

# Evaluation of the East Merton Social Prescribing Pilot

July 2018

Report by Healthy Dialogues Ltd.

Pilot delivered by:

  
Merton  
Clinical Commissioning Group



# East Merton Social Prescribing Pilot Highlights

 Evaluation by Healthy Dialogues

 **206**  
patients seen



**77%**  
patients with  
better wellbeing



**33%**  
fewer GP  
appointments



**50%**  
fewer A&E visits

## What are people saying?

*It's really valuable to have that option within the surgery for the patients.*

**GP**

*I am very proud that we're up and running so successfully!*

**Commissioner**

*Every time I have the opportunity... I tell them to make sure their GP has Social Prescribing!*

**Patient**

## What next for Year Two?



**7** additional  
GP practices



**2** additional  
Social Prescribing  
Coordinators



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# Executive Summary

## The East Merton Social Prescribing Pilot

Merton CCG and Merton Council set out to test a model of Social Prescribing that would connect medical care with local voluntary and community resources. Its aims were to improve patient health and wellbeing and reduce pressures on local GP and A&E services. The Merton Voluntary Service Council Social Prescribing Coordinator (SPC) delivered the pilot through two GP Practices, Wideway Medical Centre and Tamworth House Medical Centre.

This report is a summative evaluation of the East Merton Social Prescribing programme's first year and a review of its pathway.

## Evaluation Findings

Overall the programme was a marked success. The pilot saw a significant increase in health and wellbeing as well as significant decreases in both GP appointments and A&E attendances in patients referred to the service.

Conversations with patients and stakeholders alike showed that the pilot was highly valued and seen as a necessary service that filled a gap in local needs. Patients credited the programme to improving their wellbeing, bringing them back to recovery and linking them to support close to their doorsteps that they did not otherwise know about.

GPs valued that they are able to provide additional support for patients with wider health and wellbeing needs from within the practice and as a result GPs noted that some patients required fewer appointments with them. Those from the voluntary and community sector services spoke positively about how the programme fills a need in Merton of providing holistic support for patients.



## Conclusion

The pilot demonstrated a model of Social Prescribing that fits well within the East Merton context. The success of the programme is testament to the commitment and expertise of the Implementation Group, the SPC and champion GPs, the flexibility and simplicity of the service, strong engagement and the programme's visibility within the practices.

The key factors for success are outlined and recommendations for up-scaling the programme are provided in this report.

## Next steps

From April 2018 two additional SPCs have been recruited and the programme has begun to be rolled out across a total of 9 GP practices in east Merton.



# Introduction

Working in partnership Merton CCG, Merton Council and Merton Voluntary Service Council set out to pilot a model of Social Prescribing that would connect clinical services with local voluntary and community services. Its aims were to improve patient health and wellbeing and reduce pressures on local GP and A&E services.

This report is an evaluation of the first year of the pilot. First it will provide an overview of Social Prescribing, the pilot and how it was evaluated. It will then present the results of the evaluation in terms of who was engaged by the service and their outcomes. Finally, the report will highlight some of the key factors that contributed to the success of the pilot and present a qualitative review of the pilot's Social Prescribing pathway and recommendations for upscaling the programme.

## A Case for Change

The case for community-based models for health and wellbeing promotion such as Social Prescribing is strong. The Five Year Forward View (NHS England, 2014) emphasises that NHS systems are increasingly under pressure as our population lives longer with more complex health issues. Demands on GP services are also increasing at a time when funding and workforce resources are reducing (Baird et al, 2016).

According to the Department of Health (2015), people with long term conditions are the most frequent users of health care services, accounting for 50% of all GP appointments and 70% of all inpatient bed days. Citizen's Advice (2016) estimates that 20% of GP appointments are for patients who need non-medical help or support.

The sustainability of the NHS and its systems is reliant on a radical upgrade of prevention and public health work. The Five Year Forward View highlights several ways in which this can be achieved, including:



- Empowering patients by improving their access to the right information
- Supporting patients to manage their own health
- Building stronger partnerships with the voluntary and community sectors (NHS England 2014).

Additionally, the Care Act of 2014 puts duties and responsibilities on local authorities to promote wellbeing and ensure people have access to the information and advice they need to make decisions about their care and support. Existing resources from within the local community can ensure that people have access to a range of high quality, appropriate services to choose from in the area they live in.

Southwest London Sustainability and Transformation plan (SWLCCG, 2016) goes one step further with ambitions to deliver more care in the community and implement robust multidisciplinary community work supported by Social Prescribing.

### What is Social Prescribing?

Social Prescribing provides GPs with a non-medical referral option that can operate alongside existing clinical treatments to improve health and well-being and address the social determinants of health-the conditions in which people are born, grow, live, work and age (WHO, 2018).

The National Social Prescribing Network describe Social Prescribing as-

“A means of enabling GP’s and other frontline healthcare professionals to refer patients to a link worker - to provide them with a face to face conversation during which they can learn about the possibilities and design their own personalised solutions, i.e. ‘co-produce’ their ‘social prescription’- so that people with social, emotional or practical needs are empowered to find solutions which will improve their health and wellbeing, often using services provided by the voluntary, community and social enterprise sector”

- Social Prescribing Network Conference Report (2016)



The social, emotional and practical needs can have a significant impact on improving and maintaining health and wellbeing and help with these social determinants are typically available within local communities (Parsfield et al, 2015).

## **What is the evidence for Social Prescribing?**

Evaluation of the effects of Social Prescribing is growing. Most recent studies are showing improvements in patient engagement and wellbeing and a reduction in health care usage following a Social Prescribing intervention. For example, a wellbeing Social Prescribing programme based in Rotherham found that patients showed significant improvement in wellbeing, depression and anxiety and a potential reduction in GP appointments three months following a Social Prescribing intervention (Kimberlee et al, 2013).

A Dundee programme reported that patients, including those who can be difficult to engage and support, found the scheme appropriate to their needs, helpful and accessible with a range of activities and support. Additionally, pre- and post- intervention data shows significant improvements in wellbeing and functional ability (Friedli, 2012).

A six-month pilot scheme in Tower Hamlets showed that patients got involved in a range of activities as a result of the Social Prescribing intervention including volunteering, taking a course, gaining a qualification, stopping smoking, starting a hobby and gaining control over their financial situation. 35% of patients took up one or two referred services and 75% stated that their issue was partially or fully resolved and that they were satisfied following the intervention (Hogarth et al, 2013).

A systematic review of the evidence of the impact of Social Prescribing on healthcare demand and cost implications showed average reduction in GP appointments by 28% and A&E attendance by 24% following a referral to Social Prescribing. It also showed a statistically significant reduction in referrals to hospital (Polly et al, 2017).





## **Cost-effectiveness of Social Prescribing**

The long-term cost benefits of Social Prescribing are not yet clear. However, short-term cost-effectiveness has been estimated for the Doncaster Social Prescribing programme. It used cost-utility analysis to evaluate cost-benefits of patient's improvements in health-related quality of life. The programme estimated that every £1 spent on the service produced more than £10 of benefits in terms of better health (Sheffield Hallam University, 2016).

## **East Merton Model of Health and Wellbeing**

In 2014, a population health needs assessment found that people die younger in East Merton when compared with West Merton, particularly from cardiovascular disease and cancer, with larger differences seen in younger people. The assessment looked at existing community-based models to transform care for long-term conditions and highlighted the opportunity to make imaginative and effective use of community-based approaches (Dent, 2014).

In response to this, Merton CCG are developing a new model of care to meet the health and social care needs for the people of East Merton. This East Merton Health and Wellbeing programme is a blue print for transformation across the borough that works beyond service delivery to build and develop a social model of health that looks at the wellbeing of individuals. Additionally, it looks to address the gap between shrinking NHS resources and increasing demand on services.

One of the pieces of work within this model was to pilot a Social Prescribing programme that utilises a collaborative pathway designed to free up GP professional time while connecting people to their community and community resources.



# The Pilot: An Overview

The East Merton Social Prescribing pilot programme was funded by Merton Partnership, Merton CCG and Merton Council Public Health to run for just over one year from January 2017. The pilot began to see patients from the 1<sup>st</sup> of February 2017.

The pilot was guided by an implementation group of stakeholders from the voluntary and community sector, CCG, Local Authority and General Practice. The pilot programme was delivered by Merton Voluntary Service Council, who employed a Social Prescribing Coordinator (SPC).

Two GP practices in East Merton; Tamworth House Medical Centre and Wide Way Medical Centre, were selected to host the pilot programme as they were ideally located within the east of Merton. The SPC worked at both practices for two days a week each and was visible as a fully integrated member of the practice teams.

The pilot aimed to promote self-help, social engagement and resilience to its population in East Merton by:

- Providing a model of service delivery that connects medical care with local resources; and
- Establishing a collaborative pathway between the primary care and voluntary and community services.

The overarching aims of the pilot were to:

- Improve the health and wellbeing of patients by providing access to non-medical support.
- Reduce general practice clinical workload while increasing skill-mix within primary care.
- Reduce avoidable costs including A&E attendances and hospital admissions.



Typically, GPs would refer patients to the programme if they presented with the following criteria:

- Frequent attendance to GP services
- Social isolation
- Mild/moderate mental health issues
- Social needs
- Recent hospital admissions

The SPC would book a one-hour initial consultation appointment and offer the patient a needs assessment that is structured around the Wellbeing STAR (Figure 5, page 18). The SPC and patient would then agree a plan of action based on that needs assessment that may include making a referral or signposting to activities provided by the local voluntary and community sector, basic assistance with form filling, benefits eligibility checks or engagement with mental health services. Where needed the SPC would offer a follow-up appointment at three-monthly intervals.

From April 2018 the programme has begun to be rolled out across all nine practices in East Merton, with two additional SPCs.



# Evaluation: What We Did

This evaluation employed a mixed-methods approach to review how effective the Social Prescribing pilot is in improving the health and wellbeing of patients and reducing GP practice clinical workload. The evaluation looked at the processes involved in the development of the Social Prescribing pilot, its impact and potential by exploring all the different facets within the Social Prescribing Pilot Logic Model (Figure 1).

Patient data was collected from the GP database EMIS and the Outcomes STAR- a health and wellbeing questionnaire that patients completed at each visit (figure 5, page 18) . The researchers spoke with a range of people involved in the programme about their experiences of the pilot and views on the following: pathway, access to engagement, communication and data transfer and scalability.

