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BRISTOL

# Developing a Social Prescribing approach for Bristol

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*We have seen how hard it is to engage some people, and how much patience and time some people need. In health we are often quick to judge, slow to listen, and feel too busy to care in the way we would want to. Having ******* (a local social prescribing project) as a partner in our striving to deliver good care for our registered population is like having an extra pair of arms. The team are amazing in their resourcefulness and we are very much richer for the work they are doing.*

(A local Bristol based GP)

**Contents**


| | |
|---|---|
| Contents | 4 |
| Executive Summary | 5 |
| Aims | 8 |
| Acknowledgments | 10 |
| Introduction | 11 |
| What is Social Prescribing? | 14 |
| Different models of Social Prescribing | 16 |
| The effectiveness of Social Prescribing | 25 |
| Costs | 31 |
| Some challenges to consider when implementing Social Prescribing | 34 |
| What is to be done? | 36 |
| Conclusion | 38 |
| References | 39 |

Appendix 1 Abbreviations

Appendix 2 Maps of Social Prescribing Provision in Bristol

**Executive Summary**

It is very clear from this literature review and the interviews/focus groups undertaken for this report that there is no single, agreed understanding of what constitutes social prescribing (SP) in the city or what interventions/approaches can be called SP. Despite this local projects consulted for this report frequently define and promote themselves as social prescribers.

For this report I have run three focus groups with: GPs, Practitioners/ Service Users and officials from Bristol City Council and Public Health. I have spoken to 14 different SP projects and interviewed 7 more GPs and several Bristol City Council officials.

Current interest in SP has arisen because of three distinct issues:

- The increasing burden of mental health and other long-term conditions and the cost implications this poses for service provision;
- The crisis in general practice as recognised by Clare Gerada the Chair of the College of General Practitioners;
- The Modernising Mental Health agenda in Bristol.

This report will outline three different models of SP to help to describe the types of SP practice provided across the city: *Social Prescribing Light, Social Prescribing Medium* and *Social Prescribing Holistic*. It will briefly outline local examples of each.

There are 57 GP surgeries in BristoI, of which 12% (n=7) practice some form of SP. There maybe more. However there are very few opportunities of sharing best practice and experience of SP in the city to ensure its development as an option for supporting patients in primary care.

For a project to be defined as *Social Prescribing Holistic* it must have:

- a clear GP/Primary Care referral process;
- a local remit and have developed local knowledge of supportive organizations and events;
- be a jointly developed intervention which has been sustained over time;
- a method to address beneficiary needs in a *holistic* way;
- no limits to the amount of time a health facilitator/worker/officer spends with a referred beneficiary;
- address beneficiary well-being but anticipate that mental health needs may also be discovered.

SP *Holistic* projects are adopting a holistic and preventive approach and aim to work with beneficiaries with long-term conditions. They encourage beneficiaries to play a central role in managing their own care.

All of the local SP *Holistic* projects identified here have emerged from organic partnerships that have independently developed between GPs in practice and their local third sector partners to address

perceived well-being needs that they both identify. They have evolved over time and sometimes from SP projects that could be previously described as *light* and *medium* SP models.

Links between primary health care services and third sector organizations are often underdeveloped and require considerable time and patience to develop and evolve (South, 2008:310), thus the projects that have evolved locally represent a considerable pioneering achievement and are a testament to the level of partnership work that has been developed.

SP projects present a lot of qualitative evidence to demonstrate the transformative effect their SP intervention has on beneficiary' lives. Their impact should not be underestimated. In adopting a holistic approach the complexity of the challenges addressed and the achievements they attain can be effectively demonstrated.

The GPs interviewed here believe that their SP *Holistic* projects are making a real impact on the patients they refer.

I have found only one Randomised Control Trial to assess the cost effectiveness of SP. But it only looked at an intervention I would describe as a SP *medium* project. Its conclusion was that SP beneficiaries of the project were seen to be less depressed and less anxious, but their care was more costly compared with routine care and their contact with primary care was not reduced (Grant et al, 2000:419).

Data monitoring methodologies are under developed across the third sector. This includes many projects that deliver SP in the city. Limited resources, cultural pressures and some resistances to monitoring have stymied their progress.

Two of the SP *holistic* projects highlighted here have understood the importance of the on-going need for data collection for monitoring and evaluation purposes and have invested in methodologies to *prove their value.*

Data from one SP holistic project suggests that three months after a beneficiary's induction on the project beneficiaries show statistically significant improvement in: PHQ9 ($p=0.001$), GAD7($p=0.001$) , Friendship Scale ($p=0.001$), ONS Wellbeing measures (item range $p=0.05$ through to $p= 0.001$) and IPAQ items for *moderate exercise*.

Analysis of GP contact times also suggest that for 6 in 10 SP Holistic beneficiaries there is a reduction in their GP attendance rates in the 12 months post intervention compared to the 12 months period prior to the referral. For 26% of beneficiaries it stayed the same and for 14% it actually increased. Prescription data and impact on referrals to secondary care are still awaited.

It is hard to make cost comparisons across SP projects. Particularly inter-SP models. Even intra-model comparisons are fraught with difficulty. The organic development of all SP *Holistic* projects make them very unique. Each has a different focus and they have evolved in time to meet varying local need.

Amongst the *holistic* SP projects there are differences in the number and type of staff recruited. One model relies on a full time Health Worker with supporting volunteers. Another works with a male and a female Health Worker to deliver gender assigned one-to-one support. These cost variances

also apply to fixed costs; some projects receive benefit in kind support in terms of having accommodation and telephone access. One GP practice supports their SP project by covering these costs which are a great benefit to the project. Other projects rely on external funding to cover their costs and sustain their work.

By simply looking at the staffing costs/ beneficiary supported there is a range of cost effective ratios from: £223.74 to £833 for each beneficiary supported across SP holistic projects. A potential core cost of around £500/beneficiary for mature holistic projects would not be unreasonable to consider for future commissioning of holistic approaches.

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

In a recent review of the economic costs involved in mental health prevention the importance of intervening to prevent worse outcomes cannot be underestimated (Platt et. al.2006). Simply looking at non-fatal suicide events it is estimated that costs are averted to £66,797 per year per person of working age where suicide is delayed. Figures vary depending on the means of the suicide attempt. 14% of costs are associated with A&E attendance and medical or surgical care; but…. more than 70% of costs are incurred through follow-up with psychiatric inpatient and outpatient care (Knapp et al, 2011:26).

Commissioners should be aware of the additional economic value provided through SP projects which include: harnessing volunteers, beneficiaries returning to employment and training and child care responsibilities and community capacity enhanced.

This report highlights the challenges involved in developing SP projects including: non take up of GP referral, the importance of the GP/SP provider relationships, the initial increase in GP workload, the third sector's capacity to develop data monitoring.

This report also makes some suggestions around future commissioning and advises sustaining the legacy of those that currently deliver and can demonstrate a *holistic* approach to ensure the resources hitherto invested in very effective SP *holistic* interventions do not disappear.

It also recommends offering new GP/Third sector partnerships an opportunity and an incentive to start their own journey to support GP referred patients that local GP practices have no immediate medical solution and/or sufficient time available to address their often multi-faceted problems. In a situation of tight fiscal control giving new GP/third sector partnerships an opportunity to deliver SP *holistic* interventions, particularly in areas of deprivation, would be an effective way of broadening the development of SP services across the city.

**Aims of this report**

This piece of work was commissioned by the Bristol Clinical Commissioning Group. It has been led by an Associate Director in Public Health. It was initiated to run in parallel with the decision to re-commission mental health services in Bristol. Originally social prescribing (SP) was seen as part of the procurement process for mental health services for the city. However, advice was sought on how best to commission SP in the future. To this end this report seeks to offer guidance by providing:

- A summary of inter/national evidence on SP
- An outline of alternative SP models
- An assessment of their impact and effectiveness
- A review of the different models of SP used in Bristol
- An assessment of the cost/effectiveness of different models
- An assessment of whether SP for mental health and wellbeing is the same, or different to SP for preventative measures like falls prevention or physical health.

