# Social prescribing evaluation report for 2022/23

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## Summary


- The Social Prescribers have received 1063 referrals during 2022/23.
- 851 were from GPs or practice staff and 206 were self referrals or from external agencies.
- The main referral reasons are for social isolation, support with money, debt or benefits, employment and training, lifestyle, housing information and advice and support for Carers
- The evaluation data is leaning towards improvement in mental health after working with a Social Prescriber, despite the incomplete data. See main report for more detail.
- In 2022 we introduced a Young Persons Social Prescribing service which was funded by the council and Hyde Housing association.


## Successes

- The service works well when the Social Prescriber is able to develop a good working relationship with practice staff through a regular presence or by attending Multi Disciplinary Team (MDT) meetings.
- Having the service hosted and supported by the local authority means the team can work closely together under one manager. They have access to other council teams that support them with referrals eg housing, benefits, communities etc
- We have some fantastic examples where people have been able to turn their lives around because they have been supported by their Social Prescriber. Often people just need time, support and guidance.
- The introduction of Care Coordinators, Health and wellbeing coaches and now Mental Health Coaches has led to some early positive outcomes for the team with much more opportunity for joined up working.

## Challenges

- Not having access to the GP patient record system creates more admin and makes it harder to feedback to GPs. It also means we are unable to fully measure the impact of the service and, therefore the investment, on Primary Care.
- Building meaningful working relationships with those practices that are unable to accommodate the Social Prescriber due to lack of space.
- Managing the volume of referrals and complex people. The demand for the service is growing and effectively each practice has around 0.5wte of Social Prescriber time. We could happily double that and still be busy.
- We have found an increase in working age people who find themselves out of work because of work/life related stress and would welcome discussions around focusing on this group as the Proactive Social Prescribing topic in the future.
- The Young Persons service has been slow to develop. It is difficult to reach young people and gain their trust in a new service.

**Plans for 2023/24**

- Secure funding for 2024/25 and beyond
- Gain a better understanding of the reasons why people do not engage with the service and why this varies across the practices.
- Gain wider support and funding for the 'antidote to loneliness' work with Creative Routes Alliance, providers of complimentary activities.
- Work with NHS Sussex to progress a digital platform which will make evaluation of the service much more effective.
- Working closely with the other primary care roles will be essential moving forward, to share learning and also support people to move in a coordinated way between the different services.
- We will continue to develop and publicise the young persons service with a view to an all ages services being funded in the new GP contract.

**Main report**

Social Prescribing is a person-centred service, always putting the needs of the patient at the heart of the work and it is important that the language we use reflects this. So, throughout this report I will be referring to patients or clients as people or individuals.

Social Prescribers provide an opportunity, for people to talk through some of the non-medical issues in their life, which may be having an adverse impact on their health and wellbeing. During the appointments, the person can discuss ways to improve how they feel and explore opportunities for them to connect to the practical or emotional support available in their community. Some people require a signposting or referral, and others may benefit from some support to make a change. At the heart of social prescribing is what 'matters most to you' and as such the 'softer' outcomes are just as important as the numbers that demonstrate value for money. With this in mind, this report focuses on 2022/23 and includes both quantitative and qualitative data.

The service is funded by the two Primary Care Networks (PCNs) in the district Chichester Alliance of Medical Practitioners (CHaMP) and Rural North (RNC). The requirements for the service are set out in the Primary Care contract. The Council was approached in 2018 to contribute funding and host the service in its early days and sees the benefit of this for its residents.

**Social Prescribing team**

The team currently consists of 6.9 wte Social Prescribers (including Team Leader and Admin Support) funded until March 31st, 2024.

During 2022 we recruited a Young Persons Social Prescriber who is able to work with young people aged 13 – 19. A contribution for this role has been made from the current service, see below, with additional funding from housing providers and Chichester District Council.

**Young Persons Social Prescribing**

The Young Persons Social Prescriber has received 23 referrals from GPs, Early Help and self referral. The gender split is more even for young people 50:50 and the age range 13 – 22. We took the decision to work with young people out of the original age range as they have additional needs.

The main reasons for referral have been around anxiety and school refusal, emotional wellbeing and social isolation, support with careers and accessing further education and training. It is too soon to report any further success measures at this time.

As the service has been slow to develop, we took the decision to reduce capacity to part time therefore extending the length of the pilot time period by a further 6 months.

