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Evaluation Report of the Social Prescribing Demonstrator Site in Shropshire – Final Report

July 2019

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The Social Prescribing Unit @ University of Westminster

is focused on innovation in the field of social prescribing and growing new ideas. The team has considerable expertise in contract research, consultancy, evaluation and mixed methods research. We are also experts in supporting the implementation of social prescribing within organisations in the VCSE sector, the public sector and the private sector. We have provided advice to policy makers and have led major initiatives in social prescribing nationally and internationally. We founded and Co-Chair the Social Prescribing Network, have produced guidance documents, collaborated to develop the Medical Student Social Prescribing Network and the Social Prescribing Youth Network. We have worked alongside NHS England to shape social prescribing and fully believe that change happens by collaboration not competition.

Acknowledgements

We would like to thank all the participants who agreed to take part in the service evaluation. We would also like to thank the Shropshire Council for commissioning this evaluation and in particular the Help2Change team, including the public health consultants for their input and teamwork throughout the first phase of this evaluation. In particular, we really appreciated the help and support given to us by the people below:

- Katy Warren Social Prescribing Project Lead Help2Change, Shropshire
- Dr Kevin Lewis Director of Help2Change, Shropshire
- Jo Robins Consultant in Public Health, NHS E Regional Facilitator - Midlands Social Prescribing Network, Shropshire Public Health
- Claire Sweeney Help2Change Lead Advisor, Shropshire
- Emma Sandbach Public Health Specialist, Shropshire Council
- Craig McArthur H2C Data Management and Audit Specialist, Help2Change, Shropshire

Disclaimer

The views expressed in this report are those of the authors and do not necessarily represent those of Shropshire Council

How to cite this report

Polley M, Seers H and Fixsen A (2019). Evaluation Report of the Social Prescribing Demonstrator Site in Shropshire – Final Report. University of Westminster, London.

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"Well, I can't thank them enough for what they did for me"

What was the most important thing about this service? "Being able to open up and discuss concerns, where doctors and nurses keep telling me I need to lose weight but don't have time to advise…"

What was the most important thing about this service? "Helping me reach my goals and not judging me, but most of all treating me as a person and not a number."

"The initial appointment with the social prescribing advisor has changed my life. I am now fitter and have lost 2 stone in weight. I feel more energetic and healthier"

Executive Summary

Aim: To develop a robust social prescribing service using best practice in development and data collection.

Objectives: To evaluate the Shropshire social prescribing demonstrator site to understand why the social prescribing programme is being used and how well the components of the social prescribing model are working together.

Design: Formative service evaluation using mixed-methods data. A single arm, quasi-experimental pre-post data collection design was used to see the longitudinal benefits of the Social Prescribing service. A matched control was used to compare health service usage between people who did and didn't use the social prescribing service. Ethics approval was received from the University of Westminster Research Ethics Committee before the evaluation was started.

Participants and recruitment: Participants were identified retrospectively based on a CVD Qrisk2 score of 10% or more, and by pre-diabetes risk from Hba1c 42-28 mmol/mol. Participants were also opportunistically referred to the social prescribing link worker via Qube, Adult Social Care, the Department of Work and Pensions, Adult Social Care, Oswestry library, or by local GPs during appointments.

Data collection:

Quantitative data: A questionnaire pack was administered by the social prescribing advisors at baseline and 3 months follow-up. Interviews with professional stakeholders setting up the social prescribing service and with service users to were carried out to capture their experiences. The questionnaire pack consisted of:

1. Measure Yourself Concerns and Wellbeing (MYCaW**)** – measures patient concerns – self completion with five questions (either self-completion and/or as part of an initial appointment).
2. Patient Activation Measure (PAM) – series of 13 statements about beliefs and patient confidence around the management of their individual condition (linked to health behaviours, clinical outcomes and costs for delivering care)
3. De Jong Gierveld Loneliness scale – 6 items
4. Working status and relationship status
5. Patient Satisfaction Survey (administered at 3-month follow-up only)

Qualitative data: Interviews with 24 stakeholders including service users were carried out, recorded, transcribed and thematically analysed. Key themes were identified to understand how people valued the social prescribing service and the impact it was having.

Findings:

- **The service design adhered to best practice as set nationally by the Social Prescribing Network and NHS England**, whilst developing the service on a practice by practice basis and only using existing resources. This required encouraging collaborations between many stakeholders, including the GP champion, GP practice manager, Operational Project Lead, Data lead, and Lead Adviser role. Importantly this project has enabled greater collaboration between the local authority and CCG.

- **The Shropshire social prescribing approach was highly aligned with the most recent Public Health strategy**[1] as well as with potentially reducing the need for core aspects of Adult Social Care services. The Care Act, 2014 explains that it is the responsibility of the local authority to promote the wellbeing of individuals. Wellbeing is comprised of personal dignity; physical, mental and emotional well-being; protection from abuse and neglect; control over day-today life; participation in work, education, training or recreation; social and economic wellbeing; domestic, family and personal relationships; suitability of living conditions and the individuals' contribution to society.

- **An agile management approach to service development was deliberately employed** and the local Help2Change team carefully tested things out, then paused and reflected before proceeding. An expanding range of different sectors are now getting involved in the social prescribing service and it has expanded from an initial demonstrator site in Oswestry and Ellesmere to covering 5 regions in Shropshire.

- **Between May 2017 – May 2019 515 referrals were made into the social prescribing service** via 4 services in Oswestry/Ellesmere, Albrighton, Bishop's Castle, Bridgnorth and 4 GP practices in Shrewsbury, which incorporates 11 GP practices. 134 people were recruited into the evaluation, with 3-month follow up data from 105 people.

- **Feedback from service users was very positive. Satisfaction ratings were 4.8/5 for suitability of times, convenience of venue and feeling able to discuss concerns with the social prescribing advisor.** Participants reported feeling heard and supported, and that the service was meeting their needs by addressing them not as a 'condition' or disability, but as a person, with their own set of social and emotional wishes and wants.

- **The social prescribing service supported unmet needs *beyond* the expected remit, due to the inclusion of link workers in the service, which provided an individualised element.** The MYCaW concerns that participants reported ranged from lifestyle advice through to social determinants of health and concerns related to adult social care.

- **The patient reported outcome data demonstrated statistically significant improvements** in participants' MYCaW concerns (p=0.001) and Wellbeing (p=0.001),

[1] Department of Health and Social Care (2018). Prevention is better than cure. Our vision to help you live well for longer

activation levels (PAM) (p=0.000), and the De Jong Gierveld measure of emotional loneliness (p=0.05).

- **Score changes translated into improvements in weight, BMI, cholesterol (p=0.043), blood pressure (p=0.007, diastolic), levels of smoking and physical activity.**

- **Reasons why the social prescribing service has triggered changes have been captured** via qualitative interviews and the MYCaW tool. Participants particularly valued the role of the social prescribing advisor. Not only was this due to the 1:1 time with a social prescribing advisor, but their training in motivational interviewing amongst other things, and the support an individual received to access an appropriate group when the time was right.

- **Overall the full set of data captured provides a compelling explanation for the statistically significant (40%) reduction in GP appointments** for participants at the 3-month follow-up, compared to a matched control group of people who did not use the social prescribing service.

- Above all, the **social prescribing service seeks to address real life social complexity and inequalities** by offering integrated, holistic solutions to multifaceted health and social care issues.

Recommendations:

- It is recommended that the social prescribing team discuss the intention and benefits of the social prescribing service with GPs, to develop more relationships that will lead to an increase in referrals and integration of social prescribing into the GP consultation.
- Regularly review referral and audit processes to be to ensure that the people are clear about why they are being referred to a social prescribing advisor, and that those whose needs can be addressed by the service are being referred.
- We would recommend seeking out more ways to access those people who are lonely and isolated, including young people (widening the service to people under 18 years of age), who could be referred Department of Work and Pensions, or even through colleges.
- It is recommended that attention is given to informing service users if the social prescribing advisor is going to change.
- It is recommended that social prescribing advisors receive CPD training in areas such as mental health issues and alcohol and substance abuse.
- It is recommended that review of collecting physiological data such as weight, is undertaken to address issues identified around lack of rooming or equipment if future evaluation is to be carried out.

1.0 Introduction

1.1 Challenges facing population health in Shropshire

Shropshire is a rural county in the West Midlands of England near the border of Wales. The rurality creates challenges for the local population, for example, with limited transport and difficulty accessing services and response times for the emergency services.

The key public health issues in Shropshire which cause the highest demand for health and social care expenditure include cardiovascular disease, musculoskeletal disease, respiratory disease and falls in older people. Furthermore, an estimated 23,000 people in Shropshire have type 2 diabetes and 31,600 adults estimated to have prediabetes. Public Health funding of only £39 per head has been allocated until 2019 (England average £59 per head); thus to achieve positive impact on health and wellbeing requires strategic vision.[2] These health inequalities in Shropshire contribute to a difference in life expectancy of 5.8yrs and 2.6 year's lower for men and women respectively, compared with the least deprived areas.

Many of the 'high spend' non-communicable diseases affecting the Shropshire population have modifiable risk factors which, with support, a person can change. The modifiable risk factors include, obesity, high cholesterol levels, high blood pressure, physical inactivity, smoking, and excess alcohol consumption. It is also understood that when a person becomes more physically active, this will also improve other risk factors such as obesity and has multiple physical and mental health benefits. These benefits include a lower risk of cardiovascular disease, high blood pressure, breast cancer, colon cancer and delayed onset of dementia. [3]

Interventions such as social prescribing can support a person to address these modifiable risk factors and have a positive impact on a person's health and wellbeing and reduce the usage of health care utilisation. In a review of health service usage, where social prescribing schemes were implemented, a significant reduction in GP appointments, admissions to A&E, unplanned admissions to secondary care and a reduction in prescribing were all found.[4]

1.2 Social prescribing

Social prescribing is an innovation that formally links patients with non-medical sources of support within the voluntary, community, social enterprise sector (VCSE), in order to improve their long-term health and wellbeing. Identified individuals can be referred into a social prescribing service

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[2] Shropshire Council (2018) The public Health vision

[3] World Health Organisation (2010). Global recommendations on physical activity for health. Geneva.

[4] Polley M et al (2017). A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications. Commissioned by NHS England. Download at https://westminsterresearch.westminster.ac.uk/item/q1455/a-review-of-the-evidence-assessing-impact-of-social-prescribing-on-healthcare-demand-and-cost-implications

via a range of referral routes (e.g. primary care, secondary care, allied health, social care or statutory services) by a 'link worker'[5]. For the Shropshire social prescribing service, the link worker is called a social prescribing advisor and therefore this role will be referred to as the social prescribing advisor henceforth. The social prescribing advisor is a non-clinical person who excels at developing relationships so that people feel able to explain what is happening in their life. A consultation with a social prescribing advisor may last 1 hour, in which time a person's preferences and unmet needs are discerned. The individual is then supported to access appropriate support, usually via the VCSE.[6,7] For some individuals, they may have several consultations with the social prescribing advisor before being ready to move onto a community group or activity. The time spent building trust and agency with the social prescribing advisor is seen as a key part of the social prescribing intervention.

Social prescribing was first reported in 2008. Since January 2016 with the development of the Social Prescribing Network, and collaborative working with NHS England, social prescribing is now a key part of the government's Connected Society strategy.[8] Under the new NHS England universal personalised care strategy, the scaling up of social prescribing to all Clinical Commissioning Groups (CCGs) is underway. For the first time in history, social prescribing is part of a GP contract in the UK. This represents a system-level response to tackling loneliness and social isolation as well as reducing health care utilisation and improving health and wellbeing.

From a public health perspective, the recently announced public health strategy[9] emphasises the need for substantial improvement to be made to lifestyles – e.g. a reduction in smoking, reduction in obesity, reduction in excessive alcohol intake. The strategy also acknowledges the value of paid work and volunteering, and social connections and sets out a need for health and social care system to be integrated with communities and employers. Importantly for public health, it highlights the leadership role that directors of public health can have via place-based and integrated offers to support the wider determinants of health. With the recent announcements and funding commitments to social prescribing, it is critical to now develop robust, sustainable, integrated and evidence-informed place-based services, where all key stakeholders are working together.

The Care Act, 2014[10] requires the local authority to promote the wellbeing of individuals. Wellbeing is comprised of personal dignity; physical, mental and emotional well-being; protection from abuse and neglect; control over day-today life; participation in work, education, training or

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[5] The link worker is the generic name for this role, and is referred to in all national policy information about social prescribing. For the Shropshire service this role is called the Social Prescribing Advisor.