**Primary Research Undertaken**

In addition to undertaking a literary review of current evidence I have visited and interviewed service users, practitioners and some commissioners involved well-being interventions. Those included here are self-defined as SP projects. In doing this I have always guaranteed anonymity for participants and assured participants that their identity would remain unknown in order to facilitate open reflection and comment on the scale and impact of SP in the city. This was important. Many providers of well-being services sometimes find themselves in competition with each other to win funding to deliver and sustain their services. It was important to ensure that they felt that this research was not an evaluation of assessment of their service per se but more an examination of the best approach to develop for people in the future. Organizations across the city (particularly in the third sector), who run tight budgets are acutely aware that there will be diminishing resources in the future and have developed a heightened sense of a need to showcase their work. In guaranteeing anonymity it means participants in this consultation have been able to provide open reflection on local SP.

This work has taken more time and resources than unanticipated at the start of the consultation. This is partly because it was commissioned in August when many people were away on vacation and therefore unavailable for consultation. Secondly, to get a GP perspective on SP it proved necessary to fit around GP's tight timescales which meant interviewing outside lengthy working days. And, thirdly, because additional organizations that were not identified in the initial remit began to contact me to ensure that their views were included in this process. Given the development and changes in Bristol's mental health services anticipated by service providers I felt I had to broaden and include these organizations who felt they had something to contribute and insisted that they should be consulted.

To this end the following organizations and individuals were approached:

Focus Groups

• Social prescribing practitioners and service users (8 participants)
• Bristol City Council/Public Health employees (6 participants)
• GPs (4 participants)

Interviews

Practitioners/projects:

- Knowle West Healthy Living Centre
- Positive Minds
- Health and social care pilot focussed on people with autism
- New Directions Project
- Care Forum
- Second Step
- Wellspring Healthy Living Centre
- Orchard Medical Centre
- Windmill Hill City Farm
- Art on Prescription
- Mind
- Lightbox project
- Walking Groups based at Whitchurch surgery
- Bristol Homeopathy
- Falls Prevention project
- A Community Self Build Project
- LinkAge
- Willow Tree Surgery
- Social Mirror Project
- Three GPs in three other practices

Bristol City Council/Public Health

- Wendy Sharman

Bristol Clinical Commissioning Group

- Glen Townsend
- Jo Kapp
- Grace Elias

Projects contacted but not connected with:

- Exercise on prescription
- Exercise for older people

**Acknowledgments**

This report is informed by some of the interviews and work I have undertaken with practitioners and beneficiaries working with different projects over the last five years including: The Wellspring Healthy Living Centre, the Knowle West Healthy Living Centre, the Care Forum and LinkAge. It is also informed by the regional evaluation I undertook with colleagues to evaluate the Big Lottery funded South West Well-Being project which included three Bristol based SP projects (Jones and Kimberlee et al, 2009). I am extremely grateful to all the organizations listed above who spent time with me discussing the role and influence of social prescribing in primary care in Bristol.

## Introduction

SP is increasingly talked about in primary care across the city. Different wellbeing services and projects are describing themselves as SP. This increasing interest in SP seems to come from three distinct pressures. Namely, the perceived growth in the burden of mental illness and the economic costs this entails. The growing strain exacted on primary care services and GP services in particular. And, locally, the modernising mental health agenda which is seeking to review the delivery of mental health services for the city.

### *Increasing burden of mental health*

One in four people in the UK are known to suffer a mental health problem in the course of a year. It is also acknowledged that within primary care around 30% of all consultations and 50% of consecutive attendances concern some form of psychiatric problem, predominantly depression or anxiety (Kessler et al, 2001; Scottish Executive, 2005). The cost of mental health problems to the economy in England have been estimated at £105 billion, and treatment costs are expected to double in the next 20 years. In 2011/12, NHS Bristol spent just over £50 million on mental health services for the city – the largest spend by the former Primary Care Trust on non-acute hospital services (NHS Bristol, 2012:4). This is a personal cost that we all share. It is estimated that the economic costs of mental health are €2000 per annum for each European household (ESN, 2011:8). Mental health is high on the government's agenda. The *No Health without Mental Health*, document published by the Department of Health (2011) urged the development of a cross government approach to address the issue with a focus on outcomes for people with a mental illness as a way of developing and promoting solutions to reduce the burden. Although the picture varies across Europe, the emphasis in mental health services has moved towards the development of a more person-centred approach, based on principles of SP (ESN, 2011:8)

### *Crisis in General Practice*

There is mounting evidence to suggest that primary care services are under increasing strain. GP surgeries are facing an increase in numbers of presentees. In reality GPs are not necessarily equipped to handle all the social and psychological burdens that patients present with. The traditional GP model of service delivery is changing. It has come a long way from a model where patients were examined in their living room. GPs now usually practice in stand – alone surgeries and healthy living centres which offer an ever broadening range of services. Which services they develop and offer can vary across GP practices. But these changes and pressures coupled with complex reforms have led Clare Gerada the Chair of the College of General Practitioners (CGP) to conclude that *general practice is in crisis*!

(Gerada, 2013, Accessed 8th October 2013). Survey work commissioned by the College and undertaken by the Kings Fund reveals that:

- 85% of GPs believe their service is in crisis;
- nearly 50% think they can no longer guarantee safe patient care;
- most GPs are conducting 40-60 patient consultations each day and working 11 hour days in the consulting room
- and, most GPs predict that patients will have to wait longer for an appointment.

(Gerada, 2013, Accessed 8th October 2013)

With an aging population this burden is going to increase and it is anticipated that consultation rates will increase by 5% over the next 20 years. GPs also perceive that their patients are demanding better services and expect more. In particular younger patients are seen as less likely to grin and bear their ailments compared to older generations (Everington, 2013). Unlike other health services primary care has no waiting list or referral criteria—they are forced to deal with the here and now *in all its ramifications on a daily basis* (Hardy, 2013:347).

With pressures on GPs growing some GPs are advocating and developing new approaches to their service delivery. This fresh approach includes SP. Dr Sam Everington Chairman of Tower Hamlets CCG has argued that GPs need assistance to manage their workload (Beavers, 2013:5) and believes that GPs should be offered more incentives to develop partnerships to make their services work more effectively. The Chair of the CGP recently argued that GPs need all providers of health and social care, within a geographically aligned area to come together and pool resources (Gerada, 2013, Accessed 8th October 2013). According to a retired GP from Bethnal Green Health Centre writing in the BMJ it requires commissioners and GPs to undertake a:

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

Part of this push to encourage primary care services to develop collaborative working is the realization that the burden of managing long-term conditions calls for a holistic approach.

There are 15 million people in the UK living with a long-term condition. Typically this can include people who are repeat attendees in surgeries for which SP is increasingly seen as a potential solution. Recent Kings Fund Caring Research has led to a call for GPs to be more proactive and preventive in their approach.

> *Improving care for people with long-term conditions must involve a shift away from a reactive, disease-focused, fragmented model of care towards one that is more proactive, holistic and preventive, in which people with long-term conditions are encouraged to play a central role in managing their own care*, (Coulter, 2013:2)

*Modernising mental health services in Bristol*

With the responsibility for the commissioning of healthcare services transferred to the Bristol Clinical Commissioning Group (CCG) on 1 April 2013, issues raised by the city's modernising mental health agenda in the city posed fresh challenges and uncertainties. A decision to re-commission mental health services followed serious concern expressed by GPs and service users about existing mental health services over a number of years. Part of the process has subsequently seen the development of an overarching model of care. The model seeks to relocate services closer to individuals and the communities where they live. The suggested model is proposing multiple access points in accessible and non-stigmatising settings. This model was widely supported amongst the stakeholder groups that were consulted (2012b:15).

As part of the modernisation of mental health services a Recovery Pathway has been outlined (as opposed to a chaotic or crisis pathway) which will see the needs of individuals with on-going mental health needs supported. The plan aspires to meet the needs of these individuals via a recovery plan informed with input from the service user, their carer, the GP and supporting mental health specialists, social care and 3rd sector agencies. Social prescribing is seen as part of this pathway (Bristol NHS, 2013:13). And identified as an intervention that can be an:

> *early intervention with an emphasis on promotion, prevention, early intervention, recovery/resilience and grassroots community provision* (NHS Bristol, 2012:6)

.

**What is Social Prescribing?**

It is very clear from the literature review and the interviews/focus groups which I undertook that there is no single, agreed understanding of what constitutes SP. Or what interventions/approaches can be called SP. In a lot of the literature including local policy documentation around the modernising mental health agenda SP is often used interchangeably with social intervention. In fact around the city the term SP is applied to a variety of different interventions aimed at promoting well-being and/or health.

