Shropshire Social Prescribing Evaluation – Phase 1
Conducted by Westminster University
May 2017 to November 2018

Key Points

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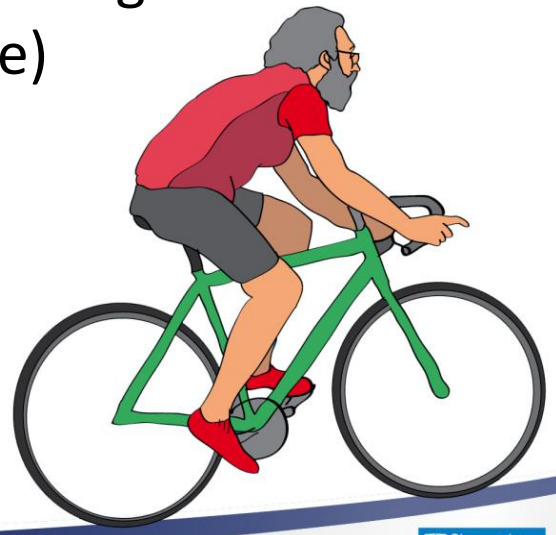
Focus of Evaluation

- Westminster University commissioned to carry out an evaluation of the ‘demonstrator site’ – 4 GP practices in the north of Shropshire
- To understand why the programme was being used and how well the components worked together
- To develop a robust service using best practice in development and data collection
- To assess the impact of key measures being used on patient outcomes
- To understand the impact of the service using a range of validated tools and measures (qualitative and quantitative)



Implementation

- **The model has been implemented with limited resources**
- Adhering to best practice and using a multi-disciplinary team approach (focus on Help2Change, community enablement, adult social care, public health)
- **Iterative learning cycles used to address local challenges during operational development**
- Evaluation built in from the outset – this added complexity

Measures Used in the Evaluation

- MYCaW – Measure Yourself Concerns and Wellbeing
- Patient Activation Measures – series of 13 statements about beliefs and patient confidence around management of individual conditions (linked to behaviour change, clinical outcomes and costs for delivering care)
- De Jong de Gierveld Loneliness Scale
- Working status and relationship status
- Patient Satisfaction Survey
- Interviews with key stakeholders and service users

Evaluation Outcomes – Impact on People

- 4 GP Practices involved
- Referrals via opportunistic and audit (Cardiovascular Risk Audit of medical records at two GP practices)
- Between May 2017-Oct 2018 – 277 referrals made
- 89 people recruited onto evaluation
- Evaluation participants – highly satisfied and positive experiences
- Statistically significant improvements in MYCaw concern scores achieved - identified people needing support for lifestyle advice and concerns relating to social determinants
- **Participants appreciated time with advisor, being listened to, feeling supported, reassured and confident to put changes into action**

Evaluation Outcomes – Impact on People

- Patient Activation Measure – improvement in agency in participants identified in the changes in the scores and in the role of the social prescribing advisor
- Patient activation significantly improved in 36% of participants at 3 month follow up with an increase in activation levels
- **Associated with reduction in health care usage and a reduction in costs for the health service**
- **Two people stopped smoking and 59% more physically active at 3 month follow up**

Development of the Model – Key Stages

- Scoping phase in 2016 interviewing key stakeholders determined the existing provision, gaps and therefore the scope
- Social Prescribing can focus on different needs according to population needs
- **Focus for Shropshire – lifestyle risk factors, low level mental health, risk of loneliness and isolation, long term conditions**
- Purpose was to identify where it might fit with existing services

The Gap in Shropshire

- **Aimed at those less likely to take up signposting without the support of an Advisor**
- **Aimed at those with low agency**
- Demonstrator site identified to test out the model
- Then translation and scaling up, to leave a legacy for the future
- Referring agencies – GP's, adult social care, voluntary sector, job Centre, voluntary sector, mental health access team, libraries

Methodology

- Single arm quasi-experimental pre-post, mixed methods, data collection
- Ethical approval via University of Westminster Faculty Research Ethics Committee
- Referrals via CVD Qrisk2 score (10% or more)
- Those at risk of loneliness or social isolation opportunistically via GP's, library, Job Centre
- **Data collection – administered by SP Advisors and at 3 month follow up**
- Data on health service usage for GP practice and hospital visits analysed

