been returned to home from hospital. Additionally, some *front of house* staff/practice managers have made referrals to the service to reduce the dependency on GPs.

And we know from the Low Commission inquiry into social welfare advice provision chaired by Lord Colin Low, that advice services located in primary care settings could cut time spent by GPs on benefits issues by 15% and reduce repeat appointments and prescriptions.

Looking at primary care data we can see a clear reduction in the number of patient encounters with GP services. The data available is limited. Partially because it only looks at 44 GP practices and not the 82 referral sources identified on the social prescribing data base. It looks at the patient records of 1,147 different patients who have been referred to the social prescribing service. Secondly it relies on read codes to identify patients who received social prescribing which we know generally underestimates the number of patients who actually receive social prescribing. Nevertheless we received GP attendance data on 56% (n=1080) of referred patients. The data suggests a decreasing dependence on primary care. The table below shows that GP appointments declined by 21% in the six months after referral to a social prescribing co-ordinator compared to six months before. The number of home visits have declined by 26% and the number of telephone calls by 6%.

Table 11: Mean appointment per patient attending a GP practice six month before social prescribing and six months after social prescribing.

| | Six months prior to referral to social prescribing service | Six months after referral to social prescribing service | Difference |
|-----------------------|--|---|------------|
| GP attendance | 5.93 | 4.71 | -1.22 |
| Home visit | 0.38 | 0.28 | -0.1 |
| Telephone call | 2.62 | 2.46 | -0.16 |

Although the sample is smaller than desired it fits in with the intuitive sense that GPs report when questioned about impact. All the GPs interviewed for this research felt that the social prescribing service had helped to reduce patient attendance at their surgeries. In particular amongst patients who had previously been frequent attenders:

I have no doubts whatsoever about its impact. Particularly in terms of impact on patients that would turn up on a regular basis. We see them a lot less. I used to have one patient who would grab an appointment every other week. Now she just waves at me in the High Street. It such a refreshing change for both her and me. (A GP)

More impact and innovation

The full impact of the social prescribing initiative cannot be fully quantified here. Having expanded the service over time; GPs, the voluntary and community sector and patients have now begun to expect it as an option in terms of treatment. It has also encouraged and fostered other initiatives. There is not sufficient time here to summarise them all; but, by way of an example, one innovative initiative developed by one GP practice in partnership with the Barnwood Trust has seen the local GP hosting a social prescribing stand in the town where they have distributed social prescriptions to passing shoppers in cleverly designed pill cartons. Please see the front cover of this report.

The project has also raised the profile of social prescribing beyond the county and has inspired others to consider countywide roll-out e.g. Shropshire CCG are exploring it as a possible option.

Involvement in the project has also increased awareness amongst health care practitioners of what can be delivered by the co-ordinators and this has a value in the future, both in terms of continuing the project but also in raising the profile of social prescribing to health care professionals who will continue to develop the project organically.

Realising the value of social prescribing

It is clear that different attempts have been made to measure the cost effectiveness of social prescribing e.g. cost consequence analysis (Roslyn et al, 2001), cost benefit analysis (Dayson et al, 2014) and Social Return on Investment (SROI) (Kimberlee, 2016) amongst others. Comparison between studies is very difficult because a lot of the studies will actually monetise different things. Exploring the case of SROI the SPN have collated several studies and have discovered that social prescribing studies show that for every £1 invested there is a SOCIAL return on investment of between £1.20 and £3.10 in the first year. So these benefits go to various stakeholders, including the health service.

But let's look at one model where there is some reasonably good cost effectiveness analysis done at different times in different places on the same model. These are the Bristol and Rotherham studies where the social prescribing project uses individual prescribers to take primary care patients with long term conditions and offer them a range of community-based services to complement traditional medical interventions.

In the Bristol study (Amalthea Project) the cost benefit analysis monetised primary outcomes gathered in a randomised controlled trial (RCT): psychological wellbeing, social support, quality of life and contact costs with primary care. All patients displaying psychosocial problems were considered eligible and referred by the GP and primary healthcare team to one or more activities delivered by the third sector. Referrals were managed by voluntary organisations that trained and supervised project facilitators. Patients were offered an initial assessment within 7 days of referral and follow ups at 1 and 4 months where they were given support and encouragement to continue attending. The project linked 161 patients from 26 general practices with local and national voluntary support. It was found that the cost of GP care alone was cheaper than GP care plus referral to Amalthea; referral to Amalthea (£153) cost more than GP care alone (£133) over 4 months. However the subsequent contact with the third sector resulted in clinically important benefits compared with usual general practitioner care in managing psychosocial problems; this was at a higher cost in the first year. Beneficiaries of the project were seen to be less depressed and less anxious even though their care was more costly compared with routine care and their contact with primary care was not actually seen to be reduced (Grant et al, 2000:419) .