Over the last couple of years Bristol practitioners involved with delivering SP projects have spent considerable time reflecting on their practice and developing a definition of their work:

> *Social prescribing provides a pathway to refer clients to non-clinical services, linking clients to support from within the community to promote their wellbeing, to encourage social inclusion, to promote self-care where appropriate and to build resilience within the community and for the individual* (Social Prescribing in Bristol Working Group, 2012).

At a general level SP has emerged as a mechanism for linking people using primary care with support in the community (Brown et al., 2004, Scottish Development Centre for Mental Health, 2007:12). It is sometimes called community referral. SP projects usually have a referral system in place and the SP element is often, but not exclusively delivered by the third sector. SP involves the creation of referral pathways that allow primary health care patients with non-clinical needs to be directed to local third sector groups. Such schemes typically use community development workers or health workers with local knowledge or with skills to *navigate* locally. And they are formally linked to primary health care settings. SP assist individual beneficiaries who present with social or psychological needs to access health resources and social support outside of the National Health Service. But they may also assist with patients who may present with a somatoform disorder i.e. where a patient has a mental disorder characterized by symptoms that suggest physical illness or injury – symptoms that cannot be explained fully by the individual. Or, where the GP believes that a non-medical approach could achieve better outcomes. These patients usually have not had a formal mental health diagnosis before. In fact they may not be suffering from a mental health disorder. But they are patients who present for which there are no obvious medical solutions.

Social prescribing can therefore strengthen the links between health care providers and community, voluntary and local authority services. In these services there are potential solutions to *the wider determinants of mental health, for example, leisure, welfare,*

*education, culture, employment and the environment* (Scottish Development Centre for Mental Health, 2003:5). But these links between primary health care services and the voluntary and community sector organizations are often underdeveloped and require considerable time and patience to develop and evolve (South, 2008:310).

In many SP projects the focus can often be on vulnerable and at risk groups and people with enduring and long term mental health problems (Frasure –Smith 2000, Greene 2000, Harris 1999). But what characterises the SP more than anything else is that they are services that are seen as offering a *holistic* approach (Brandling and House, 2007) to a beneficiary. And in many ways SP is also a route to reducing social exclusion, both for disadvantaged, isolated and vulnerable populations in general, and for people with enduring mental health problems (Evans, et al., 2011).

But they are very much a local solution galvanising local resources to help their beneficiaries:

> *Social prescribing creates a formal means of enabling primary care services to refer patients with social, emotional or practical needs to a variety of holistic, local non-Clinical services* (Brandling and House, 2007).

SP therefore aims to provide a referred patient with a holistic package of support tailored to their individual need. Practitioners in Bristol often highlight that beneficiaries would primarily be around clusters 1–6 (See Mental Health Cluster booklet 2011-12), although all SP projects work with clients beyond these clusters. In most cases patients referred will not necessarily present with a mental health diagnosis. So their location on the cluster framework frequently comes after the referral has been made and the beneficiary has engaged with the individual SP project. They also acknowledge that SP may also be an effective part of a recovery and crisis support plan (Social Prescribing in Bristol: Working Group, 2012).

SP packages can often be delivered through or alongside other opportunities e.g.: arts and creativity, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help etc. This could involve the SP worker offering an array of support around issues as diverse as: quitting smoking, addiction, relationship problems through to practical things like advice around housing, debt, legal advice, benefits or parenting problems. The Health Worker may also have additional skills around complementary therapies e.g. Reiki in the case of one SP project in Bristol.

**Different models of social prescribing**

It is clear from my discussions with providers, practitioners and local authority employees that there is no clear agreement as to what they mean by SP. Focus group discussions tended to reach a reasoned understanding of what constitutes SP after considerable deliberation. But even then people did not necessarily agree on all aspects of SP or whether their experience of SP matched any broadly agreed criteria. To capture the range of approaches to SP across the city this report outlines different models below. This is an attempt to capture and present the range of SP offerings available across the city. Most of the offerings do not conform to the definition of SP suggested by Brandling and House (2007). This model of SP I will call: *Social Prescribing holistic*. Projects in this category share certain clear features:

- There is a direct primary care **referral**, usually from a GP practice, to an external SP provider. This is often formalised in terms of a letter, form, an on-line application or even a telephone call.
- The SP provider has a clear **local** remit and draws on local knowledge of local services to connect beneficiaries to important sources of support and aid.
- The SP intervention has been developed and sustained jointly over time and in its present form represents a product of joint **partnership** work between the primary care provider and the SP provider.
- The SP provider addresses the beneficiary's needs in a **holistic** way. A patient may be referred to a SP project to improve diet, but in doing so the SP project will look at all needs and may offer support in terms of e.g. budgeting, nutrition, loneliness etc.
- There are **no limits** to the number of times a beneficiary is seen on a SP project. Time parameters may be set but the number of sessions offered can be more or less depending on the needs discovered in the holistic approach.
- SP projects seek to improve beneficiary' **well-being**. They may not necessarily initially be concerned with addressing mental health issues (although some are). Most beneficiaries who attend SP projects have undiagnosed mental health issues. Although in adopting a holistic approach the SP project may delineate the mental health needs of the beneficiary and these will be addressed or sometimes a beneficiary will be referred on to mental health services.

Below I outline the different models of social prescribing that are practised in Bristol and the surrounding area. There are 57 GP surgeries in Bristol (Shepherd, 2010) of which 12% (n=7) are known to practice some form of SP. There are probably more but there may be some not yet known to the author. All the projects would describe themselves as social prescribing. However they do not necessarily contain all the elements I outlined above in

Social Prescribing *Holistic* model. They contain some elements and may even be in a transition to another model.

*Social Prescribing as Signposting*

In this model the SP project is doing little more than signposting beneficiaries onto appropriate networks and groups who may assist an individual beneficiary to address their well-being needs. All SP models have an element of signposting in their delivery. GPs can directly refer to the project and leave the patient to their own devices to access and follow through on the local well-being offerings available. Or the SP project may seek to address beneficiary needs independent of the GP and will simply share the space of the practice but not necessarily have any regular or formal link with GPs. The activities that they may be referred too could include: a gym, a cooking project, peer support or a variety of counselling opportunities etc. The practice may not have a strong direct relationship with the SP project and their maybe little follow-up and/or feedback. The projects will have only minimal evaluation of outcomes.

Local examples:

The Social Mirror Project, Knowle West

This is actually a tablet (IT) application that has been developed to help beneficiaries *measure, visualise, and see the potential for change* by allowing them to access online and offline networks of well-being support. Using funding from the Nominet Trust, the RSA Action and Research Centre are delivering the project in different UK settings and are currently applying for NIHR Innovation funding to support the continued development of their tablet based app' which they have piloted in two GP practices in Knowle West. In essence it is a brokerage approach with the SP project highlighting gateways for beneficiaries to access.

Well Aware, The Care Forum

This is a useful, on-line, free at the point of access, guide to thousands of health, wellbeing and community initiatives in Bristol, South Gloucestershire, Bath & North East Somerset, North Somerset and Somerset. It is enthusiastically run by the Care Forum, a health and social care voluntary organisation who provide a mixture of frontline services and support to individuals, groups and organisations. It also provides a Mental Health Employment Portal for beneficiaries to access.

*Bristol Mind*

Bristol Mind have also got plans to develop their own support/planning/brokerage function for Personal Health Budgets for Mental Health.

To be effective SP very much depends on staff having good knowledge of what services are available in their local community. Mapping local, community groups and services into electronic health directories to facilitate signposting and referral helps SP projects to develop their knowledge base of what is available (Coulter 2013:16). However to be effective SP projects tend to also employ local, trained, community health trainers to assist in the development and implementation of a signposting project. As well as providing a variety of support services alongside the database they also take up the opportunity to improve beneficiary lifestyle by linking advice and practical support around: smoking, stress, diet, alcohol, physical activity and obesity. This approach has been developed by HealthWORKS in Newcastle. A recent evaluation of this project revealed that: 70% of all referrals did engage with a link worker of which 91% set goals. Of those that were set goals 41% achieved their goals, but 59% did not. Monitoring data shows 69% of patients, based on completed records, experienced an increase in SWEMWB score and that 64% have achieved an increase in confidence in managing their long-term condition (ERS, 2013:54).