**Funding / service costs for 2022/23**

NB: This does not include service management and other support costs which the council contributes inkind

**Expenditure for adult service**

| Staff | Costs |
|---|---|
| 6.9 WTE Social Prescribers (incl admin) | £235,197 |
| Contribution to YP SP post | £9,000 |
| Additional expenditure eg training, mileage, room hire | £8,504 |
| **Total** | **£252,701** |

**Income for adult service**

| Funding source | Income |
|---|---|
| CHaMP PCN (4 wte and management costs) | £136,975 |
| RNC PCN (1.5 wte and management costs) | £54,585 |
| Chichester District Council | £17,000 |
| Opening balance from 2021/22 | £116,905 |
| **Total** | **£325,465** |
| **Closing reserve** | **£72,764** |

The closing reserve for 2022/23 will be utilised for a further contribution to the Young Persons Social Prescriber during 2023/24 and a contingency fund for redundancy costs should the service be discontinued. Funding for the service is currently secured until March 31st, 2024, and future funding is unknown at the time of writing this report. It is widely anticipated that the new GP contract will include provision for an all ages service.

**Service data**

NB: 216 people are still being worked with so the data for these is not yet available

In total for the 2022/23, 1983 individual sessions were provided. It should be noted that there the amount of time spent with individuals varies considerably depending on their needs and ability to engage. Some people require home visits which take longer whereas others are happy with information provided during one phone call. During 2022/23 we introduced ‘surgery signposting’, an information sheet of local services that surgery staff can use to provide quick solutions for people, if that meets their needs, rather than waiting for a referral.

| Clinic Appointments | Phone Consultations | Home / Community Visits | Total sessions provided |
|---|---|---|---|
| 65 | 1468 | 169 | 1702 |

In total for 2022/23, 1063 referrals were made to the service. I have included the numbers of referrals from previous years as it shows how the service has picked up post pandemic and continues to be busy.

| Number of referrals to the service | June 2018/19 | 2019/20 | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|---|---|
| CHAMP practices | 343 | 282 | 319 | 698 | 708 |
| Rural North Chichester Practices | 263 | 185 | 118 | 275 | 355 |
| Total | 606 | 467 | 437 | 973 | 1063 |

**Observations**

- Referrals dipped during 2019/20 and 2020/21 due to the Corona virus pandemic
- We opened referrals to external service providers during the pandemic as numbers reduced dramatically and we needed to ensure people could still access the service. There was some initial concern that external referrals may overwhelm the service but with careful management this has not been the case as 206 referrals came from agencies other than GPs. To put a positive spin on this, 206 people were able to access the service without the need for a GP appointment.
- Additional funding was made available from CHaMP PCN for 2021 onwards to recruit new team members thereby increasing capacity within the team which is reflected in the additional referrals received in this year.
- Some of the Social Prescribers are invited to a monthly MDT meeting where they have the opportunity to discuss referrals with the team. This has led to increases in referrals for those practices as the team are more aware of the service and what Social Prescribing can achieve for people.
- Overall, 29% of people referred did not engage with the service. The Social Prescribers report a variety of reasons for this.
- When staff leave the team there is a gap in the time it takes to recruit and train a new Social Prescriber. Sometimes we have found that people no longer need the service as they have received support from elsewhere or have resolved the issue themselves. This is particularly the case for Southbourne and Wittering Surgeries who had a gap in service due to staff vacancy and sickness. Riverbank surgery have seen the most frequent changes in staff due to turn over and maternity absence.
- People may not understand the nature of the service and what the Social Prescribers are able to do for them, so found the service unsuitable.
- People may not be ready to make the changes that have been suggested or their lives are too chaotic to engage at that time.

**Referrals**

| Referring agency | Number |
|---|---|
| GP and surgery staff | 857 |
| Self-referral | 45 |
| WSCC (Social Care, PAT team) | 33 |
| Chichester District Council (Wellbeing / housing / benefits teams) | 46 |

| Other NHS providers eg Community nurse, Proactive Care, | 33 |
|---|---|
| Mental health services (Chapel Street, Time to Talk, Pathfinder) | 25 |
| Other incl Hyde, Carers Support, CGL, Job Centre | 24 |
| **Total** | **1063** |

**Observations**

- Referrals from external agencies are fairly consistent and manageable. NB: all referrals to the service are coded to the relevant practice regardless of where the referral comes from.
- Inappropriate referrals, where the patient needs another service that is outside of the remit of social prescribing, are most frequent from Adult Social Care or mental Health services.
- Each practice generally refers 2-3 people a week. The team carry a caseload of 20-30 active cases that they are working with for up to six sessions over a period of time agreed with the patient. They also manage those that have engaged but gone quiet and need a follow up and those that need to be closed and feedback provided to the practice for S1 recording.