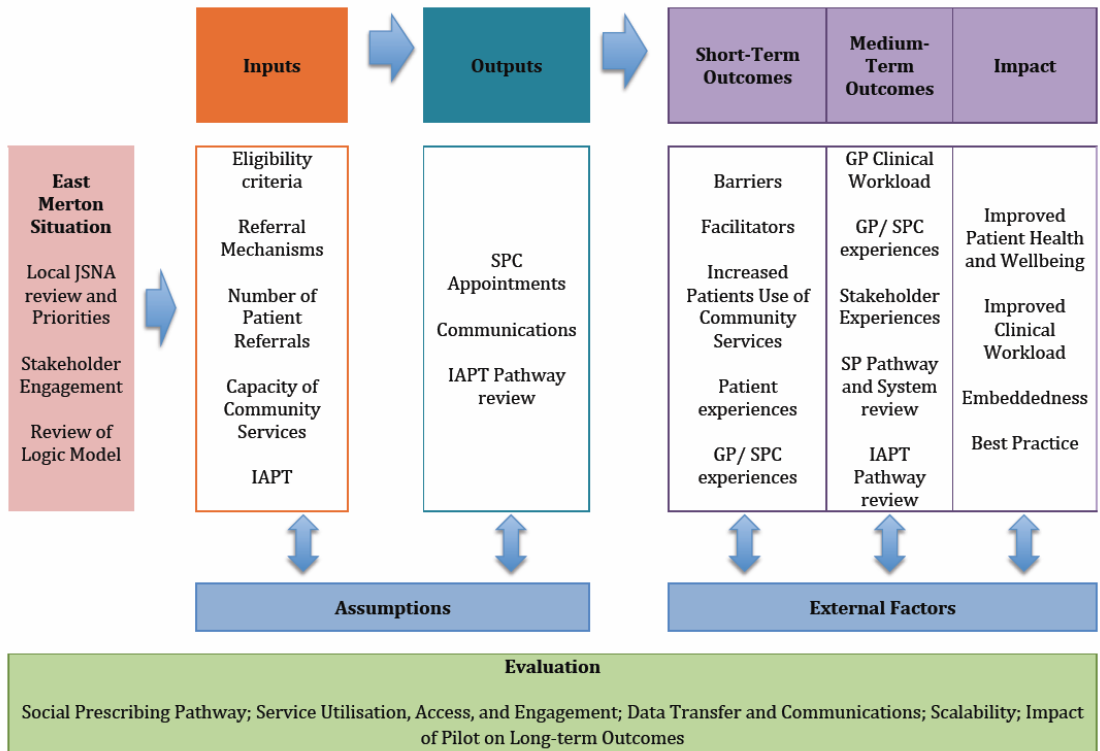
The following people participated in interviews or focus groups for this evaluation:

- GP practice staff
- Patients
- Social Prescribing Coordinator
- Implementation Group members and stakeholders
- Voluntary and community service providers

Additionally, the evaluators observed the Social Prescribing interventions at the beginning of the pilot and towards the end of the pilot to feedback on the behaviour change conversations. Each of the qualitative analyses are summarised in the appendices.



**Figure 1: East Merton Social Prescribing Pilot Logic Model.**



The results in this report are presented as an analysis of patient demographics, reasons for referral and outcomes. Additionally, the interviews and focus groups have provided insight as to the key factors of success, how the pilot pathway works and recommendations for upscaling in 2018.



# Results

The researchers undertook an analysis of the patients that have been referred to the Social Prescribing programme in the first year of the pilot (1<sup>st</sup> February 2017 to 31<sup>st</sup> January 2018). The analysis that follows provides an overview of those referred, their wellbeing, GP appointments and A&E attendances.

## Patient demographics

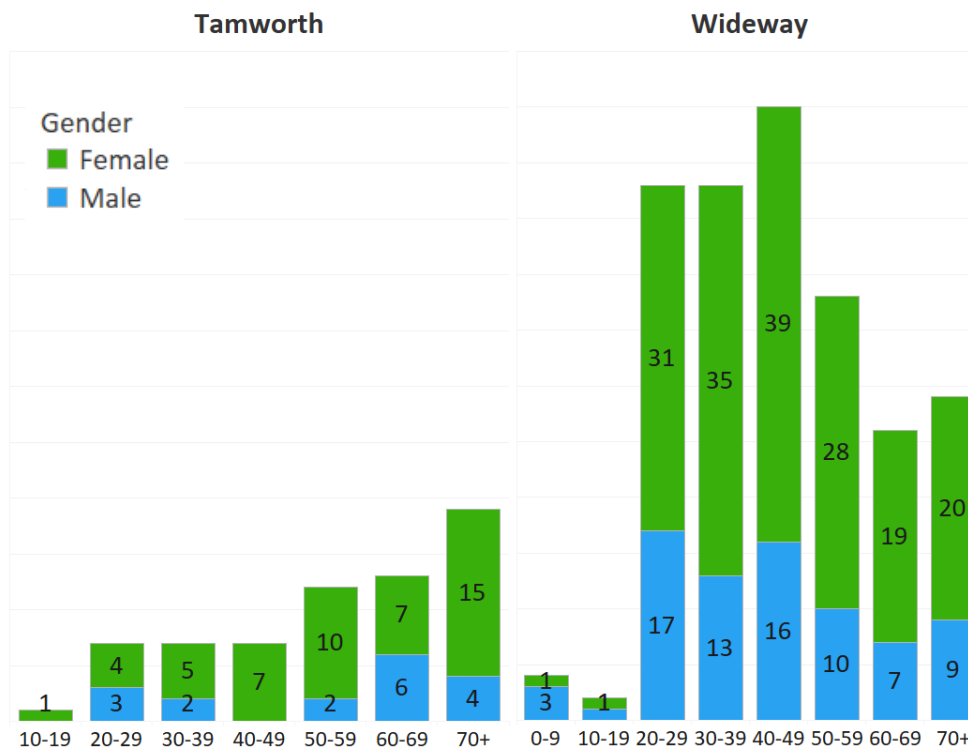
In the 12 month pilot period between the 1<sup>st</sup> of February 2017 to 31<sup>st</sup> January 2018 316 patients were referred to the East Merton Social Prescribing programme, 250 of whom were from the Wide Way Medical Centre and 66 from Tamworth House Medical Centre (see figure 2). What follows is a breakdown of these referrals by age, gender and ethnicity.

## Age and gender

There is generally good engagement with all age groups for the Social Prescribing programme. The largest proportion of patients (15%) are between 40 and 49 years of age and more women (71%) have been referred to the programme than men (29%).



Figure 2. Number of Social Prescribing patients by age-group, gender and practice

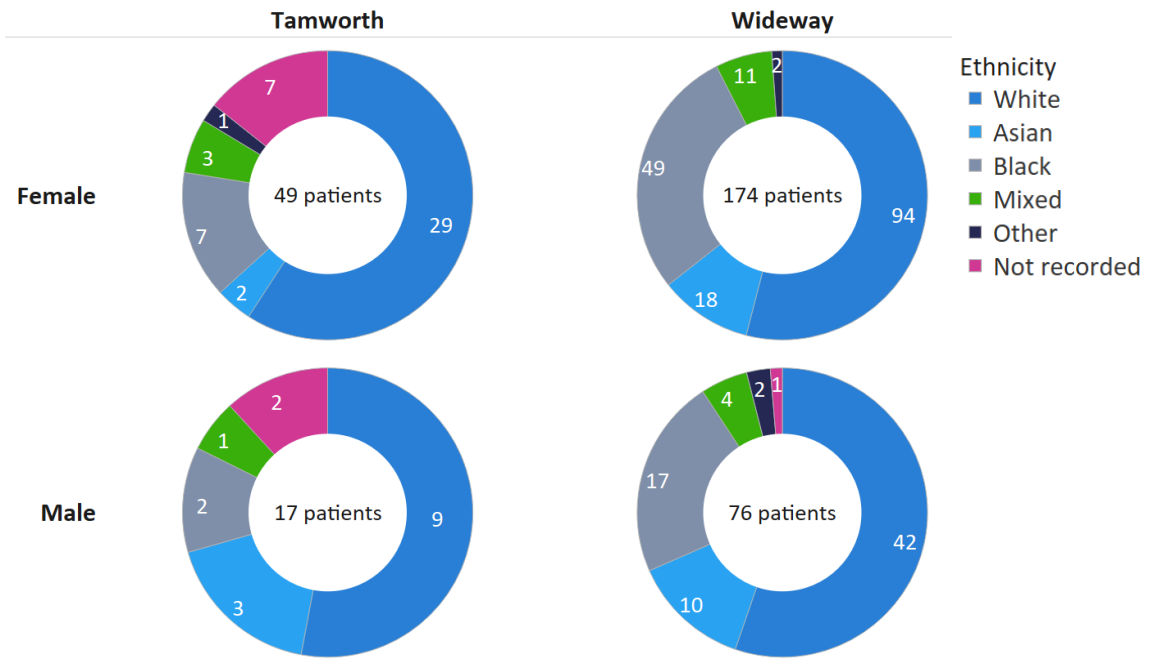


### Ethnicity

Over half (55%) of patients referred were white, followed by black (24%) and Asian (10%). The ethnicity reach of the programme generally reflects the ethnic make-up of the local area (Dent, 2014).



**Figure 3. Number of Social Prescribing patients by ethnicity, gender and practice**



### Reasons for referral

The researchers looked at the reasons for referral to review which patients were being referred to the service and whether the agreed eligibility criteria was appropriate for the needs of the patients and the programme.

Our analysis of the reason for referral to the Social Prescribing programme was based on the SPC data rather than GP practice data. This means that the reasons as determined by the SPC may differ from the GP's original reasons. The researchers adapted this approach because the SPC data was more complete.

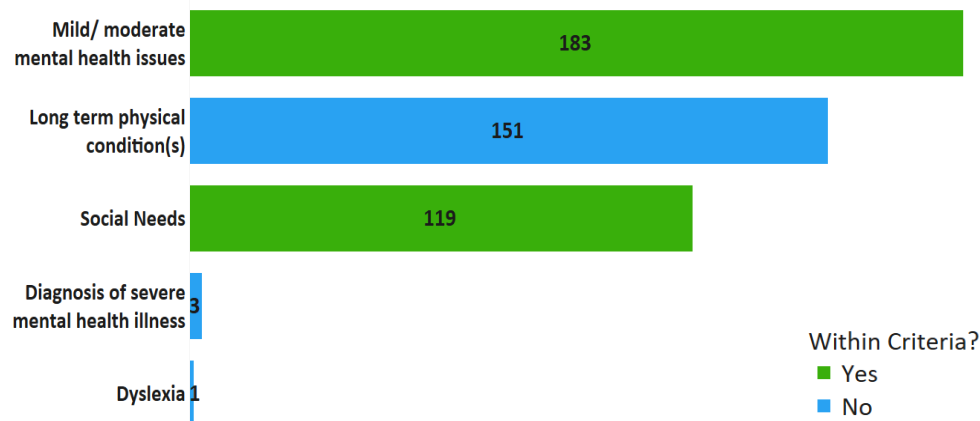
The majority of the patients referred to the Social Prescribing programme were referred for more than one reason. The most common reason cited was mild/moderate mental health issues (see figure 4). The next most common reasons cited was for long-term physical condition(s) which was not within the agreed referral criteria for the intervention.





These results are indicative of which patients are eligible for the programme and future evaluations can review the eligibility criteria more clearly once all GPs are routinely following an agreed referral process.