*Social Prescribing Light*

This is perhaps the most common form of SP. These are community and/or primary-care based projects which refer at risk or vulnerable patients to a specific programme to address a specific need or to encourage a patient to reach a specific objective e.g. exercise on prescription, prescription for learning and Arts on prescription (see Aldridge and Lavender, 2000; Friedli and Watson, 2004; Tyldesley and Rigby, 2003; and Millin, 2003).

*Whitchurch Surgery*

Is a 'Wellbeing (Social) Prescription' project, not a walking group run under the auspices of the RSVP. It is an extension to their surgery based groups in Bristol, South Gloucestershire, North Somerset and Bath & North East Somerset that hosts volunteers to support a variety of activities around a surgery. The initiative is new and only recently developed in response to a local need to address social isolation through walking. It should not be confused with Walk for Health a Bristol wide initiative that

invites local groups to establish their own walking groups. There is no evaluation of the work they do but it has an enthusiastic pioneer.

*LinkAge*

LinkAge has existed in Bristol since 2007. LinkAge works with people aged 55+ in their local communities across the city of Bristol. Initially, the programme aimed to promote and enhance the lives of older people through a range of activities. This includes fostering social awareness and encouraging older people to share their skills with both young people within the community and their families. In a sense it aims to inspire older people and people within the local community to share time and experiences with older people who for one reason or another have become isolated. Based around five hubs across the city it employs a community development worker to develop local well-being activities at community venues. However it does not have any direct links with GP services although one of its hubs has been shown to significantly reduce isolation, promote well-being and increase physical activity rates (Kimberlee et al, 2012).

*Social Prescribing Medium*

The best example of this approach can be found at the College Surgery Partnership in Cullompton, Devon. It was developed by senior partner Michael Dixon who had been a GP in Cullompton for 26 years. He has been chair of NHS Alliance, representing primary care, PCTs and practice based commissioners since 1998. Other national roles also include chairing the National Life Check Board and being a member of the National Stakeholder Forum. He is a Senior Associate of the King's Fund and Honorary Senior Fellow in Public Policy at Birmingham University. Like other SP initiatives their SP project includes the employment of a Health Facilitator. This role developed out of an exercise on prescription scheme developed by the local surgeries and the local Council ten years before.

The health facilitator sees referred patients. Using Life Check and other tools the facilitator provides advice on exercise, nutrition, diet etc. She promotes self-care using an on line Thought Field Therapy programme (rather like CBT) and also signpost to voluntary organisations or self-help groups e.g. for specific disease areas - e.g. patients with heart disease, diabetes and fibromyalgia or specific needs - e.g. a Knit and Natter group for people who are socially isolated, an amblers group for the overweight and unfit, creative writing, printing and book reading groups for patients needing directed activity/socialisation.

Although the project has a clear local remit in that it works within a distinct geographically defined neighbourhood and it is the product of joint partnership work. It does not obviously seek to address the beneficiary' needs in a holistic way instead it aims to address certain needs or behaviours identified by the GP.

*Social Prescribing Holistic model*

This model is sometimes known as the Bromley-By-Bow Model. In essence it is a flexible model and represents the development of a project that had previously delivered at a lower level of SP. Thus these SP projects tend to evolve flexibly over time. They have also evolved organically in partnerships between GP surgeries and largely third sector organizations. They are innovative and are seen by local practitioners to be a catalyst for enabling health providers to think much more creatively and holistically about addressing people's wide-ranging mental health and social care needs within a non-stigmatising and empowering approach (CSIP 2009:9). They have frequently emerged to meet an acknowledged local need e.g. somatoform patients, vulnerable families, high attendees, people with certain mental health issues. They have also emerged because the GP practice accepts that an alternative solution should be considered to address a perceived health need or issue that they themselves cannot immediately address in the normal appointment time. In acknowledging the issue they also accept that the SP project offers a potential solution to the issue.

These projects are frequently built over a long time. They are not a quick fix or a bolt-on. They are a reasoned intervention developed in partnership. The Bromley-By-Bow SP approach evolved out of the development of a local Healthy Living Centre built in 1999. The approach sought to break down barriers that had traditionally separated services in a bid to meet the diverse needs of their patients. Primary Care services are run as a GP partnership and their other services operate as a charity with their own distinct but connected governance arrangements. GPs have a referral letter on their desk top and they tick what a client needs are e.g. anything from dietary advice through to welfare advice, housing advice etc. (Beavers, 2013:5). GP Dr Everington from the local CCG argues that:

> *From a GPs perspective it broadens the armoury of what they can prescribe, gives an alternative to a drug prescription and also reduces GP's workload.*
> (Beavers, 2013:5).

Locally there has been an attempt to develop criteria and/or a description of a SP service. Referrals are taken from NHS (where 'medical' services aren't working or are not the best treatment type). In essence it sees SP as having the role of identifying the issues that have

triggered a health or wellbeing issue such as depression. This by necessity means that practical, emotional and social support is often offered to beneficiaries. They can access help around debt, legal, family, benefits, housing, etc. This includes ensuring beneficiaries are engaged/represented at statutory meetings such as: Common Assessment Framework meeting or a family court. The SP worker may even act as an advocate with services or departments (e.g. housing). Support on the project is offered through one-to-one support and group work. There is no additional prescribing of drugs or clinical services. And the *holistic* projects usually have an array of activities available for beneficiaries to receive. Referrals can be made and beneficiaries can often enjoy tasters and peer support to get involved with activities: like therapeutic activities (arts, gardening, etc), volunteer or befriending opportunities. All the way through projects demonstrate to their beneficiaries the progress made and distance travelled (Social Prescribing in Bristol: Working Group, 2012).

Below there are brief outlines of local projects that match the SP *holistic* model.

Project: Developing Health & Independence (DHI) Wellbeing Project at The Orchard Medical Centre.
Location: Kingswood, South Gloucestershire
Sessions: Unlimited
Funding: Local Authority

This project has been running for four years. It has funding to sustain its existence until April 2014. 90% of referrals are drawn from medical centre clinicians. The majority of patients are seen in the surgery but some will receive a home visit or telephonic support. Complexity of patient needs means the number of 1 to 1 sessions offered to beneficiaries extend both in number and time. The worker takes a holistic approach to addressing beneficiary needs. The full time Health Worker is supported by a part time audit worker. The project also facilitates various group sessions: Into Action, Art Group, Yoga 4 Health etc.. And it is embedded in developing multi-agency approaches as well as signposting to other activities and projects. Two additional volunteers support existing patients who are historical high users of statutory services and who struggle to make or maintain change (DHI, 2013).

Project: *Positive Minds: Hartcliffe Health and Environment Action Group*
Location: Hartcliffe
Staff: One health worker and volunteer support
Sessions per beneficiary: 1-12
Funding: Local Authority

Positive Minds, started in 2009 arising from Healthy Lifestyles Network project to help establish independence from primary and secondary mental health services for those experiencing isolation, depression, anxiety; and also those moving out of secondary care. Positive Minds provides one-to-one support to help reduce the impact of mental and emotional stress. Their beneficiaries include referrals from a local GP practice. They have their own signposting database of local resources. Beneficiary' needs are addressed holistically. They work with beneficiaries to develop personal action plans to bring about positive change. This includes signposting to local groups, organizations and community activities to help support the development of *positive mental health*. The project puts on occasional activities with the local NHS staff like the Living Well Day event that encouraged local residents to consider positive simple ways of promoting well-being. This is based around the new economics foundation's Five Ways to Well-Being which involved taster sessions around Tai Chi, massage and relaxation.

Project: *New Routes*
Location: *Keynsham*
Staff: One full time co-ordinator and two part time co-ordinators.
Funded by: B&NES Council and the DH Health and Social Care Volunteering Fund.
Delivered: The Care Forum
Sessions per beneficiary: Usually up to three assessments but can be between 1-12 sessions.

The idea behind New Routes came from a local GP who was looking to provide a holistic alternative for GPs to use with those patients who were taking up time and who may have complex non-medical needs. Eligible patients on the programme include people with: low to moderate mental health issues, those who are housebound and/or lack of mobility, those with physical health conditions which inadvertently cause a decline in mental health and well-being, the unemployed or low income, those recently made redundant, long-term sick or retired and carers or ex-carers, those with learning and physical disabilities and other vulnerable adults. Three GP practices refer on to the programme. Beneficiaries are often met in the surgeries, in their home or at other locations.

