# A study of the upscaling of the Social Prescribing Service in Merton

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# Forward

As a GP in Merton and former NHS Merton CCG chair, I have been engaged with the development of social prescribing in our borough over the last few years and have witnessed first-hand the benefits for patients.

It is very encouraging to now see the positive impact of upscaling the programme clearly demonstrated, through both patient stories and hard numbers.

The improvement in patients' lives and the freeing up of GP time to deal with more patients is impressive and I highly commend the team and all the key partners who have worked with great commitment and dedication on this over the last 4 years.

- ***Dr Andrew Murray, NHS South West London CCG Chair***

Merton has been one of the forerunners in social prescribing as a creative, community-based approach to health and wellbeing, championed by Merton Health and Wellbeing Board as early as 2016, and turned into a thriving service through the tireless leadership from both our primary care clinicians and voluntary sector partners.

Our ongoing commitment to Social Prescribing is included both in our Health and Wellbeing Strategy 2019-2024 and through the work of Merton Health and Care Together, as an intrinsic part of our holistic approach to health and care.

This report presents the latest contribution to what is becoming a growing body of evidence that social prescribing can lead to a range of positive health and wellbeing outcomes and deliver real benefits, to both Merton residents and patients.

I am delighted to commend this study and its findings and look forward to the continued rollout of social prescribing across Merton.

- ***Dr Dagmar Zeuner, Director of Public Health, London Borough of Merton***

The team of Social Prescribers that Merton Connected (trading name of MVSC) supports is part of a huge success story, as evidenced in this report. From a single person, to the team we have now, covering all 22 GP practices, the impressive benefits highlighted in both the statistics, but brought to life by the case studies, provide the evidence of why Social Prescribing is now a nationwide service.

The collaborative working of health services, the local council and the voluntary, community and faith sectors in the borough that has enabled Social Prescribing to flourish in Merton, to the real benefit of so many local residents. Innovation and improvement of the service is a continuous process and will provide a future that I am confident will reflect the success of the last four and a half years.

- ***Simon Shimmens, CEO, Merton Connected***

# Acknowledgements

The authors would like to acknowledge the assistance and support of the Merton Social Prescribing Team. Particular thanks is extended to Charesse Miller, Kemi Oyebode, Mel Palachandran, Nicole Lau, Marina Caroli, Adrianna Jones and Ben Halschka who composed and compiled the poignant case studies for this report.

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# Executive Summary

The Social Prescribing Link Worker service began in Merton as a pilot in February 2017 in two East Merton Practices and has expanded across Merton with nine link workers now working in 22 practices.

This report provides an analysis and evaluation of the impact of Social Prescribing in Merton from 2016/17 to 2018/19. It looks the impact of the programme on the health and wellbeing of patients and the wider system. It incorporates a review of patient referral and outcome data, feedback from GPs, and case studies composed by link workers and their patients.

In total there were 576 referrals made to the service between 2016/17 and 2018/19. While numbers varied each year, typically more than two-thirds of patients referred were female. The most common referred ethnicity was White British and the next most common was black or black British - Caribbean. The most common reason for referral to the service was social needs or frequent attenders of GP appointments (2018/19 data).

Results show that the programme has had a positive impact in several areas:

- Patients self-reported health and wellbeing scores significantly increased between Social Prescribing visits, by an average of 26%.
- Patients visited the GP significantly less in the three, six, nine and 12-months after visiting the Social Prescribing Link Worker than in the same time period before by a reduction of 23.9%, 14.4%, 8%, 7.2% respectively.

GP feedback has described the social prescribers as key and proactive members of practice team, who provide an integral service for patients with non-clinical and wellbeing needs.

Case studies illustrate ways the social prescribers provide bespoke support and link patients to a range of community and statutory services. The case studies have shown the link workers to provide a vital service in supporting people to navigate their personal challenges and feel less isolated.

The onset of the COVID-19 pandemic has brought substantial changes to the health and wellbeing needs of Merton communities as well as the working practices of the Social Prescribing team. Next steps will be to evaluate the impact of Social Prescribing in Merton during the COVID-19 pandemic measures and recovery.

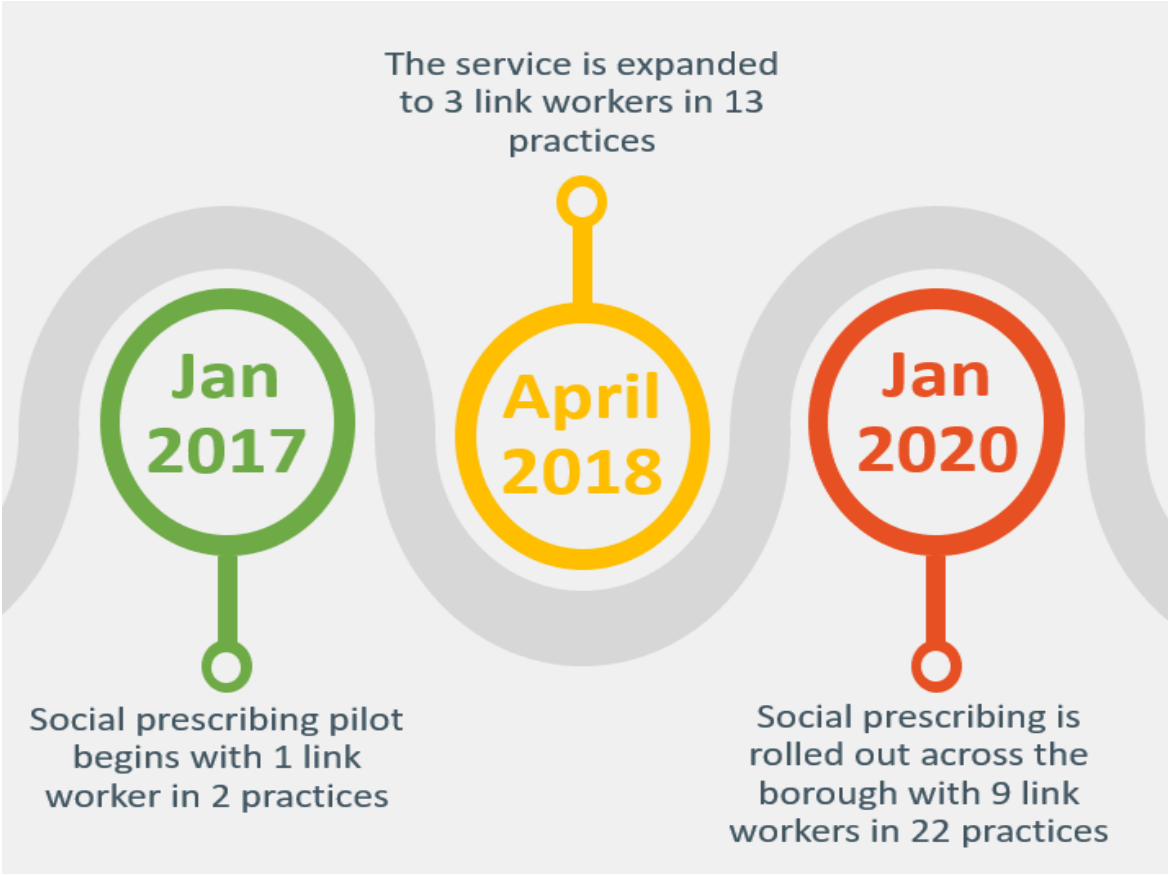
# Introduction

The pressures on general practice are continuing to grow, as the ageing population and rise in multimorbidity are creating a larger and more complex workload ("Pressures in General Practice," 2020). Alongside this, there is a strong sense amongst GPs that a lot of time in general practice is spent on non-health related issues during appointments, and that this leaves less time available for other patients with health-related issues (Caper & Plunkett, 2015). Specifically, in a survey to 1,002 GPs, it was found: that around one fifth of their consultation time was estimated to be taken up by non-health-related issues; that one in four GPs felt that this resulted in less time available for patients with health-related issues; and further to that, two-thirds of GPs felt that this led to increased stress levels in their job (Caper & Plunkett, 2015). It is clear from this that there is a need to address these non-medical issues outside of GP consultations in order to alleviate some of the pressure that is put on General Practice.