However if this initial RCT study had taken into account the long term savings made beyond a year and compared the costs to what would have happened if the patients had been referred to a specialist and secondary care; then the savings to the health service would have been far greater (Thornett, 2000). Thus savings of a social prescribing service are not achieved in the first year but are more likely to be realised in the second and subsequent years for the health service. This study of course also failed to take account of long term community benefits and reduction in demand for social services (Goodhart & Graffy, 2000), i.e. the social return on investment for such initiatives are always likely to be much greater.

The more recent Rotherham study provides similar findings for a similar model. Monetising from a health service perspective: inpatient admissions, A and E attendance and out-patient attendance; they found a decline in health service attendance over a year. Monetising these

changes they were able to see a return (not social) on investment of 0.33p (33 pence for each pound invested) in the first year. Subsequent annual returns were estimated to be closer to 0.43p / year because take up is greater in subsequent years. Modelling led them to assume that the cost of recouping the investment would take at least two and half years. Thus savings to the health service were not made in the first year, they are only realised in the medium term; with an estimated return on investment of £1.98 after five years (Dayson et al, 2016:30).

In the Rotherham study they interestingly decided to move beyond a normal health service economic evaluation and model the value of a range of social benefits associated with the intervention using financial proxies and techniques often associated with SROI analysis. Amongst the social impacts valued was improved wellbeing. They see social benefits to service users accrue at a faster rate. The estimated social value of the well-being benefits experienced by service users was between £0.57 million and £0.62 million in the first year following engagement with social prescribing: again greater than the costs of delivering the service. In Year 1, they estimated a return on investment was between 0.30 and 0.34 per £1 invested and in Year 2 it was between 1.16 and 1.30 per £1 invested. This means that in Year 2 of the intervention the estimated well-being value created was greater than the input cost of delivering the service (Dayson et al, 2016).

What about the GCCG project? Unfortunately we do not have data that runs over 12 months. The impact data on health outcomes remains limited to six months post referral. Exploration of the costs attached to the hospital episodes suggests that there was very little change in costs post referral compared to before referral despite the decline in the actual admissions and the stabilization in A and E attendance.

However if we look at the potential savings from reduced dependence on GP services we can see that patients who received social prescribing were visiting GP practices 1.2 fewer times over six months. This is a known and verified decline. The per patient cost with a GP lasting 11.7 minutes costs £44 (PSSRU, 2016). If we assume that all social prescribing patients went to GP 1.2 appointment times less frequently in six months the savings to the CCG would be £83,529. If we assume that the savings continue over 12 months then the savings would be £167,059. If we look at the decline in GP home visits then the reduction of 0.1 home visit per social prescribing patient at a cost of £45 per patient would yield a saving of £7,141.5 over six months and £14,283 over twelve months (PSSRU, 2016). And the 0.16 decline in telephone calls at a cost of £27 per patient would yield a saving of £13,668 over 12 months.

I have been unable to scrutinise the A and E cost data as recorded and reported from GCCG. Such data is vulnerable to outliers. However it is clear that amongst those who received a social prescribing service there was a 23% decline in A and E admissions in the six months after compared to the six months before. This meant there was a 0.03/patient decline in emergency admissions. Using the lowest unit cost for emergency admission (Admitted Emergency Medicine Category 1) this translates into a six monthly saving of £6,312 over 6 months and £12,624 over 12 months (www.gov.uk, 2016).

Table 12: Savings in health provision made by the social prescribing service in Gloucestershire

| Item | 6 months saving | 12 months savings |
|-------------------------------|-----------------|-------------------|
| Decline in A and E admissions | £6,312 | £12,624 |
| Decline in A and E attendance | 0 | 0 |
| Decline in GP appointments | £83,529 | £167,059 |
| Decline in Home Visits | £7,141 | £14,283 |
| Decline in telephone calls | £6,834 | £13,668 |
| Total | £103,816 | £207,632 |

The cost of the social prescribing service in Gloucestershire represents a £480,819 investment. This in line with the estimates suggested by Sam Everington, the chair of Tower Hamlets CCG, as to the cost to a local health economy, which would bring returns 'in no time at all' (Roberts, 2016) This makes the unit cost per patient referred to the service in Gloucestershire as £234.88/patient. This is similar to the £245.60/patient unit cost for Hackney and City scheme (Bertotti, 2014). And it also compares favourably to the Rotherham unit cost spend of £301/patient (Dayson, 2014).

Looking at the 12 month modelled savings outlined in Table 12 the estimated savings created for the health service we see that there is a return on investment of 43p for every £1 spent on the social prescribing service.

However, there are additional health benefits and savings that have accrued to the health service as a result of the activities undertaken by the social prescribing co-ordinators. This largely stems from actions they undertake in terms of promoting healthy living and preventative work. This includes things like falls prevention. An examination of the case notes on the data base reveals that several patients have been referred to OT and falls prevention advice. Often the co-ordinator goes that extra mile to garner community resources to help support patients referred to their service.

