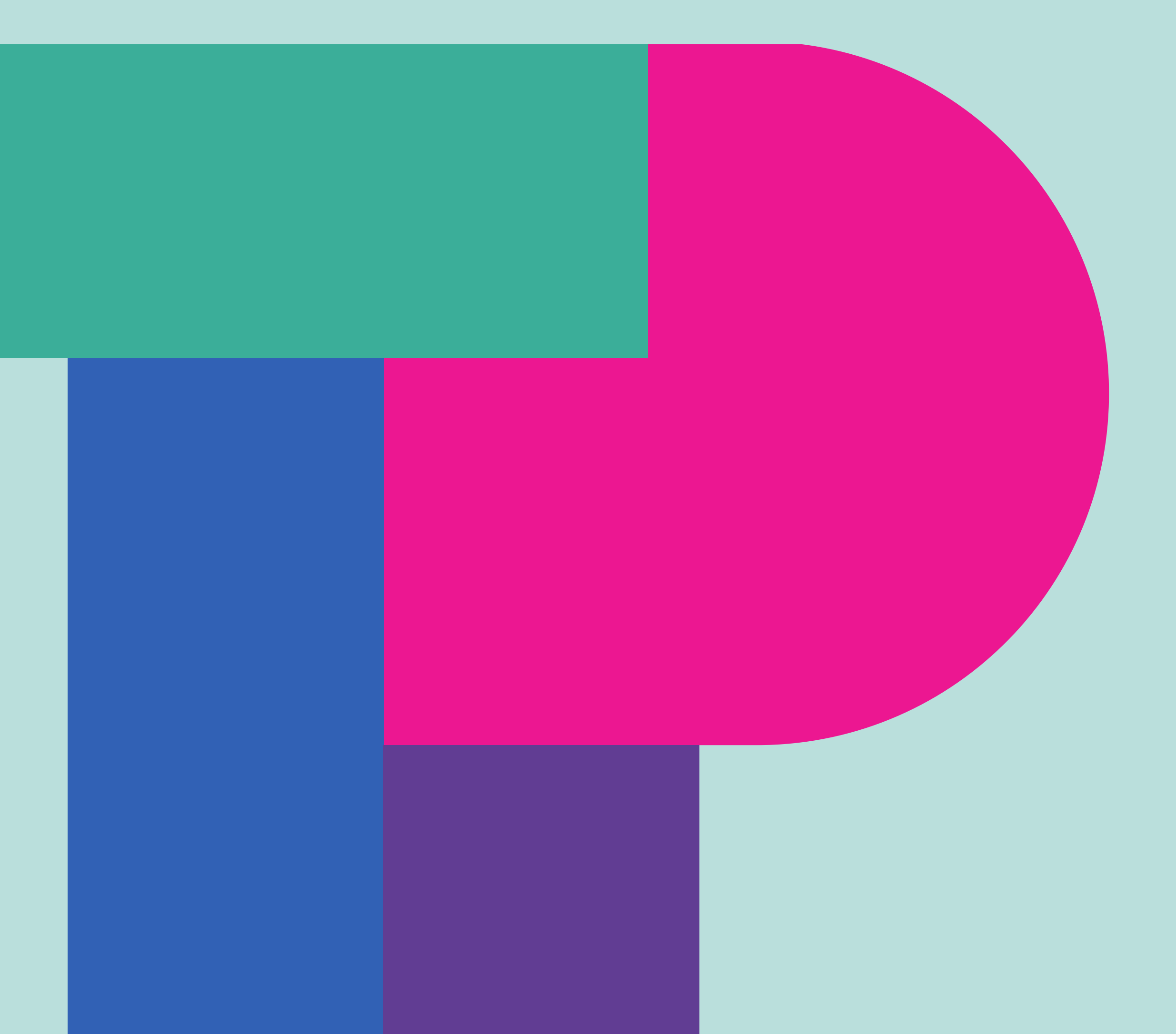


Transformation Partners
in Health and Care

Social Prescribing and evaluation across London

Approaches and examples to demonstrate the impact of social prescribing

Social prescribing and community led prevention team

rf-tr.socialprescribing@nhs.net

2024

NWL

- Commissioning Joy across all boroughs for Social Prescribing
- Working with NAPC (National Association of primary care) on evaluation. Action Learning Sets being undertaken with each borough to look at:
- Controls: Tools and Technology within the work systems; Colleagues: People's behaviours, the process used, culture of MDTs etc; Caseloads: patient management, task generation, onwards support, patient activation.
- Evaluation frameworks being designed by the voluntary sector locally and the Bi-borough partnership

Barnet, Age UK: Borough wide system for regular reporting SP data. Working with public health on yearly report and GP attendance yearly report, linking data. Elemental shares a gap report about services with SPLWs.

NCL

- Developed list of recommended patient outcome measures for SP
- Looking at what outcomes are being captured across different boroughs to understand how consistency could be improved
- ICB wide use of MyCaw as part of Long Terms Conditions work within personalised care support planning.
- Wide variety of case management systems being used
- Supports Pop health strategy

Camden: Working to embed evaluation in VCSE employers and SP, working with UCL evaluation exchange

NEL

- Pilot site for National Minimum data set work
- Developed template for EMIS/SystmOne/Joy including minimum dataset and extra information
- Data is feeding into the ICB wide PowerBI dashboard
- They hold a regular evaluation group focused on embedding ONS-4 data collection into SPLW consultations and data analysis using the dashboard

North Central London

North East London

North West London

South West London

South East London

Tower Hamlets: Co-produced 6 outcome, 40 indicator measure what makes a good life (BBBC). Rolling this out for SPLWs and wider.

Harrow: Used data from Joy on services, to support recommissioning of Housing support

Westminster: Holding borough wide group for all connector roles – called Octopus, now looking at KPIs for services, to show impact

Lambeth: Social prescribing innovators project designed a process for evaluation with SPLWs at the core including joint staff and resident feedback forums, and yearly report

Merton: Undertook separate evaluations of HWBCs and SPLWs

Hammersmith and Fulham: Healthwatch is carrying out an evaluation of the SP service

Sutton: Procured Joy and has designated a lead to implement the system.

Southwark: Feedbacks data on gaps across borough to ICBs to inform commissioning through SP oversight group.

Bromley: Collecting monthly cumulative referrals via EMIS (GP fed)
SP activity providers are running their own evaluation – Bromley Well.
Healthwatch evaluation of SP service at the patient, SPLW and GP level

Directory of examples contained in this slide pack (1)

	Example name	Led by	Purpose	Outputs
1	North East London (NEL) ICB template and dashboard	Lauren Moy, Programme Manager, NEL ICB	Establish a system wide way to measure impact of social prescribing which can be visualised to all across NEL	Clinical Template Dashboard
2	Barnet Age UK Social Prescribing reporting	Caitlin Bays, Social Prescribing Manager, Age UK Barnet	Develop set of reports to show the impact of social prescribing for multiple stakeholders and inform public health commissioning	Monthly, quarterly and annual report
3	3ST Evaluation Framework for impact of VCSE (North West London - NWL)	Fiona Hill, NWL VCSE alliance lead	Develop a framework to support VCSE organisations to show their impact across NWL in a more standardised way to support commissioning from health	Evaluation framework
4	NWL wide approach to monitoring SP data and Ealing case study	Clare Gallagher, NHS North West London Digital First lead	Enable consistent collection of data for patients on the social prescribing pathway to enable better patient management and to demonstrate the impact	Joy implemented across all 7 NWL boroughs
5	Setting up an evaluation process in Lambeth with SP teams at the heart	Alex Norman, Social Prescribing Lead, Age UK Lambeth	Demonstrate the impact of the service beyond referral targets and support wellbeing and retention of SPLWs by enabling then to demonstrate value	Evaluation process established Toolkit for others to learn from

Directory of examples contained in this slide pack (2)

	Example name	Led by	Purpose	Outputs
6	Healthwatch evaluation of Bromley GP based Social Prescribing Link Workers	Diana Norris, Lead Social Prescribing Link Worker, Bromley GP Alliance Charlotte Bradford – Programme manager, Healthwatch Bromley	To undertake an independent evaluation of the GP based social prescribing SPLWs, looking at the impact of service users, SP teams and PCNs	Evaluation report
7	Mapping social prescribing outcome measurement in NCL ICB	Sue Hogarth Assistant Director of Public Health – Camden and Islington Katie Coleman, Primary care clinical lead NCL ICB	To understand what measures are being used in NCL and develop a standardised process to enable SP teams to be confident in selecting outcome measures to demonstrate the value of social prescribing	Logic model for social prescribing Recommended outcome measures to use Guide for using both to evaluate social prescribing
8	Evaluation of social prescribing in Merton	Mohan Sekeram – GP, GP trainer, Southwest London lead for personalised care Amrinder Sehgal - Senior Programme Manager – Social Prescribing and Self-Management (Merton and Wandsworth CCGs)	Demonstrate the impact of social prescribing, particularly on demand for primary care services and support continued investment in the parties providing SP for the boroughs of Merton and Wandsworth.	Evaluation slides Continued investment in SP service

1. An ICB wide approach to understanding the impact of social prescribing – North East London ICB

- **NEL landscape**: around 14 SP teams across 47 PCNs across 7 place based partnerships – mix of VCSE, PCN, Local authority based SPLWs
- All using different systems for data capture and case management, using a mix of CRMs, spreadsheets to support
- **Formed a monthly/bimonthly NEL Social Prescribing Evaluation group** – mainly managers, SPLWs and others who have an interest – aim was to build a minimum dataset, agree the key fields, get a sense of what is out there and coproduce what the 'minimum' would look like to create NEL consistency. This group is now shifting to talking about how data and evaluation can support decision making.
- **NEL minimum data set template developed** with the clinical effectiveness group – majority of services use this in EMIS/System one. Reviewed how it was being used, continually making improvements based on SPLW feedback.
- **Worked with Bearing Point to visualise the data** in a dashboard from clinical systems>discover> BI dashboard. Data at PCN and practice level.
- **Supported procurement of case management system in two boroughs with embedded MDS template** – Newham and Barking and Dagenham now using Joy
- **Quality improvement cycles to improve template and dashboard** and Joy implementation, ongoing for >1 year now. Still working through getting all data to flow to dashboard and encourage use of template.
- **NEL supporting national implementation of MDS work** and developing a NEL wide dataset.
- **Looking to join up local data to investigate capacity gaps in VCSE sector to support commissioning from health and VCSE and identify impact of funding**

More details can be found in the appendices of this slide pack.

What's helped?

- Having quality improvement processes already set up in NEL
- Clinical effectiveness group working with different partners to develop the template
- Developing what we already had, support from clinical leads and digital experts

Challenges

- Not having GP IT system or case management – so can't contribute to dashboard without double data entry

The Dashboard

- Number of referrals, declined, not suitable referral reasons, support offered + trends and rates per population
- Age, ethnicity demographics, employment, living situation, carers
- Information about data completeness
- ONS scores

2. Barnet Age UK Social Prescribing reporting

Overview

- Social Prescribing Manager (employed by Age UK for 6/7 PCNs across Barnet and part funded by public health) leads on reporting for the service and creates reporting for PCN they do not manage
- Collect data through both Elemental (all PCNs have access) and EMIS (EMIS provided GP fed analyst)
- VCSE organisations have provider access to Elemental and hosts a public facing directory for them to upload details e.g. capacity, service remit, and generate reports around their demand
- Monthly, quarterly and annual reporting to PCNs, CDs, GP Fed, public health, Age UK, ICB (monthly)

What does the monthly report contact?

- Service Referrals per PCN vs DES target (upper and lower).
- New referrals and re-referrals by Practice
- Referral reasons
- Number of appointments and duration
- Wait list update.

What does the quarterly/annual report contact?

- Monthly trend of referrals
- Appointment details – contact types
- Demographics and referral reasons
- Where people are signposted and referred to – showing the utilisation of these and gaps (more details on slide 17-20)
- Feedback survey/outcomes

What's helped?

- Good collaboration with GP fed to use EMIS data to combine with SP data for reporting
- Involvement of local authority, allowing this to be joined up to VCSE provision, gaps and priorities across the borough
- Having a SP manager with time to develop reporting, plugged into health, VCSE and public health – local authority.