Social prescribing has been serving this very purpose in Merton since its pilot begun in January 2017. Social prescribing provides health care professionals with a non-medical referral pathway, so that the social determinants of health and wellbeing can be addressed without a need for the GP ("What is social prescribing?" 2017). A social prescriber, or link worker, can spend more time with a patient than would be possible in a GP consultation. During an appointment, the link worker will discuss with the patient their various non-medical needs and will then support the patient in finding the most appropriate local services to address those needs.

In Merton, the social prescribing service started with one link worker based in two practices in the east of the borough. The success of the pilot led to the service expanding to host three link workers in thirteen practices from April 2018. In January 2019, the NHS Long Term Plan (LTP) outlined that there would be a shift in focus towards self-management and personalised care. One of the key approaches to this that the LTP identified was Social Prescribing. The LTP committed to embedding link workers within each Primary Care Network (PCN), with the aim of having 900,000 people referred to Social Prescribing across England by 2023/24 ("NHS Long Term Plan," 2019). By January 2020, the Merton social prescribing service had therefore been rolled out across the borough, with nine link workers working in twenty-two practices across six PCNs.

**Timeline of Social Prescribing in Merton**




## The Social Prescribing Model

In Merton, social prescribing follows a model whereby healthcare professionals within the practice, having established a need for social prescribing, will refer a patient to the link worker via their electronic patient record systems, EMIS and Elemental. Within each practice the link worker is present on an allocated day each week, as a fully integrated member of the team. Having received the referral, the link worker will then review it and contact the patient to arrange their first appointment. Over an hour appointment, the link worker will establish the main needs of the patient and then signpost or refer them to appropriate services within the community. Depending on the needs of the patient, the link worker will then offer them a three and/or six-month follow up to review their progress and offer any additional support needed.

## Purpose of this report

This report will look back at how the Social Prescribing service in Merton has fared from the pilot phase with one link workers, to the expansion to three link workers across nine practices up until the end of the financial year 2018/19. It will look at data on who is being referred and

why, the services they are being referred to and the outcomes in terms of patient wellbeing, GP appointments, Accident and Emergency (A&E) visits and emergency admissions. The report will go on to discuss what lessons have been learnt over the course of the programme's expansion and what actions the service may need to take, going into the future.

## A Note on Covid-19

With the onset of the coronavirus pandemic in March 2020, there were significant changes both to the social prescribing service and to the healthcare system. For example, the link workers went from having a maximum of six face-to-face social prescribing appointments per day before the pandemic, to contacting upwards of twenty patients per day by phone. Furthermore, primary care consultations fell by 30% the week after the introduction of a national lockdown in mid-March 2020 compared to the week before; a figure which did not greatly change through to July 2020 (Watt et al., 2020). As the data analysis pulls data from up to twelve months before and after a social prescribing appointment, the time-period from April 2019 onwards, including the expansion to nine link workers across twenty-two practices, has not been included in this analysis. This is because with the changes described above, it would not be possible to assess the true impact that social prescribing has had on patients during this time-period.

# Methodology

The data extraction and analysis was completed by Andy Noble from NEL CSU.

The analysis employed a mixed method approach. This was done in order assess the outcomes of the service both in terms of patient wellbeing, the effects of the healthcare system, and to understand who is accessing the service and for what purpose. Quantitative methods were used to pull together data in relation to the demographics of patients from 2016 to 2019, and their outcomes before and after the social prescribing service. Qualitative methods were then used to obtain responses from both GPs and service users through case study examples.

## Quantitative Methodology

During the pilot phase, data on demographics, including age, gender and ethnicity, as well as information on the number of GP appointments, acute admissions, A&E attendances, Elective Admissions and Outpatient Attendances before and after a social prescribing appointment were taken from EMIS – the electronic health records system used by the NHS in Merton. The anonymised data was analysed on SQL before being transferred to Excel to produce summary tables and charts.

From July 2018 onwards, the link workers used an Excel template to record the data on demographics as listed above, as well as the reason for referral. The reasons for referral were entered into the spreadsheet using predetermined categories, which can be found below. The link workers would send their completed spreadsheets every month to NEL CSU, where the data would be processed. This dataset was then linked with the data from EMIS, as listed above. Following the analysis, the data was transferred to Excel to produce tables and charts.

| **Reason for referral categories:** | | |
|---|---|---|
| • Frequent attender | • Recent hospital admissions | • Social needs |
| • Mental health | • Socially isolated | • Other |

Patient wellbeing was measured using the Wellbeing Star, which has been found to be reliable and valid as a measure of wellbeing (Mackeith et al, 2010 and Mackeith, 2011). The tool looks at eight health and well-being sub-categories that patient's rate on a scale ranging from 1 (not

thinking about it) to 5 (as good as it can be). The sub-categories are: Lifestyle; looking after yourself; managing symptoms; work, volunteering and other activities; money; where you live; family and friends; and feeling positive. The results are displayed in a star diagram that the patients can see and compare with previous results at each appointment (Mackeith, 2014). Wellbeing Star data could only be extracted for 2018/19.

## Qualitative Methodology

As part of this evaluation, GPs were also asked to provide their views on what they felt worked well, and areas for improvement. They were sent a survey focusing on the impact of the social prescribing service within their practice and recommendations for improvement. Questions included; 'what benefits/ changes has the social prescribing programme brought to your practice', 'what works well and why', 'where, that you have seen, has social prescribing had the biggest impact', 'what needs to change in order for the Merton programme to provide a better experience for clinicians and patients?'

Several case studies have also been used within this evaluation to demonstrate the impact of the social prescribing service on service users, and how the link workers supported them. These case studies have been documented by link workers within practices, with some written in collaboration with the service user.

# Results

## Demographics

A total of 576 patients were referred to social prescribing in the financial years 2016/17 to 2018/19. Of these patients, around one quarter (159, 27%) were male and 72% (415) were female (Figure 1). The largest proportion of patients referred were between the ages of 50 and 59, 136 of patients from this age group were referred to the social prescribing team (Figure 2).

**Figure 1. Gender profile 2016/17**

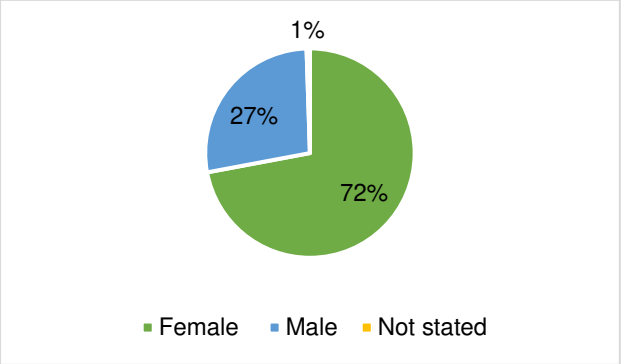
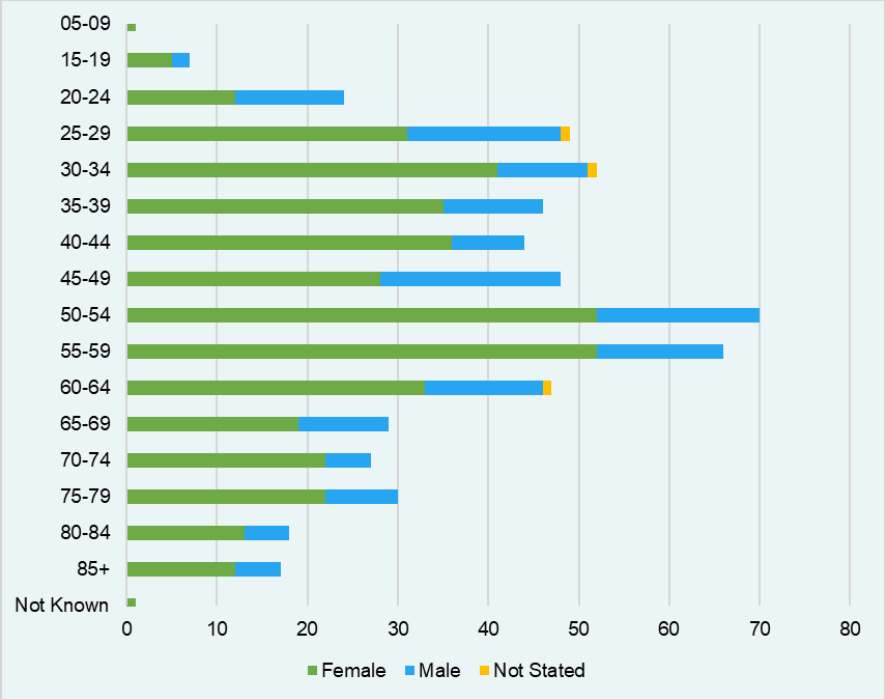



