

Self-Care Social Prescribing

Kensington & Chelsea Social Council and
NHS West London Clinical Commissioning Group

Social Return on Investment

January 2018



‘All good GPs understand that healthcare and wellbeing is made up of physical, psychological and social problems. Providing holistic care involves all these elements...however if somebody’s **prime issue is loneliness [or social isolation], it’s much better that they’re NOT seeing a GP but getting support from other parts of the community and other parts of the system.**

In the [consultation] room, all the time I’m suggesting to [older] patients: charities, local health groups, support groups; things they can join and make them feel valued, worthwhile, and important members of society.

I wasn’t trained to give social care advice, I was trained to do medicine, but we care about our patients and want to give holistic all-round care’

Dame Helen Stokes-Lampard
Chair of the Royal College of General Practitioners
12 October 2017, BBC News



This report was prepared by Envoy Partnership, an advisor in evidence-based research and strategic communications. We specialise in measuring and demonstrating the value of social, economic and environmental impacts. We are dedicated to providing organisations, stakeholders, investors and policy makers with the most holistic and robust evaluation tools with which to enhance their decision-making, performance management and operating practices.

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Executive summary



Health and social care services in North and West London are building positive new models of cross-sector working to make better use of joined-up resources. Such cultural and operational change is needed to improve choices available for patients, and to support professionals to go beyond the medical model alone. The status quo is not sustainable, given our ageing population and the growing prevalence of long-term life limiting illnesses.

In West London, a frail older patient can take up an average of 30 GP practice visits per year, over 12 days in hospital per spell, and 8 visits to outpatient clinics annually. Many older patients are at risk of being increasingly isolated, housebound, and are suffering from poor social and emotional wellbeing. This further amplifies the problems with their existing health conditions and can lead to more rapid deterioration. However, treating such *non-medical* drivers of poor health and wellbeing are not the conventional domain of doctors, nurses, and other clinical professionals.

The Self-Care social prescribing model enables GP practice staff to refer patients with a *non-medical* health and wellbeing need onto appropriate specialist services from the voluntary and community sector (VCS). Patients are provided with a personal consultation with a Case Manager or Health and Social Care Assistant at their GP practice, to identify their needs, interests, and goals. One option available is for the patient to be prescribed a service on the Self-Care directory.

Patients are contacted by the service provider within a week to arrange their sessions and work on their progression. The general aim of Self-Care is to increase patient confidence in making informed decisions about their health, and increase lifestyle changes and new healthy habits, through accessing more community-based support sessions. **The Self-Care social prescribing model has led to reduced avoidable need for hospitalisations, reduced need for GP practice hours, and reduced levels of physical pain and depression for patients.**

This Self-Care social prescribing model and directory of services is managed by Kensington and Chelsea Social Council (KCSC) on behalf of West London Clinical Commissioning Group (WLCCG). The model forms part of WLCCG's integrated 'My Care, My Way' (MCMW) programme, which places over-65s at the heart of a personalised and holistic care and support plan. Envoy Partnership were commissioned to conduct research to evaluate the impact of this model and include a Social Return on Investment (SROI) analysis. This is detailed comprehensively in the main report, which describes the total SROI value created when compared with the annual contract budget of £250,000. The results are as follows:

£+ **£2.80** of social value created per **£1** invested

Executive summary

YEAR END TO MARCH 2018 – FORECASTED ‘SROI’

- c.£6.25 for every £1 invested, including health service value (c.£1.22) and patient health and well-being value (c.£5.03).
- After accounting for the attribution due to other factors, the ‘attributable’ SROI is c. £2.80.

PILOT YEAR TO MARCH 2017 – ‘SROI’

- c.£4.30 of value is created for every £1 invested, including health service resource value (c.£0.85) and patient health and well-being value (c.£3.45).
- After accounting for the contribution of other factors that affect patients’ health and wellbeing outcomes (the attribution), **c.£1.90 of attributable value was created for every £1 invested.**

The Self Care model reached around 800 frail older patients in the pilot year and is forecasted to reach around 1300 patients in the year to March 2018.

Patient impacts observed from the research include:

- Reduced physical pain and discomfort
- Reduced depression and severe anxiety
- Reduced levels of loneliness and social isolation
- Improved self-confidence/self-worth
- Improved sense of health equality i.e. feeling valued the same as other people by care services

- Maintained independence and dignity, especially when enabled to access income support
- Reduced avoidable need for entering primary and secondary care

Total attributable worth (or ‘utility’) to patients of these impacts is valued at £278,400 for the pilot year to March 2017. Patients receive six sessions, with an option for re-referral for another six sessions, sometimes with a different related service. Through patient surveys (see Table A) we observed an increase in the proportions of patients who feel: i) No pain or little pain (+24%), ii) No feelings of being down or depressed (+17%), and iii) No feelings of anxiety (+14%).

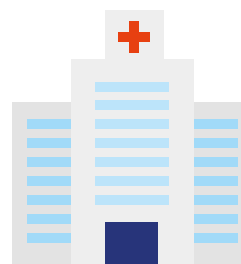
Table A. Patient survey responses regarding health status outcomes resulting from social prescribing (based on the short EQ5-d and PHQ9 surveys, N=134)

% of Patients responding	Before	After	Change
Little or No pain	15%	39%	+24%
No feelings of being depressed	30%	47%	+17%
No feelings of anxiety	29%	43%	+14%

Resource value to health services

The social prescribing model has also led to **resource savings** to GP practice staff - including Health and Social Care Assistants (HSCAs) and Case Managers – valued at **£102,000 for the pilot year** (April ‘16-March ‘17) and forecasted at **£150,000 to March 2018**. Resource savings for **hospitals** are valued at **£106,000 for the pilot year** and forecasted at **£154,000 to March 2018** (see Table B). This is calculated for acute episodes, by drawing on improved Patient Activation Measure (PAM) scores. PAMs are recorded by GP staff *with* patients, at different points in time.

According to the PAM scoring system¹ used by WLCCG, an improvement by one-point correlates to **2% reduced hospitalisation** likelihood. Around **62% showed an improvement** from our sample. The average improvement for those 62% was **5.8 points**. Therefore, one of the areas of resource savings indicated by the improvement in patient activation would be an average 11.6% rate of reduced hospitalisations, for the relevant proportion of patients who improved.



c.11.5%
reduced
hospitalisations



1300 patients
reached in 2018

Table B presents avoidable demand and resource value to local health services, at GP practice level and hospital level, with hospital estimates linked to the PAM score for the proportion of patients who showed improvement. *Patient utility was valued separately using a QALY approach.*

Table B. Resource value to health services (from 24 GP practices, values rounded to nearest 1000)

Areas of resource saving	Total reduction Pilot year to Mar 2017	Equivalent consult'ns per practice Pilot year	Total Value Pilot year to Mar 2017	Total Value forecast YE to Mar 2018	Average incidence per patient per year, MCMW
GP Practice level total			£102,000	£150,000	
Diverted GP hours: initial consultations (w/ re-referral)	340 hours	57	£18,000	£27,000	30 GP practice visits per patient
Diverted HSCA & CM research/support hours: initial consultations (w/ re-referral)	1025 hours	171	£21,000	£31,000	
Avoided GP hours from patients stopping need for consultations (6-month period)	590 hours	98	£32,000	£46,000	
Avoided HSCA & Case Manager hours from patients stopping need for consultations (6-month period)	1480 hours	247	£31,000	£46,000	
Hospital level total			£106,000	£154,000	
Reduced need for Hospital spells	51 incidences	n/a	£68,000	£99,000	1.19 episodes @12 bed days
Reduced need for A & E	54 incidences	n/a	£6,000	£9,000	1.23 episodes
Reduced need for Outpatient visits	579 incidences	n/a	£32,000	£46,000	8 episodes

¹ Licensed by NHS services from the US company, Insignia Health

Executive summary

Key strengths of the model identified in our research are that:

- The Self-Care offer enables agile and flexible commissioning, whilst supporting some frontline administrative functions.
- GP practices and patients are able to reach more VCS services appropriate to their needs (and thus work more effectively with their time).
- Management of the model by an accountable VCS umbrella organisation, such as KCSC, generates trust between providers, health services, patients, and other statutory stakeholders.
- It can foster cross-sector collaboration to better join-up resources and access capacity.
- There are significant contributions to patient wellbeing, motivation/activation, and confidence.
- Resource savings are created for care services, especially reduced hospitalisations, and GP time and Case Manager time spent on care co-ordination, planning, and research.

Recommendations for the model are focused on:

- The need to improve feedback about patient progression into Care Plans, through better integration of information between two different software systems used by WLCCG and KCSC.
- Expanding services to less frail patients therefore supporting a preventive approach.
- Increasing initial number of sessions, whilst reducing the need for re-referrals.
- Building the profile of the model and building confidence more widely amongst professionals.
- Improving compliance and guidance, regarding Quality standards and Information adequacy.
- Ensuring service providers and health professionals meet their responsibility to collectively improve learning and share best practices.

1. Background



Kensington and Chelsea Social Council (KCSC) is operating a social prescribing model, known as Self-Care, on behalf of West London Clinical Commissioning Group (WLCCG). The Self-Care model links patients in primary care with sources of health and wellbeing support from specialist voluntary and community services. The Self-Care programme is targeted at patients aged 65+ with long-term conditions. It provides GP practices in Kensington and Chelsea and the Queens Park and Paddington areas of Westminster with a non-medical referral option.

