



# ARCBITE



Brokering Innovation Through Evidence

## Evidencing the Impacts of Social Prescribing

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### Background

The most recent NHS long term plan aspires to refer at least 900,000 individuals through social prescribing (SP) by 2024, with this aim playing a key role in contributing to the personalised care agenda and addressing health inequalities. There is already a considerable amount of social prescribing activity taking place across the UK. Researchers have made concerted efforts to evaluate the effectiveness of SP and contribute to a growing literature base. However, there is a gap in research that demonstrates how SP might be positively or negatively influencing health inequalities. This project explored the data held by two SP link worker services in Pennine Lancashire to identify what information this could provide about the reach of the service and evidencing impacts on health inequalities.

### How did we involve people?

The research was undertaken by the ARC-NWC Equitable Place-Based Health & Care (EPHC) theme. The ARC-NWC Improving Population Health Theme was also a collaborator on the project and undertook the quantitative data analysis. Key stakeholders including SP service managers, commissioning leads and two public advisors were involved in the planning and conduct of the mixed-methods research. Two SP organisations based in Pennine Lancashire were identified that used case management systems to record service user data.

## What did we do?

Data sharing agreements were set up to comply with data regulations. Data from April 2020 - April 2021 was extracted. Data analysis involved comparing local demographic and service user profiles where possible and focused on three areas: 1) who was accessing the service 2) how they were accessing & 3) what outcomes were being demonstrated.

Between July-Sept 2021 focus groups (n=5) were also undertaken with link workers in both sites (n=3) and professionals (n=2) involved in commissioning, service delivery or monitoring and evaluation roles to reflect on the initial data findings.

## What did we find?

### Data collection process

We found that both services were committed to collecting data on service users and had systems in place to record this information. However, our findings support previous research that highlights how data collection processes and systems can vary across organisations delivering SP. This means that it is difficult to draw conclusions on outcomes and impact for service users based on existing data. For both sites, data quality was affected by missing data. In one site data quality was additionally impacted by the use of two separate data collection systems and not all of the link workers were using both or inputting the same detail.

### Summary of data gaps:

- Service user characteristics were limited to basic demographic data such as age, gender, ethnicity & postcode;
- The wider determinants of health such as employment, housing status, long term health conditions, disability or carer status were not recorded in the data collection systems;
- Inconsistent recording of information such as who was referring into the service, organisation, primary care network or role provided;
- Insufficient information on further referrals and if there was take up of additional support;
- Not all data being recorded in an accessible format for quantitative analysis - for example, actions undertaken by link worker, ongoing referrals & service uptake were recorded in typed case notes and would have required someone to categorise information and code text.

## Who is accessing social prescribing?

Although there were some limitations to the data, we did find young people, those from minority communities and men, were less represented in the data that was available. This reflects national findings that indicate these groups are less likely to access SP. Nationally, referrals for women have been shown to be 1.5 times higher than men and 1.4 times lower for those from non-white ethnic backgrounds. Referrals from those aged over 65 were twice as high compared to other age groups.

The focus groups explored possible explanations and barriers for these groups as described in the box.

## Measuring impact and outcomes

Outcome measures were considered to be an integral part of data collection to capture impact in both sites. However, there were low numbers of pre and post measures completed at the beginning of link worker contact when a person is referred to the service and then at the end of contact. Both services were using the ONS4 well-being measure<sup>1</sup> (which includes 4 well-being questions) and one of the services was using an additional measure known as the Outcome star<sup>2</sup> (which includes 10 broad areas of a person's life such as physical health, self-care, social networks, managing money, meaningful use of time, motivation, housing, substance misuse, anti-social behaviour).

The challenges of collecting evidence on the impact of SP were raised in the focus groups and these included difficulties accessing individuals to complete pre and post measures, language used and suitability or appropriateness of measures for service users. Link workers also reported that they do not always complete measures for every service user or omitted questions they felt were not appropriate. This suggests that there are likely to be inconsistencies with how the measures are being used.

### Barriers identified

- Men and young people accessing primary care/GP less and not opening up about wider issues
- Minority communities having more informal support networks
- Cultural barriers
- Language being used for SP and understanding of SP
- GP buy-in and understanding
- Lower referrals from practices in areas with higher BAME populations

*"... Don't always get a true picture when you're asking something quite formal... They want to come out scoring quite well, but you know, so you, you're not always getting a true reflection.... think we gauge a lot about where somebody is by having a conversation rather than being that formal" (Link worker)*

*"We have great case studies. We know it works, but when it comes to data, it has been one of the challenges that we've had" (NHS Commissioner )*

1. <https://measure.whatworkswellbeing.org/measures-bank/ons4/>

2. <https://www.outcomesstar.org.uk/using-the-star/find-your-star/health/>

While there was a general understanding for the need for outcome measures to evidence impact particularly for funding and commissioning purposes, it was felt outcome measures such as the ONS4 do not really reflect the role of link workers or demonstrate the true impact of SP for individuals. Individual service user case studies are collected regularly by both SP organisations and were considered by stakeholders to be more impactful than data.

## What does this mean for service delivery and research?

There is a considerable amount of SP data being collected across the NWC. Some of this information is held in organisational data systems but NHS data collection systems such as EMIS (primary care records data system) are also being used to capture information on SP service users. GPs are also required to report where a patient has been offered SP, then if they have declined the offer or accepted and referred on. Therefore, data held in EMIS can provide additional information on the characteristics of patients who decline or accept the offer. Access to this data would facilitate research on equity around who is offered and referred to SP.

In terms of groups (young people, men and BAME) that are less represented in the social prescribing data this project highlights opportunities for:

- Service improvement - how such groups are reached and what is communicated about the offer, improving referral pathways;
- Research - why some groups may not be accessing SP, the appropriateness of SP services for these groups, what barriers exist and how can these be addressed, how referral pathways influence uptake.

We must also consider that if the main referral route is through primary care; social prescribing may exclude groups who do not access primary care services in the same way as others.

To consider impacts of SP service provision on health equity we need to ensure that relevant data is being collected. We need to move beyond the focus of recording basic demographics such as age, gender, ethnicity and postcode and consider factors that relate to the wider determinants of health such as employment, housing, carer, disability status as well as health conditions. But more importantly we need to consider equity across access, experience and outcomes.



Improving the collection of outcome measures is important to demonstrate impacts. However, outcome measures need to be meaningful from the perspectives of those commissioning, delivering and accessing SP. It is important to note that those that access SP will have individual needs. Their priorities or desired improvements may not necessarily be reflected in outcome measures currently used. However, some measures such as the Outcome star reflect more broader needs that individuals may identify with the link worker and may therefore provide a more meaningful measure of improvements based on need. Exploring outcomes related to specific needs, met or unmet, may also provide a better reflection on SP impacts.

## Next steps

Internal reports summarising the data findings for each site have been produced and will be used to identify key actions for data collection, reporting or service delivery and any further research priorities. We will feed into the ARC-NWC SP network to explore how ideas can be developed into a funded research project and opportunities for collaboration.

In addition, the EPHC theme:

- Will be conducting a pilot project accessing primary care data to explore possible inequalities in those who are offered, those who accept and those who are ultimately referred to SP (Jan - March 22);
- Feeds into the NHS England and NHS Improvement initiative supporting the development of a minimum dataset for SP to help standardise data collection, which will be published between March - June 22.

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