**Other new Primary Care roles**

The introduction of Care Coordinators, Health and wellbeing coaches and now Mental Health Coaches has led to some early positive outcomes for the team with much more opportunity for joined up working. It's still very early on in the development of these new roles. Joined up working will be essential moving forward, to share learning but most importantly support people to move in a coordinated way between the different services. There may also be opportunity to run joint projects together, to offer group support to focus groups of clients.

**Recent feedback from one of the Mental Health Support Coordinators**

"Hi Karen, Thank you so much. Such a great example of working in partnership, striving for the optimal outcome for service users. I have now spoken with the client and he is engaging well with the service."

**Gender breakdown**

The majority of people referred to the service during 2022/23 were female which is fairly typical for this type of service. Male 394/ Female 669. We do not currently record other gender identities or sexual orientation.

**Age profile across the whole serevice**

| <18 | 18-25 | 26-30 | 31-40 | 41-50 | 51-60 | 61-70 | 71-80 | 81+ |
|---|---|---|---|---|---|---|---|---|
| 5 | 63 | 56 | 127 | 133 | 182 | 157 | 144 | 196 |

The age profile of referrals reflects the demographic of the district. Chichester has a significantly higher than the national average older age population which is likely to increase over time. This is also linked to higher than average economic inactivity as people retire to the area and over time become dependent on local services and have greater care and support needs. We have found an increase in working age people who find themselves out of work because of work/life related stress. The challenge is that most activities in the community are geared up to reduce isolation in older people. Which means there's a big gap for the younger people to meet other lonely people in their community, a lack of multigenerational projects.

**Reasons for referral**

NB: Referrals are usually made for more than one reason

**Social isolation (598)**

People are supported to access groups and activity in their locality such as Chichester Festival theatre and Pallant House gallery who have accessible schemes to support people into art and cultural activity. The team have developed a network for lone providers of complimentary activity to come together for support. Creative Routes Community Alliance provides, equine, art, music and creative writing therapies long with Qui Gong and mindful walks. There is a growing need for these types of activities due to the rise in working age people being referred into the service. As well as connecting people to local activities and groups and discussing volunteering opportunities to get outdoors and take care of their community – which we know leads to a greater sense of belonging for people struggling with loneliness. Rural North has a few groups where local people are supported including the new Midhurst Community Hub, Rother Valley Together, Pathfinder services etc

**Lifestyle issues (359)**

People are referred to Chichester Wellbeing service for support with giving up smoking, losing weight, being more active, reducing alcohol etc

**Money / debt advice (288)**

People are supported to access Citizens Advice for help with financial issues as they have the expertise, but often they need help to make the first approach so the team will sometimes enable this by accompanying them to a first appointment. They also refer to Christians against Poverty and Liaise for debt advice.

**Housing issues (220)**

The team have very good links with the councils housing team and meet with them fortnightly to discuss any issues that people are having with accessing the housing register. This has proved to be an invaluable relationship as they can ask questions on the client's behalf and get direct advice. More frequently the team are supporting people who are hoarders which can be extremely complex to manage. The links with local housing providers and support to pay for house clearance has proved vital is supporting people in these cases. Since the pandemic neighbour disputes are more frequent. The councils Community Safety team and Community Wardens are a great resource to tap into.

**Carers support (219)**

Carers Support West Sussex and the Carers Health team have proved to be an excellent resource for people, with groups, equipment, counselling, financial support in the form of small grants and claiming benefits. As well as more local peer and family support groups e.g. Aldingbourne Trust, Parents & Carers Support Organisation (PACSO), Reaching families, Family Support Work etc

**Benefits advice (199)**

The councils Supporting You Team are new for 2022/23, they work closely with the Social Prescribers providing support to maximise income, access benefits and budget planning.

**Employment and training (120)**

The councils Choose Work team have proved to be a good referral route for people wanting support into employment and training. The team are also able to refer into organisations with more specialism in supporting people with additional needs e.g. Workaid & Workability. Another example might be organisations like Clean Sheet, who support people with convictions to find jobs, start to rebuild their lives, and as a result reduce the likelihood of reoffending.

