PRESCRIPTION PLUS CRAWLEY

The Case for Project Expansion
Interim report April 2017

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Acknowledgments:

The authors gratefully acknowledge evidence from Dr Richard Kimberlee at the University of the West of England. Dr Kimberlee is a leading researcher in the field. Thanks also go to Crawley Borough Council for having the foresight to agree to fund the pilot social prescribing scheme – Prescription Plus - featured in this report; to the Social Prescribing Network at the University of Westminster for providing links to other evidential sources and reports; and to Chris Dayson et al at the Centre for Economic and Social Research at Sheffield Hallam University.

REPORT CONTENTS

This report draws together evidence about the effectiveness of social prescribing as a means of helping patients with complex needs and conditions that are both medical and non-medical. The report draws together specific experience and evidence from Prescription Plus - Crawley's pilot social prescribing scheme - alongside evidence from the national context and well established social prescribing schemes in other parts of the country.

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INTRODUCTION

IN BRIEF

What the report will tell us
This report will make the case for the financing and expansion of Prescription Plus in Crawley. This pilot and small-scale social prescribing scheme has been open since September 2016 and will complete its pilot period in December 2017. The latter part of the report will provide an early evaluation of the project and will make the case for investment in extending Prescription Plus in Crawley where it currently partners with four GP surgeries and is experiencing considerable demand beyond the modest capacity the service has to deal with demand.

This report will also tell the reader about social prescribing in general; provide evidence about effectiveness locally and in other areas; and provide details about the primary care context that has given rise to an expansion of social prescribing in various parts of the country.

What is social prescribing?
According to the Social Prescribing Network led by the College of Medicine and the University of Westminster:

> "Social prescribing involves empowering individuals to improve their health and wellbeing and social welfare by connecting them to non-medical and community support services.[1]"

Social prescribing involves skilled "community advisers" engaging with targeted patients, enabling them to participate in community, leisure and health activities; seek and get advice and support; and improve their well-being. Social prescribing creates bespoke, patient-centred, non-medical solutions and packages for patients by bringing the range of community, social, leisure and care services to the patient. Research by the Social Prescribing Network[2] (Polley, 2016) estimates there to be over 400 different social prescribing projects. These social prescribing schemes have similar methods in triaging patients, hooking them into positive activities and support, and building/improving the support "market" so it can work better for patients. Social prescribing is being significantly advanced in Scotland as well as parts of England. The footnote below has a link to introductory three-minute videos[3] on social prescribing topics.

They vary substantially in scale from smaller single adviser projects in two or three GP surgeries up to large scale programmes of half-a-million to £1 million turnover each year spread across many surgeries. One of the first social prescribing schemes in the UK was set up in 2005 by Dr. Frank Weber in his GP surgery in Dundee. He wanted the scheme to provide something for what he termed the "heart-sink" patients. He estimated that a third of his patients had problems that he couldn't do anything about – non-medical needs or medical needs made worse by other non-medical factors.

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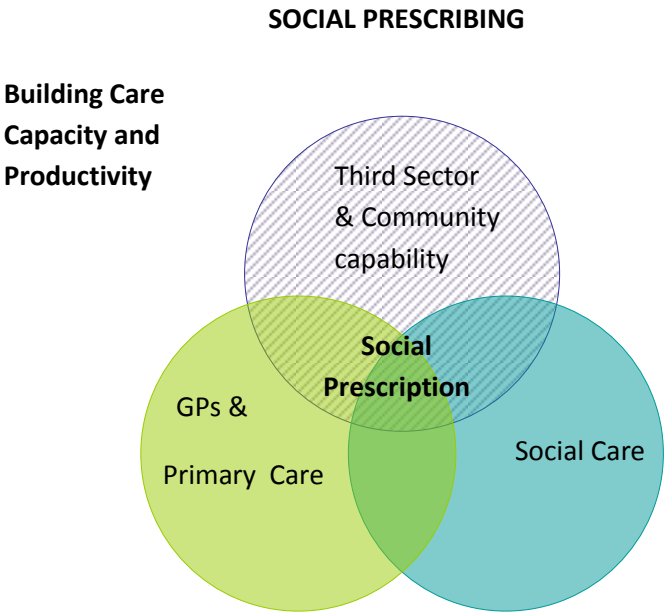
[1] https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network Accessed 23/02/17
[2] Polley, M. *The Social Prescribing Network,* Conference address, 20/10/16
[3] Video On Gloucester SP: https://www.youtube.com/watch?v=MSDUKcdKvsw
Video introducing the concept of SP:https://www.youtube.com/watch?v=H_jHxtMiuLU&index=7&list=PLdtTilZi8S795eYpNQXJsn5C0KKritEzM

Social prescribing brings the capability and diversity of the third sector and the wider community to bear on patients' social, well-being and economic needs:



The third sector - community and voluntary organisations, clubs and societies etc - has enormous diversity in what it does and capability in supporting people and patients. Social prescribing packages up social, advisory and therapeutic activities specifically for the patient and their needs. Social prescribing also enables the care pathways to work more efficiently. Social prescribing helps the care system as a whole to improve its productivity, releasing primary care time, reducing wasted resources and making the care "market" develop more effectively.

The case for social prescribing expansion and financing

Primary care is under pressure. The estimated 20% of GP consultation time spent on non-medical issues (costing the NHS around £400 million every year) is indication that something different needs to be done to support patients stuck in the complexity of their medical and non-medical needs.

Across the UK, social prescribing is increasingly becoming a compelling, flexible and cost-efficient answer to this dilemma. This person-centred, holistic approach to meeting the patient where they are, and wrapping existing, community-based support around them is paying dividends.

In Gloucestershire, for example, where a social prescribing scheme has been running since 2014, a social return on investment of £1.69 for every £1 spent has been recorded. This breaks down to health savings in excess of £200K over a one-year period, and social care savings of more than £600K. In Rotherham, significant drops in urgent care demand have been noted with a return on investment of £1.98 for every £1 invested.

It is still early days for Crawley's pilot social prescribing project, Prescription Plus. But even with just six months' operation under its belt, and four months of data, we are already seeing parallels with its more long-standing counterparts in other parts of the country and it is beginning to show an encouraging direction of travel.

Like the schemes in Gloucestershire and Rotherham, for example, Prescription Plus offers holistic support based on a menu of local services and activities. Its client-base is also predominantly women (70%, compared to 60% in Gloucester), and it has so far catered mainly to people in the older age range, as have other projects around the country. Demand for particular types of services has mirrored trends in other projects, with social and leisure activities, and information, advice and practical support topping the list.

But perhaps most importantly for the purposes of this report, is that Prescription Plus has not only shown reported improvement in patients' wellbeing in a similar vein to what has been experienced elsewhere, but from a health service point of view it is already showing promising signs of reduced demand on health services and cost savings. Though results this early into the project and over such a short time period must be treated with an element of caution, Prescription Plus is heading in the right direction. To conclusively demonstrate its positive impact, it needs more time to root in and develop.

NATIONAL CONTEXT

Problems in primary care
GP consultation levels continue to grow. The complexity of non-medical and medical problems that GPs and other health professional are asked to deal with continues to grow in scale and complexity. The population is increasing whilst people are living longer.

It is estimated by the National Audit Office[4] that GP consultations grew by 3.5% each year over the ten year period 2004 to 2014. Furthermore GP workload has increased by 16% over the past seven years[5] and various studies have shown GP surgeries to be at crisis point. Patients are suffering also with a fifth of patients reporting that opening hours are not convenient and wait-times in primary care are increasing[6].

Whilst primary care is trying to cope with demand outstripping supply, GPs are also using nearly 20% of consultation time[7] on non-medical needs. Anecdotally many GPs report a far higher rate. Most GPs also report that non-medical demand is increasing year-on-year. This use of primary care resources translates to a cost of £400 million without the corresponding benefits of non-medical needs being met from elsewhere. Social prescribing is a direct and sophisticated response to this problem that can provide a holistic, full and diverse package of responses if it is adequately funded and resourced.

Social prescribing - What does it do? How well does it do it? Why does it work?
Social prescribing is a holistic method for supporting patients with, in the main, having their non-medical needs met. “Link workers” or “community advisers”, often based in GP surgeries, link patients with social, therapeutic and practical support in their locality provided primarily by voluntary and community sector organisations. Where patients present with self-care, health, fitness and wellbeing needs these are targeted by social prescribing also. Social prescribing therefore also positively affects medical needs in many cases. For this reason some social prescribing schemes up and down the country have targeted specific conditions like diabetes/pre-diabetes or targeted patients with co-morbidities and complex needs.

Non-medical interventions can include anything from combating loneliness with befriending to money, benefit and housing advice, carer support, participation in fitness/leisure pursuits, or support groups and clubs. What social prescribing does is to bring the full range of support mechanisms to the patient and packages these in a way that best suits the specific need of the individual patient.

So link workers are skilled case workers with a great deal of local knowledge. Social prescribing schemes have “menus” of support activities often including specifically funded activities that are bought in to support patients.

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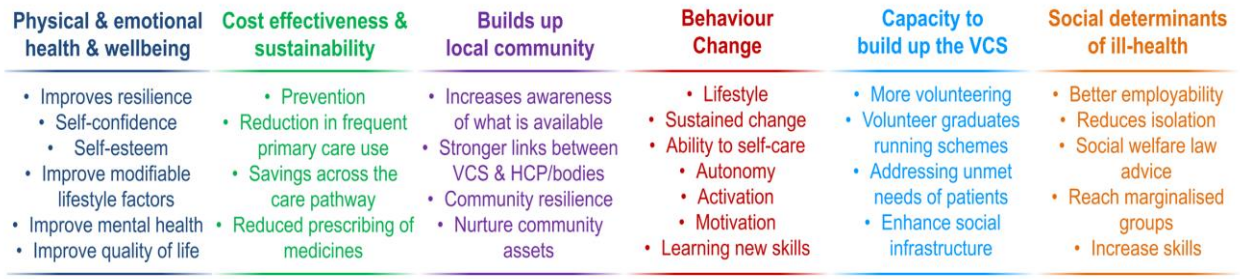
[4] *National Audit Office, Stocktake of access to general practice in England,* 2015 https://www.nao.org.uk/wp-content/uploads/2015/11/Stocktake-of-access-to-general-practice-in-England-Summary.pdf Accessed 24/2/17
[5] Royal College of General Practitioners *Surgery Times Don’t Give the full story* http://www.rcgp.org.uk/news/2017/february/surgery-time-figures-dont-give-the-full-story-of-whats-happening-in-general-practice.aspx Accessed 26/2/17
[6] *Ibid* 3
[7] Citizens Advice/ComRes *A very general practice, 2015,* https://www.citizensadvice.org.uk/about-us/policy/policy-research-topics/health-and-care-policy-research/public-services-policy-research/a-very-general-practice-how-much-time-do-gps-spend-on-issues-other-than-health/ Accessed 23/2/17

Social prescribing schemes are doing well in improving wellbeing and freeing up primary care resources that are not designed to deal with complex non-medical and support needs. There are examples of this shown in the next two sections with more detailed evidence. There are several reasons why social prescribing works and why it is one of the few areas of increased investment in the health and social care field. Firstly it deals immediately with a patient's needs forming a trusting, collaborative relationship and providing support, advice, activity and action straight away. Secondly it brings the whole set of support mechanisms available in the wider community - and especially in voluntary and community sector - to the patient. Thirdly social prescribing schemes refine and improve the care and support "market". As social prescribing schemes get bigger more referral is made to the more effective and popular ways of supporting people. So, over time, the market for support and care can thus be more streamlined to the needs and preferences of patients.