*It all started because I had a car crash. I was in a wheelchair for a year. I had post-traumatic stress. Social services were going to put the children in care. I was desperate for help. My garden is a nice space but I couldn't look after it and one day I slipped on the wet grass while I was walking on my crutches that I was given after I had got rid of my wheel chair. Now what he did was that he got me a grant to help with gardening. But the charity went bust but ***** is very good at finding volunteers and he has got them, he's got people from the community coming round to dig up the grass so that I can have a patio. He supervised quotations from different builders for the lay. It was brilliant. ***** always keeps in touch. I don't know what I would have done without this service. (Female social prescribing patient)*

Other preventative work includes suicide prevention. This has been identified as a major concern by those GPs who have referred their patients because of social isolation. In fact 14% of patients referred to the social prescribing service are referred because of social isolation. Social isolation is a big problem. In one group interview with four social prescribing patients (who had never met before) each confessed that they had suicidal thoughts with two admitting that they had actually called the Samaritans.

I am stuck in this wheel chair and have a lot of problems. I knew that my GP just wanted to get rid of me out of the door. I knew she didn't want to open up the can of worms that were in my head and forcing me to talk to the Samaritans. (Male social prescribing patient)

The Health and Wellbeing Board are very aware that Gloucestershire's suicide rate is significantly higher than the national rate; in Gloucestershire 11.5 people per 100,000 die by suicide, compared to 10.1 per 100,000 in the South-West and 8.8 per 100,000 in England (age standardised rate per 100,000, 3 year average 2011-2013, (Gloucestershire Mental Health and Wellbeing Partnership, 2015:4). Roughly 69 people commit suicide in the county each year. An audit of suicide in Gloucestershire reveals that 21% of people who died by suicide (within the reporting period 2011-2013) were unemployed, 40% were living alone, 34% were single, 84% were White British. Reducing the suicide rate in Gloucestershire has been identified as a key area for improvement in the Health and Wellbeing Strategy.

We know from recent research in the UK that 45% of patients who complete suicide contact a primary care provider (e.g. their GP) in the month preceding their death (Dolton, 2013:347). Thus having a social prescribing service to address social isolation might be a vital resource in suicide prevention. In a DoH review of the economic costs involved in mental health prevention the importance of intervening to prevent worse outcomes cannot be underestimated (Platt et. al.2006). Simply looking at non-fatal suicide events it is estimated that costs are averted to £66,797 per year/person of working age where suicide is delayed (i.e. non-fatal). Figures vary depending on the means of the suicide attempt. But 14% of costs are associated with A&E attendance and medical or surgical care; but more than 70% of costs are incurred through follow-up with psychiatric inpatient and outpatient care (Knapp et al, 2011:26). A completed suicide for those of working age in England is £1.67M (based on 2009 prices), (Platt et al. 2006, updated to 2009 prices). This includes intangible costs as well as lost output, police time and funerals.

We don't know how many patients may have gone on to commit suicide if they had not met the social prescribing service. Certainly the stories revealed in one group interview revealed that there was considerable desperation in some people's lives. This is echoed by the baseline wellbeing scores. All co-ordinators reveal that they have some experience of patients discussing suicidal intention. However it is hard to put a figure on this because there is no universal method of recording disclosure in case notes. In Gloucestershire we know that 11.5 people per 100,000 die by suicide. And recent research suggests that non-fatal suicide attempts could be 40 times more common than completed suicides, with about

10 people experiencing suicidal thoughts for every suicide attempt (Chang, et al. 2013). This would suggest that there are 460 attempted suicides in the county each year. It is feasible that the co-ordinator teams may have prevented one suicide each that may have otherwise necessitated a hospital admission. If this is the case it is possible to suggest that this preventative work may have yielded social savings of £467, 579.

It is clear that the social prescribing service is a multi-faceted intervention achieving a broad range of outcomes to achieve a sense of well-being. Interviews with stakeholders and patients clearly report improvement in patient wellbeing. Where we have matched WEMWBSs it is clear that 78% report an improvement in their wellbeing. But how can we valorise this. We know that in a recent report for the DoH on the economic costs of mental health one case study was provided of a multicomponent intervention aimed at improving well-being for adults. It was estimated to cost £80 per person per year (McDaid et al 2011b:22). We have used this proxy before to valorise wellbeing improvement (Kimberlee, 2016). It is a lower value than £139 value used in the Rotherham study to valorise 'feeling positive' on their 'well-being outcome tool' (Dayson, 2014). Thus the value of the improved sense of wellbeing experienced by 78% of people who use the social prescribing service is equivalent to £103,022.

