An evaluation of Social Prescribing in the London Borough of Redbridge: final evaluation report

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Institute for Health and Human Development (University of East London)
The Institute for Health and Human Development is engaged in research and training into the social, economic and cultural productions of health and well-being. IHHD has attracted funding from UK research councils, charitable trusts, NHS, and the European Commission. We have major programmes of intervention innovation and development including the Well Communities programme, and an NIHR programme grant developing new models of antenatal care. We have also developed considerable expertise in the evaluation of social prescribing interventions and are key partners of the social prescribing network.

Disclaimer
The views expressed in this report are those of the authors and do not necessarily represent those of Redbridge Borough Council or Redbridge Clinical Commissioning Group

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1 Executive Summary

Background

Redbridge Borough Council and Redbridge Clinical Commissioning Group have commissioned the Institute for Health and Human Development based at the University of East London (UEL) to conduct an evaluation of the London Borough of Redbridge social prescribing service as part of the Health and Well-being fund (Department of Health and Social Care). The Social Prescribing service in Redbridge is being delivered by Redbridge CVS. As agreed in the document submitted to the funder, this final evaluation report presents health and social outcomes for participants in the period between baseline (November 2018 - October 2019) and follow-up (April 2019 – Mar 2020) as well as findings from the process and economic evaluation.

Methodology

The evaluation was based on a mixed methods approach which included the following:

- Health and social outcome evaluation: baseline and six months follow up survey of social prescribing users (July 2018 and completed in March 2020). Personal wellbeing, mental wellbeing, quality of life, loneliness and social capital. A total of 182 baseline service users questionnaires and 103 follow-up questionnaires from the same users were collected by Health and Wellbeing Buddies (HWBs) prior to Aug 2019 and by both HWBs and Social Prescribing Advisors (SPAs) after that.
- Process evaluation: the outcome evaluation was supported by a process evaluation consisting of in-depth qualitative interviews and a focus group with key stakeholders (including service-users) documenting their experience of the intervention.
- Economic evaluation: cost-benefit analysis (SROI) and analysis of healthcare service use (GP consultation and A&E attendance)

Key Findings

- Data analysis show that the Redbridge social prescribing scheme is reaching its intended target population
- The evaluation reported positive statistically significant changes between baseline and follow up were recorded for quality of life, mental well-being and health. Meaningful and statistically significant changes in mental well-being were found. Personal wellbeing also improved overall, but there was no statistically significant difference between baseline and follow up.
- The most important point that appears to emerge from respondents is that concerns are highly interrelated and addressing a primary concern such as ‘practical support’ (housekeeping, caring needs and obtaining specialist equipment) is very likely to lead to addressing other concerns such as anxiety and depression (sec 6.1.7)

- Analysis showed a small reduction in loneliness, particularly for people who experienced 'extreme loneliness' (6.1.8). However, this was small and Lonelinessnon-statistically significant. On the other hand, there was a positive change in social capital over the two periods of data collection. Given the positive changes in social capital and mental well-being, we found it strange that respondents only reported small reductions in loneliness. The only potential problem may be the loneliness instrument used. Future research should probably use other more widely used instruments such as the 'De Jong Gierveld Loneliness Scale'.
- Interviews with stakeholders revealed that Redbridge social prescribing service is well-structured and responsive, supported by committed and passionate individuals from Redbridge Council, Redbridge CVS and Redbridge Clinical Commissioning Group. There is a focus on constantly seeking to improve the service. The Health and Wellbeing Buddies and Social Prescribing Advisers were thoughtfully recruited (e.g. emphasis on recruitment from the community and with life experience) and well-supported with training and clinical supervision. However, there continues to be a struggle between demands to manage high number of referrals, and maintain quality and health/social outcomes in the face of ever increasing complexity of cases.
- In relation to the experience of service users, the picture is overall positive. However, it is important to focus on some of the key barriers which require continuous adaptation and sense checking. In particular, service user experience could be improved further with more formal clarification of the boundaries of this relationship including the number of sessions, frequency of sessions and clear information on how and when they can make contact with their Health and Wellbeing Buddies and Social Prescribing Advisers (see 6.2.1 and 7.5 for more detail).
- The economic evaluation showed a positive, above average, Social Return on Investment (£1:£2.86) for the first year (sec 6.3.1 for more detail). The total savings in terms of GP consultations are £2,489 for 103 people over 6 months. Total savings seem to be low but they only relate to a short period and a limited sample. More detailed analysis using GP practice routine data would provide a more accurate estimate of cost savings. We found a small increase in A&E attendance over the period.
- We reported some reflection about the key challenges and opportunities for social prescribing during Covid-19 (see sec. 7.7) and relate these with the development of social prescribing in Redbridge.

Key recommendations

We just provided a summary of the recommendations here. For more detail see sec. 8 (p.47) of the report.

Recommendation 1: Continue to deliver the current service and carefully adapt to current changes due to the pandemic. The recruitment of health coaches and care coordinators may provide a significant opportunity to improve the capacity of the service and maintain the current quality.

Recommendation 2: Specific training for HWBs and SPAs may be considered in view of the different support needs caused by the pandemic.

Recommendation 3: consider providing service users with written information stating: the name of their HWB and the service they are attached to, when they will have contact with their HWB next, the number of sessions to be expected and over what period, and when and how they can be contacted by the client if needed. It is also important to give service users clear advance notice of when the last session will be and when they will be discharged from the service.

Recommendation 4: strengthen the monitoring of users' referrals to activities and services in order to understand where further investment in the VCSE and statutory sectors is needed.

Recommendation 5: consider an analysis of GP consultations, A%E attendance, hospital admissions, and use of medication drawing on routine data available in GP practices.

3 Introduction

Social prescribing is now firmly at the forefront of UK health policy with the recent commitment from the Department of Health and Social Care to refer 900,000 people to social prescribing schemes by 2024. Alongside this, the NHS Long Term Plan is set to recruit and train 1,000 Social Prescribing Link Workers to work within primary care services by the end of 2020/21 (DH, 2019). Social prescribing was recognised as an important model for the future of the NHS in its Five Year Forward View (NHS,2014) and The General Practice Forward View (NHS, 2016) has also recognised social prescribing as one of the 10 high impact interventions to release capacity in GP practices and would do so by making greater use of assets available in the community such as the third sector.

Key challenges in primary care include: (i) the growing pressure on GP practices, partly driven by the number of patients who frequently attend a GP with medically unexplained symptoms. About, 20% of patients consult their GPs for problems that are primarily social rather than medical (Torjesen, 2016); (ii) the rising tide of long-term conditions growing by 5 million in the next ten years (Dept of Health, 2013). Yet, 70-80% of people with long term conditions (LTCs) could be supported to manage their own conditions (DH 2005); (iii) growing health inequalities which result in long-term medical conditions disproportionately affecting people in deprived areas (Marmot et al., 2010; Cawston, 2011; Hutt and Gilmour, 2010). Life expectancy is eight years lower in the most deprived areas of England, compared to least deprived areas. Life in 'good health' is 20 years lower (ONS, 2010-12). (iv) Early mortality for social isolation is as high as established risk factors such as smoking and obesity (Holt Lunstad et al, 2015). Thus, tackling social isolation has become an important priority of health policy (DCMS, 2018).

In an attempt to seek solutions to these problems, the concept of social prescribing holds significant promise. Social prescribing '*enables healthcare professionals to refer patients to a link worker, to co-design a non-clinical social prescription to improve their health and well-being*' (NSPN, 2016; p.19). In addition, social prescribing has the potential to help deliver other government priorities in the field of health such as: the merger of health and social care, developing and delivering health at the community level and delivering a patient centred approach which supports patients to access community activities thereby empowering the patient to decide what is right for them.

In this context, the Institute for Health and Human Development based at the University of East London (UEL) was commissioned by Redbridge Borough Council and Redbridge Clinical Commissioning Group to conduct an evaluation of the social prescribing scheme in Redbridge, focussing on the process, outcomes and cost effectiveness of the service.

This final evaluation report presents the findings from the period of between baseline (November 2018 - October 2019) and follow-up (April 2019 – Mar 2020) and includes outcomes from the cohort study, learning from the process evaluation and stakeholder experiences of the scheme and an economic cost-benefit analysis.

4 Description of the Social Prescribing Service in Redbridge

The social prescribing service in Redbridge is being implemented by Redbridge CVS (a charity and umbrella organisation representing the voluntary sector in the borough) and was launched in October 2017 in nine General Practices within Fairlop. Following a successful funding bid to the Department of Health and Social Care, it was expanded to include all 42 General Practices in Redbridge from December 2018.The aim of this study was to evaluate the process, outcome and cost-effectiveness of social prescribing in the London Borough of Redbridge. It evaluated the impact of social prescribing on individuals and local health services. The evaluation lasted for 27 months (July 2018 to June 2020). The main aims of the social prescribing scheme are to improve the health and wellbeing of patients over 18 years presenting with one of the following referral criteria:

- Type-2 Diabetes
- Low level mental health
- Social Isolation
- Carers

In the original referral pathway GPs refer patients who meet the above criteria to a Social Prescribing Co-ordinator for assessment. The patient is then allocated a Health and Wellbeing Buddy (HWB) who offers them up to five one-to-one sessions in a 12 week period (although this can be flexible) to build an action plan towards personal goals and further support from community and statutory services if appropriate.

Redbridge CVS made changes to their team structure by recruiting four Social Prescribing Advisors (SPAs) in July 2019, to work alongside the two SP Coordinators and four Health and Wellbeing Buddies. SP coordinators focus primarily on engaging and promote the service to other parts of the system, particularly GP practices. SPAs work with clients on a one-to-one basis throughout the 12 week period and are supported by the Health and Wellbeing Buddies who accompany clients with high support needs in accessing services. The advisors triage all clients from a first phone call and work with the HWBs to meet clients' needs which can include: accompanying them to a service, chaperoning, research and language support. HWBs are employed on 'casual' contracts and offer a support role, although in some cases they deal with caseloads on their own, particularly where there is a need for their specific skills.

In response to the rise in complex referrals and the challenging work of engaging with very vulnerable clients, Redbridge CVS hired the services of an independent Integrative Psychotherapist from June 2019, the SP team have access to one hour monthly Supervision sessions with her. The supervision provides a regular, confidential space for the team to discuss issues related to their work. The aim is to support the team in taking care of their own wellbeing needs whilst they are supporting clients and the wider needs of the service.

5 Methods

5.1 Study aims and design

We use a mixed method approach to investigate SP in Redbridge including a survey of health and social outcome, qualitative interviews, a process evaluation and an economic evaluation. The study started in July 2018 and was completed in March 2020. The methodology for each of these is described below.

5.2 Health and social outcomes evaluation: cohort study

The prospective cohort study collected data from social prescribing participants at baseline (Nov 2018) and six months follow up (April 2019). Data collection was carried out by the Health and Wellbeing Buddies (HWBs) (trained by the UEL research team) and Social Prescribing Advisors (after Aug 2019) who both work on a one to one basis with patients referred into the SP service. Baseline and follow-up questionnaires included a set of validated questions to measure quality of life, mental wellbeing and levels of social connectedness (see Table 1: The evaluation of social prescribing in Redbridge in the next page below).

Table 1: The evaluation of social prescribing in Redbridge

Type of evaluation	Themes	Design and methods of data collection
Outcome evaluation	To capture individual changes in mental wellbeing, physical health and social connectedness	
	Changes in the following: - Wellbeing (overall and mental) - Quality of Life - Loneliness - Social capital (social networks, soc. Support) - Use of health services (GP consultations, A&E attendance, hospital admission) Follow up additional questions: - Name of organisation/training attended and frequency of attendance	Methods: baseline and 6 months follow up **cohort study**. Baseline survey of at least 300 people (Nov 2018-Oct 2019). 6 months follow up on at least 150 participants (May 2019 – Mar 2020). Data collection: Baseline and follow up data collected and inputted by Health and Wellbeing Buddies (HWBs) and Social Prescribing Advisors (SPA) employed by Redbridge Council for Voluntary Service (CVS) and trained in data collection by UEL.

		Data analysis and outputs: regression analysis and economic assessment
Process evaluation	To examine mechanisms and contextual factors including fidelity, dosage, access, and sustainability	
	- Fidelity: Was actual programme performance met original goals for implementation? Which elements worked and which didn't and how these have affected, altered or amended the original plan and aims of the programme? - Dosage: the intended outcomes of the programme activities such as number of sessions delivered, number of Health and Wellbeing Buddies trained, number of service users engaging in each stage of the programme. - Access: were the intended people able to access the programme effectively? Who did and why did not have access?; what were the barriers - Sustainability: was the programme sustainable?	Fidelity and access (Aug – Nov 2019): 15 semi-structured **qualitative interviews** with service users; according to level of engagement (led by UEL) Contextual factors and mechanisms (incl sustainability) (July-Dec 2019)-: **Stakeholders interviews** (5 in total) and one **focus group** with Health and Wellbeing Buddies (led by UEL) Dosage and access (Nov 2018 – Mar 2020): staff at each site to collect the following **monitoring data**: - No of users attending at least one session with HWBs and SPAs - No. of sessions with HWBs and SPAs. Average time spent with each user. - No. of people who have not attended (DNAs) - Reasons for not attending - No. of users attending community organisations - Name or organizations and types of activities users have been referred to. - Name or organisations and types of activities users actually attended after referral (at least for the 5-10 major community support organisations) and number of times they attended activities. RedbridgeCVS to submit quarterly monitoring data

5.3 Process evaluation

The process evaluation aimed to examine the mechanisms and contextual factors of the implementation of social prescribing including fidelity, dosage, access and sustainability.

