Evaluation of HALE Community Connectors Social Prescribing Service 2018-19

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Executive Summary

Hale has been delivering the Community Connectors Social Prescribing Service in Bradford since March 2017. This report provides the findings of an independent evaluation of the service for 2018-19 by Sheffield Hallam University. It builds on an earlier evaluation report published in February 2018, reinforcing a series of positive findings about the benefits of a social prescription for people in Bradford. The key messages are as follows.

1. The reach of Community Connectors

The Community Connectors service continued its considerable reach into the community: **between January 2018 and June 2019 1,984 local people were referred for support** by **their GP practice or other health professional.** Importantly, the period since the end of the pilot has seen the reach of the service almost double from an initial 26 GP practices to cover every practice in NHS Bradford City and District Clinical Commissioning Group area. In addition, a further 199 people have been supported through an offshoot of the Community Connector service based at the Bradford Royal Infirmary which received additional funding to help alleviate winter pressures. All together this means that since it was established in 2017 2,886 people have accessed social prescribing from the Community Connectors service.

People tended to be referred to **Community Connectors to address social issues such as anxiety, low mood and social isolation**. A significant proportion of service users were also in poor health, with **more than two-thirds reporting at least one long term health condition and almost a third reporting more than three long term conditions**. The **most common conditions were associated with mental health** – such as anxiety and depression, although physical conditions such as arthritis, pain and diabetes were also reported.

2. The impact of Community Connectors on health, well-being and wider outcomes

The evaluation measured Community Connectors service users' distance travelled against a number of outcome measures in the three months following referral to the service. The results demonstrate a positive direction of travel for many service users:

- **Health:** the overall Health Related Quality of Life of many service users improved following their referral. Improvements were most pronounced for anxiety and depression, including for those service users who reported severe or extreme anxiety and depression.
- **Mental well-being:** the mental well-being of almost three-quarters of service users improved following their referral.
- **Trust:** the overall level of trust service users reported they had in people in their community improved following their referral.
- **Social connectedness:** the social connectedness and social relationships of many service users improved after they were referred to social prescribing. There were increases in the proportion of service users who were content with their friendships and

relationships, saying they have enough people they feel comfortable asking for help at any time, and saying their relationships are as satisfying as they would want them to be.

- **Self-care:** a small proportion of service users reported a reduction in their reliance on their GP and pharmacists for treating 'common' minor ailments and an increase in how often they self-treat with home remedy/over the counter medicine before calling GP.

The positive progress identified in service users' mental health and wellbeing is particularly important when you consider that around half of referrals were made to address anxiety and/or low mood, and around four-fifths of service users reported anxiety or depression as one of their long-term conditions.

In addition to positive outcomes, service users' experience of Community Connectors was almost universally positive. **More than nine out of ten service users were satisfied with the support received**, felt support was tailored to their needs, and would recommend Community Connectors to family and friends.

3. Implications for primary and secondary care

It has not been possible to assess directly the impact of Community Connectors on demand for primary or second care. Although we explored the possibility of using data recorded on primary systems such as System One for this evaluation we were not able to use it in its current form.

However, the **high proportion of service users reporting improvements in their health and mental wellbeing** according to validated measures, and the fact that **more than two-thirds of service users had at least one long term health condition**, means that **some of these benefits will be realised by primary and secondary care services**.

If commissioners, GPs and other healthcare practitioners wish to use healthcare data to better understand the impact of social prescribing on primary and secondary care we recommend the following steps be taken:

1. Focussed work with GPs and other healthcare professionals to **develop a 'theory of change'** about how social prescribing is expected to reduce demand on primary and secondary.
2. Work to refine the data that is collected at a practice level to enable it to be used for the purposes described above. This should include a consistent approach to recording and coding GP appointments.
3. For understanding the impacts on secondary care, **Hospital Episodes Statistics (HES)** – which NHS Digital can provide to CCGs in pseudonymised form - may be **more accurate than GP data**. HALE and the CCG may wish to explore utilising this data for future evaluations.

1. Introduction

Since March 2017 HALE has been working in partnership with Bradford and City District CCGs and GPs across Bradford to deliver the **Community Connectors Social Prescribing Service**.

The service starts with a referral from a GP or other practice staff or healthcare professionals (including the Virtual Ward at Accident and Emergency) via SystemOne or Care Navigation. These referrals tend to be patients who could benefit from additional socially focussed support, including people who are isolated, feeling low or lacking in confidence and those may need support to access other services in their community such as benefits advice, housing, bereavement and mental health services. This is then followed by a home visit or meeting in a mutually agreed setting with a Community Connector who will work alongside the individual to establish what support is required and what they are interested in. The Community Connector would then help identify what services and activities are available locally that fit those interests and support the individual to access them. Support is usually offered for up to six sessions of up to an hour, although in some cases support has been provided over an extended period if it was believed that this would help sustain lasting change.

In its broadest sense the service was commissioned to:

- Improve the health, well-being and social connectedness of local people.
- Reduce unplanned and unnecessary demand on primary and secondary health services.

A full list of the outcomes the service was commissioned to achieve is provided in table 1.

Figure 1: Number of meetings with Community Connectors

Better quality of life	Improved individual health and wellbeing outcomes
	Improvements in mental wellbeing
	Reduced levels of social isolation and loneliness
Improved health behaviours	Improvements in confidence levels, self-esteem and ability to self-care
	Better use of third Sector services
	Improved access to non-medical social activities and support
Reduced healthcare resources	Reduced demand on GP services
	Reduced demand on urgent care and secondary care services
	Improved patient experience

This second short report provides the findings of an independent evaluation by researchers at Sheffield Hallam University with expertise in social prescribing. It picks-up where the

previous left off[1], covering the period between January 2018 and June 2019 and addresses some key evaluative questions about the Community Connectors Social Prescribing Service to support future commissioning by the CCG and its partners.

The evaluation has drawn on two main data sources:

- Community Connector monitoring data (n=1,361), including a service user questionnaire[2] completed at two points in time (n=399)[3]: at the first appointment with a Community Connector and then after approximately three months.
- Data from each GP practice who had made referrals to the Community Connector service.

Four service user case studies collected by Hale have also been included to provide additional contextual information about people's reasons for referral, the types of support provided, and the impact this support has had.

[1] The first evaluation report covered the first 9 months of the service (March-November 2017). It is available here: Dayson, C. and Leather, D. (2018) *Evaluation of HALE Community Connectors Social Prescribing Service 2017*. Sheffield: CRESR, Sheffield Hallam University.