**Figure 2. Age profile 2016/17**



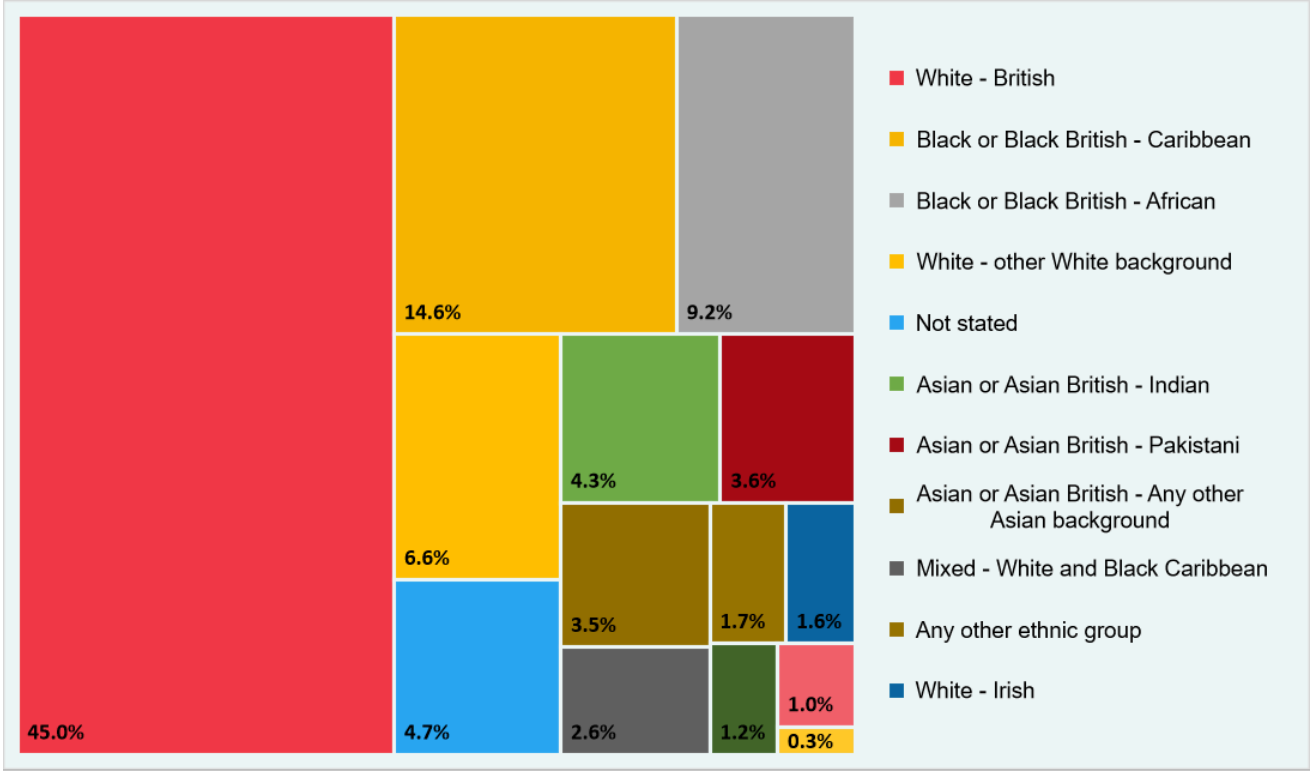
Nearly half of the patients referred were White-British (45%), with the next largest percentage of referrals being for Black or Black British-Caribbean (14.6%), Black or Black British- African (9.2%) (Figure 3).

Of the general population in Merton, 41.8% are White-British, 3.7% are Black British-Caribbean and 4.7% are Black or Black British- African. The third largest ethnic group in Merton is Asian-Other which makes up 9.1% of the population (Merton Data, 2021).

This highlights that while White-British are proportionally represented within the social prescribing patient cohort in Merton, there is disproportionately high representation by Black British-Caribbean and Black or Black British- African. This might be reflective of higher social needs among these groups.

There is marked underrepresentation of Asian-Other, currently 3.5% of those who are accessing social prescribing are Asian-Other, whereas they represent 9.1% of Merton population. This may be due to a discrepancy in how ethnicity is recorded within primary care in comparison to GLA data projections, it could mean that this group are less likely to require the social prescribing service, or that they are simply not accessing the service. This requires further exploration.

**Figure 3. Ethnicity profile 2016/17 to 2018/19**

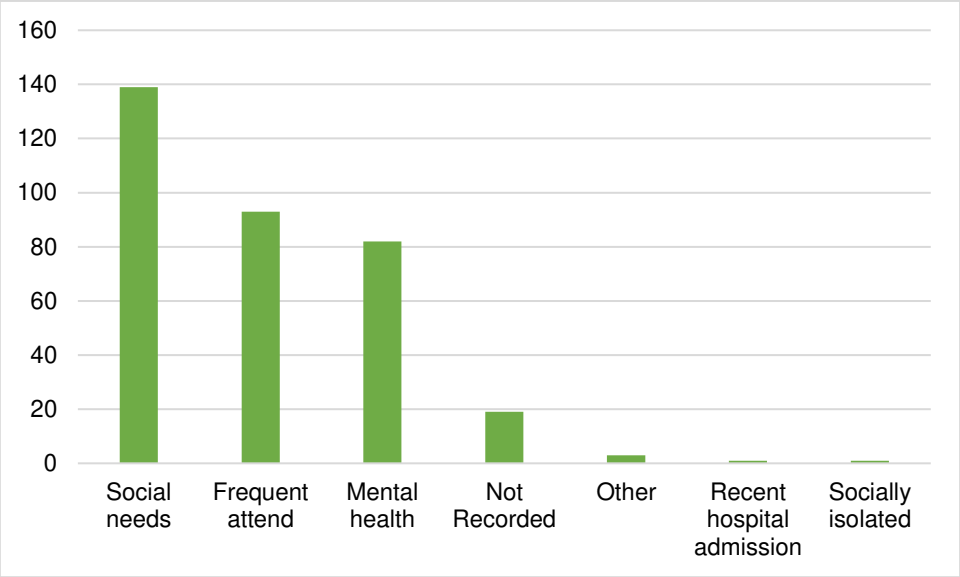


# Reason for referral

### 2018/19 Reason for referral

For the financial year 2018/19, data could be extracted from the referral form on reasons for referral to the social prescribing service. Figure 4 shows that the most common reason for referring patients to social prescribing was due to social needs, and that being a frequent attender and having mental health needs were also common reasons for referrals. Recent hospital admissions and social isolation were the least common reasons for referral.