The Self-Care social prescribing model is part of the 'Whole-Systems' initiative, which is a cross-sector network of commissioning authorities across health care, social care, and other statutory support. Self-Care currently operates within the larger integrated 'My Care, My Way' (MCMW) programme, which places over-65s at the heart of a personalised and holistic care and support plan. The aim of the Self-Care approach is to increase patient confidence in making informed decisions about their health. Simple lifestyle changes and new healthy habits and goals are encouraged. Consequently, Self-Care is expected to positively contribute to patients' confidence and motivation, which in turn is expected to contribute towards a long-term reduction in use of primary, secondary, and some tertiary services.

It was originally planned that only patients in Tiers 2 and 3 (as described below) would receive Self-Care services. This was later expanded to Tier 1 patients.

The Tiers of patients are defined as follows:

- Tier 0:** +65 years of age and are mostly healthy.
- Tier 1:** +65 years of age and have one well-managed Long-Term Condition (LTC).
- Tier 2:** +65 years of age and have two LTCs, mental health or social care needs.
- Tier 3:** +65 years of age and have three or more LTCs, mental health or social care needs.

The key aspect of Self-Care social prescribing is that it focuses on provision of services and activities to patients by Voluntary and Community Sector (VCS) organisations who specialise in providing health and wellbeing services to older residents.

Rationale for developing the Self-Care model

Self-Care was created to offer a range of broader benefits for anyone aged 65 or over, including:

1. Background

- **More time** – patients have longer appointments with their GP practice (as their appointments can also be with non-GP staff). This helps GPs to focus their time on medical rather than non-medical factors affecting health and wellbeing.
- **More support** – access to a broader range of health and social care professionals to support health and wellbeing.
- **More help** – through creating integrated care centres that can offer a wide range of services under one roof – including diabetes clinics, pharmacists and social care services (such as St Charles Integrated Care Centre).
- **More choice** – patients are offered local activities to support them in looking after their own physical, social, and emotional wellbeing.

(adapted from WLCCG service specification for Self-Care 2015)

After assessing and agreeing the patient's needs and choices, Case Managers or HSCAs refer the patient via KCSC to one of the Self-Care services or activities. KCSC receives the referral and notifies the provider, who in turn contacts the patient and arranges to deliver the activity or service. KCSC have no direct contact with any patients, and act as a bridge between the VCS providers and practice-based staff who have responsibility for patient contact. The graphic in Figure 1 illustrates the pathway of how the six sessions are prescribed within My Care, My Way.

With the innovative approach to working in partnership, HSCA's are employed by Age UK K&C and Senior Case Managers and Case Managers are employed by Central London Community Healthcare NHS Trust (CLCH). HSCA's are line managed by SCM's or CM's, CM's are line managed by the SCM's and the SCM's are line managed by the Clinical Business Unit manager in CLCH.

Self-Care social prescribing model

The Self-Care referral process is conducted in three main steps, as part of the My Care, My Way offer to older patients:

As part of a collaborative approach to managing both clinical staff and non-clinical frontline staff, HSCAs are line-managed by the local *Age UK in Kensington & Chelsea*, whilst Case Managers are line managed by WLCCG

Step 1. Patient is allocated to a practice-based Health and Social Care Assistant (HSCA) or Case Manager (CM)



Step 2. Patient assessment conducted by HSCA or Case Manager, which includes:

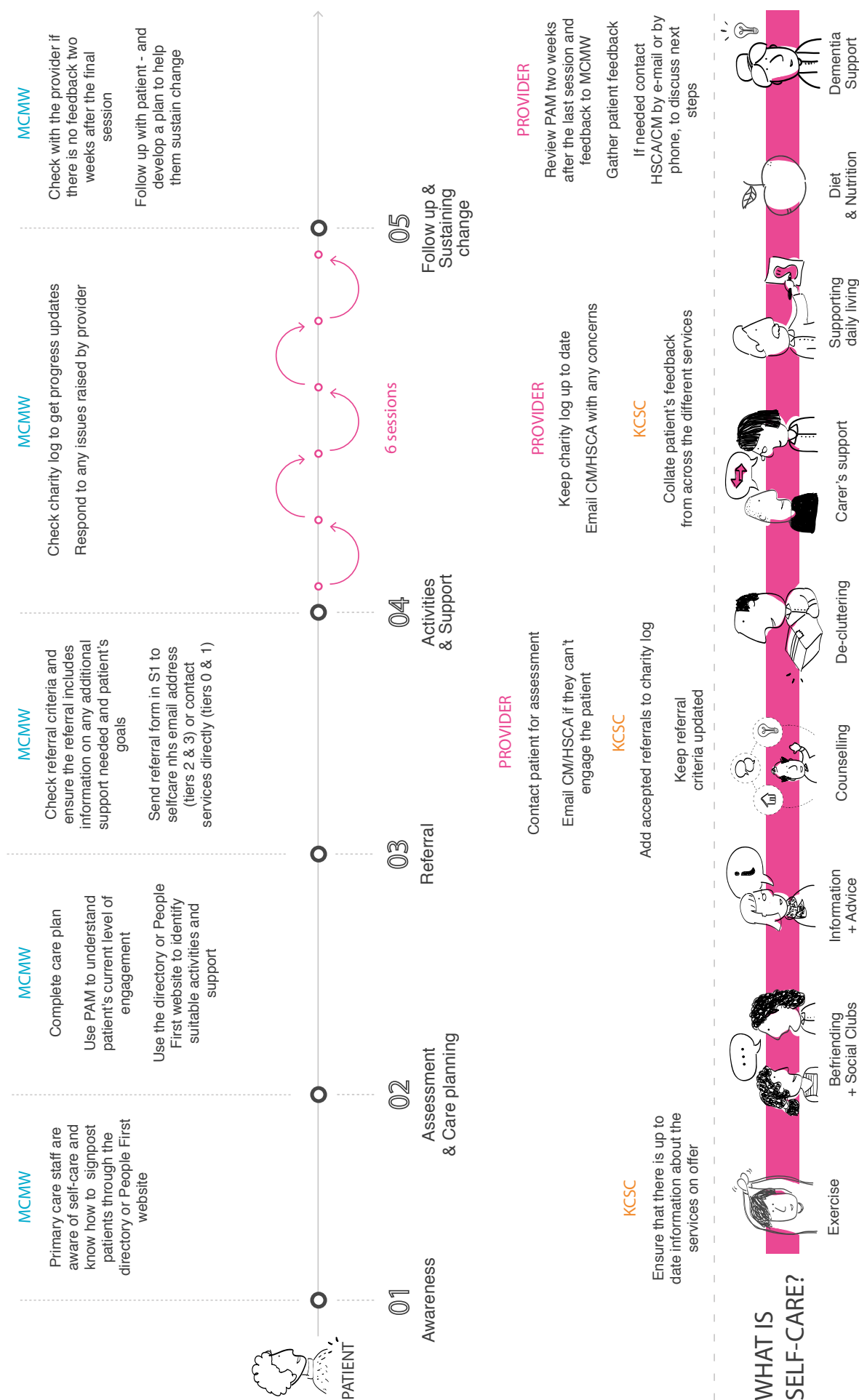


- Recording of a Patient Activation Measure (PAM) on 'SystmOne' software
- Recording of goals for the patient's Care Plan
- Completion of referral form with patient's requirements and notes on their situation
- Direct referral to an appropriate service from the Self-Care directory of services

Step 3. Referral completion, where KCSC informs the VCS provider of referral details. The Provider must contact patients within 7 days to double-check suitability, and commence first of **six service sessions**.

Figure 1. Social prescribing for Self-Care services, within My Care, My Way (source: WLCCG)

SELF-CARE PATHWAY



2. Services available through social prescribing



Referred patients can have up to six sessions of their chosen activity or service. Patients can also be re-referred once, giving access to a total of twelve sessions.

The services provide a range of personal one-to-one interventions and group activities. This 'roster' of services is demand-led, and so can change depending on which types of services prove popular.

The five highest funded services during the pilot phase (between May 2016 and March 2017) were also the most popular: 'Dementia 1-2-1 support' (c.80 referrals), 'Link Up' (c.180 referrals), 'Information and Advice' (c.155 referrals), 'Exercise at Home' (c.135 referrals), and Massage therapy (c.85 referrals).

Services provided during the pilot phase are briefly described and categorised below:

African Dance

Group sessions to encourage physical activity, balance, and inter-cultural awareness through learning traditional African Dances.

Arts and Culture In The Community (for dementia)

Activities range from group sessions for those in residential care to one-to-one interventions for people living in their own homes and at risk

of isolation. Activities include supported visits to galleries, heritage buildings, and theatres that enhance and compliment individual care plans, and help people to feel part of their wider community. Creative and cultural befriending is also offered on a one-to-one basis.

Befriending

Weekly one-to-one visits to those patients who live alone in Kensington & Chelsea and are at risk of becoming isolated. People are able to keep in touch with the outside world through their befrienders who help to combat isolation by making regular visits to older people, providing companionship and a listening ear.

Carers Support Network

Provides a tailored service to unpaid carers, informing and supporting them to identify their needs and empowering them to make informed choices and pathways for themselves and the person they care for.

De-cluttering at home

Using proven de-cluttering techniques, the personalised service assists clients wanting to sort their belongings at home. This can be because they want to downsize, reduce clutter, or reduce anxiety about growing volumes of paperwork e.g. bills,

notices, official letters. This can help with reducing the risk of trip hazards or fire traps, and can also help those clients who require support at end of life.