[6] Kilgarriff-Foster, A., & O'Cathain, A. (2015). Exploring the components and impact of social prescribing. *Journal of Public Mental Health*, *14*(3), 127–134. http://doi.org/10.1108/JPMH-06-2014-0027

[7] Kimberlee, R. (2015). What is social prescribing? *Advances in Social Sciences Research Journal*, *2*(1). http://doi.org/10.14738/assrj.21.808

[8] HM Government (2018). A connected Society. A strategy for tackling loneliness – laying the foundations for change. Department for Digital, Culture, Media and Sport.

[9] Department of Health and Social Care (2018). Prevention is better than cure. Our vision to help you live well for longer.

[10] The Care Act (2014) HM Government

recreation; social and economic wellbeing; domestic, family and personal relationships; suitability of living conditions and the individual's contribution to society. Social prescribing has been of benefit for individuals who would have needed adult social care support e.g. where people need support after discharge from hospital. This was evidenced by a significant reduction in unplanned admissions to hospital.[11]

Research[12] has indicated 7 core principles that provide new social prescribing with the best chance of success. These include:

- Collaborative relationships with people in different sectors
- Funding commitment
- Understanding of social prescribing and buy in from intended referring professionals
- Simple, clear referral process
- Skilled link worker, liaising with Voluntary Community and Social Enterprises (VCSE)
- Person centred scheme, flexible in time and location
- Vibrant and sustainable VCSE

Ingredients seen as integral to social prescribing schemes are:

- Governance
- Communication and feedback
- Research data

1.3 The development of the Shropshire social prescribing service

The Shropshire health and wellbeing strategy aims to promote and maintain health by working collectively and collaboratively to identify and test out solutions[13]. As part of this strategy, there is an aim to reduce health inequalities within this community.

A scoping phase in November 2016 involved interviewing key stakeholders including those from the voluntary sector, the local hospice, the Clinical Commissioning Group, Help2change and council directors. The Social Prescribing Demonstrator Site in Shropshire identified several needs

[11] Polley M et al (2017). A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications. Commissioned by NHS England.

[12] Polley M et al (2016). Annual National Social Prescribing Network Conference report. University of Westminster, London

[13] Shropshire Council (2018) The public Health vision

to focus its services on – lifestyle risk factors, long-term conditions, low level mental health and risk of loneliness and isolation. [14, 15]

The aim of the initial phase of work was therefore to understand where social prescribing might fit in to existing services – represented in Figure 1 below.

Figure 1. The key foci identified for the Social prescribing demonstrator service

Different social prescribing schemes focus on different needs, which can be adjusted to the needs of a given population. The Shropshire social prescribing service is targeting health and social problems known to have a wide impact on its population. In practice this means identifying the people with low agency, and those who are at risk of either poor health in the future or finding themselves in difficult circumstances. Furthermore, relieving the load on GP practices was also identified as a key aim of this social prescribing service.

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[14] Friedli, L., Jackson, C., Abernethy, H., & Stansfield, J. (2008). *Social prescribing for mental health- a guide to commissioning and delivery*. *Care Services Improvement Partnership* (Vol. 9). Retrieved from https://www.centreforwelfarereform.org/uploads/attachment/339/social-prescribing-for-mental-health.pdf

[15] South, J., Higgins, T. J., Woodall, J., & White, S. M. (2008). Can social prescribing provide the missing link? *Primary Health Care Research and Development*, *9*(4), 310–318. http://doi.org/10.1017/S146342360800087X

The development of this particular social prescribing service was innovative for several reasons. Very few existing social prescribing services have a prevention focus to them, therefore there is very little existing learning to go on. Furthermore, it is important to understand that no additional budget was available to implement social prescribing, therefore integrating existing resources and knowledge was essential. These are important considerations when contextualising progress and outcomes achieved. Using a multidisciplinary team approach was deemed as essential. This involved many professionals but particularly those from community enablement, adult social care, Help2Change e.g. social prescribing advisors, data system lead and operational locality lead, to get the social prescribing service up and running. There was also the involvement of GP and CCG colleagues.

The aim was therefore to design and implement a demonstrator site service with referrals from four GP practices. Working at a local scale would create the strong foundations of a successful and sustainable integrated social prescribing demonstrator service. The learning from this implementation phase could then be translated and scaled up across other parts of Shropshire, as well as leaving a legacy over the next 20 years.

As well as GP surgeries, agencies who refer to the social prescribing advisor include adult social care and voluntary sector organisations, e.g. Age UK, libraries, local groups (e.g. Qube, Support for families), and the Department for Work and Pensions. This approach is aligned with the strategic direction of integration for both public health and social prescribing.[16,17]

Alongside the implementation of the Shropshire social prescribing service, an independent evaluation by the University of Westminster was commissioned. The evaluation aimed to understand why the social prescribing programme is being used and how well the components of the social prescribing model are working together.

This was represented by 2 key objectives:

1. To inform the implementation of a robust social prescribing service using best practice in development and data collection.

2. To understand the impact of the social prescribing service

[16] Department of Health and Social Care (2018). Prevention is better than cure. Our vision to help you live well for longer

[17] HM Government (2018). A connected Society. A strategy for tackling loneliness – laying the foundations for change. Department for Digital, Culture, Media and Sport

2.0 Methods

This section will outline the methods used to recruit participants, collect and analyse data in the service evaluation.

2.1 Design:

A single arm, quasi-experimental pre-post, mixed-methods, data collection design was used to investigate the longitudinal benefits of the Social Prescribing service. Ethical approval was gained from University of Westminster's Faculty Research Ethics Committee.

2.2 Participants and recruitment:

Individuals were referred to the social prescribing advisor via 2 main routes. Firstly, patients at two of the participating GP practices were identified retrospectively based on a CVD Qrisk2 score of 10% or more, or pre-diabetes risk. These patients were contacted via letter from their GP practice and offered an appointment with a social prescribing advisor to review ways of reducing their risk of CVD in the future. Secondly, individuals who met any of the Social Prescribing Service eligibility criteria (loneliness, mental health issues, long term conditions) could also be opportunistically referred via the GP surgeries as well as organisations such as Job centres, and Oswestry library.

Individuals who opted to have a consultation with the social prescribing advisor at the social prescribing services were provided with information about the service evaluation, with a request to consent to take part. Individuals were recruited into the service evaluation by the social prescribing advisor at the first consultation before evaluation data was collected.

2.3 Data collection:

2.3.1 Patient Reported Outcomes Measures

Table 1 shows the range of quantitative and qualitative data collected using patient reported questionnaires. A questionnaire pack was administered by the social prescribing advisors at the first consultation (baseline) and 3 months follow-up (Jan 2018- onwards).

2.3.2 Physiological Data and Health service usage

Data on blood pressure, weight, body mass index (BMI), cholesterol levels, physical activity and smoking status were retrieved from participants' electronic medical records. The number of GP and nurse appointments, visits to A&E, inpatient and outpatient appointment and unplanned visits to hospital were also extracted from medical records.

Domain	Measurement tool	Information
Peoples concerns about their health and wellbeing	Measure Yourself Concerns and Wellbeing questionnaire	Validated self-completed and patient led. Capture concerns and wellbeing and qualitative data on the value of the service and other things affecting health.
Patient activation	Patient Activation Measure questionnaire	13 statements on beliefs and patient confidence around the management of their individual health condition. Linked to clinical outcomes and costs for delivering care)
Loneliness levels	De Jong Gierveld Loneliness Scale 6 items questionnaire	Validated 6 items questionnaire, which can discern emotional and social isolation.
Work and relationship status	Bespoke questions	To ascertain more information about participants
Service satisfaction	Bespoke satisfaction survey	Anonymous survey administered at the 3 months follow up only rating satisfaction and providing space to feedback comments.

Table 1. Summary of questionnaire data collected at baseline and 3-month follow-up.

2.3.3 Stakeholder Interviews

One-to-one, semi structured interviews were carried out with 24 individuals over a 10-month period. Participants included 6 staff members directly involved in the designing, implementation and running of the scheme; 6 people from the CVD risk register who had met with a link worker on at least one occasion; 4 non-CVD service users and finally, external stakeholders and organizations referring into the scheme. Prior to all the interviews, participants were sent copies of the participant information sheet to read and/or had the study explained to them. All but one participant then consented to take part (one service user felt they were not up to doing it). Topic guides rather than set questions were employed so that participants could feel free to relate their stories and unanticipated issues could emerge. Interviews were held at the convenience of the participant, and the dialogue was digitally recorded. Individual interviews lasted from 30-60 minutes. All participants were debriefed and thanked by email within a week of the interview. Interview data were transcribed by an agency and stored securely as password protected files on a password-protected computer.

Semi-structured Interviews (* real role but pseudonyms)								
Key Staff*	**Year**		**Other stakeholders***	**Year**		**Service users**	**Year**	**Referral reason**
Link worker (Carol)	2018		Practice manager (Keith)	2018		Female	2018	CVD
Public health manager (Joan)	2018		DWP Disability Employment Advisor (Sue)	2019		Female	2018	CVD
Project Manager (Ken)	2018		DWP Employment Advisor (Pat)	2019		Female	2018	CVD
IT manager (Chris)	2018		DWP Employment Advisor (Ann)	2019		Male	2018	CVD
Service manager (Kath)	2018		Adult social care worker (Jill)	2019		Male	2018	CVD
Public Health consultant (Elise)	2018		Adult social care worker (Mel)	2019		Male	2018	CVD
Link worker (Emily)	2019		GP (Nick)	2019		Female	2019	Other
			GP (Liz)	2019		Female	2019	Other
						Male	2019	Mental Health
						Female	2019	Other

Table 2. Characteristics of participants taking part in semi-structured interviews (real roles but pseudonyms). **Link worker** = social prescribing link worker***;*** **DWP =** Department of Work and Pensions***;*** **Service user** = a person who has met with a social prescribing link worker***;*** **CVD** = service user is on a CVD register***;*** **Other** = service user has been identified or self identifies as having health issues related to life style, weight; **Mental health** = patient has been identified as having mental health needs.

2.4 Data Analysis

2.4.1 Qualitative Analysis

Thematic data analysis was conducted in phases using NVivo to analyse different sections of the data in various ways. By repeatedly listening to the digital recordings and reading transcripts of interviews, the author familiarized herself with all the data covering the full range of themes. NVivo was then used to extract more codes and analyse different sections of the data in various ways. Maps and diagrams were then used to creatively synthesize ideas. As ideas were generated, they were discussed with the research team and with different stakeholders. Data was coded using a modified constant comparison approach inspecting and comparing all data and fragments arising in a given case and moving from a larger to more compact data set.

2.4.2 Quantitative Analysis

The numerical data from outcome measures was not normally distributed, therefore non-parametric Wilcoxon Repeated Measures statistical tests were used to test the data for significant differences showing changes in scores on the questionnaires.

Measure Yourself Concerns and Wellbeing (MYCaW)

MYCaW concerns, wellbeing and profile score were calculated individually and the mean score for the cohort calculated at each time point. Qualitative data from the MYCaW tool was analysed using content analysis. [18,19]

Patient Activation Measure (PAM)

All scores from PAM were analysed for total score change pre-post and individual score changes of 4 or more points was deemed clinically significant. Scores were also calculated as activation levels and comparisons of frequencies of activation levels made.

De Jong Gierveld Loneliness Scale

Pre-post score changes for social loneliness, emotional loneliness and total loneliness were calculated individually and the mean score for the cohort calculated at each time point.

Physiological health data

Physiological health data was collected from the GP practice records or by the social prescribing advisor. This measured height (cm), weight (kg), BMI, systolic BP (mmHg), diastolic BP (mmHg), total cholesterol (mmol/L), HDL cholesterol (mmol/L), non-HDL cholesterol (mmol/L), cholesterol

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[18] Polley MJ, et al (2007). How to summarise and report written qualitative data from patients: a method for use in cancer support care. Supportive Care in Cancer 15(8)963-71.
[19] Seers HE, et al. (2009) Individualised and complex experiences of integrative cancer support care: combining qualitative and quantitative data. Support Care Cancer.17(9) p1159

ratio, smoking status, level of declared physical activity and weight classification. Data was non-parametric and, where possible was analysed by Wilcoxson Repeated Measures tests.

Health service usage data

Health service usage data was collected in terms of frequencies of attendance at: GP practice, nurse, hospital unplanned, hospital inpatient, hospital outpatient for the three months before attending the social prescribing service, and then the three months prior to follow-up appointment at the social prescribing service. A matched control group of people who were offered social prescribing but did not take it up was used to compare health service usage at each time point.

Employment status

Frequency of employment status was captured to see changes in frequencies in people's social status.