In order to capture more detailed information about these aspects of the service, we conducted in-depth face to face interviews with 12 service users, in order to gain a feel for their experiences of and satisfaction with the service. Participants represented a range of experiences from those who had satisfactorily completed the intervention; to those who had had less positive experiences or had dropped-out of the

pathway. Information about the background of social prescribing users, their experience with healthcare professionals, Health and Wellbeing Buddies and community/statutory services was also collected. This enabled us add context to the outcome findings from the prospective cohort study and provide more information for the further improvement of the service.

The process evaluation evaluated the development and implementation of the social prescribing scheme in Redbridge. Six in-depth interviews were carried out with key stakeholders involved in the design, implementation and delivery of the service. These included: a GP, health commissioner, council project leaders and managers, as well as a senior social prescriber. A focus group was also carried out with eight Health and Wellbeing Buddies (HWB's) and Social Prescribing Advisors (SPAs) capturing their experiences at the frontline of the service.

Both qualitative interviews with service users, stakeholders and the focus group with HWBs/SPAs were analysed through Thematic analysis (Braun & Clarke, 2006) which enable to create patterns across interviews with different stakeholders.

5.4 Economic Evaluation

We conducted a cost-benefit analysis of social prescribing by calculating a Social Return on Investment (SROI) and a cost assessment of healthcare service use (GP consultations and A&E attendance). There are different forms of cost-benefit analysis and different types of SROI. We followed the well-being valuation approach which has not yet been used in evaluations of social prescribing to date (Fujiwara, 2013). Yet, the well-being valuation approach has been supported by HM Treasury Green Book which includes a range of recommended approaches to economic analysis (HM Treasury, 2018). The well-being valuation approach is based on a different economic rationale involving the use of routine large-scale data (e.g. British Household Panel Survey; Understanding Society, Crime Survey for England and Wales). As Trotter et al. (2014) explain, large-scale data is used to identify the impact that target activity (e.g. volunteering) have on self-reported life satisfaction, once adjusted for all the other factors that may impact on individuals' satisfaction levels. Using the same statistical techniques, one can calculate the amount of money needed to induce the same change in life satisfaction and that constitutes the well-being value for that activity. The advantage of this approach is that is uses data from large scale routinely collected studies in order to produce financial proxies. It thus therefore represents the opinion of a large number of people.[1]

[1] For example, large-scale data is used to identify the impact that volunteering has on self-reported life satisfaction, once adjusted for all the other factors that may impact on individuals' satisfaction levels. This may show that volunteering leads to an average increase of 3% in people's satisfaction levels. Using the same statistical techniques, one can calculate the amount of money needed to induce the same change in life satisfaction of 3%, say for example (£5,000). This is the well-being value for that activity.

6 Results

6.1 Health and social outcomes evaluation

The cohort study collected baseline data from 182 service users and 103 service users at follow-up. Data was collected by Health and Wellbeing Buddies (HWBs) prior to Aug 2019 and by both HWBs and Social Prescribing Advisors (SPAs) after that. Data collected were analysed at the Institute for Health and Human Development (IHHD) based at University of East London.

6.1.1 Descriptive analyses of participant characteristics

There are no major differences between baseline and follow up sample used for data collection. However, there are some differences between the sample of respondents and the population of Redbridge. Over 50% of the sample is over 65, compared with only 12% for Redbridge (
Table 2). This is to be expected as the target group of social prescribing in Redbridge is primarily the socially isolated. Two out of three were female (63.8%) to only 50.5% for the borough. Greater response and greater attendance to social prescribing from women is common across different social prescribing schemes. The BAME (Black and Asian Minority Ethnic) representation in the sample is lower than for Redbridge (42.1% compared with 57.5%). Nearly half (46.2%) of service users live alone. This is not unexpected given the large number of elderly (65 and over) people represented. Some 44.1% of respondents at baseline were retired from paid work and about one out of five respondents (22.6%) were 'unable to work due to long term sickness'. There were also a considerable proportion of service users who were unemployed (7.9%) and three out of four respondents (75.7%) had a long standing physical/mental illness.

Table 2: Participant characteristics at baseline and follow-up

Profile	Baseline		Follow up		Redbridge (*)
	n	%	n	%	%
Age groups (years)					
18-24	6	3.3	2	1.9	65.0
25-34	17	9.3	8	7.5	
35-44	22	12.1	13	12.3	
45-54	24	13.2	13	12.3	
55-64	23	12.6	14	13.2	
65-74	19	10.4	14	13.2	12.0
75-84	42	23.1	25	23.6	
>=85	29	15.9	17	16.0	
Gender					
Male	58	32.0	38	36.2	49.5 (***)
Female	122	67.4	67	63.8	50.5 (***)
Other	1	0.6	0	0	
Ethnicity					
White British	72	40.4	38	37.3	
White other	11	6.2	9	8.8	
Mixed	4	2.2	2	2.0	
Black or Black British	13	7.3	9	8.8	
Asian or Asian British	61	34.3	34	33.3	57.5
Other	17	9.6	10	9.8	
Employment					
Full Time	4	2.3	3	2.9	
Part Time	9	5.1	8	7.8	
Self-employed	2	1.1	1	1.0	
Unemployed and Looking for job	14	7.9	9	8.7	
At school or Full-time education	2	1.1	1	1.0	
Unable to work due to illness	40	22.6	19	18.4	
Looking after house/family	10	5.6	7	6.8	
Retired from paid work	78	44.1	49	47.6	
Other	18	10.2	6	5.9	
Living Arrangements					
Alone	82	45.6	49	46.2	
With spouse, partner	45	25.0	27	25.5	
With housemate	7	3.9	1	0.9	
Secure housing	9	5.0	6	5.7	
Temporary accommodation	9	5.0	3	2.8	
Rough sleeping	1	0.6	0	0.0	
Other	27	15.0	20	18.9	
Carer Status					
Yes	36	20.9	13	14.3	
No	130	75.6	78	85.7	
Other	6	3.5	0	0	
Long standing physical/mental illness (**)					
No	42	24.3	11	24.4	
Yes, limited a little	46	26.6	11	24.4	
Yes, limited a lot	85	49.1	23	51.1	

(*) data from London borough atlas 2015; (**) Are your day-to-day activities limited because of a health problem or disability, which has lasted, or is expected to last, at least 12 months? ;(***) Census 2011

At follow up (

Table 2), participants characteristics substantially confirm the baseline picture, with some slight exceptions: respondents are slightly older, slightly more male, and from ethnic minority population, fewer people are also carers.

6.1.2 Statistical analysis of changes in health outcomes over time

This section provides a summary of statistical tests on health outcomes including personal well-being, health, quality of life and mental well-being. The following sections will analyse each of these outcomes in more details. Table 3 summarises the results from statistical tests assessing whether there is a statistically significant difference between a number of health outcomes between baseline and follow up. Unless otherwise stated, most of the tests performed here are paired sample t-tests which compare the means at baseline and follow up and statistical significance is indicated as a p value in bold.

Personal well-being: although most components of personal well-being show a mean improvement from baseline to follow up, most of these are not statistically significant, except life satisfaction.

Health: respondents were asked to state their health on a scale from 0 to 100 were 0 is the worst health state and 100 the best possible health state. Again, test shows a statistical significance change in health

Quality of life: the overall quality of life score shows a statistically significant positive change in the five components of quality of life (mobility, self-care, pain/discomfort, and anxiety/depression).

Mental well-being: mental well-being also shows a statistical positive change over the period (mean=3.31; p=0.022).

Table 3: Statistical analysis of health outcomes between baseline and follow-up

Measure	**Effect of SP**		
	N	**Net change[2]**	**Significance**
		Coef. (95%CI)	*P value(*)*
Personal Well-being (ONS)			
Life satisfaction	99	0.808 (.248 -0.316)	**0.002**

[2] Net change refers to the difference in the average score between baseline and follow-up.

Things in your life are worthwhile	97	0.464 (-.069-0.996)	0.087
Happiness	97	0.423 (-0.153-0.999)	0.148
Anxiety	100	0.080 (-0.707-0.867)(**)	0.841
Health (EQ-VAS)	105	4.467 (-.001 – 8.935)	**0.050**
Quality of life (index score)(EQ-5D-5L)	97	0.056 (0.006- 0.105)	**0.028**
Mental Well-being (SWEMWBS)	104	3.31 (***)	**0.022**

(*) Significant p values in bold, p <= 0.05; (**) this is to be interpreted as a negative change in anxiety (but see sec.6.1.5, for more details); (***) Wilcoxon Signed Ranks Test

6.1.3 Changes in quality of life

Quality of life was measured via a validated measuring instrument called EuroQol (EQ5D-5L). This instrument is made up of five components including mobility (ability to walking about), self-care (ability to wash or dress oneself), usual activities, pain/discomfort, anxiety and/or depression. As expected, the Redbridge sample at baseline reported significant problems in relation to a representative sample of the UK population for all five components of quality of life (Table 4). Such difference is to be expected as the Redbridge sample is made up of a vulnerable population. However, the difference was extreme, particularly in relation to self-care, which was 43.5% (versus 4.3% for the UK population).

Table 4: Reported problems in quality of life components

	SP Redbridge (%) Baseline	**SP Redbridge (%) Follow up**	**UK (*) (%)**
	N=177	N=106	N=3,395
Mobility	72.3	68	18.4
Self-care	43.5	40.6	4.2
Usual activities	67.4	65.1	16.2

Pain/Discomfort	79.5	81	32.9
Anxiety/Depression	83.7	79.5	20.9

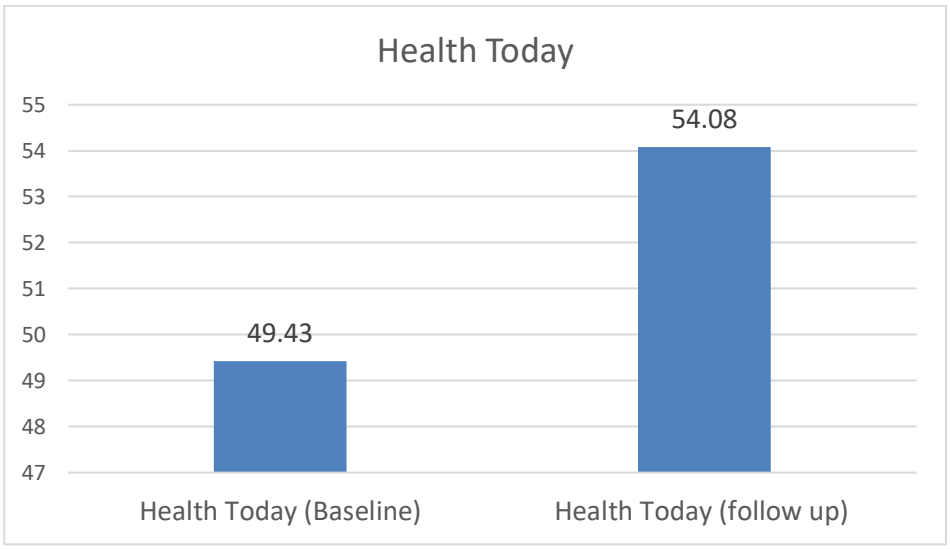
(*) Szende, Janssen, Cabases (2014) p.143

Although the difference in relation to the UK sample has been maintained at follow up, the proportion of people with reported problems in mobility, self-care, usual activities and anxiety/depression was lower at follow up than baseline. The positive change in overall quality of life is also statistically significant as show in Table 3 (mean=0.056; p=0.028).

6.1.4 General Health

Respondents were asked to rate their own health on the day they completed the questionnaire, using a tool called EQ VAS (Visual Analog Scale) which rates health between 0 (worst possible) and 100 (best possible). EQ VAS shows respondent's own assessment of their health rather than responses to a set of questions. As shown in Table 3, analysis showed a statistically significant positive change in respondents' own rate of health between baseline and follow up. This change is corroborated by the mean change from 49.43 to 54.08 in Figure 1.