Dementia One-To-One Support

The service offers personalised support in coming to terms with diagnosis, providing activities that can promote cognitive ability, slow disease progression, and future planning. Interactive activities are tailored to the client's interests and abilities, depending on their level of progression.

Escorting

Clients are provided with personalised assistance to attend GP, clinic, hospital or other healthcare appointments, with a trained person who can accompany and travel from home to the appointment, support and advocate during any consultations, and ensure clients return home safely.

Exercise at Home

One-to-one tailored service with a case worker with a health and fitness background, to undertake gentle home-based exercise. Exercise plans can help improve core strength, balance and flexibility, increase confidence, promote cardiovascular fitness, reduce stress, assist with weight control, and reduce falls risk.

Information and Advice

Provides impartial and independent advice on a range of issues, including Attendance Allowance, welfare benefits, health, disabilities, housing advice, social care needs, fuel poverty and energy efficiency, family issues, and form-filling assistance.

‘Link Up’

Link-Up is a hub-based service, available to help older clients access physical, creative and mentally stimulating activities, to help improve the health and wellbeing. A large variety of support activities are available, both at home and in the community, on a one-to-one basis or in groups.

Massage Therapy

Massage therapy is specifically for patients who are frail, often isolated, and suffer from limiting long-term conditions and chronic pain, but are unable to easily access services through disability or lack of mobility.

Macular Degeneration Support Group

Provision of advice and support for people with macular conditions and related sight-loss problems, including age-related macular degeneration.

Memory Cafe

Social support group for people with memory problems, and their friends, family, and carers. Can include memory exercises, mental stimulation activities, and general learning and interaction.

Men’s Only Activities

Hub-based peer-based group for supporting men’s health and well-being behaviours, health knowledge, socialising, cooking and nutrition, and interactive activities in the community.

Nutrition and Community Lunches

Enables older people to attend healthy community lunches and nutrition groups, to improve diet, nutrition intake, and reduce social isolation.

Safety at Home and Falls Prevention

Provides support to people who, due to health reasons or their living conditions, are at risk of falling within their homes. The service aims to reduce the risk of falls in the home, reduce harm from other hazards in the home, recommend the equipment or repairs necessary to improve safety, and provide information and advice on ‘de-cluttered’, healthier lifestyles.

2. Services available through social prescribing

Supported Gym Sessions

Group or one-to-one sessions for light exercise with patients, to build strength, cardiovascular health, and mobility.

Walking Support

One-to-one support to get clients out and about within their local communities at their own pace, promoting wellness, building confidence, improving

balance, and reducing social isolation. This may involve taking immobile clients out in their wheelchairs, or providing guided walking support for those using mobility aids such as sticks or walking frames.

New services are added when there is a need. New services for 2018 include opportunities for gardening, and more cultural activities for those with mental health illnesses.

Barbara's case study



Barbara previously had cancer twice and had recently suffered a broken hip due to brittle bones (partly due to intensive radiotherapy treatment). She also suffers from cellulitis, resulting in one leg being almost twice the size of the other. This is extremely painful, heavy-feeling, and impedes her walking. Barbara currently can't get dressed by herself and has carers who come to help with her personal care.

As part of WLCCG's My Care My Way programme, Barbara's GP – with whom she has a very good relationship – initially called to ask if she wanted to be part of the Self-Care project. She was provided with a consultation with her Case Manager. They discussed various options to help with her rehabilitation and get out and about in the community to build her confidence. She recorded a PAM score with her Case Manager of 55.7 and was referred to the walking support service.

The walking support provider got in touch to arrange her weekly sessions, and also to check if she had any additional mental wellbeing needs. For the first session, they went to the end of the

road and back – 'not very far'. She had to rest at the end. For the second session, Barbara needed some shopping, so they walked a little further to the supermarket. During later sessions she was able to walk to the park and was getting further with each session. Barbara felt the service was flexible, and that her walking support worker was very nice and kind.

'I hadn't realised how difficult I would find holding on to a stick and checking both ways for traffic. I wouldn't have been confident going out alone. The worker is very patient when I need to stop and rest. I was worried she would be marching me up and down the road, but in fact she is very kind, and not over-protective.'

'I just want to say how nice everyone is. Not patronising at all. I'm very impressed, the attitude of all staff – they want to help so much. Everyone who I have dealt with in this service and in the special unit at St Charles has been so good' (a local integrated care hub).

Barbara's motivation and confidence for her own Self-Care improved significantly; her follow-up PAM score improved to 67.8, an increase of 12 points. She feels there is less risk of her falling and of being isolated at home. Barbara is keen to continue getting out and about, and is looking into walking to French language classes near her home.

Patient's name changed for confidentiality purposes

3. Impact evaluation objectives and method



In May 2017, KCSC commissioned Envoy Partnership to produce an Impact Evaluation with a Social Return on Investment (SROI) analysis of the Self-Care social prescribing pilot. KCSC and WLCCG felt this approach would provide the most comprehensive and holistic form of evidence, as it includes the identification and measurement of outcomes for material stakeholders,² as well as valuation of social (health and wellbeing) and economic outcomes.

The key research themes in this evaluation are as follows:

- **Patients** – Did the Self-Care pilot make a positive contribution to patient confidence and motivation to look after their own health?
- **Carers and Families** – Did the Self-Care pilot make a positive contribution in supporting patients' carers and families?
- **Cost Effectiveness** – Did the Self-Care pilot make a positive contribution to a reduction in primary and secondary care use?
- **Value for Money** – What are the broader social and economic impacts of the Self-Care pilot?

- **Voluntary and Community Sector (VCS)** – Did the Self-Care pilot enable the VCS providers to attract or leverage in additional funding? Did the Self-Care pilot facilitate wider strategic or organisational change within provider organisations?
- **KCSC** – How effective is KCSC in harnessing partnerships? As a result of KCSC as the accountable body, are providers working together in new, innovative ways?

A separate document containing a process effectiveness report has also been produced as part of our research remit, and this contains an in-depth analysis of the efficacy of the Self-Care model's processes and structuring of activities. The report is available from KCSC and WLCCG.

Social Return on Investment methodology

Social Return on Investment is a type of cost-benefit analysis that quantifies and values social as well as economic benefits. The methodology followed in this report directly draws on the UK Cabinet Office's *Guide to Social Return on Investment*.³ SROI proceeds via six distinct stages, as defined in the guide.

² In SROI terms, material stakeholders are those who experience material outcomes, i.e. outcomes that are relevant and significant enough to be measured, valued, and incorporated into the SROI model

³ A *guide to Social Return on Investment*, (2012), Cabinet Office. For more details, see socialvalueuk.org/resources/sroi-guide

3. Impact evaluation objectives and method

SROI is a *mixed methodology* approach, relying on both *qualitative* research (particularly in stage 2 below) and *quantitative* research (particularly in stages 3 and 4 below):⁴

Six SROI stages

1. Establishing scope and identifying key stakeholders
2. Mapping of outcomes
3. Evidencing outcomes and giving them a value
4. Establishing impact
5. Calculating the SROI
6. Reporting, using and embedding

The Envoy research team conducted the SROI research between May and November 2017. The research was underpinned by the **Seven Principles** of SROI as set out in the Cabinet Office SROI Guide,⁵ and shown in the box below.

The Seven Principles of SROI

1. Involve stakeholders
2. Understand what changes
3. Value the things that matter
4. Only include what is material
5. Do not over-claim
6. Be transparent
7. Verify the result

Mapping a theory of change

SROI analysis involves the development of a *Theory of Change* (under SROI stage 2 'Mapping Outcomes'). This shows the stakeholders affected by the Self-Care services, the inputs and activities that occur, and the outcomes created by the Self-Care pilot. The outcomes identified in the Theory of Change are then measured. The measurement focuses on the outcomes, i.e. the ultimate benefit or change experienced by stakeholders, as well as the outputs, i.e. the quantifications of activities e.g. the number patients, or the number of episodes. The Theory of Change is shown in section four.

Measuring outcomes for patients

To measure outcomes, we drew on validated questions from existing clinical health questionnaires, including *EQ-5d*, *Warwick-Edinburgh Mental Wellbeing Scale* (WEMWBS), *PHQ-9* (Patient Health Questionnaire), *ICECAP-A*, and *SF-12* (see Appendices Part D for details).

There are a range of methods to: i) measure subjective wellbeing outcomes, and ii) value subjective wellbeing outcomes. Often, the challenge is to ensure that the outcome is measured in a way that allows it to then be valued appropriately. Our recommendation is that binary measures (e.g. Yes / No questions) should be avoided; instead, measures that show the magnitude of change experienced by patients should be used. The validated questions above fit this criterion.

Establishing impact

In SROI terminology, 'Impact' is a measure of the difference made by the project or organisation being evaluated. It recognises that there is likely to be a difference between the change observed, and the change for which the project or organisation can claim credit. Such considerations are important to ensure that the analysis does not over-estimate value created.

Four key areas are considered here:

- Deadweight (what outcomes are likely to have happened anyway)
- Attribution (the extent to which outcomes arise because of social prescribing, rather than because of the contribution of other people or organisations)
- Displacement (whether any value is 'displaced' elsewhere)

⁴ Ibid., pages 9–10

⁵ *A guide to Social Return on Investment*, (2012), Cabinet Office. For more details, see socialvalueuk.org/resources/sroi-guide

- Drop Off (the extent to which outcomes are sustained over time)

The details for these considerations are further explained in Appendices part B.

Primary data

The primary research conducted for this evaluation is summarised in Table 1 below.