The diagram[8] below shows the different benefits that are being created by the social prescribing method:



Social prescribing is collaborative and diverse in the ways it seeks to help patients. It is collaborative in that it works with GPs to help with a range of patients and disease groups in a variety of ways. One study[9] showed that 90% of GPs feel patients would benefit from a social prescription despite most GPs not really knowing that much about how social prescribing works. Social prescribing offers choices from a menu for patients and collaborates with them in trying to find ways of solving problems they present with – "co-production" of effective pathways for patients to improve their lives.

It is more efficient for GPs to have partnership relationships with this triage style of operation than to have many partnerships with many providers some of whom will only work with one or two patients at a time providing one or two interventions. Social prescribing has a proven track record - more on this below - that makes social prescribing worth commissioning, developing and deploying more in partnership with GP practices, CCGs and others.

Growing recognition of effectiveness - expansion of the social prescribing method and model

There is a growing body of evidence about the effectiveness of social prescribing most of which shows positive effects on patients' wellbeing and health - as the primary objective - with evidence also of positive effects on freeing up GP and urgent care resources. In some cases social prescribing schemes make considerable savings in GP consultations (see details in the next section below).

[8] Social Prescribing Network

[9] Nesta, *Social prescriptions should be available from GP surgeries,* 2013 http://www.nesta.org.uk/news/social-prescriptions-should-be-available-gp-surgeries-say-four-five-gps Accessed 25/2/17

Dr Michael Dixon has been an early adopter of social prescribing having funded a link worker in his GP practice for several years. He says[10]:

> "Where it's well run it's reducing GP workload and pressure... For the sake of general practice and the extremely heavy workloads, we now have to look at universalising it."

There is a growing recognition of the effectiveness of social prescribing methods and models with large schemes now commissioned in place as diverse as Gloucestershire, Rotherham, Tower Hamlets, Newcastle and City and Hackney. These larger programmes have tended to follow on from evaluation of pilot schemes. New schemes have emerged across the country with about 400 projects across the country that follow some kind of social prescribing model.

Social prescribing schemes have common features such as the provision of a link worker and referral to a large suite of help sources. Some have more specific features such as concentrating on a certain age, condition, morbidity or other demographic group. Also social prescribing schemes vary a little in terms of the intensity and depth of support that they provide to patients. "Light", "medium", and "holistic" social prescribing types have been proposed as a useful typology. Light schemes focus on referral and minimal involvement with patients; holistic schemes have a broad range of activities to offer patients and the capability to work more intensively over short time periods with patients who have high needs. Medium schemes are somewhere between the two. Evidence (and reason) suggests that holistic schemes are required to tackle patients with ongoing or complex needs or multiple morbidities. The Social Prescribing Network neatly describes the benefits of holistic-type social prescribing:

> "Social prescribing can alleviate some of these pressures by addressing unmet needs of patients, whose needs are not currently met by the NHS. It can also alleviate pressure on GPs and other healthcare professionals, general practices and the health service more widely..."

> "By facilitating the patients' access to a whole range of voluntary and local services... there is much potential to nurture local social capital and catalyse health-creating communities that strengthen their ability to care for themselves and each other."

Examples of good practice and success

This section focuses on evidence of effectiveness from some of the larger social prescribing schemes. It focuses on Gloucester and Rotherham in particular as these two have been more substantially evaluated and Prescription Plus has chosen to broadly replicate the early stages of the holistic model of social prescribing that these schemes typify.

Gloucester Clinical Commissioning Groups' Social Prescribing Service

Gloucester is one of a group of larger more established social prescribing schemes in the country. The scheme began as a pilot in two areas and was launched by Gloucester CCG in 2014. Following these pilots the CCG decided to roll out the social prescribing service to all GPs in Gloucestershire. From March 2016 all 81 GP practices, plus staff in 21 integrated Community Teams were able to make referrals into the social prescribing service with co-ordination staff based in surgeries. The scheme worked to the high-level aims described below[11] that show wellbeing improvement to be the primary driver.

[10] *Pulse,* November 2016 issue

[11] Kimberlee, R. (2016) *Gloucestershire Clinical Commissioning Group's Social Prescribing Service: Evaluation Report*. Project Report. University of the West of England. Page 16

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

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

Gloucestershire's social prescribing project has benefitted from a deep evaluation of effectiveness and impact carried out independently. The evaluation was based on a large sample of 1,147 patients. Gloucestershire's social prescribing users were 60% female with a median age category of 56-65. 29.2% of patients self-identify as disabled. Below are some snapshot conclusions on effectiveness from the study:

Impact evidence from Gloucestershire's social prescribing services:

- **Well-being values increased.** From a baseline score of 79% "low wellbeing" reduced to 60.5%, and moderate wellbeing was increased from 20.5% to 38%. Wellbeing was the primary measure of success deployed in the scheme design.

- **234 different organisations** and their abilities have been brought to bear in supporting patients - mostly third sector organisations with some in primary care, leisure/sports and the private sector (such as care homes). The most used were Age UK, the Barnwood Trust (housing and community spaces), Citizens Advice and Carers Gloucestershire.

- **GP appointments declined by 21%** in the six months after intervention from the social prescribing service compared to the six months before; GP home visits declined by 26%. The scheme therefore was highly successful at freeing up primary care time.

- **A & E admission declined by 23%** in the six months before and six months after intervention from the social prescribing service.

- Reasons for referral varied with **wellbeing and mental health being the largest category** followed by benefits, housing and environmental advice; generic health and fitness; and carers support.

- There is **a £1.69 (health £0.43, social £1.36) return on investment for every £1 spent** by the CCG on the social prescribing service (see more on this below).

- Gloucester CCG sees social prescribing as a key component of **a more proactive, holistic and preventative model of care** and a strategy in tackling reactive, fragmentary systems of care.

Table 1 below shows that social prescribing has far greater potential to make savings and free up time in GP consultation levels – more so than with savings in A and E admissions simply because these occur far less frequently.

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

TABLE 1 – SAVINGS IN HEALTH PROVISION MADE BY THE SOCIAL PRESCRIBING SERVICE IN GLOUCESTHERSHIRE

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

TABLE 2 – ANNUAL SOCIAL VALUE CREATED BY THE SOCIAL PRESCRIBING SERVICE

The evaluation goes on to say:

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

Rotherham social prescribing service

Rotherham is one of the larger and better known social prescribing schemes. It is also one of the holistic schemes delivering social prescribing link worker support from a menu of 20+ organisations.

Here are some results from its work as described in its January 2016 annual evaluation report:

- Urgent care demand was reduced: A and E by 17%, non-elective in-patient spells by 11%, and non-elective in-patient episodes by 7%;
- These figures were far higher for under 80s: e.g. 20% reduction in in-patient spells (the above measures involved comparing the 12 months before with 12 months after using their services);
- The scheme achieved high wellbeing distance travelled and social impact with 84% reporting improvements in at least one out of eight categories;
- The three largest areas of demand were for community-based leisure and social activities, information and advice and befriending;
- The scheme is large with 779 users in 2013/14 and 994 in 2014/15 and has engaged over 2000 users over three years;
- Overall the data suggest a return to the NHS and others of £1.98 for each £1.00 invested;
- Overall the scheme has had 62% female and 38% male users;
- The scheme has had 44% use by over 80s, 30% 70-79s, 14% 60-69s, and 14% under 60s (some are unaccounted for). 93% were of white ethnicity.
- The scheme costs over £500,000 p.a.;
- Rotherham was originally a two year pilot service later extended to five years funding through Better Care Fund.

Rotherham used a model of self-evaluation by users using a scoring system under these eight headings for measuring wellbeing. Distance travelled was measured by using a before and after measure.

Feeling positive	Work, volunteering and other activities
Lifestyle	Money
Looking after yourself	Where you live
Managing symptoms	Family and friends

- Some positive results were partly down to the particularities locally - for instance big improvements in “where you live” and “money” suggest two particular foci locally;
- Rotherham suggests that “social prescribing has a far greater effect for people who are able to engage fully beyond their initial ‘social prescription’”;
- One cautionary note is that both the monitoring and evaluation processes for the scheme are substantial and well funded – not easily replicated and especially not in the early life of a scheme or a small scheme.

Other social prescribing schemes:

Here are some summary findings from other social prescribing schemes – more details of these are in Appendix 1:

Bristol, Wellspring:

- 60% of beneficiaries have reduced GP use; 26% about the same; 14% increased;
- Scheme dealt with unaddressed issues such as agoraphobia, addiction, relationship breakdown at an earlier stage demonstrating preventative capability;
- Social Return on Investment of £2.90 for every £1.00 spent.

Surrey, Wellbeing Prescription Service:

- Return on investment of between £0.20 and £0.46 (tentatively offered as based on a small sample);
- A 37% fall in GP appointments amongst patient group (tentatively offered as based on a small sample; also could indicate some temporary substitution in some cases of GP appointments with Wellbeing Service appointments).

City and Hackney:

- Positive changes in patients' assessment of their wellbeing comparing before and after measures;
- Little change in primary care use or medical measures of illness/wellness[12];
- Scheme re-commissioned as it was seen as making a big difference to improving and deploying the asset of the third sector.

[12] This scheme appears to show either rogue data or incomplete data. We do not know the reasons for this – it could be due to flaws in the evaluation process; operational issues; or significant differences in the delivery model of SP. Some of these concerns were referred to in the schemes evaluation

The funding of social prescribing
Below are examples of social prescribing schemes and their funding sources as researched in early 2017. This is not an exhaustive list - it provides examples of social prescribing schemes and their funders.