[2] The Questionnaire incorporates a number of validated and commonly used survey measures:

- The Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) to measure mental wellbeing: https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs
- EQ5D to measure five dimensions of health and overall Health Related Quality of Life (HRQL): https://euroqol.org/
- Further measures from the Office for National Statistics Measuring Wellbeing programme, and measures proposed by the New Economics Foundation and The Campaign to End Loneliness.

[3] This is a very good sample for this type of evaluation.

2. Key Findings

Who has benefitted from the service?

Between January 2018 and June 2019 HALE's Community Connectors supported more than 1,984 service users, the majority of whom had been referred by their GP. Figure 1 shows that 42 per cent of service users had between one and two meetings with a Community Connector and 58 per cent had three or more (up to a maximum of six).

Figure 1: Number of meetings with Community Connectors

Base: 1,093

An overview of these service users' demographic characteristics and the presenting issues for which they were referred to social prescribing is provided below.

Case Study A: Tina

Reason for referral

Tina lives with her daughter in rented accommodation and suffered a stroke aged 41 which affected her right side and left her with aphasia. Tina found the loss of speech very distressing and it left her with limited confidence and low mood. She was identified as someone who would benefit from Community Connectors by a colleague who attended a Stroke Support Group with her own client and recognised that Tina had limited resources to build on.

Support provided

With the help of Tina's mum, the Community Connector visited and listened to what Tina and her family needed and wanted. In response, the Community Connector researched information from the Stroke Association website and provide Tina with some information about Stroke Support Groups in her area. She was also provided with information about peer-support groups for people with aphasia and a referral to Speech and Language Therapy was made.

As Tina was struggling with daily tasks the Community Connector supported her to visit the Equality Together equipment showroom and shop where she was able to try out aids for the kitchen and bathroom.

The Community Connector also made a referral to Adult Social Care for a Community Occupational Therapy Assessment and then accompanied Tina to the assessment. Following the assessment Tina had grab rails fitted outside, on the stairs and in the bathroom and a bath board to allow her to shower comfortably and safely. Tina also received sessions with an Occupational Therapist who visited her home and taught her some exercises and provided splints to ease the pain and swelling. The Occupational Therapist was also able to sign a medical form so that Tina could obtain a disabled persons bus pass.

Tina was also supported by the Community Connector to visit a project that uses art as therapy for people recovering after stroke was able to meet other people with aphasia there. They also supported Tina to set-up a text service with a local taxi company so that she could travel around more easily, including to the hairdressers and to have her nails done.

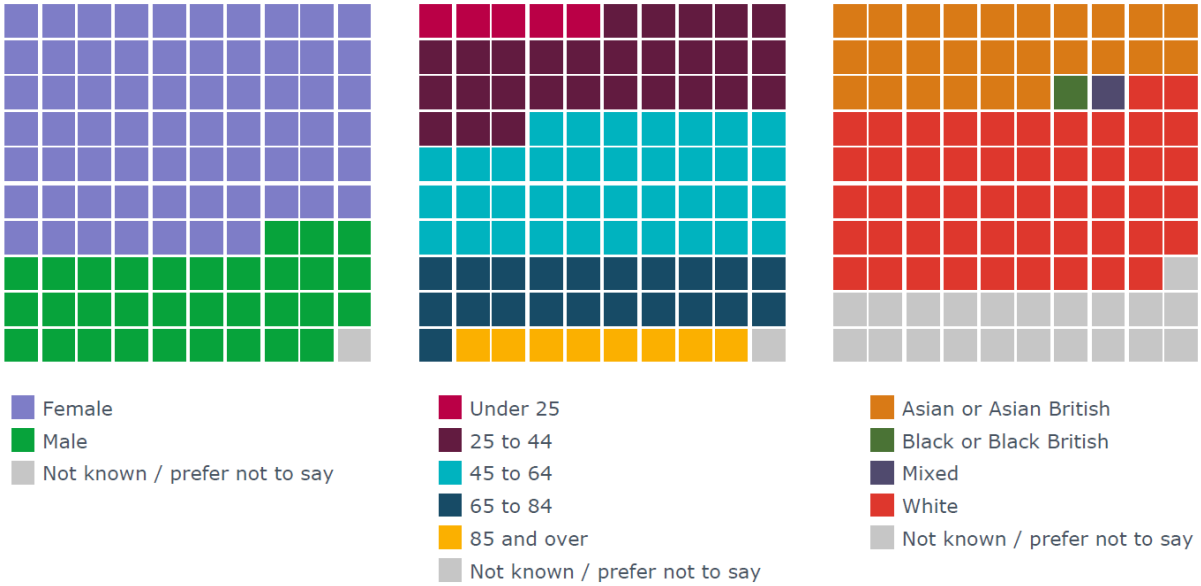
Impact

Following the referral to Community Connectors Tina's ability and confidence to communicate increased significantly and people were able to understand her speech more easily. When communication does become difficult, she is now able to laugh when people mistake what she means and always has pen and paper ready if she needs to get her message across.

Tina has also become much more independent. She makes regular use of the taxi service and bus pass to get out and about, walks her dogs up to four times a day, chats with her neighbours and has even been abroad on a 'girls' holiday.