Figure 1: changes in health from respondents' own views



6.1.5 Mental wellbeing

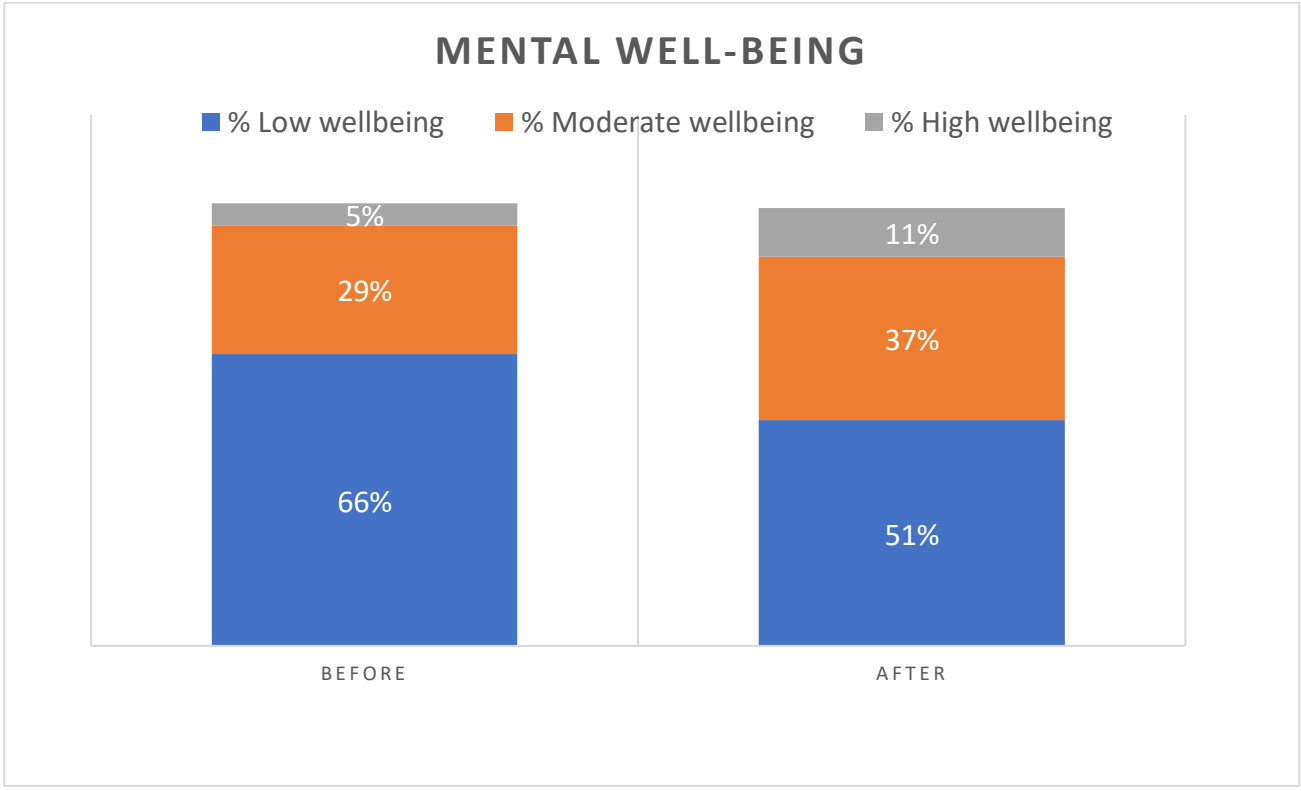
Mental well-being was measured using the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) which is a validated scale of 7 items used for the measurement of mental wellbeing of any population aged 13 to 74. It comprises seven positively worded statements and participants are asked to rank on a Likert

Scale (from 'None of the time' to 'All of the time') each mental wellbeing statement in the previous two weeks. Mental wellbeing refers here to positive states of being, thinking, behaving and feeling and is a good indicator of how people and populations are able to function and thrive (Putz et al 2012).

At baseline, the mean from the Redbridge sample was 16.8. This is considerably lower than the Health Survey for England (2011) which produced a mean of 23.6 from a nationally representative sample of 7,196 people. Thus, in line with other data (e.g. MYCAW), mental wellbeing was, at baseline, considerably lower than the national average.

Changes in mental well-being have been both statistically significant (Table 3) and 'meaningful'[3] (Figure 1)**Error! Reference source not found.** reinforces this point further by showing how the proportion of respondents reporting low mental well-being declines (66% to 51%) and those reporting moderate (29% to 37%) and high wellbeing (5% to 11%) at follow up increase.

Figure 2: changes in mental well-being



[3] Guideline on mental well-being from (Putz et al., 2012) regards as 'meaningful', a change between 3 and 8 points in SWEMWBS score between baseline and follow up in both positive and negative directions.

6.1.6 Personal well-being

Personal well-being is a validated and widely use of personal well-being used routinely by the Office for National Statistics (ONS). It is made up of four components including life satisfaction, a worthwhile life, happiness and anxiety. Respondents are asked to rate these four components from '0' (not at all satisfied) to '10' (completely satisfied). We found that the values for the wellbeing component 'anxiety' was confusing and contradictory with the results from other outcomes so we have not included that in this report. We suspect an issue with data collection as anxiety is the only question that is framed from positive to negative (see 7.2 for more details).

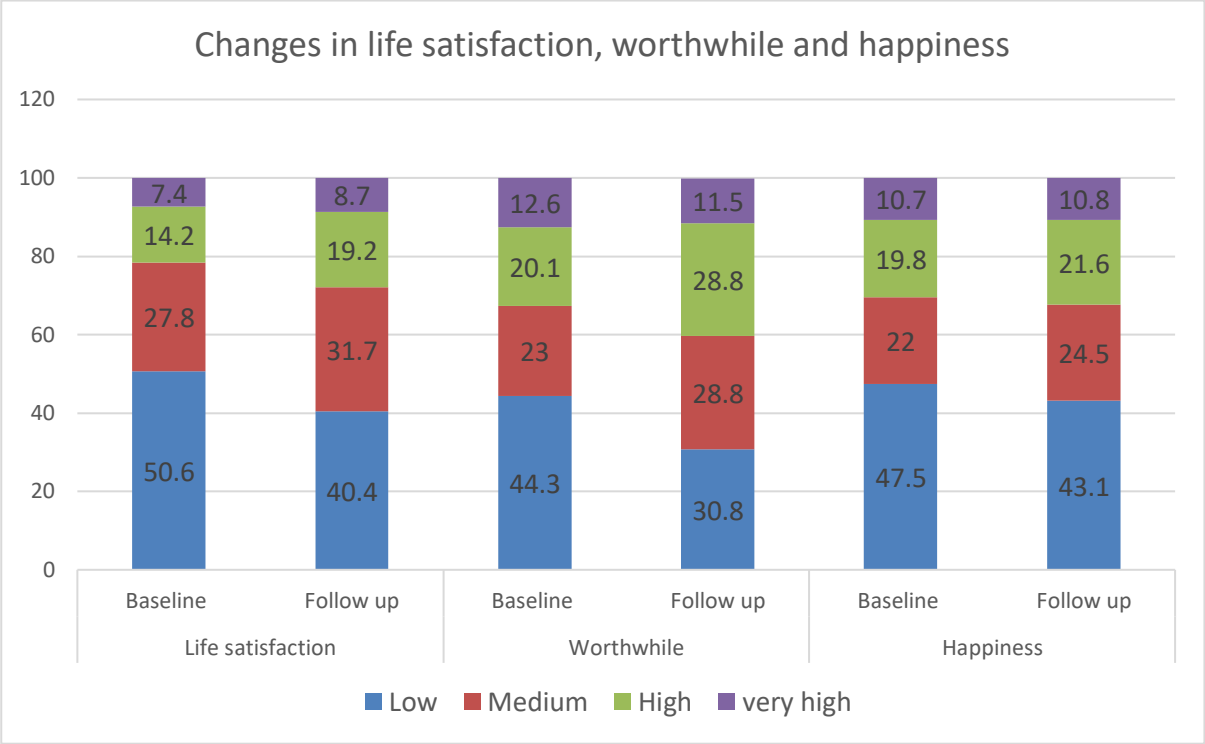
As shown in Table 3 (p.14), statistical test shows that although life satisfaction, worthwhile and happiness registered a positive mean change, only life satisfaction recorded a positive statistically significant change between baseline and follow up.

Figure 3: personal well-being mean scores at baseline, follow up and for Redbridge

Figure 3 shows the changes in life satisfaction, worthwhile and happiness between baseline and follow up and compares these to the mean score for Redbridge between 2012-15. The mean score for the components has increased from baseline but it still considerably lower than the average for borough of Redbridge as a whole.

In Figure 4, we report the main changes from baseline (N=177) to follow up (N=105) for low, medium, high and very high life satisfaction, worthwhile and happiness. All low values for the three components declined from baseline to follow up. On the other hand, all the medium, high and very high values for the three components of personal well-being increased over the two period.

Figure 4: Changes in life satisfaction, worthwhile and happiness

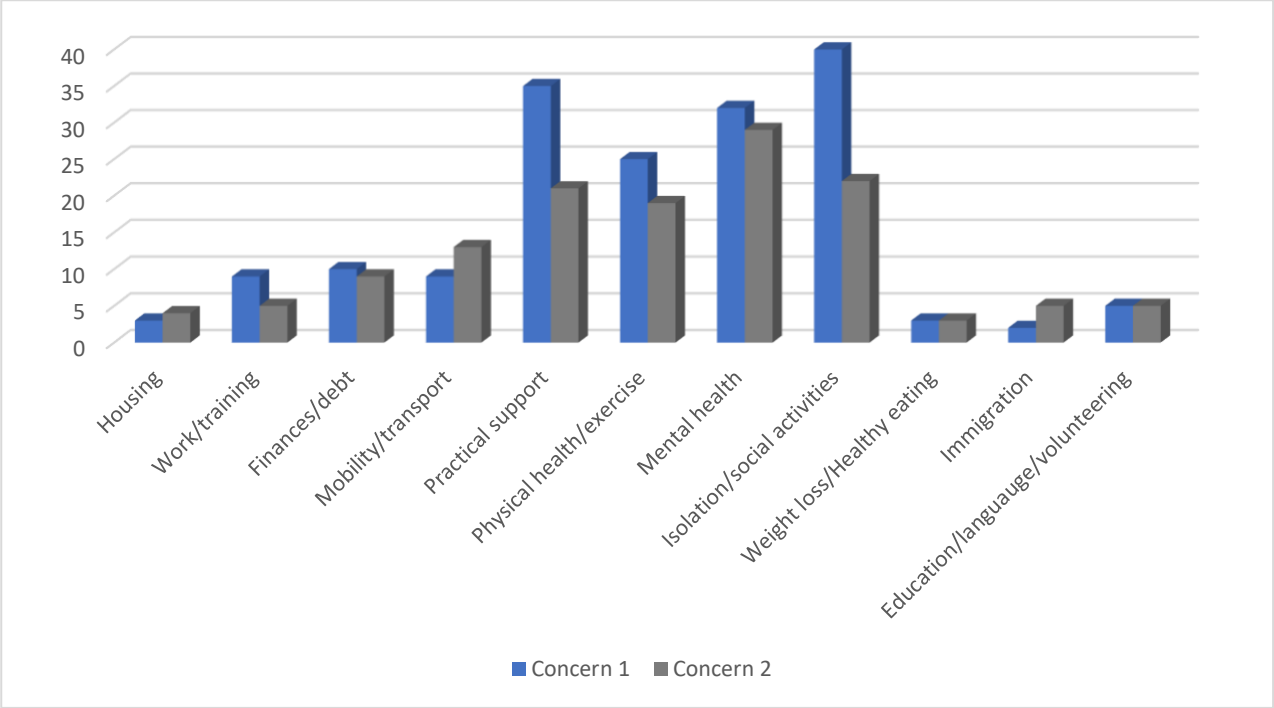


6.1.7 Participant primary and secondary concerns

The MYCAW (Measure Yourself Concerns and Wellbeing) tool enables respondents to determine the two key concerns affecting them at the beginning of the social prescribing intervention (baseline) (Paterson et al., 2007). Figure 5 shows the number of respondents at baseline whose primary or secondary concern fell into each category 'Social isolation' followed by 'practical support'[4] and then 'mental health' were the three most common primary concerns for respondents entering social prescribing. Secondary concerns cited these three categories again, although mental health overtook the other two as most commonly cited secondary concern.

[4] Please note, the 'practical support' category encompasses housekeeping and caring needs, as well as help obtaining specialist equipment. The mobility/transport category included those experiencing difficulties with both physical mobility as well as those requiring help with transportation.

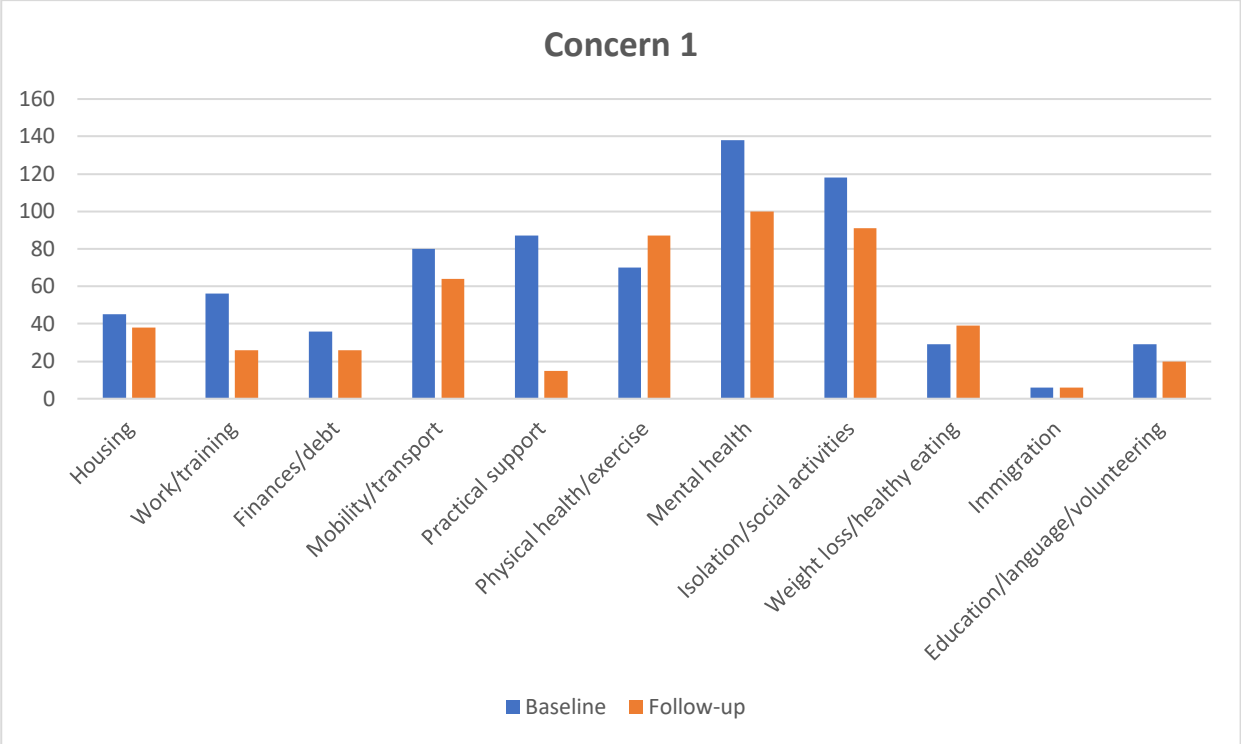
Figure 5: Primary and secondary concerns



The spread of concerns reflects two of the main referral criteria (social isolation and low-level mental health) as well as the large number of older people included in the sample. Social activities are used as an indication that people feel socially isolated and has therefore been included as 'isolation/social activities'. The presence of mental health as the highest secondary concern suggests that some service users who were referred by their GP for anxiety or depression may have also been experiencing another issue that was impacting negatively on their mental health (for example, the need for practical support). Receiving help with a 'practical concern' like this through the social prescribing pathway may therefore help to resolve secondary mental health issues.