SCHEME ***Schemes across the UK – data via a survey of Social Prescribing Network members***	**FINANCE** ***Over half reported CCG funding (this accounts for far more than half the funding as most large schemes are health funded). Also Local Authorities, Public Health England and National Lottery were prominent funders often of pilot projects.***
Rotherham Social Prescribing Service	Now funded by NHS Rotherham CCG £548,000 p.a. (2014/2015). Better Care Fund – first as a two-year pilot.
Gloucester Social Prescribing	CCG funded initial pilot in two areas – then funded rolled out across the whole area of 81 GP practices – a £480,000 p.a. programme. Run by Gloucester VCS Alliance (Voluntary and Community Sector) with GP and many other partners.
Reading Voluntary Action Social Prescribing	Funded by Berkshire West CCG.
Community Navigators, Hertfordshire	Funded by Herts Valley CCG and Hertfordshire County Council.
City and Hackney	Funded by City and Hackney CCG across 23 GP surgeries. Family Action run the Scheme.
NHS Barnsley	Just signed up to an £821,000 scheme with South Yorkshire Housing Association.
Ways to Wellness, Newcastle West	Large seven-year scheme including CCG, Cabinet Office and Big Lottery as funders. Run in part through VONNE - Voluntary Organisations Network North East.
Colchester – 'My Social Prescription'	Funded by North East Essex CCG.
Wellbeing Prescription, Surrey	Funded by Surrey County Council, hosted by Tandridge District Council.
Connect Well Essex	Essex County Council Public Health funded.

Community Navigators, Brighton and Hove	Funding of £172,000 over two years via EPIC (Extended Primary Integrated Care) and Prime Ministers Challenge Fund. Scheme extending. Volunteer based support.
Bromley by Bow, Tower Hamlets, East London	CCG funds this with a recent £240,00 expansion from an original £30,000 pilot with the Bromley-by-Bow Centre.
Active Cumbria	CCG funded exercise prescription service.
Bright Ideas in Health Awards, Gateshead	Funded by the medical groups for Primary Care Navigator role.
A Devon based GP practice	Funds its own adviser.
Wellspring Healthy Living, Bristol focussed in Barton Hill area	Was predominantly funded by Henry Smith and Tudor back in 2008, £83,000 p.a.
Arts on Prescription in Sefton	Funded by NHS Sefton and Sefton MBC back in 2006.
Culm Valley, Devon	Health Adviser Service for Type 2 Diabetes patients or those at risk or this.
Merseyside Recovery College	Now funded by Dept of Work and Pensions. Peer supporters and training in self-care.
East Birmingham	Supported by Birmingham Cross City CCG – one year pilot 2015/2016.
Glasgow and Dundee	Currently piloting ten Links Workers with 40 workers in place by 2018.

Concluding points on the national picture of social prescribing

1. Social prescribing is a growing method of supporting patients with non-medical needs and, to an extent, with medical needs too especially in the areas of mental health, physical activity and general well-being.

2. Social prescribing is a way of delivering many interventions that deal with the social determinants of ill health and wellbeing that GPs can't deliver on.

3. About 400 different schemes from the very small to the large are operating in the UK and Ireland.

4. Most of the funding for social prescribing schemes comes from NHS sources and most of this is allocated at a local level.

5. The best evidence demonstrates that social prescribing can deliver lasting benefits over time. These benefits include enhanced wellbeing and social participation for patients as well as releasing the time and resources of primary care staff.

6. Social prescribing is a collaborative method that requires the active participation of GPs, third sector organisations and the patient. When this happens all parties benefit.

7. Social prescribing is able to incentivise, improve, refine and develop "the offer" from the third sector so that the best ways of helping patients are extended.

PRESCRIPTION PLUS IN CRAWLEY

LOOKING BACK

THE PROJECT

Overview
Prescription Plus, as a short term pilot, delivers to the CCG's clinical priorities as outlined in the CCG's Sustainability and Transformation plan[13]:

> "The four clinical priority areas in which the hubs will redesign support and reduce demand for hospital based care are:
>
> - Prevention
> - Urgent care
> - Long term condition management
> - Frail and complex patients
>
> Already, through projects like Communities of Practice, the Primary Care Home Vanguard, social prescribing and improvements to our Urgent Care Centre at Crawley Hospital, we are beginning to see the impact of working more proactively and coordinating care, albeit in a narrow cohort of patients or geographical area."

Furthermore there is no argument about the value and benefit of social prescribing from the NHS's viewpoint locally[14]:

> "The transformation of primary care and the development of new models of self and supported care will enable us to deliver on the prevention agenda (most importantly on secondary prevention).The work we are doing to establish the Crawley social prescribing programme will help to improve pathways which connect individuals and communities to services and community resources."

Type of social prescribing model being delivered in Crawley (and its unique potential)
Prescription Plus is a pilot social prescribing project in Crawley which improves the health and wellbeing of local people by connecting them to community support and activities. Available through GP surgeries, support is free or low cost and includes social groups, physical activities, counselling, information and advice around debt, housing and benefits, help with particular issues or conditions and more.

Launched in September 2016, Prescription Plus has funding to deliver until the end of December 2017. Four GP surgeries – Southgate Medical Group, Langley Corner Surgery, Leacroft Medical Practice and Gossops Green Medical Centre - are participating in the pilot. Patients visiting these surgeries who are 18+, have one or more long term conditions, visit their GP more than is medically necessary, and have other non-medical needs, can be referred to the project's Community Support Coordinator, who will see patients either in the GP surgeries, or at the patient's home for an assessment visit.

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[13] NHS Crawley CCG. *Introducing Sustainability and Transformation Plans for Local Communities* http://www.crawleyccg.nhs.uk/about-us/sustainability-and-transformation/ Accessed 24/2/17

[14] Crawley CCG and Horsham and Mid-Sussed CCG *2016/17 OperatingPlan .* Accessed 25/2/17 http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0ahUKEwjfi-2vrKnSAhVoIsAKHTvgCNkQFgghMAE&url=http%3A%2F%2Fwww.crawleyccg.nhs.uk%2FEasysiteWeb%2Fgetresource.axd%3FAssetID%3D433181%26type%3Dfull%26servicetype%3DAttachment&usg=AFQjCNF_MOmQU7zgIXCRqKi9QayS5PYjTw

During that visit, the Coordinator will take the time to find out what is going on for that person, and using a menu of local support and activities offered by more than 37 local statutory, and voluntary and community sector organisations in Crawley, will work out with the person what might help them to feel better and more in control of their own situation. The Coordinator not only refers patients to appropriate services, but also helps them to engage by accompanying them to the first session, introducing them to the person coordinating a particular service or activity and following up with them to encourage them to continue with engagement. Needs are gauged on an individual basis, and the level of support offered is adapted accordingly.

Services and activities are free (or low cost) at the point of delivery, but all voluntary and community sector organisations (VCS) offering services are paid through project funding for every session/activity they have delivered. This is built into the project to support sustainability of local VCS groups and organisations.

The project is managed by Crawley Community & Voluntary Service (CCVS) and overseen by a Steering Group made up of local statutory and voluntary sector partners. CCVS and the Steering Group are working closely with the Crawley Clinical Commissioning Group (CCG) to investigate potential future funding. The project vision is to expand Prescription Plus so that it is available in GP surgeries across Crawley on a long-term basis.

TRENDS

Who has been referred?

During the first six months of delivery, 120 GP referrals were received, as shown in Table 3 below.

Referring surgery	Number of referrals	% of referrals
Southgate Medical Group	80	67%
Leacroft	22	18%
Langley Corner	14	12%
Gossops Green *joined the project mid-February*	4	3%

TABLE 3 – REFERRALS BY SURGERY

Of the 120 referrals, 42% agreed to an assessment and initial support, a further 17% were waiting for initial contact at the six-month point, and 28% had declined an assessment visit. A further 13% were either unavailable, or were deemed inappropriate referrals.

70% of referrals were women and 30% men. Although the age of clients referred ranged from 21-98, the majority of referrals were older people with an overall average age of 72.

How has Prescription Plus supported them?

A total of 141 referrals or signposts have been made in the first six months, comprising 75 supported referrals to more than half the organisations on the project menu, and a further 66 signposts to 37 different organisations and services not on the menu, or for clients referred to us from non-participating GP surgeries. (See Appendix 2 for a full list of organisations receiving referrals.)

One of the project strengths is its flexible and holistic support of clients, meeting each individual at their point of greatest social need. Most clients were referred to more than one organisation for support. On average, each Prescription Plus client has been supported by 2.4 supported referrals or signposts.

The type of support needed during the first six months can be broken down as follows:

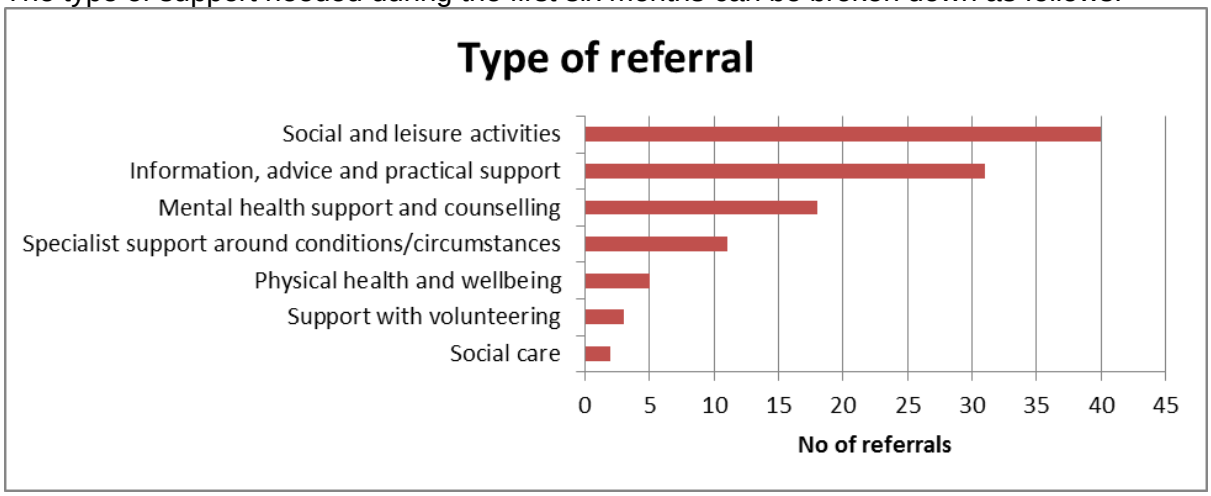


CHART 1 – TYPE OF REFERRAL

IMPACT ON WELLBEING

What has been the impact on clients' wellbeing?

Clients referred to the project complete a simple monitoring form before support begins scoring various aspects of their wellbeing from one to five, and a second, identical form when their support has ended. The project measures the "distance-travelled" between each score, giving us an overall picture of any improvement in wellbeing.