Demographic characteristics

Figure 2: Demographic characteristics of Community Connectors service users



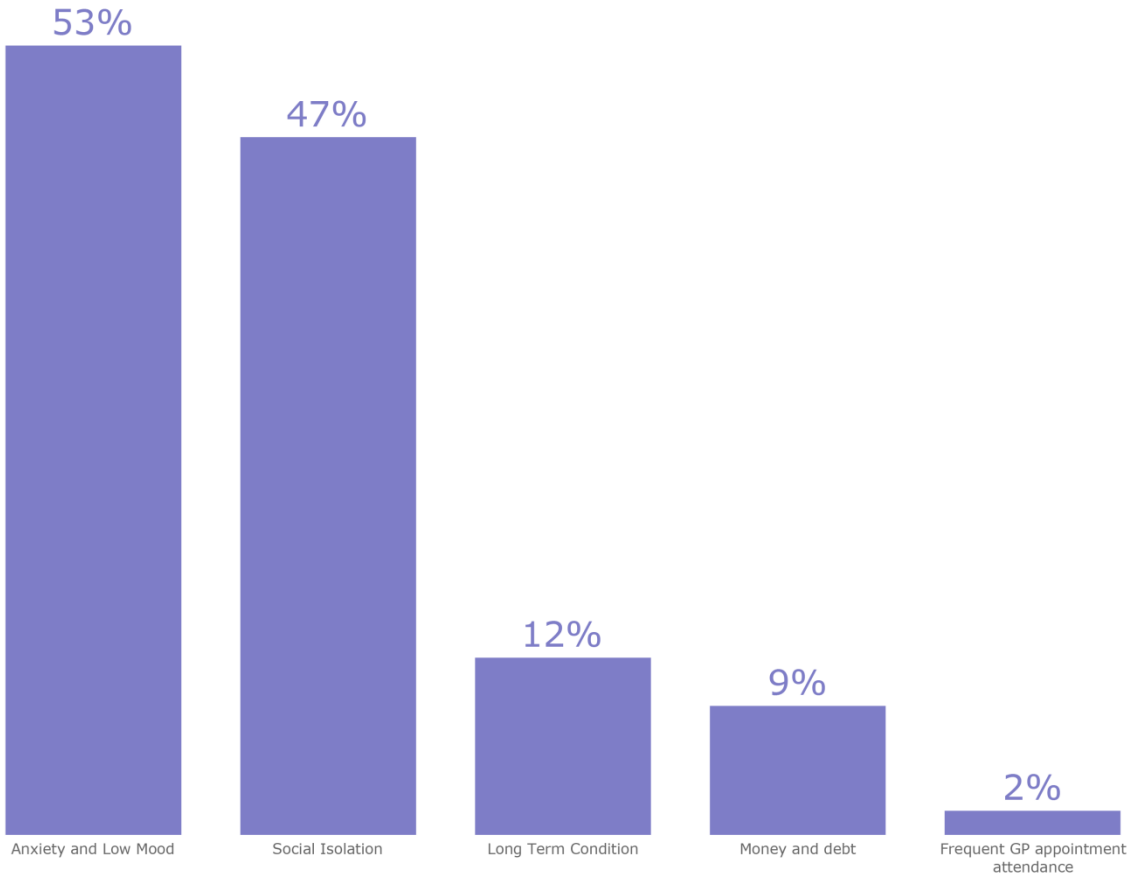
Base: 1,329, 1,329, 1,305

Figure 2 demonstrates that Community Connectors service users were more likely to be female than male, were distributed relatively evenly across the adult age ranges, and we predominantly of either White British or Pakistani ethnic origin.

- **Gender:** 69 per cent were female and only 32 per cent were male.
- **Age:** five per cent were aged under 25, 28 per cent were aged 25-44, 37 per cent were aged 45-65, 21 per cent were aged 65-84, and 8 per cent were age 85 and over.
- **Ethnicity:** 51 per cent were White British, 26 per cent were Asian or Asian-British, 1 per cent were Black or Black British and 1 per cent mixed. The remaining 21 per cent were of another or unknown ethnic origin or preferred not to provide this information.

Presenting issues

Figure 3: Presenting issues of Community Connectors service users



Base: 1,360. Note that percentages sum to more than 100 as multiple responses were possible.

Figure 3 shows that a significant proportion of service users had been referred to Community Connectors for social wellbeing reasons: 53 per cent were referred for anxiety and low mood and 47 per cent were referred due to social isolation. By contrast only 12 per cent were referred due to a long-term health condition, 9 per cent for money and debt and 2 per cent were referred as frequent attendees at their GP practice.

Case Study B: Abdel

Reason for referral

Abdel is a 45-year-old Moroccan asylum seeker who has been living in Bradford with his wife and young children for four years. He was awaiting the outcome of his asylum application following a number of expensive and stressful legal cases and reviews. At the time he was required to report to the Home Office in Leeds every two weeks which required him to take three buses from his home. The family were living on £152 per week and were struggling to sustain a reasonable quality of life.

The uncertainty around Abdel's case, and the feeling of being unable to provide for his family, had led to low mood, poor mental health, anxiety and depression. He also suffered from diabetes, high blood pressure, raised cholesterol and asthma. The uncertainty around the asylum case and Abdel's poor health has also had an impact on his wife and children, with behavioural issues at school and in the home, including bed wetting.

Support provided

The Community Connector agreed to support Abdel and his family to address his immediate mental and physical health needs by identifying groups and activities to give him a sense of focus and build a network of wider support to draw on if and when it was needed. The Community Connector also supported Abdel to attend his Home Office meetings as this was a major source of anxiety and liaised with his solicitor so that he could be kept up to date with the progress of his case.

Abdel was introduced to Bradford Stories Production run by Theatre in the Mill. He was very engaged and found a new level of confidence with other attendees, developed good friendships through sharing their life stories and experiences. He was also supported to attend Heaton Tennis and Squash club for mixed ability sports and took part in yoga and boxing. Abdel was also introduced to St Martins Church where his children could attend a variety of activities and he was able to join the Champions Show the Way walking group. The family were also referred to the Faith Centre who were able to provide a £200 grant for essential items for the home.

Impact

Since his referral to Community Connectors Abdel and his family have been supported to negotiate less frequent attendance at the Home Office which was causing significant anxiety. The Community Connector was also able to support the family's application to the home office and they have since received a one-year extension to their asylum status. This has removed much of Abdel's immediate anxiety and he is now much more positive in his overall outlook and feels more connected to local support services, especially St Martins Church and the Faith Centre.