**General signposting (110)**

Some people are offered general signposting support as often they just need to know the best organisation to contact and can do it themselves. We have provided the practices with a signposting list so that they can support people quickly with simple requests for information.

**Long term health issues and mental health**

Mental health issues are often a contributing factor and impact greatly on people's ability to manage life, 319 referrals included mental health as a long term condition. Other long-term conditions recorded are, arthritis (72), back pain (41), dementia (55), stroke (19), COPD (27), cancer (20), Type 2 diabetes (22)

**CHaMP - Proactive Social Prescribing (21 people)**

In 2022/23 we introduced proactive social prescribing for a cohort of people who could be targeted with more focused support.

We chose people diagnosed with Fibromyalgia or Ehlers – Danlos Syndrome (EDS) as it was felt, from experience, that this is a cohort of people who present with complex social issues, who would benefit significantly from that side-by-side approach that the Social Prescribers can offer.

From December 2022 – March 2023, Care Coordinators in the practices were asked to directly contact people diagnosed with Fibromyalgia or EDS and proactively offer them the service. 21 people were referred for support. Nearly all for social isolation along with lifestyle support and for advice with money and benefits advice. Often these people were living with other long-term conditions like back pain, anxiety and depression or other mental health problems

In addition to the normal service, we proactively offered support with accessing lifestyle support via specific physical activity classes and other wellbeing services.

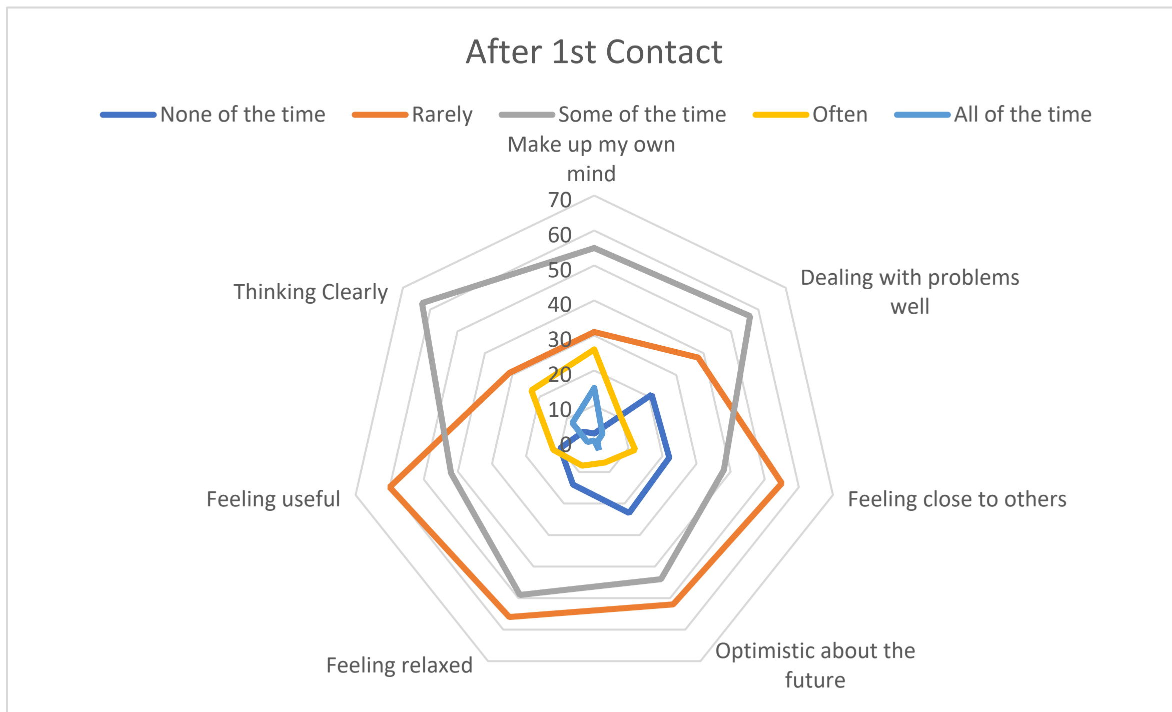
**RNC – proactive social prescribing**

Rural North Chichester worked with partner agencies to establish better connections for families with young children who have become isolated since the pandemic and cost of living pressures.

**Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS)**

The **SWEMWBS** is a short version of the Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS). The WEMWBS was developed to enable the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. The scale uses seven statements about thoughts and feelings and are positively worded within a scale of categories from' none of the time' to 'all of the time', people are asked to describe their experiences over a two-week period.

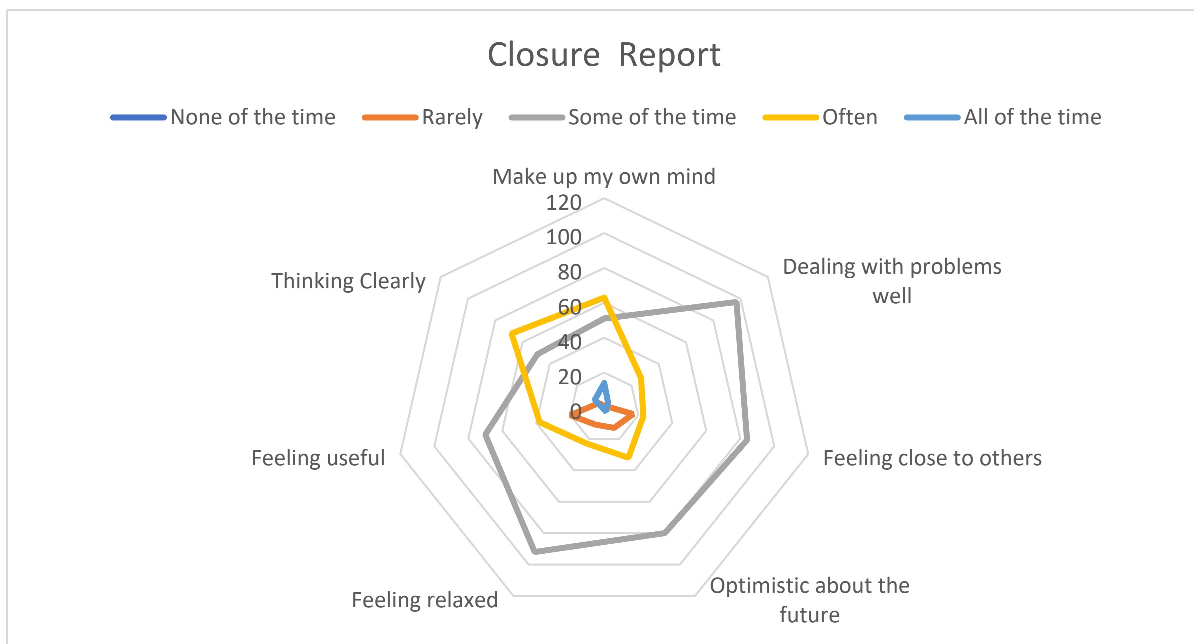
**SWEMWBS** recorded at first contact




This graph shows how well people report feeling at the time they engage with their Social Prescriber. The highest scores are for 'some of the time' and 'rarely'. When compared with the last session where more people report 'often' in these categories.

NB: it should be noted that the data recorded on the last session in incomplete as it is often difficult to collect especially if it was a short intervention or where the client is no longer engaged with the service. Despite this, the change looks promising in that many people had moved from 'none of the time' or 'rarely' to 'some of the time' and 'often'.

**SWEMWBS** recorded during the last session



**Impact on primary care**

The impact of Social Prescribing on Primary Care services is important and would enable us to really demonstrate the value this service has brought to the system. However, the complexity of accessing the IT system means that we are unable to provide this data. We do not have direct access to System One, neither do the PCN team have capacity to interrogate the data for us.

There is a definite case for investment in a digital platform eg Social RX which is tailor made to interact with NHS systems and generate reports in minutes. Other Social Prescribing services use this with great success.

**Case studies and testimonials**

To examine the impact on other services and community groups we asked some of our local services and partners the questions below.

- How do you or your organisation/group work to help the community? Please provide a brief overview of your service
- Can you provide examples of positive joint working with the Social Prescribing service
- How would you describe the impact of Social Prescribing on your work? And on the individuals, you have referred or worked jointly with?

**Choose Work**

**How do you or your organisation/group work to help the community?**

Choose Work is an employability programme supporting Chichester residents take their next steps towards work or training. We support a wide range of people and use a holistic approach to be able to support each persons' unique situation. Our requirements are simple: People live in the Chichester District, and they are ready and are choosing to move forward in finding employment.