Methodology and Data Analysis

- One to one interviews with key stakeholders (13 people), including participants
- Appropriate statistical tests used for qualitative and quantitative measures
- Physiological health data collected from GP practice record or SP Advisor
- Health service usage data collected for frequency of attendance at GP practice, nurse, hospital unplanned and hospital inpatient, hospital outpatient at 3 month follow up
- Employment status
- Satisfaction of participants

Key Findings – Development of the Model

- **Shropshire's model is innovative model as very few existing social prescribing services have a prevention focus – little existing learning established**
- **Targeting health and social problems known to have a bigger impact on the population**
- **Identification of those at risk and those with low agency**
- Relieving the demand on primary care and other services
- Using a multi-disciplinary team approach – Team of Teams

Results – Phase 1 – First Cut of the Data – The Model

Design and Implementation

- **Working to core principles gives the best chance of success**
- **The service is upholding and demonstrating the core principles in a robust manner – better for sustainability**
- **Set up was systematic and iterative – action learning ethos, each step documented and operational agile management**

Design and Implementation

- Collaborative working
- Quality assurance of interventions
- Implementation challenges
- Time and part time staff with other responsibilities
- Independent evaluation brought extra work – collection of data –GDPR
- Data collection – practical challenges
- Funding and resourcing – limited budgets
- Avoiding duplication such as C&CC's

Results – First Cut of the Data - People

Service Referrals 277 05/2017-10/2018

- Expansion of service to 10 GP practices
- **Opportunistic from – Adult Social Care, Job Centre, H2Change, Oswestry library, Enable, Qube, Mental Health Access Team, Age UK, First Point of Contact, Pharmacy**
- Referrals variable (2-14)

Reasons for Referral

- Mental health issues
- **Lifestyle risk factors**
- Loneliness/isolation
- Long Term Conditions
- Catering for a wide range of ages
- **68% 40-79 year olds**

Results - People

Cardiovascular Disease Risk - audit

- 238 people invited via GP letter to use the service
- 190 successfully contacted
- **48% accepted offer of appointment**
- **52% declined the appointment**

Evaluation Specific

- 80% of participants in the ‘evaluation’ came via CVD audit
- 20% via opportunistic referrals

Implementation - Recommendations from the Stakeholders

- Use a sound methodology to develop the model, nail down the requirements of the service and evaluation asap
- Keep a data trail and record the learning
- Cultivate main sources of referral
- Data collection process needs to be factored into a real world SP project

Results – Qualitative

Service User Satisfaction

- Convenience of times
- Convenience and suitability of venue
- Feeling able to discuss concerns with the SP Advisor
- 2 participants unsure why they had been invited into the service
- **19/20 felt they were referred to a suitable intervention or service**

Person Centred
Incentive is Key

"Knowing that the SP Advisor had said to me "I'll see you in 3 months and we'll see how we're going". That actually was a very good incentive. I've been to things like Weight Watchers but the Advisor was taking the trouble to see me, giving me one to one, which I think is very important, I didn't want to let her down anymore than I wanted to let myself down."

Service User Experience

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

Follow up calls to check the client had followed up actions –

“if they hadn’t persisted I’d have just forgotten about it. If it had been just one visit to the surgery I’m sure there would have been a very different outcome.”

Qualitative Feedback

“I started going to the gym twice a week and as I say the GP’s, nobody had ever suggested it to me. This was all through the social prescribing lady that I went down that route. I now go, well mostly three times .. But I’ve lost 2 stone in weight, I feel much healthier, happier. That really sums it up”.

Qualitative feedback

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

…”Listened carefully and came up with good answers and suggestions.”

“We talked over obviously, weight issues and as to how I might go about doing this positively.”