Table 1. Primary research

Stakeholder groups	Sample	Methodology
Qualitative		
Patients (Tiers 2 and 3)	33	Face-to-face interviews, often in the patient's home
Case Managers & HSCAs	31	Telephone interviews
VCS providers	9	Face-to-face interviews
Statutory authorities (public health, adult care)	3	Face-to-face interviews
GP lead for Self-Care	1	Telephone interview
WLCCG managers for Self-Care	2	Face-to-face interviews
Quantitative		
Patients (Tiers 1,2,3)	134	Paper survey delivered by post
Case Managers and HSCAs (75 actively referring)	42	Online survey

The secondary data analysed for the evaluation is as follows:

- WLCCG data regarding the average number of GP appointments per year for all My Care, My Way patients, in the period April 2016 – July 2017
- WLCCG aggregate data for MCMW acute hospital episodes from 29 practices, in the period April 2016 – March 2017

- WLCCG social prescribing PAM scores data for the period April 2016–July 2017

- Insignia Health research into the impact of PAM scores on patients

- WLCCG GP practice staff cost data

Data limitations

- De-identified acute hospitalisation data and GP appointment data was shared by WLCCG but was not made available by episode type (e.g. specialist surgery, diabetes, cancer). We therefore were only able to use unit costs for *average* incidence costs.
- PAMs survey wording is seen by many patients and practice staff as inappropriate for some conditions, e.g. dementia. In these cases, PAMs data was not collected; a simpler alternative version would have been needed if data was to be collected. Nonetheless, a reasonable amount of data was collected; we received 247 baseline and follow-up PAM scores to analyse.
- For certain outcomes, e.g. preventive effects of interventions, our analysis is reliant on subjective indicators through primary survey data from HSCAs and Case Managers. This data shows their perceptions on the extent to which preventive effects are being achieved. However, we remain confident with the results; we achieved a sample of over half of the HSCA/ Case Manager population who were actively referring. Improvements observed in PAM scores for our sample also provide confidence that a significant proportion of patients benefit from reduced need.
- We did not receive patient postal survey returns for all services, particularly for those with a low number of referrals. There were no returns from T'ai Chi, African Dance, or community lunch, for example.

4. Findings: Patients



Service themes and patient outcomes

In our research, we identified different categories of services that led to slightly different groups of outcomes, as shown below in Table 2:

Table 2: Patient benefits from Self-Care services

Service theme	Patient outcomes
Physical & Exercise activities <ul style="list-style-type: none"> • African Dance • Escorting • Exercise at Home • Massage Therapy • Supported Gym Sessions • Walking support 	Physical wellbeing Reduced isolation Mental and Emotional wellbeing Reduced anxiety Maintain independence Respite for patients' carers (during patient sessions)
Mental wellbeing and reduced isolation (non-dementia specific) <ul style="list-style-type: none"> • Befriending • 'Link Up' activities • Memory Café • Men's Only Club Activities • Carers Support Group 	Reduced isolation Mental and Emotional wellbeing Reduced depression Reduced anxiety Maintain independence Memory retention Respite for patients' carers (during patient sessions)
Dementia-specific support <ul style="list-style-type: none"> • Arts and Culture in The Community (for dementia) • Creative and Cultural befriending • Dementia One-To-One Support <p>N.B. Exercise at Home and Walking Support are also provided to dementia referrals with a tailored approach</p>	Mental stimulation and concentration Reduced isolation Reduced depression Mental and Emotional wellbeing Improved Self-Worth Reduced anxiety Maintain independence Respite for patients' carers (during patient sessions)
Safety & Welfare Information and Advice <ul style="list-style-type: none"> • De-cluttering at home (can also be considered as part of mental wellbeing services) • Safety and falls prevention at home • Information and Welfare support advice 	New source of income support Reduced anxiety Maintain independence Physical wellbeing Improved living conditions Respite for patients' carers (during patient sessions)
Health Education & Nutrition <ul style="list-style-type: none"> • Healthy Lungs • Macular Degeneration Group • Nutrition and community lunches 	Physical wellbeing Reduced isolation Maintain independence Improve health knowledge

Chart 1 shows the proportion of referrals by service theme for the pilot period (Apr '16 – Mar '17). The largest categories of referrals were physical activity, mental/emotional wellbeing and isolation, and information/advice and safety at home.

Chart 1. Referrals by service theme, Apr 16 – Mar 17

Patient referral proportions by service type (n=807)

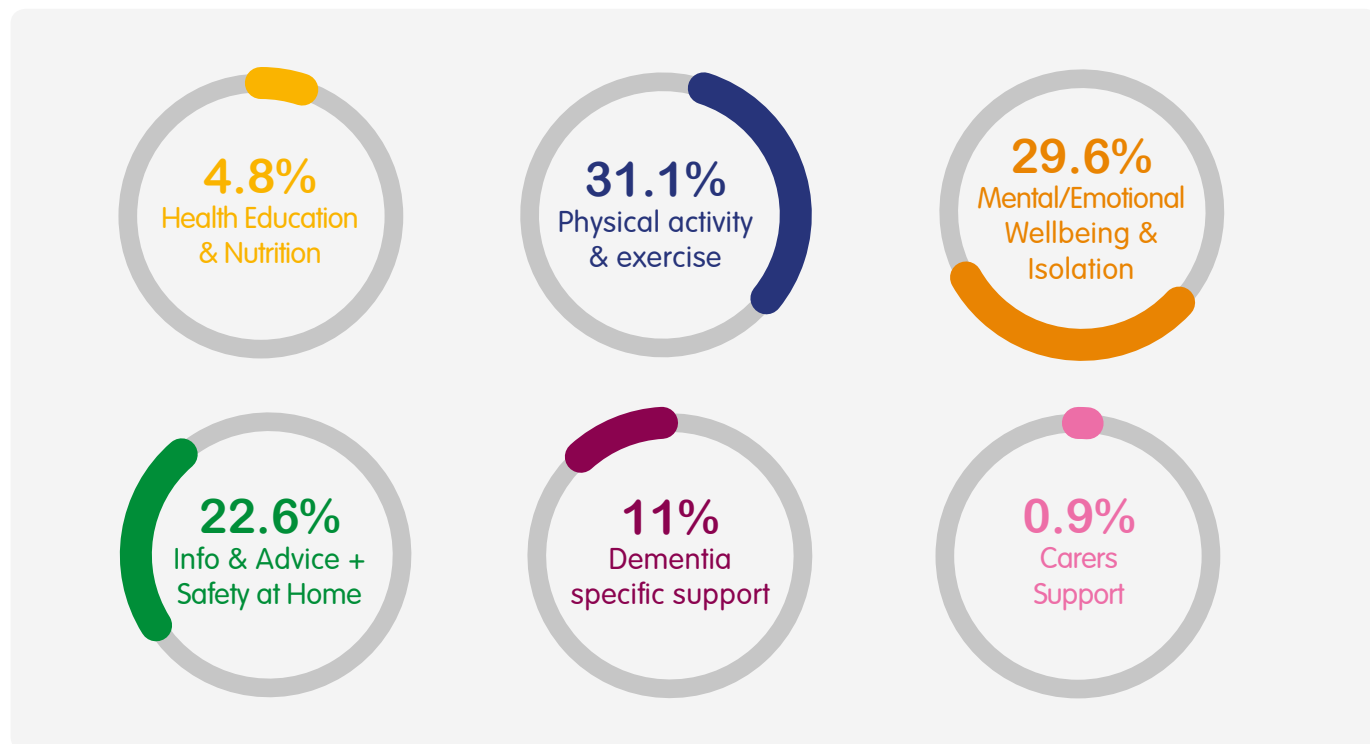
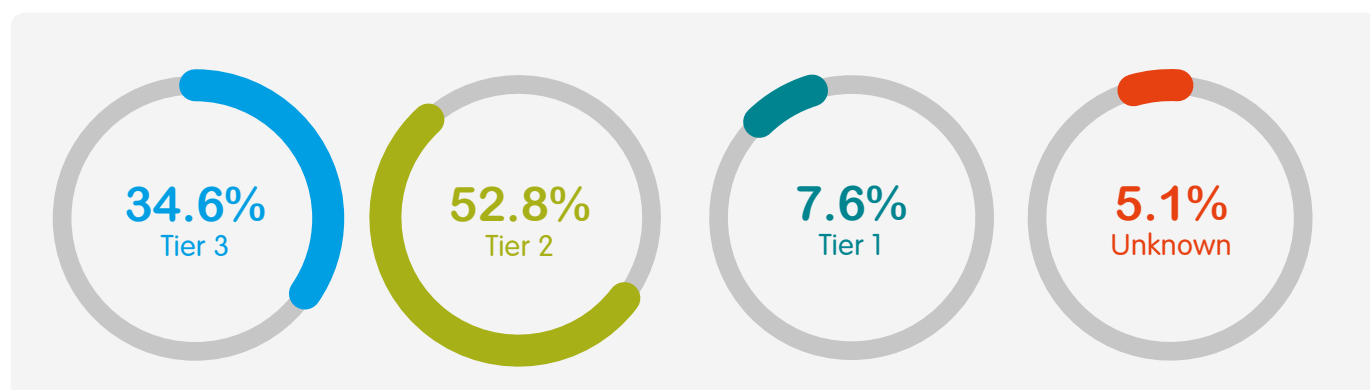


Chart 2 illustrates that the majority of referrals for the pilot period were comprised of Tier 2 patients (almost 53%) with just over a third from Tier 3. A much lower proportion of 7.6% were Tier 1 patients.