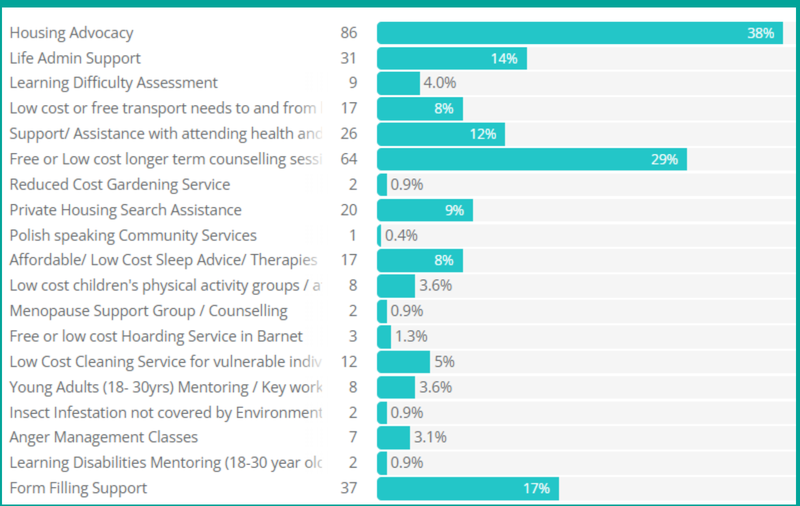


Chart from report – showing where social prescribing patients are referred to

More details can be found in the appendices of this slide pack.

3. 3ST Evaluation Framework for impact of VCSE

What is Third Sector Together?

- Collaborative of voluntary sector organisations across NWL at ICB, place and PCN level, working to have a voice within the NHS
- Leadership team; strategic team (over 30 organisations across boroughs including CVS), working to make sure this is representative
- Help influence and input to decisions at different levels of the system, sit on ICB boards, and borough based partnerships

What is the impact framework in development?

- To help charities show the impact they are having that is relevant for the NHS and health system
- It'll enable datasets to be developed that the VCSE sector can use to share impact, that can fit in with the NWL Wizik database
- Considers other evaluation frameworks in development from NHS England and other places

How it'll help

- Enable business cases to be easier to develop
- Allow the data already being collected in third sector to be shared across NHS and commissioners easier
- Help develop the infrastructure around VCSE data and impact sharing

Where did the funding come from?

- Initial pot from NHS England as recognised as trailblazers in this area
- Money from population health team in ICB to develop as a network, after they'd developed
- A specific 2 year pot for an evaluation framework to support demonstrating voluntary sector to demonstrate impact, to support commissioner decision making

What else they are doing

- PCN and neighbourhood mapping in Hillingdon of what the VCSE offer is in the local area and what are the gaps

More detail on the evaluation framework can be found in the appendices of this slide pack.

4. NWL wide approach to monitoring SP data and Ealing case study

Digital Social Prescribing

Across **Ealing**, the social prescribing service has been running for 9 months and is hosted by **a2dominion**. Currently, there is 1x WTE social prescribing link worker in post, soon to be 2x WTE, who support **10 practices** across the TEN PCN. In December 2021, the service was looking for ways to digitally **streamline** and **improve** processes.

What were the issues?:

- *Multiple Directory of Services (Dos) across the patch*
- *Multiple log ins to SystmOne*
- *Inconsistent referrals into the service making it difficult to track and manage them*
- *Multiple spreadsheets to manage patient information*
- *Unable to report on activity, outcomes and demand*

The team engaged with the market to understand how a case management system could support with some of the issues and improve the **digital maturity** of the service. Following this, a license with the supplier **Joy** was procured and has now been in use for 8 months.

To find out more information, contact claregallagher@nhs.net

IT Systems

- Case Management System (CMS): **Joy**
- GP IT system: **TPP SystmOne**
- Integration between systems so patient information can be easily shared between IT systems
- Social prescribers have access to a laptop to support remote working in the community

Benefits

- An easy-to-use Directory of services (DoS) with services providers all in one place
- Ability to track referrals out to service providers
- Ability to produce reports on demand and capacity
- Team management of inboxes
- Streamlined and consistent referral into the social prescribing service
- Ability to track patients progress and outcomes

Change Management / Training

- To support the initial implementation of the system the lead Social Prescriber worked closely with Joy to configure the system and deliver a comprehensive training package
- An example of training material can be found here
- The lead Social Prescriber also linked in with GP practices through F2F & virtual meetings, and presentations to promote the new IT system and ways of working

Data / Reporting

- Within the CMS there are multiple reports available to extract data from. Some reports used by the social prescribing team include:
  - Client feedback and satisfaction rates
  - Number of contacts *(**181** contacts recorded)*
  - Clients overall wellbeing *(**31%** average improvement)*
  - ONS4 score improvements *(**27.5%** improvement)*
  - Patient demographics breakdown
  - Most popular client needs *(Some examples; **23.7%** loneliness, **19.08%** LTC management, **16.1%** day-to-day helping hand)*
  - GP annual surgery appointments *(**6%** reduction)*

Top Tips

- Spend time configuring the system to meet the PCNs needs
- Use the system to organise workloads through the task list function and scheduling
- Be hands on with GPs when rolling out the system and encourage social prescribers to be part of MDTs demoing and promoting the system
- Use data and reporting functions to understand service performance and identify where improvements are needed
- Clinical leadership & buy-in is key to support with training, implementation and utilisation of the CMS

Published: August 2022

5. Setting up an evaluation process for the social prescribing team in Lambeth

Overview of social prescribing in Lambeth

- Age UK service serving 6/9 PCNs in Lambeth – 17 SPLW, partner with one other PCN to provide training
- No process to hear the views of social prescribers on the service or improve and develop the service, leading to poor job satisfaction
- No process to hear feedback from patients

What led to this happening?

- Small amount of funding from the Social Prescribing Innovators Programme

What was involved

- Developing an evaluation toolkit to evaluate both GP and non GP based social prescribing services
- Plan to run this process annually
- Working with SPLWs, PCNs and clients to inform the evaluation toolkit
- Holding workshops to gather views in person and online
- Designed surveys for SPLWs, PCNs and clients

More details can be found in the appendices of this slide pack.

Challenges

- Limited time for social prescribing manager
- Minimising data being collected in surveys

What helped

- Emphasised it is helping PCNs – we are evaluating the service for you, and that it will drive change
- Linking it to proactive social prescribing and helping meet PCN targets
- Used monetary incentives and refreshments at events to attract clients to event

6. Healthwatch evaluation of Bromley GP based Social Prescribing Link Workers

Overview of social prescribing in Bromley

- Bromley Well is a collaborative of voluntary sector organisations supporting people with the social determinants of health, based in the community.
- There are also teams of social prescribers sitting within primary care, following a traditional GP referral model.

What led to the evaluation?

- Commissioned by local authority, carried out by Healthwatch Bromley. They do two research studies a year on a different local service, set by shared priorities across local partners, primary care, trusts and committee members who are Bromley residents

What is included?

- Three-part evaluation: patient voice, social prescribers, primary care – three sets of data
- Focus on primary care based SPLWs. Bromley Well was evaluated previously here
- Coproduced questions to ask people to ensure relevant, carried out surveys and qualitative interviews.

Headline results

- Building awareness of the service is key, among public but also primary care and other parts of the system in Bromley doing similar things
- There was good feedback from those who had received social prescribing, however there was scope for improvement to patient outcomes and experience
- Social prescribers were satisfied in their roles, although there was a feeling across the board that increased capacity of the team is needed
- 11 key recommendations for SEL ICB were shared

What's next?

- Social prescribing team and commissioners meeting to review what to do next as a result of the evaluation
- Scoping how to collect data regularly on social prescribing across services, whether a borough wide platform is feasible and useful
- Looking at Simply Connect – directory of services, can this connect to the GP IT system to look at impact on primary care pressures

Quotes

*"I think it is **a fantastic service for lonely and vulnerable patients** to offer them support that is not always clinical, but vital to their day-to-day functions therefore improving their clinical health and reducing the need."*

*"It will become more essential with cost-of-living crisis and **decreasing GP workforce**."*

*"We have possibly only seen our social prescriber once since 2019. **Very slow service** and **have to chase up referrals** all the time."*

7. Supporting use of SP Outcome Measures NCL wide

What was the context?

- There were establishing SP services across NCL within Care Closer to Home programme within the ICB

What happened?

- The ICB developed a logic model to identify elements required to implement and embed social prescribing consistently and effectively across NCL
- Evaluation and capturing outcomes was identified as critical for success
- The ICB set up a task and finish groups set up to deliver these – informal group

Who was involved in the task and finish group?

- VCSE, public health, training hubs, ICB, social prescribers
- Specific focus on outcome measures – they reviewed outcome measures being used to make recommendations
- Led to three recommended measures

Challenges

- Resistance to take up measurement in infancy of SP set up
- Different platforms being used to capture data

The logic model established is on the next slide, it details the inputs, outputs and expected outcomes for social prescribing.

There is an accompanying word document with more detail for social prescribing services, shown below and available here.

Social Prescribing Outcomes & Evaluation Framework

About this framework

This framework has been developed to support the measurement and evaluation of social prescribing services. It categorises what information is required from each part of the system in terms of *structure* (what building blocks need to be in place), *process* (how things need to work in practice) and *outcome* (what we hope to achieve) for each part of the system. This makes it possible to identify what data and measurement will help evaluate the effectiveness of social prescribing interventions without being reliant on outcomes that are distant and difficult to capture.

What is required of different stakeholders to deliver an effective social prescribing offer?

	Social Prescribing Link Workers	VCSE organisations	Primary Care Networks	Commissioners	People
Structure	Understand the need for SPLW services, ensure people who need the service are proactively as well as opportunistically identified and ensure the offer is appropriate for all people (i.e. that provision is need and not demand led). Need to be able to identify and draw attention to any gaps in local services.	Have clarity about intended model of provision (is it time bound, ongoing).	Have a clear sense of the value they seek from social prescribing. Identify through proactive and opportunistic routes, particular target groups and so benefits are met. Consider how social prescribing is embedded into practice so it can be systematically to best effect. Need to consider what records are kept and for	Have a clear vision for social prescribing. Ensure that enabling infrastructure is in place. Identify particular VCS relationships that require direct commissioning.	Be willing to engage with self-assessment and goal setting. Have easy access to service offer.

7. Supporting use of SP Outcome Measures NCL wide (cont.)

Social prescribing / patient activation logic model

INPUTS What we will invest – people, expertise, money, time	OUTPUTS		OUTCOMES		
	Activities What we will do – projects, education initiatives, business cases, pilots, quick wins	**Participants** Who we will reach	**Short-term** The results we want to see	**Medium-term** **The results we want to see**	**Long-term – The results we want to see**
• Network DES funding for social prescriber workers • National and local outcome measures for both individual contacts and system outcomes • National JD for social prescribing link worker and competency framework • Technological support • Digital directory • Training budgets • Universal Personalised care model • Warm welcome learning • Gap analysis/asset mapping – what we have and what is needed (where are existing link workers (in LA?) • Current funding for VCS and social activities • Borough based personalised care groups • Online patient access to own record • Care navigation pilot schemes	**Information and Technology** • GP practices receive electronic feedback from navigation service • VCS and social activity service activity captured • E-referrals available • Identify population segments that will benefit the most • Data linkage to demonstrate impact • Develop digital platform using MyHealthLondon (MiDoS) **Design Principles** • Agree design principles and building blocks required • Develop support offers to VCS and social activity providers around fund applications etc. • Target resources to those with greatest need. • Referral process/pathways (incl. self ref) **Workforce** • Develop training – skills and capacity develop for all providers, including VCS. • Outreach to Universities and Schools • Develop SP apprenticeships • Develop volunteering opportunities – peer support • Care navigators are supported to use PAM tool **Comms and Marketing** • Clear and consistent terminology for SP • Develop comprehensive communication and marketing plan for SP targeted to referrers, VCSE sector, commissioners and patients/public **Outcomes** • Agree local individual and system wide outcomes • Evaluation	• Residents/patients across different levels of need -From healthy adults in need of information and advice about community activities and lifestyle apps to -High intensity users of health and care services requiring high intensity support VIA • Debt and cost of living services • Employment services • Housing departments • Advice/Rights services • Social services • Voluntary sector and social activity providers • Community service providers • Mental Health providers • Health and care providers • GP Federations • A&E departments • Health and care support staff e.g. GP reception staff, A&E reception etc. • Leisure centre providers • Libraries • Community pharmacists • PPGs • Education	• Patients are supported to identify issues that are most pressing to them. • Patients understand what activities or services are available to support their most pressing issue(s). • Patients and carers are actively involved in their most pressing issues. • People have increased involvement in their self care, prevention and health promotion programmes • Patients are activated and engaged with their care record.	• Patients are able to navigate their way through support with easier access to • appropriate support – health, social care, wider council services, • lay and voluntary organisations. • People are able to access local services in their community • Improved patient health and wellbeing • Reduced social isolation	• Patient outcomes including: • Easier accessing appropriate support in their community • Improved patient health and wellbeing • Reduced social isolation • Reduced demand on GP appointments • Reduced demand on A&E appointments • Reduced demand for social care assessments • Greater sustainability of VCS and social activities due to funding following demand

Potential risks	EXTERNAL FACTORS
1. Potential over medicalization 2. Not securing buy in/engagement from clinical staff 3. Overburdening voluntary sector providers 4. Failing to track impact of intervention 5. Data protection	1. Capacity of the voluntary sector 2. Administrative platforms/data integration 3. Digital support

EVALUATION PLAN:

To include refinement and testing of the logic model with attention to inputs, outputs and outcomes (including patient activation, distance travelled measures, health outcomes and utilisation of health services)
Attention is need to identify opportunities for data collection, to ensure appropriate recording and to plan analysis

8. Merton evaluation of social prescribing

What was the context?