Service user satisfaction

An anonymous satisfaction questionnaire asked people to reflect on their experience of the service using Likert scales of satisfaction, and provided qualitative data relating to patient experience and satisfaction. The data generated from this tool was only post-service, and therefore statistical tests were not performed on it.

3.0 Results

This social prescribing service was an innovative step forwards for Shropshire Council and results are reported to reflect data gathered from May 2017 to May 2019 [20].

This section is split into 4 sections, to allow the different aspects of the evaluation to be reported, these are:

3.1 Service Design and implementation
3.2 Service referrals and demographics
3.3 Service user satisfaction and experiences
3.4 Impact of the service

Throughout the results, we have used qualitative data from the questionnaires and interviews of stakeholders to provide real examples of people's responses to the social prescribing service to complement the quantitative data being presented.

3.1 Service Design and Implementation

This section themes that emerged from qualitative analysis of interviews relating to core elements, learning and challenges experienced when setting up the social prescribing demonstrator site.

Best practice and action learning

Working according to certain core principles developed through early research into successful factors in social prescribing[21] gives the service the best chance of success. Our findings suggest that the Shropshire social prescribing service is upholding and demonstrating these core principles in a robust manner. This will provide the service with the best chance of sustainability and long-term success.

The setting up of the service was both systematic and iterative. The ethos of action learning is also fully embedded in the Shropshire social prescribing service, and the team is making use of multiple opportunities to learn and progress the social prescribing model. Each step of the learning process had been documented by the implementation team, through agile management meetings.

The learning gained from the practices adopting social prescribing informed the development of the service in later practices, with successful elements replicated, and less effective elements discarded. For example, a practice manager explained how a decision had been made to free up a practice room in the surgery one day a week, so that the patient knew the scheme was connected to the GP service, and also to allow patients to combine the visit with other actions

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[20] Please note, a previous version of this report was generated for data collected between May 2017 and October 2018 – this was Phase 1, and this current report represents the full findings of the complete evaluation from May 2017 to May 2019.

[21] Polley M et al (2016). Annual National Social Prescribing Network Conference report. University of Westminster, London

such as discussing a prescription. Service users who were interviewed agreed that having the social prescribing meeting in the GP surgery had made attendance relatively straightforward.

"A young lady came and interviewed me from Shropshire Council, at the doctor's"

"The times were very convenient and the ease in which dates could be altered was really helpful. The room and atmosphere in the appointments were very relaxed which made 'opening up' so much easier."

"We've got a large medical centre in Oswestry and I met her there."

Collaborative working

All staff interviewed about the project agreed that it was a collaborative venture. An important step was engaging with local stakeholders in the Shropshire area (GP practices, organisations) and working on a model that they could start to implement. It was considered important to treat these stakeholders as equal partners, and not dictate to them.

The top 'go to' organisations/groups were identified early on, which was useful in terms of linking in with voluntary sector contracts commissioned by the council. These VCSE services could be walking groups, talking groups, physical activity groups, whatever exists locally that could support people.

The Shropshire social prescribing scheme is now making good use of the rich resources and assets within the local area, while seeking ways to overcome local problems such as physical isolation and transport limitations. Underpinning the service was the belief that communities can come up with their own solutions, but that the social prescribing service offers them a framework through which to do this. Voluntary organisations in the area had also benefited from the formal referral and feedback system, because it helps to validate their work as a positive health intervention.

Quality assurance (QA)

QA of the social prescribing interventions was regarded as a priority when designing the social prescribing service. The social prescribing service shared the QA procedure with the VCSEs who would receive individual referrals. These organisations then had to self-report about their policies

and procedures regarding safeguarding, health and safety and information governance. This was necessary to ensure the organisations were suitable to refer to. Cases considered “too challenging” or “too severe” for the social prescribing service, e.g. serious mental health issues and suicidal cases, were referred by the social prescribing advisor to emergency intervention from mental health services. It was important to give confidence to GPs to refer to the social prescribing service.

Implementation challenges

Part of the team’s learning journey has been recognising and learning from the challenges of setting up a new, fully integrated service from scratch with finite numbers of people and financial resources. Team members identified the following challenges, and that others setting up similar schemes could learn from them.

Time

Setting up a social prescribing project, with all its complexities, was a time-consuming process involving much learning in action. The decision to create a service of a very high quality and standard, which was fully documented and independently evaluated from the onset, made the whole process more iterative than expected. While the enthusiasm, team spirit and dedication across the team was emphasised, team members had other work duties as well.

Staff directly working for the social prescribing service did so on a part-time basis which slowed down both the setting up of different aspects of the service (e.g. evaluation) and communication between different parties. The various GP practices also needed to be invited in, and this required time for discussion, but was acknowledged as an essential element in the implementation process.

For those involved at the operational level, having an independent evaluation had created its own set of challenges. Capturing the right data proved time consuming with delays in the rolling out and collection of evaluation data. The national regulations around GDPR were also introduced whilst this project was in process. A necessary but time-consuming part of the process was ensuring that data sharing agreements and suitable ways of managing the data between GP practices, Help2Change (Shropshire council) and the evaluation team (University of Westminster) were all in place. This was balanced against the growing pressure to demonstrate the outcomes to the financial stakeholders.

Data collection

The social prescribing advisors faced practical challenges when collecting evaluation data, in particular how to negotiate or integrate data collection into the consultation process. There were concerns at times as to how data collection may affect the consultation. The first social

prescribing advisors at the demonstrator site were supported by the evaluation team from the University of Westminster, to enable high quality data collection to occur i.e. adhering to the appropriate procedures associated with informed consent, outcomes measures and data handling and storage. Whilst some stakeholders wanted particular data, it was acknowledged that a social prescribing advisor may not be in a position to collect the data – this was sometimes dependent on how the first consultation was progressing. This was a fine line to navigate, however, the individual service users' needs were always put first.

Participants were interviewed by the evaluation team as part of the service evaluation, which meant they had been asked to complete several questionnaires at the initial and follow up meetings with the social prescribing advisor. None of the participants expressed any objections to answering the questionnaires and at least two had appreciated being part of a research project. One described the questions as "not taking very long" although another remembered that it had involved "ticking a lot of boxes."

Funding and resourcing

With a limited budget, resourcing was a challenge. The team managed with in-house resources (across the wider council and public health) and the voluntary sector, which had been "very positive" about contributing towards the scheme. They had taken a system wide approach, but budget limitations meant the service had to be strategically targeted.

Pressure on the social prescribing team, from external stakeholders to "show results" led to some "interesting conversations" when some team members were challenged about the data in terms of impact and numbers of referrals, part-way through the evaluation. The social prescribing service took longer to set up that anticipated, however, it adhered to the core principles associated with long term success. Having these challenging conversations was viewed as constructive by the social prescribing team. Having a development and reflection process that enabled critical friends to be involved was part of the ethos of the action learning approach from day one.

Avoiding duplication

Another challenge was convincing some stakeholders that the social prescribing service was not duplicating services already offered, such as by the Community Care Coordinators (C&CCs). The focus of the C&CCs was primarily on practically supporting the frail and elderly (via care coordination, aids, adaptations, alarms etc.) as well as supporting people who were experiencing loneliness, whereas the Shropshire social prescribing service was aimed at *preventing* diseases from occurring in later life and *preventing* loneliness.

To summarise

A robust and informed approach to developing a social prescribing service was used. Efficient use of limited resources and existing assets in the local area was made and best practice was adhered where possible. Choosing to have an independent evaluation carried out from the

beginning of the project added a layer of complexity but has enabled independent data analysis to be captured. The iterative learning cycles and learning from the evaluation enabled the service to evolve as necessary, responding to local challenges in the operating environment. Learning gained was used to inform development of schemes countywide.

Governance, in the form of protection of vulnerable clients, ensured that people unsuited to social prescribing were referred to the appropriate agencies, such as mental health services.

Other elements of a sustainable social prescribing service identified in this study include; involving local communities from inception; a phased role out involved multiple testing of the different parts of the model with the gathering of different stakeholder perspectives and reflections; pre-service training and networking; collaborative relationships with external stakeholders and supervision and support for social prescribing link workers.

Problems experienced implementing and running the service that were identified in this study include; making choices around allocation of limited resources; establishing eligibility and the suitability of clients and interventions; keeping communication and feedback loops active; managing concerns about duplication or overloading of services, administrative and technological challenges, and undergoing a rigorous, longitudinal service evaluation while being under pressure to rapidly produce the evidence required to secure long-term funding.

Stakeholders recommendations for implementing future social prescribing projects were;

- Use a sound methodology to develop the model and nail down the requirements of the service and its evaluation as soon as possible.
- Keep a data trail and recording the learning, “the steps and the iterations that we’ve gone through.”
- Cultivate the main sources of referral, i.e. the keenest GP practices. “They really want it to happen, they’ve taken ownership of it… they’re part of the process from the beginning.”
- The data collection process itself needs to be factored into any analysis of a real-world social prescribing project.

3.2 Service referrals and demographics

In this section we present information on referrals into the social prescribing service across Shropshire (n=515) and then referrals associated with the evaluation (n=105).

Shropshire wide

Overall the Shropshire social prescribing service has expanded to 4 services in Oswestry/Ellesmere, Albrighton, Bishop's Castle, Bridgnorth and 4 services in Shrewsbury, which incorporated 11 GP practices. Data below reflects 515 referrals (both opportunistic referrals and systematic identification through an audit of the patient record) made between May 2017 – May 2019.

- Opportunistic referrals were made by a range of other services as well as by the GP surgeries which include Adult Social Care, Oswestry & Shrewsbury Job Centre, Help2Change, Oswestry library, Early Help, Enable, Qube, Mental Health Access team, Age UK, First Point of Contact, Pharmacy in Albrighton and Physiotherapy.

- Opportunistic Referral rates from the GP practices were variable ranging from 4 referrals (Caxton) to 56 referrals (Bridgnorth) which reflects the length of time they have been involved in social prescribing and whether they are focussing on systematic or opportunistic referrals (See Appendix A for breakdown of referrals by GP practices).

- The social prescribing service is catering for a very wide range of ages, 79% of service users are between 40-79 years old (See Figure 2 below).

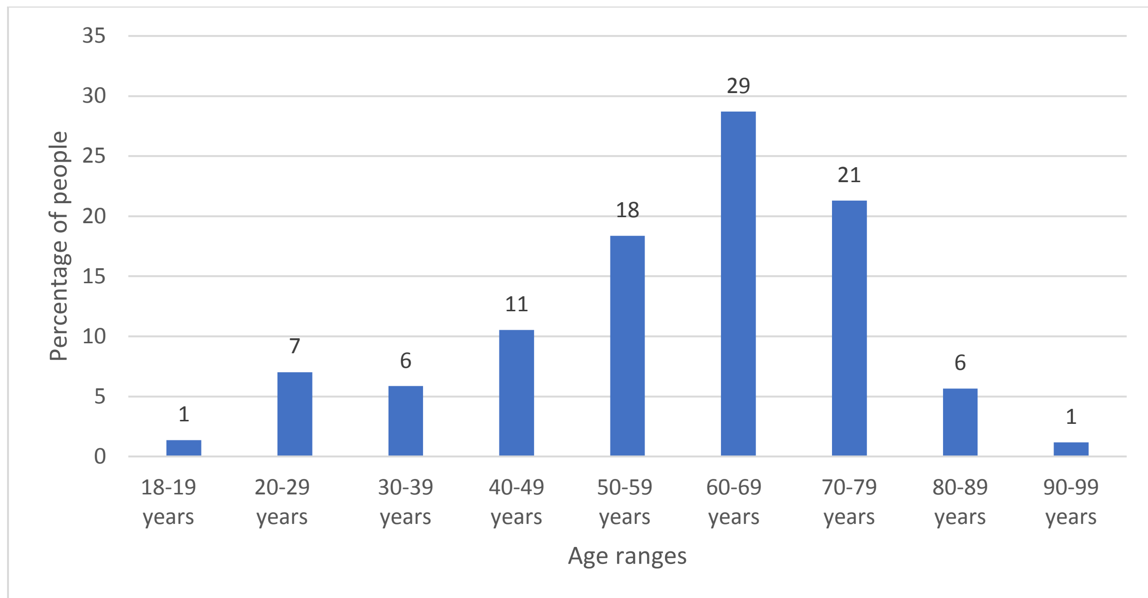

Figure 2. Range and frequency of ages of service users.

Reasons of opportunistic referral into the social prescribing service are presented in Figure 3 below. The most frequent reason was for mental health issues, closely followed by lifestyle risk factors and loneliness or isolation issues.