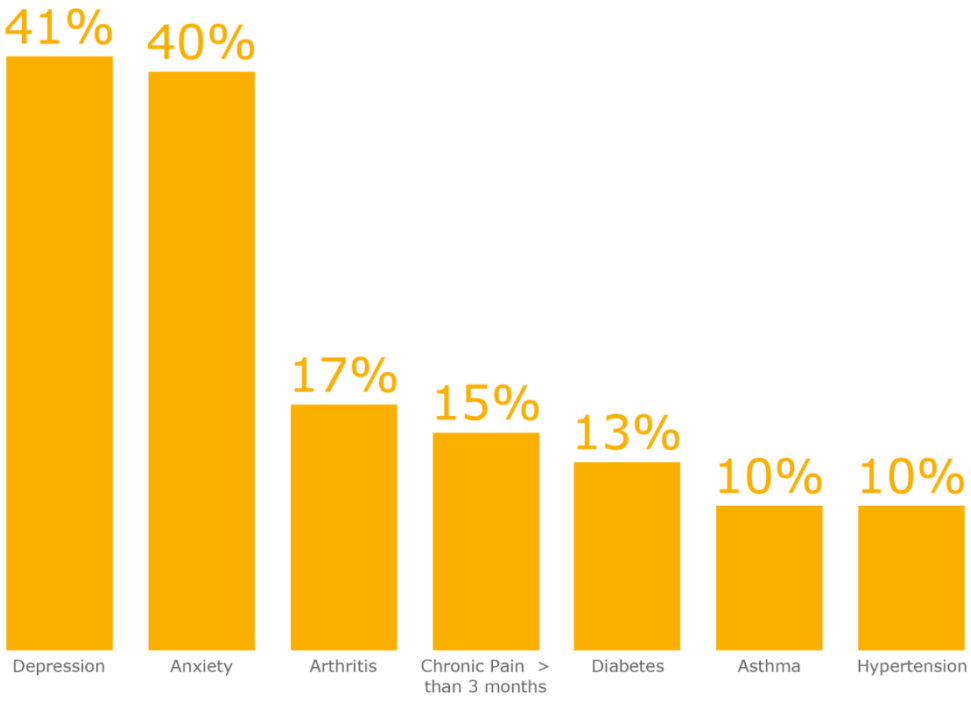
What do we know about the health of service users?

Although most service users had not been referred to Community Connectors because of a health condition a significant proportion were nevertheless in poor health.

Figure 4: Community Connector service users with long term health conditions

Base: 1,329

Figure 5: Most common long-term conditions amongst Community Connector service users



Base: 1,329. Note that percentages sum to more than 100 as multiple conditions could be reported.

Figure 4 demonstrates that 67 per cent of service users reported having a long-term health condition, including 31 per cent who had three or more conditions. Figure 5 shows that the most common health conditions were depression and anxiety followed by arthritis, chronic pain, diabetes, asthma and hypertension.

Case Study C: Jean

Reason for referral

Jean is 54 years old and was referred to Community Connectors by her after she had been made redundant and began drinking heavily. She had also lost one of her parents two years previously and had experienced a recent relationship breakdown. These life events had left Jean with low mood, low confidence and self-worth, and she was experiencing anxiety.

At the time of the referral Jean felt like she was not motivated to look after herself and she was not going out and doing any food shopping. However, she didn't feel bereavement counselling, or any other talking therapy, would be of benefit to her but said that she would like to attend a group which involved crafts as she loved knitting.

Support provided

Jean agreed to work with a Community Connector to re-build her confidence and to motivate her by getting involved in social activities. She also requested support to complete a Personal Independence Payment (PIP) application and help with establishing some routines such as shopping for groceries, which she had not been managing and making appointments such as the hairdressers which was important to Jean.

Jean was referred by the Community Connector to Equality Together for support to complete her PIP application and introduced to a craft group at Kirkgate Community Centre. Jean also began to attempt to reduce her alcohol intake.

Impact

Jean's PIP application was successful, and she has begun doing her grocery shopping and visiting the hairdresser independently. She is now attending the crafts group regularly and goes swimming with the members of the group. As a result, Jean now feels more confident and her self-esteem has improved markedly. She has also reduced her alcohol intake and is eating a more balanced and healthy diet.

Does receiving support improve people's health?

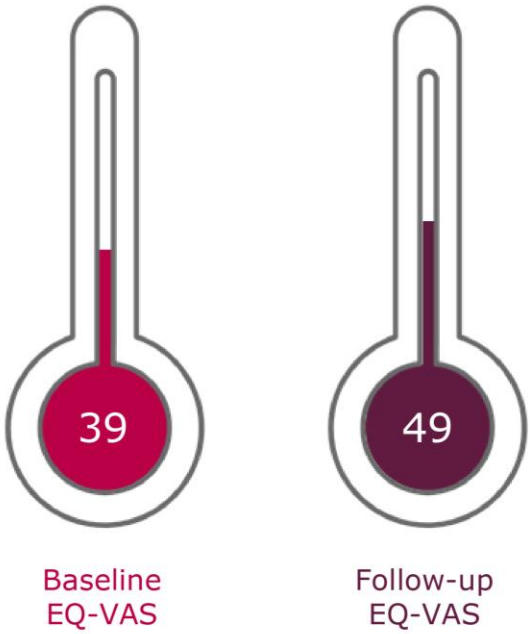
The evaluation has identified improvements in overall health of Community Connectors service users according to EQ-VAS scale and notable improvements on all five EQ-5D measures following support from a community connector.

In terms of overall health (Health Related Quality of Life – HRQL), figure 6 shows that the services users' average score on the EQ-VAS scale (0-100) improved from 39 to 49 following referral to a Community Connector. This improvement is also evident in the mean EQ5D HRQL scores, which increased from 0.43 at baseline to 0.49 at follow-up. This overall improvement in HRQL is further evidence by figure 7, which shows the proportion of services

users whose HRQL was below 0.60 reduced from 65 per cent to 60 per cent between baseline and follow-up[4].

In terms of specific elements of health-related quality of life (HRQL), figure 9 demonstrates that improvements were most pronounced for anxiety and depression (39 per cent of service users improved), followed by usual activities (20 per cent improved) and pain and discomfort (14 per cent improved). By contrast improvements in self-care (8 per cent) and mobility (9 per cent) were less marked. This pattern was more-or-less replicated for those service users who reported severe or extreme problems for each measure (figure 9): the largest reduction was in the number of service users with a severe or extreme score anxiety and depression (14 per cent) followed by usual activities and self-care (both 3 per cent) and severe or extreme pain and discomfort and mobility (both 2 per cent).