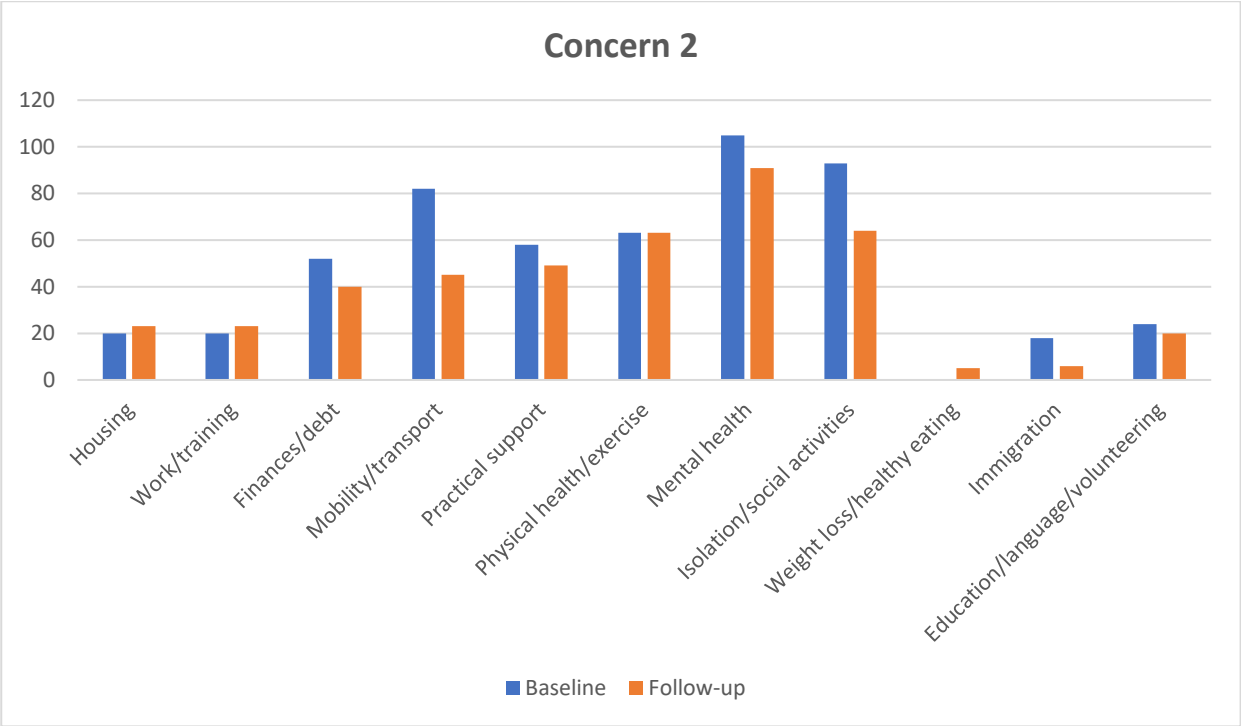
Likert scale scores for each primary (Figure 6) and secondary concern (Figure 7) were then summed for respondents with complete baseline and follow-up data (n=120) allowing a comparison to be made between baseline and follow-up for each area of concern across the population. It is important to remember that respondents were asked to provide scores at follow-up for their original primary and secondary concerns at baseline. They were not asked about new concerns at follow-up.

Figure 6: Changes in respondent's primary concern between baseline and follow-up



In almost all areas representing their primary concern, respondents reported an improvement after the social prescribing intervention. This is particularly apparent where the concern involved the need for practical support of some kind e.g. needing a carer or help with filling in forms. The two exceptions.

Figure 7: Changes in respondent's secondary concern between baseline and follow-up



Again, most areas represented by respondent's secondary concern improved after the social prescribing intervention. Exceptions to this were where the concern involved housing or work and training. These issues often appear as primary concerns in social prescribing pathways and it is possible that respondents who cited them as secondary concerns were less motivated to focus on making improvements in this area. Furthermore, housing issues can take long time to be resolved, hence the lower reported level of improvement of this concern.

6.1.8 Loneliness

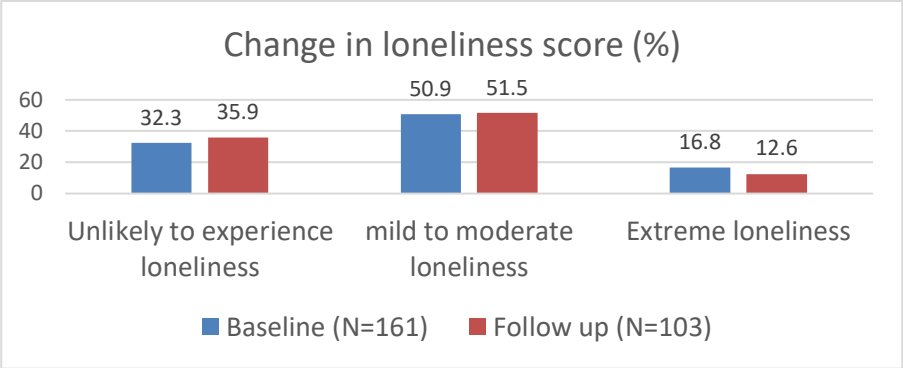
We used the Campaign to End Loneliness (2014) created measurement tool to assess loneliness. Loneliness was assessed by asking three positive questions with no mention of the word loneliness. This wording attempts to infer a state of loneliness rather than asking the question directly and potentially trigger a different response. Respondents were asked to answer these questions on a five-point Likert scale ranging from 'Strongly disagree' to 'Strongly agree'. At baseline, two out of three people (67.7%) felt some sense of loneliness, with16.8% of the sample experiencing extreme loneliness.

This wording attempts to infer a state of loneliness rather than asking the question directly and potentially trigger a different response. Respondents were asked to answer these questions on a five points Likert scale ranging from 'Strongly disagree' to 'Strongly agree'. Overall, there was a small mean decline in the

level of loneliness by 0.58 from 5.51 to 4.93 on a scale between 0 (Least lonely) and 12 (most lonely)[5]. This change is not statistically significant (p=0.426)

More details are provided by Figure 8. Whilst mild to moderate loneliness has remained stable, the proportion of respondents experiencing extreme loneliness declined whilst those unlikely to experience loneliness at follow up increased by almost the same amount.

Figure 8: Change is loneliness score



6.1.9 Social capital

In the questionnaire, we asked social prescribing service users questions about social capital by using questions from the social capital harmonised questionnaire set. These include two dimensions of social capital: social networks and social support. Social networks could be likened to the 'quantity' of social capital whilst social support could be likened to the 'quality' of social capital. 'Social networks' was measured by asking people questions about their interaction with relative, friends and neighbours through different means of communication including phone, letter, email, chatroom and text. 'Social support' was measured by asking respondents three questions whether they would be comfortable with asking others help with their shopping if they were unwell, asking others to lend them money or asking others for advice and support in a crisis.

Social networks: Figure 9 shows that contact between service users and friends, relatives and neighbours increased over the period. It is also clear that the most used means of communication was spoken rather than via text, email or chatrooms. It is particularly noticeable that the proportion of people who 'never' spoke with friends, relative or neighbours declined in all, signalling a considerable increase in spoken communication. That appears particularly significant in relation to the target population who have experienced social isolation and loneliness. Although there is no comparison group in this evaluation, thus

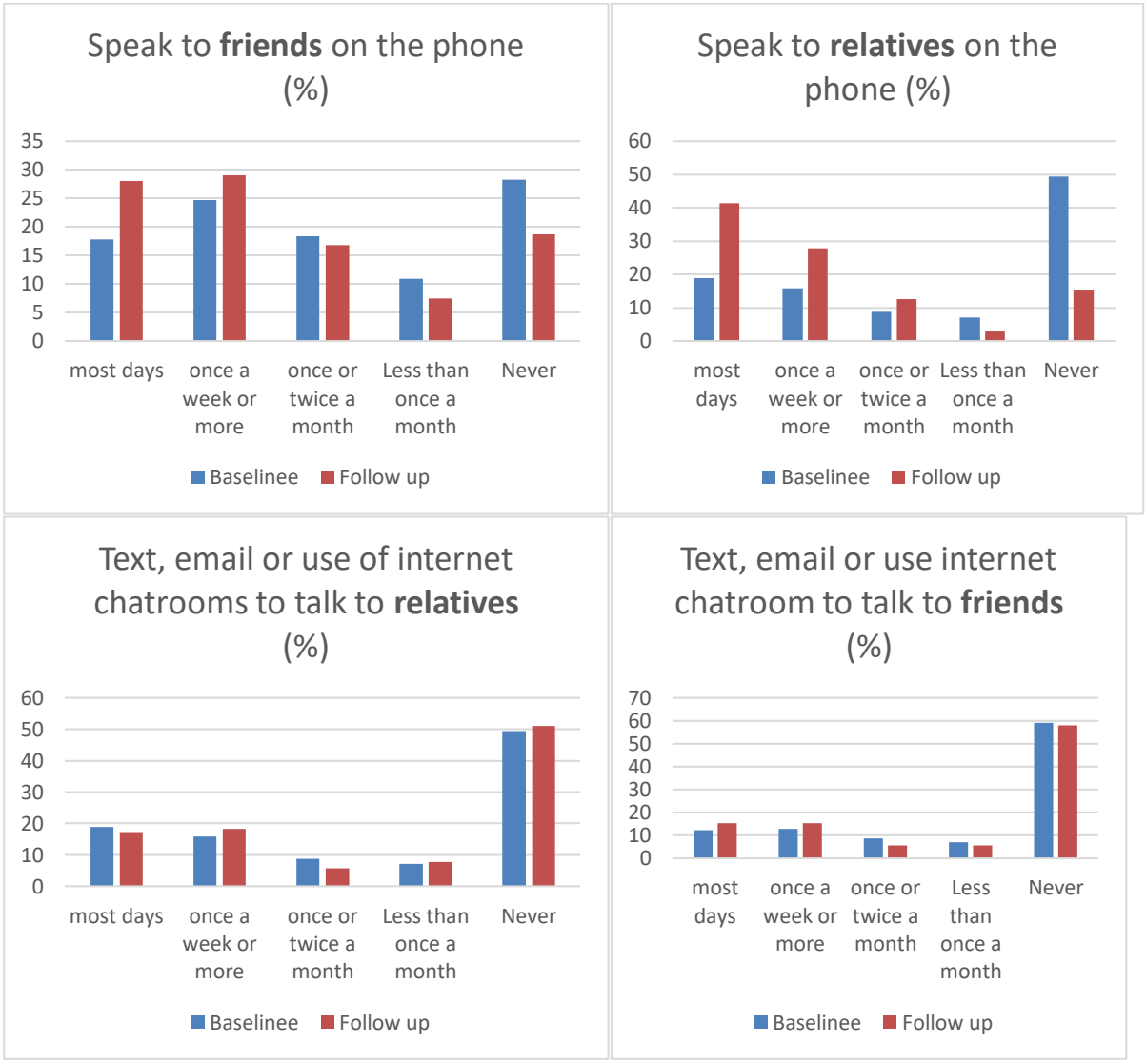
[5] It is not possible to attribute a percentage value to the change as changes between different scores may not reflect proportional changes in loneliness.

it is important to be cautious, there appears to be consistent improvement in the 'quantity' of social capital over the period in which social prescribing was delivered.

Social support: Figure 10 shows a positive change in the number of individuals (relatives, friends or neighbours outside their home) service users would be willing to ask for help with groceries, finance and advice. The vast majority of respondents (between 30-50%) rely on 'one or two' individuals in all categories of support, and relatively fewer (under 30%) rely on more than two individuals. Overall, this shows a positive change in the 'quality' of social capital.

Overall, it can be concluded that over the period of the delivery of social prescribing, there has been a positive change in social capital across both dimensions, although it is difficult to draw firm conclusion without the presence of a comparison group.