Given the early stage of the project, when the majority of clients are still being supported, we have compiled for this interim report a spot check of four clients aged 66-73, three women and one man, who between them have received support from Age UK, CAB, Crawley Baptist Church, Forget Me Nots, Posh Club and Sage Counselling. They have also been signposted to Christians Against Poverty Debt Advice Line, Crawley Lions, Crawley U3A, Cruse Bereavement, Easter Team, Family Mosaic, Macmillan, the Olive Tree, Silverline and the Warm Home Discount Scheme. Without exception, these four clients, who collectively presented with multiple health issues, social isolation, depression, anxiety and issues around housing and finance reported a positive increase in wellbeing as evidenced in Charts 2a-2g below.

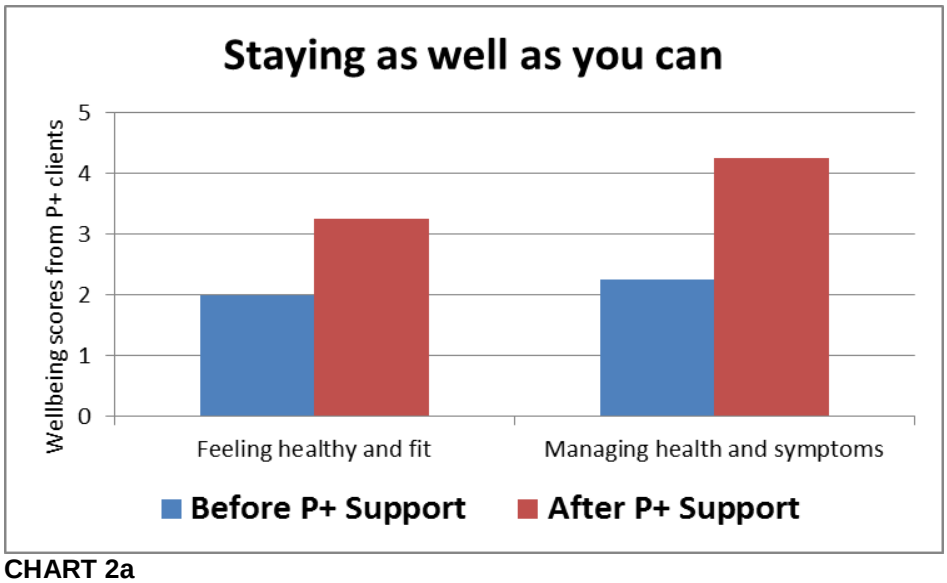


CHART 2a

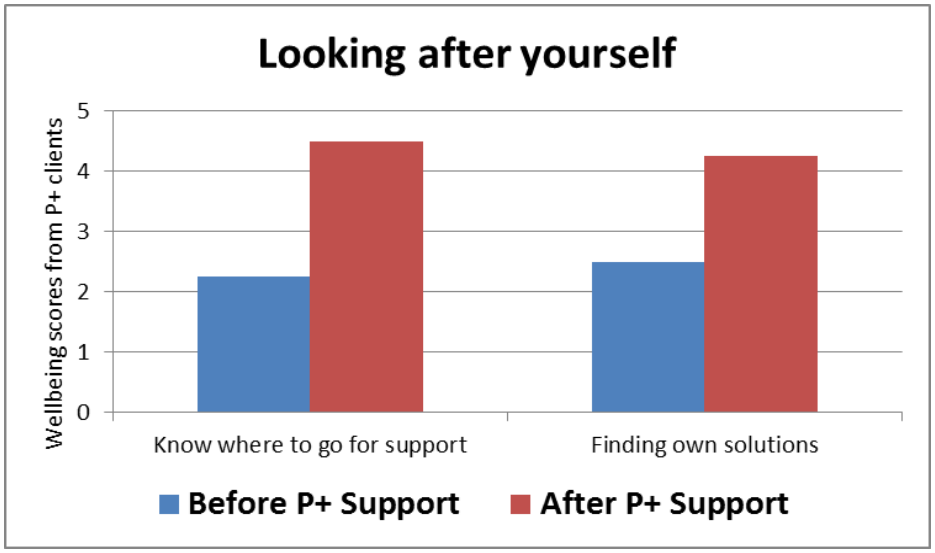


CHART 2b

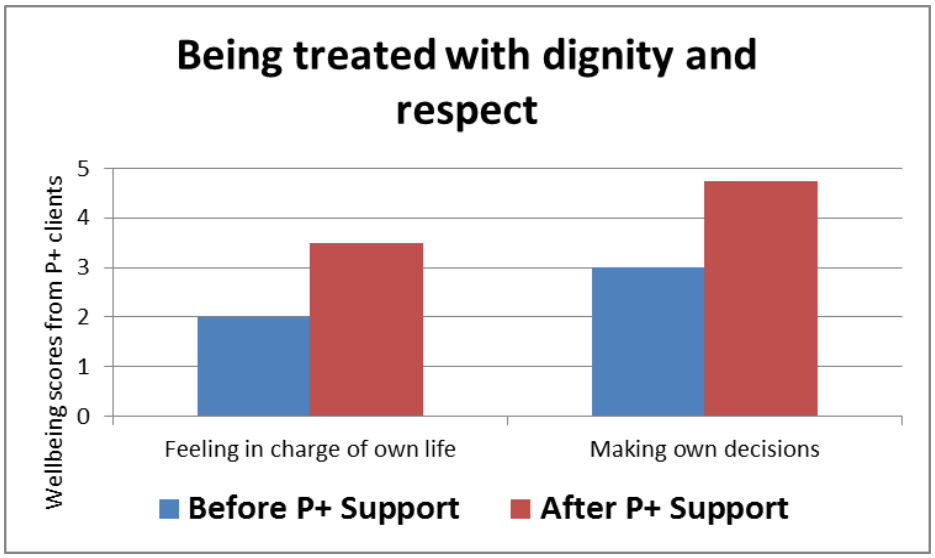


CHART 2c

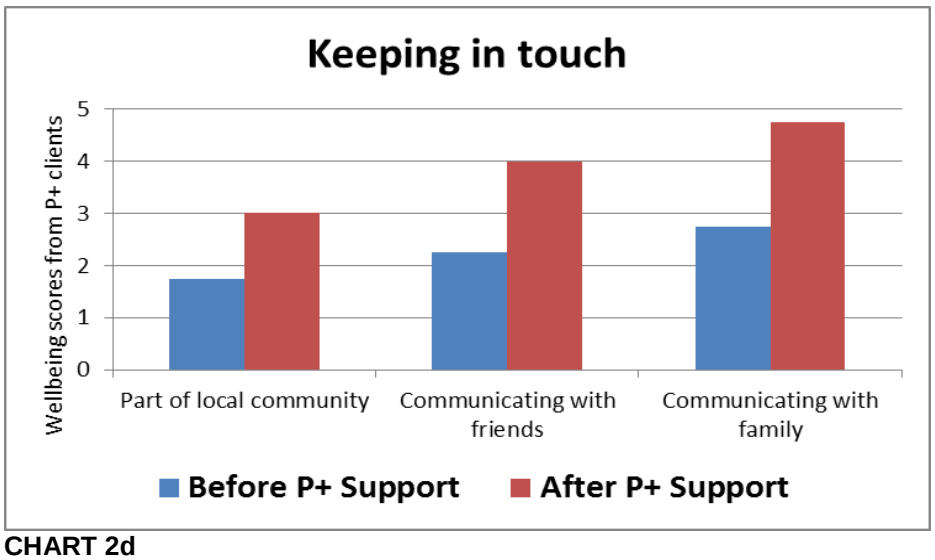


CHART 2d

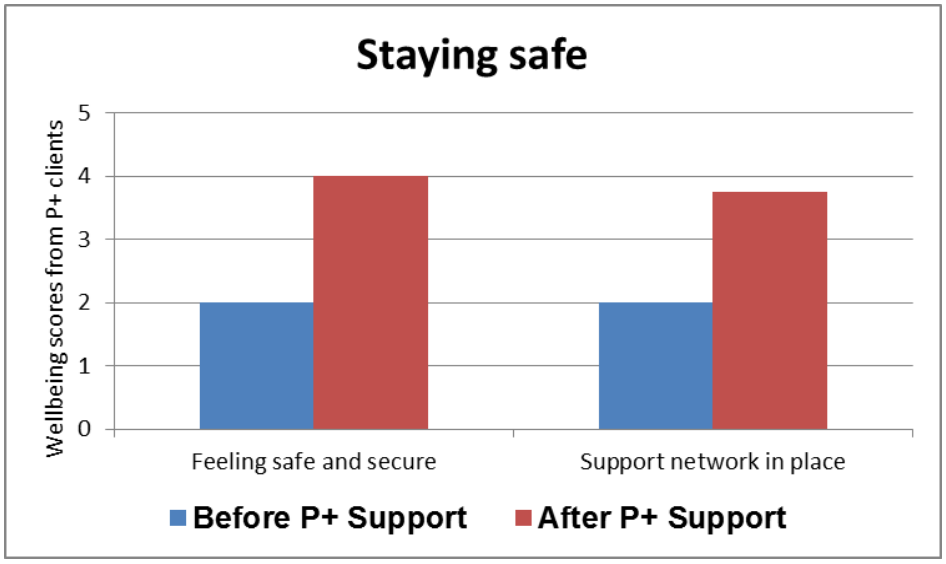


CHART 2e

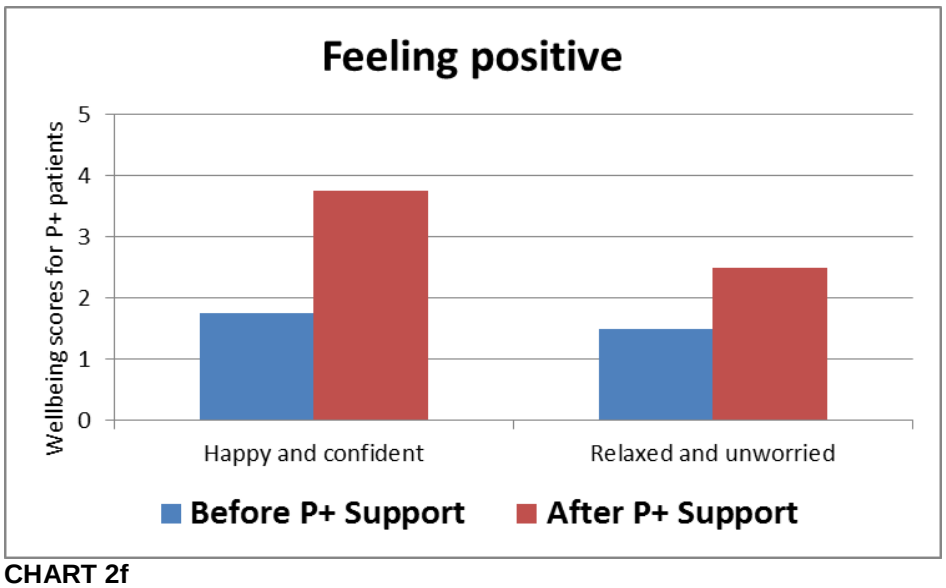


CHART 2f

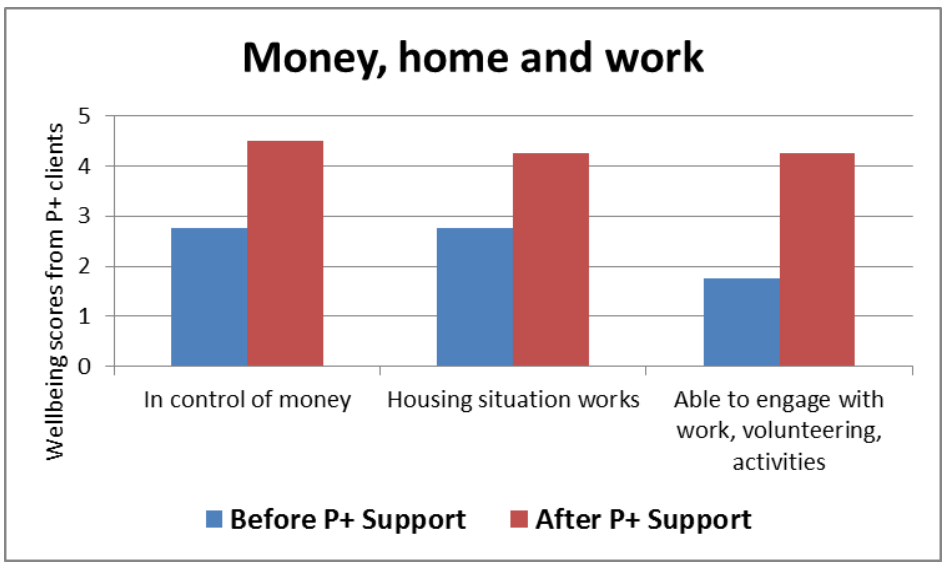


CHART 2g

What have clients told us?
"I was referred to Tracy [Co-ordinator] by one of the Practice Nurses. I was about to put my head in the oven due to my medical problems and financial worries. Tracy made contact with me and has been brilliant. I have now sorted out my finances and have a Blue Badge so I can go out and about. She has been fantastic. Because of one of my medical conditions, I need extra toiletries which I could not afford before. I now have financial help to buy these. Thanks to Tracy. I cannot fault her."
70 year old patient with cancer, COPD, anxiety and depression

"What a brilliant service. This has really helped me. I do not know what I would have done without this; please do not let it stop."
73 year old patient, diabetic with asthma and depression

"Mum and Dad think it is good work for me and my sister is very proud of me. I would recommend volunteering to those that are in my situation."
25 year old patient, with additional learning needs and living at home

What have delivering organisations told us?
"It is clear from the number of referrals we have already received that Prescription Plus is a much needed service in Crawley. Despite our best efforts, we have had limited contact with GPs in this area and few referrals in the past, so from our perspective this has bridged an important gap between our service and GP surgeries, allowing us to reach out to more isolated older people."
Helen Kirkham, Service Manager, Royal Voluntary Service

For full case studies, please see Appendix 3.

IMPACT ON HEALTH SERVICES

Executive Summary
With increasing interest in the contribution made by non-medical interventions to patient health and wellbeing, it is important to understand the effectiveness of social prescribing on the demand in primary and secondary care as well as understand the profile of the patients who are likely to benefit the most from such support.

A Risk Stratification system (Artemus 2 – Docobo), that links primary and secondary care data at patient level utilised by the Crawley Clinical Commissioning Group (CCG) provides the perfect opportunity and a valuable resource to monitor this in the cohort receiving social prescribing support through Prescription Plus.

This interim report serves to highlight the type of information that will be available when monitored long term for the final report on the pilot in October with respect to the patient profile, activity and costs, and what other parameters will be available to enrich the current intelligence.

There is some reduction in unplanned bed days and stabilisation in A&E attendances and emergency admissions over a four-month period in those patients who have received Prescription Plus support. These reductions are also beginning to be reflected in the costs.

Introduction
The clinical aim of Prescription Plus is to integrate health care with social support provided by the voluntary sector. Reducing pressures on General Practice as a result of the growing demand placed by the ageing population is an additional ambition.

In addition to the qualitative evaluation, the project also looks at the quantitative evaluation of the impact of non-clinical support on primary care consultations and secondary care activity and associated costs where available.

This will inform commissioning decisions and contribute towards an understanding of the success of Prescription Plus with respect to the outcomes and objectives set out below.

Target Group
As stated earlier, the target population is adults aged 18+, with a diagnosis of one or more long term conditions, who are frequent attenders to primary care and those identified as requiring non-medical needs. Long term conditions have no cure and are currently managed with medications and other techniques. Managing multiple long term conditions (co-morbidities) is difficult and is compounded by different requirements and medications. It is also known to affect the patients psychologically, generating anxiety. Effective management of long term conditions via psycho social models have proved to improve the quality of life and stability.

Outcomes and objectives
- Reduce social isolation