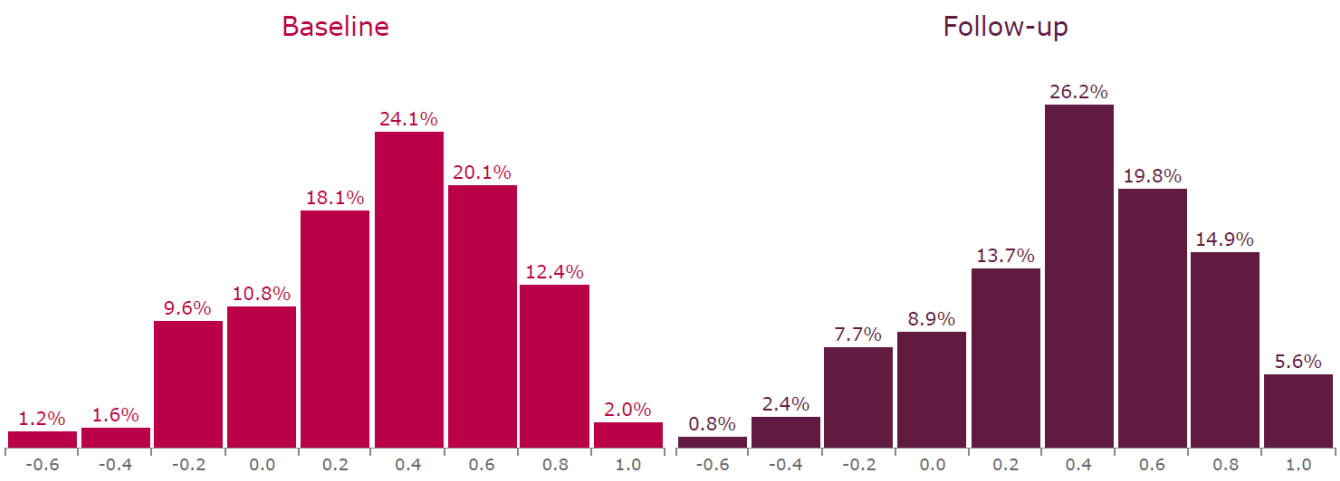
Figure 6: Average (mean) baseline and follow-up scores on the EQ-VAS scale (overall health) amongst Community Connectors service users



Base: 244

[4] The national average (mean) HRQL sore is 0.86

Figure 7: Overview of EQ-5D Health Related Quality of Life scores at baseline at follow-up



Base: 219

Case Study D: Betty

Reason for referral

Betty is 93 years old and was referred to Community Connectors following several falls which had knocked her confidence and meant that she struggled to do the housework and was unable to use public transport anymore. She liked to pay her bills every Monday at the post office but hadn't been in a few weeks and was worried about getting behind on her bills. The falls were often happening at night due to the distance between Betty's bedroom and the bathroom.

Support provided

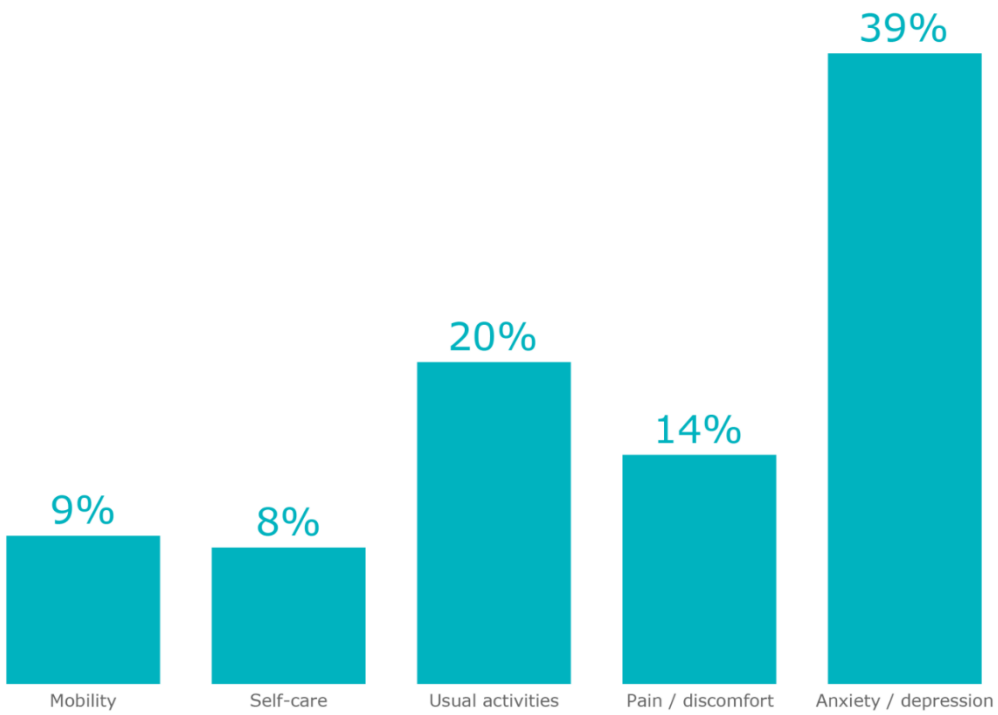
In order to help reduce the risk of falls Betty was provided with a commode from her GP and a Safe and sound pendant was fitted so that she could raise the alarm if a fall did occur. At Betty's request, the Community Connector set up a visit from Diamond Home Support who now supports her once a week for two hours to help with her cleaning and take her to attend appointments and to pay her bills at the post

The Community Connector made a referral for Betty for the access bus service, which she now uses this to go to Morrison's every Monday and Friday morning. She was also supported to attend Café West luncheon club and day centre for which transport was provided and Betty now attends every Tuesday and Thursday.