Literally you have to scream, to get any help for anything. I was desperate and suicidal. They say just go to the website. I wanted help for looking after my father. I kept asking social services can you help and literally threw a brick through their window. I was referred by my GP and I didn't know it (social prescribing) existed. It was literally round the corner. (Carer of a referred social prescribing patient)

One of the achievements of the social prescribing service is that co-ordinators often refer and support patients into voluntary opportunities. This helps to build community capacity and, supports the patient to address issues associated with social isolation and helps other people to receive support and direction from others. The value that volunteering brings varies. In 2011 the Annual Survey of Hours and Earnings (2011) recommended that volunteers working full time were worth £12.56 and part time £8.00 (Office National Statistics, 2011). And although the Big Lottery Fund does not put a financial value on volunteers' time European Structural Funds accepts volunteers' time as match funding. Various studies have valorised voluntary labour and it is often usual to cost volunteer at the level of the hourly minimum wage which currently stands at £7.20 for adults aged 25 and over (<http://www.minimum-wage.co.uk>, 2016).

Returns from the database document that at least 31 people went on to volunteer for a voluntary organization in Gloucestershire. We know that people who regularly took part in informal volunteering spent an average of 7.7 hours doing voluntary activity for their organization (Timebank, 2016). If we assume that the 31 patients referred to voluntary work

made this level of commitment for a year then an added social value of £2687 would be realised.

The database also documents that 40 patients were directly referred on to some form of training. The type of training varied from IT training through to returning to college, apprenticeships, manual handling skills etc. We again feel that the number who were supported into and actually accessed training is underestimated. We also know that 4 patients were directly supported into employment as a result of their engagement with the social prescribing service. If we modestly estimate that a total of 10 patients accessed employment for six months after being dependent on benefits then assuming they were single and claiming Council Tax and JSA rates and aged over 25, further social value has been realised.

Table 13: Annual social value created by the social prescribing service

| Impact | Quantity | Value (£) |
|--|-----------------|------------------|
| Attempted suicide prevented | 7 | 467, 579. |
| Improved wellbeing in patients receiving wellbeing | 1287 | 103,022 |
| Value of voluntary labour to the local community | 31 | 2,687 |
| Return to employment | 10 | 31,460 |
| Total additional Return on investment | | 604,748 |

Adding the 12 months savings to the health service with the estimated (social) savings we believe that in the first year there is a £1.69 (health £0.43, social £1.36) return on investment for every £1 spent by GCCG on the social prescribing service.

Refining the service

In this section I make a few suggestions for the social prescribing service to consider and discuss in order to help refine the delivery of work in the future. I stress it should be discussed because this is a service that has been grown organically in six different places and what is suitable for one co-ordinating hub is not necessarily applicable or suitable for all.

Collection of demographic and impact data has been patchy across the county. More effort needs to be put into supporting the co-ordinators to collect impact data. An annual training day with all co-ordinators in attendance can help to solidify practice and develop confidence.

Some hubs have worked extraordinarily hard to ensure they can accurately report on their patients, their work with the patient and the requested outcomes. Doing this is standard on any health intervention. They provide real insight into their patients and effort. Some hubs have not fully complied with this. It is vital as the service moves forward that all co-ordinators understand that reporting their engagement with the service is vital for accountability and for growing the service.

The CCG should look at getting monthly reports on patients referred to their social prescribing service. Co-ordinators in the hubs should give a monthly report from their database to the CCG so that the CCG can have an up to date understanding of the demographic profile of their patients, time spent and where they are being referred onto.

The registration form developed by the CCG has served its purpose but it fails to capture vital information that would enable the service to better understand the circumstances of patients presenting at surgeries. There is no space to capture employment circumstances or housing status. Both pieces of information will help in the therapeutic process; as well as aiding a better understanding of patient circumstance. In particular social metrics can help to promote a future refinement of service to address health inequalities.

Some social prescribing projects around the UK record information on benefits and income which is highly correlated with wellbeing. The CCG might want to look at alternative ways of capturing deprivation and inequality and seek advice on this.

Other changes to data collection would similarly be useful. Currently a patient's age is collected in age brackets. There is a ceiling effect because 31% (n=683) fall into the 75+ category. This was a change to the initial pilot evaluation which recorded age in discreet and but equal groups. Why not simply ask age and then distribute into any age framework later?

The utilisation of the (short) Warwick Edinburgh Mental Wellbeing Scale poses challenges both in terms of completion rates particularly at follow-up and also in terms of patient comprehension. The co-ordinators and the CCG have done well to deliver 19.4% (n=399) matched baseline and follow up short WEMWBS sample. It is a robust performance compared to a lot of similar wellbeing interventions. The impact of the social prescribing service has now been documented. Continued use of the scale is not necessary. Impact has been reported here. The co-ordinators and the CCG might like to consider a more therapeutic and/or practical tool to assist in the engagement with and impact of the service.

Social prescribers might find the ONS wellbeing scale easier to complete but also more relevant to analysing the patient baseline. With national comparators on many demographics the CCG would gain through having a better understanding of the patient profile they refer for social prescription. They would also understand how wellbeing changes over time in the different districts across the county. It will also enable future evaluators to better estimate deadweight effects in their return on investment analysis.