- Enable individuals to manage their long term conditions as a result of improved wellbeing and to feel more in control
- Decrease contacts in primary care
- Decrease activity in secondary care
- Decrease associated costs in primary and secondary care

Method
Crawley CCG has access to a risk stratification tool that relies on primary care information with respect to demographics, diagnosis and medications linked with secondary care data that provides information on secondary care activity at patient level. The data that resides within the tool is for the registered population for Crawley CCG. It is a rich data source. The tool predicts risk of admission based on two years' historic data.

As a result, data is available for a period before the start of an intervention and after a defined period of time has elapsed post-intervention. At the time of writing this report, the CCGs were transitioning to an enhanced version of the tool (Artemus v2) that the CCGs have developed jointly with the software provider (Docobo). Initial analysis has been carried out with data in version 1 of the tool for this interim report. The final report due in October will evaluate the whole intervention cohort from version 2 of the tool.

The principle of the activity in secondary care remains the same. However, the cost information differs in that in version 1 they are tariff based, whilst in version 2, we will have actual costs incurred (payment by results). Also version 2 will have data on practice contacts and better information on prescriptions which can be added to the analysis for the final report.

Comparable Cohort who did not receive social prescription support as controls
Those patients who are eligible for Prescription Plus support but who decline the support are being transferred to a cohort who will act as controls to understand the differences in outcomes for the intervention cohort and the non-intervention cohort.

Quantitative Evaluation
The following parameters were evaluated for the initial cohort (n=28):

1) Understanding the patient profile:
   - Risk of admission score
   - Cohort long term conditions and co-morbidities
   - Social isolation risk factors

2) Understanding the impact, pre and post-intervention, of support received through Prescription Plus. In an ideal situation, 12 months pre-intervention and 12 months post-intervention data should be evaluated. However, at this stage a preliminary analysis post-four months intervention was feasible to start looking at the emerging trends. The data below provides the type of information that we will be able to look for in the final report in October alongside wellbeing measures derived from internal evaluation:
   - Change in risk of admission
   - Hospital episode statistics
   - Secondary care costs

The referral source for the patients evaluated here is predominantly Southgate Medical Group and Leacroft Medical Practice. The number of referrals to Prescription Plus by the end of March was 120. The number of evaluated early referrals in this report is 28.

Findings / Results

Patient Profile: Risk of admission

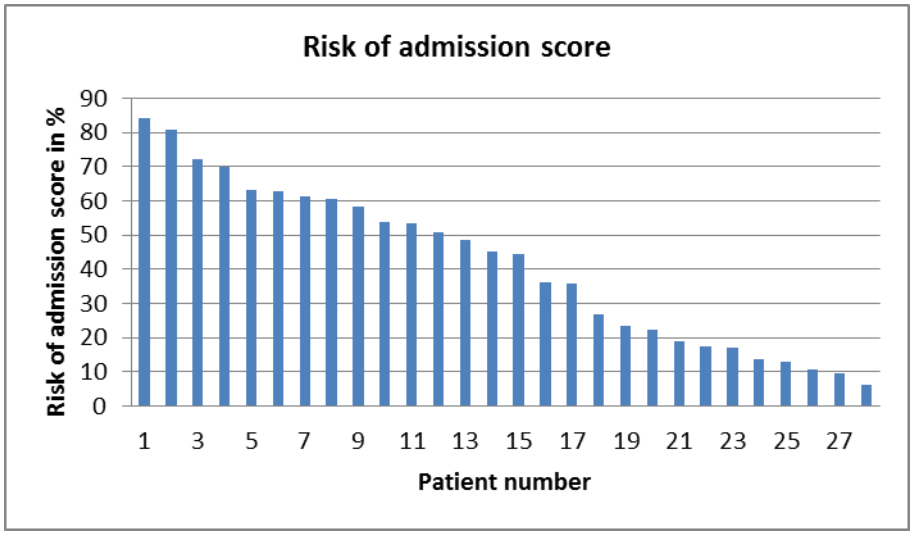


CHART 3: THE CHART ILLUSTRATES THE RISK OF ADMISSION SCORE, EXPRESSED AS A PERCENTAGE RISK OF ADMISSION

The risk of admission score for patients (n=28), ranged from about 6% (low risk of admission to) 84% (very high risk of admission).

The risk score for 12 out of 28 patients – is considered to be high risk of admission (greater than 50% risk of admission).

The age profile for the patients is greater than age 65. In this group of patients evaluated, 24 are female and four male.

Patient Profile: Long term conditions and co morbidities

Patient	Stroke-Tia	Chronic Arterial Disease	Chronic Obstructive Pulmonary Disease	ASTHMA	Chrobic Heart Failure	Atrial Fibrillation	Mental Health	Fall Risk	Dementia	Hypertension	Depression	Cancer	Diabetes	Chronic kidney disease	Number of Long Term Conditions
1			1	1			1	1		1					5
2	1		1							1	1			1	5
3									1			1			2
4				1	1	1	1			1	1		1		7
5		1			1	1				1				1	5
6	1	1					1	1		1		1			6
7		1		1						1			1		4
8								1		1				1	3
9	1	1	1	1						1	1			1	7
10		1			1	1				1				1	5
11				1						1	1		1		4
12			1	1						1	1				4
13		1		1	1					1	1		1		6
14		1		1						1			1	1	5
15	1	1		1	1	1		1		1			1	1	9
16	1			1				1		1					4
17			1	1			1				1				4
18											1				1
19		1		1			1	1		1	1				6
20										1		1		1	3
21								1		1		1		1	4
22															0
23	1										1	1		1	4
24						1								1	2
25			1	1			1				1	1			5
26						1				1	1				3
27		1								1		1			3
28		1		1						1	1				4

TABLE 4: THE TABLE ABOVE SHOWS THE TYPE AND NUMBER OF LONG TERM CONDITIONS FOR EACH PATIENT IN THE COHORT

The majority of patients in this cohort have two or more long term conditions. The most common conditions and in descending order of prevalence are the following long term conditions:

- Hypertension
- Asthma
- Depression
- Chronic Arterial Disease
- Chronic Kidney Disease

Social Isolation Risk Factors

Patient	Cancer	Dementia	Depression	Lives Alone
1				1
2				1
3			1	1
4			1	1
5			1	1
6	1			
7			1	1
8			1	
9				
10	1	1		
11				
12	1			
13			1	
14			1	
15				
16				
17				
18			1	
19			1	
20				
21	1			
22	1		1	
23			1	
24				
25	1			
26	1		1	
27				
28			1	

TABLE 5: THE TABLE ABOVE SHOWS THE RISK FACTORS IDENTIFIED TO SOCIAL ISOLATION FOR THE COHORT.