**Figure 4. Reasons for referral**



## Outcomes

### Wellbeing

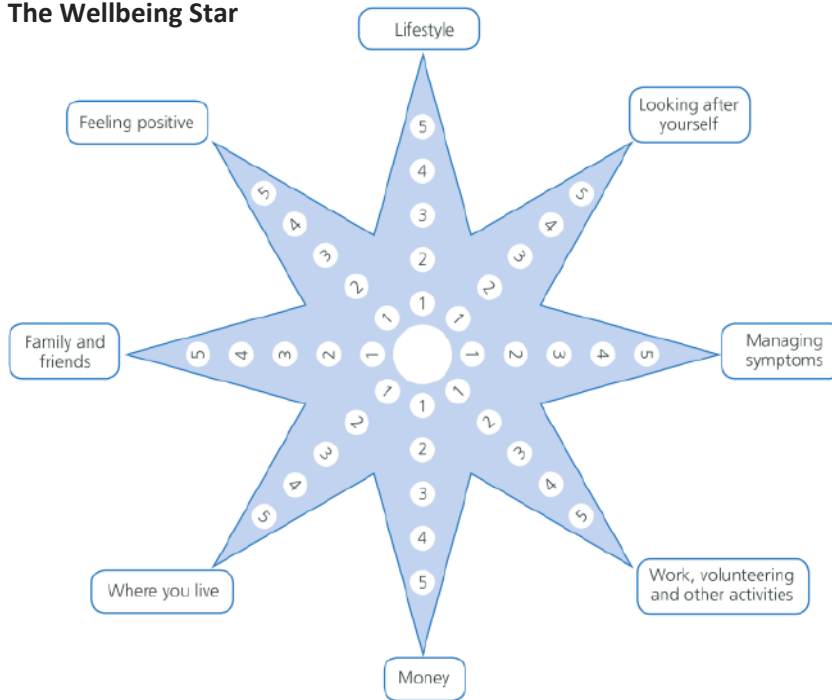
At each Social Prescribing appointment, the SPC asks the patients to fill in the Wellbeing Star. There are some occasions when the patient does not complete the questionnaire, this is typically due to language barriers, learning disability or emotional distress at the time of the appointment.

The Wellbeing Star is a reliable and valid tool (Mackeith et al, 2010 and Mackeith, 2011) that looks at eight health and well-being sub-categories that patients rate on a scale ranging from 1 (not thinking about it) to 5 (as good as it can be).

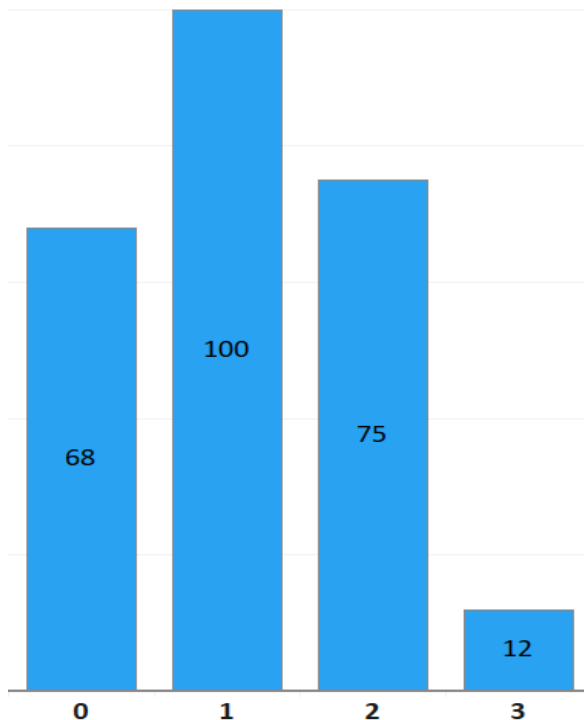
The results are displayed in a star diagram that the patients can see and compare with previous results at each appointment (Mackeith, 2014). The Star and its sub-categories are shown in Figure 5.



**Figure 5: The Wellbeing Star**



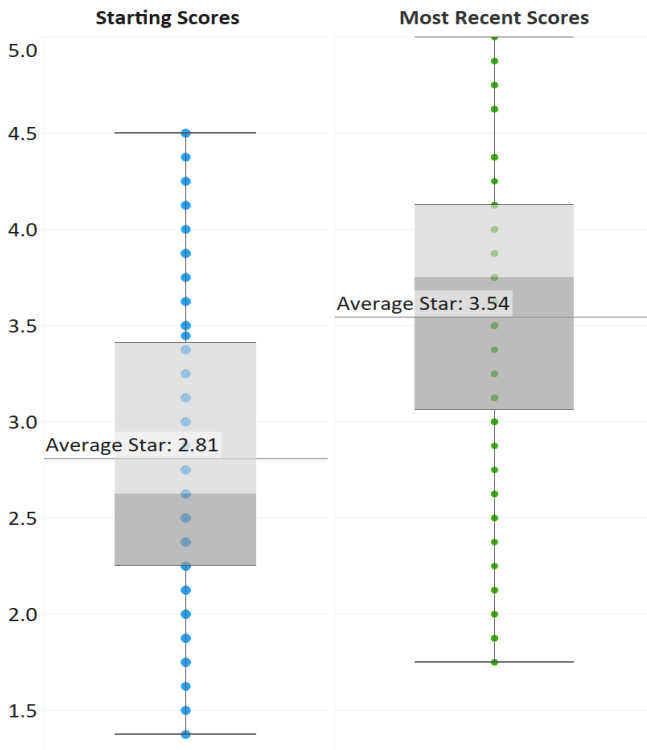
**Figure 6: The Number of Star readings per patient.**



During the pilot the SPC saw 206 patients, 187 of whom had a Star assessment. 100 patients had only had one assessment by the end of the pilot period. Seventy-five patients completed two Star assessments and 12 completed three.



**Figure 7. Distribution of overall Wellbeing scores during first and latest SPC session**



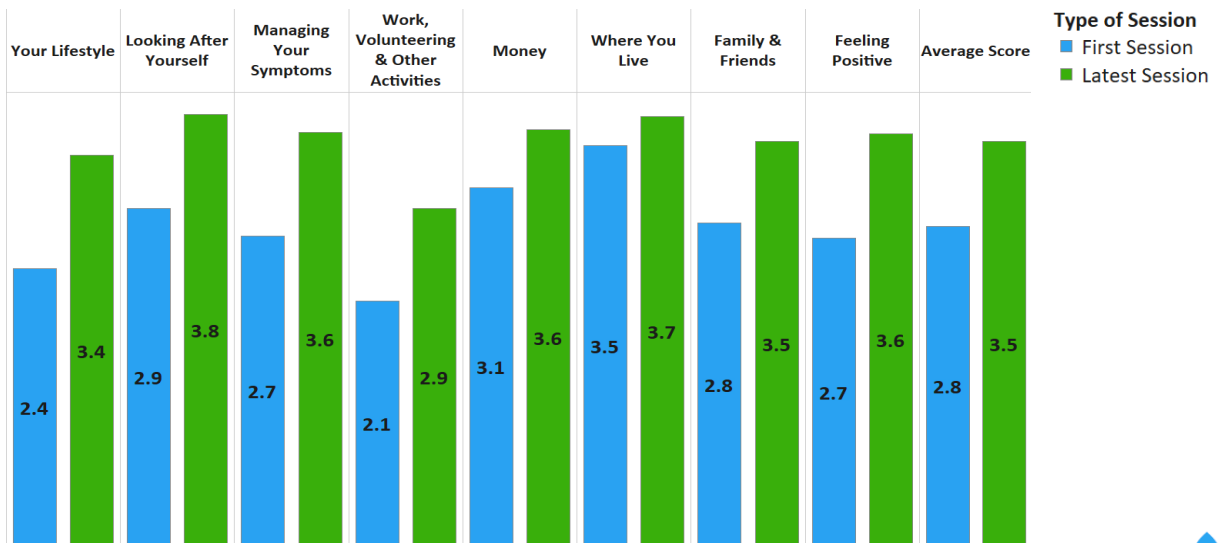
Analysis shows that altogether, patients who attended Social Prescribing experienced an improvement in their overall wellbeing score (see figure 7).

The patient's average score at the first appointment was 2.8 (SD = 0.80). This increased to 3.5 (SD = 0.83) by their last appointment.

Pair samples t-test analysis shows that this is a **significant** increase ( $t(86)=1.99$ ;  $p=0.00$ ).

All eight domains of the STAR measure improved at three month follow up, with the greatest in the 'lifestyle' domain and the least in the 'where you live' domain (Figure 8). A statistically significant increase was found across each domain.

**Figure 8. Wellbeing scores during first and latest SPC session**



## GP appointments

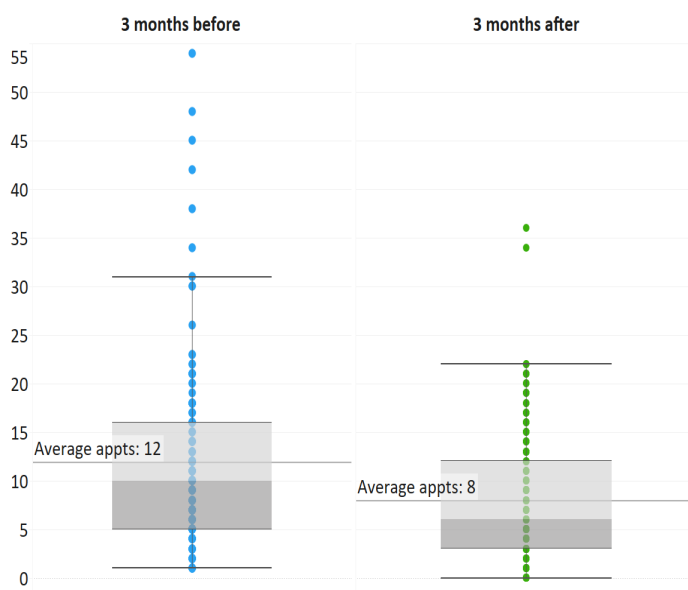
The number of GP appointments a patient attends before and after engaging with the programme can indicate whether there is any impact on clinical outcomes.

To improve the accuracy of the assessment, the day the patient was first seen by the SPC and a Star assessment carried out was used as the baseline date. The researchers looked at the number of GP appointments at three and six months pre- and post Social Prescribing intervention.

### Three month change in GP appointments

At the point of data collection, there were 138 patients seen by the SPC at least 3 months before the data collection point. This allowed the study to examine their GP appointment rates three months before and three after first seeing the SPC. In all, they took up 1,641 appointments before the Social Prescribing intervention and 1,098 afterwards, representing a reduction of 543 appointments (33%) in the pilot year.

**Figure 9: Distribution of GP appointments, three months pre- and post Social Prescribing**



The average number of appointments per patient reduced from 11.9 (SD = 9.48) to 8 (SD = 6.85).