**Can you provide examples of positive joint working with the Social Prescribing service.**

A client referred to us through Richmond Fellowship in supporting him into finding work. Unfortunately, his living conditions were so appalling, and he was shortly about to be made homeless. It was very difficult to focus on finding work when he was so stressed about his living arrangements. His mental health rapidly declined, and I was concerned as he talked about suicide. Without the help and support of the social prescriber (Kerry) I believe he would have attempted suicide. She supported him in finding temporary accommodation – he is now safely in Westwood House. His mental health has improved and just 2 weeks after he was put in the hostel, he was ready to start working with Choose Work. Four weeks later and he has now got his first paying customers for his IT coaching business and been booked to run a beginner's IT course. I would never have got him to be motivated and focussed without their help.

Another client I am working with is having multiple issues and I am getting support from Karen in helping her with these. Some of our Choose Work people have multiple and complex barriers that make supporting them in to work complicated. Karen has eased this burden. As has many of the team who I have asked for help in the past.

**How would you describe the impact of Social Prescribing on your work? And on the individuals, you have referred or worked jointly with.**

Their support is invaluable. It helps us to concentrate on what we are meant to be doing – supporting our people towards paid work. It also plays a pivotal role in easing the complex burden of issues which many of our people are experiencing. To be able to signpost them to the social prescribing team and know that each client will be handled with kindness and in safe hands is fantastic.

**Supporting You**

**How do you or your organisation/group work to help the community?**

Supporting You Service helps people who are struggling with a variety of problems and issues due to the current cost of living crisis. This ranges from completing benefit forms, helping people budget appropriately and referring people to appropriate services.

**Can you provide examples of positive joint working with the Social Prescribing service.**

Working with Karen as a joint approach to a client who has two adult daughters with significant needs which means she has been unable to obtain the appropriate benefits. Daughter and mother can be difficult so to have Karen's support and guidance and to work as a team has been invaluable. As the client sometimes only hears what she wants to hear, the fact that we can back each other up has been good to reiterate to the client what has been said or documented.

**How would you describe the impact of Social Prescribing on your work? And on the individuals, you have referred or worked jointly with.**

The impact has been positive and ongoing as we get to know each other. We have had questions and queries from social prescribers about people which I can help answer to make their job easier and vice versa. It has been good to have their support. The people referred to the service have all said that it is good to feel that they are being supported and not ignored.

**Age UK WSX Brighton and Hove**

**How do you or your organisation/group work to help the community? Please provide a brief overview of your service**

The Community Agent for Age UK WSBH work with older people 50 plus with a focus on those 65 plus to help reduce social isolation and loneliness. We focus on mapping and understanding the Chichester District area to know what the community resources are to enable those we support to engage with social groups and activities. We are also able to signpost or refer to appropriate services whether to our services or others. AGE UK WSBH also provide services such as Help at Home, Home Visiting, Support at Home After Hospital and Take Home and Settle from Hospital and Information & Advice for various queries including benefit support.

**Can you provide examples of positive joint working with the Social Prescribing service.**

Social Prescribers have taken part in the regular Older People's Network meetings organised by AGE UK WSBH. The Community Agent (CA) has maintained a good working relationship with SPs. SPs have referred people to the CA and there have been joint home visits to people. The CA has also referred to SPs. There has also been positive communication in terms of looking for services and this has worked both ways. For those people referred feedback of outcome of the intervention is communicated.

**How would you describe the impact of Social Prescribing on your work? And on the individuals, you have referred or worked jointly with?**

The SPs have been a positive and helpful resource to refer into but also to receive referrals. To be able to discuss services or fact finding about services has also proven beneficial as well as being able to discuss if referrals are appropriate or not and if there is an alternative.

The individuals have benefitted from an introduction to the CA with the SP being there for the first visit which is reassuring for those in need of this. Some people have benefitted from referrals into our Help at Home or Home Visiting Services and to the services our partners offer such as RVS' Good Neighbour or Befriending. People referred have been given information about local social groups and activities such as lunch clubs, coffee morning groups, exercise groups which has enabled them to make connections with others.

**CASE STUDY – DEEP CLEAN**

This case study provides an example of the benefits of multi agency working to achieve a successful outcome.