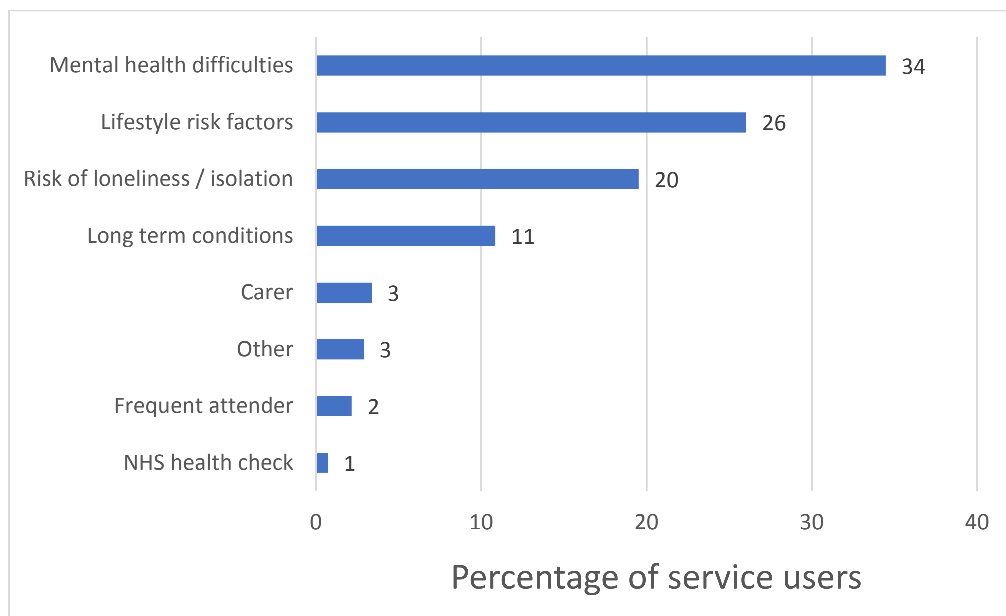

Figure 3. Reasons for opportunistically referring individuals into the social prescribing services. Individuals (n=301) were referred for a total of 415 reasons as individuals can be referred for more than one reason.

A CVD audit of the medical records in 2 of the Oswestry and Ellesmere (O&E) GP practices was carried out to find patients who had a CVD Qrisk2 score of ≥10%. Details of the process undertaken between Jan 2018 – February 2019 as follows (note not all CVD audit data available therefore this only represents a proportion of the service activity):

- 294 people were invited by a letter from their GP practice to use the social prescribing service
- 239 (81%) of these were successfully contacted by the social prescribing advisor after the letter had been sent
    - 109 (46%) accepted the offer of an appointment;
    - 113 (47%) declined the appointment
    - 17 (7%) had no record for declining or accepting.

Evaluation specific recruitment

The Oswestry/Ellesmere social prescribing service was the first social prescribing service to be implemented and the only one running when the evaluation was set-up. Evaluation participants were initially therefore only able to be recruited from the 4 GP practices involved in this social prescribing service. Recruitment later expanded to include social prescribing clients from 3 practices in Shrewsbury, from Albrighton Medical Practice and from Bridgnorth.

Of the 515 individuals who used the social prescribing service between May 2017 and May 2019, 134 consented to take part in the evaluation: 113 Oswestry/Ellesmere; 17 Shrewsbury; 2 Albrighton; 2 Bridgnorth. 105 of these participants attended their 3 months follow-up appointment. 87 Oswestry/Ellesmere; 15 Shrewsbury; 1 Albrighton; 2 Bridgnorth.

As the social prescribing service was new, there was no prior data to inform the choice of inclusion criteria. Initially the inclusion criteria was agreed as systematic referral of people at risk of CVD, i.e. Qrisk2 score of ≥10% and opportunistic referral of people who were socially isolated or lonely. Later on, the inclusion criteria of the opportunistic group was widened (See Fig 4). Overall, 68% of evaluation participants were via the CVD audit, 32% were via opportunistic referrals.

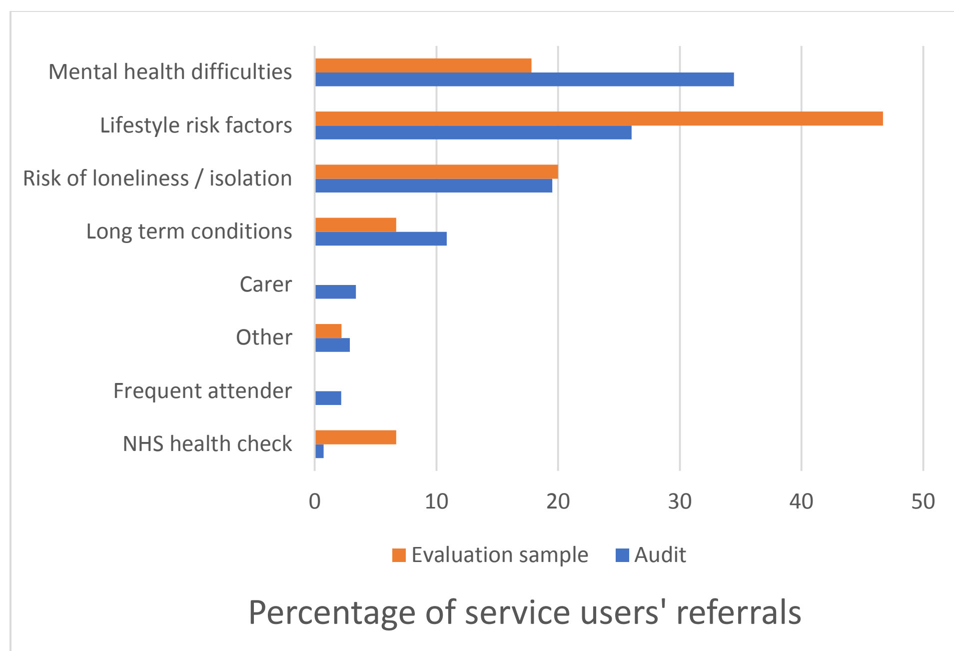

Figure 4. Comparison of opportunistic referrals from Oswestry & Ellesmere GP practices vs evaluation practices.

Opportunistic referrals into the whole service are recorded in blue on Figure 4. Individuals who consented to the evaluation did represent the majority of categories of opportunistic referrals, but not necessarily in the same proportions.

Participant demographics

The demographics of the evaluation participants at baseline and at 3-month follow-up are shown in Table 3. The 3-month follow-up group showed the same demographics as the full group at baseline, except there were a smaller relative percentage of single people and higher percentage of widowed people in the follow-up group. There were also a smaller percentage of employed people in the follow-up group.

Demographic	Detail	Number (%) of Baseline (n=134)	Number (%) at 3 months' follow-up (n=105)
Gender	Male	62 (46%)	48 (46%)
	Female	71 (53%)	57 (54%)
Mean age		61.31 years (SD 12.6)	62.21 years (SD 11.9)
Referral type	Systematic (CVD risk identified)	90 (67%)	71 (68%)
	Opportunistic (not CVD risk identified)	18 (13%)	16 (15%)
	Other	26 (19%)	18 (17%)
Marital status	Married	63 (47%)	48 (46%)
	Single	40 (30%)	31 (30%)
	Divorced	17 (12%)	13 (12%)
	Widowed	11 (8%)	10 (10%)
	Separated (same sex relationship)	1 (1%)	1 (1%)
	Other/Rather not say	2 (2%)	2 (2%)
Ethnicity	White	129 (9%)	103 (98%)
	Other	1 (1%)	1 (1%)
	Not declared	2 (2%)	2 (2%)
Employment status	Retired	62 (46%)	53 (51%)
	Employed	38 (28%)	27 (26%)
	Unemployed	23 (17%)	16 (15%)
	Disabled	7 (5%)	5 (5%)
	Housewife/Husband	2 (2%)	2 (2%)
	Sick leave	1 (1%)	1 (1%)
	Volunteering	1 (1%)	1 (1%)

Table 3: Demographic data of individuals who participated in the evaluation. Data is presented for all participants in the evaluation at baseline (n=134) and for those with 3-month follow-up (n=105).

3.3 Service user satisfaction and experience

3.3.1 Satisfaction ratings

A service satisfaction questionnaire was completed anonymously by 72 participants. This was done separately to the other questionnaires used in the evaluation as it is a standard part of the service. As it was anonymous, it was impossible to chase up non-responders. Of the people who responded, results showed an extremely high level of satisfaction with the social prescribing service.

- Convenience of times, (4.85/5)
- Convenience and suitability of venue (4.82/5),
- Feeling able to discuss concerns with the social prescribing advisor (4.89/5).

56/72 (78%) responded that they knew why they were referred, 9/72 (13%) did not know why

52/72 (72%) participants felt they were referred to a suitable intervention or support service, 3/72 (4%) did not.

3.3.2 Service user experience

Qualitative analysis was carried out on data from the service users, to understand what their experience was like, what was particularly important or anything that could be improved. This section briefly reports on key themes that were identified in the qualitative analysis relating to service user experience. These include working with people with low agency and the value of the social prescribing advisor which is split into the following aspects; the referral; the relationship with the social prescribing advisor; tackling loneliness and isolation; incentivising.

Supporting people with low agency:

One aim of the social prescribing service was to support people with low agency. Initial feedback from service users demonstrated that this group of people were being identified.

"I think I'd been to the doctors about my cholesterol and the issue of weight came into it, which I had been aware of for some time, but really done nothing about it"

"I was a regular smoker and of course every time I meet with a health care professional they tell me, this is not a very good idea you know".

The value of the social prescribing advisor

Service users (and staff) saw the role of the social prescribing advisor as crucial to the social prescribing experience. Several aspects specifically relating to the social prescribing advisor were highlighted by users as valuable and positive. These included the referral process, the relationship they established, and the incentive provided, which are explained in more detail below.

The referral

Whilst individuals were referred into the service via multiple agencies, all participants interviewed had been referred by, and had received a letter from their GP surgery (as part of the CVD risk audit). Most participants remembered receiving the referral letter and a follow up call from the social prescribing advisor. This demonstrates the value of following up the letter with an introductory call from the social prescribing advisor, particularly if a person had low agency and was unlikely to proactively book an appointment.

> ***"I got a call from xx (the SP Advisor), explaining who she was and saying would I like to go down and talk to her for an hour, and it really snowballed from there."***

Relationship with social prescribing advisor

Meetings with the social prescribing advisor were seen as central to the social prescribing service, as it is here that individuals, through a process of co-production, could establish their health needs and put a plan into place.

Most participants recalled their first meeting with the social prescribing advisor. Participants expressed an appreciation of the length of time allocated for this meeting and for exploring their personal health needs; e.g.

> ***"I think partly the attraction of it was, that there was somebody who was happy to talk about my problem and also say, I can give you an hour."***

This participant acknowledged how rarely such an in-depth conversation about their health and wellbeing needs took place in a GP practice; e.g.

> ***"How often do you get offered an hour's chat about a particular problem in a doctor's medical centre? You don't and I do have to say that was really quite an incentive."***

Impressions of the social prescribing advisors were generally very favourable. One participant described their advisor as "very helpful" and "supportive," remarking on how the advisor had

> ***"listened carefully and came up with good answers and suggestions."***

Another participant described the Advisor as:

> ***"a very nice lady… who suggested there were things I could do that would not so much improve my health - but more sort out the wellbeing things."***

Participants appreciated the fact that it was that it was more like a sort of discussion about what they wanted and what was going to work for them. One participant explained how useful it was to discuss their problems concerning weight loss with someone who was really prepared to listen:

> ***"[It was] Very helpful. We talked over, obviously, weight issues and as to how I might go about doing this more positively."***

Tackling loneliness and isolation

Reducing and preventing loneliness and isolation was a goal of social prescribing service, and user responses suggested that that the privacy and empathic nature of consultation process with the social prescribing advisor played a part in this:

"The advisor has been a sensitive and helpful advisor, who's given me enough latitude to open up about what are quite private matters."

"Issues are difficult to talk about but felt able to share things not shared before because of advisors."

While participants in our study had been referred to a wide range of services, many had opted to pursue a group activity or intervention, which could bring social and emotional as well as physical benefits:

"As a result of speaking with the Adviser, I have joined a weekly walking group and also joined a leisure centre where I go to swim once or twice a weekly."

"Started baby and mother gym classes and will be starting group activities too."

Not all service users were able to engage in energetic activities, and for those who were isolated, other solutions were found, such as home visits from professionals and volunteers.