- The ICB (then CCG) in Merton and Wandsworth carried out a social prescribing pilot, developing the social prescribing team with funding from the CCG, which was later increased with the introduction of the DES funding for SPLWs.
- The ICB was responsible for commissioning and looking at the performance of social prescribing

What was involved

- The ICB project manager worked with the social prescribing employers – Enable and Surrey Physio in Wandsworth and Merton Connected in Merton, alongside CSU analysts to gather data on social prescribing and combine in with GP and secondary care data to look at impact
- Now the team works with ICB analysts rather than the externally commissioned CSU, linking to SWL's dashboard HealthInsights platform, which enables linkage to demographics and healthcare use with pseudonymized patient data
- SPLWs use Elemental and EMIS to record data

What outcome measures are used

- ONS-4
- They also explored use of the Wellbeing star and PAM but they didn't work well, adding to appointment time and making conversation overly formal

See the full evaluation report in the appendices of this slide pack.

Watch the recording about the SP evaluation here.

Challenges

- Before ICB analysts were working on the data social prescribing link workers had to double enter data onto Elemental and a spreadsheet to allow data to be linked

What is included in the report/evaluation?

- Referral demographics, impact on GP service demand, onward referral breakdowns, impact on patients with specific conditions e.g. diabetes

What the evaluation has led to

- Supported Merton Health and Wellbeing Board in championing social prescribing from 2016
- Demonstrated value of the programme, having more than one SPLW per PCN and collecting the data

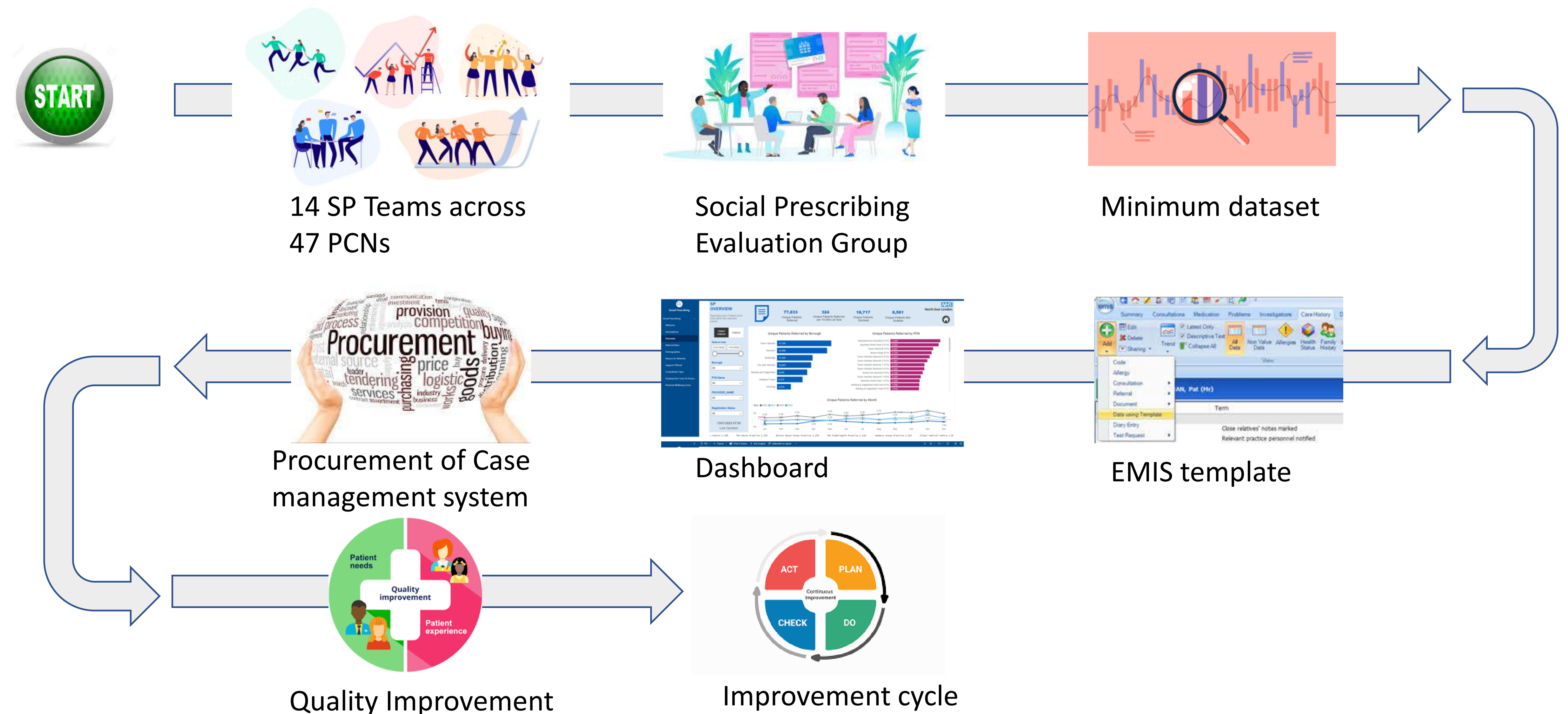
What is next?

- Merton Connected and Enable exploring jointly commissioning Joy and Elemental
- Set up BI dashboard to show up to date data from Joy and Elemental
- Use data to inform integrated neighbourhood working and tailor SP deliver to needs and be more proactive e.g. target men who aren't accessing as much as women

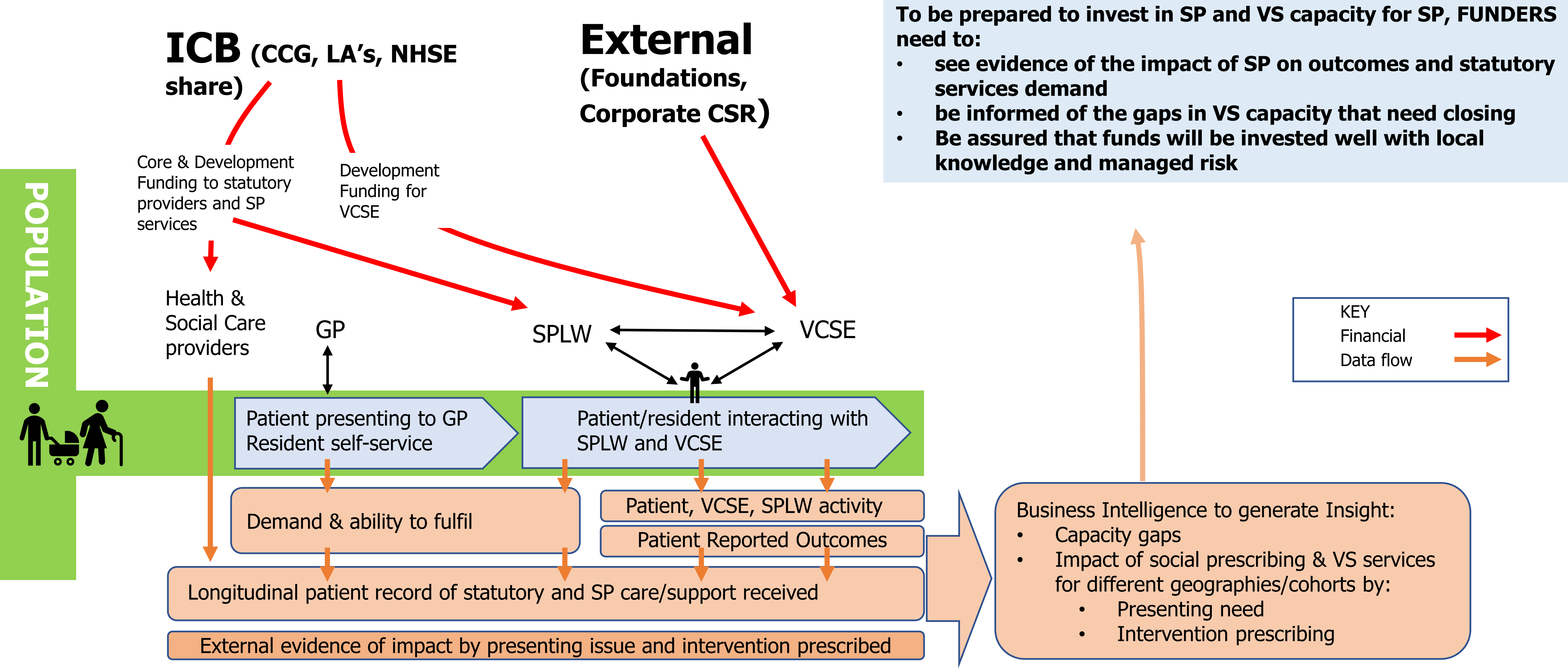
Appendices

NEL ICB template and dashboard

NEL Minimum dataset – Template & Dashboard



Funding Social Prescribing



Challenges / Future work

Challenges

- Build confidence in teams that systematic data capture is worth the effort and time (culture and behavioural change)
- Work with SP teams to become data consumers (evidence based decision making)
- Limits of functionality with clinical systems e.g. Snomed coding
- Alignment of datasets across systems (eg EMIS vs Joy)
- Capturing patient feedback on SP services

Enablers / Success factors

- Collaborative learning environments – sharing best practice
- Honesty and realism about challenges and barriers
- Staff / Places engaged in the process – empowered to lead and deliver
- Close working with digital and data specialists
- Clinical/Operational sponsorship
- Definition and articulation of the benefits

What next?

- Continue roll out of CMS and refinement of datasets/templates/reporting capability
- Develop capability to capture more voluntary sector information
- Develop capability to capture patient feedback and attendance data
- Move to focus on Quality Improvement informed by data
- Continue to optimise digital tools for the capture and reporting of activity and outcome data

Case Study

Helping teams capture and evaluate their work

With link workers, managers, GPs, PBPs and primary care networks, we collaboratively and painstakingly pioneered a **personalised care minimum dataset** that all our PBPs are using and which informed development of the national dataset with NHS England. It also includes an easy-to-use **social prescribing dashboard**. All teams can see at a glance the demographics of those accessing social prescribing, and get an idea of why.

Barnet Age UK Social Prescribing reporting

Barnet
Social
Prescribing
Service

Reporting In Barnet

Caitlin Bays

SP and Integrated Services Manager

Age UK Barnet

Reporting Process

- Reporting To: PCN CD's, Public Health, Age UK Barnet Trustees and CEO, Barnet GP Federation
- Software Used: Elemental and Emis
- Frequency:
- Monthly, Quarterly, Annually

Monthly Reporting

- Service Referrals vs DES target (upper and lower).
- Referrals By Practice
- Referral Reasons
- Appointment Total
- Appointment Duration
- Wait List update.