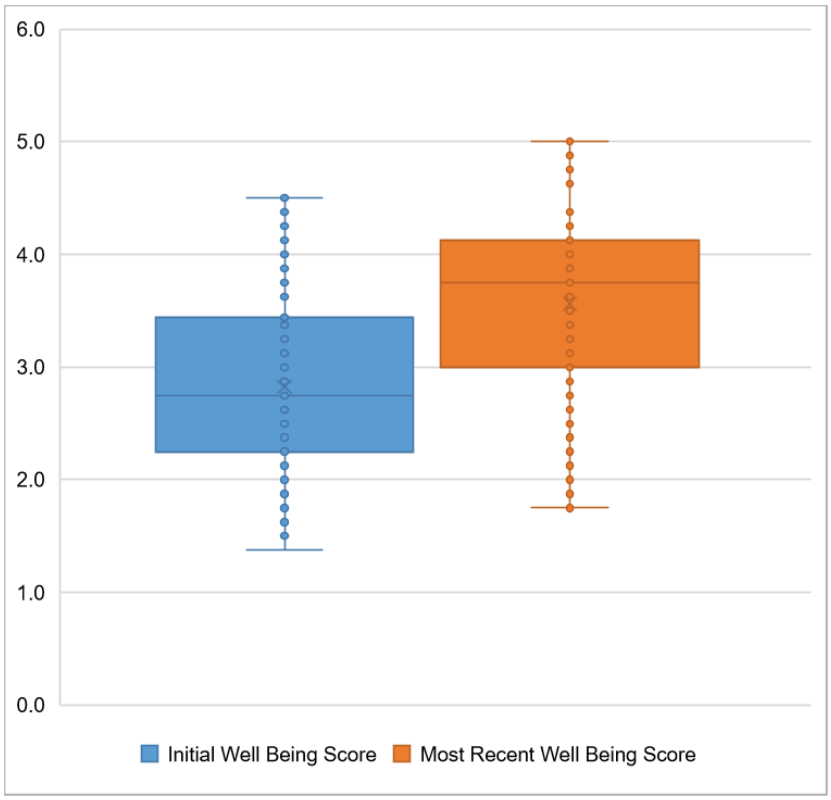
**Figure 4. Reason for referral 2018/19**




# Outcomes – patient wellbeing

Patient wellbeing is measured using the Wellbeing Star. Changes in patient wellbeing were calculated for patients who attended more than one social prescribing appointment and completed the Well-being Star at both appointments. Of the 576 referrals received, 91 had provided a wellbeing score more than once and were therefore included in this analysis. Across the borough the average Wellbeing Score at the initial appointment was 2.83 (Standard deviation = 0.79) out of 5 and at the most recent appointment was 3.56 (Standard Deviation=0.83) (see Figure 5). This was an overall statistically significant improvement in Wellbeing Scores of 0.74, or 26% ($t(100)=9.77$ $p=0.00$).

**Figure 5. Distribution of overall Wellbeing scores during first and latest social prescribing appointment, 2016/17 to 2018/19**




## Outcomes – GP appointments

To understand the potential impact of the social prescribing programme on GP usage the number of GP appointments at three, six, nine and twelve months before and after a social prescribing appointment was analysed.

Data shows that patients who accessed the Merton social prescribing service between 2016/17 and 2018/19 had fewer appointments with their GP (Figure 5). This was seen at three, six, nine and twelve months, but most substantially at three months with a reduction of 23.9% of appointments. This equates to a total of 631 appointments in that time period an average of 1.3 in reduction of appointments per patients at the three-month point. The average reduction of appointments per patient is illustrated in Figure 6.

**Figure 5. GP appointments activity % variance in 3-, 6-, 9- and 12-month periods before and after a Social Prescribing appointment, 2016/17 to 2018/19**

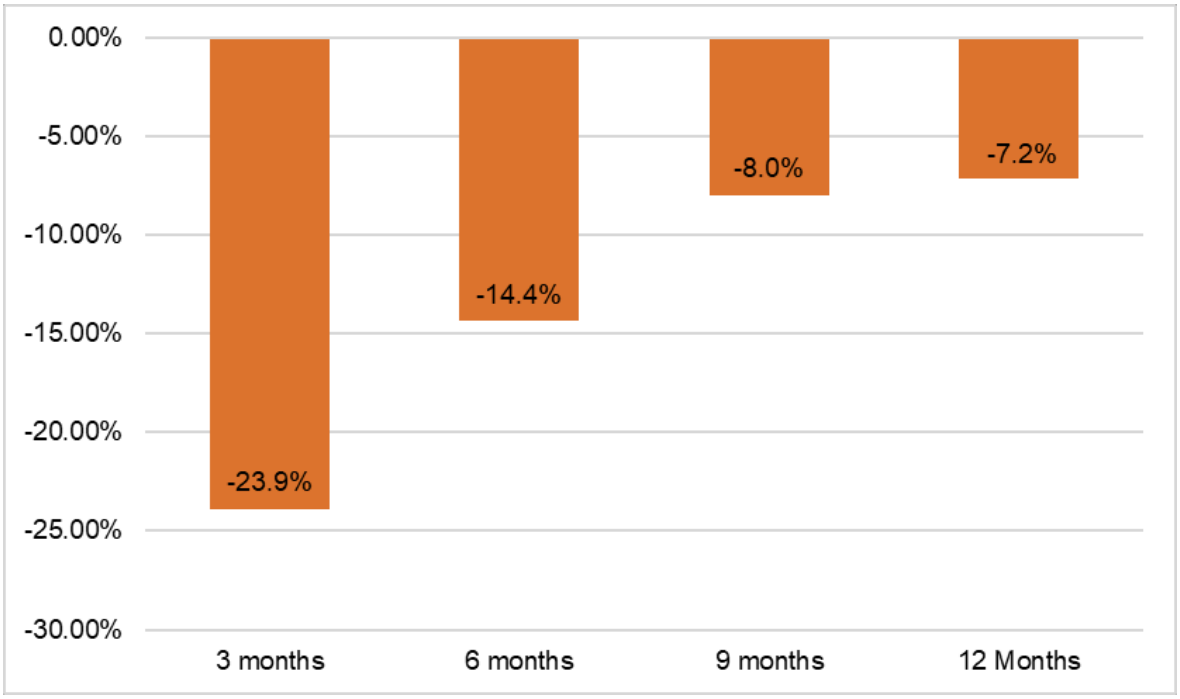
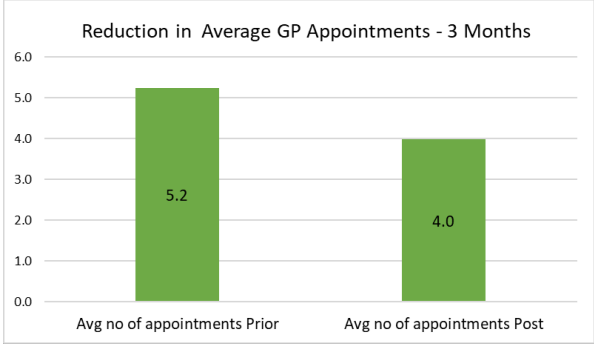
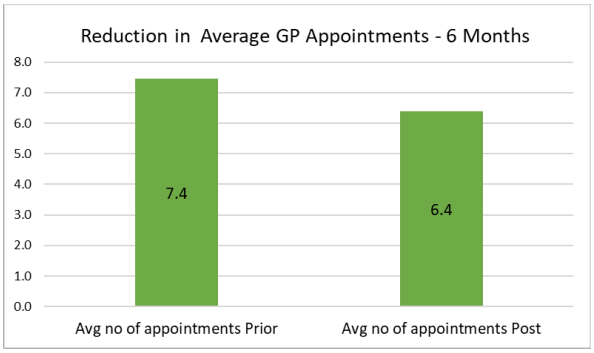
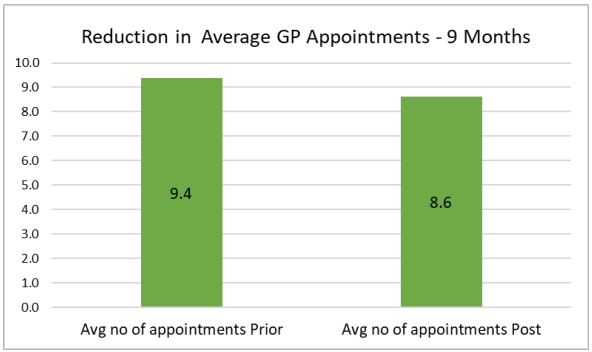
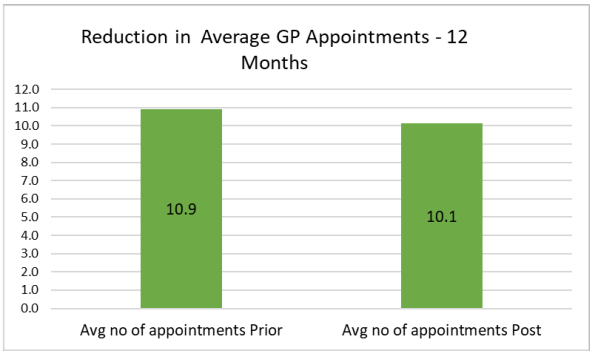