Incentivising

It was clear from the interviews that the social prescribing advisor/client meeting had led people to consider their health more seriously and to look for ways to improve it. The conversation and trust established with their Advisor had, for some, acted as an incentive in itself:

> ***"Knowing that [the SP Advisor] had said to me, 'I'll see you in three months and we'll see how we're going.' That actually was a very good incentive. I've been to things like Weight Watchers and things like that before…but [the SP Advisor] was taking the trouble to see me, giving me one to one, which I think is very important…I didn't want to let her down any more than I wanted to let myself down."***

Important for some participants were the follow up calls by the social prescribing advisor to check that the client had followed up their recommendation. One participant spoke of how they had gone away and forgotten about the conversation until they received a reminder call;

> ***"If they hadn't persisted I'd have just forgotten about it. If it had just been one visit to the surgery I'm sure…there would have been a very different outcome."***

3.4 Impact of the service

This next section of the results reports on the measures that were used to capture changes as a result of the social prescribing service. Underpinning these quantitative results is further data ascertained from interviewing participants about their experience of the service.

3.4.1 Measure Yourself Concerns and Wellbeing (MYCaW)

Capturing and applying a person's voice

Previous research has recognised that people may be referred to a service for one reason, but upon consultation, (in this case with a social prescribing advisor), areas of unmet needs are revealed that initial referring professional may not have been aware. Thus, the reason a person is referred is not necessarily the thing that they most need addressing, for their health and wellbeing to improve. This data can then be used to understand what a service could be providing to *fully* meet the needs of the service users.

MYCaW allows an individual to easily voice what they feel really needs addressing within the first consultation with the social prescribing advisor. Importantly this captures the true person-centred aspect of social prescribing and demonstrates why the social prescribing advisor is such an important part of the service provision. Participants in the evaluation were asked to say what two things concerned them most and score the severity of these concerns – this was not restricted to health but could be anything in their life at that point in time.

MYCaW Concerns

The MYCaW concerns data demonstrates the importance of the social prescribing advisor consultation, to determine what unmet needs exist and how to most appropriately support these unmet needs.

134 people reported 216 concerns and only 2% (6) people reported no concerns, showing very few people were referred inappropriately.

Whilst 67% of participants were referred due to their risk of CVD, only 52% (113) of concerns were about getting support to reduce their risk of CVD – see Figure 5.

A range of other concerns were also identified (See Figure 6), including social, welfare and employment concerns. Participants who said they wanted to get out more, were interpreted as a group of people who are either experiencing or at risk of loneliness or social isolation.

Some participants reported concerns related pain and arthritis. Getting people more physically active is a priority in reducing current and future health problems in Shropshire and nationwide. There is little chance, however, of these individuals becoming more physically active until their pain is appropriately managed. Family relationships, money and work were all concerns that participants reported urgently wanting support with all of which were not identified during the initial opportunistic referral to the social prescribing service. Meeting these unmet needs could be viewed as an additional benefit of the current social prescribing service.

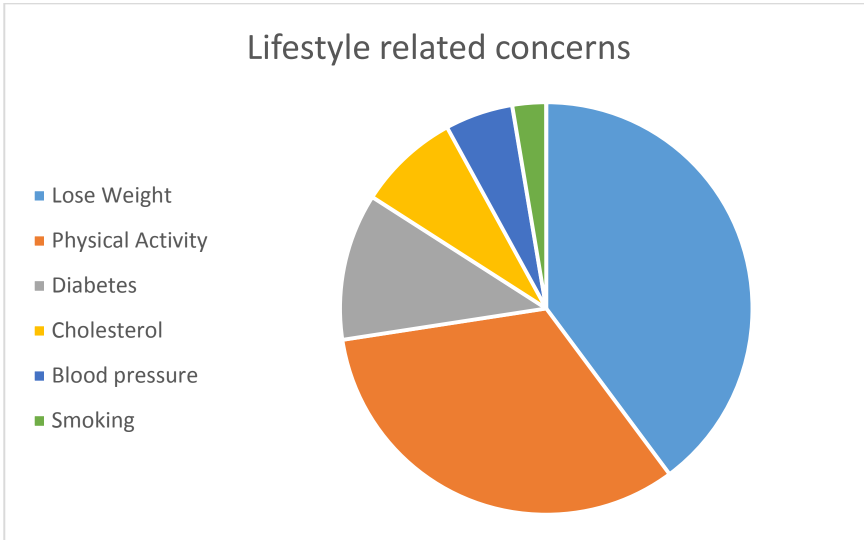

Figure 5. MYCaW concerns related to modifiable risk factors for CVD. n=113 concerns expressed by 52% of participants.

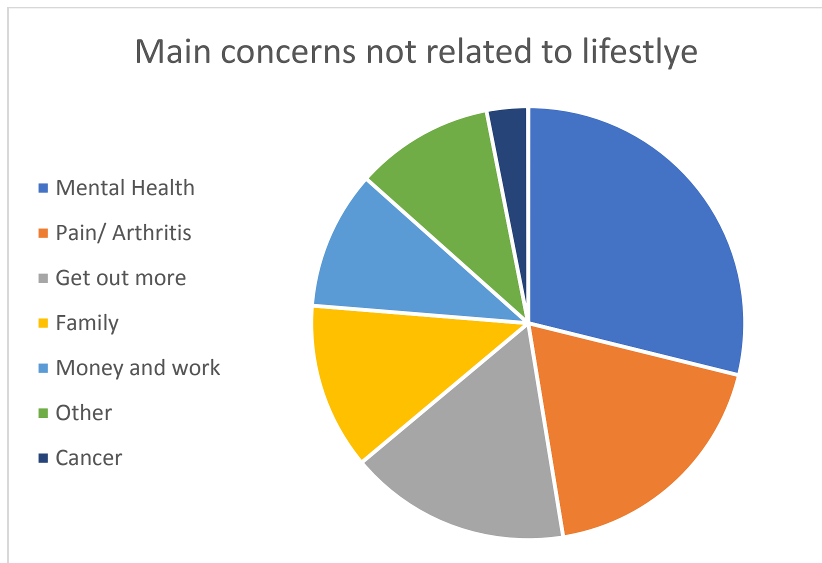

Figure 6. All other MYCaW concerns not directly related to modifiable risk factors for CVD. n=97 concerns expressed by 45% of participants.

MYCaW Scores

Participants were asked to rate the severity of each concern and to also rate their wellbeing, see Table 4 and Figure 7.

There are clear improvements in concerns and wellbeing scores from this service. This indicates that after going through the social prescribing service, participants' unmet needs had been supported. The mean change in Concerns are statistically significant in their improvement comparing baseline paired to three months follow up (p=0.0001 Concern1 and p=0.003 Concern 2). Changes for both MYCaW concerns are over the minimum important change threshold which means this change translates into an actual noticeable improvement in their lives.

There was also a statistically significant improvement in overall wellbeing for the participants at 3 months. The MYCaW wellbeing score reflects all parts of a person's life and it is normal for these score changes to be between 0.6-1.0. The smallest score change considered clinically relevant is 0.5[22], and this was reached for the wellbeing, confirmed by the statistically significant test result.

MYCaW scores	Baseline Mean [SD] (n)	Follow-up Mean [SD] (n)	Mean Score change Wilcoxon Z score and p value
Concern 1	**4.86** [1.29] (97)	**3.34** [1.80] (97)	**-1.18*** z = -6.23 **p=0.0001**
Concern 2	**4.65** [1.36] (60)	**3.13** [1.96] (60)	**-0.93** z = - 4.17 **p=0.003**
Wellbeing	**3.45** [1.48] (99)	**2.51** [1.54] (99)	**-0.50** z = - 3.49 **p=0.000**
Profile score	**4.32** [1.13] (60)	**3.11** [1.47] (60)	**-0.87** z = - 4.89 **p=0.000**

*Table 4. MYCaW Concerns and Wellbeing scores. Concern scores are rated between 0 -6, where 6 is most severe, hence a reduction in concern score is an improvement. Wellbeing scores are rated 0-6 where 6 is the worst it can be, hence a decrease in wellbeing score is an improvement. Statistical significance is reached when p ≤0.05. Not every participant filled in every section, n values are provided accordingly. *An improvement over 1 represents a clinically significant change in that problem.*

[22] Seers HE, et al. (2009) Individualised and complex experiences of integrative cancer support care: combining qualitative and quantitative data. Support Care Cancer.17(9) p1159

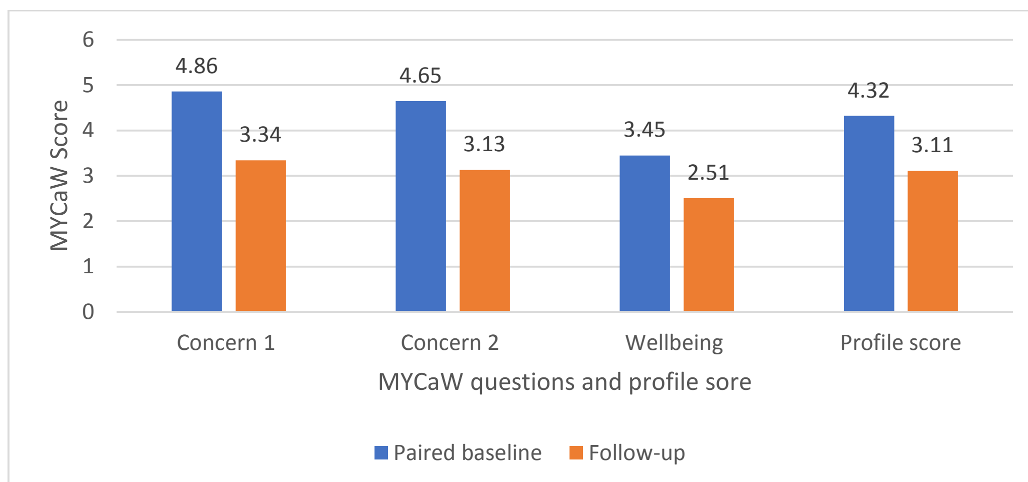

*Figure 7. MYCaW concerns and wellbeing scores at baseline vs. 3 months follow-up. Concern scores are rated between 0 -6, where 6 is most severe, hence a reduction in concern score is an improvement. Wellbeing scores are rated 0-6 where 6 is the worst it can be, hence a decrease in wellbeing score is an improvement. Statistical significance is reached when p ≤0.05. Not every participant filled in every section, n values are provided accordingly. *An improvement over 1 represents a clinically significant change in that problem.*

What else is going on in your life that is affecting your health?

On the follow-up MYCaW form, participants are asked if there was anything else happening in their life that is affecting their health - 75 people responded to this. This question is most commonly answered if the events are particularly positive or negative. 60 people reported negative health issues, such are injuries, pain or operations and on-going worries with money and family. All these other issues affect a person's wellbeing and how able a person is to make and sustain positive lifestyle changes.

Positive events (n=15) highlighted included changes to participants' wellbeing due to the changes they were making with their diet and physical activity. This serves to reinforce the impact that the social prescribing services is having on their lives. Other events included having a holiday booked or having more support with carer duties for parents.

What was the most important thing about the service?

On the follow-up MYCaW form, participants could write down what they found most helpful about the social prescribing service they experienced.

This data corroborated the service user satisfaction and experience data (p30-34), as participants appreciated feeling supported, being able to talk things through with someone and feeling reassured.

"Good to have the chance to talk to someone specifically about health and well-being. This has prompted some dietary changes which have resulted in weight loss and a reduction in total cholesterol/increase in HDL."

People appreciated the information and guidance received and feeling more confident. These are two themes that are directly associated with patient activation.

"Meeting someone and being able to talk things through and feeling supported, has given me confidence."

Activation was also demonstrated by some participants who thought the best thing about the service was that they had made changes as a result of the service.

"Increasing physical activity levels, improved health and mood. I am walking 1.5 miles twice a day and trying other activities…my family have noticed positive changes."

Other people thought the referral from the social prescribing advisor out to the group/intervention was most valuable.

"Referral to Active Buddies and info/advice"

Overall the data from all aspects of MYCaW indicated that participants concerns were being identified and appropriately supported. Statistically significant improvements in mean concerns and wellbeing scores were achieved. Participants appreciated talking through issues with the social prescribing advisor, being listened to, and feeling supported, reassured, and felt more confident to put changes into action.

3.4.2 Patient Activation

The Patient Activation Measure (PAM), assesses the confidence, knowledge and ability a person has to improve their health. Thirteen questions are completed and scored. Observation studies in England and the USA have demonstrated that clinically significant improvements in PAM scores are associated with a reduction in health service usage and lower incidence of long-term health conditions over time.[23],[24] This measure is also now being adopted by NHS England as part of their personalised care strategy.