Quarterly / Annual Reporting

- Referrals (By month, Vs Target,) as well as Referrals by Practice
- Appointment details
- Demographics
- Referral Reasons
- Most Prescribed/ Signposted services from that PCN
- Feedback Survey / Outcomes - Patients are able to fill out feedback around the service which goes into the Elemental system
- Gaps
- Updates and Successes

Gaps in Services

- Elemental is able to record cohorts.
- Cohorts can be utilised for any need or specific interest for your service.
- Our team share gaps In services as part of their 1-1s with the SP manager and this is done anecdotally. May identify if a lack of knowledge of services or training – identify this as a group or whether it is a gap for Barnet.
- Previously we used to have a slide on our reporting slides for gaps in services which were just listed. – No evident / weight of the need was able to be evidenced.
- This goes into quarterly reporting and is of specific interest to public Health to find a way to evidence the Community gaps to see the number of client who were in need of the provision.
- Led to conversation with public health and specific managers around provision of services in specific areas of Barnet e.g. mental health and housing. Help inform their projects

Barnet
Social
Prescribing
Service

Gaps Identified By the SPLW Team Ongoing (Anecdotal)

- **Mental Health:**
- Long waiting lists for counselling, lack of translating options for counselling and lack of free longer term counselling support for more complex MH cases.
- More evening classes for wellbeing support or seminars.
- Young adults Mental health support groups 18-25 year olds.
- One to one support for life admin.
- Anger Management Classes
- Pet Therapies for MH and dementia

- **Family and Children:**
- Lack of free Children's clubs for family's who can not afford activity clubs.
- Child care cost support for single parents of low income.
- Key worker support for vulnerable young adults (17-25).
- Family Support for people suffering with MS.

Housing

- Form filling support for housebound individuals
- Housing Form filling support for people with learning difficulties and/ or people with learning difficulties needing assistance with searching for suitable private renting options.
- Housing Advocacy

Other:

- Financial support for people waiting to hear back from the home office regarding their visa application as they are not eligible for financial support during the waiting period.
- Free transport options for people needing assistance with hospital appointments.
- Affordable diet and nutrition support for weight loss as well as improving nutrition.
- Affordable Sleep Improvement Support (advice and therapies).
- Menopause support groups.

Older Adults:

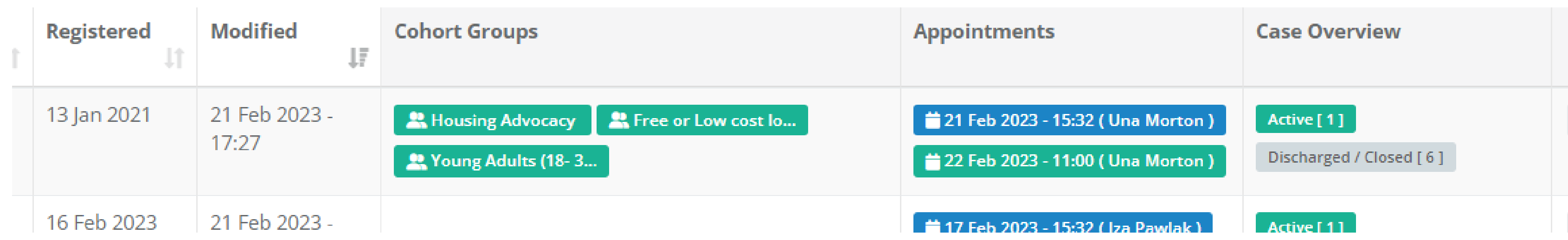
- Affordable and low cost gardening services
- PA like duties (helping with life admin)
- Day Activity / Day Centres for non dementia patients.

Challenge: the identification of gaps isn't weighted i.e. there is no number to describe the amount of demand for each gap

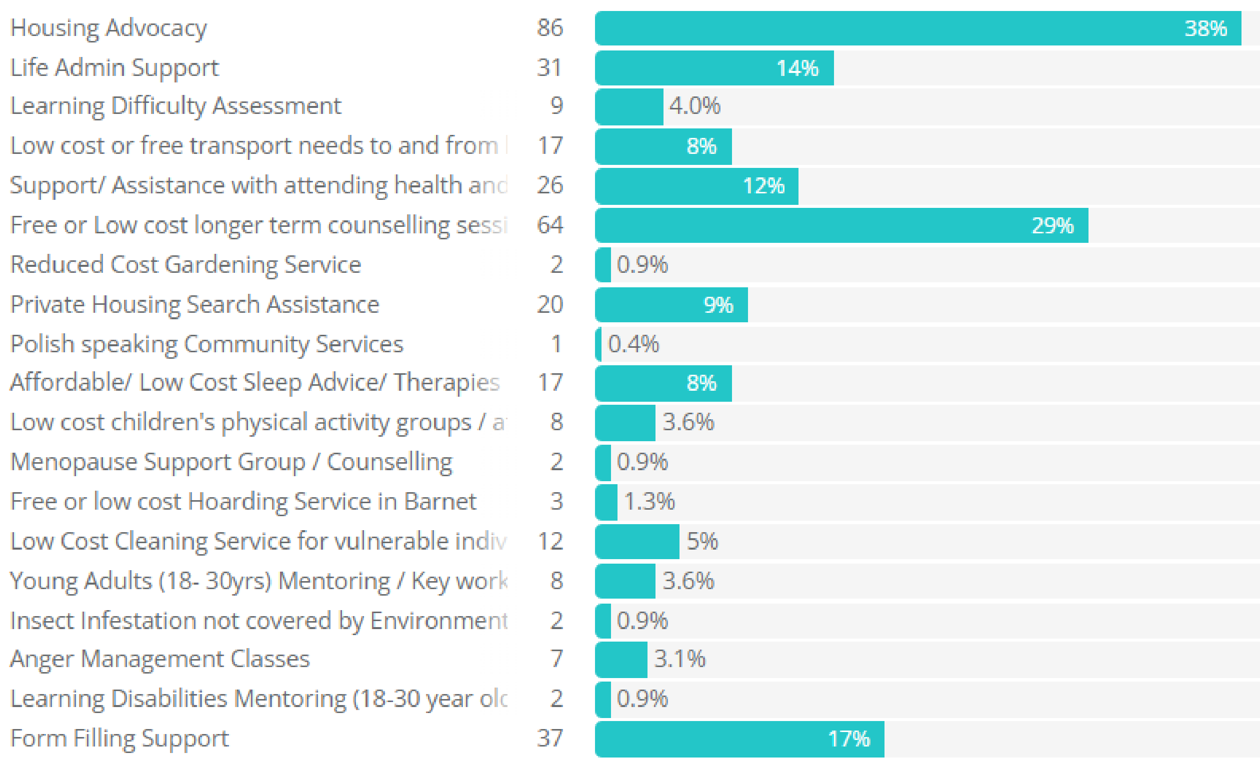
April 2022 Development

- Spoke to elemental to see how gaps can be documented in a more robust way with an idea of demand. From the start of this financial year we added our most needed gaps to our case management system under Cohorts, to record demand.
- Our team now add ‘cohort’ tags to their patients who require that provision so now we can see the total numbers who are in need. You can use as many tags as apply. E.g. can use to tag particular needs rather than demands e.g. suicidal tendencies.
- Other organisations have used this to pull reports for specific VCSE organisations so they understand their demand better.
- This demand is then added to the quarterly reporting and split by location / PCN and postal codes.
- From the end of 22/23 financial year, I will be creating a Barnet Service Gap Report for the full financial year to help create a case for further funding and provision needs for the priority needs required for our community.

Example



Client Case Note View



Report Screenshot

Barnet Social Prescribing Service

Plan going forward

- Full Financial Year 22-23 Report created.
- SP manager meeting with key partners to discuss their gap experiences, and any data collection they have to add to the report for key partner support, what are the burdens on services, discuss challenges (CAB, Boost, Barnet Homes, Prevention and Wellbeing Team). Also engaging a mental health charity.
- Report shared to key stakeholders for our service and across the local authority.
- The co-owned report will be shared with PCNs, Public health and the Local authority to support their work.
- Mini Gap Reports can be created for community partners i.e Housing, MH etc. where there are specific challenges, support with funding bids, data to document need.
- Barnet SP Advisory Group created to meet once per quarter to discuss provisions, community needs and updates of services, funding streams to help improve services and care for local communities.
- Public health also doing own analysis on the SP service, focusing more on demographics, utilisation and outcomes.

3ST Evaluation Framework development

3ST THIRD SECTOR TOGETHER

in north west London

3ST aspires to creating environments where all NWL residents have access to responsive, fully-integrated, quality and culturally-appropriate support and advice that reduce health inequalities and helps them to stay independent and to take control of their lives

Impact Framework

Objectives

- Agree with NWL ICB the criteria that can effectively demonstrate the measurable impact of 3ST organisations.
- Engage and collaborate with relevant audience/stakeholders to distil the impact criteria into metrics that can be applied to a wide range of 3ST organisations.
- Develop an Impact Framework until November '23 by using metrics that are endorsed by NWL ICB to effectively integrate 3ST into the NWL system.

Methodology

- The project plan adopts the Design Council's "Double Diamond" approach, encompassing four phases – Discover, Define, Develop, and Deliver – to explore a wide range of possibilities and refine the ideas using an iterative process
- Broad spectrum themes such as Wellbeing and Patient Activation that can be applied to a majority of 3ST organizations will serve as the starting point of this activity.
- Co-design and co-production methodologies will ensure that the perspectives of a wide array of stakeholders are captured.
- Specialist organizations will provide support in developing structured data and metrics that highlight Return on Investment.

Benefits

- Streamlined and systematic measurement of impact enabling smoother commissioning of 3ST organisations by NWL ICB.
- Efficient engagement between 3ST and NWL ICB, facilitating strategic planning and decision-making.
- Recognition of 3ST organisations within NWL ICB as integrated providers of preventive healthcare.
- Capacity building for smaller organizations by helping them evidence their impact and communicate outcomes effectively.

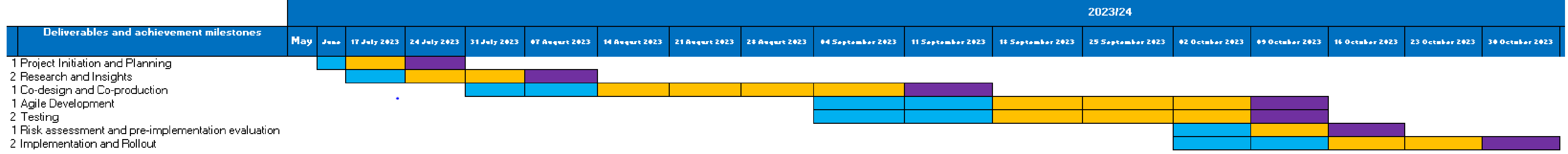
Progress so far:

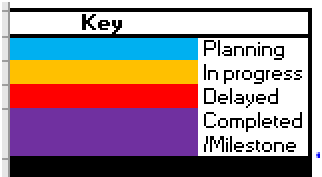
- Project initiation documents(PIDs) in place including Gantt charts, stakeholder mapping and action logs.
- Two steering group meetings held:
  - 22/6/23 - Kick off meeting:
    - Steering group member introductions.
    - Group think on the purpose and objective of the project to deliver the framework.
    - Initial thoughts on proposed methodology (Double Diamond) and key themes of discussion (Wellbeing and Patient Activation)
    - Brief overview of potential stakeholder/decision makers to be involved.
  - 20/7/23 - Planning:
    - PID and timeline discussed in detail to get consensus on the scope of the project.
    - Double diamond methodology probed into and some insights provided over key focus areas and 'what good could look like'
    - Action items agreed to flesh out the work specification and identify key stakeholders/audience with the steering group until next meeting. .

Next Steps:

- Steering group to convene next to agree the work specification and put names to stakeholders/audience that needs to be engaged.
- Work out key criteria and execute expression of interest activity to appoint specialised organisation(s) to design the framework.
- Pen down a plan to research and gather insight that define the need the framework will fulfil through:
  - Interviews/meetings with identified stakeholders/audience
  - Focus group to narrow down the problem statement (need).

Tentative timeline





Note:
Framework to be completed by November 2023. Some planning has been completed in July 2023 at the time of creation of this document already.

Phase	Tasks	Duration
Discover	Project Initiation and Planning	2 weeks (starting of July – 30/7/23)
	Research and Insights	4 weeks (17/7/23 – 11/8/23)
Define	Co-design and Co-production	4 weeks (31/7/23 – 1/9/23)
Develop	Agile Development and Testing	2 weeks (4/9/23 – 13/10/23)
Deliver	Risk assessment and pre-implementation evaluation	3 weeks (2/10/23 – 20/10/23)
	Implementation and Rollout	5 weeks (2/10/23 – 3/11/23)

Lambeth Age UK social prescribing service evaluation development

Social Prescribing Innovators Project: Evaluation on SP and supporting SPLWs

powered by...