Project: *Pathways to Health*
Location: Knowle West Health Park

Through focused individual support, family support and group-based activities, Knowle West's *Pathways to Health* project adopts a holistic approach to improving health and well-being. It works with people with poor physical health or weight management issues, people with low level mental ill health, and people with diet-related health risks. The project delivers its services from the local Healthy living Centre. Knowle West Health Park

Community Interest Company developed from the Knowle West Healthy Living Centre, which opened in 2001. It is established was a three way partnership between the local community, the PCT and Bristol.

Knowle West Health Park has undertaken a comprehensive piece of work to develop an in-house monitoring and evaluation system. This made use of before and after questionnaire health related measures. Overall the data show a marked contrast between quantitative measures and the self-reported qualitative data (Jones et al, 2011). Using a paired T test for a sample of 73 respondents, there were no clear statistically significant changes in mental health (sleeplessness, feeling depressed); physical activity (activity level, breathlessness); and healthy eating (fruit and vegetable portions). Nevertheless other data suggest positive results in terms of self-reported outcomes. For the *Pathways to Health* participants were asked to state their personal goals at the outset of activities. Table 1 shows the importance of physical activity and mental well-being related goals for many participants. At follow up, 82.9% (30 of 41 reporting) had completed the project activities and 73% of these individuals stated that they had achieved their main goals.

Table 1: Participants personal 'ultimate goals' for the Pathways to Health project activity. Sample n=67 Jan-Sept2009. Participants could identify multiple goals

| **Ultimate Goal** | **%** |
|---|---|
| Lose weight | 39 |
| Get fit / Increase exercise | 20 |
| Look after self / Get well / Time for self | 20 |
| Increase mobility | 12 |
| Beat depression | 3 |
| Reduce cannabis smoking | 3 |
| Relaxation / Reduce anxiety | 6 |
| Stop smoking | 10 |

(Source: Jones et al, 2011:146)

Project: Branching Out
Location: Wellspring Healthy Living Centre
Staff: Two full time one male and one female Health Worker.
Funded by: Various including the Tudor Trust

This project is based in Barton Hill at the Wellspring Healthy Living Centre which was founded by local residents in 2004. It evolved from several initiatives aimed at addressing beneficiary well-being developed through the centre. It serves one of the most deprived communities in England. It also has a very ethnically diverse client base: 17% of beneficiaries were from an ethnic group other than white and 9% had a first language other than English. 91% (n=115) said their first language was English. The Branching Out programme evolved

out of earlier well-being projects that sought to address the needs of adults who suffer from anxiety and depression. Most beneficiaries are referred onto the project by one of five GP practices in the Easton area. A few beneficiaries self-refer. The project works with both men and women. Two health workers offer one-to-one sessions for up to three months. Individuals will be seen on a regular basis and offered support in an array of different areas including: advocacy, emotional support, anger management etc.

All of these *holistic* projects are characterised by direct referral routes from GPs. These referral routes will have been developed over time. The mode of referral can vary. One project has a flagging system on the GPs' computers across three surgeries while another has a specific form with suggested activities to be considered. Letters of introduction have also been used. Actual utilisation of the prescription by the beneficiary is in all cases voluntary. Which underlines a central tenet of SP: beneficiary engagement with the process is important and SP exists to encourage beneficiaries to seek solutions and develop self-management techniques.

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

**The effectiveness of social prescribing**

All SP projects are enthusiastic advocates of their work. They are also confident that they have a positive impact on beneficiaries' lives. All SP projects can recant various good news stories about the impact they make on clients lives. My own interviews with SP beneficiaries reveals that the impact of SP can be enormous with clients reporting that they have been saved from trauma and even suicide and that they have turned a corner.

Beyond qualitative evidence there has been very little systematic research into the impact they make. It is also very difficult to make comparisons between SP projects. Particularly those projects following a holistic model. They are all very different. There is some evidence that certain SP based around a particular issue or behaviour change can have an impact on people's lives. For example referrals to supported exercise programmes which can include: gym-based activity; guided/health walks; green activity; cycling; swimming and aquatherapy; team sports; and exercise and dance classes have been seen to have a positive impact on beneficiary behaviour. There is robust evidence (Fox 2000) to support the mental health benefits of physical activity for clinical and non-clinical populations; but what is less clear is what works to increase the uptake of exercise (NICE 2006).

However, a true mark of the success of SP is the effect it has on local GP practices. Many local GPs still remain indifferent or even hostile to SP. A recalled story from one GP suggests that it may generate more work and greater dependency on a range of support.

> *A GP told me that he had a patient started coming in and asking for a prescription to get their electric meter read!* (A SP Practitioner)

However my research suggests that where the full SP model is introduced and it has been sustained over time then GPs are only too happy to advocate its impact on their practice and their workload.

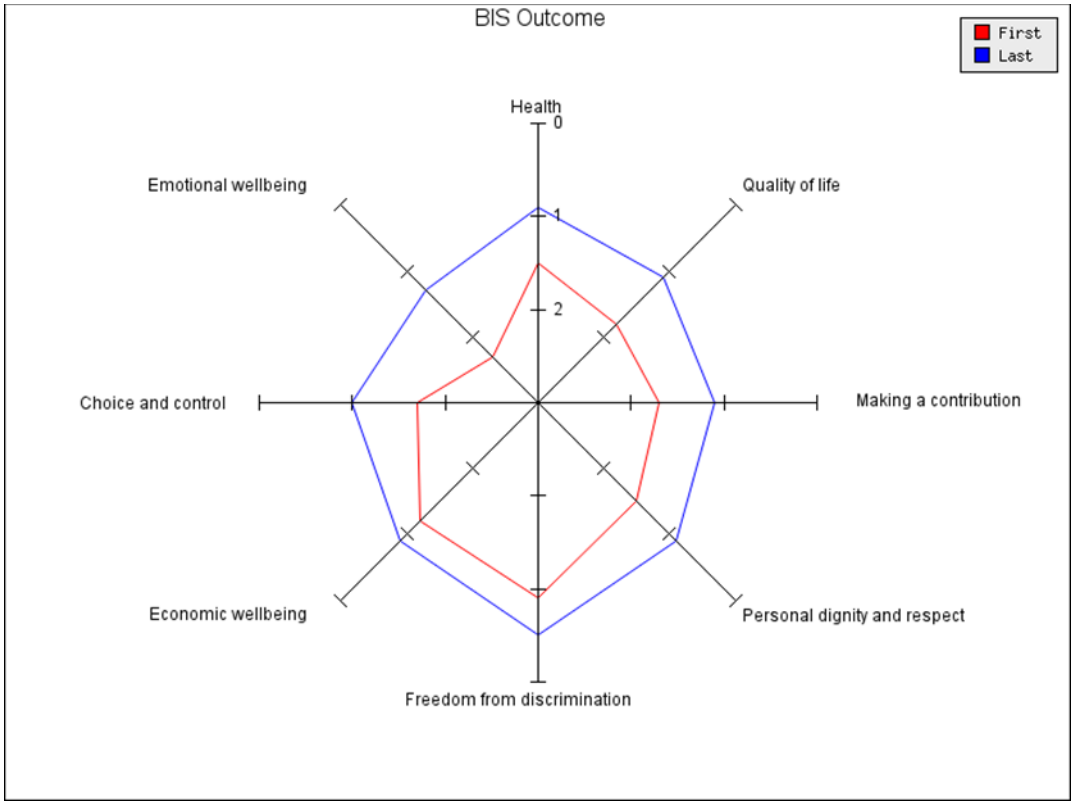
> I: *What difference has social prescribing made to the surgery?*
>
> GP: *We work in a tricky environment in health, often pressured and we see need in people's lives everywhere we turn. We often feel helpless, and even hopeless. We often medicalise people's distress as that way we can understand and deal with it more easily. Having *****around has really opened our eyes to see what can be done with a true holistic approach, having people with the time and expertise to get under the skin and find out what makes people tick, what their stresses really are in life and what resources already exist to help. It is truly*

*satisfying to see some patients make steps with the support of ******* that we wouldn't have imagined. The impact on their health, mental health and health seeking behaviour can be significant.* (Practice Manager in a SP Holistic surgery)

Evidence of SP effectiveness is varied. Local SP advocates suggest that the range of impact is as wide as the range of services with which to engage, and complex interventions such as SP are remain notoriously resistant to elucidation through research aimed at hard outcomes (Brandling et al, 2009:455). A randomised controlled trial of the SP Amalthea Project examined general practice patients with psychosocial problems who were given access to voluntary organisations. At one and four months after randomisation, those assigned to the intervention group had significant improvements in anxiety, improved ability to carry out everyday activities and improved feelings about general health and quality of life (Grant et al., 2000). Several research projects and evaluations show that SP can improving mental health outcomes for patients, improving community well-being and reduce social exclusion (Friedli and Watson, 2004).