Impact

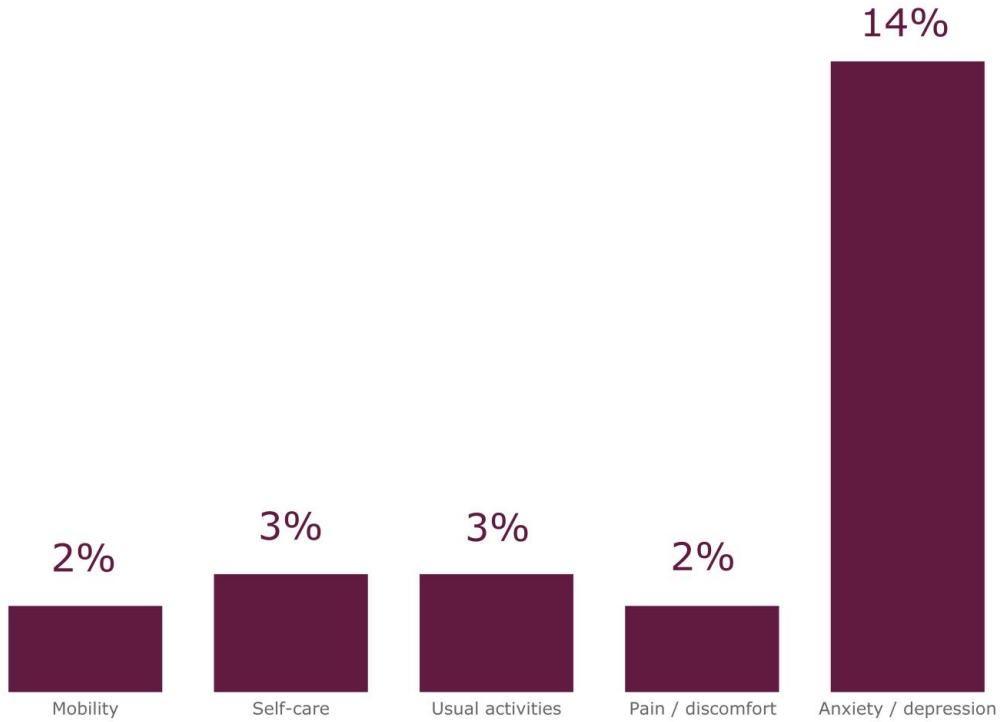
Betty now has all the support in place that she needs to live relatively independently in her home. She hasn't fallen since the commode was provided and is happy that she can go shopping twice and see her friends again. Betty has continued to attend the day centre twice a week and has recently started doing a gentle seated exercise class which runs alongside the luncheon club. Betty reports that she really enjoys going and says the meals are lovely.

Figure 8: Percentage of Community Connectors service users reporting an improvement for each EQ-5D measure (Health Related Quality of Life)



Base: 264

Figure 9: Percentage of Community Connectors service users reporting severe or extreme problems whose score reduced for each EQ-5D measure



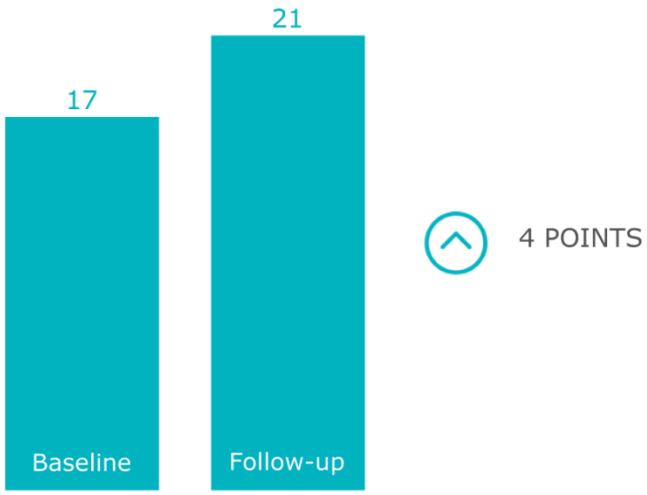
Base: 264

Does receiving support affect a wider range of outcomes?

Mental well-being

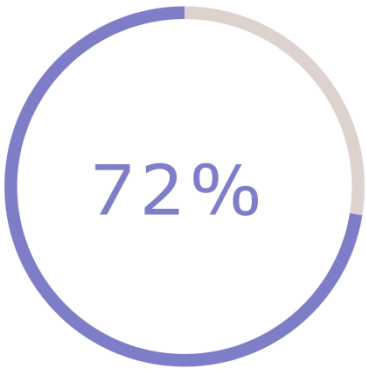
The evaluation has identified overall improvements in service users' mental well-being according to the Short Warwick Edinburgh Mental Well-being Scale (SWEMWBS).

Figure 10: Change in Community Connectors service users' mental well-being (mean SWEMWBS score)



Base: 399

Figure 11: Proportion of Community Connectors service users whose mental well-being improved (SWEMWBS)



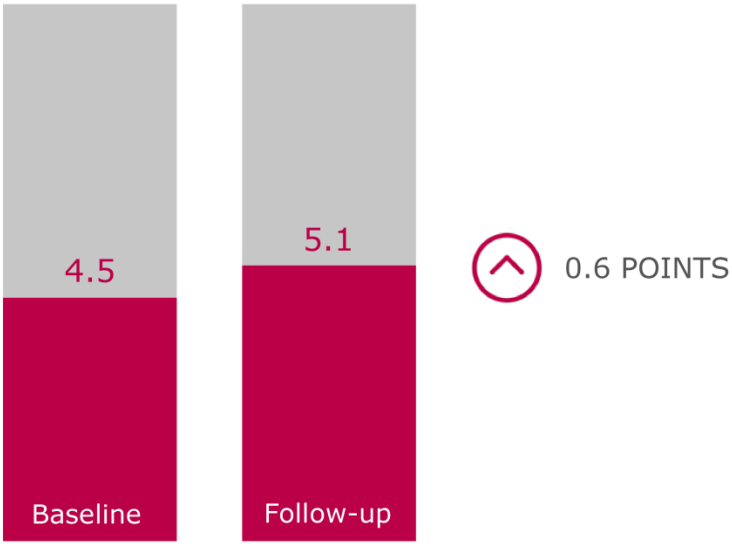
Base: 399

Figure 10 demonstrates that there was a four-point improvement in service users' average SWEMWBS score from 17 to 21, whilst figure 11 shows that nearly three-quarters of service user's scores improved.

Trust

Community Connectors service users' trust in people in their community was measured on a scale of 0-10 (0 = no trust; 10 = complete trust). Figure 12 shows that there was an improvement in their average (mean) score from 4.5 at baseline to 5.1 at follow-up.

Figure 12: Change in Community Connectors service users' trust in people in their community (mean score)