Other projects have found using an outcomes star as a good way of tracking change across important domains and a useful clinical tool for co-ordinators to monitor patient progress. Discussions around appropriate impact tools could usefully be had with the co-ordinators.

There is a real need for the co-ordinators to share good practice. Going forward time should be made available for co-ordinators to meet up to exchange good practice and knowledge. This could be done as a celebratory event where VCS partners should also be invited to share their offer enabling the broadening of links between the social prescribing service, the CCG and the community.

One of the key things that will enable the service to grow is more thought should be given to co-ordinator's training needs. Of particular importance would be training on things like social security benefits and entitlement. Currently the co-ordinators are spending considerable time researching benefit entitlements for patients referred when an appropriate training course would help them to better understand the intricacies of the benefit system.

It is clear in at least two of the hubs that requests for a social prescribing referral pathway from secondary care have been made. Particularly in terms of preparing patients to return to their homes with appropriate care and support in place. The co-ordinators have been innovative in finding appropriate solutions for primary care referrals; it is part of the organic nature of the service's development. Thus consideration should be given to trialling a secondary care referral route as an option to see what added value the co-ordinators can bring in expediting patient return to home. This report has shown that the co-ordinators have been nimble in finding unique solutions for patients with multiple morbidities. But it should be a trial to understand the challenge, blockages and barriers it may reveal. With bed-blocking costing the NHS around £900m a year it could bring more savings quickly.

Have good access to secondary data is useful for demonstrating impact. It is clear that the read codes for social prescribing do not match actual referrals. The discrepancy should be addressed to ensure the CCG know the total numbers of patients that are referred to the service.

It is important that follow-up to this work happens 12 months post referral. Given the short timescale of impact analysis it is probably certain that there is an underestimation in terms of the impact achieved by the social prescribing co-ordinators.

References

- Addicott, R. and Ham, C. (2014) *Joining up services in the community: GPs leading the way* Kings Fund: London.
- Beavers, N. (2013) Social prescribing and community facing services may be the future for GPs, *Primary Care Today*, Autumn 2013.
- Bertotti, M., Frostick, C., Findlay, G. Harden, A., Netuveli, G., Renton, A., Carnes, D., Sohanpal, R. and Hull, S and Hutt, P (2015) *Shine 2014 final report Social Prescribing: integrating GP and Community Assets for Health*, Health Foundation.
- Brandling, J. and House, W. (2007) *Investigation into the feasibility of a social prescribing service in primary care: a pilot project*. University of Bath and Bath and NE Somerset NHS.
- British Academy (2014) If you could do one thing: Nine local actions to reduce health inequalities http://www.britac.ac.uk/policy/Health_Inequalities.cfm
Accessed 27th February 2014.
- Cawston, P (2011). Social prescribing in very deprived areas, *British Journal of General Practice*, 61: 350.
- Chang, S., Stuckler, D., Yip, P. and Gunnell, D. (2013) Impact of 2008 global economic crisis on suicide: time trend study in 54 countries. *BMJ*; 347:f5239
<http://www.bmj.com/content/347/bmj.f5239.pdf%2Bhtml>
- Citizen's Advice (2016) A very general practice: How much time do GPs spend on issues other than health?
https://www.citizensadvice.org.uk/Global/CitizensAdvice/Public%20services%20publications/CitizenAdvice_AVeryGeneralPractice_May2015.pdf
Accessed 28th September 2016.
- Coulter, A., Roberts, S. and Dixon, A. (2013) *Delivering better services for people with long-term conditions: building the house of care*. Oct 2013. London: The King's Fund.
www.kingsfund.org.uk/publications/delivering-better-services-people-long-term-conditions
Accessed 17th October 2016
- Dayson, C. and Bashir, N. (2015) The social and economic impact of the Rotherham Social Prescribing Pilot: Summary Evaluation Report
<http://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham-summary.pdf>
Accessed 28th September 2016
- Dayson, C., Bashir, N., Bennet, E and Sanderson, E. (2016) *The Rotherham Social Prescribing Service for People with Long-Term Health Conditions: Annual Evaluation Report*,
http://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/rotherham-social-prescribing-annual-eval-report-2016_7.pdf
Accessed 28th September 2016
- Department of Health (2014) *What works to improve wellbeing?*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277593/What_works_to_improve_wellbeing.pdf

Accessed 26th October 2016

Dewa, C.S. and McDaid, D. (2011) Investing in the mental health of the labour force: epidemiological and economic impact of mental disorders in the workplace. In: Schultz, Izabela Z. and Rogers, E. Sally, (eds.) *Work accommodation and retention in mental health*. Springer, New York, USA, pp. 33-52.

Dixon, M. (2016) Preliminary results on the use of a "Facilitated Social Prescription" to improve the health outcomes for those with Type 2 Diabetes and those at risk of Diabetes, Presentation to the Social Prescribing Network conference, Bristol Zoo, 20th October 2016.