Figure 9: Social Networks as a measure of social capital



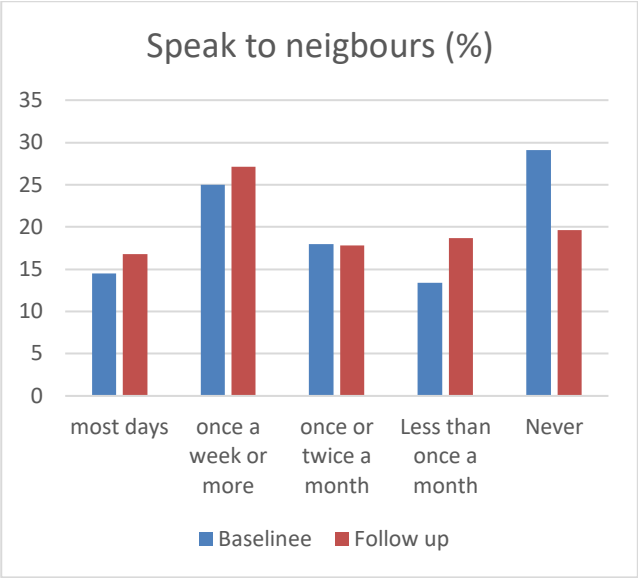
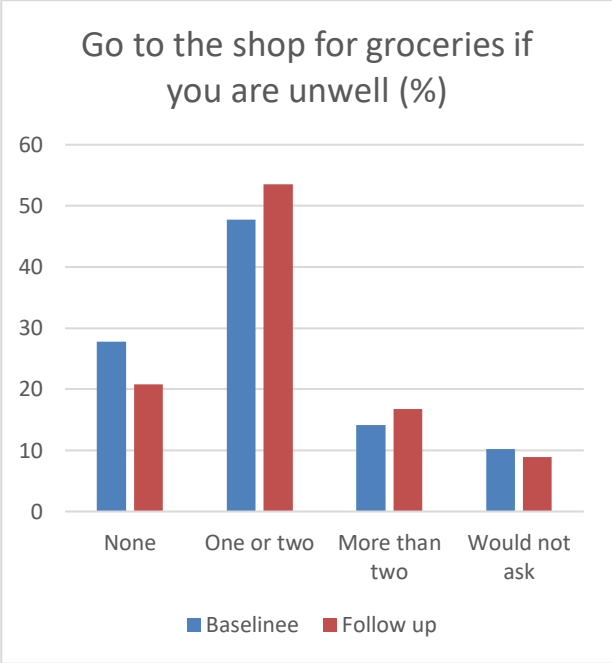
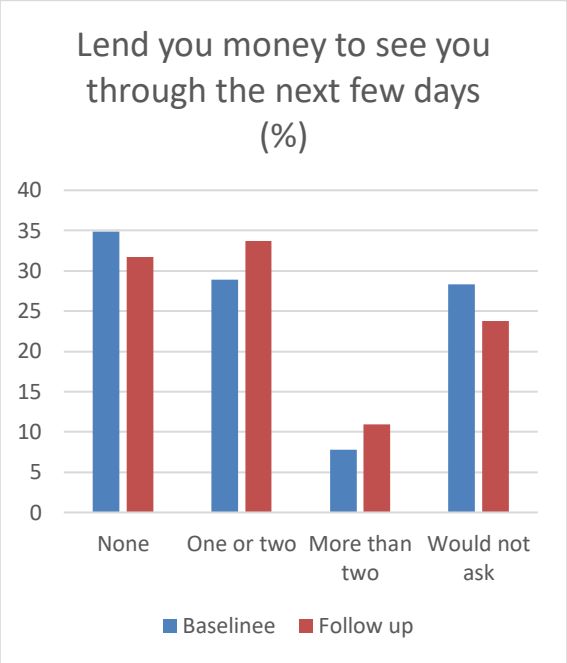
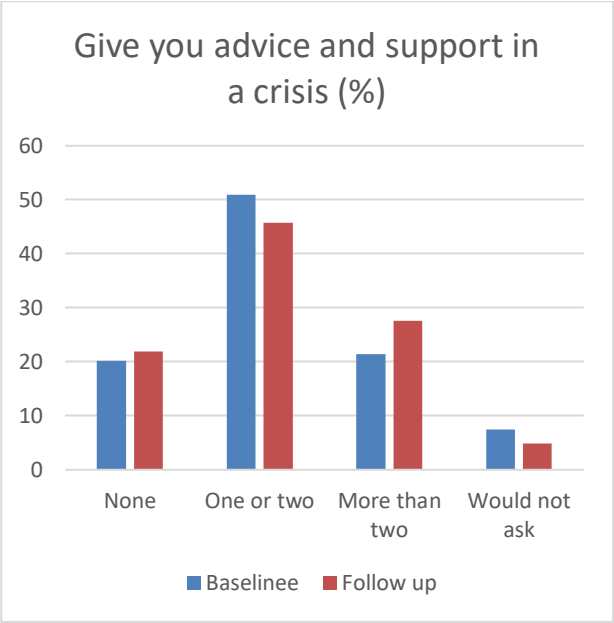


Figure 10: Social support as a measure of social capital







6.2 Process evaluation

The process evaluation aimed to examine the mechanisms and contextual factors of the implementation of social prescribing including fidelity, dosage, access and sustainability.

In order to provide evidence for these, 12 in-depth qualitative interviews were conducted with service users referred into the Redbridge social prescribing scheme. These included a range of participants who have either completed the social prescribing (attendance to activities with community/statutory organisations), dropped out of the pathway or declined to engage with the referral onto social prescribing.

Further to the 12 service-user interviews, six in-depth interviews one-to-one interviews were conducted with stakeholders which included: Two Redbridge Council representatives, two members of the Redbridge

CVS delivery team, a representative from Redbridge Clinical Commissioning Group, and a General Practitioner. A focus group with eight Health and Wellbeing Buddies (HWBs) and Social Prescribing Advisors (SPAs) also took place. Responses are presented below.

6.2.1 Fidelity of implementation

Fidelity examined whether the implementation of social prescribing met the original goals and what elements of the implementation worked well and what elements did not work so well and need to be improved.

6.2.1.1 Factors influencing the implementation of the programme

Previous consultation between key stakeholders from Redbridge Council, Redbridge Clinical Commissioning Group and Redbridge CVS had identified a need to support vulnerable patients from localities in the London Borough of Redbridge meeting at least one of three referral criteria: Type-2 diabetes, social isolation and/or low-level mental health. Learning from the existing straight signposting social prescribing service within the borough identified the need for a service that could provide more intensive and longer-term support for clients who needed help with behaviour change and accessing further support services.

"There are a lot of clients who are very capable and they don't need that hand holding so, what we say is that social prescribing is for vulnerable clients or people who need that hand holding. They might be very capable but in their life journey whatever experience that they've had using services and not getting a positive response, they have lost the confidence and our service will provide that…our goal is not to make the clients dependent on the service." Redbridge CVS representative

Change in emphasis of service

While the service was originally intended to offer more intensive support to clients than the pre-existing signposting service in Redbridge, it was originally anticipated that of the patients referred onto the pathway, only a minority of them would present in crisis. However, with a significant reduction of existing services able to meet the needs of clients in crisis, these clients became a majority:

"Background of cuts in services has turned SP into more of crisis service rather original idea of supporting people to become more socially engaged. "I think the timing of the project and what is happening in the background with all the cuts and everything, the nature of the needs of the clients we get referred are more so in terms of crisis." Senior Redbridge CVS representative

"We are seeing a lot more complex cases, so we wanted, I think right at the beginning what we were thinking was maybe 70% at a normal rate and 30% complex, now what we're seeing is, 70% complex and 30% non-complex." Redbridge CVS representative

Changes in structure of the service delivery team

While the initial concept of a co-ordinating social prescriber who triaged the work and passed on clients to the HWBs worked well initially, it became clear as the service progressed that the flexibility of the HWB role was leading to lack of continuity for clients and a back-log in the service.

"Quality of client work was not a problem, just the quantity they were able to see. We had some buddies who were taking on huge numbers, they were seeing up to 16-17 clients at one time and then we had buddies who were taking on two." Redbridge CVS representative

"Once you take on a client then we have to see them through the whole process of the first three months and then the follow up at six months. And it wouldn't be fair on the client that we keep changing the Health and Wellbeing Buddy" Senior Redbridge CVS representative

Information to participants

More detailed leaflet provided to participants about what to expect from the service given out by SP team at point of referral, in order to manage expectations. This enables them to make an informed decision on whether they feel the service can help them. When there it is not possible to help the client with their primary presenting issue (e.g. housing) they are offered support in other areas of their life:

"So what we try to do is, kind of, we can say, 'Okay you know we've made sure that you have gone and you're seeing the right people, let's look at how we can support you in other ways, of like you know, get you in to a gardening group so you can forget about that for maybe for an hour." Redbridge CVS representative

Provision of clinical supervision

The CVS team have recently begun to implement one to one clinical supervision for all the Social Prescribing Team. This move was in recognition of the greater emphasis on the number of complex clients and those in crisis accessing the service.

"we've recently started Clinical Supervision. And I had my first one and it was absolutely amazing. I went in thinking, 'What am I going to talk about?' But as soon as she asked me one question, and it all came out

and it was really practical. It was really practical. So we were able to tell her our emotional side of it and then she made it practical, of how to deal with it practically. So that was really, really helpful," I think it's one of the greatest, it's such a good decision that we made for the service, and for the team." Redbridge CVS representative

6.2.1.2 Strengths of the implementation of social prescribing

Key positive aspects of the implementation of the social prescribing in Redbridge include the relationship between service user and HWB/SPA, the relationship between CCG, council and Redbridge CVS, support for training (particularly motivational interviewing, behaviour change) and clinical supervision.

Positive relationships built between HWB/SPAs and service users

Learning from the pre-existing signposting service Redbridge referral had indicated that people needed more time to talk about their situation and this is reflected in the findings of the process evaluation. Almost all the participants interviewed expressed positive experiences of meeting their HWB and SPAs for the first time and valued the relationship they developed with them. I report some key quotes here:

"I see she is actually trying to help me…the way she talked to me was really, really nice." (Participant 3)

"She put herself out a lot, in research, researching things that I could do. And also she, chased up the OTs [Occupational Therapists] for me, because what happens, when you need something, and you're the one asking and you're vulnerable as well, I think it can come over as being erm, 'Oh well you know, I can well and I'm not professional…when it comes from a professional, which the Buddy is they do take more notice." (Participant 8)

"She [HWB/SPA] gave me the confidence to go out there again." (Participant 8)

Passion for the work and an understanding of the importance of building relationships based on trust came through strongly from the CVS team working on the frontline of the service:

"Once I got in to it, it just made so much sense to me. I developed a huge passion for it…you don't realise how much of a difference it makes to somebody." Redbridge CVS representative

"a lot of the time we see clients who have been through the system already and they've developed a mistrust… so a lot of our time goes just reengaging them back to the service." Health Wellbeing Buddy

For one participant (10) who had arrived recently in the country with no friends or family, the relationship with a HWB/SPA who could speak their native language was a lifeline and they was successfully referred onto a specialist support organisation as well much-needed ESOL classes.

Development of service and partnership between stakeholders

A major strength of the social prescribing service is apparent in the strong leadership of team at Redbridge council and their successful collaboration with Redbridge Clinical Commissioning Group (CCG) and Redbridge CVS. The structure of the quarterly board meetings is another strength where all stakeholders are encouraged to attend and contribute. There is also often the opportunity at these meetings for new potential collaborators to share ideas and contribute to the further development of the service.

"I think it's the co-production and the governance, that have, the kind of balance between that was almost perfect and I think that has probably made it so focussed around people's needs that I think has really worked well." Redbridge Council representative

"I just love, I mean I love, it's the passion that everyone brings and wanting to work together that's why I think it works well." Redbridge Council representative

Recruitment of HWBs from the community

The importance of recruiting Health and Well-being Buddies (HWBs) from the community was particularly welcome from one respondent:

"I think the interesting thing around the buddies which I felt really excited about was that they were going to be from a pool, a group of people who were part of the community themselves." Redbridge Council Representative

"We're gonna see what kind of life experience etc, they bring in to the role, just as opposed to, what experience you have in terms of qualifications …having that experience of working with somebody on a one to one basis is really really key." Redbridge CVS representative

Training and clinical support for HWBs and SPAs

HWBs/SPAs feel well supported by the social prescribing co-ordinator who is very experienced in her role. There is recognition of the complexity of their work and the experience and personal skills needed for the role. This complexity comes with the need for HWBs/SPAs to be able to off-load to trained professionals in order to ensure their own wellbeing is safely maintained. This led to the recent introduction of one to one clinical supervision. HWBs/SPAs appreciate the training they have received, including safeguarding and

motivational Interviewing and would appreciate more diversity of training to help them feel safe and competent within their role.

"Are we good enough to be with these people?" Health and Wellbeing Buddy

"I try to remember that these people have got, these people have gone through so much… if you truly want to make an impact you need to …persevere, you need to know that, you don't just give up if somebody says no to you." Redbridge CVS representative

Focus of service and bespoke courses

"Motivational interviewing. So that's the key strength and that's where we think social prescribing shines, it's for those people who are not accessing service." it's actually mediating between the client and their own wishes, so who is it that they're not going in to that service? So I think that's the huge strength, and that's what we train our team in to." Redbridge CVS representative

There is a general consensus among stakeholders that the original aims of the project have been met, particularly in the in-depth support given to clients. Bespoke courses with Redbridge Institute have been successful – especially around confidence and assertiveness training:

"we have our own kind of range of services within the organisation which is a plus point…volunteer centre or if someone is looking for employment you know, writing a cv or how to appear for an interview…the existing voluntary sector and the range of services they provide is also a plus point." Senior Redbridge CVS representative

6.2.1.3 Challenges with the implementation of social prescribing

Overall, the key challenges of implementation of the service include lack of communication about the service to users, some inappropriate referrals where service users was too high threshold for HWB/SPA support, and the lack of follow on support where requested.

Knowledge and understanding of service

For the most part service users claimed to have received little information on the service and several participants said they would have liked more. One participant (7) felt the GP was "trying to get rid of her".