The range and availability of local evidence of the impact made by holistic SP is still rather limited. One of the local SP Holistic projects collects quite minimal impact data using *the Inventory for Brokerage Service Outcomes Star* (IBSO). This is a self-report tool used at first and last appointments. The data suggests that all beneficiaries report improvement on: Health, Quality of Life, Making a contribution, Personal Dignity and Respect, Freedom from Discrimination, Economic Wellbeing, Choice and Control and Emotional Well-being. With the greatest improvement recorded on the latter.

Figure 1; Completed IBSO of all clients on a holistic SP project January-June 2013




Source: DHI (2013:6)

Data collected from another SP project as part of an independent study conducted by the University of Bath, showed a positive trend towards improved mental and general well-being amongst beneficiaries. A typical beneficiary took up two new well-being activities. One fifth of service users who began the SP project began volunteering in their community. They also found some reduction in referrals to secondary care and to a lesser extent a reduction in letters to secondary care. On this up to a third of all service users were fully engaged in the SP process. Others dropped out because of a variety of reasons e.g. felt they didn't require the service or it was inappropriate for them, they moved away or simply disengaged.

A third project in this model collected very minimal outcome data. This was justified on several grounds. Like many third sector projects they felt they had minimal resources to do the necessary research and associated admin' work to undertake an effective evaluation. Like other projects a lot of the outcomes that are achieved are with beneficiaries who were struggling to get their get basic needs met. This project was concerned to get them to address basic literacy and numeracy needs and dealing with often acute difficulties like debt, antisocial behaviour etc. Many of the clients that were seen were far from being job ready so these practitioners believe that it is important that their project's expected outcomes should be related to the starting points of beneficiaries rather than everybody

being pushing towards outcomes like employment. Many SP projects work with beneficiaries who are seen as hard to reach. They also have a multiplicity of needs. They are based in communities that are challenged by multiple deprivation, higher unemployment rates and lower levels of educational achievement. To these projects SP was less about achieving specified outcomes (e.g. achieving employment or returning to work) but it was more about preventing beneficiaries from falling down even further thus preventing them from becoming a bigger drain on other resources:

> *You have to remember that the people who live in this community face a multitude of problems and issues that effectively force people into stagnation. They withdraw and become a risk to their family and friends if they have any. If they don't have any then they could become a suicidal risk or prone to violence and addiction. We stop this decline. We do this by concentrating on very simple things first….. like… for example ….. getting out of the house and feeling safe.*
>
> (A SP practitioner)

Two of the local SP holistic projects have made a clear strategic decision to consistently collect beneficiary information in the form of using standardised registration forms and a well-being tool to measure their impact across time. A local a social enterprise has helped them to develop a client database to enable them to effectively monitor their delivery and evidence base their work. Some of the data below illustrate the impact that one of these successful SP projects has.

SP projects invite beneficiaries to complete a simple questionnaire at baseline and three months later. Their data suggests that their SP project has a profound impact on mental health. PHQ9 scores for depression significantly reduced three months after initial contact with the project. Comparing baseline and follow-up scores; at the start of the project 1 in 2 beneficiaries were scoring 20-27 (Severe Depression) on the PHQ-9 scale but only 1 in 20 were scoring this at follow up. A third of beneficiaries scored 0-4 (No depression) at follow up[1]. A similar impact was made on beneficiary' reported anxiety levels. At baseline almost 60% of beneficiaries had scored 15+ (Severe Anxiety) on the GAD-7 scale for anxiety at baseline. At follow up only 1 in 10 still reported this level of anxiety[2]. For the Scottish

[1] A paired samples t-test was conducted to evaluate the impact of the intervention on beneficiary scores on the PHQ-9 scale. There was a statistically significant decrease in PHQ-9 depression scores from baseline (M=18.38, SD=6.42) to three months after (M=8.43, SD=6.33), t (69) = 11.39, p= < 0.001. The mean decrease in PHQ-9 depression scores was 9.95 with a 95% confidence interval ranging from 8.208 to 11.692. The eta squared statistic (0.65) indicates a large effect.

[2] A paired samples t-test was conducted to evaluate the impact of the intervention on beneficiary scores on the GAD-7 scale. There was a statistically significant decrease in GAD-7 Anxiety scores from baseline (M=15.39, SD=4.67) to three months after (M=7.21, SD=5.34), t (69) = 12.83, p= < 0.001. The mean decrease in GAD-7 Anxiety scores was 8.81 with a 95% confidence interval ranging from 6.901 to 9.442. The eta squared statistic (0.70) indicates a large effect.

government the marker of success for SP is where they can evidence base the impact they make to improve mental health and wellbeing (Scottish Development Centre for Mental Health, 2007:7).

Similar significant improvements were found in terms of reduced social isolation. Using the Friendship Scale at baseline 67.8% of beneficiaries were scoring *very isolated* on the Friendship scale. At follow-up this had halved to 35.4%.[3] In terms of their general well-being beneficiaries on the SP programme report an improved sense of well-being compared to when they started their SP. The table below looks at the Office for National Statistics (ONS) Well-being Indicators. On all four measures there is significant improvement in the beneficiaries' sense of well-being. However even after participation on a SP project their sense of well-being is still lower than the Bristol and regional averages.

Table 2: Office for National Statistics (ONS) Well-being Indicator scores before and after involvement with SP.

| **ONS Wellbeing Indicator** | **Baseline (n=87)** | **Follow-up (n=48)** | **UK Adult average (ONS, 2012)** | **South West Region (ONS, 2012)** | **Bristol Region (ONS, 2012)** |
|---|---|---|---|---|---|
| **Overall, how satisfied are you with your life nowadays?** | 2.63 | 5.58 | 7.4 | 7.52 | 7.3 |
| **Overall, how happy did you feel yesterday?** | 3.26 | 6.06 | 7.3 | 7.28 | 7.18 |
| **Overall, how anxious did you feel yesterday?** | 6.0 | 3.56 | 2.9 | 2.99 | 3.21 |
| **Overall, to what extent do you feel the things you do in your life are worthwhile?** | 3.8 | 6.02 | 7.6 | 7.77 | 7.47 |

[3] A paired samples t-test was conducted to evaluate the impact of the intervention on beneficiary scores on the Friendship Scale. There was a statistically significant increase in connectedness in the Friendship Scale scores from baseline (M=8.63, SD=6.01) to three months after (M=13.17, SD=4.28), t (69) = 5.62, p= < 0.001. The mean increase in the Friendship Scale scores was

Beneficiaries on the project also report an increase in their physical activity with significant improvements in the number of people taking *moderate* exercise. On this SP project a third of beneficiaries were meeting the NHS target of 5x30 minutes of *moderate* exercise a day each week. When at baseline no beneficiary met this standard. This is against a backdrop in Bristol where the *Quality of Life* survey suggests that people in Bristol are actually undertaking less exercise than before.

> *Of concern is a rise in the proportion of people who are overweight and obese, and a fall in exercise levels, participation in active sport and creative activities* (Bristol City Council, 2011:4).

Importantly the SP project is also able to report on GP attendance and prescription data at one referring GP practice. Although the analysis of the prescription data is still on-going, preliminary results reveal a clear drop in GP attendance for most SP beneficiaries. The data below suggests that 6 in 10 beneficiaries had less GP attendance in the 12 months after joining the programme than in the 12 months before. Half the beneficiaries made less telephone contact with their GP.