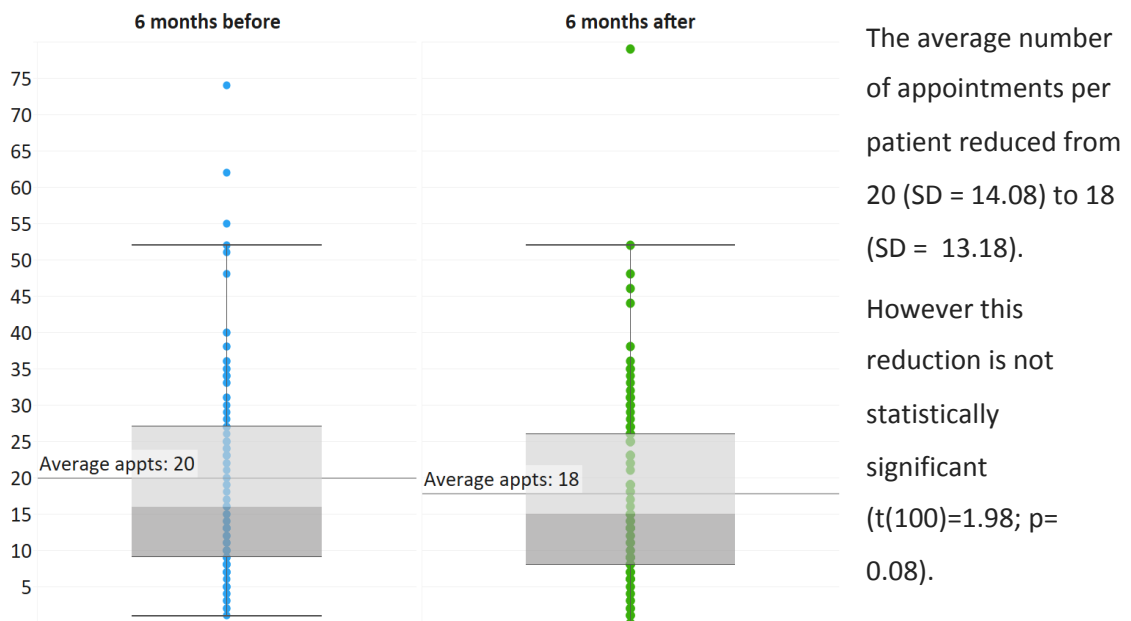
Paired samples t-test analysis shows that this is a statistically significant reduction in the number of appointments ( $t(137)=1.98$ ;  $p= 0.00$  ).



## Six month change in GP appointments

At the point of data collection, there were 101 patients seen by the SPC for whom there was six months pre-and post GP appointment figures. Altogether they took up 2,013 appointments before the Social Prescribing intervention and 1,790 afterwards, this is a reduction of 233 appointments.

**Figure 10: Distribution of GP appointments, six months pre- and post Social Prescribing**



## A&E attendances

The pilot also examined the effect of Social Prescribing on A&E attendances to ascertain how it may impact on the wider health care system.

## Three month change in A&E attendances

During the pilot, 60 patients attended A&E 39 times in the three months before the SP intervention and 20 times afterwards (a reduction of 19 overall). The average number

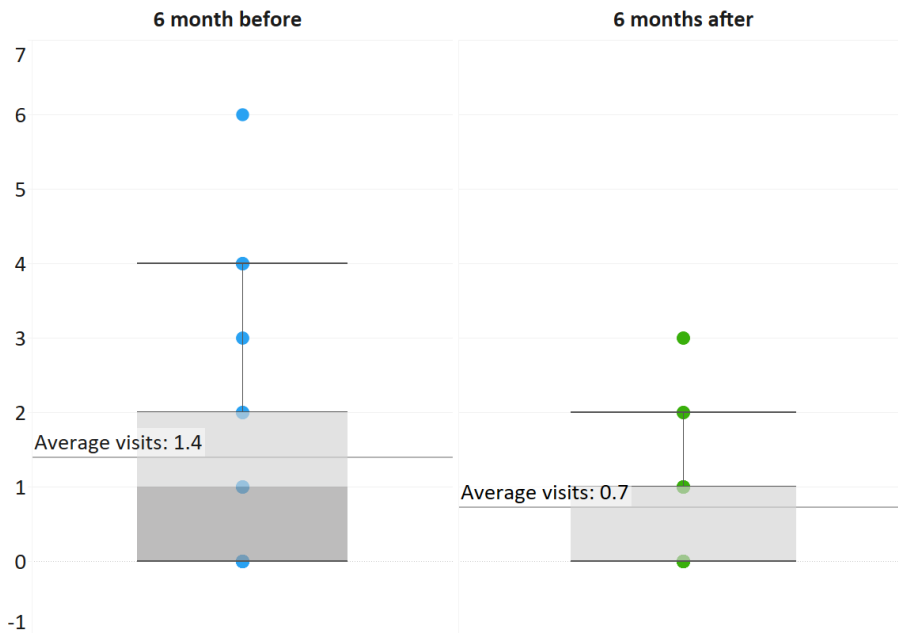


of appointments per patient dropped from 0.65 (SD = 1.31) to 0.33 (SD = 0.73). This is not a statistically significant decrease ( $t(59)=2.00$ ;  $p= 0.11$ ).

## Six month change in A&E attendances

The pilot saw 43 patients who attended A&E in the six months before the Social Prescribing intervention. In total they visited A&E 60 times before and 31 times afterwards, leading to a reduction of 29 visits overall.

**Figure 11: Distribution of A&E attendances, six months pre- and post Social Prescribing**



The average number of appointments per patient dropped from 1.4 (SD = 1.65) to 0.7 (SD = 0.93) (see Figure 11). This is a statistically **significant** decrease ( $t(59)=2.01$ ;  $p= 0.04$ ).



# Key Factors for Success

Overall, those interviewed spoke very positively about the programme. They felt that the pilot had been set up successfully, is running smoothly and providing strong health and wellbeing outcomes for patients by connecting them to resources available to them in their own community.

The key factors for success have been drawn from the interviews and focus groups and are outlined below.

## Mobilisation

- **Strong engagement within the Implementation Group** ensured that all key stakeholders had agreed on what the Social Prescribing model looked like and what the referral criteria was.
- By **using the existing systems within the practices** the Social Prescribing programme and SPC was easily embedded within the GP Practices.
- Where there was **strong engagement and visibility of the SPC within the practice**, more referrals to the programme were seen.
- By ensuring the **early set up of IT systems** the SPC had access to patient's case management systems and could book patient appointments straightaway and understand the circumstances around why they were referred.
- The **GP Champion** was key in translating the 'blue-sky' ideas in the pilot strategy into practical solutions for the project plan and pathway. He had also been key to raising the profile of the programme and championing the programme in his own practice.



## Social Prescribing appointments

- **Patients are seen within two weeks of referral** which enabled them to address their issues or concerns quickly through voluntary and community channels.
- The **Wellbeing Tool** survey added structure to the Social Prescribing appointments. This helped patients to think about their situation more thoroughly and allowed the evaluators to see the impact of Social Prescribing on the patient's health and wellbeing over time.
- The **relaxed personal approach of the SPC** helped build good rapport and a trusting relationship with the patients. Additionally the SPCs ability to address some issues 'there and then' helped patients to take that first step towards supporting their recovery which was valued highly by patients.
- The **SPC's strong links to the community** and breadth of knowledge of support available enabled patients to access the available appropriate support right away.





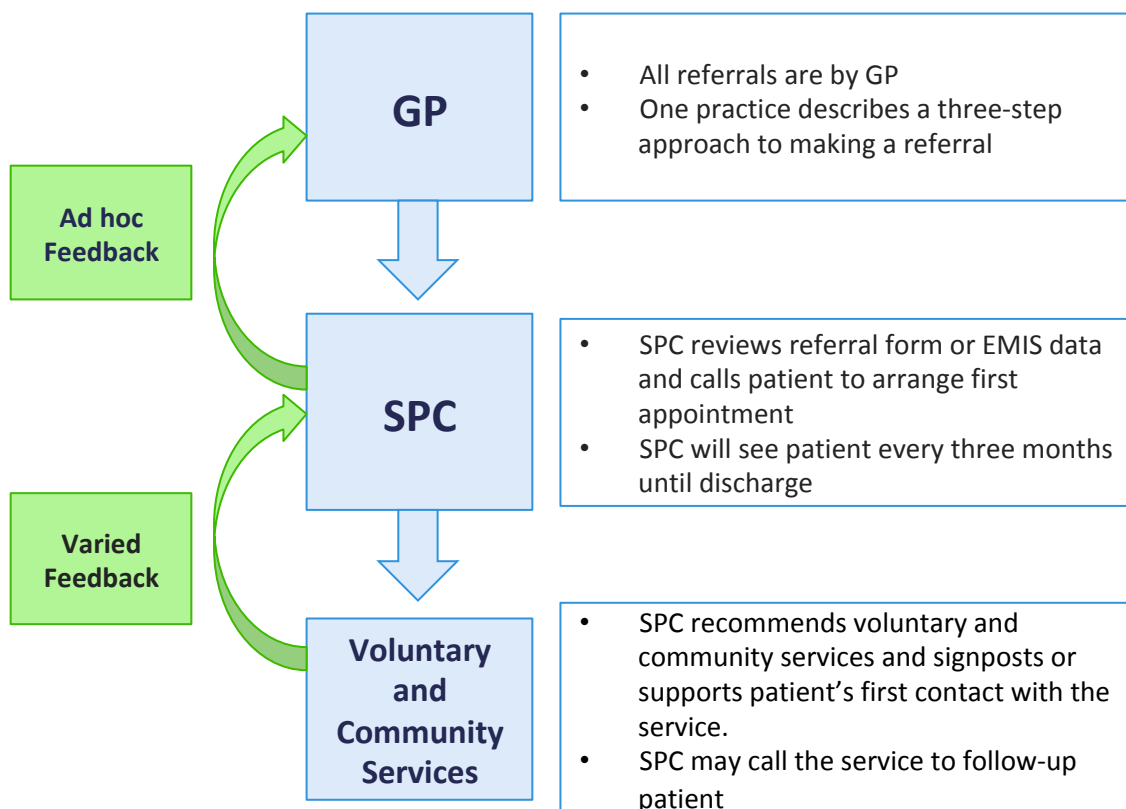
# Social Prescribing Pilot Pathway Review

This final part of this report is a qualitative review of the Social Prescribing Pilot Pathway and its key features, as described by the patients and professionals we spoke with.

The key features include: referral processes and data collection, the SPC appointment system and referrals and signposting to the voluntary and community service Sector. These are summarised in the following pages.

Figure 12 represents the pilot Social Prescribing pathway as outlined by the people interviewed throughout the year.

**Figure 12: East Merton Social Prescribing Pilot Pathway**



## Referral processes and data collection

At the beginning of the pathway the GP screens patients and then refers those eligible for the programme to the SPC.

The referral process is described by the two GP practices in different ways. Whilst Wideway Medical Centre GPs find it a quick and easy process, Tamworth House Medical Centre GPs describe a three-step process that they believe could be simplified (see Appendix B). Future programmes would benefit from co-designing the referral processes so that it fits well within the practices existing systems and GPs will find quick and easy to do.

Currently not all GPs complete the agreed referral form and instead use other means such as emails to make a referral. This sometimes made it difficult for the SPC to have a full understanding of the context of the referral as details that were in the agreed referral form were frequently missing. Additionally, the assessors found that the reasons for referral as recorded by the SPC were often different from the reasons stated by the GP. Clear guidelines on the referral criteria will help align the discrepancies between GPs and the SPC on why a patient is referred.

The two practices also describe the different levels of feedback they receive regarding the patient intervention once the GP has referred to the Social Prescribing programme. Some GPs feel that they received good feedback on the patient following their first Social Prescribing appointment, whereas others feel they would benefit from a more systematic approach to receiving feedback. A standardised comprehensive approach to providing feedback on referrals agreed by all parties will prevent any gaps in communication between the Social Prescribing programme and the clinicians referring to them.



Finally, both practice staff and patients have recommended to allow referrals from the practice's wider clinical team with a view that this will speed up referrals for patients and prevent unnecessary GP appointments.

## The Social Prescribing intervention

As the Social Prescribing programme progressed through its pilot year the SPC has tried and tested different ways to approach sessions with the patients. Additionally, the evaluator observed appointments at the beginning of the year using the Behaviour Change Counselling Index (Lane et al, 2005) and made some small recommendations regarding the intervention. These recommendations were taken on board by the SPC and effective improvements were seen when the appointments were observed for a second time towards the end of the pilot year.