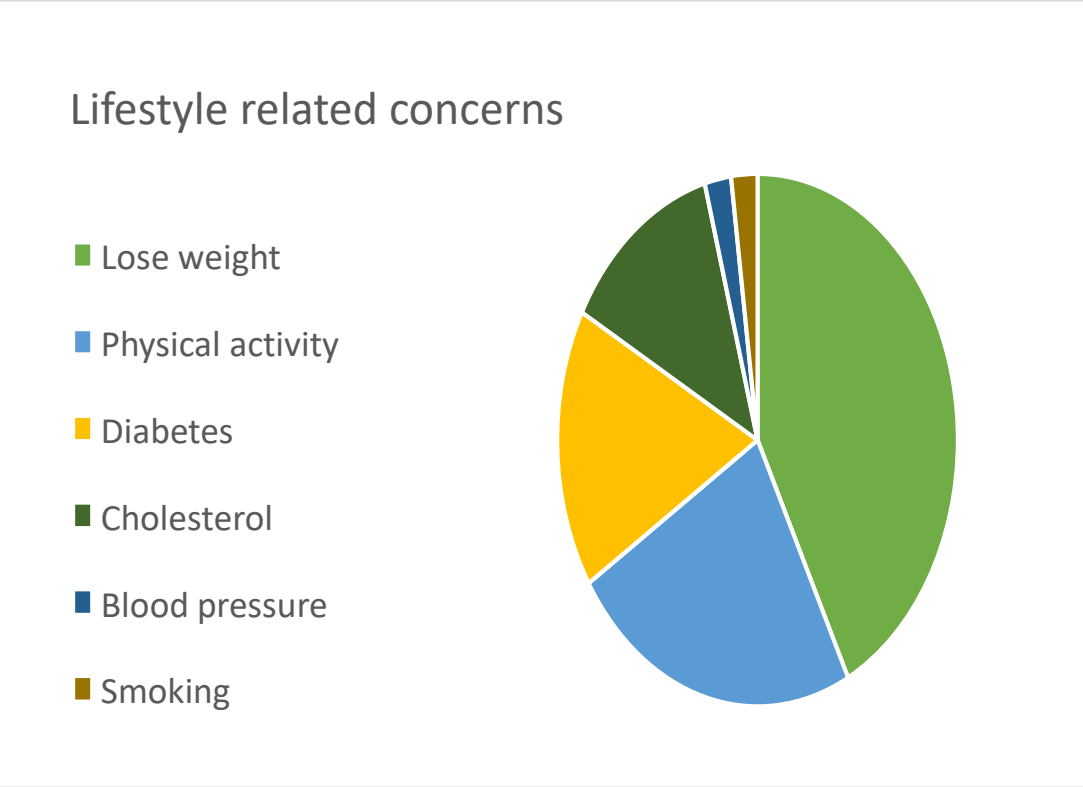
The Value of the Social Prescribing Advisor

- Involvement with the referral, the relationship developed and the incentive
- Most participants recalled a follow up call from the advisor following the GP letter (CVD audit)
- One to one meetings are central – co-production, discuss health and social needs, develop a plan
- All recalled their first meeting with the advisor
- **An appreciation of length of time allocated to explore personal health needs**

Impact of the Service – People

- MYCaW allows an individual to voice what is really important to them
- Person centred aspect of social prescribing
- 80% referred for risk of CVD – only 53% wanted support to change a related risk factor