Chart 2. Referrals by Tier, Apr 16 – Mar 17

Patient tier proportions (n=807)



4. Findings: Patients

Outcomes for patients

Much of the benefits to patients come through re-building their balance and self-confidence in their mobility (e.g. when being able to walk around outside or at home), and through reducing pain and discomfort, improving their support networks and social networks, and reducing levels of depression or anxiety. Across most of the service themes, patients feel they have benefited from reduced levels of anxiety about their condition(s) or health situation, and have also felt more valued by others – especially by the health care system.

Reduced social isolation, and improved re-connection to their community, are also particularly important for patients. Some patients felt that *maintaining* their ability to live as independently as possible was important, although for many others who are extremely frail and housebound, this may not be a realistic outcome. Maintaining independence at the same level is a good outcome for many.

Outcomes for Carers and Families

Evidence collected from interviews and surveys suggests that informal carers of patients gain some relief of around one hour during each of the patient's sessions. In most cases, carers will either use the time to continue with other tasks regarding the patient's care needs or day-to-day tasks around the patient's home. Some will use the time for respite.

15 from 134 patient survey responses fed back on respite for carers. Around half of these responses indicated that the Self-Care service was moderately to extremely helpful for creating respite time for carers. However, this is a small sub-sample, and the research indicates that the more significant outcomes actually relate to the carer feeling happier for the patient, if the patient feels better in themselves or if their health condition improves.

When information and advice support (from CAB Westminster and Age UK), leads to successful claims for welfare payments, there is a longer-term impact on carers, both in terms of relief, and their wellbeing. This appears to be a stronger outcome for carers who are the spouse or partner of the patient, and sometimes have their own health conditions to manage.

For the small number of cases where referrals were made for the carer to access specific support through the Carer's Support Network, the most important outcomes were:

- Reduced feelings of being isolated and alone
- An improved awareness about other available support
- Better able to navigate a plethora of health agency/service material and contact details, that they would otherwise feel overloaded with

There was some less positive feedback from carers. In some cases, carers express frustration and disappointment with health professionals and statutory support, claiming inadequate information about Self-Care from their GP and a disjointed approach between housing support, GP practices, and social care.

'The professionals from housing, health, social care, all look at our case one-sided, from only their viewpoint and how it affects them, rather than communicating and helping each other to avoid conflicting decisions for my frail parents...I'm upset my GP didn't mention these services [social prescribing] in the first place.'

T.B., son and carer of frail parents

'From the experience of family members' illness, a map/picture of introduction information might help people to understand A) how to get help from whom in a 'direction' guide. B) how NHS care system works in the relation with hospital, local council, nurses, and GP, and C) Basic knowledge of 'NHS uniform' meaning.'

Carer and relative of patient receiving Exercise at Home and Walking Support

Tej and his parents case study



Tej is a full-time carer for his elderly parents, who are extremely frail and housebound ('Tier 3' frailty). His parents also suffer from poor mental health. His father's condition means he is unable to speak at all, and his mother is unable to speak English.

Tej had to go through a lengthy process to obtain a Power of Attorney to represent his parents at their local health services and GP surgery. At one consultation, front-desk staff also recommended he attend a further consultation with a HSCA, to explore if there were other community-based services appropriate for his parents. After identifying the condition and needs of his parents and recording a PAM score on their behalf (c.70), the HSCA suggested either exercise at home or massage therapy, to help support his parents' overall wellbeing, mobility, and strength in their joints and muscles.

Tej was referred and contacted within a week by the provider for exercise at home, to arrange the session plans for his parents. This required Tej to be available during the sessions to translate some of the instructions, session planning, and to help ensure his parents were comfortable with a stranger in the home. The exercise instructor guided them through gentle exercises, which mostly focused on limbs, arm, hand, and neck exercises. It was important that

the provider enabled each of his parents to feel they were making progress at their own pace and within their respective capabilities, whilst the intensity increased a little for each session. After completing the sessions, Tej felt his parents were a little stronger and benefitted from better sleep. However, they still felt some pain, anxiety, and blood circulation problems; and so Tej also requested massage therapy at home, on his next HSCA appointment.

The massage therapy provider contacted Tej within a few days, and had sessions scheduled for both parents, one after the other at home. Tej described his parents as *'uncertain at first, especially have a different female [the therapist] in the home...but she [the therapist] was very sensitive and understanding...they [parents] loved and enjoyed the massage service, I can see them much happier and responsive mentally, even after just the second session...the pain reduced for them and they are more relaxed than before...and now [it's] a little less difficult to move them [around the home, or from sofa to bed], and they are more peaceful'*.

Tej felt that it was important for all frail, older people to have access to more services like those made available to his parents, especially if it gives a boost to carers to see their service user or relative benefitting so tangibly. Tej is following up with his HSCA about receiving more carer support, and exploring how to arrange more ad hoc sessions at home for his mother.

Patient's name changed for confidentiality purposes

4. Findings: Patients

Theory of Change

In an (SROI) analysis, qualitative research from stakeholder engagement should inform the creation of a *Theory of Change*. The Theory of Change is the foundation for identifying which stakeholder outcomes should be measured and valued. It presents stakeholders, activities, and outcomes that arise from the social prescribing model. It can be useful for helping understand the different pre-conditions that exist, and for helping understand where potential barriers to change might occur. It aligns with HM Treasury Magenta Book guidance on logic mapping.⁶

Figure 2 shows the Theory of Change for the Self-Care pilot. It summarises the outcomes for material stakeholders arising from core activities of the Self-Care model. It shows how the activities lead to outcomes, and how short-term outcomes lead to long-term outcomes which should be valued.

We have presented a theory of change for the whole Self-Care pilot, across all the services provided. Not all of the patient outcomes will be applicable for all of the patients. The left-hand side of the Theory of Change maps the main activities that preceded referrals into the social prescribing services. These then build from left to right into the short to medium term outcomes, and to the long-term outcomes, which we define below:

- **Short-term to Medium** outcomes are those that can happen during the sessions or in the first month after all sessions are completed (including re-referral).
- **Long-term outcomes** are those that are expected to arise around six months after the sessions are completed.

As services are paid for from the contract budget to VCS providers, they are treated as part of the overall inputs to the activities. It should be noted that outcomes for carers discussed in the previous section of this report were not monetised in our analysis, due to relatively low referral numbers for inclusion in our postal survey.

Changes to Patient Activation Measures (PAM)

One objective of Self-Care is to improve patients' activation and motivation about managing their own health and wellbeing. Patient Activation Measures (PAMs) are designed to help medical services to understand whether patients' activation and motivation has changed. PAMS are recorded by practice-based staff with patients, to track their levels of activation and motivation. This is important as part of My Care My Way's drive to educate and empower older patients to self-manage their conditions as much as possible.

We received WLCCG data for over 2,000 social prescribing PAM records across 2016 – 2017. However only 247 patients had both baseline and follow-up scores in this period. Of those patients who had follow-up PAM scores, around **62% showed an improvement**. The average improvement for those 62% was **5.8 points**.

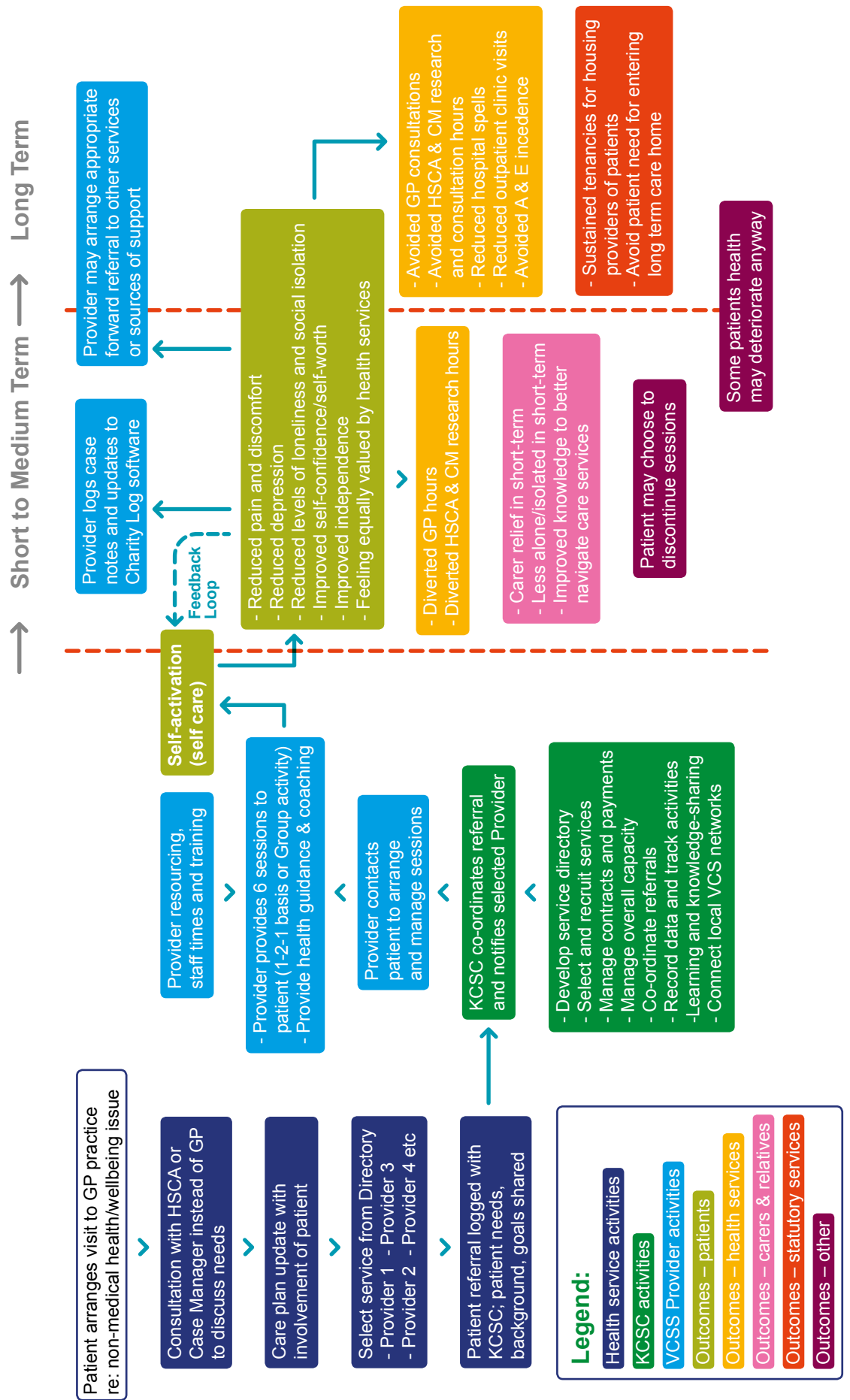
According to the PAM scoring system,⁷ an improvement by one-point correlates to **2% reduced hospitalisation** likelihood. Therefore, one of the areas of resource savings indicated by the improvement in patient activation would be an average 11.6% rate of reduced hospitalisations, for patients who showed an improvement.