## SPC appointment system

Once a patient has been referred to the programme the SPC will see them face-to-face for 45 minutes at three-monthly intervals. This was modeled on best practice gleaned from other successful Social Prescribing models across the country. The patients, SPC and practice clinical team have each highlighted that there is room for flexibility in this approach so that there are options for patients who cannot attend face to face appointments during work hours and the SPCs time can be used more efficiently.

Currently, there is no discharge guideline or policy that the programme follows, rather the patient will see the SPC until they no longer need the service or they stop attending. This has not posed any issues for the programme in this one year pilot. However, a well defined set of guidelines on discharging patients will empower the SPC to support clients to transition away from the service once they complete the intervention.



## Referrals and signposting to the voluntary and community service sector

The route from the Social Prescribing programme to the voluntary and community sector varies from service to service and depending on the needs of the patient. For example, some services require patients to self-refer which the SPC will signpost the patient to, whereas the SPC can refer to other services directly. In cases where patients would benefit from support to take that first step the SPC will make a phone call to the service to initiate the process.

Quite often services will be unaware that the Social Prescribing Programme has signposted to them or because of patient confidentiality are unable to report if a patient has been in contact with them. As a result, the feedback regarding the outcomes of these referrals is often not possible or is inconsistent. It is therefore not possible to evaluate what referrals or signposts are working well and for whom.



# Recommendations

The findings within this report were presented and discussed with representatives of the Implementation Group and the following recommendations were agreed.

## Referral Processes and Data Collection

1. The referral process from GP to SPC be co-designed with a representative from each practice and the SPC during the mobilisation phase or as soon as possible, and the referral criteria be reviewed as part of this process. This will ensure that the referral process fits well within the practice's existing systems and clinicians have an opportunity to input to its design to ensure that it's feasible for them to use.
2. The SPC to accept referrals from the practices' wider clinical team to speed up referrals times and free up GP appointments.
3. A systematic approach for the SPC to feedback to the clinician on the outcomes of the Social Prescribing intervention. This could be a simple process such as providing verbal feedback at team meetings or emails.

## Social Prescribing Intervention

4. SPCs have experience or training on behaviour change conversations so they have the skills to build rapport with patients, support them to build their self-efficacy and navigate around barriers to change.
5. Future programmes build on best practice as tried and tested by the SPC.
6. Appointments follow a clear structure that will include collaborative agenda setting, a needs assessment including using STAR Outcomes and referring/signposting. Where patients are unable to complete the STAR Outcomes survey, this should be recorded.
7. The SPC signpost to a maximum of two voluntary and community services at a time (where possible) so as to not overwhelm the patient and cause them to disengage.
8. The intervention conclude with a written agreement of steps to be taken so that they can be recorded and reviewed at further appointments.



## SPC Appointment System

9. The Social Prescribing programme should explore and test the option of a flexible appointment system whereby once the SPC has made initial contact with the patient, in cases where a 45 minute face-to-face appointment is not required the option of a telephone appointment or referral to a practice health champion is available. This will free up appointment spaces for additional patients.
10. A set of patient discharge guidelines be agreed between the SPCs and clinical team so that patients who have completed the programme can have a smooth transition away from the service.

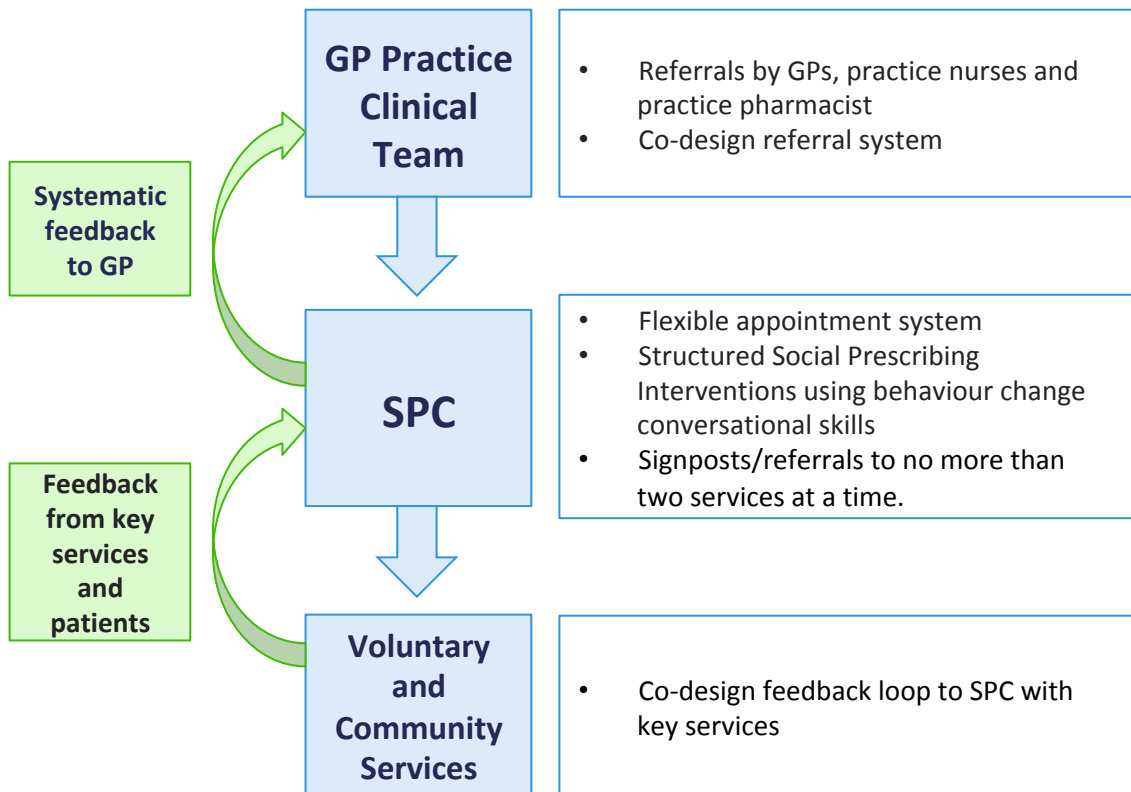
## Referrals and Signposting to the Voluntary and Community Service Sector

11. The Social Prescribing programme engages with the services they refer into most frequently to co-design a process for providing feedback on the results of the referral, including any patient outcomes.
12. The programme implements a systematic approach to obtaining feedback from patients. Ideally the SPC ascertains whether the patient followed-up on the referral or signposting, how they rated the service and verbal feedback on their views on the service. This would be recorded by the SPCs for analysis.

The resulting recommended pathway for East Merton Social Prescribing programme is presented in Figure 13.



**Figure 13: East Merton Social Prescribing Future Pathway Proposal**



# Conclusion

Merton CCG and Merton Council Public Health team set out to implement a new model of care to address health inequalities in East Merton. This Social Prescribing pilot model would provide GPs with an option to refer their patients to non-medical support for the wider determinants of health and connect them to their community and the resources within it.

This evaluation reviewed the processes and outcomes of the model, specifically the pilot pathway and whether the programme would impact on the health and wellbeing of patients, GP clinical workload and avoidable costs such as A&E attendances.

Merton Voluntary Service Council delivered the pilot through two GP Practices, Wideway Medical Centre and Tamworth House Medical Centre. The pathway and processes were modeled on best practice from other programmes in the country.

Overall the pilot was a success. The programme was effectively set up and embedded within the GP practices and generated a high number of referrals.

Positive outcomes were seen in patient's health and wellbeing and the patients interviewed reported strong health outcomes and better self-management as a result of visiting the SPC. Additionally GP appointments and A&E attendances significantly reduced in those referred to the programme which can bring huge cost savings for both GP practices and CCGs.

Interviewee's attribute the success of the programme to good planning, the drive and expertise of the GP leads and the skills and breadth of local knowledge of the SPC, GP Lead and Implementation Group.





## Next Steps

Due to the success seen in this pilot year the programme will be extended and expanded across East Merton within nine practices from April 2018. Recommendations outlined in this report highlight areas where the Social Prescribing pathway can be perfected for the coming years.



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# Appendices

**Appendix A:** Patient experiences of Social Prescribing

**Appendix B:** GP Practice Focus Groups

**Appendix C:** Interviews with Stakeholders and SPC

**Appendix D:** Interviews with the Voluntary and Community Services

**Appendix E:** Social Prescribing Intervention Observations



# Patients Experiences of Social Prescribing

This evaluation sought to attain the views of the patients who attended the East Merton Social Prescribing pilot on how they found the programme. The researchers spoke with a total of twelve patients through telephone interviews and one focus group (see Table 1).

**Table 1: Patient participant group.**

Focus Group Patients	Interview Patients
- Female – carer (age 40-49)	- Male (age 50-59)
- Female (age - 40-49)	- Female (age - 50-59)
- Male (age 70+)	- Female (age - 40-49)
- Female (age 60-69)	- Female - carer (age - 30-39)
- Female (age 40-49)	- Female (age - 40-49)
- Female (age - 30-39)	- Male (50-59)

In order to recruit patients to participate in this evaluation we contacted participants from a random list of patients who had visited the Social Prescribing programme one or more times. Twenty-three patients were telephoned by the research. Of those that could be reached, three declined to be interviewed, two could not be contacted at the agreed time and six provided a telephone interview. The researchers stopped contacting patients when they reached data saturation. Additionally, six patients who were contacted by the SPC agreed to participate in a focus group.

The focus group was held at the local community centre. Participants were given £10 vouchers for their participation.



The researchers used open-end questions in both the telephone interviews and focus groups. This allowed us to explore the range of topics while encouraging participants to express their own perspective in detail.

The focus group lasted for one hour while the telephone interviews lasted between five and 30 minutes. They were recorded, transcribed and analysed using theoretical thematic analysis. The key themes are presented below.

### Getting that first appointment

All participants the researchers spoke with had not heard of the Social Prescribing programme until their GP told them about it and made their referral. In most cases the GP gave a description of the programme and offered to make a referral. In three cases the patients were given a leaflet to take away and read more. In all but one case the SPC called the patient within a week of referral and an appointment was set up within two weeks.

*“We were dealing with my depression and time off work and the next issue was problems with debt from being off work. The GP told me about the services and how they were right there in the practice.”*

Most patients were complimentary about the speed at which they were able to see the SPC after they were referred; usually between one and three weeks. However, two patients did not feel that they were able to see the SPC as quickly as needed. One patient experienced a long delay as a result of an error in the referral process.

Five patients felt that they would benefit from a more flexible approach to the appointment system. This included more regular appointments for those patients who need it and the option of drop-in sessions.



Two patients mentioned that they would have preferred to have more flexibility in how to reach their SPC. Currently, patients have to call through to their practice reception, leave a message and wait for their SPC to call them back. Although the SPC has always responded to them in a timely fashion, they felt that the service would be a little bit more help if they were able to call or even email the SPC directly when they needed to.

*“It would be better if he could be there every day, or if there is any other way of contacting him. I don’t have his number, so I have to call the surgery and after a few days he calls me back and gives me a time I can come into the surgery. It would be great if we could get a contact number to get straight to him.”*

The focus group discussed how they would have benefited more had they been referred to the SP programme much sooner. They felt that the service could be better advertised so that it can reach those patients who need it before their situation becomes much worse.