GPs themselves also did not necessarily appreciate the full potential of the service, particularly the opportunity it afforded patients to discuss their challenges in more detail. However, once they gained more

understanding of what the social prescribing service had to offer, most of the participants interviewed felt that it was a good idea and would recommend it to others. There was also a lot of confusion of social prescribing with other services, particularly social services and participants were unclear about what scheduled meetings were for, how many sessions they were going to have with their HWB/SPA and when or if they were going to see them again. One participant was very unhappy that their details had been passed onto a third party in order to provide practical support.

"After the second time I forgot who the hell they were, and I didn't know who they were, and where they from, and then the last time, I think the second before the last time I asked, 'Who are you? Where are you from?' And they gave me a leaflet and I thought, 'I don't know where they're from." (Participant 12)

While the CCG supported the social prescribing team to attend general practice network meetings, maintaining the visibility of the service could also be a challenge. Some GPs initially engaged in the service but then lost momentum, while others were consistently hard to engage.

"We had GPs referring, there was that initial boost and then everything tapered out." CCG representative

Inappropriate referrals

While referral rates overall are felt to be relatively steady, practices and localities vary in their referral numbers with some practices providing most of the referrals to date and the others little or no referrals. As with other social prescribing schemes, there is a tendency for the service to be seen as a 'dumping' ground.

"we are seeing people who actually have a physical barrier to communication like dementia, Alzheimer's, and other kind of mental health needs." Redbridge CVS representative

However, this is recognised by senior stakeholders in the service and is addressed with those particular practices and GPs concerned.

"We still have those GPs who are kind of, 'Oh I don't know what to do with them, let's give them to social prescribing…those that are referring are referring very well, sometimes too well so they're giving a lot more than they're supposed to. And then we have those GPs who are not referring at all." Redbridge CVS representative

"Some GPs or professionals got confused and thought it was something different, it was you know, 'You're going to change the world with Social Prescribing' you can do everything." Redbridge Council representative

Greater follow-up from service

Although for the most part, participants felt able to contact the social prescribing service themselves, they were usually unsure who to contact. Several participants said they would have liked more sessions and greater follow-up from the service, particularly when referrals and signposting did not go to plan. In the case of one participant (3) experiencing mental health challenges, they would have liked their HWB to "reach out more". Not wanting to go alone to a session was a barrier for one participant and two participants were referred onto support organisations that they did not qualify for, or had to pay for, and several others found they were either unable to get through to signposted services and gave up trying or faced long waiting lists for referral organisations.

'I'm being honest because it wasn't very good in the beginning, it was a waste of time.' (Participant 8)

6.2.2 Dosage

The Redbridge social prescribing team collected data on the activities service users were referred to and attended. This is an important information in order to assess the types of services users were referred to and whether they attended such services.

Figure 11 shows the types of activities and support services users were referred to and those they actually attended. Overall, 183 respondents were referred to 421 activities and services and attended 255 of these (61%).

This may be due to different reasons including the person is unreachable, distance, time of activity, waiting lists. There is evidence from other evaluations that some services tend to be oversubscribed and therefore waiting to access activities or services may have put off the user from attending altogether.

The types of activities[6] are a mix of health (e.g. mental and physical) and social support services (e.g. social networking, training). 'Social networking' is the largest category, followed by 'mental health/well-being' and 'Training'. However, it is important to note that training included a large number of people referred to 'confidence building' courses. The importance of mental health/wellbeing for people who are socially isolated and lonely is not at all surprising as there is a clear association between social isolation/loneliness and depression/anxiety (Erzen et al. 2018).

[6] It was sometimes difficult to place activities or services in specific categories. Social networking included Age UK unspecified referrals, lunch clubs, attendance to mosque; physical activity (e.g. yoga, netball, walking groups); mental wellbeing (e.g. talking therapies, mindfulness, counselling, PTSD); arts and music (e.g. library, art classes); benefit advice (e.g. food vouchers and general legal advice); mobility support (e.g. Taxicard); Health advice (e.g. healthy eating, MS, Age UK fall prevention); training (e.g. IT support, confidence building)

Figure 11: Activities and services referred and attended

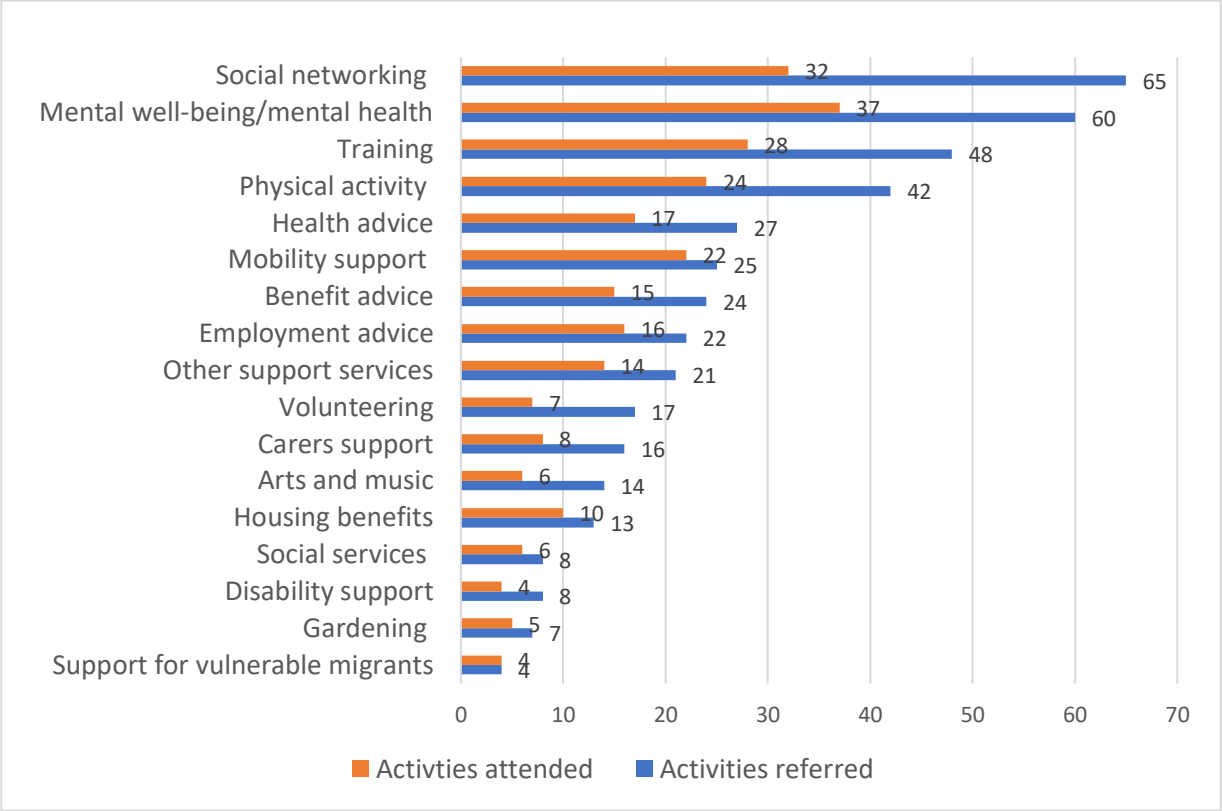
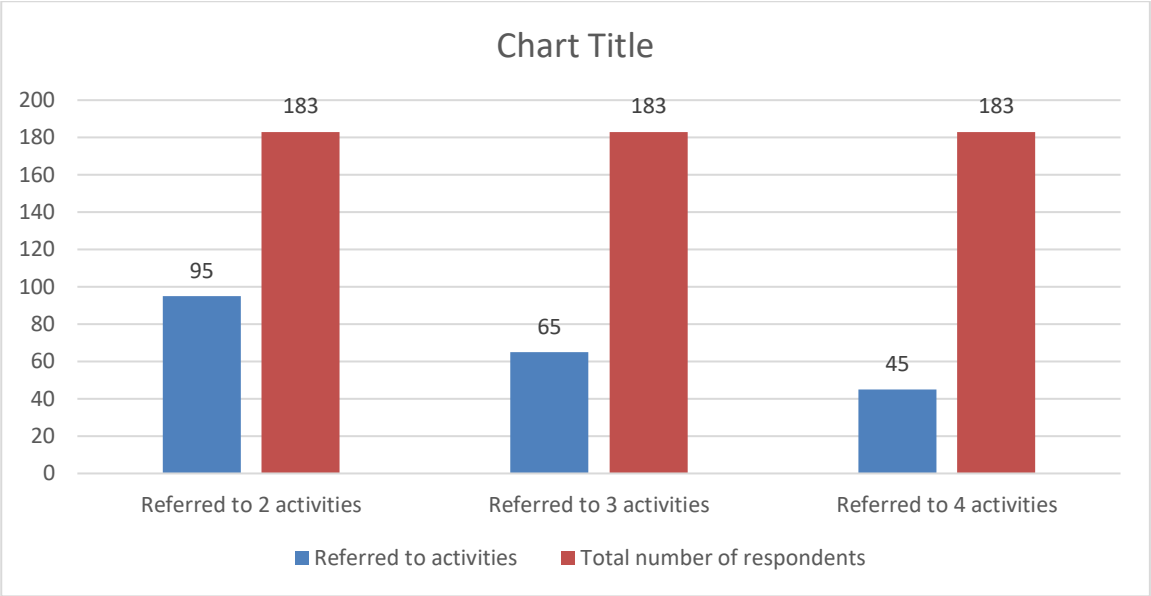


Figure 12 shows the number of SP service users who have been referred to two, three and four activities/services. About 52% of respondents have been referred to two activities/services, about 35% to three activities/services and 25% to four services/activities. This shows that service users often present with complex and multiple needs and therefore need multiple forms of support (e.g. mental well-being and fall prevention).

Figure 12: Users referred to multiple activities/services



6.2.3 Access

The evaluation sought to collect information about the level of access of service users to activities and other support services. Service users commonly reported having to wait 3 or 4 weeks between referral by their GP and the for their first appointment with their Health and Wellbeing Buddy. In two instances service users reported waiting between six and nine months for their first meeting with their HWB. However, as many service users were unclear as to whether these appointments were with their HWB or another organisation, the reported waiting may have been post HWB referral rather than in the first meeting with HWBs.

A shortage of provision of support services, particularly for the elderly, in some cases led to long waiting lists for service-users. Examples of services particularly affected include: CAB, RAMFEL, transport (dial-a-ride) and Age UK. These often led to ongoing or closed/no-outcome records for those service users who could not progress at this stage. This was also very frustrating for their HWBs as all the work of their sessions together would go unrecorded.

6.2.4 Sustainability

When asked about the long-term sustainability of the Redbridge social prescribing scheme, all the stakeholders felt that it would continue and potentially expand, with the main question being how it fitted with other existing services and the restructuring of health delivery at a national level.

"I do see a future for it because it's something that central government is interested in and they have provided a funding, because funding is one key issue for service…What it will look like going forward I can't say for sure now because the PCNs (Primary Care Networks) need to agree what they want to do and they are having discussions now. But certainly, we will have social prescribing and that's good to know." CCG representative

"we can sense the commitment from our commissioners that they want to make it really kind of embedded within the health and social care remit and they want to expand it." Senior Redbridge CVS representative

Redbridge Council representatives were interested in developing a more family orientated service in future and there was also acknowledgment of the need to work with others to maximise resources and avoid duplicating services.

"We're looking at social isolation and loneliness strategy for the local authority. So one of the things that we've done an evidence review for them to consider that as a working group and to come up with a strategy and recommendations. So I think that will, this is again planning for future." Senior Redbridge Council representative

"we're not going to look at savings just for the NHS we're also going to be looking at savings for the wider social care. Because a lot of these patients, I know, anecdotally they also, if they can't get to GPs then they would, go to the front of the social care." Senior Redbridge Council representative

6.3 Economic evaluation

6.3.1 Social Return on Investment

There are many different approaches to calculate Social Return on Investment Fujiwara and Campbell, 2011). One of these is the well-being valuation method which enables to place a financial value to each point change in the Warwick Edinburgh Mental Well-being Scale (Trotter, Adams and M-K, 2017) and also to other changes in service users' including employment, volunteering, financial manageability, and training.

The combination of these value offers a social return on investment ratio. The social return on investment ratio is calculated by the difference between the financial value of outcomes and the financial value of inputs (cost).

Mapping Inputs: Redbridge CVS provided the cost for the delivery of social prescribing for the period between Nov 2018 and Mar 2020. These includes staff salaries, travel and subsistence, volunteer staff time, admin, mobile phone use, postage, rent, and clinical supervision. The total cost of delivering the service was £290,700. During the same period, the number of clients assisted was 519 which gives a cost per user of £560. This cost is higher than other social prescribing evaluations (Bertotti et al., 2015; Bertotti et al., 2017; Bertotti and Temirov, 2020). However, Redbridge social prescribing developed a unique model based on an in-depth interaction between well-being buddies and service users which requires more time as it is delivered in service user's home, effort to identify the right activity/services needed, and more time to accompany the service user to chosen activities.

Mapping outcomes: the outcomes calculated in this SROI include mental well-being, financial manageability, volunteering, training and employment. We included only information available from respondents who completed baseline and six months follow up for each outcome (about 90 people).

Establishing impact: in order to establish impact, we followed guidelines provided by Trotter (2014) which could be interpreted as strict but provide a conservative value of SROI rather than potentially falling into the trap of providing an overestimation. Following these guidelines, we applied suggested deadweight values and restricted the effect of all outcomes to one year, although it is likely that many of these outcomes will last much longer than that. In extending the principle of providing a conservative value, we also recorded positive as well as negative changes in outcomes, while many other economic evaluations only record positive changes. For instance, if respondents did not volunteer at baseline but did volunteer at follow up, the response was recorded as positive. On the other hand, if they did volunteer at baseline but did not volunteer at follow up, the response was recorded as negative, alongside the corresponding negative financial value.