Table 3: GP attendance data before and after involvement with SP.

| Number of consultations After 12 months | Face to Face (n=37) | Telephone (n=40) |
|---|---|---|
| Fewer | 60% | 50% |
| The Same | 26% | 24% |
| More | 14% | 26% |

The table above confirms the views of the GP referrers I have interviewed for this research who believed in their practice SP is having an impact.

> *Without doubt I am seeing certain clients less than before. It is having an impact with them which provides me with hope that social prescribing has made a real difference to our practice.*
>
> (A referring GP)

Forthcoming research results can be anticipated from a MSc. project started in January 2013 which is exploring the impact of SP has on patients who are high users of A&E and those with long-term conditions.

**Costs**

There has been very little research to explore the cost effectiveness of SP. The Amalthea Project which was based around 26 GP surgeries in Avon using the referral services of a Health facilitator is the most recent investigation. This was very much a SP *medium* project. It worked with 90 beneficiaries who were referred to a voluntary organisation to manage their access onto a SP project. It is one of only a few projects to have been comprehensively evaluated, using a randomised controlled trial and economic evaluation. As reported above referral to the Amalthea Project and subsequent contact with the voluntary sector resulted in clinically important benefits compared with usual general practitioner care in managing psychosocial problems; but at a higher cost. Beneficiaries of the project were seen to be less depressed and less anxious but their care was more costly compared with routine care and their contact with primary care was not reduced (Grant et al, 2000:419):

> *Psychological interventions in primary care can, but do not necessarily, result in savings in mental health prescribing.*

However this study did not look at the long term savings made beyond a year and did not compare the costs to what would have happened if the patients had been referred to a specialist and secondary care (Thornett, 2000).

Are RCTs an appropriate way to measure the cost effectiveness of SP projects? Current policy guidance and recommendations suggests that it is important to assess the potential saving of future costs (Freidli, 2007:9). SP fits in with the long-term strategic reorientation towards promoting health, independence and wellbeing, and in essence practitioners believe that by investing in SP now it will reduce future costs of ill health. Thus there are several critics who argue that short-term economic evaluations are limited in concluding that it costs more than usual general practitioner care.

> *Experience of the Hackney Well Family Service, a family support project we have developed jointly with the Family Welfare Association, suggests this is short-sighted. It fails to take into account of the long-term benefits to the community,*

*and the consequent reduced burden on all support services, when the cycle of deprivation can be broken* (Goodhart, 1999; 525).

This need for a long term view on costs has been realised in one of the SP Holistic projects discussed in this consultation. Their analysis of their own experience suggests some general trends towards reduced resource utilisation over 12 months or more, although these results were inconclusive, they came with the caveat that SP should be evaluated on a long-term basis as outcomes are often slow when working with isolated and often poorly motivated clients (The Care Forum, 2012). This is because SP beneficiaries frequently require a considerable amount of time to enable the SP worker to address their multi-faceted needs. But, if these needs are not addressed and a person reaches a crisis point, it then becomes much more difficult and costly to restore their health, employment and social status, with a subsequent exacerbation of economic and health inequalities (Freidli, et al 2007:45).

We should also remember the extra value that these projects can potentially bring which are not immediately quantifiable in a simple cost benefit analysis. Adopting a Social Return On Investment (SROI) approach as recommended by the Cabinet Office for assessing third sector value (Cabinet Office, 2009), it is possible to quantify the broader value that these projects achieve. SROI approaches compare the monetary benefits of a program or intervention with the program costs (Phillips, 1991). SROI represents a development from traditional cost–benefit analysis in the late 1990's and sought to fully valorise all social impacts of any intervention (Emerson, 2000).

One of the key impacts that SP practitioners claim is that for many beneficiaries they (the practitioners) are often the only support they have in the community. Without the SP project patients run the risk of causing society more costs because of the inevitable decline in mental health if left they are left untreated. In particular, these patients run the risk of an increase in the chances of a Major Outcome Occurring e.g. suicide. Many beneficiaries who come onto SP holistic projects report suicidal tendencies.

*I was at my wit's end. I was like……. Things were so bad I could have topped myself. I just had nowhere to go. I had such a row with my partner, it was bad I just smashed things up.* (A SP Beneficiary)

*Somebody I have met has brought me back to life. The woman downstairs* (the doctor in the GP surgery) *didn't give me any help at all.* (A SP Beneficiary)

Platt et al (2006) have argued that the average cost of a completed suicide for those of working age only in England is £1.67m (2009 prices). This includes intangible costs (loss of

life to the individual and the pain and suffering of relatives), as well as lost output (e.g. employment), (both waged and unwaged), police time and funerals. There are also costs to the public purse from recurrent non-fatal suicide events. Overall it is estimated that costs are averted to £66,797 per year per person of working age where suicide is delayed. Figures will vary depending on the means of suicide attempt. One recent English study indicates that only 14% of costs are associated with A&E attendance and medical or surgical care; more than 70% of costs are incurred through follow up with psychiatric inpatient and outpatient care (Knapp et al, 2011:26).

All SP projects bring to the broader community and the health services greater value. For the LinkAge project we calculated that for every £1 invested in the Whitehall and St. George Hub there was a SROI of £1.20. But we guessed that this was *probably an underestimation of the potential return in the medium term*, because the LinkAge hub was in the first year of operation and these projects tend to face severe challenges in their initial set-up year and then gather momentum after a few years. By far the biggest added value that SP projects can bring is the large amount of unpaid volunteer time provided by individuals to help support SP activities. We parsimoniously calculated for one LinkAge hub they had worked an additional 2,430 hours across the year. Another *holistic* SP project reports that one fifth of their beneficiaries have begun volunteering as a direct result of their involvement in a local SP project (The Care Forum, 2012).

It is hard to make cost comparisons across SP projects. Particularly across the different SP models as presented here. Even intra-model comparisons are fraught with difficulty. All SP projects are unique. Each has a different focus they have evolved in time to meet local need. Thus amongst the *holistic* SP projects there are differences in staff recruited. One model relies on a full time Health Worker with supporting volunteers. Another works with a male and a female Health Worker to deliver gender assigned one-to-one support. These variances can also apply to fixed costs; some projects receive benefit in kind in terms of having accommodation and access to a telephone. One GP practice supports their SP project by covering these costs which are a great benefit to the project. Other projects rely on external funding to cover these costs and sustain their work.

However I have looked at some of the reported costs involved in running the four projects adopting the SP holistic approach in the local area. I concentrate on reported staff costs. This of course ignores other costs like room hire, postage, telephone costs, mobile phone usage, travel costs for those who may advocate for a beneficiary or who needs to be visited in their home. The staff costs/beneficiary vary considerably.

Table 4: Cost illustrations of local SP projects

| Project | Annual Staffing Budget | Beneficiaries | Cost/Beneficiary |
|---|---|---|---|
| Project A | £50,000 | 154 | £324.67 |
| Project B | £27,967 | 125 | £223.74 |
| Project C | £50,000 | 60 | £833.33 |
| Project D | £57,686 | 129 | £447.17 |
| Total | £185,653 | 468 | £457.23 |

**Some challenges to consider when implementing Social Prescribing**

Involvement in SP is voluntary. Not all prescriptions are taken up by beneficiaries. One of the SP *Holistic* projects report varying take-up rates of between 63% and 88% for different quarterly referral periods. What happens to those who fail to follow through with their prescription is unclear and is unreported on by GPs.

In a review of several SP projects in the county of Durham what appears to be a proven key to success is the relationship between the primary care providers and the community services delivering the social prescribing activities. These need to be strong and nurtured and develop over time (White and Salamon, 2010). SP is not a bolt on or a quick fix as some local interviewees have suggested in the course of consultation around this report.

One of the main practical challenges in implementing SP include: agreeing referral routes and appropriate criteria. In all holistic projects these tend to evolve over time and they often need considerable negotiation between the GP practice and the SP provider to ensure that both are aware of the patients who can benefit from the service available.

Effective SP has been shown to depend on the quality of partnership, joint working and co-operation between primary care staff and the SP provider as well as statutory providers like local authorities can be key to ensuring SP success. Cultural differences between medical and community development models can emerge as a strong potential source of tension. These need to be ameliorated through partnership working if SP is to be a success (Scottish Development Centre For Mental Health, 2007:6).