Why Evaluate?

Our challenge is that Social Prescribing Link Workers (SPLWs) aren't consulted for service development. Our service has been running for 3 years. It has evolved, but the PCNs, and NHS data requirements, drive changes. While this is important, this leads to issues:

1. We miss a wealth of knowledge and relevant experience from our SPLWs.
2. Lack of consultation is having an impact on their wellbeing and job satisfaction.
3. Where's the client/ patients voice in all of this?

Our aim is to develop an evaluation toolkit relevant to social prescribing. The evaluation toolkit would then run annually for ongoing service development and impact measurement.

The Project

Identified **three key stakeholders**:

- SPLWs
- PCNs
- Clients/ patients (current and previous)

Survey Feedback

Focused workshops

Review and design:
The evaluation toolkit would then be run annually for ongoing service development and impact measurement.

Training Opportunities for SPLWs:
Evaluation, monitoring impact and facilitation.

Activities Planned

Survey- begin completing survey with clients

Survey designed for PCNs and SPLWs- to be circulated

SPLW Feedback Workshop organised (postponed due to train strike)

TNA completed with SPLWs and researching training opportunities

Merton evaluation of Social Prescribing Services

Social Prescribing Merton

Amrinder Sehgal ,
Ben Hasch
and Mohan Sekeram

Social Prescribing in Merton PCNs

- In 2016 Merton Health and Wellbeing board commissioned a Pilot social prescribing programme
- In March 2019, following the announcement of the PCN DES Contract, SWL ICB saw an opportunity to further enhance the service and deliver a borough wide model.
- SWL ICB approach all Merton PCNs with the offer to commission an enhanced social prescribing model and manage the contract on their behalf.
- In October, SWL ICB in collaboration with Merton PCNs commissioned Merton Connected to deliver Merton's boroughwide social prescribing model.
- This includes the original 3 Link Workers from the first expansion

Social Prescribing – what is it?

- Links patients to ' non-medical' community basis of support (20 %)
- Many factors affect Health and wellbeing (one factor Social)
- Social need
  - Housing
  - Finance
  - Loneliness
  - Long term condition
- Presenting as
  - Depression underlying bereavement
  - Recurrent infections / respiratory flare ups -underlying poor housing

- Time with patient - embedded in primary care

The Merton Model of Social Prescribing

- The Social Prescribing contract for Merton is held by Merton Connected since 2017
- The Merton SP service is one of the most established and mature services in the UK
- The SP team consists of a total of 12 Link Workers, an equivalent of 9 fulltime Link Workers
- Each of the 6 Merton PCN receives support from 1.5 Link Workers
- The project is monitored through monthly contract monitor meetings with the ICB, quarterly quality assurance reports to the ICS
- The project has been clinically evaluated by Oxford University in 2022
- The Merton SP project won the award ‘ highly recommended programme of the year’, National Association of Link Workers’, 2020.

Primary Care Networks

- There are 6 Primary Care Networks in Merton:
    - East Merton PCN
    - North Merton PCN
    - West Merton PCN
    - North West Merton PCN
    - South West PCN
    - Morden PCN

New referrals received

Top reasons for referrals

1. Mental Health
2. Social Isolation and Loneliness
3. Financial Advice
4. Housing
5. Support for Carers

October 2022 – September 2023

3745 new referrals received

October 2021 – September 2022

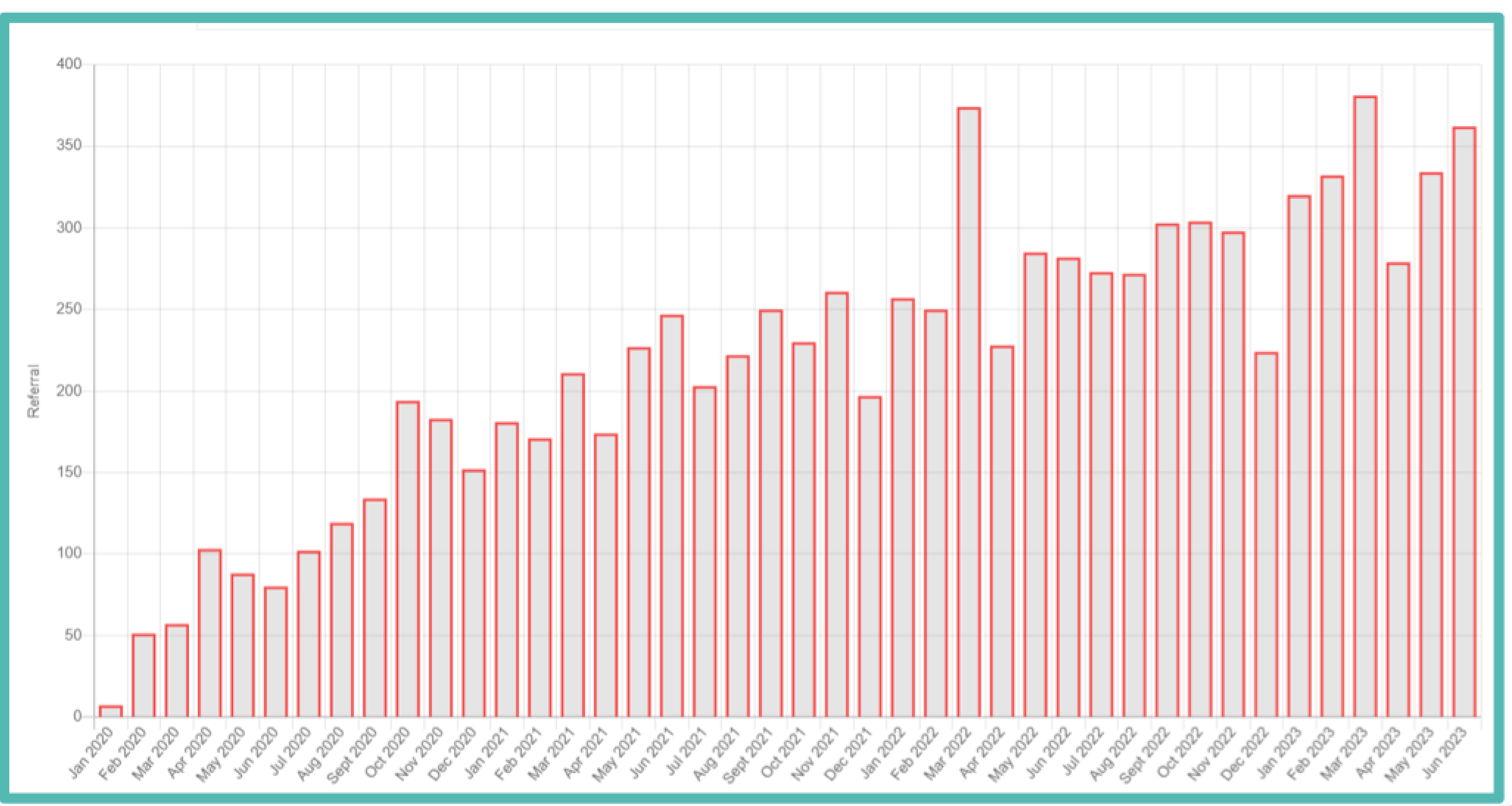
3224 new referrals received

Overview Of All Referrals Since Beginning Of Licensee

The project has been using Elemental from the following date:
Merton Connected: 8th January 2020 (**3 Years, 5 Months**)

Throughout the course of the project, a total of **9,202** referrals have been made with the help of Elemental Software.

View Results: [9,202 Referrals]



Cases Created Per Hub / Client Demographics (All Time)

Gender

Gender	Count	%
Female	5986	66%
Male	3053	34%
Transgender	8	0.1%
Other	4	0%
Prefer not to say	2	0%

Age

(on referral date)

Age	Count	%
Up to 14	94	1.0%
15 to 18	76	0.8%
19 to 24	487	5%
25 to 34	1213	13%
35 to 44	1391	15%
45 to 54	1544	17%
55 to 64	1424	16%
65 to 74	1012	11%
75 to 84	1066	12%
85+	746	8%

- The most populated age range among **Merton** clients is the age range of ***45 to 54***, representing ***17%***.
- The age group of ***55 to 64*** is in 2nd place, making up ***16%*** of referrals.
- From the diagram below, we can see that the targeted group is younger adult / middle aged of society, vs. an younger / older skew.
- ***9,053*** Cases that were created were Female (***66%***), there was ***3,053*** Referrals for Male, representing (***34%***)

The total number of cases made is **9,053**.

View Results: [9,053 Cases]

Health Impact Statistics (All Time)

Since the project's formation, we have tracked your clients using our Monitoring Tools – the **Merton Connected** licensee uses the **ONS** monitoring tool.

This measures client Satisfaction, Worthwhile, Happiness (**ONS 1,2,3**), and monitors their Anxiety (**ONS 4**) over time.

Merton:

- ONS 1: **66%** Increase
- ONS 2: **60.2%** Increase
- ONS 3: **62%** Increase
- ONS 4: **60.5%** Decrease

Impact (ONS - Satisfaction)

239
411
Avg Δ1.47
1261

Negative Change
No Change
Positive Change

Feb 2020 Jul 2020 Dec 2020 May 2021 Oct 2021 Mar 2022 Aug 2022 Jan 2023 Jun 2023

Total | Negative Change | No Change | Positive Change | Average Change (Δ)

Impact (ONS - Worthwhile)

300
461
Avg Δ1.2
1150

Negative Change
No Change
Positive Change

Feb 2020 Jul 2020 Dec 2020 May 2021 Oct 2021 Mar 2022 Aug 2022 Jan 2023 Jun 2023

Total | Negative Change | No Change | Positive Change | Average Change (Δ)

Impact (ONS - Happiness)

318
408
Avg Δ1.4
1185

Negative Change
No Change
Positive Change

Feb 2020 Jul 2020 Dec 2020 May 2021 Oct 2021 Mar 2022 Aug 2022 Jan 2023 Jun 2023

Total | Negative Change | No Change | Positive Change | Average Change (Δ)

Impact (ONS - Q4. Anxiety)

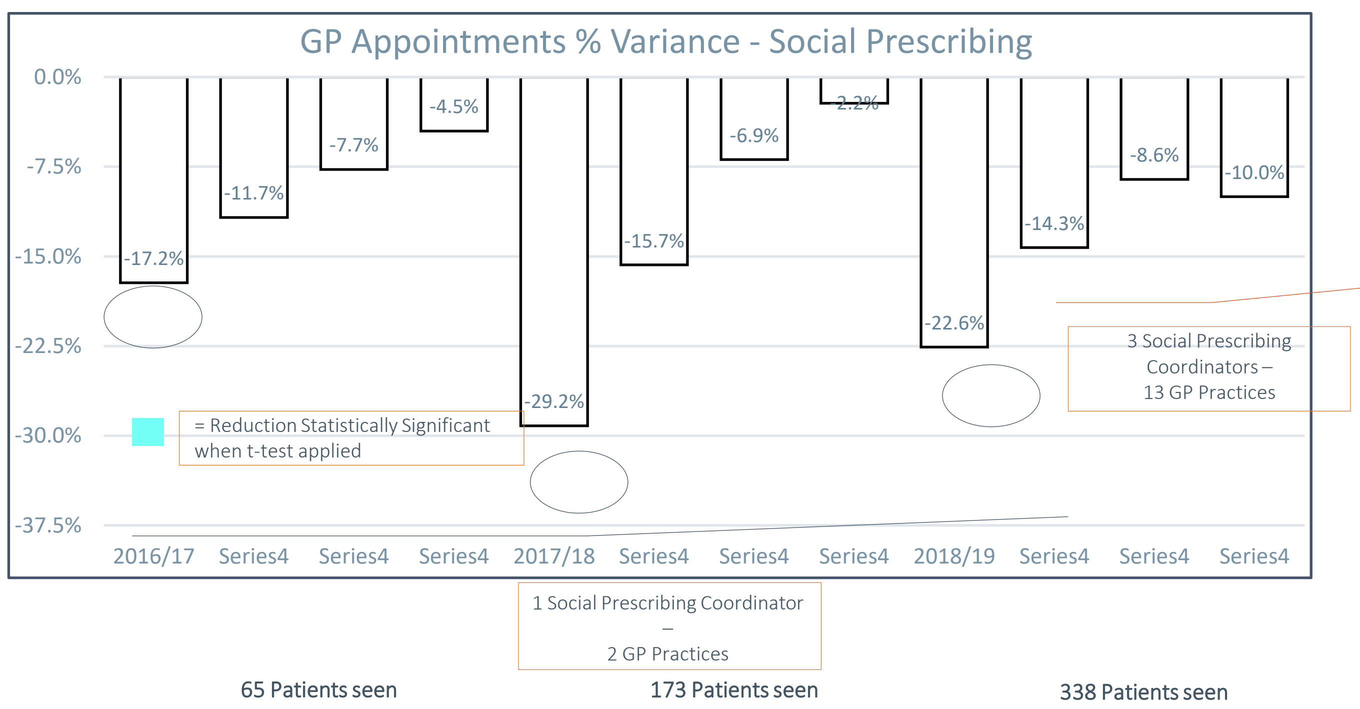
370
384
Avg Δ-1.34
1157

Negative Change
No Change
Positive Change

Feb 2020 Jul 2020 Dec 2020 May 2021 Oct 2021 Mar 2022 Aug 2022 Jan 2023 Jun 2023

Total | Negative Change | No Change | Positive Change | Average Change (Δ)