In order to provide an as accurate as possible SROI, calculations include deadweight and drop-off. Deadweight accounts for attribution. How much of the changes that have recorded would have happened without social prescribing? The valuation approach methodology provides deadweight values for both changes in health and social circumstances[7].

[7] Deadweight is based on the HACT valuation methodology: mental well-being (27%), volunteering (19%), employment (15%), managing financially (19%), and skills training (15%)

Drop-off estimates the loss in the value of the outcomes in future years. In order to calculate drop-off, we followed drop off calculated in other studies which used multiple follow up points (Bertotti et al. 2020)[8]. This is to account for the fact that most outcomes will have a value during or just after the evaluation, but such outcomes are likely to lose value over time.

The final SROI is calculated over a 12 months period and on the population of respondents between baseline and six months follow up (mean 96 people). We adjusted the cost of delivering social prescribing to this population of respondents (£53,771).

Table 5 shows a summary of the net positive and negative changes in key outcomes, value of financial proxies used as part of the well-being valuation approach and HACT (Trotter 2014; HACT, 2018). The final 'conservative' Social Return on Investment ratio is £1: £2.86. It means that for £1 investment in social prescribing, the annual return for the first year alone is £2.86. As mentioned, this is a conservative estimate: if we assumed that outcomes last for four years, the SROI ratio would increase to £1:£6.42. Thus, the SROI return could range between £2.30 and £6.42.

Table 5: Outcomes and financial proxies for social prescribing

Outcome	Data source	Net change	Proxy and source	Value (£) (**)
Mental well-being	Cohort study: SWEMWBS	97 (40 net positive change)	Warwick-Edinburgh Mental Well-being Scale (Trotter et al 2014)	£137,013.10
Volunteering	Cohort Study	89 (net positive change is 4)	Volunteering (£3,249)	£5,263.29
Employment	Cohort Study	102 (net positive change is 0)	Self-employment (£11,588) Part-time employment (£1,229)	-£4,402.63
Managing Financially	Cohort Study	95(net benefit change is 4)	Financial comfort (£8,917)	£14,445.82
Skills Training	Cohort Study	95(net benefit change is 4)	Government training scheme (£9,447)	£16,059.56

(**) this values are over 6 months and include deadweight

It is important to notice here that the number of people assisted by social prescribing over the period of assessment (n= 519 people) is much larger than the number of respondents for the SROI calculation at six

8 For each year passing, drop off for mental well-being (39%), whilst drop-off for all the other outcomes is 15%.

months (n=96). Thus, the SROI for the overall population is likely to be much higher, up to five times higher if we assume that the results from our SROI calculation apply to the population as a whole.

There are some limitations to the creation of this SROI and the well-being valuation approach:

- The financial proxies were derived from large scale surveys of the UK population, rather than from the sample of social prescribing service users that completed the baseline and follow up questionnaires.
- The last scenario above is only a rough estimate of the potential SROI value for the overall population, not a true account measured through data collection from all 519 individuals. No statistical analysis has been undertaken to assess whether the profile of our sample matches the larger sample of service users.
- The cost calculated here is the cost of delivering the social prescribing service. This does not include the cost of activities or services delivered by the voluntary sector or other statutory sector agencies.

6.3.2 Health service use changes and cost analysis

We also analysed changes in A&E attendance, GP consultations, mental health services and social care services between baseline and follow up. We analysed these separately from the SROI above as the methodologies used are different and so cannot be used alongside each other. Baseline and follow up data about health service use was collected by asking respondents to recollect their attendance in the previous six months. This is not the best possible way to collect this data as it is open to recall bias, respondents may not accurately remember how many times they have used health services in the previous six months. However, given the resource constraints for this evaluation, this was the best possible option to provide an economic analysis of health service use.

This section examines the use of health and social services in the last six months including A&E attendance, and GP attendance. At baseline, almost one out of three of respondents (32.5%) had attended A&E in the last six months. The most widely used definition of 'frequent attendance' to A&E is five times or over per year (Hayhurst, Smith and Chambers, 2017). According to this definition, 7.4% of respondents were frequent attenders to A&E with one out of five respondents (20.1%), at baseline, admitted to hospital in the preceding six months. The average mean GP consultation at baseline was six visits, once per month, suggesting that more than half of respondents (56.3%) could be classified as frequent attenders to GP practices (Bellon, 2008).

At follow up, we tested whether there is a statistically significant difference between health service use at baseline and follow up. However, we could only perform statistical tests on GP consultation and A&E attendance as the assumptions for the other healthcare services were violated. We used a paired sample t-test which looks at whether there is a significant change in means between baseline and follow up. The test revealed a statistically significant difference between baseline and follow up in GP consultations (p=0.014), whilst the other indicators did not show any statistically significant change.

Table 6: statistical test of changes in health care service use

Measure	**Effect of SP**		
	N	**Net change[9]**	**Significance**
		Coef. (95%CI)	*P value(*)*
GP consultations	103	- 0.718 (**)	**0.014**
A&E attendance	102	0.039	0.726

(*) Significant p values in bold; (**) Wilcoxon Signed Ranks Test

Beyond statistical tests, all health service use indicators showed a decline over the period. The mean A&E attendance declined from 0.75 to 0.45 (-0.3).

Table 7: mean changes in health care service use

Last 6 months	**Baseline**	**Follow-up**	**Change between baseline and follow up** (minus denotes a decline in service use)
A&E (mean)	0.41	0.45	0.3
GP (mean)	4.92	4.20	-0.718
Mental health services (count)	32	19	-13
Social care services (count)	25	17	-8

[9] Net change refers to the difference in the average score between baseline and follow-up.

Analysis of GP consultation rates

A total of 103 SP users provided baseline and follow up data on the number of visits to GP in the previous six months. SP users reported, on average, 1.95 fewer GP consultations six months after interventions in relation to baseline for a total of 110 fewer consultations. We need to apply a deadweight of 27% (Trotter et al. 2014) to account for the fact that not all reductions in GP consultations are due to social prescribing. We derived financial proxies by using established sources such as Curtis et al., (2018) which estimates the cost of £31 per GP consultation. The total savings in terms of GP consultations are £2,489 for 103 people over 6 months.

The evaluation only examined 103 completed cases. If we expect the same changes in GP consultation rates and extend this to the actual number of service users (n=519) supported over the period, we estimate financial savings in GP consultations of £12,543. If we project such savings over a period longer than six months, say 12 months, projected savings could be as much as £25,086. It is important to note that the calculation of these savings is only based on the cost of GP's time rather than the GP practice as a whole (e.g. receptionist) or other costs (e.g. prescriptions), thus this is probably a gross underestimate of real financial savings realised.

Table 8: Health service costs for the sample of respondents over 6 months

Health service in the last 6 months (N=102)	**Baseline**	**Follow-up**	**Net change**	**Financial proxy and source**	**Value (*)**
GP (£)	£15,345	£11,935	£3,410	£31 per consultation	£2,489
A&E (£)	£6,720	£7,360	-£640	£160 per attendance	-£467

(*) this is the value in the six month period including deadweight; minus values indicate increased cost from baseline;

Analysis of A&E attendance

A total of 102 SP service users provided baseline and follow up data on the number of visits to A&E in the six months prior to data collection. NHS Improvement (2018) provides unit costs by point of delivery for

A&E attendance (£160 per patient per attendance)[10]. Most people (n=69) did not experience any changes in the period, whilst a marginal number of users experienced an increase in A&E attendance over the period (n=17 increased over n=16 decline). Overall, if deadweight is considered A&E costs has increased by £467.

7 Discussion

This section of the report summarises the key points emerging from the results section and its policy implications for the further development of social prescribing in Redbridge. Although most of the data collected pre-date the beginning of the pandemic, we discussed some implications of this work for the development of the service during the period of the pandemic as the latter has introduced a range of challenges but also opportunities for the future implementation of social prescribing.

7.1 Demographic profile

The demographic profile is broadly in line with the target group for social prescribing. There are some differences between the sample of respondents and the population of Redbridge. Over 50% of the sample is over 65, compared with only 12% for Redbridge (
Table 2), primarily due to the target group of social prescribing in Redbridge which is primarily the socially isolated. Two out of three were female (63.8%) to only 50.5% for the borough. The age and gender distributions also reflect the findings from other social prescribing pilots (e.g. Kimberlee, 2016; Bertotti et al 2015). Nearly half (46.2%) of service users live alone and three out of four respondents (75.7%) had a long standing physical/mental illness. The BAME (Black and Asian Minority Ethnic) representation in the sample is lower than for Redbridge (42.1% compared with 57.5%). It is important to remember that the population of respondents to the survey may differ from the population of Redbridge service users.

7.2 Quality of life, mental well-being and health

Positive statistically significant changes between baseline and follow up were recorded for quality of life, mental well-being and health. Although quality of life is still far from the national average (**Error! Reference source not found.**, p.14), all components of quality of life – mobility, self-care, usual activities, and anxiety/depression – except pain/discomfort recorded a decline in reported problems. Changes in mental well-being have been both statistically significant and positively meaningful (defined as changes in score of

[10] This is based on a Finished Consultant Episode (FCE) and includes elective as well as non-elective inpatients. Where two or more consultants in the episode provide care, one consultant takes responsibility and only on FCE is recorded. Thus, it does potentially underestimate the true cost of the attendance.

3 or more points). This result is corroborated by wider evidence of the impact of social prescribing on mental well-being (Woodall et al. 2019; Bickerdike et al. 2018).

NHS England has created a Common Outcomes Framework which proposes to collect specific measures across different social prescribing schemes to enable comparison across different schemes on specific measures. One of these is Office for National Statistics (ONS) 'Personal well-being' measure which is made up of four components include life satisfaction, worthwhile life, happiness and anxiety. The analysis showed that only life satisfaction showed a positive statistically significant change between baseline and follow up. Worthwhile and happiness also showed improvements, although not statistically significant. In relation to 'Anxiety', we noted an increase in anxiety over the two periods of data collection. This is contradictory with all the other data but may be explained by the problem of asking this question alongside the other three questions of personal well-being. Whilst the direction of the other three questions is from low to high (e.g. not at all happy to completely happy), anxiety is framed in the opposite direction (from not at anxious to completely anxious) which may create confusion in the respondent.

7.3 Respondents own assessment of need and health

The most important point that appears to emerge from respondents is that concerns are highly interrelated and addressing a primary concern such as 'practical support' (housekeeping, caring needs and obtaining specialist equipment) is very likely to lead to addressing other concerns such as anxiety and depression (sec 6.1.7). It is important to note here that the importance of 'practical support' is likely to be due to the old age profile of respondents whom were often asking for support with their frailty and seeking to obtain specialist equipment such as wheelchairs or other equipment to prevent them from falling. Follow up analysis shows marked improvements in practical support as well as the other two baseline concerns 'mental health' and 'social isolation'.

7.4 Social outcomes: loneliness and social capital

Analysis showed a small reduction in loneliness, particularly for people who experienced 'extreme loneliness' (6.1.8). However, this was small and Lonelinessnon-statistically significant. On the other hand, there was a positive change in social capital over the two periods of data collection. The two components of social capital, 'Social networks' as the quantity of social capital and 'social support' as the quality of social capital both improved over the period. In addition, spoken communication was the preferred way of communicating with relative and friends over 'text, email or use of internet chatrooms' and this increased over the period. This is consistent with a realist review by Tierney et al., (2020) which found that social prescribing contributes to increased trust, sense of belonging and overall strengthening of social capital. Some evidence (Woodall et al., 2018) also show that social prescribing may increase the level of social interaction and social support between individuals in the community. Wider research also shows that

people with a good range and frequency of social contacts report higher levels of life satisfaction and happiness and also mental health (Lelkes, 2010; Helliwell, 2008). There is also strong evidence of a positive association between social capital and health (e.g. Kawachi and Berkman, 2001; Poortinga, 2006).

Given the positive changes in social capital and mental well-being, we found it strange that respondents only reported small reductions in loneliness. In addition to the positive changes in social capital, mental well-being has improved significantly and meaningfully as reported above.

As many scholars found that social isolation and loneliness lead to worsening of mental health problems, we found it difficult to justify the difference results in terms of loneliness here. The only potential problem may be the loneliness instrument used. Future research should probably use other more widely used instruments such as the 'De Jong Gierveld Loneliness Scale'.

7.5 Process evaluation: factors affecting the delivery of social prescribing

The process evaluation aimed to examine the mechanisms and contextual factors of the implementation of social prescribing including fidelity, dosage, access and sustainability. The service has experience substantial changes in the model from inception with a shift from a service focussed primarily on HWBs to a service structured around the collaboration between Social Prescribing Advisers (SPAs) and HWBs with further support from SP coordinators occupied with engaging other support services both GP practices and VCSE sector delivery.

Interviews with stakeholders revealed that Redbridge social prescribing service is well-structured and responsive, supported by committed and passionate individuals from Redbridge Council, Redbridge CVS and Redbridge Clinical Commissioning Group. There is a focus on constantly seeking to improve the service and outside agencies and individuals are actively encouraged to bring in new ideas and become involved. Where there have been problems with delivery (such as the structure of the HWB role and higher than expected numbers of service users in crisis) these have been recognised and the service has adapted well to meet these challenges. The Health and Wellbeing Buddies and Social Prescribing Advisers were thoughtfully recruited (e.g. emphasis on recruitment from the community and with life experience) and well-supported. As a result, they have become a significant asset, building trust relationships with their clients and supporting them effectively.