PAM scores are presented by Tier level in Table 3. There are only marginal differences between Tier 2 and Tier 3.

⁶ The Magenta Book: Guidance for Evaluation, HM Treasury (2011) see logic model in Chapter 5

⁷ Licensed from the US company Insignia Health

Figure 2. Theory of Change for the Self-Care social prescribing model



4. Findings: Patients

Table 3: Change in PAM scores of the 62% of Self-Care patients showing an improvement.

n=247 for Self-Care patients with baseline and follow-up scores, n=151 for those who see an improvement.

Tier 3	Tier 2	Tier 1
+ 5.9 (51.1 to 57.0)	+ 6.4 (50.2 to 56.6)	+ 3.2 (56.8 to 60.0)

PAM results also indicate that approximately 38% of referred patients either experienced no change in activation, or a reduction in activation. The SROI model assumes that this reduction in activation would have occurred anyway; the age and frailty of many patients means that a reduction in activation over time might be expected. The qualitative research gave no indication that the services significantly reduced activation, and the survey responses from Case Managers and HCSAs indicate that the proportion of patients whose health got worse as a result of the Self-Care intervention is negligible.⁸

Furthermore, the SROI model may under-estimate the positive impact of the Self-Care pilot. For those patients who experience an increase in PAM score, it might be that their PAM score would have fallen without Self-Care, meaning that Self-Care's impact would be greater than stated here. Likewise, for those patients who experience a decrease in PAM score, it might be that their PAM score would have fallen even more without Self-Care. Without data from a control group, getting a credible estimate of such change is difficult.

PAM scoring is not necessarily an indicator of health. Improvements in patient activation and motivation do not necessarily result in improved health outcomes in all cases – but receiving a Self-Care service may have helped those patients manage their condition better and maintain important aspects of their quality of life, even if there has been no increase in PAM score.

'Very good and I have no suggestions to make. My main adversary is laziness – hardly your fault!'

'I think Men's Only activities do a wonderful job, it is just what I need to motivate myself into a better and healthier way of life'

'A wonderful idea to keep the elderly [like me] active and motivated.'

Self-Care patients' feedback

'Linking patients in with activities, or the increased level of interaction provided by services such as walking support etc – very clearly improves outcomes in terms of emotional wellbeing and isolation.'

HSCA feedback, Kensington & Chelsea

Measures of change for patients

In addition to evidence collected through qualitative interviews, we also collected 134 patient surveys across different Self-Care service themes (Table 2). The aim was to quantify the outcomes identified in the qualitative research. The measures are presented below in Chart 3 and Table 4.

⁸ See section 5

Chart 3 shows patients' level of agreement with statements regarding their well-being, both before and after the Self-Care service. The largest change (67% to 78%) was in patients' sense of self-worth and motivation to take care of their own health and medication,⁹ and feeling more valued by the health care system. Before their Self-Care referral, 63% felt as valued by health services as other people. This increased to 69% after their referral.

There is also a small reduction in isolation, with slightly more patients reporting they had enough people they personally felt close to in their lives after the service (69%) compared to before (65%).

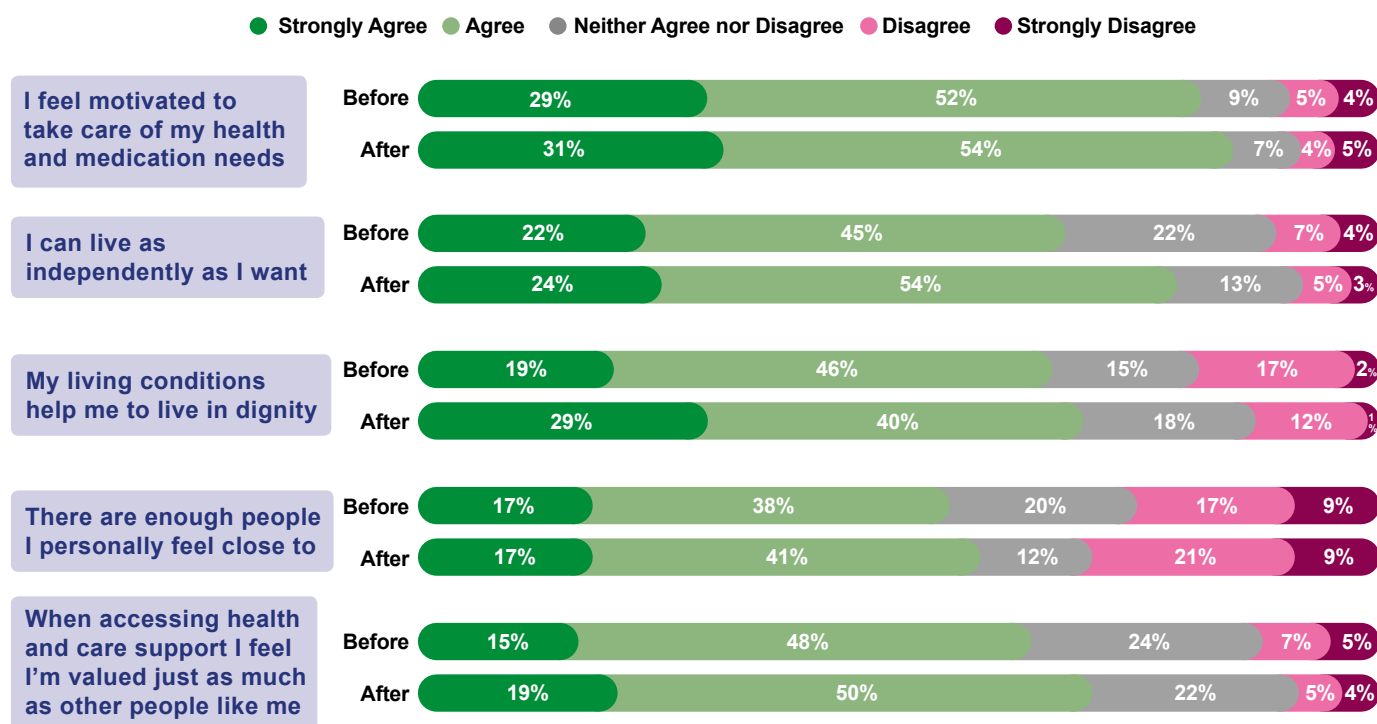
Chart 3 also indicates that there are small changes for independence and dignity. For many of the patients, there appears to be a lower starting point for the 'Before' referral score for living independently, relative to other indicators. It was clear from our interviews that maintaining the independence that they have is a good outcome for many patients.

Table 4 Shows patients' responses on pain, depression and anxiety. We can see increases in the proportions of patients who feel: i) No pain or little pain (+24%), ii) No feelings of being down or depressed (+17%), and iii) No feelings of anxiety (+14%). Survey questions in Table 4 were based on the short EQ5-d and PHQ9 surveys.

Table 4. Patient survey responses regarding health status outcomes

% of Patients responding	Before	After	Change
Little or No pain	15%	39%	+24%
No feelings of being depressed	30%	47%	+17%
No feelings of anxiety	29%	43%	+14%

Chart 3. Patient's self-reported change in well-being



Q. "Please put a cross (X) in the box that best describes how much you agree or disagree with each statement below:"
All self-care patients responding to survey, Nov/Dec 2017. n=89, 98, 87, 95, 68, 78, 77, 85, 85, 94.

⁹ As corroborated by PAM improvements: see Table 3

5. Findings: Valuing the utility of patient health and wellbeing outcomes



SROI requires the monetisation of social, environmental and economic outcomes.¹⁰ Patient wellbeing outcomes valued in our analysis are as follows:

- Reduced pain and discomfort
- Reduced depression
- Reduced levels of loneliness and social isolation
- Improved self-confidence/self-worth
- Improved sense of health equality i.e. feeling equally valued by health services
- Improved independence

Approach to valuation

Our approach to valuing patient outcomes are based on Quality Adjusted Life Year (QALY) approaches to valuing health. These align with similar approaches used by both WLCCG, and the NHS and the National Institute for Health

and Care Excellence (NICE) more broadly. In terms of QALY value, we have used the British Medical Association's guidance from their recent paper about preventive intervention, *Exploring the cost effectiveness of early intervention and prevention* (2017). This states that NICE considers interventions costing up to £20,000 per QALY gained as cost effective. The BMA also refers to a NICE analysis on 200 interventions between 2006 and 2010, where 70.5% (i.e. a clear majority) costed less than £20,000 per QALY gained'.