**Figure 6. Average reduction in GP appointments per patient in 3-, 6-, 9- and 12-month periods before and after a Social Prescribing appointment; 2016/17 to 2018/19.**



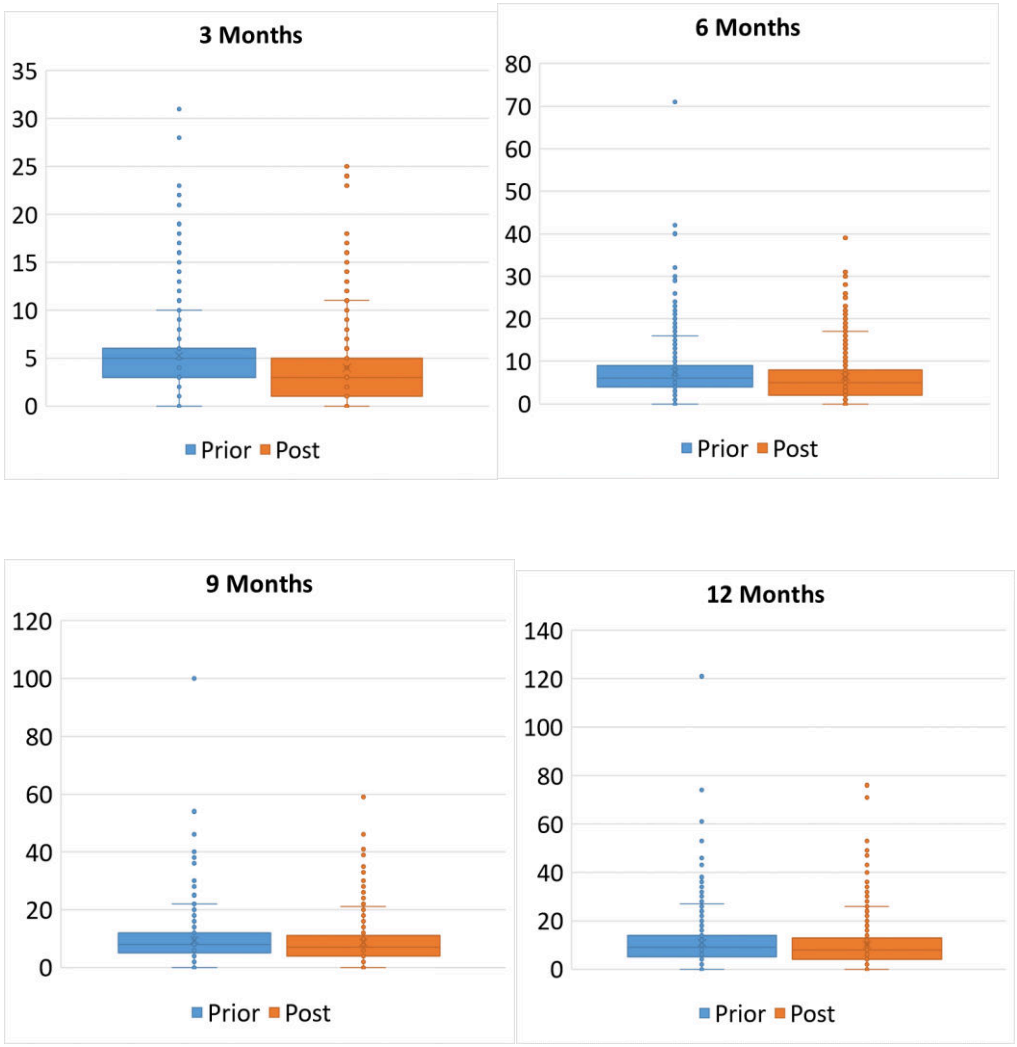



Statistical analysis (one-tailed t-test) was carried on each of the timeframes and found a significant reduction in GP appointments following a social prescribing appointment (*three months*: t(100)=7.85 p=0.00; *six months*; t(100)=4.57 p=0.00; *nine months*: t(100)=2.49 p=0.01 and *12 months* t(100)=2.09, *p*=0.02). The variance is illustrated in the box plots in Figure 7.

**Figure 7. GP appointments activity % variance in 3, 6, 9 & 12-month periods before and after a Social Prescribing appointment, 2016/17 to 2018/19**

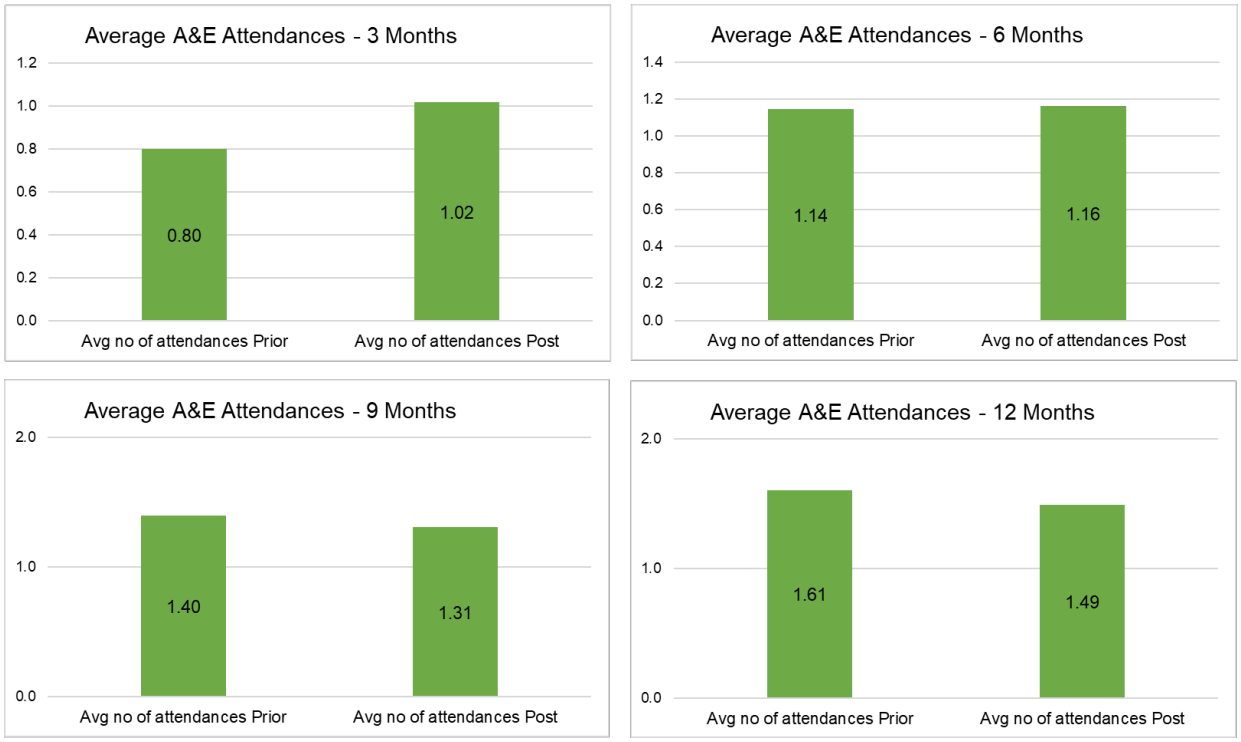



## Outcomes – A&E Attendances

Emergency admissions for patients within the three, six, nine and 12-month time periods before and after a social prescribing appointment were explored. Little variation between the before and after number of attendances was found. The charts presented in Figure 8 below

show the average number of A&E attendances per patient following a social prescribing appointment.