2016/17, 2017/18 and 2018/19 3,6,9 and 12 monthly Analysis – GP Appointments % Activity Variance



Comment

GP appointments analysis has been presented as an % activity variance by quarter over the years 2016/17, 2017/18 and 2018/19. These shows that the Highest % reductions in GP appointments are shown after 3 months (Q1) before reducing in Q2s,Q3 and Q4. In 2018/19 when the service was rolled out to 13 GP Practices although the % reductions between the quarters reduced there was still a 10% reduction in Q4 which was a lot higher that the 4.5% reduction in Q4 2016/17 and 2.2% reduction in Q4 2018/19.

Signpostings (Whole Project)

SIGNPOSTINGS

Results: 8,475 Signpostings

Signposting	Count	%
WIMBLEDON GUILD	696	8%
ONE YOU MERTON	359	4.2%
AGE UK MERTON	313	3.7%
Citizens Advice Lambeth and Merton (C/	257	3.0%
Merton Uplift	239	2.8%
MERTON UPLIFT - WELLBEING WORKSH	222	2.6%
South West London Law Centre	217	2.6%
SUNSHINE RECOVERY CAFE	214	2.5%
MERTON UPLIFT - IAPT	186	2.2%
Carers Support Merton	185	2.2%
South West London Law Centre - Financ	182	2.1%
Merton Benefits Service	179	2.1%
Wimbledon Guild Talking therapies	166	2.0%
Merton Council Needs Assessment	148	1.7%
MERTON MENCAP	141	1.7%
Dementia Hub Merton	122	1.4%
Walk and Talk movement - Wimbledon	117	1.4%
Age UK Merton	112	1.3%
Sustainable Merton - Merton's Commun	101	1.2%
Wimbledon Guild Welfare Grant	95	1.1%
Merton Carers Support	85	1.0%
DONS Local Action Group	76	0.9%
Merton Housing	75	0.9%
Homestart Merton	70	0.8%
Off the Record - Merton	69	0.8%
MCIL (Merton Centre for Independent Li	66	0.8%
Hestia - Recovery Cafe for Mental Health	54	0.6%
Age Uk Merton	54	0.6%
Studio Upstairs	49	0.6%
Wimbledon Food Bank	49	0.6%

Signposting	Count	%
Walk and Talk movement - Morden Hall	49	0.6%
TURN2US	45	0.5%
WIMBLEDON FOODBANK	44	0.5%
St Raphaels - The Wellbeing centre	44	0.5%
RAYNES PARK BEREAVEMENT	42	0.5%
IMAGINE INDEPENDENCE	41	0.5%
Occupational Therapy Merton (OTSS Me	41	0.5%
Better Gyms - Morden Leisure Centre	39	0.5%
FAITH IN ACTION	38	0.4%
Walk and Talk movement - Canons Hous	37	0.4%
The Trussell Trust - Food Bank	35	0.4%
Merton Connected - Volunteering	35	0.4%
Home Instead Wimbledon and Kingston	34	0.4%
Central London Community Healthcare	34	0.4%
Grants - WaterSure and WaterHelp	33	0.4%
WDP Merton	33	0.4%
VICTIM SUPPORT	31	0.4%
Ethnic Minority Centre	31	0.4%
Merton Libraries services - Wimbledon	30	0.4%
Inner Strength Network	30	0.4%
The Caravan Drop-In Counselling Service	29	0.3%
Recovery College	29	0.3%
MACMILLAN	29	0.3%
Merton Family Services Directory - Famil	29	0.3%
MERTON WALKS FOR LIFE	28	0.3%
CRUSE BEREAVEMENT	28	0.3%
CHS Healthcare	27	0.3%
IESOHEALTH	27	0.3%
Connect Health - Nelson, Cricket Green,	27	0.3%
MAGGIES CENTRES	26	0.3%
JIGSAW 4U	26	0.3%

These are the most heavily assigned signposting's within the **Merton** project:

- **Wimbledon Guild** (**696**)
- **One You Merton** (**359**)
- **Age UK Merton** (**313**)
- **Citizens Advice Lambeth And Merton (Cab)** (**257**)
- **Merton Uplift** (**239**)
- **Merton Uplift - Wellbeing Workshops** (222)
- **Southwest London Law Centre** (**217**)
- **Sunshine Recovery Café** (**214**)
- **Merton Uplift – IAPT** (**186**)
- **Carers Support Merton** (**185**)

Social Prescribing evidence (nationally recognised)

- Initial pilot 2018 - funded by public health Merton
  - https://healthydialogues.co.uk/wp-content/uploads/2019/04/East-Merton-Social-Prescribing-Evaluation-Report-2018.pdf
- Powerful video by Health London Partnership
  - https://www.healthydialogues.co.uk/wp-content/uploads/2019/04/Merton-SP-evaluation-report-August-2021-V2.3.pdf
- A study of the upscaling of the Social Prescribing Service in Merton (2021)
  - whttps://www.healthydialogues.co.uk/wp-content/uploads/2019/04/Merton-SP-evaluation-report-August-2021-V2.3.pdf
- Finalists HSJ Award for pilot 2018
  - https://fabnhsstuff.net/fab-stuff/social-prescribing-in-merton

Further information

Response of social prescribing during Covid:

https://www.england.nhs.uk/personalisedcare/social-prescribing/case-studies/a-gp-perspective-on-social-prescribing-and-the-response-to-covid-19/

Enhanced Social Prescribing

- Children and Young Person's Social Prescribing Pilot in East Merton and Morden PCN.

- PCN Proactive Social Prescribing programmes to increase access and uptake of Social Prescribing. Each PCN has identified a specific cohort to work with which are currently underrepresented in the current Social Prescribing referrals.

- MacMillan Cancer Link Worker programme which operates across Merton, Wandsworth and Croydon. The programme aims to improve the awareness of, access to, and uptake of services available to those living with and beyond cancer, whilst ensuring that holistic support is offered locally at key points in the cancer pathway.

Proactive SP in Merton – additional projects

- High Intensity User Support
- Support for patients with Learning Disabilities
- 7 Green Social Prescribing projects
- Children and Young People's SP
- SP support for patients diagnosed with cancer
- A SP patients' Support Group
- Delivering the National Qualification of Level 3 certificate in Social Prescribing
- Support for patients of a Pain Clinic in Sutton, Secondary Care

Social Prescribing - Overview

Back to Content Page

You have selected a cohort of **2,184** patients who attended a Social Prescribing appointment

Period between **April 2018** and **September 2021**

Total Patients referred

2,364

Total Patients attended

2,184

Total appointments made

8,513

Number of attendances

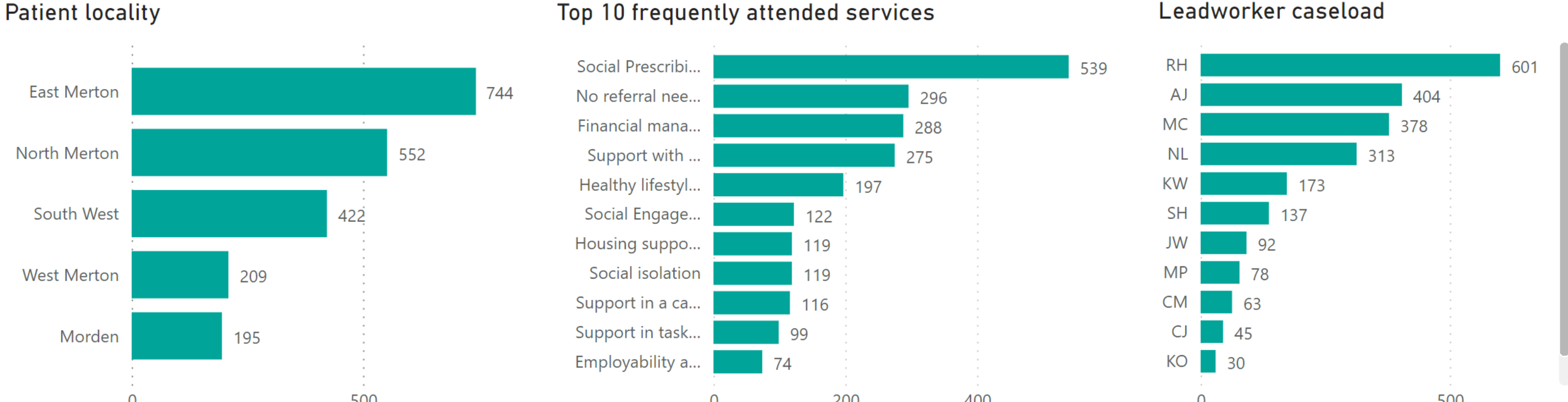
7,051

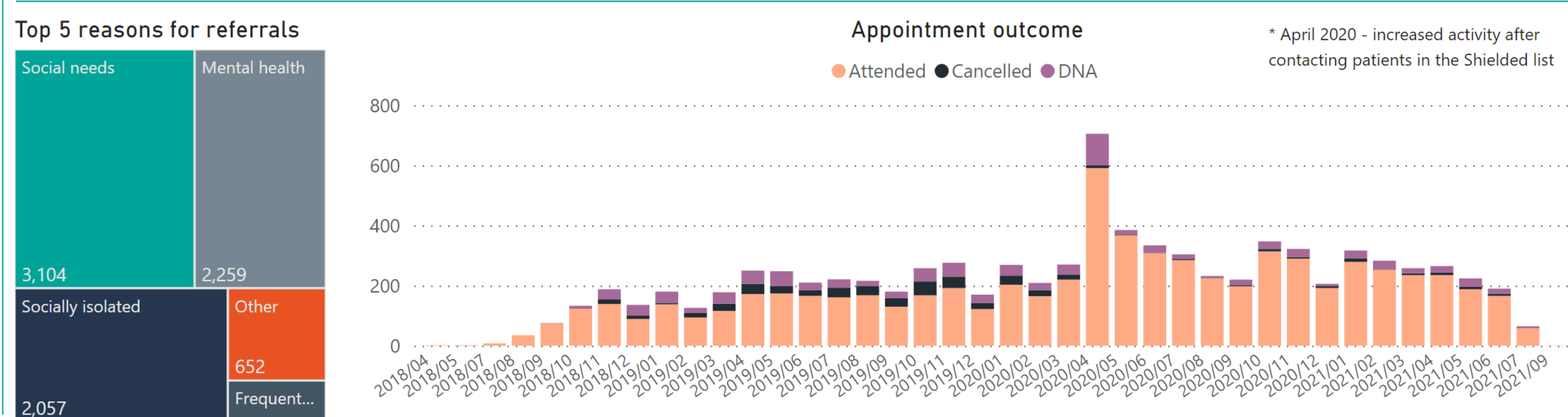
Average attendances per patient

3.2

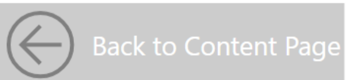
% DNAs and Cancellations

17%





Social Prescribing - Demographics



You have selected a cohort of **2,184** patients who attended a Social Prescribing appointment

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Number of attendances **7,051**