Change in PAM scores over time

The mean PAM score change for the 102 participants with baseline and 3 months follow up data was 5.13. A change of 4 points or more denotes a clinically significant change. Over whole dataset, therefore, a valuable increase in the activation levels and the ability of participants to make and sustain lifestyle changes was achieved.

Upon further analysis 53/102 (52%) had clinically significant improvements in PAM scores. This means that there is a likelihood that these 53 participants will use less health service resources from now on, as a result of using the social prescribing service.

PAM	Paired baseline Mean [SD] and (n)	Follow-up Mean [SD] and (n)	Score change Mean Wilcoxon Z score and p value
PAM Score /100	58.11 [11.4] (102)	63.23 [12.9] (102)	**5.13 z = -4.54 p = 0.000**

Table 5. Comparison of PAM scores for participants at baseline and at the 3-month follow-up time point (n=102). A change of 4 or more points denotes a clinically significant improvement. Data is statistically significant when p ≤0.05.

Changes in PAM levels of activation

PAM scores can also be designated as levels of activation, where level 1 = least activated and level 4 = most highly activated. Figure 8 shows that after receiving social prescribing there were

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[23] J.H.Hibbard, M.Tusler (2007)Assessing activation stage and employing a 'next steps' approach to supporting patient self-management. J Ambul Care Manage, 30 (2007), pp.2-8

[24] Turner A, Anderson JK, Wallace LM, Bourne C. An evaluation of a self-management program for patients with long-term conditions. Patient Educ Couns. 2015 Feb;98(2):213-9. doi: 10.1016/j.pec.2014.08.022. Epub 2014 Oct 22

more participants with the highest levels of activation (levels 3 & 4), and an overall reduction in the lowest levels of activation (Levels 1 & 2).

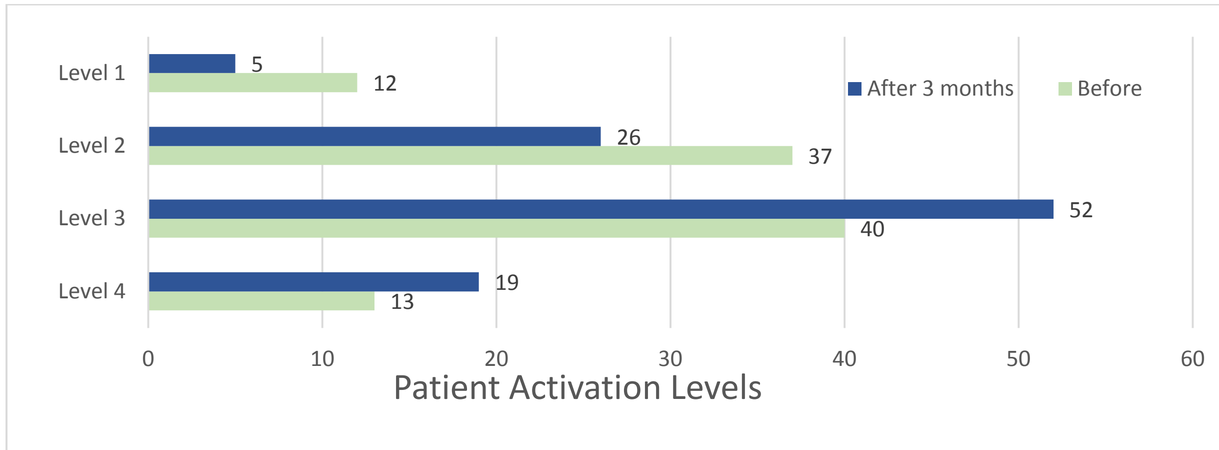

Figure 8. A comparison of participant activation levels before and 3 months after being referred into the social prescribing service (n=102 people).

The PAM data can also be reviewed in terms of low activators (Level 1+2) who are unlikely to make change without support, and high activators (Level 3+4) who can make and sustain change with minimal support. As shown in Figure 9, when people entered the social prescribing service (baseline), there was a near equal split in high vs. low activators. After three months of the social prescribing service, over two thirds of these participants scored as high activators (70%)

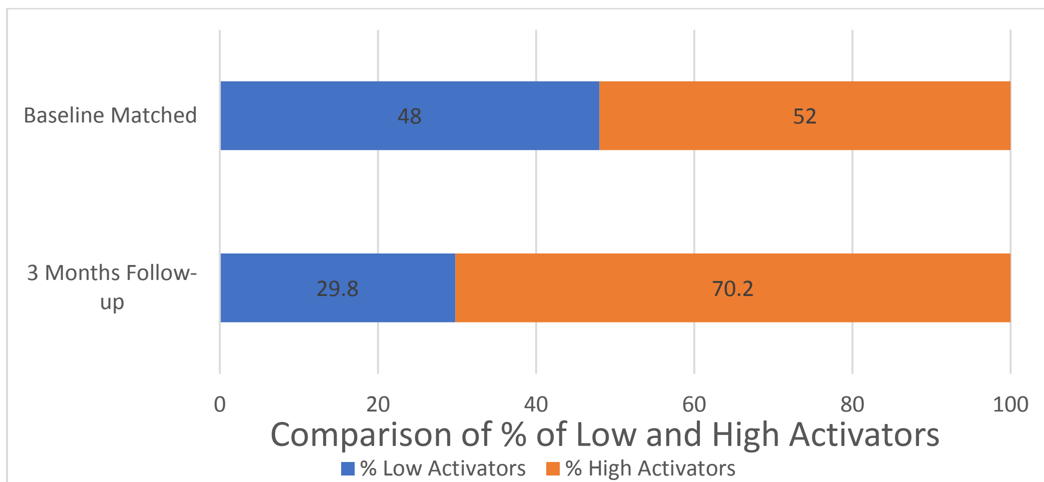

Figure 9. Comparison of the proportion of participant's activation levels. Participants scored as low or high activators on the patient activation measure (PAM), upon entering the social prescribing service (baseline) and when followed up 3 months later.

Not all participants improved their PAM scores, 18/102, (18%) had a decrease of 4 or more points. Interestingly, 11/18 of these of these participants also reported other negative events occurring in their lives on the MYCaW questionnaire. The effect of these negative events, such as bereavement, job loss, moving to a new house are a possible explanation for some of the decreases in activation levels, which occurred externally to the social prescribing service.

Changes in key items on the PAM

To understand why participants' activation was being improved we analysed each PAM question separately and found that 6 items in particular showed statistically significant improvements at follow-up (n=102). Significant change designated when p≤0.05.

PAM Question	Z	P value
1. I am the person who is responsible for taking care of my health	-1.52	0.13
2. Taking an active role in my own healthcare is the most important thing that affects my health	**-2.78**	**0.005**
3. I am confident I can help prevent or reduce problems associated with my health	-1.30	0.19
4. I know what each of my prescribed medications do	-1.51	0.13
5. I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself	-1.34	0.18
6. I am confident that I can tell a doctor or nurse concerns I have even when he or she does not ask	**-2.14**	**0.03**
7. I am confident that I can carry out medical treatments I may need to do at home	-1.18	0.24
8. I understand my health problems and what causes them	**-2.82**	**0.005**
9. I know what treatments are available for my health problems	**-2.99**	**0.003**
10. I have been able to maintain lifestyle changes, like healthy eating or exercising	**-3.60**	**0.000**
11. I know how to prevent problems with my health	-1.22	0.22
12. I am confident I can work out solutions when new problems arise with my health	-1.27	0.20
13. I am confident that I can maintain lifestyle changes, like healthy eating and exercising, even during times of stress	**-3.27**	**0.001**

Table 6. PAM questions that showed statistically significant improvements in scores. Significant change designated with p≤0.05.

This PAM data correlates with the data from the interviews with service users on their experience of the service (p30-34), and what they deemed most important about the service (p38-39).

All but one participant opted to pursue an activity or intervention that had been suggested and discussed at their first meeting with the social prescribing advisor.   Examples of how this led to positive action are below. One participant took up exercise in the form of swimming;

"[I met a] really nice lady who…said, 'Come along to the pool and see what we do and if you think it's for you…all you have to do is get your GP to sign a form.'…So I went and saw what is was like and thought, yes, that's, I could cope with that."

"I opted for Help2Slim and Help2Swim…I was certainly on Help2Slim…And then I was introduced to a lady…who organised for me to have swimming lessons with a buddy.

One participant explained about the fun they had from joining a weekly swimming class,

"It's an arthritis group, and I have been going ever since…a physiotherapist leads it and we all try to follow what she is doing…which is a bit of a laugh really."

Another participant had stopped their hydrotherapy sessions and instead had become a regular at a low-cost gym.

"I haven't got time to go there [the hydrotherapy] now because I go to the gym three times a week."

3.4.3 Loneliness

Understanding to what extent the social prescribing demonstrator service could be used to support people who were lonely was an aim of the evaluation at outset. 15% of opportunistic referrals to the social prescribing service were for issues relating to loneliness, however, only a small proportion of these individuals consented to take part in the evaluation.

As the social prescribing service was new all participants were asked to complete the De Jong Gierveld Loneliness scale, irrespective of their referral reason. This scale measures total loneliness, emotional loneliness, (absence of an intimate relationship or close emotional attachment) and social loneliness (absence of broader group of contacts/ engaging in social network).

The overall scores showed that loneliness at baseline for the whole cohort was not severe, yet at the 3-month follow-up there was still a statistically significant reduction in the mean emotional loneliness component of the scale (Table 7 below). Therefore, despite the majority of participants not expressing primary concerns about loneliness, the scores show that engaging in social networks or with a broader group of contacts had increased significantly, which is a very positive finding.

De Jong Gierveld Loneliness scale	Paired baseline Mean [SD] (n)	Follow-up Mean [SD] and (n)	Mean Score change Wilcoxon Z score and p value
Total loneliness	2.47 [2.12] (100)	2.25 [2.08] (100)	-0.22 z = -1.23 NS
Emotional loneliness	1.23 [1.17] (100)	1.07 [1.16] (100)	**-0.16 z = -2.02 p = 0.044**
Social loneliness	1.25 [1.21] (100)	1.18 [1.23] (100)	-0.07 Z = -0.43 NS

Table 7. Comparison of levels of loneliness in evaluation participants (n=100). The total De Jong Gierveld scale is scored out of 6, this is split into the emotional and social components, each scored out of 3. A reduction in score denotes an improvement. Significant change designated when p≤0.05.

Further analysis was carried out to determine whether there were significant improvements in scores for people who were specifically referred for or reported loneliness to the social prescribing advisor. In total, 30/42 participants who reported loneliness provided questionnaire data and a statistically significant improvement was reported at the 3 months follow up in Total Loneliness and Emotional Loneliness (Table 12, Fig 10). This indicates the ability of the social prescribing service to successfully support people who are experiencing loneliness.

De Jong Gierveld Loneliness scale	Mean Paired baseline [SD] (n)	Mean Follow-up [SD] (n)	Score change Mean Wilcoxon Z score and p value
Total loneliness	3.9 [1.77] (30)	3.17 [2.04] (30)	**-0.73 z = -1.94 p = 0.05**
Emotional loneliness	2.07 [1.17] (30)	1.63 [1.16] (30)	**-0.44 z = -2.29 p = 0.02**
Social loneliness	1.83 [1.12] (30)	1.53 [1.16] (30)	-0.30 Z = -1.5 NS

Table 8. Levels of loneliness. 30 evaluation participants were specifically referred for or stated loneliness as a MYCaW concern. The total scale is scored out of 6, this is split into the emotional and social components, each scored out of 3. A reduction in score denotes an improvement. Significant change designated when p≤0.05.

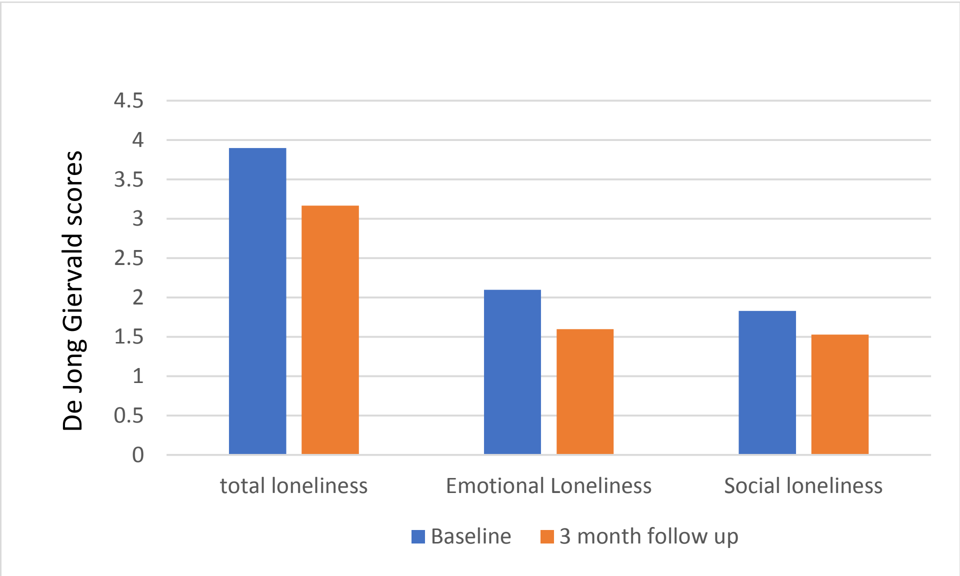

Figure 10. De Jong Gierveld Loneliness scale scores. baseline vs. 3 months follow-up (n=30). The total scale is scored out of 6, this is split into the emotional and social components, each scored out of 3. A reduction in score denotes an improvement.