We drew on a range of sources for valuations. These value ranges are described in the Appendix Part C. These included Devlin, Shah et al, from the Office for Health Economics and University of Sheffield, published in the Journal of Health Economics (JHE) in 2016,¹¹ and Jia and Lubetkin, in the journal, Health and Quality of Life Outcomes (2017).¹² We also drew on guidance from other research (New Economy Manchester; and Bield Housing, Hanover Scotland and Trust Housing),¹³ in order to attach value ranges to the overall measures of patient wellbeing. The value or worth of subjective wellbeing is termed 'utility' in the JHE research.

¹⁰ However, environmental outcomes are out of scope of our research as they were deemed immaterial

¹¹ *Valuing health-related quality of life: An EQ-5D-5L value set for England (March 2016)*

¹² *Incremental decreases in quality-adjusted life years (QALY) associated with higher levels of depressive symptoms for U.S. Adults aged 65 years and older (2017)*

¹³ New Economy Manchester (2012) *Understanding the Wider Value of Public Policy Interventions*, and Bield, Hanover and Trust Housing (2012) *SROI of Stage Three Adaptations, and SROI of Very Sheltered Housing*

Through applying these value ranges to the amount of change experienced by patients, we calculated the values of the outcomes experienced by patients. The values are presented by service category total, and on a per patient average basis, in Table 5. The results account for attribution adjustment, to reflect that patients recorded c.23% attribution to the services for the overall impact experienced (see Appendices Part B, and also section three).

Our results indicate that services supporting physical activity and exercise, and mental wellbeing and isolation tend to generate higher values, both per patient and overall. However, Table 5 also indicates that dementia-specific support has a relatively high 'per patient' value, even though there were fewer referrals.

According to our patient survey, around one in four patients who received Information and Advice support went on to receive welfare payments. The average amount received by patients was c.£2,732 per year. Most payments were Attendance Allowance payments (e.g. payments to attend health appointments when it is physically difficult to do so without support), and smaller allowances for energy support.

Table 5. Attributable values for patients' health and wellbeing outcomes, pilot year to March 2017 (rounded)

Service category	Overall Health and Wellbeing value per patient pre-attribution	Health and Wellbeing value per patient after attribution	Number of patients	Attributable Health and Well-being Value – All patients
Physical & Exercise	£1,330	£290	251	£73,500
Mental wellbeing & Isolation	£1,000	£230	239	£54,500
Safety at home & Welfare Information/Advice*	£330	£70	182	£13,000*
Health Education & Nutrition	£50	£10	39	£400
Dementia-specific support	£1,280	£280	89	£25,000

*Excludes new welfare payments to patients of c.£112,000 in total

5. Findings: Valuing the utility of patient health and wellbeing outcomes

Moira's case study



Moira has dementia, lives alone, and needs her walking stick to walk for long periods. Her HSCA at the local GP clinic identified Moira's strong interest in arts and culture and that she was comfortable interacting with other people. As part of her consultation and Care Plan, to avoid the negative effects of loneliness and isolation on her dementia, Moira's HSCA referred her to attend arts and culture activities for people with dementia. The service contacted Moira and clearly explained how the activities would work; what support would be available for her during the activity; they provided clear instructions and directions to attend; and followed up with a reminder through her support worker. This encouraged Moira and put her at ease.

The service enabled Moira to attend dementia-friendly group activities at various culture and arts venues. This included visits to art galleries, Kensington Palace, and an opera production in Holland Park – with a backstage tour with the opera singers. At the activities, the provider's session workers are posted at different locations at the venue and near the entrance, to welcome

participants, help with wayfinding, and help find resting points.

There are often many interactive components of the activity, which requires input and sharing of ideas and stories between participants, as well as learning from speakers or learning from people working at the venue e.g. a costume and set designer, an opera conductor, or a heritage specialist.

This really suited Moira, who has a sharp sense of humour and has a fun-loving personality, and is keen to get involved and learn the value of objects and artefacts. The activities are designed in a way which enables her to be engaged with by friendly staff and group participants, and to participate in creative activities, including art work, walking tours, music, and singing. She stated that some of the experiences with Resonate were *'just wonderful'* and that she felt *'very lucky to join in...it's so nice to be with such special people [including the volunteers]'*. Moira continues to access the service *'on her own steam'* as this is one of her only opportunities for combining social interaction, enrichment, and mental stimulation. It gives her *'quite a boost to feeling good...and builds confidence'* when managing her condition.

Patient's name changed for confidentiality purposes

6. Findings: Health and Care system



Major priorities for GP practices taking part in the Self-Care pilot include tackling diabetes (for example, through improvements in active lifestyle, diet, and medical compliance), managing dementia, and reducing the effect of social and emotional isolation on older patients' overall wellbeing. The service themes within the social prescribing directory therefore seem appropriate as they contribute towards supporting patients with these health problems.

HSCAs and Case Managers reported back on the health status of patients now, compared to before their referral. Table 6 shows the average proportion of patients who have improved. Improvement was higher for Mental Wellbeing than Physical health. Within Physical health the proportions for 'Much better' health were highest for Tier 2 and Tier 1. Proportions of patients who had got worse after the service were negligible.

Table 6. HSCA and Case Manager survey responses on physical health and wellbeing status (n=42)

Health status summary	Physical health NOW vs before referral			Mental wellbeing NOW vs before referral		
	Tier 3	Tier 2	Tier 1	Tier 3	Tier 2	Tier 1
% of referrals 'Much better'	3%	10%	27%	20%	33%	34%
Total % of referrals 'Much better' and 'Somewhat better'	58%	70%	66%	83%	91%	90%

The 'Much better' responses corroborate well with proportions indicated by patient survey results.

Conversely, a lower proportion of HSCA and Care Managers (38%) agreed that their GPs recognised the VCS providers as partners in their work. Even fewer (36%) agreed that GPs had a clear appreciation of the outcomes from social prescribing referrals. This suggests that some knowledge barriers may exist around the benefits of cross-sector collaboration and recognition about the Self-Care social prescribing model.

To compound this challenge, in our analysis of process effectiveness, we also observed that there is a need for effective feedback to be more regularly recorded, and accessed by practices. This is especially important as GPs are accountable for their patient Care Plans. Currently there are two software systems where a lot of information is recorded but needs to be better integrated: 'SystemOne' (used by health services) and 'Charity Log' (used by VCS case partners).

6. Findings: Health and Care system

Preventive impacts

The research highlighted a number of preventative impacts of the Self-Care pilot. Case Manager and HCSAs gave estimates of the proportion of patients who stopped the need for frequent GP visits; this is presented in Table 7 below. Case Managers and HCSAs indicate a lower proportion for Tier 3 than Tiers 1 or 2. We have used this lower proportion (23%) to avoid over-claiming in our calculations. Our calculations therefore estimate this to be the equivalent of 185 patients stopping the need for GP appointments during the pilot period.

Table 7. Case Manager and HSCA perceptions of proportion of patients stopping the need for frequent GP visits (n=42)

Response summary	Tier 3	Tier 2	Tier 1
% referrals stopped need for frequent GP visits	23%	31%	40%

According to WLCCG data for older patients across all of My Care, My Way, the average number of GP appointments per year is 30 per patient (excluding no-shows).

In addition, we collected HSCA and Case Manager perspectives on the preventive effect of the Self-Care model. By preventative effect, we mean reduction in health deterioration and the need for other services in the future. The results are shown in Table 8.

Table 8. Case Manager and HSCA survey perceptions of preventive effect of services (n=42)

Response summary	Tier 3	Tier 2	Tier 1
% staff reporting High to Very High preventive effect	32%	57%	67%

Outcomes for health and care services

‘I had a patient who was calling the surgery and requesting call outs from the G.P. mainly due to health anxiety. When the services began working with him his call-outs dramatically reduced and he engaged better [with therapy].’

Case Manager feedback,
Knightsbridge practice

‘We had a 91-year-old gentleman who had a stroke. Prior to being referred, his living carer was constantly calling the GP Practice and... even called the London ambulance service (LAS). Once he was referred to our service, we had the opportunity to undertake a holistic assessment... He is now able to walk with his walking aid and goes out for walk daily with his carer... he gets physio input [plus] in terms of Self-Care, he receives massage [therapy] which he enjoys. The phone calls to the surgery have been stopped, including those to the LAS.’

Case Manager feedback,
Pembridge Villas practice

In order to quantify the preventive impacts in more detail, we have analysed data from WLCCG for GP appointments and acute hospital incidences across My Care, My Way, and triangulated this with PAM score data and our survey findings. There are also number of key considerations arising from our research, which underpin our overall measurement. These are all explored in the following sections.

Deadweight considerations

‘Deadweight’ in our analysis is a similar concept to *counterfactual* – meaning the likelihood that some outcomes would happen anyway without the services. This acknowledges that observing and measuring change does not in itself tell us that the change only happened because of the intervention.