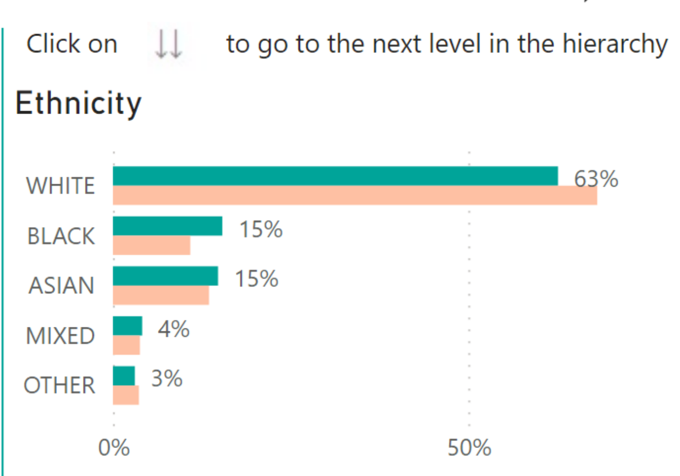
Average attendances per patient **3.2**

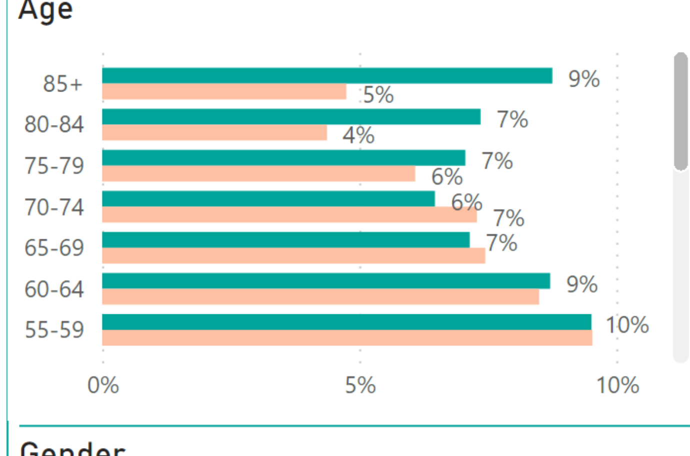
% DNAs and Cancellations **17%**

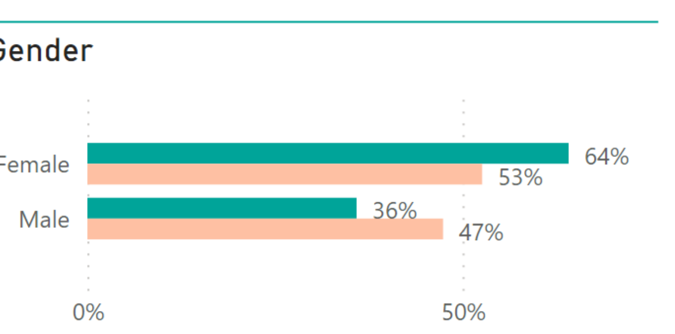
Click on ↓↓ to go to the next level in the hierarchy

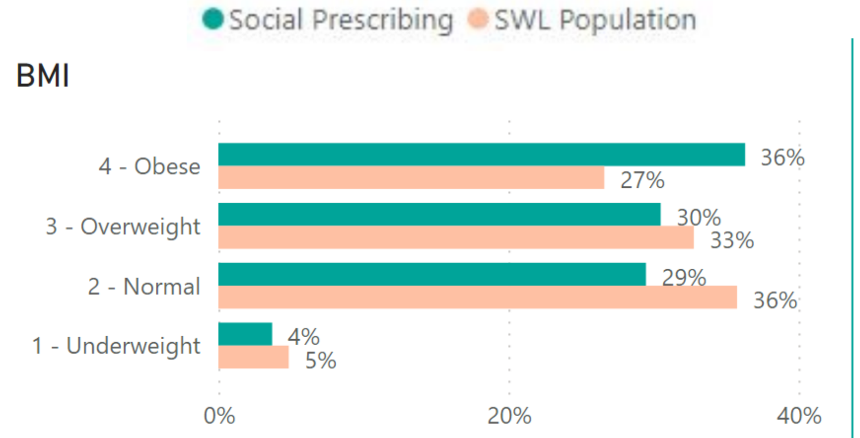
● Social Prescribing ● SWL Population

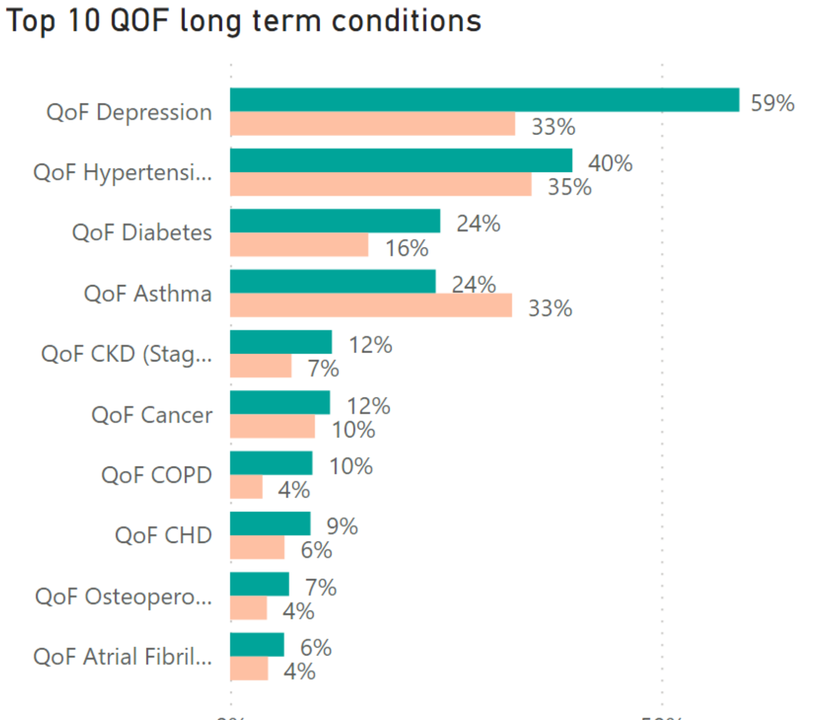
Refer to *[Report Notes]* - *Deprivation* for definitions

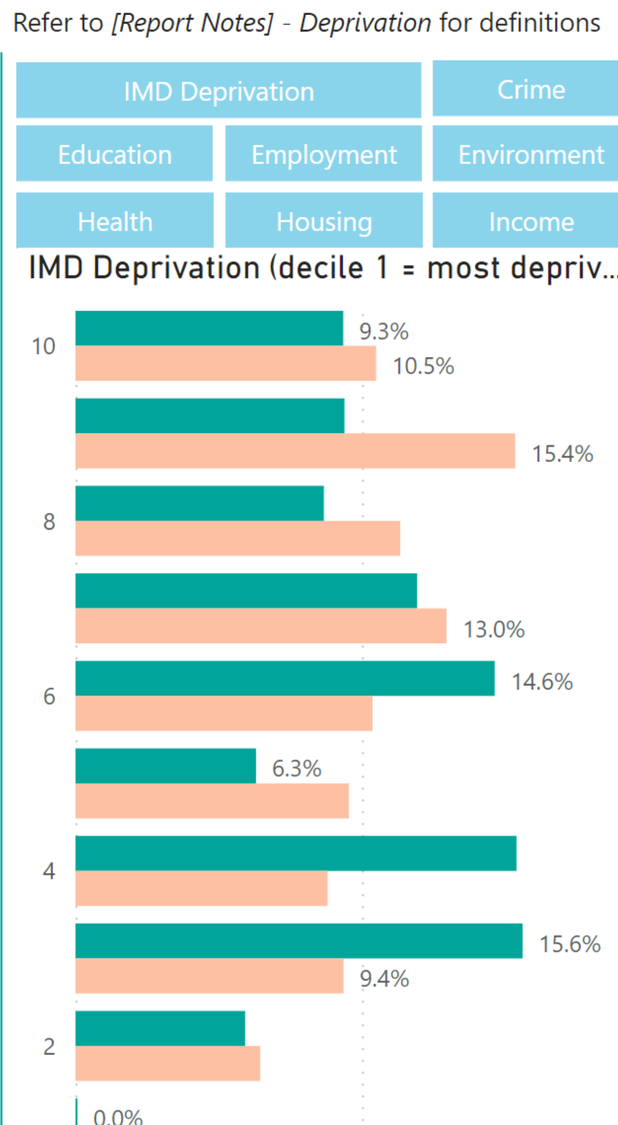












Report Notes

Reporting on Merton patients at the time of writing - December 2021. It is anticipated the Social Prescribing programme will eventually roll out to other boroughs in South West London.

Records with data items recorded as either null, blank or invalid have been omitted from reporting together with patients that have recently passed away.

Pathway summary and pathway patient level pertain to activity over the last 24 months.

Link worker's full name have been omitted and replaced with their initials for confidentiality purposes.

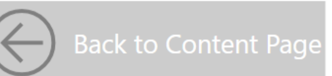
Targets used for monitoring patients with **Diabetes**:

- HbA1C 58 mmol/mol or below
- Cholesterol below 5 mmol/l
- Blood Pressure 140/80 and below

Targets used for monitoring patients with **Mental Health**:

- Smoking
- Body Mass Index (BMI)
- Alcohol
- Blood Pressure 140/80 and below

Social Prescribing - Impact on patients with diabetes



Total Patients referred

549

Total Patients attended

517

Total appointments made

1,944

Number of attendances

1,660

Average attendances per patient

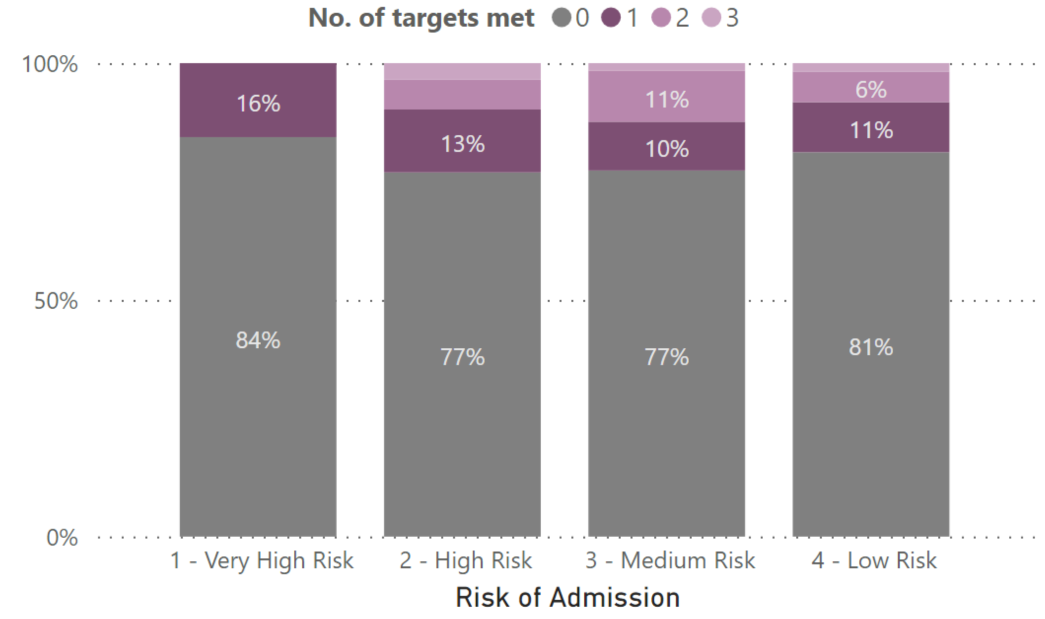
3.2

% DNAs and Cancellations

14%

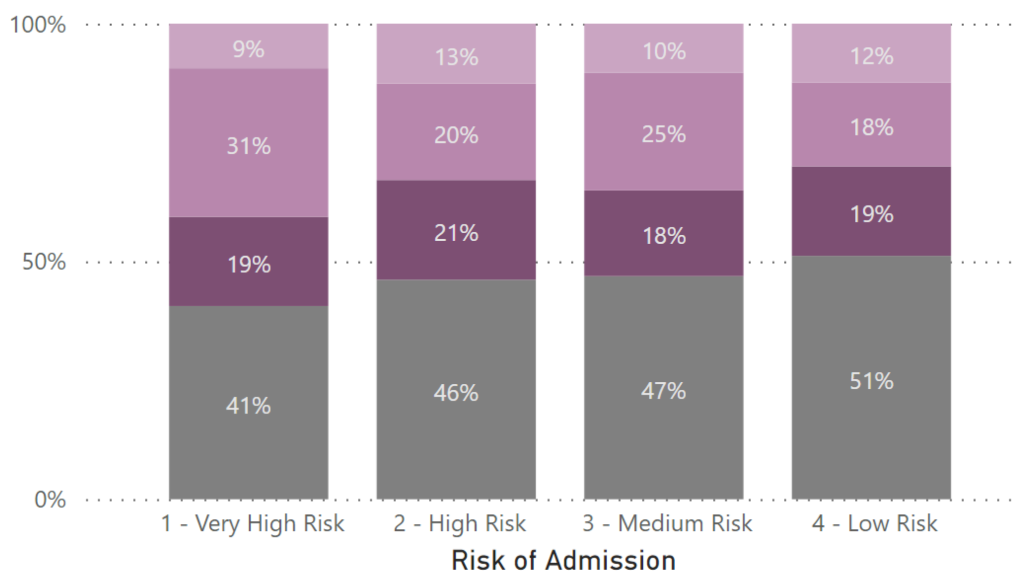
Targets met within 12 months **prior** to first contact