*“When you are in a state, there are so many other things going on, any help is something... one of the main things is that I found really hard is that I had to hit rock bottom before knowing about the Social Prescribing. You sit in the GPs all the time and there’s the wall with the leaflets, and there is nothing there about Social Prescribing. I had never heard of it before. I had never heard of the contacts that the SPC gave me.”*

*“I had hit the point where I felt so overwhelmed that I didn’t know where to turn to, I literally live down the road and I didn’t know the services were just there.”*

*“It was not until I saw him (the SPC) did I find out about things that could have helped my parents 10 years ago. It made me very sad.”*





### The Wellbeing tool

Four of the interviewees talked about the Wellbeing tool as a useful way of examining their current situation.

They described how the SPC would work through the Wellbeing Star questionnaire at the beginning of their appointment. Each topic in the Outcomes STAR acts as a prompt to talk about their situation and highlight any issues that they could work on together with the SPC.

*“The STAR makes you think about things, instead of saying “everything is fine” it makes you realise you aren’t being truly honest with yourself”*

The questionnaire also serves as a reminder of what they talked about at their last meeting and what has changed since then.

*“It gives some perspective on how you are feeling and remember what has improved and what is good”*

### Flexibility of approach

All the patients we spoke with appreciated the relaxed and flexible approach of the SPC during their appointments for a number of reasons. For example, the SPC gave the time to explore their situation; patients had up to one hour to talk in their initial meetings. Participants stated the SPC uses that time to listen without rushing, jumping to solutions or making judgements.

*“He is the person that makes you feel that what you are doing is ok, and everything that you are doing is just what you should be doing.”*

*“He is very open, very good on how he leads the conversation, he opens things up and makes you think about your situation.”*

*“It is more nurturing, whereas the GP has only got 10 minutes.”*



Additionally a huge value to the patients was the SPC's ability to 'simply pick up the phone there and then' to contact services, especially at times when patients were going through a crisis and feel unable to take that first step.

*"[The SPC] is able to sit with you. You are frightened to pick up the phone, or you don't remember, but he skips that and says: right we are going to fill out your forms now, we can phone them for you now.... You are at this point where you are feeling that 'there is no help for me, I can't cope'. It's a relief that there is someone in the community that was working almost on our side. To help us take that step ahead and to almost keep an eye on you. It has been amazing."*

Patients did say that they would benefit from more regular appointments. Currently, patients who see the SPC regularly have appointments at six-week intervals. For some of the patients, this is too long a gap.

*"There is no outside appointment to see how the referral went and if it worked."*

### Links with the community

Most interviewees described the wealth of information that the SPC has to hand and provides to them. They appreciate the knowledge and connections the SPC has with the services within the community.

*"He got me in touch with places I didn't even think about, I didn't know that was there, yet it was across the road"*

*"I had to hit to the point where I felt so overwhelmed that I didn't know where to turn to, I literally live down the road and I didn't know the services were just there."*



They described the simple process by which they are provided information about their community. Sometimes the SPC would print out information for them, or give them a leaflet. Sometimes they SPC would make that first phone call to the service to get the ball rolling.

*“[The SPC] called the community centre right away and told me when I could go there and gave me a timetable. ‘These are their details’.”*

Of the services brought up, the Commonside Community Centre was mentioned most often and most favourably. Many of the patients we spoke to were referred to the community navigator employed at the centre who was able to talk through their problems with them and provide a range of practical support to them.

Most patients felt that they got the support they needed in the community. However, two patients did mention that they would have liked to have gone to some support services for carers. These patients care for their elderly parents while working full time, and therefore are unable to attend during the opening hours of these services. Positively, they were able to get the support they needed through the Commonside community navigator instead.

Four patients talked about the mental health support they were referred to. Once they had received the mental health support they were very pleased with the service. They did however discuss long waiting times before getting their first appointment.

### **What the service has done for them**

Most patients talked favourably about the service and how it helped connect them to the resources they needed or helped them try out new things that would benefit them, such as volunteering or social activities. Others credit the programme for helping bring them back to recovery.



*“I got involved in volunteering, it keeping me occupied and focused on what was good and off the depression itself. That was good.”*

*“He asked me what I like doing, I told him that I enjoyed making cards and he put me in touch with the local card making group which I went to.”*

One patient felt that although the SPC was able to connect to activities that she would not have otherwise used, she did not get the help she specifically needed to help her manage her debt issues.

*“The basics were there, when I mentioned my financial problems; he gave me information on housing benefits and tax credits, but they weren’t relevant to my situation. I needed help with sorting out my debt.”*

Eight of the patients credited the SP service to helping bring them back to recovery. For example, one patient said she would not have been back to work if it were not for the service. Another said she is coping a lot better and is managing her depression a lot better because of visiting the service. Yet another said she is able to help herself and others with the simple yet really helpful information she got from the service.

*“I would not have been back to work if it wasn’t for the help I got, and I would probably be on anti-depressants”*

### The location of the service

The consensus among the focus group was that the room of their Social Prescribing appointment was not ideal. They discussed how the desk felt like a barrier and the room was very clinical and uncomfortable. They suggested removing the desk and having comfortable chairs. They also suggested using a different location so that they are less exposed when going to the SPC for help.



*“It was at the doctors surgery so it felt a bit formal. It felt very medical, I don’t know whether it was the right place for it.”*

*“You are in your community, and there are people that know you. I was in this situation where I couldn’t cope, and I didn’t want people to know I couldn’t cope and it was going to the doctor, it was just another thing. If it was like a community centre where you just walk in the door and people are always coming in and out...or even upstairs, that would be better”*

Overall, patients were pleased with the service they received from their SPC and through the services they were signposted to in the community. Eleven of the 12 patients we spoke to would recommend Social Prescribing to others.



# GP Practice Focus Groups

To explore the Social Prescribing programme from a clinician's point of view we held a focus group at each pilot practice. Participants included GPs, GP Registrars, Practice Nurses and a CCG Prescribing Pharmacist.

We asked the Clinical Team at each practice to map out a patient's Social Prescribing pathway from the GPs' viewpoint.

They described the processes to which patients are identified and referred to the Social Prescribing appointment and what happens next. At each stage they were asked to describe what worked well and what could be improved. Key themes are outlined below.

## The Patient Journey

Each patient journey can vary depending on how they are identified, what their needs are and how they respond to the service. Figure 1 outlines what a typical patient journey can look like from the eyes of a clinician.

**Figure 1: Patient journey from clinician perspective**

1	Patient is identified by a practice staff member and is given a Social Prescribing booklet.
2	The GP will see the patient and if the patient is willing the GP will make a referral to the SPC
3	The practice administrator receives the referral form and forwards it to the SPC
4	The SPC reviews the patient's notes, makes a Triage call and books an appointment
5	The SPC sees the patient and updates the patient notes on EMIS



### Identifying Patients

Patients are identified through a number of means, for example, through GP appointments, lunchtime discussions between clinicians and during patient dressings. Additionally, Wideway Medical Centre discussed how the reception team have been great at identifying patients when they come in for frequent appointments, or when a patients expresses a need that cannot be addressed by the medical team. Tamworth House Medical Centre have not yet involved their reception team in identifying patients.

There are vast differences between the practices in the numbers of patients being referred. Wideway Medical Centre are referring so many that the SPC has built a waiting list, whereas Tamworth House Medical Centre do not fill all the SPC appointments. Tamworth House Medical Centre discussed how they would like more information from Wideway Medical Centre on who they are referring through and how they are identifying them.

### Making the referral

The team at Tamworth House Medical Centre describe a “three-step” process to making the referral (see figure 2):

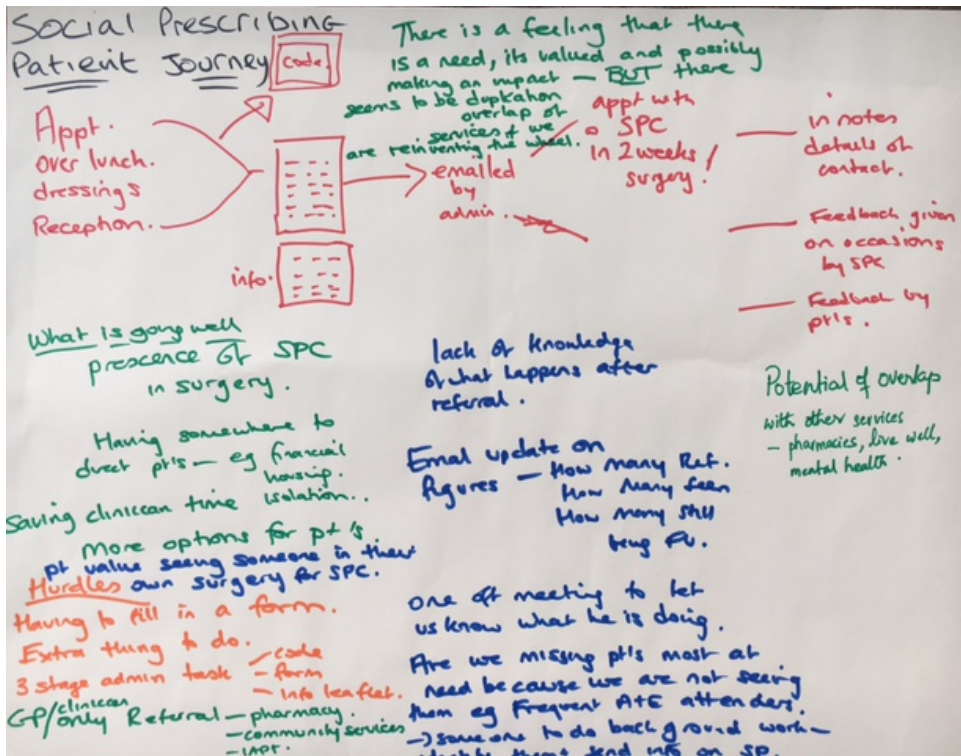
1. Coding the referral type
2. Filling in the referral form for administration team to email to the SPC
3. Giving the patient the leaflet

They felt that this could be simplified by changing the referral to a 1-2 line email sent directly to the SPC. The SPC can look up additional information through the patient notes held on the EMIS.

Conversely, Wideway Medical Centre felt the referral process was relatively simple as their referral forms are automatically populated by the EMIS system. They did not feel any valuable changes could be made.