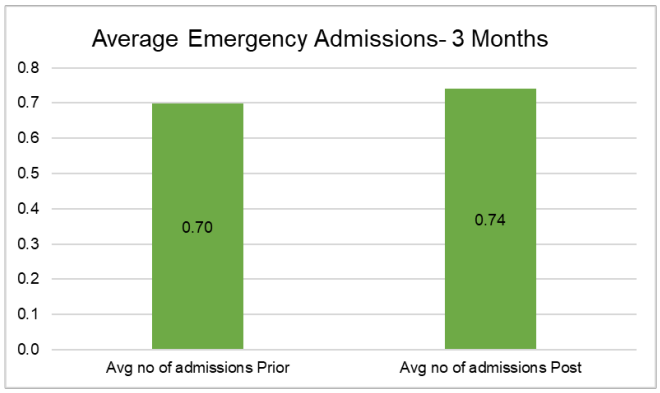
**Figure 8. Average reduction in A&E visits in 3-, 6-, 9- and 12-month periods before and after a Social Prescribing appointment, 2016/17 to 2018/19**

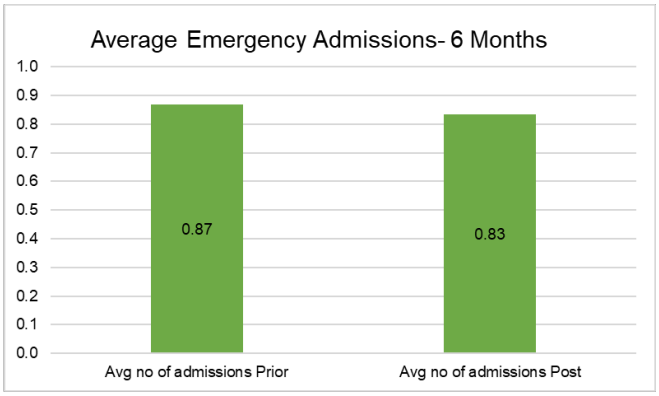


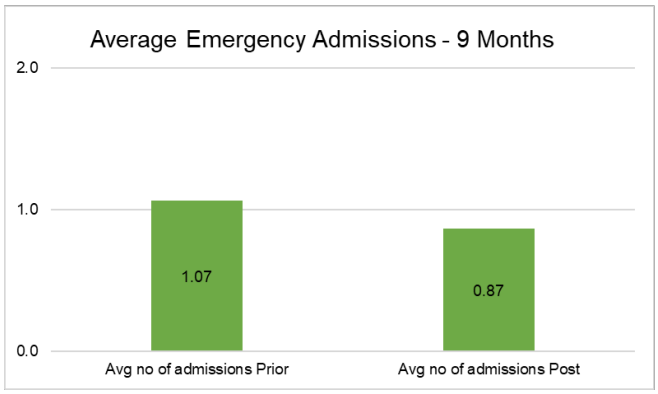

## Outcomes – Emergency Admissions

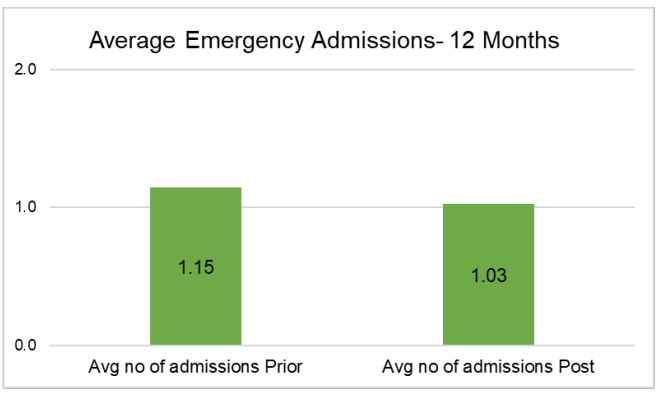
Little variation was found when comparing the number of emergency admissions in the same time periods (three, six, nine and twelve months) before and after a social prescribing appointment. Figure 9 presents the average change in emergency admissions by time period.

**Figure 9. Average reduction in emergency admissions at 3-, 6-, 9- and 12-month periods before and after a Social Prescribing appointment, 2016/17 to 2018/19**



# GP Feedback

A total of 11 GPs from nine practices responded to a survey about their views on the Social Prescribing service within their practice. The survey explored GP views on the benefits, challenges, and impact of the programme.

Overall, the feedback was very positive. When asked what benefits or changes the social prescribing programme has brought to their practice, the GPs felt that the social prescribing service has reduced the demand by frequent patient attenders and reduced the number of patients attending with social problems as opposed to medical issues. This allowed GPs to spend more time on clinical discussions. Additionally, they found that patients are more satisfied with the support they receive at the practice. The social prescribing link workers can spend more time with their patients providing non-clinical support which would previously have been done within a 10-minute consultation:

*"The Social Prescriber role has been immensely helpful to the practice as a whole. GPs are able to give more time to clinical discussions, more patients' satisfaction as link worker spending more time with them and able to provide more non-clinical support than would have been in a 10 min consultation"*

As well as patient satisfaction, GPs reported that social prescribing service and the link workers are vital and integral within the practice:

*"...Social Prescribing has been immensely beneficial to our patients over the past year with the Pandemic/lockdown"*

*" [Social Prescribing] provides a service that is not provided by anyone in the practice and it has become essential"*

In terms of what works well, GPs focused on the referring system and the Social Prescribing Link Worker fitting into the team.

GPs reported that the referring system to the social prescribing service was efficient and worked well. The process allows for patients to be booked directly into their clinic as soon as required, making the process well-organised and preventing patients from waiting for long periods to be seen by a social prescriber:

*"Referral process is very sleek and easy. We can book patients directly into their clinic while seeing the patient. Extra learning for GPs as link work workers give wide support with a number of services"*

*"Referral system is great, easy and quick. I can book an appointment straight away for the patient"*

*"Easy to refer, embedded elemental referral link"*

The link workers were also seen as valued members of practice. By joining the wider team, the Social Prescribing Link Workers were able to developed good relationships with the clinic staff. Not only is this efficient when discussing patients, but it has also allowed clinicians and link workers to develop good working practice. The link workers are able to sit in on clinic meetings, contribute and be a part of decision making, and provide advice and expertise to the wider team on the non-clinical issues that were relevant to patient treatment and care.