3.4.4 Physiological data

To understand if statistically significant score changes from the patient reported outcomes in activation and supporting concerns translated into changes in physical health, analysis of physiological measurements was carried on 44 pairs of baseline/follow-up data (Table 9). This data set was the most challenging to collect, as not all participants wanted measurements to be taken, sometimes a clinical room was not available to carry out the measurements or the appropriate equipment was not in the room when needed by the social prescribing advisor.

The data in Tables 9 and 10 indicate the potential that the social prescribing service has in terms of improving physiological parameters that are known to be modifiable risk factors for several long-term conditions such as CVD, diabetes and cancer.

Despite the low n value, enough data was collected to enable statistical analysis, and statistically significant improvements in diastolic blood pressure (p=0.007), total cholesterol (p=0.043) and LDL cholesterol (p=0.04) were achieved.

	Baseline mean paired (n=44)	Follow up Mean (n=44)	Difference Baseline/ Follow up	Statistically Significant difference?
Height (cm)	170.5	N/A	N/A	N/A
Weight (kg)	94.76	93.97	-0.79	NS
BMI	32.5	32.2	-0.3	NS
Systolic BP (mmHg)	135	131	-4	NS
Diastolic BP (mmHg)	**82**	**78**	**-4**	**0.007***
Total Cholesterol (mmol/L)	**5.48**	**5.01**	**-0.47**	**0.043***
HDL Cholesterol (mmol/L)	1.16	1.16	0	NS
LDL Cholesterol (mmol/L)	**4.32**	**3.85**	**-0.47**	**0.04**
Cholesterol Ratio	5.22	4.77	-0.45	NS

*Table 9. Comparison of physiological data upon referral to the social prescribing service and at the 3-month follow-up (n=44). * Statistically significant change in paired data when p=<0.05.*

Physical activity and smoking

63/105 (60%), of participants reported an increase their physical activity and 3/13 participants had stopped smoking at the 3 months follow-up. One person declared smoking at 3 months follow-up, when previously stating they were a non-smoker.

"It was the [the social prescribing advisor] I think, who first mentioned this new treatment to help give up smoking. So that was part of that consultation…and I opted to go on a Quit Smoking programme…So I met with the nurse [who is] able to prescribe the drug, so a few days later I was able to collect my first prescription from the pharmacy. I then saw the Help2Quit nurse every three weeks, I think, for a period of about three months."

"I started going to the gym twice a week and, and as I say, the GP's, nobody had ever suggested it to me. This was all through the social prescribing lady that I went down that route. I now go, well mostly three times…but I've lost two stone in weight, I feel much healthier, happier. That really sums it up.

Body Mass Index (BMI)

The changes in BMI (n=49) were analysed in more depth (Table 10). Overall there was a net movement of weight loss, with 56% of participants experiencing some degree of weight loss, compared to 4% of participants experiencing weight gain. This is an important result as being overweight and obese is known to contribute to several long-term conditions, including cancer, blood pressure, diabetes and CVD and a reduction in weight can therefore contribute to preventing these conditions.

"I've lost one stone three pounds in six months, which is very, very heart-warming"

- 27/49 (56%) people reported a weight loss at 3 months follow up.
- 9/49 (20%) reported a weight loss of 3kgs or more.
- One overweight participant returned to normal weight,
- Two participants moved from obese I to overweight.
- Two people put on more than 3kgs in weight.

BMI category	Paired Baseline (45)	3-month follow-up Paired (49)
Normal	2 (4.4%)	3 (6.12%)
Overweight	20 (44.4%)	22 (44.9%)
Obese I	11 (24.4%)	10 (20.4%)
Obese II	5 (11.11%)	7 (14.3%)
Obese III	7 (15.6%)	7 (14.3%)

Table 10. Analysis of changes to BMI categories (n=49)

3.4.5 Health service usage

Improvements in patient activation are associated with reduction in health service usage data.[25] All available data on health service usage for the participants was therefore analysed comparing service usage in the 3 months prior to the first consultation with the social prescribing advisor and over the 3 months between initial consultation and follow-up.

This data was then compared to a case-matched control group for participants referred for CVD risk as data could be extracted from electronic medical records.

A case-matched control group was selected from anonymous patient records who had a CVD Qrisk2 score of 10% or more. They were matched to by age and gender to the social prescribing group. Control patients may have been invited to use the social prescribing service and not attended or might not have been included in the initial retrospective list of invitations. Any patient who had used the social prescribing service was excluded from the control group.

All patients in the control group also had a Pearson correlation for gender (p= 0.05) and age (p = 0.046) showed a positive similarity between the control group (N=85) and the paired pre/post sample (N=105). Mean age for control was 63.3 years compared to 62.2 years (social prescribing group). There were 45/85 males (53%) and 40/86 females (47%) in the control group, compared to 48/105 males (46%) and 57/105 females (54%) in the experimental group.

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[25] Roberts et al (2018). Measuring patient activation: The utility of the Patient Activation Measure within a UK context—Results from four exemplar studies and potential future applications. Patient Education and Counselling. 99(10); 1739-1746

A statistically significant reduction was seen in visits to the GP (reduced by 40%, p=0.00) for people who used the social prescribing service. There was no statistically significant reduction in visits to the GP in the control group. **It is therefore highly likely that the social prescribing service is having a significant reduction on the number of GP consultations, for participants who were referred due to their risk of CVD.**

Nurse and total visits also showed a significant reduction for participants using the social prescribing service and for the control group. It is not clear why this is - the control group had a larger starting amount of nurse appointments compared to the social prescribing group. Nurse appointments may be high as CVD patients have regular checks with nurses to monitor blood pressure and other risk indicators. Therefore, it is not possible to conclude that the social prescribing service has affected the nurse appointments, it is likely that other factors have contributed to the reduction in visits to the nurse.

	ALL PRE BASELINE PAIR CVD ONLY (N=71)			ALL FOLLOW UP CVD ONLY PAIR (N=71)					
Health Care type	Total N (range)	Mean	Std. Deviation	Total N (range)	Mean	Std. Deviation	Difference in Means	Z score	P Value
GP	**136 (0-10)**	**1.92**	**1.89**	**82 (0-6)**	**1.15**	**1.28**	**-0.76**	**-3.63**	**0.00**
Nurse	125 (0-12)	1.76	1.99	75 (0-11)	1.06	1.79	-0.38	-3.45	0.00
Unplanned	6 (0-1)	0.08	0.28	11 (0-2)	0.15	0.47	0.08	-1.23	NS
Inpatient	0	0.00	0.00	3 (0-1)	0.04	0.20	0.04	-1.73	NS
Outpatient	58 (0-5)	0.82	1.17	73 (0-5)	1.03	1.23	0.10	-1.45	NS
Total	325 (0-20)	4.58	3.90	244 (0-16)	3.44	3.45	-0.64	-2.73	0.01
	CONTROL BASELINE			CONTROL FOLLOW UP					
Health Care type	Total N (range)	Mean	Std. Deviation	Total N (range)	Mean	Std. Deviation	Difference in Means	Z score	P Value
GP	**128 (1-7)**	**2.25**	**1.35**	**97 (1-6)**	**2.16**	**1.30**	**-0.09**	**-.564**	**NS**
Nurse	230 (1-8)	2.74	1.72	98 (1-12)	1.85	1.81	-0.89	-4.264	0.000
Unplanned	7 (1)	1.00	0.00	10 (1-2)	1.25	0.46	0.25	.000	NS
Inpatient	3 (1-2)	1.50	0.71	4 (1)	1.00	0.00	-0.50	-	-
Outpatient	64 (1-5)	1.68	0.93	69 (1-5)	1.60	0.88	-0.08	-.832	NS
Total	432 (1-13)	5.08	2.66	278 (0-14)	3.27	2.92	-1.81	-4.953	0.000

*Table 11. Changes to health service usage in the 3 months prior to first consultation with the social prescribing advisor compared to service usage for three months prior to follow-up. *Statistical significance is when p≤0.05*

3.4.6 Working situation

People were asked to provide information about their work status over the three months prior to meeting with the social prescribing advisor and then for the 3 months prior to follow-up (Table 13). Only a small data set of 18 was collected as some people did not fill in the questions provided as they did not feel they were relevant to them, as they were not currently in work. With such a small number of people it is unlikely that any changes would be picked up and indeed no statistically significant changes found comparing hours worked, days ill, weeks unemployed (Table 13).

	Paired Baseline (n=18)	**Follow up Mean (n=18)**	**Difference**
Hours Worked	23.9	29.4	+5.5
Days Ill	0.39	0.14	-0.25
Weeks Unemployed	12.21	13	+0.79
	Frequency n= 105 (percent)	Frequency n= 105 (percent)	
Retired	53 (50.5)	54 (51.4)	+1
Employed	27 (25.7)	25 (23.8)	-2
Unemployed	16 9 (15.2)	17 (16.2)	+1
Disabled	5 (4.8)	3 (2.9)	-2
Housewife/Husband	2 (1.9)	1 (1)	-1
Sick leave	1 (1)	0 (0)	-1
Volunteering	1 (1)	3 (2.9)	+2
Missing data	0 (0)	2 (1.9)	+2

Table 12. Analysis of participants' work-related activities

4.0 Conclusion

For the Shropshire Social Prescribing team, the journey from theoretical model to implementing and growing the social prescribing service has been challenging, but also highly rewarding and a positive learning experience.

- **The service design has adhered to best practice as set nationally by the Social Prescribing Network and NHS England**, whilst developing the service on a practice by practice basis and only using existing resources. This required encouraging stakeholders to come together, including the GP champion, GP practice manager, Operational Project Lead, Data lead, and Lead Adviser role. Importantly this project has enabled greater collaboration between the local authority and CCG.
- **The Shropshire social prescribing approach was highly aligned with the most recent Public Health strategy[26]** as well as with potentially reducing the need for core aspects of Adult Social Care services. The Care Act, 2014 explains that it is the responsibility of the local authority to promote the wellbeing of individuals. Wellbeing is comprised of personal dignity; physical, mental and emotional well-being; protection from abuse and neglect; control over day-today life; participation in work, education, training or recreation; social and economic wellbeing; domestic, family and personal relationships; suitability of living conditions and the individuals' contribution to society.
- **An agile management approach to service development was deliberately employed** and the local Help2Change team carefully tested things out, then paused and reflected before proceeding. An expanding range of different sectors are now getting involved in the social prescribing service and it has successfully expanded from an initial demonstrator site in Oswestry and Ellesmere to covering 5 regions in Shropshire.
- **Between May 2017 – May 2019, 515 referrals were made into the social prescribing service** via 4 services in Oswestry/Ellesmere, Albrighton, Bishop's Castle, Bridgnorth and 4 GP practices in Shrewsbury, which incorporates 11 GP practices. 134 people were recruited into the evaluation, with 3-month follow up data from 105 people.
- **Feedback from service users was very positive. Satisfaction ratings were 4.8/5 for suitability of times, convenience of venue and feeling able to discuss concerns with the social prescribing advisor.** This demonstrated that participants were feeling heard and supported, and that the service was meeting peoples' needs by addressing them not as a 'condition' or disability, but as a person, with their own set of social and emotional wishes and wants.
- **The social prescribing service supported unmet needs *beyond* the expected remit, due to the inclusion of a link workers in the service, which provided an individualised element.** The MYCaW concerns that participants reported ranged from lifestyle advice through to social determinants of health and concerns related to adult social care.
- **The patient reported outcome data demonstrated statistically significant improvements** in participants' MYCaW concerns (p=0.001) and Wellbeing (p=0.001),

[26] Department of Health and Social Care (2018). Prevention is better than cure. Our vision to help you live well for longer

activation levels (PAM) (p=0.000), and the De Jong Gierveld measures of loneliness (p=0.05).