Risk Score Band	0	1	2	3	Total
1 - Very High Risk	84%	16%			**100%**
2 - High Risk	77%	13%	6%	3%	**100%**
3 - Medium Risk	77%	10%	11%	2%	**100%**
4 - Low Risk	81%	11%	6%	2%	**100%**

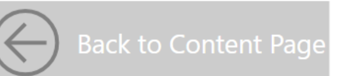


Targets met within 12 months **after** first contact

Risk Score Band	0	1	2	3	Total
1 - Very High Risk	41%	19%	31%	9%	**100%**
2 - High Risk	46%	21%	20%	13%	**100%**
3 - Medium Risk	47%	18%	25%	10%	**100%**
4 - Low Risk	51%	19%	18%	12%	**100%**



Social Prescribing - Impact on patients with Mental Health



Total Patients referred

252

Total Patients attended

226

Total appointments made

814

Number of attendances

670

Average attendances per patient

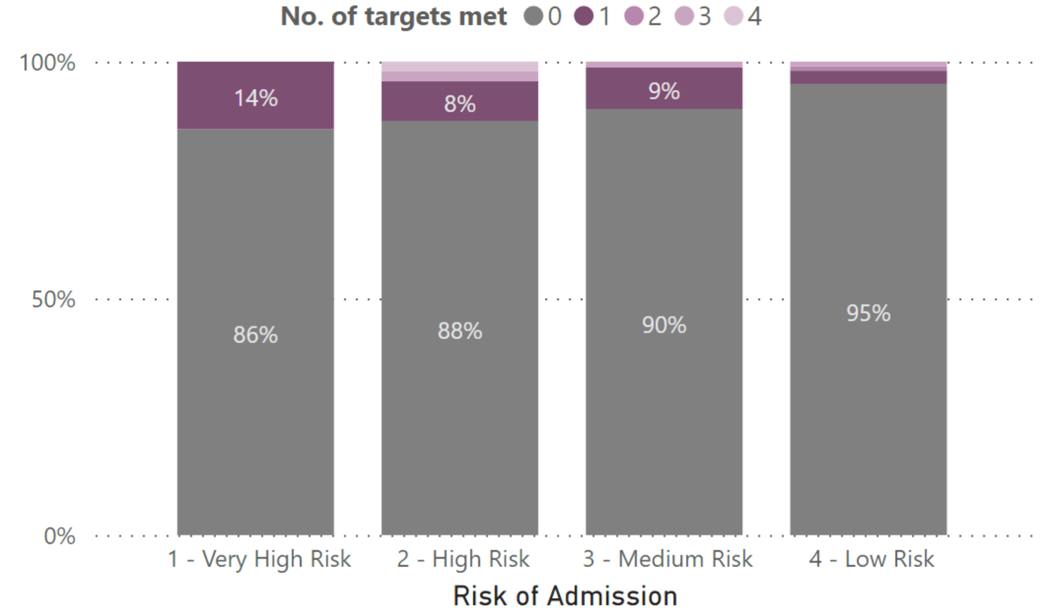
3.0

% DNAs and Cancellations

17%

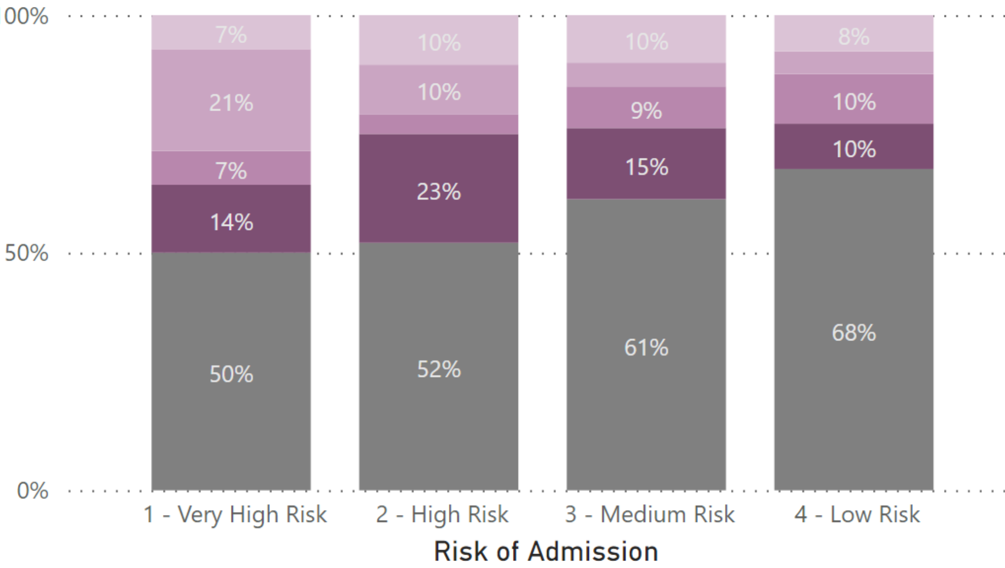
Targets met within 12 months **prior** to first contact

Risk Score Band	0	1	2	3	4	**Total**
1 - Very High Risk	86%	14%				**100%**
2 - High Risk	88%	8%		2%	2%	**100%**
3 - Medium Risk	90%	9%		1%		**100%**
4 - Low Risk	95%	3%	1%	1%		**100%**

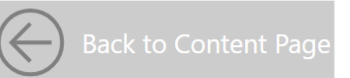


Targets met within 12 months **after** first contact

Risk Score Band	0	1	2	3	4	**Total**
1 - Very High Risk	50%	14%	7%	21%	7%	**100%**
2 - High Risk	52%	23%	4%	10%	10%	**100%**
3 - Medium Risk	61%	15%	9%	5%	10%	**100%**
4 - Low Risk	68%	10%	10%	5%	8%	**100%**



Social Prescribing - Impact on patients with Asthma and/or COPD



Total Patients referred

676

Total Patients attended

628

Total appointments made

2,580

Number of attendances

2,152

Average attendances per patient

3.4

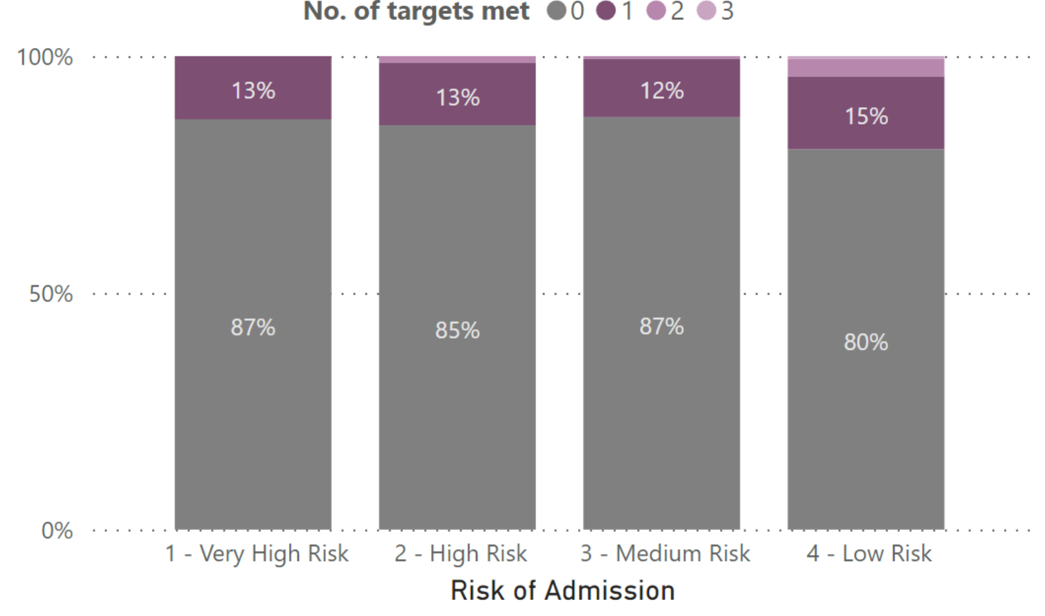
% DNAs and Cancellations

17%

Note there were **zero** patients that met all 4 targets pre or post 12 months from their first Social Prescribing contact date. To discuss, may need to revisit logic or replace with other measures.

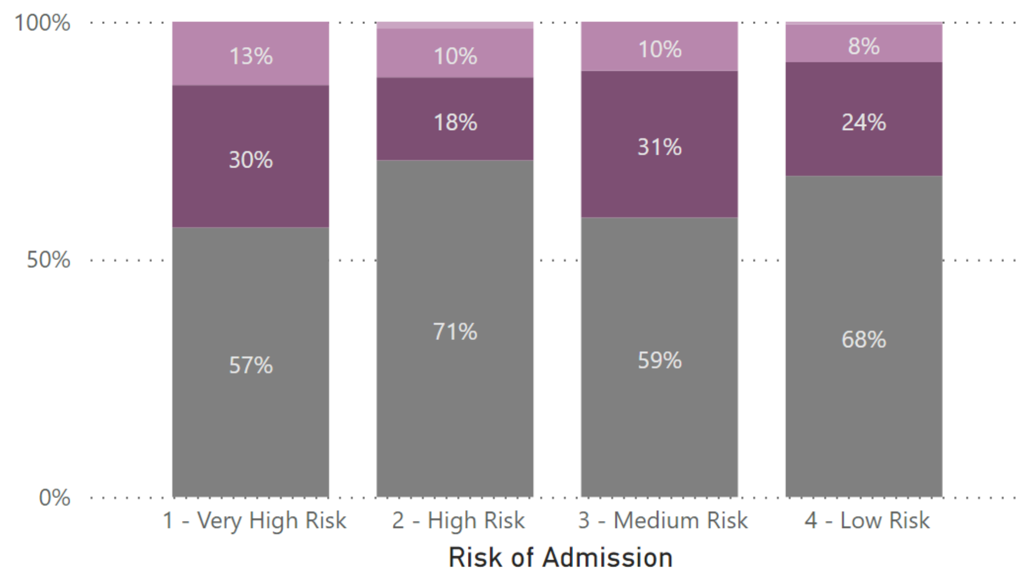
Targets met within 12 months **prior** to first contact

Risk Score Band	0	1	2	3	Total
1 - Very High Risk	87%	13%			**100%**
2 - High Risk	85%	13%	1%		**100%**
3 - Medium Risk	87%	12%	1%		**100%**
4 - Low Risk	80%	15%	4%	1%	**100%**



Targets met within 12 months **after** first contact

Risk Score Band	0	1	2	3	Total
1 - Very High Risk	57%	30%	13%		**100%**
2 - High Risk	71%	18%	10%	1%	**100%**
3 - Medium Risk	59%	31%	10%		**100%**
4 - Low Risk	68%	24%	8%	1%	**100%**



Possible future opportunities - require funding and capacity

- Self referrals
- Front door pilot work with Social Care?
- Community chest development ?
- Pro active projects - target long term condition
- Community integration

Watch the recording of the presentation about the service and evaluation here.