*"We've been very lucky with our SPs who have been proactive and integrated well with the wider team and attending clinics meetings and MDTs has been crucial as they have been able to contribute as well as advice wider team"*

*"Our SP is part of our Practice Team and attends our Practice meetings and we have good communication and a great relationship"*

*"Good communication with the social prescriber, feel able to provide more holistic care"*

When asked where Social Prescribing has had the biggest impact, GPs unanimously agreed that biggest impact was seen on reducing the effects of isolation and mental health issues amongst their patients. In addition, the practical support they provide for topics such as benefits and housing is hugely valuable:

*"In supporting patients who are socially isolated, elderly, frail housebound, with mental health issues and patients with welfare needs, for example, supporting them with housing and benefit issues"*

*"Tackling loneliness on our patient group"*

*"They have been especially helpful to provide patient support in channelling to services like housing, benefits, CAB advice and support."*

*"Well-being of people. Not feeling abandoned. Not feeling doctors can't help, no one can help or is helping"*

These are topics that GPs would not necessarily have the time or expertise to effectively support their patients with. Additionally, the link-worker service has allowed for reduced,

repeated appointments with the GP, allowing for more time to be invested for clinical appointments:

When asked what would need to change in order for the Merton programme to provide a better experience for clinicians and patients, there were varying responses suggesting there are still many ways in which the social prescribing service could be utilised. For instance, one GP's response suspected that demand will increase within the next year, and scalability would need to be considered:

*"… Currently at our practice we are managing but would be helpful to perhaps have "floating" capacity if demand is high in certain areas or parts of the year to scale accordingly. Difficult to implement I'm sure unfortunately!"*

Some GPs felt that there needs to be a way for the service to integrate further into the community to ensure that the reach of the service is effective and as wide as possible. Some suggestions included increasing the number of social prescribers doing home visits. Another GP suggested that the programme should consider how it can reach other ethnically diverse communities, and perhaps recruiting social prescribers who can communicate in respective languages. There was also a recommendation to consider how the program could fit into other systems, for example, job centre, workplaces and chamber of commerce, and perhaps not just being placed within GP practice.

Overall, 100% of the respondents recommended a social prescribing service to other GP practices. This demonstrates the positive impact social prescribers and link workers have on the overall running of a practice, reducing the number of patients been seen by GPs with non-clinical issues and allowing for GPs to have more time with patients who require it.

Below is the positive and encouraging feedback left by GPs:

*"Excellent initiative resources, perhaps should be weighted towards areas that need them most as demand may not be equal across the borough."*

*"A fantastic and very useful resource / service which has benefited a significant number of our patients."*

*"Really helpful to refer patients where as a clinician you understand there are psychosocial issues keeping patients from getting well."*

*"Link workers will be needed in future as well and GPs will support them."*

*"Well worth bringing in link workers into primary care, allows us to be more holistic in our care for complex patients."*

# Service user case studies

Social prescribing link workers had compiled case studies of service users that have accessed the service. Some of the case studies outlined below demonstrate the positive impact that the social prescribing service has had on them through the support of link workers. The names of the service users have been anonymised.

## Sue & Rob (alias)

*A Case study of Sue & Rob, written by Rob and Kemi Oyebode their Social Prescriber.*

Kemi – It was the third week in August when I received a referral for a patient from Lambton Road Surgery. I had opportunity to speak with the patient's partner on three previous occasions and exchanged emails about relevant information. It was just before I took a summer break and the end of my role at the surgery.

**Why were they referred to the social prescriber?**

Sue had suffered from a stroke a few years ago, which affected her walking and speech. Her partner Rob, become her main carer. In the years that followed, Sue stopped taking medication, began drinking more alcohol and disengaged in efforts to improve her health. A referral to the social prescribing service was made by her GP.

Because of Sue's difficulty with speech, Rob spoke on her behalf. He gave a brief history of the patient stating how he gave up his employment to take on the caring role. As he spoke, I felt that it would be important to include his needs as a carer recognising the impact on his health and wellbeing. With Rob's consent we completed the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) to get a picture of his mental wellbeing and what is impacting on his mental wellbeing at that moment.

The main issues identified by Rob were:

- Sue's refusal to take her medication which was worsening her stomach complaints
- Her increased drinking of alcohol

- Her worsening her ability to walk
- Her loss of motivation to do things for herself and be engaged in her health and wellbeing

**How did the social prescribing service help?**

Completing the SWEMWBS gave Rob an opportunity to talk about his feelings and concerns. Rob felt that she was consuming excess alcohol which was affecting her health.

I completed a joint referral form for Sue & Rob for an assessment for Carers Support Merton, and Rob was signposted to the WDP, an organisation that can help with alcohol dependency. As Sue lived on the borders of the borough of Merton; access to services in the neighbouring borough was considered for practical reasons.

As Sue was not able to speak directly about her condition, the person-centred care for the patient referral may have been impacted. However, contact with Rob provided space for him to reflect on his caring role, consider an alternative approach to what he was doing, and reduce his sense of isolation and helplessness.

**The impact of the social prescribing service:**

Rob- “Sue and I are getting on alright at the moment. She is now taking her medication without fuss and has reduced her drinking.

Your social prescribing service at least gave me a chance to discuss problems and I think Maria took note of my concerns. In September I did contact Kingston Wellbeing, which provides the same services as WDP in Merton Borough, but Sue gently refused treatment.”

# Stephen

*This case study has been written by Stephen, a patient from Nelson Medical Centre with the support of his Social Prescriber, Marina Caroli.*

**Stephen's story: Tell us a bit about yourself? Anything interesting you would like us to know?**

I love my dog – she comes first. She gives me something else to care about other than myself. I started to play music again after many years. I am a gentleman and want to be kind to other people and repay the kindness that has been shown to me. Once I have recovered from the stress of the last few months, I will be able to make more changes to improve my health and social life.

**What was the issue and how did the social prescriber support you?**

I knew the Social Prescriber as I was referred to her by a GP the previous year with a similar issue. At the beginning of the lockdown, I asked her if she could help me again.

My disability benefits were cut and lost my Motability car after a benefits' review. After the decision, I felt stuck at home. I could not walk. I was no longer able to make ends meet. I started to despair.

The Social Prescriber referred me to Merton CIL, which decided to take on my case. I was allocated a supervised volunteer to appeal the decision at the tribunal. At that time, the council welfare benefits department was not able to help me. The Social Prescriber liaised with some of the services to get evidence for the appeal and wrote a compelling supporting letter. She also called regularly for updates. I was worried that if I l had lost the appeal, I would no longer be entitled to financial support.

Unfortunately, I could no longer afford to pay all the bills, watch television, use the internet, buy food and so on. The SP referred me to the Wimbledon dons. Every Friday two lovely volunteers turned up with a grocery parcel, which included dog food. These ladies saw how depressed I was. They turned up even on a Sunday to give me puzzles and crosswords books. They cheered me up. They saw that I returned some food items and I explained that my cooker had been broken for 7 years.

On the day of my birthday, one of the volunteers turned up with her husband. They had arranged to install a new cooker and took away the broken one. The volunteers also invited

me to their social club at Dorset Road to make friends, as they realised that I was a rugby fan and even suggested that I could play my music there. So, I am really looking forward to watching live sports with them.

**The impact of the social prescribing service:**

Social prescribing, the local charities and the volunteers have made a big difference. I have won the PIP appeal after waiting for 9 months. I developed a good relationship with the Wimbledon Dons and the volunteers. I have felt I could socialise again and able to make friends. They made me feel like I was an ok person - more of a member of society and the community than I believed I was. I have had many doubts in the last years if people would want to be around me.

A social prescriber is a person with an all-round knowledge and contacts that can help. Every time I asked for help, the social prescriber has come up with the right words, information and services to help me. I cannot tell you how much her help has meant to me.

# Eric (patient alias)

*A case study by Adrianna Jones, Senior Social Prescribing Coordinator, MVSC*

**Why were you referred to the Social Prescriber?**

Eric- I was introduced to the Merton Social Prescribing Service by the call handler, Kemi, at the Merton Community Hub in September 2020. Kemi asked me if I had ever heard of social prescribing at my GP practice, Mitcham Medical Centre, I said no but was intrigued to know how a Social Prescriber could help me. She said, with my consent, she could ask the Social Prescriber at my GP practice to get in touch with me and I agreed.

I explained to them that I was finding it difficult accessing my computer and getting online.

Adrianna contacted me promptly after speaking with Kemi, she explained her role and how she could help me access the appropriate support. I explained to her that I was registered blind and wanted to be able to access the internet and use my computer efficiently.