- **Score changes translated into improvements in weight, BMI, total cholesterol (p=0.043), LDL cholesterol (p=0.04), blood pressure (p=0.007, diastolic), levels of smoking and physical activity.**
- **Reasons why the social prescribing service has triggered changes have been captured** through via qualitative interviews and the MYCaW tool. Participants particularly valued the role of the social prescribing advisor. Not only was this due to the 1:1 time with a social prescribing advisor, but their training in motivational interviewing amongst other things, and the support an individual received to access an appropriate group when the time was right.
- **Overall the full set of data captured provides a compelling reasoning for the statistically significant (40%) reduction in GP appointments** for participants at the 3-month follow-up, compared to a case-matched control group of people who did not use the social prescribing service.
- **Above all, the social prescribing service seeks to address real life social complexity and inequalities by offering integrated, holistic solutions to multifaceted health and social care issues.**

5.0 Recommendations

Evaluation data from the social prescribing service has demonstrated a significant impact on individual users and health service usage. Below are key aspects that were identified to support the continuing development and improvement of the social prescribing service.

More involvement from general practice

1. **It is recommended that the social prescribing team discuss the intention and benefits of the social prescribing service with GPs, to develop more relationships that will lead to an increase in referrals and integration of social prescribing into the GP consultation.**

Overall participants agreed with the ethos of social prescribing and the direction of healthcare toward a more sustainable and preventative approach. Participants highlighted that they wanted their GPs to be more involved in the service, including discussing social prescribing as an option with their patients, e.g.

"I think you need to, to involve, if you're talking about people's overall general welfare and health then you need to get the GPs more involved"; " [There was] no communication, no reference to social prescribing at all during the session with the GP."

The referral data showed a varying level of referrals from GP practices who are involved in the social prescribing scheme. Partly this reflects the differing points in which they became involved in the social prescribing service as it was rolled out across Shropshire. It also reflects how engaged different practices and GPs are and what is already offered by the practice. Social prescribing has been brought into general practice very quickly, with little underpinning professional development support. Neither was it included in the medical curriculum or the GP contract. This initiative also comes at a time of crisis within the GP profession and could be seen as yet *another* change to make on top of the already mountainous workload. The Shropshire social prescribing service does offer support to reduce workload on practices in start-up phase via the social prescribing team.

Appropriate referral processes

> **2. It is recommended that referral and audit processes are reviewed to ensure that the people who see the social prescribing advisor do have concerns that need addressing and that they are clear on why they are being referred.**

Most data demonstrated that people who are referred into the service had concerns that needs supporting. A small number of individuals did not feel they had any concerns that needed support and therefore were probably not considered in need of the social prescribing service.

A small number of people who attended the social prescribing service via the CVD audit were also unsure about why they had been offered it. As such it is important that any minor amendments to processes are made to ensure that people understand fully why they are being referred to the social prescribing service. Furthermore, ensuring the social prescribing service and the role of social prescribing advisor is explained in the same way by all social prescribing advisors will support a greater community knowledge of the service.

> **3. We would recommend seeking out more ways to access those people who are lonely and isolated, including young people (widening the service to people under 18 years of age), who could be referred Department of Work and Pensions, or even through colleges.**

Managing the social prescribing advisor/service user relationship.

> **4. It is recommended that attention is given to informing service users if the social prescribing advisor is going to change.**

The relationship between a particular social prescribing advisor and service user has been highlighted as a key aspect of the positive experience. Most participants were satisfied with the length of time spent with the social prescribing advisor, however one expressed disappointment when their original advisor had moved. Although the subsequent advisor was still very good, the participant had established a rapport with the first advisor.

These visits took place during a period in which new advisors were being trained up and similar disappointments were expressed about changes of GPs and other health professionals. These comments confirm the importance that some participants attached to one-to one-relationships

they establish with professionals, the trust placed in these relationships and the potential impact of person-centred care on patient outcomes. This also highlights the need to ensure continuation of employment for link workers and to avoid short term contracting arrangements.

Additional training for social prescribing advisors

5. It is recommended that social prescribing advisors receive further training in areas such as mental health issues and alcohol and substance abuse.

Social prescribing Advisors frequently deal with multiple, sometimes complex issues. Some clients had a lot of things going on in their lives (e.g. debt problems, domestic problems.). While Advisors needed to recognise the limits of their role, at least one Advisor felt that additional training on specific topics such as anxiety, depression, and alcohol issues would be beneficial.

Evaluation

6. It is recommended that review of collecting physiological data such as weight, is undertaken to address issues identified around lack of rooming or equipment, if future evaluation is to be carried out.

The evaluation overall was successful but has presented several challenges to the social prescribing team. Being able to translate changes in patient outcomes measures, into physiological changes is also an important aspect of understanding how far reaching the impact of the social prescribing service is. It is therefore important to address any practical barriers to collecting this data.

7. "Do it, without a doubt."

Participants who were interviewed were asked if they had any recommendations to others considering using the service, all but one was definite that others should try it, e.g.

"I'd say do it, without a doubt"

"Well I can't thank them enough for what they did for me."

"Things are ongoing but moving! And in the right direction! Great feeling empowered and ready for battling!"

Appendix A - Referring medical practices

Medical Practice	Opportunistic referral	CVD audit	Total people from each practice
Cambrian	23	86	109
Plas Ffynnon	17	51	68
Albrighton	42	4	46
Bishops' Castle	27	0	27
Ellesmere	20	0	20
Marden	40	0	40
Radbrook Green	11	0	11
Caxton	4	0	4
Claremont Bank	16	0	16
Severn Fields	14	0	14
Bridgnorth	56	0	56

Table 13. Breakdown of how people entered the social prescribing service per medical practices in Shropshire.

Appendix B – Organisations and services referred to by the Link Workers

Organisation/Activity	Description
Age UK - Advocacy support & representation	
Age UK - Benefit Advice	
Age UK – Dementia Respite Service	
Age UK - Diamond Drop-in	
Age UK - Help at Home	
Age UK – Living Well	
Age UK – Lunch Clubs	
Age UK - Opel Day Centre Bridgnorth	
Age UK - Opel Day Centre Ellesmere	
Age UK - Opel Day Centre Oswestry	
Age UK - Opel Day Centres Shrewsbury	
Age UK - Volunteer Befriending	
Alzheimer's Society – Art Therapy	
Alzheimer's Society - Dementia café	
Alzheimer's Society - Home support	
Alzheimer's Society - Peer Support Group	
Alzheimer’s Society - Singing for The Brain	
Bayston Hill Library - Personalised Library Induction	Personalised Library Induction regarding health information and library activities
Carers Trust4All - Bridgnorth Carers Group	
Carers Trust4All - Carer breaks	
Carers Trust4All - Carers Group for Carers of Adults with a Learning Disability	
Carers Trust4All - Carers Groups/Advice sessions	
Christians Against Poverty – Debt Counselling	
Citizens Advice Shropshire - Advice and Information service for Debt	
Citizen's Advice Shropshire - Benefit Check	
Citizens Advice Shropshire – General Advice	General Advice (e.g. Housing, Employment, Health/Community Care, Relationships)
Citizens Advice Shropshire - My Money Matter Community Project	
Citizens Advice Shropshire - Pensionwise	Guidance for over 50's
Citizens Advice Shropshire - SEND advice	Special educational needs and disability advice for 0-25 year olds
Codsall Leisure Centre (South Shropshire Council) - Forward to Health	12-week exercise scheme
Community Mental Health Team – One-to-one Support	
Designs In Mind - Arts based activity	For people with mental health issues
Designs In Mind - Mindfulness	
Designs In Mind - Open Maker Night	
Designs In Mind - Support into Employment	
Diabetes UK – Peer Support Group (Bishops Castle)	
Dolly Mixtures Bishop’s Castle - Mixed ability ladies running group	
Ellesmere Library Our Space - Books on Prescription	
Ellesmere Library Our Space - Ellesmere Opportunities Group	Group for people with Learning Disabilities
Ellesmere Library Our Space - Family Knit	
Ellesmere Library Our Space - Friendship Group	Older persons’ day respite service
Ellesmere Library Our Space – Get Online	
Ellesmere Library Our Space - Memory Cafe	
Ellesmere Library Our Space - Reading Group	
Ellesmere Library Our Space - Rhyme Time	
Ellesmere Library Our Space - Time to Listen	Reading group
Ellesmere Library Our Space - Volunteer Opportunities	

Enable - Supported Employment Service	For people with disabilities and mental health illness
Energize - Elevate	Balance and strength classes for everyday life
Exercise on referral – Made through GP	
Extend - Extend	Low impact, gentle exercise to music
Green Oak Foundation	Counselling Therapy
Help2Change – Help2Quit	
Help2Change – Help2Slim	
Help2Change – Managing Your Joint Pain	
Ingeus - Healthier You (NHS National Diabetes Prevention Programme)	
Library at The Lantern - Personalised Library Induction	Personalised Library Induction regarding health information and library activities
Lifestyle Fitness - Exercise on Referral	
Lifestyle Fitness - Get Active Feel Good	
Marches Energy – Energy Advice & Support	
MHA - Shifnal, Albrighton & District Live at Home Scheme	
MHA - Volunteering (Shifnal & Albrighton)	
MIND - Crafty Afty	
MIND - Drop-in	
MIND - Reconnect programme	
North Shropshire College - Assertiveness for Life course	
North Shropshire College - Five Ways to Wellbeing course	
North Shropshire College - Mindfulness course	
Oswestry Leisure Centre - Exercise on Referral	
Oswestry Leisure Centre - Healthy Lives	
Oswestry Library - IT Sessions	
Oswestry Library - Books on prescription	
Oswestry Library - Home Library Service	
Oswestry Library - Quick Reads	
Oswestry Library – Time To Listen	
Pontesbury Library	Personalised Library Induction regarding health information and library activities
Qube - Arts and creativity courses	
Qube - Dial a Ride	
Qube - Health and well-being courses	
Qube - Shop Mobility	
Qube - Social Group	
Qube – Volunteering	
REMAP - Aids for disabled persons	
REMAP - Volunteering	
South Shropshire Housing Association – Housing Advice	
South Shropshire Housing Association – Lunches 4 All	
South Shropshire Housing Association – Mobile Lunches	
South Shropshire Housing Association – Pedals for Health	
Shrewsbury Library - Personalised Library Induction	Personalised Library Induction regarding health information and library activities
Shrewsbury Town in the Community - Extra Time	
Shrewsbury Town in the Community - Heads Up	
Shrewsbury Town in the Community - Kick Cancer	
Shrewsbury Town in the Community - Short breaks for parents of children with disabilities	
Shrewsbury Town in the Community - Walking Football	
Shropshire Community Leisure Trust - Sports & Leisure Activities	
Shropshire Outdoor Partnerships - Parish Paths Partnerships	

Shropshire Outdoor Partnerships - Shropshire Wild Teams	Landscape management projects and other outdoor activities
Shropshire Outdoor Partnerships - Volunteer Rangers	
Shropshire Outdoor Partnerships - Walking 4 Health	
Shropshire RCC - Active Buddies	
Shropshire RCC - Albrighton Care & Share Group	For family carers and family members with mild to moderate dementia
Shropshire RCC - FFMOT	Functional Fitness MOT
Shropshire RCC - Hearing Loss Support to hearing aid users	
Shropshire RCC - Sight loss support	
Shropshire Wildlife Trust - Feed The Birds Beneficiary	
Shropshire Wildlife Trust - Feed The Birds Volunteer	
STAR Housing - Sustain Housing Support Services	Housing support and benefit advice
Sustain Consortium (Care Plus Part) - Housing related support	
Swan Mere Day Centre - Day Care provision	
The Albrighton Trust - Angling, horticulture or woodcraft	Volunteering, or participating, in angling, horticulture or woodcraft sessions at the Moat & Gardens
The New Saints Football Club - Community Postural Stability Instruction	
The New Saints Football Club - Exercise on Referral	
The New Saints Football Club - Get Up and Go	Activity sessions for the over 60s
The New Saints Football Club - Otago	Balance and Strength Classes
The New Saints Football Club - Seated Exercise to Music	
The New Saints Football Club - Walking Football	
The New Saints Football Club - Zumba/Hoola Hooping Classes	
Through the Doorway - Art 4 Well-being	
Through the Doorway - Be Good to Yourself	
Through the Doorway - Cooking 4 Life	
Through the Doorway - Music for Well-being	
Through the Doorway - Pilates	
Through the Doorway - Tai Chi	
Through the Doorway - Yoga	

***Table 14**. The organisations and services referred to by the social prescribing advisors*

END