However, there continues to be a struggle between demands to manage high number of referrals, and maintain quality and health/social outcomes in the face of ever increasing complexity of cases. Given the

positive health and social outcomes achieved via this flexible model which includes home delivery of the service where needed, coordination between HWBs and SPAs, and potentially accompanying service users to activity, it would be advisable not to change the service too much but introduce step changes and adapt slowly to new challenges, particularly the current pandemic. The current pandemic has forced significant adjustments of all social prescribing services in terms of changes to sessions delivery and the identification of additional support services to tackle additional demand, particularly bereavement and befriending. These changes may also require additional specific training for HWBs and SPAs to support people experiencing domestic violence and other problems related to being confined at home during Covid-19, particularly the more vulnerable and elderly population whom are the conventional target for social prescribing.

In relation to the experience of service users, the picture is overall positive. Even those whose experience of the pathway did not go smoothly thought the social prescribing service was a good idea and would recommend it to others. However, it is important to focus on some of the key barriers which require continuous adaptation and sense checking. Most service users had no prior knowledge of social prescribing and felt they had received little information and did not know what to expect. There was often confusion over social prescribing and other services, particularly social services. While almost all service-users found their Health and Wellbeing Buddy friendly and supportive, many had no clear idea of how many sessions with their HWBs/SPAs they were going to get and when/if they would see them again. Referral or signposting onwards did not always go smoothly and some respondents did not know how to make contact to get process back on track.

In this context, service user experience could be improved further with more formal clarification of the boundaries of this relationship including the number of sessions, frequency of sessions and clear information on how and when they can make contact with their Health and Wellbeing Buddies. HWBs/SPAs must also make it clear well in advance when the last session or contact will be in order to avoid uncertainty for their clients. Information on the remit of the social prescribing service needs to be clear for GPs as well as service-users in order for expectations across the pathway to be aligned. All stakeholders would benefit from improved feedback mechanisms detailing the progression of service-users.

7.6 Economic evaluation

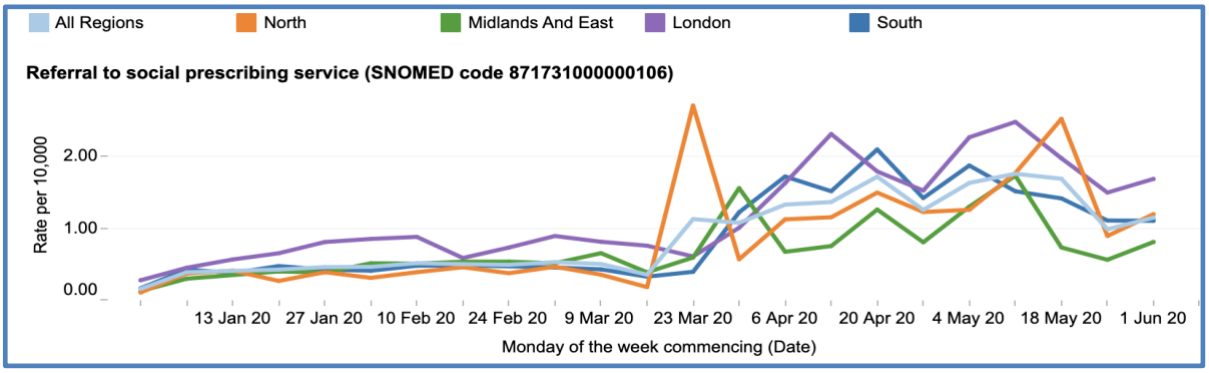
We analysed the Social Return on Investment (SROI) and costs from healthcare use. Overall, depending on different assumptions, the SROI can range from £2.86 to £6.42 for the population of respondents (sec 6.3.1). This means that for £1 invested in social prescribing, the social return varies between £2.86 and £6.42. Even the more conservative estimate is slightly higher than the average of social prescribing

schemes which is £1:£2.30 (Polley et al., 2017). The financial value of outcomes from mental well-being is particularly high £137,013, whilst employment recorded a negative value. It is important to note that this SROI is likely to be a substantial underestimation of the real SROI value because it only includes the population of respondents (n=96) rather than the total population of service users (n=519) over the period. In terms of the healthcare care use cost analysis, we found a statistically significant reductions in GP consultation rates with an associated cost saving of £2,489 which does seem to be small. However, this change is only limited to the population of respondents (n=102) and limited to period of data collection, i.e. six months. Furthermore, the calculation of these savings is only based on the cost of the time General Practitioners consultation rather than the cost of GP practices as a whole (e.g. receptionist) or other costs (e.g. prescriptions), thus this is probably a gross underestimate of real financial savings realised. More detailed analysis using GP practice routine data would provide a more accurate estimate of cost savings. In terms of A&E attendance, the data showed an overall increase between baseline and follow up, although this was not statistically significant and was of minimal additional cost (£467).

7.7 Challenges and opportunities for social prescribing during Covid-19

Although much of the data collected for this evaluation does not cover the pandemic, it is clear that the current pandemic has led to a range of radical changes in social prescribing that this scheme should consider. The social prescribing observatory[11] which provides a routine data on the development of social prescribing referrals shows that since the end of March, the number of social prescribing referrals in London have increased substantially with peaks of four times pre-Covid level (
Figure 13).

Figure 13: Referral to social prescribing services nationally



[11] The Social Prescribing Observatory is managed by the University of Oxford, Royal College of General Practice, and also supported by NHS England. More details can be found to the following link (please note that the site takes time to load): https://clininf.eu/index.php/social-prescribing-observatory-prod/

Although data on the development of social prescribing during the pandemic has only started to emerge, some of the **key challenges** include the following:

1. From face-to-face to online and telephone delivery: It has transformed the delivery of social prescribing from face-to-face primarily to a telephone-based service. This meant that link workers (Health Well-being buddies in Redbridge) need to adjust the way they deliver conversation and support users as lack of communication through body language may have somewhat weakened the conversation between link worker and service user. This is an area where further training and research is needed by for example learning from the experience of other social prescribing services which have traditionally delivered the service over the phone (e.g. Waltham Forest social prescribing). This may be particularly challenging for Redbridge as the service was primarily delivered face-to-face.
2. Adjusting service offer: In some areas, the target service user has changed to readily meet the crisis ensued by the pandemic including delivering food and medicine, and providing a brief mental health intervention over the phone. This has meant building new contacts within the VCSE sector to meet the needs of service users during the pandemic.
3. Broadened profile of service users: the profile of service users has broadened to include more people facing immediate and urgent issues such as domestic violence and extreme social isolation. This led to an increase of link workers' time spent to address these urgent cases and the increased need to development risk assessment processes and training to deal specifically with these new cases.
4. Additional pressure on link workers: home working and the need to face additional family pressures have increased the need to provide support for link workers in terms of more frequent clinical supervision and the setting up of peer support link worker groups.

It is also important to consider some **significant opportunities** which may provide a route map for a more effective delivery of social prescribing in the future:

1. Engagement of previously dis-engaged GP practices: Many GP practices that have traditionally found it difficult to refer patients to social prescribing have started doing so as the pandemic crisis pushed them to consider alternatives to their current care. This opened up social prescribing to a much source of referrals.
2. Widened and broadened access: As GP practices needed to provide timely support to vulnerable groups, they started asking link workers to use GP practices databases to contact vulnerable patients. This led to an opening up of the social prescribing service to new people whom were not know to the service previously. It is also important to remember that this may help to reduce GP consultation rates by offering link workers direct access to EMIS databases and provide an opportunity for further targeting social prescribing on specific areas of need.
3. Changes in service offer: Redbridge target group was changing toward a 'crisis' service, the pandemic is likely to have accelerated this further. In other areas of London (e.g. Hackney), the social prescribing service supported a greater number of people facing problems with accessing benefit and at risk of

housing eviction. Emergency grants (up to £200) have been made available to support people with immediate needs and other projects to support 'people with no recurse to public fund' (e.g. people with unclear immigration status) have been set up. Examples from other social prescribing schemes show that the lack of face-to-face contact pushed the emergence of online peer support groups and other online support activities (e.g. choirs).

4. Changes in the wider policy landscape: the NHS has set up recruitment of health coaches and care coordinators. Provided that a sense of coordination and coherence will accompany these changes, the capacity of the system to support people should improve further in the coming months. A big question mark remains the ability of the VCSE sector to adapt to a non-face-to-face delivery of activities. Although support from the government in the form of furlough schemes, grants and loans are likely to soften the impact of the pandemic, the medium to long-term future of the VCSE sector is extremely fragile.

8 Key Recommendations

In formulating recommendations for the development of Redbridge social prescribing, we have focussed on the evidence gathered through the evaluation as well as the recent changes to social prescribing due to Covid-19.

8.1 Preserving and adapting the current model of social prescribing

Overall, this evaluation showed statistically significant positive health and social care outcomes as well as positive economic returns. In addition, despite some challenges, service users found their sessions with HWBs useful and stakeholders responded to challenges by continuing to learn and adapt the model. Despite these positive aspects, there is a continued danger that the service may sacrifice quality for quantity in an attempt to meet the ever-growing number of referrals, and complex referrals, from primary care, especially during the current pandemic. The danger is that social prescribing may become more like a 'signposting' service where the contact between HWBs/SPAs and service users is minimised in order to increase the total caseload for each HWB/SPA. The wider evidence of social prescribing to date shows that behaviour change and support for people experiencing social isolation and facing issues with housing, employment, and frailty is stronger if trust, and empathy is built between HWBs/SPA and service users. This can only happen if HWBs are given the autonomy and flexibility to decide how and for how long to support service users. Thus, due consideration should be given to preserve a model that can be delivered to users' homes when required and continue to focus on the coordination between Health and Wellbeing Buddies and Social Prescribing Advisers. An important opportunity to integrate this and improve capacity is represented by the recent NHS announcement to recruit 'health coaches' and 'care coordinators'. Health

coaches are seen as providing more expertise and focus on supporting more complex cases, whilst 'care coordinators' are more similar to HWBs and providing support with milder cases. These could be integrated in the current service and provide additional capacity which will help to achieve quantity and maintain quality.

Recommendation 1: Continue to deliver the current service and carefully adapt to current changes due to the pandemic. The recruitment of health coaches and care coordinators may provide a significant opportunity to improve the capacity of the service and maintain the current quality.

8.2 Continued training to support complex cases

As both the recent development of social prescribing and Covid-19 have pushed HWBs to provide support for increasingly more complex cases, training would play an important to instil greater confidence in HWBs to respond appropriately. Health and Wellbeing Buddies would benefit from continued training opportunities to build their skills and confidence, particularly when working with clients in crisis.

Recommendation 2: Specific training for HWBs and SPAs may be considered in view of the different support needs caused by the pandemic

8.3 Greater attention toward informing service users

Service users lack understanding of how they are expected to progress through the social prescribing pathway. Although this information may well be being delivered by Health and Wellbeing Buddies, it is likely that their clients are not taking it in. Feedback mechanisms between each stage of the pathway could also be improved. This includes communicating outcomes of patients to their GPs by the social prescribing team as well as communication from community organisations as to client attendance. This may also help with inappropriate referrals where criteria are still not clear to GPs.

Recommendation 3: consider providing service users with written information stating: the name of their HWB and the service they are attached to, when they will have contact with their HWB next, the number of sessions to be expected and over what period, and when and how they can be contacted by the client if needed. It is also important to give service users clear advance notice of when the last session will be and when they will be discharged from the service.

8.4 Improve the rate of attendance to activities/services

Whilst at the moment physical attendance to activities and support services has been significantly affected by the pandemic, the pre-pandemic results from this evaluation show that the difference between referred and attended activities/services is considerable (61% of services referred are actually attended). There are multiple reasons for this including the service user is unreachable, distance from activity/service, time of activity/service, and waiting lists. The last of these, waiting lists, seem to be predominant in Redbridge but there is wider evidence that this is the case across London and beyond. Some services tend to be oversubscribed and therefore waiting to access activities or services may have put off the user from attending altogether. This point to the chronic lack of resources for VCSE and statutory sector provision and, unfortunately, there is no simple answer as funding from central government to local authorities has been declining for a number of years. Yet, an analysis of what types of activities/services users attend, frequency, time and location of those activities/services would help to inform future investment in strengthening the VCSE sector as well as statutory sector provision.

Recommendation 4: strengthen the monitoring of users' referrals to activities and services in order to understand where further investment in the VCSE and statutory sectors is needed.

8.5 Further healthcare resource use analysis

The economic evaluation showed a positive, above average, Social Return on Investment (£1:£2.86) for the first year (sec 6.3.1 for more detail). GP consultation rates and A&E attendance was also analysed but this was based on survey responses and recollection from respondents may have affected the results. As part of the implementation of social prescribing, Redbridge CVS collected NHS numbers for each service user. This would enable an accurate analysis of GP consultations, A&E attendance, hospital admission and use of medication by drawing on routine GP practice data available through CSU (commissioning support unit). Further to this, it would be possible to create a matched control group with the same profile of social prescribing users so that comparison can be made between service users and non-users. It would also be possible to check whether there is a direct relationship between attendance to activities/services and use of primary and secondary care services. In the past, University of East London partnered with Queen Mary university to produce similar work (Carnes et al., 2017) so it would be able to assist with this.

Recommendation 5: consider an analysis of GP consultations, A%E attendance, hospital admissions, and use of medication drawing on routine data available in GP practices.

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