Dolton, E. (2013) GPs may be the last port of call in suicide, *BMJ* 2013;347:f6472
doi: <http://dx.doi.org/10.1136/bmj.f6472>.

Edwards, H. and Deighton, G. (2016) *Social Prescribing in Gloucestershire*, Speech to the Social Prescribing Network conference, 20th October 2016, Bristol Zoo.

ERS Research and Consultancy (2013) *Newcastle Social Prescribing Project Final Report*, August 2013

Friedli, L., Jackson, C., Abernethy, H. and Stansfield, J. (2007) *Social prescribing for mental health – a guide to commissioning and delivery*, CSIP North West.

<http://www.mhne.co.uk/files/MHNE126.pdf>

Accessed 17th October 2016.

Gerada, C. (2013) Final keynote speech to the Royal College of General Practitioners Annual conference, 3rd October 2013, Harrogate, London.

<http://www.rcgp.org.uk/annualconference>

Accessed 8th September 2016.

Gloucestershire Clinical Commissioning Group (2014) *Joining Up Your Care: 2014-19*

<http://www.gloucestershireccg.nhs.uk/wp-content/uploads/2014/03/JUYC-5year-Strategy-1.6.pdf>

Accessed 5th October 2016

Gloucestershire Mental Health and Wellbeing Partnership (2015) *Gloucestershire Suicide Prevention Strategy: July 2015 to June 2020*.

<http://www.gloucestershire.gov.uk/CHttpHandler.ashx?id=64216&p=0>

Accessed 11th October 2016

Goodhart, C., Layzell, S., Cook, A. and Graffy J. Family Support in General Practice. *J R Soc Med* 1999;92:525-528.

Gulbrandsen P, Hjortdahl P, and Fugelli P (1997), General practitioners' knowledge of their patients' psychosocial problems: multipractice questionnaire survey. *BMJ*, Apr 5;314 (7086):1014-8.

Hardy, J. (2013) Putting less emphasis on classifying mental disorders and more on collaborative working, *BMJ*, 2013;347:f5873.

Hawkes, N. (2012a) Better training is needed to deal with increasing multi-morbidity, *BMJ* 2012; 344:e3336.

Hawkes, N. (2012b) NHS spending should focus on mental rather than physical health to promote wellbeing, *BMJ* 2012; 345:e7914.

Kimberlee, R. (2013) *Developing a Social Prescribing Approach for Bristol, A report for Bristol Clinical Commissioning Group*, October 2013.

Kimberlee, R. (2015) What is social prescribing? *Advances in Social Sciences Research Journal*, Volume 2, No1.

Kimberlee, R. (2016) What is the value of social prescribing? *Advances in Social Sciences Research Journal*, 3 (3). pp. 29-35. ISSN 2055-0286.

Kings Fund (2016) Quarterly Monitoring Report 20,
<http://qmr.kingsfund.org.uk/2016/20/data/#/bf325726-550b-49cc-9628-f6769439413b>
Accessed 7th October 2016.

Low Commission (2014) *A strategy for access to advice and legal support on social welfare law in England and Wales*, January 2014.
<http://www.lowcommission.org.uk/dyn/1389221772932/Low-Commission-Report-FINAL-VERSION.pdf>
3rd October 2016

McCrone, P., Park, A. and Knapp, M. (2011) Early intervention for psychosis, in Knapp, M., McDaid, D., & Parsonage, M. (Eds.). (2011). *Mental health promotion and mental illness prevention: The economic case*. London: Department of Health.

McDaid, D., King, D., La Park, a. and Parsonage, M. (2011) Promoting wellbeing in the workplace, *Mental health promotion and mental illness prevention: The economic case*. London: Department of Health

National Audit Office (2015) *Stocktake of access to general practice in England*,
<https://www.nao.org.uk/wp-content/uploads/2015/11/Stocktake-of-access-to-general-practice-in-England.pdf>
Accessed 3rd October 2016.

Office National Statistics (2011) *2011 Annual Survey of Hours and Earnings (SOC 2000)*,
http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171778_241497.pdf
Accessed 11th October 2016.

Platt S, McLean J, McCollam A et al (2006) Evaluation of the First Phase of Choose Life: the National Strategy and Action Plan to Prevent Suicide in Scotland. Edinburgh: Scottish Executive.

Polley, M. (2016) *The Social Prescribing Network*, Speech to the Social Prescribing Network conference, 20th October 2016, Bristol Zoo.

Popay, J, Kowarzik, S, Mallinson, S, Mackian, S and Barker, J. (2007) Social problems, primary care and pathways to help and support: addressing health inequalities at the individual level. Part II: lay perspectives. *Journal of Epidemiological Community Health*, 2007 November; 61(11): 972–977.

PSSRU (2016) *Unit Costs of Health & Social Care 2015*
<http://www.pssru.ac.uk/project-pages/unit-costs/2015/index.php>
Accessed 3rd October 2016.