Figure 2: Tamworth House Medical Centre's Focus Group Feedback



## The number of patients seen by the SPC

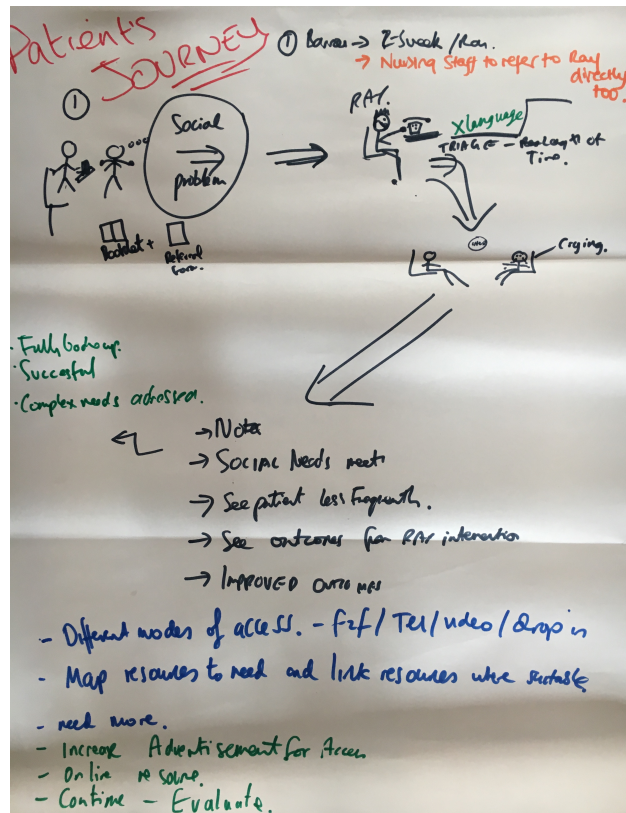
There was some discussion in both meetings regarding how many patients the SPC books for each day. Currently the SPC reserves 45 minutes for each patient. He also allows for 15 minutes before and after each appointment to review and update patient notes, make referrals and planning. Although both practices would like more patients seen in a day, they both recognised the value of allowing the patient to have that time with the SPC.

Both practices identified the opportunity to introduce some flexibility to the appointments, for example, some time could be allocated for drop-in sessions. Internet, telephone and video appointments were also discussed as an option to explore further with the idea that it can free up some appointment time and be flexible to the patients needs (see figure 3 as example).





**Figure 3: Wideway Medical Centre's Focus Group Feedback**



## Who makes the referrals

At present, referrals to the SPC are by the practice GPs only. Both practices discussed how this could be opened up somewhat to broaden the reach of the SPC and to lessen the workload of the GP. Currently, if the practice nurse or receptionist identifies a patient who may benefit the SPC, they have to inform the GP who then makes the referral.

Practice nurses, pharmacists and perhaps even receptionists were discussed as options.

## Feedback following a referral

The Tamworth House Medical Centre team expressed that they would like more updates from the SPC on their patients' progress. This could be in the form of regular verbal feedback, for example at team meetings, or via an emailed summary.



They felt that this would help them see more of the value of the service for the patient.

The summary should include:

- How many patients are referred
- How many patients are seen
- What further follow-ups or plans have been made

The team welcomed the SPC to attend their team meetings and join them in their discussions regarding eligible patients and the progress of their patients.

### Impact

Wideway Medical Centre have begun to see the impact of the Social Prescribing programme on their patients. They have found that one or two frequent attenders have been attending less frequently.

*“Patients who come in for depression and are prescribed anti-depressants often come back less depressed and no longer needing their medication because they have been referred to the social prescriber for a related issue like housing or loneliness”*

Both practices felt that the presence of the SPC in the practice was very positive as there is a need for the service and the SPC has more time to be able to spend with patients.

*“We often see patients that we can’t do anything for because their issues are about their housing, finances or isolation, it is really valuable to have that option within the surgery for the patient.”*



# Interviews with Stakeholders and SPC

Seven stakeholders identified from the Implementation Group were interviewed to elicit their views on the SP pilot, mobilisation process and expectations for this evaluation. The stakeholders were:

- Ray Hautot, Social Prescribing Coordinator
- Khadiru Mahdi, Chief Executive of the MVSC
- Dr Amanda Killoran, Former Public Health Consultant at London Borough of Merton
- Dr Mohan Sekeram, GP Lead for Social Prescribing from Wide Way Medical Centre.
- John Dimmer, Head of Policy, Strategy and Partnerships for London Borough of Merton.
- Anne-Marie Liew, former Community Development Coordinator for London Borough of Merton
- Dr Douglas Hing, GP and Merton CCG Clinical Director

Semi-structured interviews using open-ended questions were conducted to allow these stakeholders to express their own perspective in detail. The questions were developed based on the processes outlined in the logic model. Each interview lasted between 20-60 minutes. They were recorded and analysed using theoretical thematic analysis. The key themes around hopes, challenges and success are outlined.

## Hopes for Social Prescribing Pilot

*“We want GPs recognising that they are a community organisation”*

- Khadiru Mahdi

*“Giving people another outlet by showing them other ways of sustaining their wellbeing.”*

- Khadiru Mahdi



Stakeholders are very positive about the Social Prescribing pilot and feel that it fits well within the strategic context of East Merton. Stakeholder expectations/hopes include:

- Demonstration of a successful model of delivery that connects bio-medical care to community resources and fits with the East Merton context
- Health and wellbeing improvement in residents by providing access to non-medical support that addresses their wider needs
- Demonstration that it is a sustainable model
- Establish a collaborative pathway between primary care voluntary, community and statutory services and utilise community resources more effectively
- Establish a practice learning network as part of wider transformation work for East Merton

### Hopes for this Evaluation

*“We want to understand what the most effective Social Prescribing pathway is, particularly as embedded in General Practice, if robust can be planned to be taken up in practices in East Merton”*

-Dr Amanda Killoran

There are several key research questions the stakeholders hope to explore in the Social Prescribing pilot. These include:

- Community resources: Are we making best use of existing community resources and offering things like access to reading and gardening clubs? What does the evaluation recommend for the volunteering strategy?
- Patient outcomes: Are we seeing improved wellbeing of patients as a result of the Social Prescribing intervention? Are we demonstrating good outcomes for patients who are not benefiting from medical interventions?
- GP workload: Is the SP pilot resulting in fewer GP appointments for these patients? Or if patients are engaging in their own health more, will it lead to more GP appointments?



- A formative evaluation: There is a general consensus among the stakeholder group that they want to understand the ‘nuts and bolts’ of how the pathway is working.
- Strengths and weaknesses: Overall the stakeholder group would like to know what is working well and what can be improved to ensure cost-effectiveness and embeddedness of the Social Prescribing programme.
- Sharing Learning: Provide the evidence that this is working, not just about the patients, to ensure that we have some learning for the GPs, so they can see that this is making a difference for the patients.

### Barriers to mobilisation/Concerns about SP pilot

We asked the stakeholders questions around the challenges and barriers to setting up this Social Prescribing Pilot. The general consensus from the groups was that any potential challenges were anticipated and addressed early on during mobilisation.

*“I am very proud that the programme is up and running so successfully and this can be seen high number patients are already going through.”*

-Dr Amanda Killoran

The steering group was able to draw from learning from a previous Community Navigator programme in Merton that some members had been leading on. Key learning points from this programme showed that good visibility and engagement with the GPs was key to ensuring the programme is welcome and connected to the systems within the practice.

Setting up IT systems such as EMIS and establishing where the Social Prescribing Coordinator will be based within the practice takes time to agree and arrange. The East Merton Pilot team ensured that these systems were set up prior to the SPC coming into post and some of the engagement within the practices had begun. This enabled him to start seeing patients right at the outset.



One stakeholder reported that the set up did take some time and recommended that more time and resources should be allowed to prepare for the implementation phase ahead of the go live date.

*“Fleshing out the finer details of logistics is just as important as the overall vision to putting it into practice”*

- Anne Marie Liew

She recommended providing a briefing to every staff member at the practices, including reception staff, so that everyone knows what is going on, has an opportunity to ask questions and feels that their part to play is valued.

*“Every practice member is an important part of the cog in the process and should feel part of the wider dialogue”*

- Anne Marie Liew

She highlighted the importance of enabling the SPC and practice staff to feedback to each other once the programme is up and running, on how it is working and how the patients are responding to it. She also recommended that co-design of the programme with a cross-section of the practice staff from the onset will encourage genuine buy-in at all levels rather than simply in name.

The SPC also highlighted that there is substantial training that is required before an SPC is ready to use the systems within the practice and see patients and this needs to be accounted for within the implementation phase.

All stakeholders raised concerns around the capacity of community and voluntary services in East Merton and their ability to deal with the increased volume of referrals generated via the SP service once it gained momentum. There was also a concern whether existing services catered to the needs of ethnic minority populations. In some cases the patients do not meet the criteria for the end services as they reside outside of the borough; in these cases the SPC looks to services beyond East Merton.



With regards to delivering Social Prescribing, the method for measuring patients' wellbeing is through use of the Wellbeing Star. The SPC highlighted that this is not always appropriate for patients, particularly if there are communication issues such as a language barrier or literacy issue, or if there the patient is distressed. Additionally, the referral forms are not always completed in full by the GPs which can leave the SPC feeling not fully prepared for his patient, although the information can often be found within the patient's records.

### Successes/Enablers

Overall the stakeholder group spoke very positively about the pilot programme and attributed its successful set up to several factors including:

- Commitment and shared expertise of the Implementation Group
- Using learning from SP pilots across the country and carefully planning mobilisation of the programme
- Flexibility and simplicity of the service and End Services to meet the diverse and often complex needs of the patients

### Successful Planning

The stakeholders discussed a number of factors that they addressed in the mobilisation phase to ensure that it is embedded within the GP practices from the outset. These were anticipated by building on learning from other programmes and included:

- Strong engagement within the Implementation Group to ensure all key stakeholders agreed on what the Social Prescribing model looked like and what the referral criteria was.
- Using the existing systems within the practices to ensure that SPC is easily embedded within GP Practices
- Strong engagement and visibility with all Practice staff and patients
- Ensuring early set up of IT systems ensuring SPC had access to patient's case management systems and could book patient appointments straightaway



### Champions of the Pilot

One of the stakeholders discussed the strong sense of commitment to the pilot and the advantage of having upfront funding from the CCG and the Local Authority to strengthen strategic commitment.

The lead GPs were key in translating the 'blue-sky' ideas within the pilot strategy into practical solutions, drafting the project plan, and visualising the pathway. They also led and championed the programme within their Practices.

The SPC is also seen as a key contributor to the success of the pilot so far. His experience and background gives him skills and competence to deliver effectively. His local knowledge and networks enables an understanding of what wider support is available for patients in the community. His good listening skills enables effective consultations.

*"Fortunately, we had somebody who understands the borough very well and understands the community sector very well. He also engaged with the staff in the practices very well."*

- Khadiru Mahdi

Additionally, the community organisations have been willingly taking on the referrals from the patients and the patients have been utilising this resource.

*"We have 10 minutes appointments and we are currently geared up towards a medical model where we give something to the patients to take away with them... when patients raise social issues... we can now capture that and really make a difference and say I know someone who can help with that."*

- Dr Mohan Sekeram

*"The [SPC] is able to deal with concerns that were beyond remit of the [SPC]... and the GP can see straight away the intervention and what has happened in the follow up."*

-Khadiru Mahdi





# Interviews with the Voluntary and Community Sector Services

To understand how the Social Prescribing programme works alongside the community and voluntary services, we spoke to four services that the Social Prescribing Coordinator has been referring patients into, these are:

- Commonside Community Development Trust
- Age UK Merton
- Merton IAPT service
- Merton Voluntary Service Council's volunteering service (MVSC).

The main aim was to understand referral pathways, communication between the SPC and end services, what they thought about the intervention in general and any thoughts they had about scalability and factors we would need to consider.

*"I think it's good to have that kind of holistic view of people's wellbeing, that is not just medical; it can be much wider than that-social and community connections. I think it's a positive sign that that has been recognised"*

Overall the services were quite positive about the effectiveness of the intervention and felt that it was needed in East Merton. The conversations highlighted the need to develop robust referral pathways and systems to capture numbers and feedback.