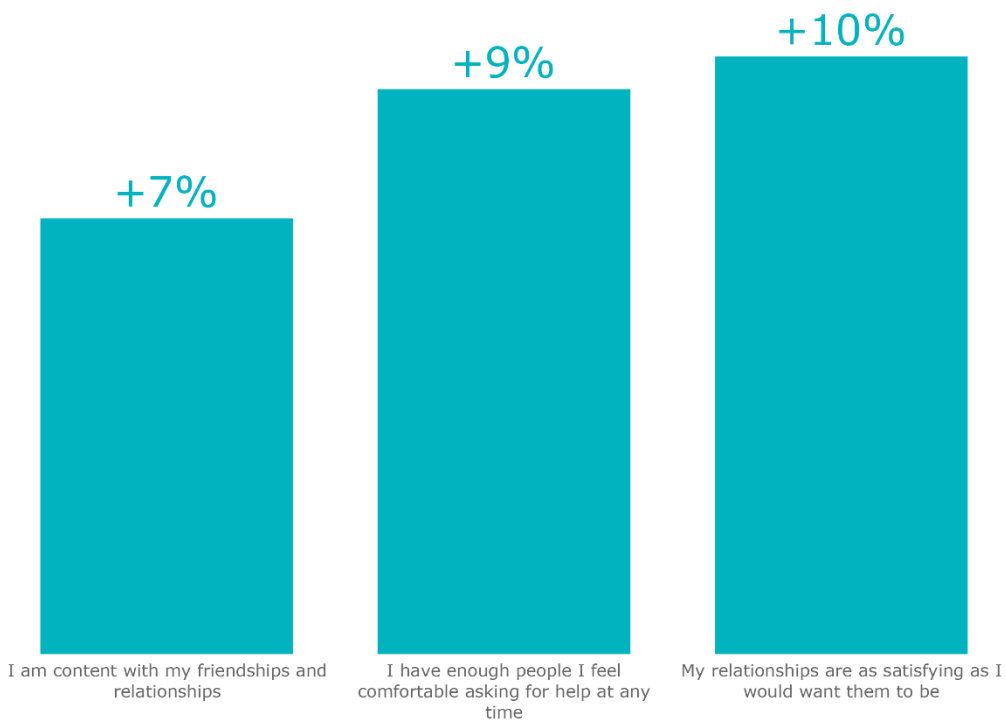


Base: 357

Connectedness and relationships

Community Connectors service users' reported improvements in both their social connectedness and social relationships after being referred to social prescribing. As figure 13 shows, there was a 10 percentage point increase in the proportion of service users content with their friendships and relationships, a 9 percentage point increase in the proportion saying they have enough people they feel comfortable asking for help at any time, and a 7 percentage point increase in the proportion saying their relationships are as satisfying as they would want them to be.

Figure 13: Change in Community Connectors service users' connectedness and relationships (percentage point change)

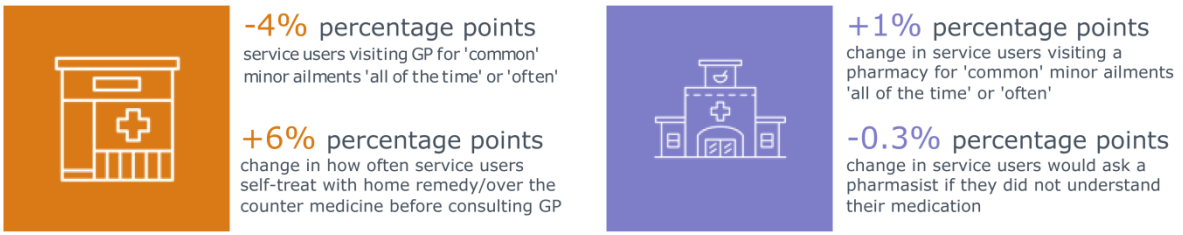


Base: 387

Self-care

Community Connectors service users' reported some small improvements in their capability to self-care after being referred to social prescribing. As Figure 14 demonstrates, in terms of their reliance on their GP, there was a 4 percentage point reduction in the proportion of service users who reported visiting their GP for 'common' minor ailments 'all of the time' or 'often' and a 'common' minor ailments, and an increase (6 percentage points) in how often they self-treat with home remedy/over the counter medicine before calling GP. However, in terms their engagement with their pharmacist, there was a one percentage point increase in the proportion of service users who reported visiting their pharmacist for 'common' minor ailments 'all of the time' or 'often' and a 'common' minor ailments, and a 0.3 percentage point reduction in the proportion who reported that, if they do not understand your medication, the would you ask the pharmacist for more information 'all of the time' or 'often'.

Figure 14: Change in Community Connectors service users' ability to self-care (percentage point change)



Base: 357

Case Study E: Nazmeen

Reason for referral

Nazmeen is a 56 year-old British Pakistani with Fibromyalgia who was referred to Community Connectors by her GP to help address low mood by engaging in new social activities. Nazmeen's condition meant that she was in a lot of pain for a lot of the time and suffered from severe headaches.

Support provided

During her meeting with a Community Connector, which started with a general chat about how her condition and how it affected her and her family Nazreem was asked about her pain. She then realised she had been focusing on the conversation and not thought about her pain for a while.

Nazreem told the Community Connector that she would like to attend a social group and start concentrating on herself and having a bit of 'me' time. A plan was made with Nazmeen to help re-build her confidence, develop her interests and to motivate her to get out to social activities. She was also supported to attend a Fibromyalgia support group provided through 'Champions Show the Way'.

Immediate impact

Nazmeen began attending the Support group regularly and felt that they understood what she was going though. She said she thought it helped because she did not feel alone anymore. She made new friends and looked forward to going and socialising as well as participating in the support group. Nazmeen reported that the support given by her HALE Community Connector excellent and really appreciated the help to move forwards.

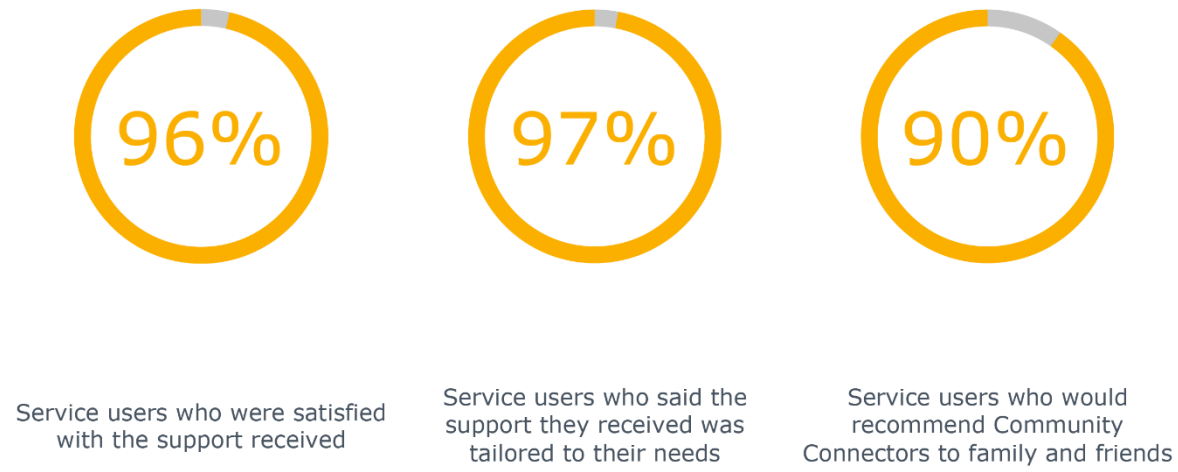
Long-term impact

Eight months later Nazmeen was attending the group on a weekly basis and expressed an interest in volunteering somewhere where she could support people experiencing similar problems to hers. Nazmeen is now supporting a new Fibromyalgia group set up by HALE and Champions Show the Way as a volunteer. Nazmeen feels like she is giving back to the community after all the support she received and says that volunteering has improved her her self-confidence, self-esteem and life satisfaction.