Putz, S., O'Hara, K., Taggart, F. and Stewart-Brown, S. (2012) *Using WEMWBS to measure the impact of your work on mental wellbeing: A practice-based user guide*,
http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/researchers/userguide/wemwbs_practice_based_user_guide_13.5.152.pdf
Accessed 23rd September 2016

Roberts, N. (2015) Analysis: What does social prescribing mean for GPs?, *GP*, 6th July 2015.
<http://www.gponline.com/analysis-does-social-prescribing-mean-gps/article/1354653>
Accessed 4th October 2016.

Roslyn, A. and Israel, M. (2001) *Preliminary report of a research project into the effectiveness of supported work rehabilitation in a therapeutic horticultural environment at Cherry Tree nursery*,

Scottish Development Centre for Mental Health (2013) *Developing Social Prescribing and Community Referrals for Mental Health in Scotland*, Edinburgh: The Stationery Office.

South, J., Higgins, T., Woodall, J. and White, S. (2008). Can social prescribing provide the missing link? *Primary Health Care Research and Development*, 9, pp 310-318.
doi:10.1017/S146342360800087X

Stewart-Brown, S and Janmohamed, K. (2008) *Warwick-Edinburgh Mental Well-being Scale (WEMWBS) User Guide, Version 1*.
<http://www.mentalhealthpromotion.net/resources/user-guide.pdf>
Accessed 22nd September 2016

Thornett A. (2000) The economic consequences of treating psychosocial disorders, *BMJ*, 320:7232.
www.bmj.com/cgi/letters/320/7232/419
Accessed 6th October 2016

Timebank (2016) Key facts about volunteering.
<http://timebank.org.uk/key-facts>
Accessed 11th October 2016

www.gov.uk (2016) National schedule of reference costs: the main schedule
<https://www.gov.uk/government/publications/nhs-reference-costs-2014-to-2015>
Accessed 6th October 2016

Appendix 1: Difference between patient numbers recorded on the database and those that are read coded.

Comment [I1]: Did all the other surgeries have the same number of read codes as that on the co-ordinators database?

| Reference Number | Surgery | District | Number of patients read coded for social prescribing | Number of patients on the co-ordinator's database for social prescribing | Difference |
|------------------|----------------------------------|--------------------------|--|--|------------|
| L84038 | Bourton and Northleach Surgeries | North Cotswold | 11 | 21 | +10 |
| L84014 | Hucclecote | Gloucester City | 18 | 27 | +9 |
| L84044 | Marybrook Medical Centre | Stroud and Berkeley Vale | 20 | 33 | +13 |
| L84009 | Hadwen Medical Practice | Gloucester City | 18 | 59 | +41 |
| L84021 | Yorkley Health Centre Forest | Forest of Dean | 39 | 38 | -1 |
| L84055 | Lechlade Medical Centre | South Cotswold | 89 | 71 | -18 |
| L84040 | Leckhampton Surgery | Cheltenham | 20 | 42 | +22 |
| L84041 | Overton Park Surgery | Cheltenham | 17 | 37 | +20 |
| L84054 | Watledge Surgery | Tewkesbury | 37 | 52 | +15 |

Appendix 2: Organizations referred to by the hub co-ordinators

2gether NHS Trust
3 Bridges Community Partnership
AA
Adult social care/help desk
Age UK Social Care Advice
Mature Movers/gentle exercise
Benefits advice
Age UK Hospital transport
Age UK General
Age UK Respite
Age UK Friends for you/befriending
Age UK Mature Movers/gentle exercise
Age UK Memory Café
Age UK choir
AIC
Alzheimers Society
Alzheimers Society: Singing for the
brain
Arthritis Care
Artlift
Art Group
Art Space
Autistic Society
Badgerfield
Barnwood Trust
Barton Court
Beacon Depression Group
Befriending Scheme
Big Deep
Big Knit
Bingo
Bishop Cleve Childrens Centre
Book Club
Books on prescription
Bookwork community transport
Bramble Memory Café
Bromford Living
CAB
CAP
Carers Gloucestershire
Care Line
Carers group
Care (Private)/Care agencies
Care and Repair
CCP

CFS
Changing Creations
Chantry house
Charlies
Cheltenham Housing Advice (CHAC)
Cheltenham Borough Homes
Church Groups/choirs
GHC
Children in Need
Chipping Practice
Christians Against Poverty
Cleaners
Community Health Trainers
Coffee and Chat/coffee morning
Community connections
Community Dementia Nurse
Community Learning Disability Team
Community Transport
Community Connexions
Connect befriending
Continence service
Council Benefit team
Councillor
Craft classes
Crossroads Care
Cruse Bereavement
Daffidil Services
Dementia UK
Dental Services
Dial a Ride
DLA
Drop in
Dursley Choir
DWP
Ebley coach trips
Elevenses activity inc Film
Engage Day Centre
Exercise Class
Exercise Referral
Expert patient Programme
Extra Care Charitable Trust
Fair Shares
Falls Clinic
Family Information Service
Fibromyalgia Babies Support
Organisation