Lifestyle Concerns Expressed by Participants - Risk Factors That can be Changed

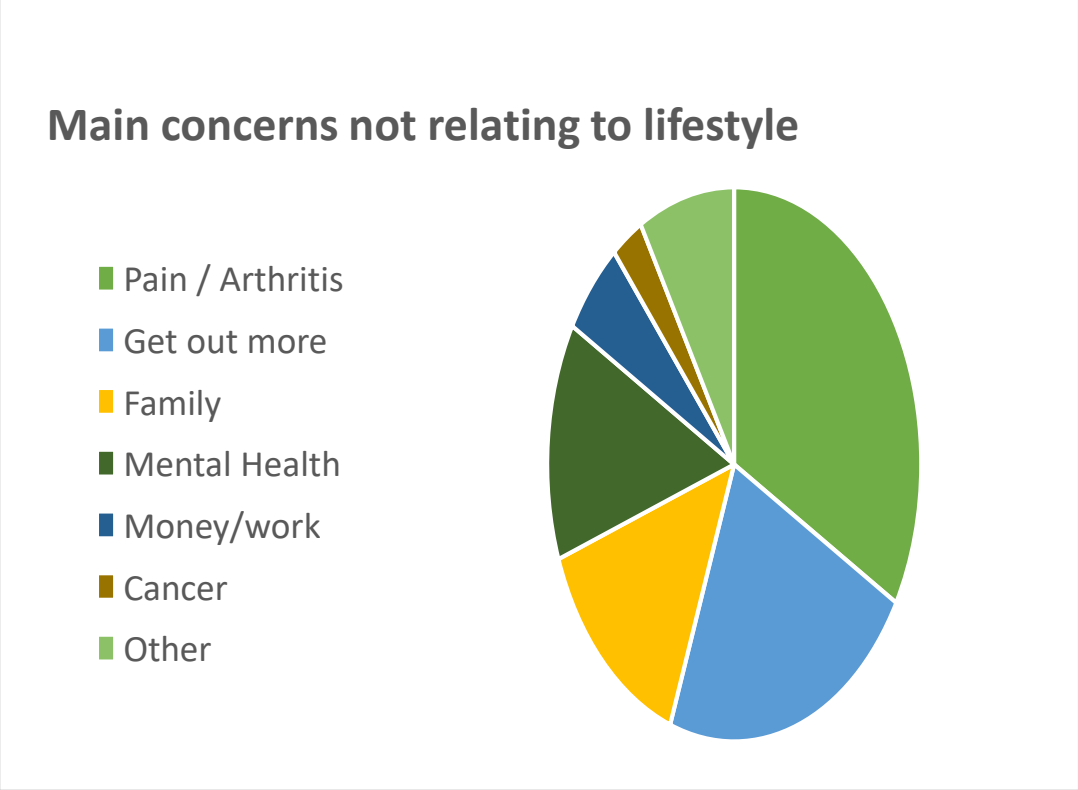


- 80% referred due to risk of cardiovascular

BUT

- Only 53 % wanted support to change those risks

The Unmet Needs Identified at Initial Meeting



- 40% had other concerns such as pain and arthritis
- Other non health concerns – family, money, mental health
- People also wanted to get out more
- 36 people had only one concern

Findings - Changes in Concerns and Behaviour

- Improvements in concerns and wellbeing scores – unmet need had been supported
- Modest improvement in overall wellbeing at 3 month follow up (not stat significant – need more data)

- Follow up – query around anything else happening in life – 25 people responded
- 9 had other health issues
- 5 reported on-going concerns with money and family
- Positive changes highlighted relating to changes in behaviour (diet, physical activity)
- At follow up

Feedback – MYCaW – This Measures Concerns – 1 month and 3 month follow up

Information and guidance

- Both associated with patient activation
- Good to have the chance to talk to someone specifically about health and well-being. Prompted dietary changes
- Activation also demonstrated by changes they had made themselves

Referral out to the group/intervention

- Referral to active Buddies and info/advice
- Increasing physical activity levels, improved health and mood. I am walking 1.5 miles twice daily.

Patient Activation – assesses confidence, knowledge and ability to improve a person's health

- Series of 13 statements
- PAM scores highlight level of activation 1=least activated, and 4=most highly activated
- After social prescribing more participants with highest level of activation and overall reduction in Level 1 and Level 2
- At 3 month follow 36% of 33 people had significant improvements in PAMS scores
- Data can also be used to assess low activators and high activators (interventions can be tailored and/or resources used appropriately)
- Increase in the proportion of HA's at 3 months

Statistically Significant Improvements – focus on 2 of the questions

“I have been able to maintain lifestyle changes like healthy eating or exercising.”

“I am confident that I can maintain lifestyle changes like healthy earing and exercising even at times of stress.”

- The data from PAMS correlates with the service user experiences of the service and what they found more important – see you in 3 months (incentive)
- All but one opted to pursue an activity or intervention suggested

“I haven’t got time to go to the hydrotherapy pool now because I go to the gym 3 times a week”.