I explained to her about a software I previously had access to called Dolphin Guide Connect which is a downloadable software for computers which allows you to make reading materials and other information accessible to people with visual impairments. My Dolphin software had expired the main issue was is that it costs around £700 and I was not able to afford the total cost as I am a pensioner.

**How did the social prescribing service help?**

Eric- Adrianna spoke to me about my options, and explained that she could connect with RNIB, a charity supporting those who have experienced sight loss. She discovered that they could provide me with a grant of up to £500 to contribute to the cost of the software.

I was very pleased with this and I asked if she could help me to make an application. Adrianna and I planned to meet in person to complete the application but unfortunately, I fell Ill. Adrianna was very helpful as she agreed to continue helping me fill this out over the phone. She read out her supporting statement to me and then posted off the form so that I could sign it and post it off to RNIB.

Adrianna**-** After speaking with Eric, I could see he was motivated to get back online, all he needed was the tools to do so. When he told me he was registered blind, I enquired as to whether he was connected with the local sight loss charity, Merton Vision. He was, and they had been supporting him for years but could not support with the cost of his new software. I then began to research national charities and came across RNIB.

I had a telephone conversation with their Technologies Grants Coordinator and he was extremely helpful, he explained how I could help Eric make the application and the type of information they required.

**The outcome of the social prescribing service:**

Adrianna**-** Eric was awarded the grant of £500 towards the cost of the Dolphin Guide Connect Software by RNIB. They offered to support him to purchase it but Eric felt confident and empowered enough to purchase this independently.

As he has a long-term support worker at Merton Vision, he is also able to contact them should he need help to install the software.

Eric now feels less isolated as he is able to access his computer and keep in touch with current affairs.

# Natalie & Olivia

*A case study of Natalie & Olivia (patient alias) written by Kemi Oyebode, their Social Prescribing Link Worker*

**Why were they referred to the social prescriber?**

Natalie and Olivia are housemates. They both have autistic spectrum disorder and physical impairments that affect their day-to-day functioning. They were referred to the social prescribing service in May 2020.

Natalie has physical disabilities and hypermobility and is depending more on her wheelchair and help from Olivia. Olivia has additional sensory and mental health issues; for these she was on a variety of medications. Olivia has a degree in pharmacology and frequently discusses side-effects from her medication with her doctors. Migraines and other flare-ups result in what the patient described as 'meltdowns' which resulted in hospital admissions. Issues with taste mean her diet was affected and she was not eating healthily.

Olivia was keen to have support from a carer, who was experienced in supporting patients with autism. An Occupational Therapy care-coordinator was in the process of arranging social care direct payments for her and a counsellor/befriender who supported her mental health.

**How did the social prescribing service help?**

**Natalie**

Natalie was under the care of a consultant and was keen to move into local accommodation that was wheelchair accessible. She had completed a request for housing and I wrote a letter to support her application. Having recently completed a course on Housing Law, I could highlight her needs in terms of housing law and the duties of the local council to her. I discussed this with the Occupation Therapist and completed a referral for an assessment. At the same time as NLB's housing officer was identified, we discussed the progress around the application. However, the council was unable to find suitable accommodation locally, Natalie was moved out of borough to continue with her housing application process. Ongoing support for wellbeing was continued by my colleague who took over her care.

**Olivia**

Olivia had expressed concerns about managing her diet and finances. Her care coordinator was an Occupational Therapist who was trying to access specialist care to support Olivia at

home. Olivia was keen to have a support carer from the National Autistic Society (NAS) as she had a better experience with them compared with carers from other organisations. Following a review of the services offered by the National Autistic Society, I referred Olivia to a course by them on managing finances. I also signposted Olivia to One You Merton for information and advice on healthy eating.

Overall, the feedback from service users was positive and there it was clear that the support from the social prescribing link workers was crucial around reducing isolation, mental health issues, and signposting service users appropriately to other agencies that they may not have been aware.

# Summary of findings and next steps

The social prescribing service in Merton has come a long way since the launch of its pilot in January 2017. The service has been through several expansions, going from serving two GP surgeries in 2017 to now serving twenty-two across the whole borough. This evaluation presents findings of the impact the service has had on the patient's health and wellbeing and on the healthcare system.

## Who is accessing the service?

A breakdown by gender, age and ethnicity showed that there are some patterns in who has accessed the social prescribing service:

- Over the three years, a far greater proportion of patients were female than male. While this does not reflect the breakdown by gender in the borough of Merton, it does mirror what other social prescribing services in the country have seen. For example, the social prescribing service in Rotherham found that females were around three times more likely to be referred to the service than males (Dayson et al., 2016).

- The age profile of the social prescribing patients is fairly young. This is as expected given age breakdown of the Merton population as a whole (Merton Data, 2021). The largest representation is among 50-59 age group, the next largest is the 30-39 age group.

- The ethnicity profiles showed that while there is proportionate representation among White-British patients, there is an over-representation by Black British-Caribbean and Black or Black British- African patients. This is likely reflective of higher social needs of these patients. There is under representation of Asian-Other. Further research is required to understand if this is an ethnicity recording error, if there is less of a need for social prescribing within this group or why they are not accessing the service.

## The outcomes of Social Prescribing

Several measures were employed to assess the outcomes for patients accessing the social prescribing service. These were the Wellbeing Star scores, the number of GP appointments attended, A&E visits and emergency admissions before and after social prescribing. GP surveys and case study examples were also included to assess the impact of the social prescribing service.

Significant improvements were seen on two of these measures: The Wellbeing Star scores and GP appointment attendances.

Patients who had recorded a Wellbeing Star score had demonstrated improved self-rated health and wellbeing between their first and last social prescribing appointment. Their average Wellbeing Star scores significantly increased by 0.74 between appointments.

The analysis of the number of GP appointments a person attended at the same time-period before and after their first social prescribing appointment showed that there were significant reductions in GP appointment attendances following social prescribing. Narrative responses from the GPs in this report showed that the social prescribing service was seen highly beneficial to them in reducing the number of repeated attendees and allowing them to spend more time in clinical discussions with patients who require it.

The reduction in GP appointments has wider reaching benefits, as it suggests that less time is being spent on patients with social needs, leaving more time to focus on those with medical issues. Case studies also highlighted how the link workers were able to support their patients in a range of psychosocial areas and demonstrated how patients benefitted from their service.

Analysis of the number of A&E visits and emergency admissions showed little variation before and after a social prescribing appointment. This suggests that social prescribing does not impact on emergency hospital usage.

Overall, these findings are encouraging. They demonstrate that patients who accessed the Merton Social Prescribing programme rate their health and wellbeing better and visit the GP less often. These findings are echoed by the GPs who also view the link workers as vital and integral members of their Primary Care team.

## Next steps

The social prescribing service in Merton has a positive impact on patients and the healthcare service. By continuing to expand the service through the recruitment of more link workers and serving more patients can even more greatly impact on the health and wellbeing of the people of the borough as well as on the health care system.

It is important however to take into consideration the impact that social prescribing has on the voluntary sector. For the financial years covered in this report there is no data on the services that the link workers are referring patients to (although this information is now gathered and

recorded on Elemental by the link workers). This work will be important not only for understanding the needs of the people being referred to social prescribing, but also for following up with the voluntary sector organisations that patients are being referred to and ensuring that they have the capacity to meet growing demands. It will also be important to identify any gaps in the voluntary sector's offer and work to build on services to cater for the as-of-yet unmet needs of the community.

This report was not able to look at the time-period that was impacted by the onset on the Coronavirus pandemic. This envelopes data from the expansion of the service to nine link workers across twenty-two practices. In the future it may be necessary to consider different ways of assessing the impact of social prescribing on patients and the healthcare system, as the country adjusts to the 'new normal'. This will be important not only for understanding the benefits of social prescribing but to also continue to make improvements and build on the service in Merton.

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