The key themes are outlined.

## First Contact with Social Prescribing Pilot

Services we spoke to knew about the SP pilot before it started or in the initial months. Some knew the pilot was coming to Merton as they had been working closely with Wideway Medical Centre and the lead GP. Others established links with the SPC and the pilot at meetings such as the Mental Health Forum.



The SPC himself was a familiar figure to most services as he has worked in the Borough previously and is aware of a lot of local organisations.

*“He (SPC) had a fairly good grasp of the work we do here and I had a memory of him and how he works. So fairly easy to establish a working relationship”*

### Referral Pathway and Communication

*“The SPC has given a lot of his clients our details, whether that’s actually resulted in them coming to access our services I don’t know. It doesn’t mean they haven’t, but it’s certainly not been something that has been obvious from our side of things”*

A clear distinction between ‘Referral’ and ‘Signposting’ was made by one of the services and the consensus was that the process by which individuals make their way from the SPC to their services was signposting.

There is no referral form and no uniform way in which the SPC communicates information about patients who are signposted to end services. Two out of four services said that they knew the SPC was giving out information about their services, but as with other self-referrals they were not able to say how many people accessed their service as a result of the intervention.

One service receives the contact details of patients signposted to them by the SPC via an email and then, based on the details they are given, they either post out a letter, telephone or email these individuals. Other services require patients to self-refer. Due to the differences in approach, feedback from services is either not available or is collected and given to the SPC in different ways.



*“We let him lead on this. If he isn’t getting the information he would let us know. He rings/ pops in with a list of people. We let his monitoring needs lead us rather than invent some monitoring for ourselves”*

The frequency of interaction with the SPC varies; in some cases, the SPC drops in weekly, is in regular communication over emails, or just meets services at common events and meetings. The SPC is based in the same office as the MVSC volunteering service which makes communication easier.

Services recognised the importance of letting the SPC know about any changes that were taking place in their services and making sure the information he had for them was not out of date. The pathway described by stakeholders is summarised in Figure 4.

**Figure 4: Signposting and feedback Pathway**

- 1 SPC speaks to patients and assesses their needs.
- 2 Patient is given leaflets/ information about service and encouraged to make contact by SPC. In other cases the SPC makes a referral.
- 3 Patient comes to service and may/may not identify as being sent by the SPC
- 4 Patient may/may not access service based on suitability and in some cases patient maybe signposted to other relevant services
- 5 Feedback to SPC is varied; there is no formal mechanism and is led by the SPC. SPC might approach services themselves to check if patients have signposted, or check with patients when they come back for second appointment



### Numbers and demographics of patients signposted

One service recorded a surge in the number of people coming through between March and May and had 40 extra people accessing their services. Another service had 10 people signposted and 8 of whom they could contact. The rest could not track their Social Prescribing referrals and were not able to comment.

One service reported that there was a greater representation of older, white working-class individuals signposted to them from the pilot.

One service mentioned that they would ideally like to have more referrals from BME populations, men, older adults and those with long-term conditions and work with the SPC around this.

### Capacity of End Services

The services that could comment on the volume of referrals they receive felt that they could cope with the demand in the short term. Should the programme be expanded or extended, this would need to be discussed with commissioners. They felt that needs of the people being referred is also an important part of the consideration.

The end services also talked about the option of accepting signposts into services they charged for or for services that are underutilised. One service is trying to increase uptake rates and said they would welcome more number of referrals coming into the service (target groups mentioned above).

### Scalability Considerations

Services talked about several factors that need to be considered if the intervention were to be upscaled. These include:



**Robust referral and feedback pathways** - Services are open to working with SPC to look at how referral pathways and systems can be set up to enable better data capture and feedback between services. For example, data sharing agreements or simply asking those who self-refer where they heard about the service.

**Understanding patient need** - To ascertain whether patients need a referral service or a signposting service.

*“If I gave a leaflet to a client, did the client really go to the agency? Was there any hesitation in there, was there anything that was missed. If that's not working, then do I fill the referral form or do I call the GP practice”*

**Data Protection** - If the pilot is up-scaled, data protection and sharing agreements will have to be revisited. It is important to not become too encumbered in processes and maintain a balance. Organisations taking part will need training around sharing information with people and this could be something that the MVSC could support with.

*“If it does go Borough wide, the problem is that it becomes encumbered with lots of control and protection systems - which are good in themselves but can stymie some of the energy that we have had in the early stages”*

**GP commitment** - There was recognition that the lead GP in Wide Way is massively committed to this and has been championing the pilot. If the pilot were to expand, other GP practices need to embrace this approach and be fully committed to its development.

*“I don't know if other GPs are as enthusiastic as them. They have to do it if they have to do it, not because they love their job. So if some GPs or other professionals in the practice were thinking that ‘oh gosh this is another thing that I need to fit in our daily jobs’, that would then kill some of its effectiveness. So, we have to sell it as something that helps their effectiveness and not something that adds to their to-do list”*



**Building Capacity within the Voluntary Sector** - Services were clear that if the project were to be upscaled, there would need to be funding put into the voluntary sector. There were some suggestions including paying the organisation per person per visit. If this was not possible, then to work in partnership to look for funding opportunities or reallocate funding from dead projects.

*“As the voluntary sector is relied on more and more to fill in gaps and pick up services, on the one hand it is getting less and less funding and on the other hand more and more referrals. At some point, that is not going to work. You can only scale it up if you can fund the voluntary sector to absorb the increased demand”*

**Geographical Considerations** - Expanding to other areas in East Merton as well as possibly having a service in West Merton so that there is a balance across the borough.

**Consider other similar models** - Stakeholders talked about other similar interventions such as the Living Well project within Age UK, care navigators, community navigators based out of the Nelson Health Centre and Commonsense Trust and the Fire Safe and Well coordinators. It would be worth looking at synergies and how these different projects could work together.

**Linking in with Funding opportunities-** Housing and regeneration partners like Merton Housing and United Living are willing to work with local stakeholders around designing services that meet the needs of the local population. They have expressed an interest in working with the SPC and do not want to duplicate efforts or set up something that does not have synergy with the SP Pilot. This could be explored with other organisations like Clarion Housing as well.



### Limitations of SP Pilot

*“It is hard to manage both the capacity of that and know what difference the signposting has made... I know there are some amazing case studies, where SPC has been able to refer someone and that person has gone from strength to strength, but like I said, if you just signpost someone, it’s quite hard to really track that against any improvement that have been made in that person's life”*

Services spoke about some of the limitations of the SP Pilot:

- Signposting system that makes it difficult to track uptake and provide feedback or prepare for any upscaling.
- End services not knowing what the actual intervention is, how many times does the patient get seen etc. which makes it difficult for them to think about impacts.
- There were concerns that for certain vulnerable groups for example older people, signposting would not be as effective as a referral.
- The SP intervention is based on the premise that there are wider services that can meet patient needs. There is a concern that there might not be enough services or capacity within those services to address needs or accept signposts.

*“Where it falls down is, it’s a fantastic idea referring people/signposting people to services, but there are increasingly fewer services. If you don't have anywhere to signpost people to, then the model falls down”*



# Social Prescribing Intervention Observations

## Observation methodology

The assessors observed five Social Prescribing consultations in July 2017, including two first appointments and three follow-up appointments. The purpose of the observations was to get an understanding of the structure of the consultations, the communication between the SPC and patient and referral process.

Observations were rated on the Behaviour Change Counselling Checklist that looks at person-centred methods for behaviour change counselling (Lane et al, 2005). Each item of the checklist is rated on a Likert scale of 0-4 whereby a higher score reflects stronger behaviour change counselling skills. Not all items on the checklist are relevant for all consultations, so an average score for the relevant items are recorded for each consultation. The observers also recorded what went well and what could be improved.

## The Social Prescribing consultation

Patients are seen by the SPC between one to four times at three-month intervals, depending on their needs and expectations. The time for the consultation varies between 15 minutes to 1 hour. Prior to meeting the patient, the SPC gathers as much information as they can about the patient's background and reason for referral using EMIS and the referral form.

The SPC begins the consultation by welcoming the patient and ensuring they are comfortable. He explains the reason for referral, describes what Social Prescribing is and asks the patient to fill in the STAR questionnaire where appropriate. During this time, the patient is able to discuss in-depth their personal circumstances and reason for referral.





The SPC offers referral options and signposting throughout the discussion when the opportunity arises. The consultation ends with an agreement to meet at a later date to review the contact with the end services.

### What went well

The SPC rates very well on the Behaviour Change Counselling Checklist with an average score of 3.2 out of a possible 4; his strengths include: encouraging the patient to talk about their behaviour and status quo, acknowledging challenges and being sensitive and understanding to the patients concerns.

Overall, it is clear that the SPC is friendly, approachable and skilled at making the patients feel at ease. He is also flexible in offering appointments of varying lengths to meet individual needs. Patients are able to discuss their personal circumstances in-depth and can talk about a range of issues without strict time constraints.

The SPC recalls the patient's information from prior meetings and from medical records. He regularly recognises, acknowledges and praises the patient's strengths, intentions and behaviours that lead

The SPC also has a wealth of knowledge of the local services available to the patients and provides support and guidance to the patients as to how they can access these services.



### Suggestions for improvements after July 2017 observations

- The consultations could often benefit from having a clearer structure. At the outset, when talking about what will be covered during the appointment, it would be beneficial to ask the patient what they would like to discuss and setting a joint agenda.
- Restrict the number of referral opportunities offered to the patient as this can be overwhelming. To narrow the focus, the patient can be asked what they hope to achieve/ what solution would work best for them. Alternatively, when there are several options, they can be shown a 'menu of options' and asked which 1-2 services would they like to begin with. This would also ensure that advice and signposting is tailored to the needs expressed by the patients and that they have more ownership on next steps.
- Instead of a verbal agreement, it would be more beneficial to have a written plan of action which has been discussed and agreed with the patient's active participation. Evidence shows that a written agreement of behaviour change is a strong indicator of positive behaviour change.

### Follow up discussion with the Social Prescribing

#### Coordinator in August 2017

These suggestions were discussed with the SPC who put them into practice from August 2017. Feedback from the SPC on the changes has been positive. He felt that the changes have allowed the patient to have more control over his signposting and that he has become more flexible in his approach to allowing the patient to set their own priorities with their consultation with him.



### December Observations:

The researchers returned to observe two more consultations in December 2017. We observed two 2<sup>nd</sup> session appointments. During those observations we rated the interaction using the Behaviour Change Counselling Checklist, the SPC scored an average of 3.9 out of a possible 4, exhibiting that the SPC was strong in his use of behaviour change counselling skills.

During the consultations the SPC had structured the consultations in a clear way, allowing the patients to co- create the agenda. The SPC had strong rapport with the patients and a relaxed approach. The signposting and referrals were in response to the patients' expressed need and action plans were agreed.



Evaluation of the East Merton Social Prescribing Pilot by Healthy Dialogues Ltd, July 2018. If you would like to learn more about this evaluation please contact:

[info@healthydialogues.co.uk](mailto:info@healthydialogues.co.uk).

The East Merton Social Prescribing Pilot was delivered by Merton CCG, Merton Council and Merton Voluntary Service Council. If you would like to know more about the Merton Social

Prescribing programme you can contact: [public.health@merton.gov.uk](mailto:public.health@merton.gov.uk).