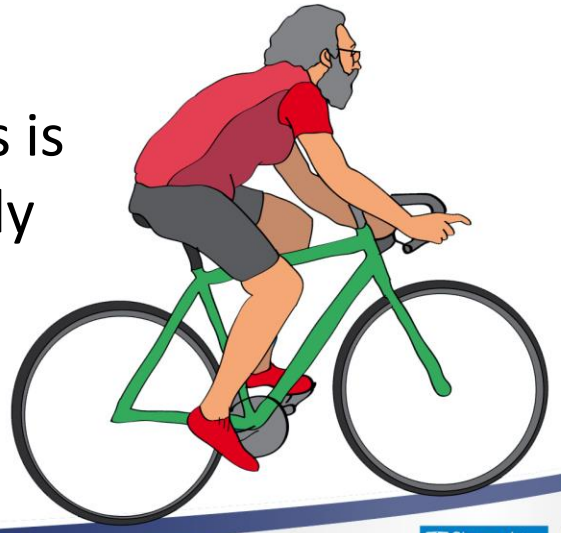
Results on Physical Health and Behaviour

Physiological Data – Changes in BMI

- 14/16 reported a weight loss at 3 month follow up
- 8/16 reported a weight loss of 3kgs or more
- 1 overweight person returned to normal weight
- 1 person moved from obese to overweight

Physical Activity and Smoking

- **19/32 (59%) reported increased physical activity**
- **2/3 had stopped smoking**
- The potential of the service to improve modifiable risk factors is considerable especially for CVD, diabetes, cancer.



Health Service Usage

- **All improvements in Patient Activation are associated with reduction in health service usage data**
- All available data was analysed comparing service usage in the 3 month prior to the first consultation and the 3 months prior to follow up
- **Although a small dataset there was a statistically significant reduction in GP visits**

Important Aspects of the Data Collection and Governance

- The patient record is key
- Social Prescribing Advisors input data onto the record
- Data sharing agreements
- PharmOutcomes used to access data

Loneliness and Social Isolation

- 22% of opportunistic referrals due to loneliness – small numbers in the evaluation cohort
- Disappointing but important to recognise wishes of the individuals taking part or not
- All 33 participants asked to complete the De Jong but loneliness not a key issue however further data is being collected in phase 2.
- Very small reduction in emotional loneliness, but no overall change in total loneliness (participants recruited for CVD audit did not appear to need support for risk of social isolation or loneliness
- 6 opportunistic referrals made for loneliness and 8 people reported MYCaW concerns, at 3 month follow up this reduced (but small numbers).

Conclusions from the Evaluation Report

- The shift from theory to a developed service has been challenging but immensely rewarding and a positive learning experience – testing things out, pause, reflect, act
- User feedback is positive – they are feeling heard and supported and needs being met not as a condition or disability but as a person
- Patient reported outcome data is demonstrating statistically significant improvements in concerns.
- There is improvement in activation levels and wellbeing
- There are improvements in physiological changes – physical activity, weight, smoking
- Real life examples of changes in action and underlying reasons why the SP Service has triggered changes have been captured through questionnaires and feedback
- Significant reduction in GP appointments for participants at 3 month follow up
- Data collection ongoing to phase 2

Conclusions from the Evaluation report

- Shropshire SP approach is closely aligned with the most recent Public Health Strategy – Prevention is Better Than Cure (2018)
- Also has the potential to reduce the need for core aspects of Adult Social Care services
- The concerns people reported demonstrate the advisor was supporting individuals with a range of issues relating to ASC
- The service seeks to address real life social complexity and inequalities by offering integrated, holistic, solutions to multi-faceted health and care issues.

Last Word from one of the Participants

“Do it without a doubt”.

Recommendations

- The Social Prescribing team discuss the intention and benefits of the service with GP's to develop more relationships to lead to increase in referrals and integration of social prescribing into the GP consultation
- Review referral processes to ensure that people who see the SP Advisor have concerns that need addressing and are clear on WHY they are being referred
- Attention is given to informing service users if the SP Advisor is going to change
- More people are directed into the evaluation from opportunistic referral
- Review on the collection of physiological data is undertaken

Phase 2 Evaluation Taking Place Now

- Opened up referrals from other practices
- Increased number of follow ups – end of February 2019
- Participants will be followed up until the first week in June; data will be analysed and written up by the end of July 2019
- Target of 100 people **followed up** in the evaluation.
- Further data analysis including analytical statistical analysis
- Use of comparator data with a population not receiving social prescribing