In addition to the co-morbidities and age, the risk factors to social isolation as shown in the table were also identified in the risk stratification system.

There are other risk factors in the risk profiling tool but not applicable to this cohort. We have a range of risk factors to social isolation available in the risk stratification system. Combining these with information on other factors such as age, medications, long term conditions and contacts in primary and secondary care will provide multidimensional intelligence to identify patients that need social prescription support, will prove valuable going forwards and need to be explored further alongside the menu of care available.

Quantitative analysis: Changes in risk of admission score

net change 4 months before September 2016	net change 4 months after September 2016	Noticeble reduction in risk of admission
1.52	2.77	
-8.86	17.26	↑
3.99	-15.32	↓
2.65	-1.41	
-4.87	-33.5	↓
-1.08	29	
13.27	-15.73	↓
0.54	1.97	
-1.81	-0.7	
26.24	14.79	
0	0	
60.43	-40.13	↓
7.2	18.34	
-6.3	4.76	
-3.64	65.31	↑
-3.56	0.41	
2.03	-16	
24.1	-41.56	↓
24.16	13.13	
-19.26	-29.33	↓
33.26	5.52	
-18.3	-0.7	
3.66	1.08	
-12.07	4.98	
5.22	-32.47	↓
1.31	62.45	↑
-13.39	-1.99	
-0.09	-5.28	↓

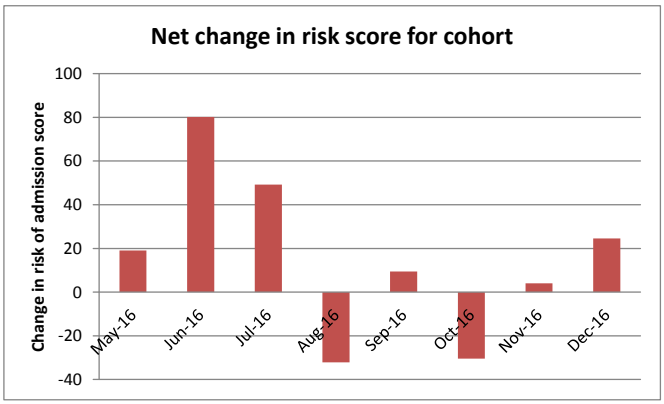
TABLE 6: SHOWS THE CHANGE IN RISK OF ADMISSION SCORE. Downward arrows demonstrate a noticeable decrease in risk score four months post intervention.

The risk stratification tool provides information on change in risk of admission score compared to the risk score the previous month on each patient when the information is updated monthly.

Patients will show variable changes in risk of admission score. Over a period of time it may increase or decrease. What we are measuring here is the net change before and a period of time following the intervention.

The table shows the net change in risk four months before September 2016 and then four months after Prescription Plus support was received.

Eight patients demonstrate a noticeable reduction in risk of admission score. The reduced variation illustrated below in the risk score post Prescription Plus support for the cohort, demonstrates in turn a reduced fluctuation in patients' physical health. It would be good to see a continuation in the trend.



Note: Patients have variable complexities and variable needs. As a result, it is difficult to measure consistent changes. What we will be looking for when monitored over a longer period is the proportion of patients who demonstrate a reduction in the risk score within the intervention cohort.

We will also demonstrate the difference when compared to a cohort of patients who were identified as eligible for Prescription Plus support but who declined.

Hospital Episode Statistics

	April 2016	May 2016	June 2016	July 2016	August 2016	Sept 2016	Nov 2016	Dec 2016	Jan 2017
Patients	28	28	28	28	28	28	28	28	28
Unplanned - Bed Days	120	125	119	137	122	97	82	76	66
Planned - Bed Days	124	134	125	109	108	87	37	37	37
Total Stay - Bed Days	244	262	247	249	233	187	122	116	106
Emergency admissions	35	35	36	40	38	34	29	29	28
Non-Emergency Admissions	13	15	15	13	12	10	7	7	7
Day Cases	10	11	11	11	12	12	12	12	13
Total Admissions	58	61	62	64	62	56	48	48	48
1st OP Appts	24	25	29	30	30	32	31	35	32
FU OP Appts	64	66	103	108	113	110	108	112	107
A&E Episodes	69	65	67	68	67	59	47	50	53

TABLE 7: THE TABLE SHOWS THE ACTIVITY IN SECONDARY CARE FOR 12 MONTHS (CUMULATIVE) PRIOR TO THE MONTHS STATED

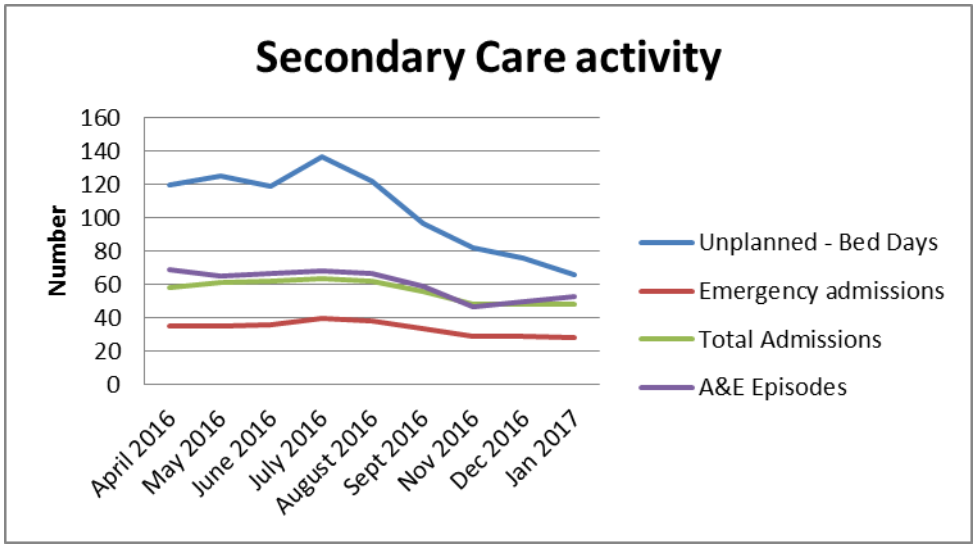


CHART 4: TREND IN SECONDARY CARE ACTIVITY

Unplanned bed days: There was already a downward trend around August 2016, before the start of Prescription Plus support. However, further reduction was noticed after September 2016. With long term monitoring, we would be looking for a continued reduction or a stabilisation.

Emergency admissions: There is a noticeable reduction and stabilisation post September.

Total Admissions: This includes elective and non-elective. This also shows a noticeable reduction and stabilisation post September.

A&E Episodes: There was already a downward trend around August 2016, before the start of Prescription Plus support. We would need to monitor over the next few months to obtain an indication of the trend.

Secondary care costs

	Cost 000's Jan-16	Cost 000's May-16	Cost 000's Aug-16	Cost 000's Jan-17
Patients	28	28	28	28
Total Cost	£72.1	£62.2	£67.6	£54.3
Elective Total Tariff	£8.1	£3.2	£3.2	£1.6
Day Case Total Tariff	£3.4	£4.4	£3.7	£3.0
Emergency Total Tariff	£43.9	£37.1	£37.1	£26.8
A&E Total Tariff	£6.5	£6.7	£7.2	£6.3
First Outpatient Appts Total Tariff	£4.9	£4.4	£5.3	£6.1
Follow UP Appts Total Tariff	£5.1	£6.3	£10.7	£10.3

TABLE 8: SHOWING TARIFF-BASED SECONDARY CARE COSTS FOR 12 MONTHS (CUMULATIVE) PRIOR TO THE MONTHS STATED IN THOUSANDS

The total cost line provides the costs for the activity represented in the table.

In an ideal situation, we should analyse September 2016 to September 2017, a year after Prescription Plus intervention commenced. This is because of the variable nature of activity for patients with clinical complexities. For example, a patient may attend A&E thrice in two successive months and then may not attend in the next three to four months.

The emergency admission costs are the highest in this group of patients. Emergency admitted patient care had already reduced ahead of August 2016, before Prescription Plus commenced for these patients. However, there is a continuing downward trend in total emergency costs. Over the long term we can demonstrate the Prescription Plus contribution to this trend. Follow up costs will show an increase, which is better as these are planned costs and lower than emergency costs.

The new risk stratification tool launched at the end of March 2017, (delayed from January 2017) has actual costs incurred (payments by results). So going forward we have a method of evaluating impact much better.

Conclusions

The patient profiles show us that the cohort (n=28) referred to Prescription Plus are complex. About 12 have high risk of admission scores and the majority of the patients have multiple long term conditions. As a result, clinical management of their long term conditions is complicated even before the wellbeing aspects are considered.

Of the social isolation risk factors, depression is dominant. Depression as a referral criterion may be a good way forward. There is a service being rolled out that improves access to psychological therapies (IAPT) at the CCGs. A collaborative approach between Prescription Plus and the IAPT programme (already underway) would add connectivity and help the integration efforts with respect to physical and mental health.

Finding patients with risk factors to social isolation and shortlisting by long term conditions and frequency of attendance in secondary care via the risk stratification tool was explored briefly, but needs to be explored further with a wider menu of care when higher numbers of referrals are considered. This is because we have the opportunity to shortlist suitable patients for review readily and target the social support in an informed manner.

Risk of admission score is a good measure of improvement in patient condition when measured over a longer period of time. This is because the activity in both primary and secondary care will decrease as will the number of medications. All these parameters are integrated as part of the risk algorithm. A net change in risk score, trending towards a reduction for a higher proportion of patients who receive Prescription Plus support over a longer period of time will reflect improved self-confidence and better self-management of long term conditions. Data for the four months post intervention demonstrates significant reduction in risk score for eight out of 28 patients, but an overall reduction in risk score of 3.89%.

With respect to activity in secondary care, there is a hint of stabilisation in A&E attendances and emergency admissions which is positive. Again long term monitoring will provide a definitive indication of the direction of travel.