What did people think of the support they received?

Community Connectors service users were almost universally positive about the social prescribing support they received. As figure 15 shows, more than 95 per cent of service users said they were satisfied with the support received and felt the support was tailored to their needs and 90 per cent would recommend Community Connectors to their family and friends.

Figure 15: Service users' experience of Community Connectors support



Base: 447, 436, 421

The impact of social prescribing on self-care – a GP perspective

Excerpt from an email from a GP to HALE, July 2019

We have been referring patients to the social prescribing service since the pilot a couple of years back. I can say that we are all extremely pleased with the service offered to patients. We have had a most excellent service from (HALE).

We have seen tangible evidence of the improvements the social prescribing service can offer to the lives of some patients. Often these patients repeatedly bounce around the medical system when the real psycho-social problems remain unaddressed. Often they have needs that we as clinicians do not have the time address. At worst, sometimes these patients become over medicalised and completely dependent on the medical system. Social prescribing has helped some of these patients find their own independence and increase their confidence allowing them to begin the journey towards self-management, hopefully for the long term.

We will continue to refer our patients, and it is highly commendable that (HALE), come to every arranged meeting and have feedback for us on the patients that they have seen.

3. Conclusion

This report provides the findings of an independent evaluation of the Community Connectors Social Prescribing service in Bradford by Sheffield Hallam University. The key findings are as follows.

1. The reach of Community Connectors

The Community Connectors Service has achieved considerable reach into the community during since it was established in 2017, with more than **2,800 local people referred for support by their GP or other health professional.** During this period the service has almost doubled the number of GP practices it works with and now covers every practice in NHS Bradford City and District Clinical Commissioning Group area. People tended to be referred to Community **Connectors to address social issues such as anxiety, low mood and social isolation**. Despite the social and community focus of the service **a significant proportion of service users were also in poor health**, with more than two-thirds reporting at least one long term health condition and almost a third reporting more than three long term conditions. **The most common conditions were associated with mental health** – such as anxiety and depression - **although physical conditions such as arthritis, pain and diabetes were also reported**.

2. The impact of Community Connectors on health, well-being and wider outcomes

The evidence on the short-term (3-6 months) impact of Community Connectors on health, well-being and a broader set of outcomes is positive for many service users. Importantly, there has been significant **progress in many service users' mental health and wellbeing** which is the most common reason for referral to social prescribing and the most common form of long-term condition that service users experience:

- **Health:** the overall Health Related Quality of Life of many service users improved following their referral. Improvements were most pronounced for anxiety and depression, including for those service users who reported severe or extreme anxiety and depression.
- **Mental well-being:** the mental well-being of almost three-quarters of service users improved following their referral.
- **Trust:** the overall level of trust service users reported they had in people in their community improved following their referral.
- **Social connectedness:** the social connectedness and social relationships of many service users improved after they were referred to social prescribing. There were increases in the proportion of service users who were content with their friendships and relationships, saying they have enough people they feel comfortable asking for help at any time, and who say their relationships are as satisfying as they would want them to be.
- **Self-care:** a small proportion of service users reported a reduction in their reliance on their GP and pharmacists for treating 'common' minor ailments and an increase in how often they self-treat with home remedy/over the counter medicine before calling GP.

In addition to positive outcomes, **service users' experience of Community Connectors was almost universally positive**. More than nine out of ten service users were satisfied with the support received, felt support was tailored to their needs, and would recommend Community Connectors to family and friends.

3. Implications for primary and secondary care

The Community Connectors social prescribing service was commissioned with a view to reducing unplanned and unnecessary contacts with primary care (i.e. GP appointments) and secondary care (i.e. inpatient hospital stays and Accident and Emergency attendances). However, has not been possible to assess this as part of this evaluation. This is because the data recorded on primary systems such as System One cannot be used for evaluative analysis in its current form. If commissioners, GPs and other healthcare practitioners wish to better understand the impact of social prescribing on primary and secondary care we recommend the following steps be taken:

1. Focussed work with GPs and other healthcare professionals to **develop a 'theory of change'** about how social prescribing is expected to reduce demand on primary and secondary. This work should seek to understand the **characteristics of people who are referred to social prescribing who are 'high' users** of primary and secondary care services; **the types of social prescribing support and activities** these 'high' users are accessing; identifying any **changes in usage patterns** following their social prescribing referral; and understanding the **different mechanisms at play** within a social prescribing intervention that have contributed to any changes in service use.
2. Work to **refine the data that is collected at a practice level** to enable it to be used for the purposes described above. This should include a **consistent approach to recording and coding GP appointments** and other types of appointment so that they can be identified more readily. It should also be considered whether it is possible to add a flag to identify whether contacts with a GP practice are deemed 'appropriate' (i.e. more a genuine medical reason) or whether the presenting issue could have been prevented if effective social support had been in place.
3. For understanding the impacts on secondary care, **Hospital Episodes Statistics (HES)** – which NHS Digital can provide to CCGs in pseudonymised form - may be **more accurate than GP data**. In order to be able to access this data HALE and/or GP practices will need to collect explicit **consent from service users** using a pre-approved form of words and agreement from the CCG to support the data linkage process. Other processes and consents may also need to be put in place locally.

However, in the absence of 'system-level' data the evaluation findings do provide some important pointers to the potential benefits of a social prescribing for the healthcare system. In particular, the high proportion of service users reporting improvements in their health and mental wellbeing according to validated measures; the fact that more than two-thirds of service users had at least one long term health condition; and feedback from GPs about the impacts they seen in their surgeries on a daily basis; means that some of these benefits will be realised by primary and secondary care services if they translated into fewer instances of unplanned or inappropriate use of primary or secondary care.