Fibromyalgia Association/UK
Find a class
Fire Service
FOD Housing Options scheme
Food bank
Foxes Bridge Day Care Centre
Full of Life Group
Gardening Club
GCHQ Employee Fund
GDASS
GL1
GL3
GL11
Gloucs Benefit Services
Gloucs Children and Famil Services
Gloucs City Homes
Gloucs Counselling Services
Gloucs Disability Fund
Gloucs Homeseeker
Gloucs Housing Team
Gloucs Law Centre
Gloucs Medical Eye centre
Gloucs Parking Services
Gloucs Rape and Sexual Abuse Centre
GL Communities
GP
GP counselling service
GRCC
GRCC - befriending
Greensquare
Gym
Headway
Healthy Lifestyles
Highways Agency
History Club/Socities
Home swappers/seekers
Horsfall House Day Care centre
Housing Options drop-in
Independence Trust
Insight Gloucestershire
Invisible Illness
Kaliedoscope Childrens Centre
Keepsafe
Kimbrose House
Knit and natter
LAC

Law Centre
Lets Talk (IAPT)
Lifeline
Link line
listening Post
Local community groups
Lunch Club
Manor House
Marah Trust
Marina Court
Mears
Mens Group
Mens Shed
Minchinhampton Hospital Care service
Money Advice Service
Movement to Music
Nailsworth Memory Club
Netmums
One You
Open Door
Open House
Optimist Club
Orchard House
OT
Outdoor Gym
P3
Parish Clerk
Parkinson Group
Patient Expert Programme
Penna Day Care Centre
Physical Activity Groups
Physical Activity Voucher
Physiotherapy (NHS)
PIP Helpline
Playgroups
Podiatry
Police
Positive Caring Programme
Quit Shop
Prepare Lung Programme
Remembering Sport at Kingsholm
Reconnect
Relate
Reablement Service
Relaxation Course
Respite Care

Riverside Housing
Roots Café
Royal British Legion Women's section
Safe at Home (Mears Group)
SAFRA
SAGE (Safer driving for older people)
Salsa
Salvation Army lunch group
Samaritans
Severn Vale Housing
Sheltered Accommodation
Sherborne Singalong
Shopability
Short mat bowling
Silver Line
Slimming World
Social Services
Social Services Notts
South Gloucestershire Care
Springfield Court
Step Change
Stonehouse Community Centre
St Oswald's Retirement Village
Stress management course
Stroke Support group
St Roses
Stroud District Council
Stroud Old People's Community Hub
Street Link
Taxi
TBC
Telecare
Third Sector Services
Turning Point
Tewkesbury BC Housing
Trinity
U3A
Uplands Day Centre
Vale Vision
Vicars/Priests various
Village Agents
Visual Impairment Group
Walks Health
Walking Group
Walking football
Warm and Well

Water workout
Wheel chair service
Where the heart is
World Jungle Dursley
Yercombe Lodge
Yoga group
Young at Heart

Appendix 3: Details of Gloucestershire VCS Alliance survey

Background

The Gloucestershire VCS Alliance ran a short survey from June-August 2016 to try and understand the impact of social prescribing on the VCS. The results have been shared with the researcher at the University of the West of England who has been evaluating social prescribing in Gloucestershire for the Clinical Commissioning Group.

Response rate

- 57 responses (56 on the survey, 1 by email)
- 49 different organisations took part; several replied more than once
- 39 VCS organisations, 2 District Councils, 3 from Learn Direct and Adult Education, 4 housing-related organisations and 1 home care service for the elderly.
- 29 replies came from those holding the Social Prescribing KiteMark

Social prescribing referrals

- 46 organisations had expressed interest in receiving referrals, 3 had not.
- 31 said they had received referrals, 18 had not.
- All organisations except for 1 are still interested in receiving referrals. The one who did not offers specialist support to a niche group.

Appendix 4: Footnotes

ⁱ Announced as part of the 'new deal' for GPs announced in June 2015 was a commitment to make 'social prescribing' a 'normal part' of the job. Roberts (2015) Analysis: What does social prescribing mean for GPs? *GP*, 6th July 2015

ⁱⁱ Source: Gloucestershire County Council (Date unknown) *Ethnicity in Gloucestershire*, http://www.gloucestershire.gov.uk/media/adobe_acrobat/c/p/Ethnicity.pdf
Accessed 3rd October 2016.

ⁱⁱⁱ Source: Gloucestershire County Council (Date unknown) *Gloucestershire County Council - Population Analysis for the Protected Characteristics*, <http://www.gloucestershire.gov.uk/CHttpHandler.ashx?id=50417&p=0>
Accessed 3rd October 2016