Reduction in these activities is also reflected in the costs. We are very excited about our capabilities to measure the actual costs incurred via payment by results from version 2 of the risk stratification tool for the final report in October. We should also be able to calculate the cost impact and return on investment more accurately for sustainability with a larger sample.

We had ambitions to monitor primary care contacts and costs in these patients for the interim report. However, due to delays with the launch of version 2 of the risk stratification tool, these will be available in the final report for the wider intervention cohort and will contribute to strengthening the quantitative analysis.

With respect to the outcomes, reduction in social isolation will be demonstrated by the qualitative analysis. Initial data does demonstrate a movement towards a stabilisation in A&E episodes and emergency admissions. There is a downward trend in the number of unplanned bed days. The implication is that the objectives that Prescription Plus set out to achieve as indicated in its clinical outcomes and objectives above can be demonstrated with longer term monitoring.

In light of the short time frame at the time of this report, we have demonstrated the impact on the patient journey via case studies which can be viewed in Appendix 3.

Final Report – October 2017
This is an interim report and looks at data only a short time after recruitment (≤ 4 months) to Prescription Plus. This helps to provide an idea of what type of monitoring has been put in place and the very rich information that will provide the assessment of the project impact.

The final report will be able to look 12 months post intervention. Long term monitoring will provide much better data. The final report will be able to compare the number of practice contacts, prescription and costs in depth as well as the control cohort mentioned above.

What have participating GP practices told us?
“I feel that this service has really assisted some of our patients who were socially isolated and the communication between yourself and the surgery has been exemplary. The decrease in calls for GP attention from some of those patients has also been beneficial too, apart from the success for them on a personal level.”
Diane Cox, Patient Services and Facilities Manager, Leacroft Medical Practice

"I think this has been beneficial for several of our patients. As a referrer I find it very easy. I float the idea to the patient and tell them that 'Tracy will ring them to discuss the options'. The referral form is very simple so doesn't take long to complete. I think it's helpful that I have a specific name to say who will contact them."
Charlotte Ruglys, GP, Leacroft Medical Practice

"The referral system works smoothly, which in a busy surgery environment is vital to its success. Clinicians are able to follow the patient's journey to social prescribing, through the individual patient's computer records which are continually updated by Tracy. This information supports the clinician to form a picture of the patient. If the patient refuses to engage or opts out of the service, then the clinicians will attempt to inspire the patients by explaining the benefits of self-management. Tracy has successfully encouraged some of our more challenging patients to become involved with this service and we are looking closely at the effect this will have on the patients, not only in the short term but also in the long term. At SMG it is felt that the social prescribing project needs to be given the time to mature so that the long term effects on patients can be assessed and the project adapted if needed to achieve the desired outcomes."
Joanne Karagoz, Deputy Practice Manager, Southgate Medical Group

"We have found that many of our patients who have been referred into the scheme have benefitted tremendously from the social interaction and activities provided, and this has helped not only their physical, but emotional and mental wellbeing. In terms of providing excellent patient care, we believe that the pilot has been and will continue to be very successful, and it has our full support."
Matthew Cullis, Practice Manager, Leacroft Medical Practice.

LEARNING POINTS

Aside from important learning around making our own internal processes tighter and more efficient, we have learned much and are addressing any issues in the following project areas:

Supporting clients

One of the key strengths of the project has always been its hand-holding, supportive offer. Although an element of signposting takes place (to non-menu organisations), clients access the majority of services through supported engagement. At the outset, we imagined this to be one assessment visit, followed by support/transport to attend the first session of any new service or activity. After this, it was envisioned that the client would work with the organisation to attend sessions individually, with some light touch phone follow up from the Community Support Coordinator.

In reality, the clients referred to us have come with multiple, complex needs, are lonely, isolated and anxious, and have generally needed more than one or two face-to-face contacts to effectively engage. Expecting them to access support independently so early on in the process was unrealistic, and would have resulted in significant setbacks. The result has been a significantly greater demand on the Community Support Coordinator's capacity than originally anticipated.

We are addressing this issue in a variety of ways:

- Through the recruitment and training of Prescription Plus volunteer buddies to accompany and support clients to continue engagement after Community Support Coordinator support has been stepped back. We are working in partnership with RVS

to achieve this. Wherever possible, we want to encourage volunteers from the project client base, and from the participating surgeries' Patient Participation Groups.
- Through monthly communication with the delivering organisations, encouraging them to think creatively about supporting engagement.
- Through developing boundary guidelines based on real experience. Although we recognise that more support than originally expected is needed to effectively support the cohort of clients coming our way, we also know that support ad infinitum is not a realistic option. Based on our frontline experience and understanding of the clients, we are putting in place some guidelines and boundaries for support which we feel best serve the client as well as making the project manageable and sustainable.
- Through managing the number of referrals made to the project at any one time (see below).
- Through referring on to partners (eg PAT, Crawley Wellbeing, Innovation Hub) where appropriate.

We are ensuring timely and effective contact with clients who don't wish to engage by sending a follow-up letter outlining the support available through the project and making them aware of how to refer back into Prescription Plus. We also sent personalised Christmas cards to every client referred to us with a project leaflet.

Working with GP surgeries
Each GP practice is different, and requires a flexible and bespoke approach. Prior to the project launching in any particular practice, we have learned that we need to allow sufficient time not only for all the practical steps to be put in place (IT, consulting room etc), but also for brief training of all practice staff so that the whole team is aware of the project and how it works.

The number and nature of referrals has also been a learning point. Issues have arisen around the number of referrals coming through at any one time (too many at once floods the system and results in a long wait for initial client contact), and the nature of some of the referrals. Only 4% of total referrals have been deemed entirely inappropriate, but we have seen a number of referrals either where needs are so complex, and the client so housebound, that the low-level support offered through Prescription Plus is not right for their needs, or where the client is high-cost with many medical needs, but with a good enough social support structure already in place so that Prescription Plus is simply not needed.

Regular communication with the participating practices has helped with all of these issues, and we are learning together. Our stance now is that the project can handle on average five referrals, per practice, per month. That is a total of 20 referrals per month, or 240 referrals per year for one Community Support Co-ordinator working in four GP Practices (around two-thirds of which will go forward, based on the first six months of the pilot).

Working with other partners
Working with other partners in Crawley has been vital, and the project Steering Group is made up of a range of statutory and voluntary and community sector organisations. During the first six months of operation, we have met with a number of statutory partners working in a similar way to Prescription Plus to ensure that as far as possible we are working in an effective and complementary way. Whilst the utopia would be a perfectly seamless, all-singing, all-dancing holistic social prescribing service for Crawley's population, an achievable reality is regular and effective partnership-working between services and simple, consistent communication to the client. This is something that will need to be developed further as Prescription Plus continues to bed down in the town.

A BRIEF LOOK FORWARD

Vision for Prescription Plus
Currently, Prescription Plus is operating in four of Crawley's 12 GP Practices, is catering for a particular cohort of patients, and is at capacity. Early results are encouraging.

At the very least, we would wish to continue at our current level, serving 240 patients each year from Southgate Medical Group, Leacroft Medical Practice, Langley Corner Surgery and Gossops Green Medical Centre, and giving the project time to show its true benefits over the longer-term. Sustainable changes in patient wellbeing and real savings to primary and secondary care will need years, not months to become fully evident.

Ultimately our vision is to make Prescription Plus available in every GP surgery in Crawley, and beyond that to involve other partners. Costs to continue the service from January 2018, and to gradually expand the service to more GP surgeries are as follows:

GP Surgeries	Community Support Coordinators	Project Volunteers	Patients	Cost
4	1	4	240	£60,556
8	2	8	480	£106,664
12	3	12	720	£149,926

TABLE 9 – PER ANNUM PROJECT COSTS

In the final pilot year report in October 2017, we anticipate being able to demonstrate year on year estimated costs savings to the Crawley CCG based on actual results from the first 12 months of the project.

CONCLUSION

Social prescribing has a cost attached to it. There is no question about that. And despite the growing body of compelling national evidence pointing towards its efficacy, it remains a relatively new way of working. Therefore, any investment involves a certain element of risk. The question remains, is it a risk worth taking? And is it a risk which will pay dividends?

We know that the national evidence says yes. Social returns on investment in the region of between £1.50-£2 for every £1 spent are testament to that. The more pertinent question for us is whether investment in Prescription Plus is a risk worth taking in Crawley.

This report has highlighted important parallels between Prescription Plus and longer-standing, larger-scale projects around the country in terms of project design and reach. More importantly, it has shown a very early, but positive direction of travel towards increased patient wellbeing, reduced demand on health services, and potentially significant cost-savings to the NHS in the long-term.

The introduction of the Risk Stratification system Artemus 2 to Crawley CCG earlier this year, and its ability to track patient use of primary and secondary care, and to compare their risk factors before and after Prescription Plus intervention, means that the data which will be available to us in October 2017 after one year of operation will be more robust, and will paint a clearer picture of the cost impact of Prescription Plus in Crawley. Early indications are that this impact will be a positive one – reductions in pressure on both primary and secondary care, and much-needed costs savings for the health service.

But in the midst of all the discussion on positive impact on the local health economy, let's always keep sight of the most important part of social prescribing of all – the patient. Prescription Plus in particular, and social prescribing in general, is based on putting the wellbeing of the patient at the heart of everything we do, and working with them to put strategies and services in place which help them to live more independent, resilient and fulfilled lives, even in the midst of their many health issues. In the words of one of the project's 73-year-old patients battling with diabetes, asthma and depression: "What a brilliant service. This has really helped me. I do not know what I would have done without this. Please do not let it stop."

APPENDICES

APPENDIX 1
Findings from other social prescribing schemes around the country

Bristol study
Various social prescribing schemes in the UK are starting to surface useful data on the efficacy of social prescribing and some early work has begun on the value. One amongst a handful of experts on the topic has published data on the value of social prescribing[15]:

Social prescribing is emerging at a time of crisis in general practice[16]. Attendance rates are rising whilst a significant proportion of patients and needs raised by them are non-medical, or they are medical matters made worse by other non-medical circumstances such as loneliness and isolation, lack of exercise, and money, housing or relationship issues. Before the arrival of social prescribing GPs had no way of generally responding potential social determinants of health and wellbeing.

One GP use and prevention the report[17] finds:

"Analysis of GP contact times also suggest that for 60% of beneficiaries there is a reduction in their GP attendance rates in the 12 months post intervention compared to the 12 months period prior to referral. For 26% of beneficiaries it stayed the same and for 14% it actually increased.

A key outcome highlighted by social prescribing practitioners is that they perceive their intervention is not simply about achieving positive outcomes like: improved well-being, a return to work or training etc. Instead it is about addressing embedded and unaddressed/undiagnosed issues like: agoraphobia brought on by abusive neighbours, relationship breakdown, addiction etc. It can also be preventative in the sense that it helps to prevent beneficiaries spiralling down to worse scenarios."