There is some evidence that GPs are concerned about their liability when referring a patient to a SP project. Although there is no discreet academic work that has been undertaken to explore the legal responsibilities of GPs and third sector organizations, some GPs have suggested using the term *referral* rather than prescription to denote the end of their responsibility in terms of the management of an individual's patient care (Scottish Development Centre For Mental Health, 2007:14).

A key issue is the third sector's capacity to manage SP. It is clear from my interviews with projects across the city that many projects are operating on stringent budgets. Most have overcome short term funding crises in order to sustain their activity. And many indirectly rely on the added value frequently provided by their committed health worker in giving more of their own time to deliver the SP project (Kimberlee et al, 2012). But there are also capacity issues around maintaining up-to-date information on sources of voluntary and community support. In the city the SP signposting projects are continually being updated and at the *holistic* end of the SP spectrum it relies on a continued commitment from Health Workers to ensure they are aware of what is happening locally. In some cases they initiate new activities to meet unmet need where none locally exists e.g. a Men's group. But where SP projects have struggled is in their capacity to evidence base their impact on beneficiaries lives. The recording and evaluating of impact and outcomes has long been a struggle for SP projects (Sykes, 2010).

Hence here has been insufficient research exploring beneficiary journeys beyond 12 months post SP engagement. Clearly with the SP signposting projects there is a fear that all the projects might do is transfer beneficiaries around sectors, thereby shelving underlying problems. (South 2012:312).

Also, new GP adopters of a SP project can anticipate an initial increase in their workload post implementation. This is not only a result of a need to develop and work on partnership building but it is also about developing the relationship with the SP provider to ensure that patients targeted and the referral routes developed are agreed and fit for purpose.

**What is to be done?**

A number of developments have created a potentially favourable policy environment for SP. These include a stronger policy emphasis on public participation and patient involvement which in essence is a central aim of SP. The government's recent concern to promote the third sector to help in the national improvement in well-being by getting the: *many other Associated Heath Professionals who believe they hold some of the keys to building a healthier nation* to tackle and treat long term conditions (Cameron, 2011). Additionally, the movement to holistic definitions of health which recognise the impact of psycho-social and socio-economic factors in determining well-being, epitomised by the ONS recording of well-being data. And the growing demand from GPs themselves that *all providers of health and social care, within a geographically aligned area* should *come together and pool resources.* (Gerada, 2013, Accessed 8th October 2013)

Similarly, the new Public Service (Social Value) Act 2012 has urged commissioners to give as much credence to social value as well as cost. Thus full comprehension should be given to consider improvements in social, economic and environmental well-being in the procurement process. Chris White MP who introduced the original bill argued the aim of the Act was to support community and volunteer organizations and social enterprises to win more public sector contracts by utilising the added value that they bring (White, 2013).

To bring the third sector into delivering services will take time but there are long term rewards to be realised. Traditionally, mental health services have been commissioned under a 'block contract'; with a single overall price for all the services provided by a single organisation. The organisation received the funding regardless of the number of patients seen or actual care given. Incentives for better care have been built into the system with the introduction of Key Performance Indicators and Payment by Results (PbR) in 2003 for certain services. PbR provides a nationally set tariff which the provider organisation will receive for each episode of care deliverd. In April 2013, the CCG Governing Body met to review plans to re-commission mental health services for Bristol. The Governing Body agreed that all community based services would be tendered while inpatient services would initially be redesigned and renegotiated with the existing provider: Avon and Wiltshire Partnership Trust (AWP). This decision was seen to increase *stability in mental health services during the transition and enable improvements to be achieved more rapidly* (Bristol Clinical Commissioning Group, 2013). The CCG has also re-advertised the Community Access Support Service.

Looking at the literature and exploring local practice around holistic SP projects it is clear that their aetiology and philosophy are very different from the way that in patient services for mental health services have been established and practised. They have emerged almost organically from local community routes and they represent a partnership between the third sector and GP practice to address local need. As such they are a partnership which GPs recognise as working for them. The projects have long histories and are networked in to

local provision to meet their beneficiary' needs as identified through their holistic approach. In this sense the projects that exist are already garnering local resources to meet need. Future commissioning of SP should consider helping to sustain these existing SP holistic resources rather than seeking to start from scratch with new initiatives for those areas of the city that already benefit from their resource (See Appendix 2). The three Bristol based projects highlighted are based in some of the more deprived areas of the city: Hartcliffe, Knowle West and Easton.

For new initiatives a space should be made available for local people to decide what sort of SP they would like. In particular what level and model of SP would suit their local needs. SP is not a bolt-on. It is something that can be developed to suit local need and address local issues. It maybe that a SP light approach based around signposting could be a good starting point for a local area or a community e.g. a LinkAge hub. But this isn't a holistic SP approach and it does not necessarily begin to build the partnership between the SP service and primary care services. But is a starting point from which a GP/SP provider partnership may want to start.

To commission SP holistic projects commissioners need to understand the long term impact that these projects can potentially deliver could take some time realise. Secondly, the economic value of SP might be realised elsewhere other than in primary care e.g. reduced referral to secondary care or reduced police resources. It takes time to develop these projects and they need funding to sustain their work in the medium term. But the lessons we can learn from this reflection on SP is that SP projects needs to suit certain criteria:

- A direct **Referral**, from primary care
- A clear **local** remit to harness resources
- The suggested SP project should be a joint **partnership** between the primary care provider and the SP provider.
- The project addresses beneficiary's needs in a **holistic** way.
- There are **no time limits** to the number of times a beneficiary is seen on a SP project.
- Aim to address **well-being** but are likely deal with beneficiaries across and including people in psychotic clusters.

In terms of good practice the SP projects should ensure that the:

- Primary care team are central as referrers and sometimes co-ordinators
- It is important to ensure the beneficiary is referred to a named person and not just a black hole;
- Activities referred too should be located in the local community and be well known to the SP project workers;
- There should be clear information on the project and activities and they are easily available to access;

- There should be a mechanisms available relating to referral pathways, feedback and review processes;
- SP projects should look at putting in place effective ways to track development and outcomes;
- The primary care team should clearly know what to look for in terms of who would benefit from referral. Typically these have been:

  Those with vague or unexplained symptoms or inconclusive diagnoses
  Frequent attenders for GP appointments
  Those with multiple symptoms
  Those with poor social support mechanisms
  Those experiencing psychological difficulties

  (based on South 2012:314)

**Conclusion**

It is clear that over time successful SP projects have developed and evolved as local partnerships to address a perceived need where medical interventions appear to have insufficiently addressed a patient's needs. In essence SP identifies the issues that have triggered a health or well-being issue. This could include an undiagnosed mental health issue like depression or anxiety or other life-changing impacts like unemployment, bereavement, familial breakdown etc. In particular, SP provides a holistic approach and offers an integrated service that can considerably improve beneficiary well-being, including mental health. As some fear, far from being about shifting responsibilities and transferring so-called problem patients, advocates argue that SP should be seen as a method of extending primary care through partnership working (South, 2008:215). Evidence presented here testifies the impact SP has had local people's lives. This includes not only the SP *holistic* approaches but the SP *light* approaches too. There is some dispute about SP projects' cost-effectiveness. In the short and medium term this may be hard to discern, but commissioners and policy makers need to take into account the costs of what would happen if such services weren't available (Knapp et al, 2011) for the most vulnerable patients often living in the most deprived communities.

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**Appendix 1: Abbreviations**

| | |
|---|---|
| CBT | Cognitive behavioral therapy |
| CCG | Clinical Commissioning Group |
| CGP | College of General Practitioners |
| CSIP | Care Services Improvement Partnership |
| ESN | European Social Network |
| GAD | Generalized Anxiety Disorder |
| GP | General Practice/Practitioner |
| IPAQ | International Physical Activity Questionnaires |
| NHS | National Health Service |
| NIHR | National Institute for Health Research |
| ONS | Office for National Statistics |
| PBR | Payment by Results |
| PCT | Primary Care Trust |
| PHQ | Patient Health Questionnaire |
| RSVP | Retired & Senior Volunteer Programme |
| SP | Social Prescribing |
| SROI | Social Return On Investment |
| SWEMWBS | Short Warwick & Edinburgh Mental Well Being Scale |

**Appendix 2: Maps of Social Prescribing Provision in Bristol**

Existing_Holistic_Prescribing_2013_GP_Bri

Existing_Holistic_Prescribing_2013_Bristol_