When we met this client, he was well into his 80s and living with complex and debilitating health and mobility issues. He explained that he had 'always' cared for his parents so had no career or family of his own. When his parents died, he managed as best as he could – alone, on a low income. He'd been brought up to 'get on with it' without complaining. He admitted to never – in his whole life - having had a holiday.

We met face to face in the community, as he said he was embarrassed to have anyone visit him at home. Things had become too much during lockdown, he said, and the house needed a good clean. He asked for help sourcing a reliable cleaner and we talked about arranging a deep clean. However, this would be beyond his means. To access any support via the Local Authority would require a home visit and he was not ready for this.

He gave consent for Social Prescriber to refer to Adult Services for Care Needs and Occupational Therapy Assessments and we gave him details for Age UK's Help at Home service.

His greatest concern, he said, was who would care for his dog if he landed up in hospital or worse happened. We discussed a plan and he said he thought his neighbour might help in an emergency.

Shortly before his next appointment with the Social Prescriber, our client collapsed at home and was taken to hospital. Ambulance staff reported self-neglect and the house being filthy and with rat droppings and dog faeces. They said there was no food in the fridge.

The referral made to Adult Services was closed when our client was admitted to hospital. A few days later he was discharged from hospital into the house without a care package. During this time, we were able to contact him on his phone and gain his consent to visit and take pictures, with a view to accessing the Minor Adaptation and Deep Clean service, West Sussex Self Neglect Multi Agency initiative. In short, this service is designed to enable isolated, ill, and disabled people to remain safely in their homes or facilitate a safe discharge from hospital. A referral was also made to the fire service for a Safe & Well check, as fire alarms were not working. The Social Prescriber worked with the GP Practice and Pro-Active Care and finally, Adult Social Care accepted an urgent re-referral.

This time the hospital discharge team was made aware of the situation. Within a week, the deep clean had been arranged by the CDC team, the home was spotless and ready for our client to return.

It's hoped that this will be a gamechanger for our client, who will now be able to stay at home safely, with the dog he loves. He'll be able to accept support offered without embarrassment, which will further improve his life and his health generally. He'll be in a position to arrange regular help with the housework and thereby keep the home as he would like it.

At the next visit, the Social Prescriber hopes to help our client secure regular help with the housework (if he hasn't already done this) and to discuss possible referrals to Meals on Wheels for him, and to the Cinnamon Trust so that his dog can be regularly walked and a contingency plan for emergency dog care can be in place.

**OBSERVATION:**

It was incredibly difficult to get our client the support he needed in a timely way. However, this was achieved in the end, because a team of people worked together to make sure it happened.

**A sense of nature- case study**

This case study shows how a small activity to support mental health and emotional wellbeing can make a big difference to a persons resilience.

K was referred to the Social Prescribing service, in need of support with benefits, her lifestyle and carers support. She has 5 children, 4 of which are disabled, who she is their registered carer for. K had been out of work long term, due to needing to care and transport her children to and from special educational schools, all over the county. She covered approximately 300 miles between schools and at least another 100-150 miles on medical appointments per week. Her children came before everything and if she wasn't supporting them, she would be attempting to support her husband. She'd simply never considered what she would do if she were to put herself first.

After completing some work with CAB for her benefits and registering with Carers Support West Sussex, for emotional and financial support, we discussed the idea of taking some time out for her. This started with the positive intention of getting out once a week, perhaps for a coffee, visiting a friend or going to the shops. After a month K decided she was ready to attempt to commit to a regular appointment and agreed to the Mindfulness walks from a medical practice.

K suffers from social anxiety and post-natal depression, so attending the walks alone was a real challenge for her. During the first walk K's phone was pinging and vibrating constantly. She resisted the urge to answer until the end of the walk, which she benefitted from, although this wasn't easy for her. Next time she left the phone on silent, removed her jacket hood (her safety blanket) and began to immerse herself in the walks and with the group.

Following the completion of the course, K took the time to provide some feedback, stating 'It has made me realise I need to slow down in life and take more time for myself and that it is ok to say no to others'. K also spoke about the course being completely different to other mindfulness courses she'd completed and put this down to the connection she made with nature and the group, saying the course gave her a sense of 'Freedom being free', which provided her the important opportunity to 'reflect on how hectic my life is but take a much needed breath, to leave that behind for even a single moment'.

K continues to attempt to get out when she can but is hoping to join another course of mindfulness walks in the near future.