Wellspring Bristol[18] saw it scoring highly in improving public health, generalised anxiety disorder, wellbeing measures and improving friendship networks. The study found that social prescribing investment from commissioners contributed a social return on investment of £2.90 for every £1.00 spent.

This study author warns of over-promising and grabbing at supposed quick wins:

"Social prescribing practitioners argue that outcomes are often slow to materialise when working with isolated and often poorly motivated clients. This is because those referred frequently require a considerable amount of time to enable the worker to address their multi-faceted needs... Thus these need to be considered long term when assessing cost-effectiveness."

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[15] Kimberlee, R. (2016).' *What is the Value of Social Prescribing?'* Advance in Social Science Research Journal, 3(3) 29-35, March 2016
[16] *Ibid 3* page 1
[17] Kimberlee, R., Ward, R., Jones, M., and Powell, J. *Measuring the economic impact of Wellspring Healthy Living Centre's Social Prescribing Wellbeing Programme for low level mental health issues encountered by GP services*, UWE 2014 http://www.wellspringhlc.org.uk/reports/POV_Final_Report_March_2014.pdf Accessed 26/2/17
[18] *Ibid 3* page 1

Another point that this and other studies have made is that social prescribing is both broadly based in what a package can potentially provide, as well as specific in that a patient-focused package is specific to that patient and their needs "co-produced" with them and the link worker. Thus unlike many other initiatives social prescribing has the potential to meet many needs and, if resourced and designed well, make a difference to the deficiencies in primary care.

- The scheme is exploring the comparison of its data to an external control group
- The scheme identifies many other benefits of social prescribing particularly the ability of some small VCOs to contribute to local health and wellbeing priorities

Learned Lessons from the City and Hackney social prescribing scheme
City and Hackney are expanding their social prescribing scheme. As regards performance, "soft" data amongst users shows consistent progress, though savings of primary care time or costs are not, as yet, bearing fruit. In spite of this the programme is expanding as social prescribing is seen as a new and effective part of primary care intervention, meeting non-medical needs and developing the "asset" of the community and voluntary sector's role in supporting patients. In their presentation they identify some useful pointers to future social prescribing development:

The Future…
- Consider how you demonstrate impact
- Make social prescribing coordinators part of the practice team
- Patient experience is powerful – strong motivator
- What are the successful qualities of the services that social prescribing refers onto?
- Opportunity to build social prescribing into any health service configuration

Wellbeing Prescription Service, Surrey – notes on early stage evaluation:
This small-scale project was evaluated by York Health Economics after one year of operation. Here are the summary points:

1. The scheme generated a Return on Investment of between £0.20 and £0.46. based tentatively on a limited sample (96 users) and a limited time scale. This is arrived at by only including a) reduction in primary care use and b) clients with weight management interventions. The evaluator's calculations appear to compare these gains with all the costs of the scheme.
2. The scheme is showing reductions in GP use with some cost savings. Analysing York's data further shows a 37% fall in GP visits over a year. This would make an enormous impact if this could be repeated even at half this rate.
3. There are problems with over-extrapolating falls in GP use. First some GP visits could be substituted with Wellbeing Prescription visits. Second visits rate may not be sustained beyond a year where patients with complex morbidity will visit with other illness issues. Thirdly this scheme's average patient age in 54 to 56 years. Reducing GP use would naturally be at a lower rate with patients where the average age is in the 70s plus age range.
4. This scheme is showing good progress with certain patient groups (middle aged, pre-diabetes, diabetes, obese) using a medium level of patient contact from the link workers – one to three visits.

The evaluation uses a primary care cost of £36 per GP visit. This seems especially low and likely it doesn't include all clinical support, investigations, management and the share of the systemic costs (CCG costs etc.) It is a costing arrived at by the University of Kent's PSSRU (Personal and Social Services Research Unit).

APPENDIX 2

Prescription Plus organisations receiving referrals

OCTOBER 2016 – MARCH 2017

Includes only referrals from participating surgeries to organisations on the menu, not signposting for referrals from other GP surgeries or signposting to organisations not on the menu.	
1. Age UK	12 (4 CANX)
2. CAB	10 (1 CANX)
3. Posh Club	9 (1 CANX) (1 SUSP)
4. Crawley Baptist Church	7 (2 CANX) (1 SUSP)
5. Sage Counselling	7 (1 CANX)
6. Horsham & Crawley Counselling Group	6
7. RVS	5 (2 CANX)
8. Prevention Assessment Team	3
9. Carers Support	2
10. Independent Lives	2
11. Volunteer Crawley	2
12. Crawley Wellbeing	2 (1 CANX)
13. Alzheimer's Society	1 (1 SUSP)
14. Brigitte Trust	1
15. Crawley Library	1
16. Forget Me Nots	1
17. Ifield Park Care Home	1 (1 SUSP)
18. Outset Youth Action	1
19. Sussex Oakleaf	1
20. Sussex Prisoners Families	1

SIGNPOSTING ONLY – NO ENGAGEMENT SUPPORT / PAYMENT

Either because the organisations are not on the project menu, or because the person being sign-posted is not registered with one of the four participating GP surgeries.

Signposting to organisations not on the menu:

1. 4Sight
2. A Band of Brothers
3. Alzheimer's Society (on menu, but non-participating GP signpost)
4. British Red Cross
5. CAP Debt Advice
6. Charis Centre (Xmas lunch)
7. Crawley Community Transport
8. Crawley Lions
9. Crawley U3A
10. Creative Futures
11. Crawley Open House
12. Cruse Bereavement
13. Easter Team
14. Falls Prevention Team
15. Family Mosaic
16. Feed Crawley
17. First Stop (Housing)
18. Headway (on menu, but non-participating GP signpost)
19. Health Coach (Impact Initiatives)
20. Home Chiropody service
21. Impact Advocacy Service
22. Lifeline
23. MacMillan
24. MASH (Multi Agency Safeguarding Hub)
25. National Homelessness Advice Centre
26. Red Cross Transport
27. Samaritans
28. Shelter
29. Silver Line
30. SMG Choir
31. Southdown Housing (on menu, but non-participating GP signpost)
32. Southgate Children & Family Centre
33. Telephone Preference Service
34. The Olive Tree
35. Warm Home Discount Scheme
36. West Sussex Care Guide
37. Worth Services

APPENDIX 3
Case studies

Case Study 1
Mr S is 69 and has cancer and is receiving ongoing treatment. He lives in a first floor flat by himself, suffers with anxiety and struggles to carry groceries up the stairs. Mr S is also struggling financially. He has a problematic neighbour directly beneath him and is afraid to say anything in case the neighbour retaliates. Mr S should be focusing on his health but from discussion with the Co-ordinator it became clear that his concerns were mainly around his housing and financial situation. He felt he was unable to focus on his health until these had been resolved. Mr S had considered going to Citizens Advice but due to his poor health, felt he would not be able to cope with the long wait to see an advisor. The Co-ordinator was able to call Citizens Advice (who are in the menu) and managed to make an appointment for Mr S a week later. Citizens Advice will be talking to Mr S about his housing need. The Co-ordinator also contacted MacMillan (who are not part of the menu) who will be in touch with Mr S to talk about any benefits he may be entitled to. Crawley Lions were also approached and their Service Committee agreed to fund Mr S a £50 voucher for groceries and much needed toiletries. Mr S has said that he felt he may be able to look at other support available to him once these issues were addressed.

Case Study 2
Mrs C is 73 has Osteo Arthritis, suffers with anxiety and has a few other long term medical conditions. She lives by herself and sees her daughter and grandchildren once or twice a month. Mrs C was the first person referred to the project and attended an appointment at SMG in October. She was most upset that SMG had referred her and couldn't understand why. She said that the only reason she came to the assessment appointment was because she was intrigued as to what it was about. By the end of the conversation, Mrs C agreed to at least try a couple of sessions. She has attended two groups to date … has opted not to attend one of the groups again but absolutely fell in love with the second group (The Posh Club). Mrs C insisted that the co-ordinator stayed with her for the duration as she was anxious but after a while, came alive at the session and mentioned over and over again how much she was enjoying herself. She has even asked the co-ordinator if she would be able to go along if any other people were referred, and was going to ask her friend to attend with her at a later date.

Case Study 3
Mrs T is 76. Her husband passed away nine years ago and she has also lost four of her friends over the last 12 months. She sees her daughter once a week. Mrs T still drives and tries to get out twice a week as she enjoys good company and chatting. She is however very lonely. Mrs T and her husband visited South Africa for over 20 years and has very fond memories of travelling and spending time with her husband and friends. Since her friends have passed away, Mrs T has become more anxious about going out and meeting new people. She agreed to try out Age UK on a Tuesday.

Mrs F is 83 and has a few medical conditions. She used to volunteer with Meals On Wheels and as an escort on a school bus assisting disabled children. Mrs F has become very anxious about leaving her house and has commented that 'it happened just like that' … there was no trigger. She never joined any clubs in the past and her anxiety has gotten so bad, that she even feels uncomfortable going up to the local shop and to her son's house for dinner. Mrs F's daughter-in-law confirmed this with the Co-ordinator and actually wished her luck in getting Mrs F to participate.

The Coordinator arranged to collect Mrs T and Mrs F to attend the Tuesday session at Age UK. Both were nervous and had to link arms to enter the main hall. They were made to feel very welcome and have decided to go back. The Coordinator was given permission to share the contact details of both and now Mrs T will be collecting Mrs F to go along to the Tuesday session.

Case Study 4
S is a 24 year old woman with learning disabilities living at home with her parents. She has in the past had an advocate who supported her to gain paid employment but the funding has come to an end. S is really interested in catering & has done a course at Central Sussex College around catering. She also did a course at Plumpton College. She has in the past been interviewed to volunteer, but the charity in questions has not responded to any correspondence. S's parents are in receipt of PIP & S gets ESA.

Through Prescription Plus, S was referred to Outset Youth Action to help her to get out and about and to engage with the local community through a volunteering role. After a home visit to S and her parents from Outset, S chose to pursue an opportunity with Feed Crawley, which is run by Crawley Community Church in West Green. The aim of this project is to provide a free hot home cooked meal to anyone in the community that may need it. Outset accompanied S to her interview, her taster day and her starting day to make sure she was familiar with where she should go and who she should report to. After her first session at Feed Crawley, S decided she wanted to help arrange the food parcels that go out to the people in need and volunteers every Wednesday 09:00 until 13:00. S chooses to walk to and from the placement (travel time is included in her volunteering hours). Currently S is making up 35 food parcels during her volunteering time.

Outset reports that S has settled in nicely and after the first initially supportive days she is able to carry on with her volunteering role confidently. She will be assessed again nearer the summer to see if she would like to try a different opportunity. "She has grown in confidence and feels that she has a purpose, and it shows in her smile."