Within our analysis, we focus on how the issue of deadweight affects healthcare resources in the following ways:

- Without the 'in-practice' role of HSCAs and Case Managers, GPs would have to use more hours dealing with non-medical consultations that could otherwise be referred through social prescribing.
- Without the 'in-practice' role of HSCAs and Case Managers, GPs would have to use more hours researching appropriate support services in the community, in addition to consultation hours.
- A proportion of MCMW patients would have been referred to other services by HSCAs and Case Managers that are *not* on the social prescribing directory, and so those patients may have experienced similar outcomes.
- Without the social prescribing model and directory, HSCAs and Case Managers would have fewer options available for patients, and would have to use more hours on research and applications support for those referred patients, in addition to the consultation hours they also provide.
- Currently hospitals don't refer their patients to social prescribing services, but may refer to other services to help with recovery, e.g. British Red Cross wheelchair loan.

We assume in our modelling that whilst some patient needs become more familiar to staff, who are then able to deal with them more efficiently, over the long-term this is balanced out by: i) new patients with new needs accessing Self-Care, and ii) staff churn and the resulting loss of expertise.

We have taken these deadweight considerations into account when quantifying the preventative impacts, before giving them a valuation.

Quantifying the preventative impacts

We have quantified these preventative impacts on an annualised basis for the pilot phase, April 2016–March 2017, and also forecasted pro-rata for the current year's activity, where there has been an increase from 800 to 1300 patients (see Table 9). We did not receive WLCCG data regarding prescription scripts for this patient group; this is therefore excluded from our analysis.

The preventative impacts are as follows:

Hospital level resource savings

- Reduced frequency of acute hospital spells, as indicated by PAM score average improvement for the relevant proportion of patients.
- Reduced frequency of A & E emergency admissions, as per PAM score.
- Reduced frequency of outpatient clinic visits, as per PAM score.

GP practice level resource savings

- *Diverted* GP hours from initial social prescribing consultations as these are conducted with Case Managers or HSCAs instead (10–20 mins per consultation, as set out in the *MCMW business case*).
- *Diverted* HSCA and Case Manager research/support time. For example, researching local services, helping with welfare applications, as this is streamlined by the KCSC directory and co-ordination (0.75 hours per consultation).
- *Avoided* GP hours from patients stopping the need for frequent consultations (proportion reported by HSCAs and Case Managers).
- *Avoided* HSCA and Case Manager research/support hours from patients stopping the need for frequent consultations (proportion reported by HSCAs and Case Managers).

6. Findings: Health and Care system

MCMW patients take up an average of 30 GP appointments per year, excluding 'no-shows'. When calculating avoided GP and HSCA consultations, we estimate that the relevant patients stop needing to visit the GP only during the **six months** after completing their sessions. This is reflective of HSCAs and Case Managers feedback: they reported the benefit period of 0.55 years for Tier 3 and 0.75 years for Tier 2. The benefit period is longer at 1.3 years for Tier 1 patients, but we have under-claimed this to ensure we are not overclaiming the impact in our analysis.

In addition, project data from the patient survey sample indicates double-counting adjustment of 1% i.e. to account for the proportion of referrals across different service themes. We have increased the double-count adjustment to 10% to be conservative, and further ensure avoidance of over-claim.

Comparisons with outcomes from external projects

In addition, data from other external projects, such as Bradford Community Health Advice Team (CHAT) suggests that the majority of their clients visited a health care professional on fewer occasions in the six months following CHAT intervention, than in the **six months** prior (Age UK, *The Social Prescribing Pilot Project, Age Concern Support Services – Yorkshire and Humber* 2012).

Alternatively, Refresh Social Prescribing service in Salford found that two-thirds of its clients had fewer visits to their GP in the *twelve months* after assessment with Refresh. About a third of clients had reduced their number of GP visits by three or more. Also, 46% of clients had a reduced number of prescription scripts in the twelve months after Refresh assessment.

The Department of Health's findings in north east England indicate that meeting older people's needs with a preventative approach can create efficiencies, such as through the Partnership for Older People project. This produced an average of around £1.20 saving in emergency bed days for every extra £1 spent on prevention. (A range of between £0.80 and £1.60 is given). These efficiency gains were on top of the £1 of additional service utility to older people (*Improving Care and Saving Money*, 2010).¹⁴ Higher efficiency gains were available from more intensive, targeted interventions, which involved very close joint working between health and social care.

This included:

- Hospital overnight stays reduced by 47%
- Accident and emergency attendances reduced by 29%
- Clinic or outpatient appointments reduced by 11%
- Physiotherapy/occupational therapy appointments reduced by 8%

However, this did not include an attribution adjustment to account for other contributing factors.

There is also relevant data for the social prescribing model in Rotherham, delivered by Voluntary Action Rotherham and VCS providers, and contracted by NHS Rotherham. A report by Sheffield Hallam indicates that A&E attendances reduced by 21%, hospital admissions reduced by 9%, and outpatient appointments reduced by 29%. This was for a patient cohort comprised of two thirds aged over-75 years, and with just 11% under the age of 60 years. Attribution adjustment for other contributing factors was also not obtained. It is clear that positive benefits were achieved with this model for both health and care resources and patient wellbeing.

¹⁴ Department of Health, *Improving Care and Saving Money: Learning the lessons on prevention and early intervention for older people* (2010)

Resource savings to health care

Table 9 illustrates the resource value for GP practices and hospitals, both for the pilot period, and for the current period to Year End March 2018. We define resource savings as the value of resources freed up for health care services. *These are not necessarily the same as cashable cost savings.*

Table 9. Resource value to health services
(values rounded to nearest ,000)

In our analysis, the social prescribing model leads to **resource savings** to GP practice staff – including HSCAs and Case Managers – valued at **£102,000 for the pilot phase**, and forecasted at **£150,000 to March 2018**.

This is specifically for: i) diverted consultation hours and related work hours from an average of two social prescribing consultations per referred patients, and ii) avoided consultation hours for patients who stopped needing to visit their GP practice in the six months after completing their sessions.

Areas of resource saving	Total reduction Pilot year to Mar 2017	Equivalent consult'ns per practice Pilot year	Total Value Pilot year to Mar 2017	Total Value forecast YE to Mar 2018	Average incidence per patient per year, MCMW
GP Practice level total			£102,000	£150,000	
Diverted GP hours: initial consultations (w/ re-referral)	340 hours	57	£18,000	£27,000	30 GP practice visits per patient
Diverted HSCA & CM research/support hours: initial consultations (w/ re-referral)	1025 hours	171	£21,000	£31,000	
Avoided GP hours from patients stopping need for consultations (6-month period)	590 hours	98	£32,000	£46,000	
Avoided HSCA & Case Manager hours from patients stopping need for consultations (6-month period)	1480 hours	247	£31,000	£46,000	
Hospital level total			£106,000	£154,000	
Reduced need for Hospital spells	51 incidences	n/a	£68,000	£99,000	1.19 episodes @12 bed days
Reduced need for A & E	54 incidences	n/a	£6,000	£9,000	1.23 episodes
Reduced need for Outpatient visits	579 incidences	n/a	£32,000	£46,000	8 episodes

6. Findings: Health and Care system

Resource savings for hospitals are valued at **£106,000 for the pilot phase**, and forecasted at **£154,000 to March 2018**. These relate to reduced need for hospital spells, emergency admissions (A&E) and outpatient visits, calculated through improvement in PAM scores for the relevant Self-Care services.

Table 10 presents the estimate of resource saving for health service outcomes described above, split by service theme for the *pilot phase* only. This provides an indication of the relative value of the different service themes, which may be useful if comparing against the average unit costs for those service themes. This indicates that Physical & Exercise services, and Dementia-specific support, have a relatively high 'per patient' value.

Table 10. Resource Value and Utility Value per patient per service category pilot phase Apr 2016–Mar 2017, adjusted for deadweight and double-count of cross-referrals between service themes (rounded)

Service category (Pilot phase Apr '16–Mar '17)	Total Health Service resource value	Resource value per patient	Attributable Health and Wellbeing Value – All patients	Health and Wellbeing value per patient after attribution
Physical & Exercise	£95,000	£380	£73,500	£290
Mental wellbeing & Isolation	£42,000	£175	£54,500	£230
Safety & Welfare Information/Advice	£29,000	£155	£13,000*	£70
Health Education & Nutrition	£7,000	£175	£400	£10
Dementia-specific support	£34,000	£380	£25,000	£280

* Excludes new welfare support payments

When the total value created is compared with the annual contract budget of £250,000, the results of the SROI are as follows:

YEAR END TO MARCH 2018 – FORECASTED 'SROI'

- c.£6.25 for every £1 invested, including health service value (c.£1.22) and patient health and well-being value (c.£5.03).
- After accounting for the attribution due to other factors, the **'attributable' SROI is c. £2.80**.

PILOT YEAR 'SROI'

- c.£4.30 of value is created for every £1 invested, including health service resource value (c.£0.85) and patient health and well-being value (c.£3.45).
- After accounting for the contribution of other factors that affect patients' health and wellbeing outcomes (the attribution), **c.£1.90 of attributable value is created for every £1 invested**

Patient health and wellbeing outcomes were valued using a lower QALY value of £20,000 (see section 5) as per NICE and BMA guidance. The attributable SROI would increase if NICE's higher £30,000 QALY threshold is used: c.£2.25 in the pilot year, and c.£3.30 in forecast to year end March 2018.

Broader material outcomes: long-term social care

Broader statutory outcomes were identified with local authority stakeholders. These related to reducing the need for patients to enter long-term care, i.e. nursing homes and care homes. Royal Borough of Kensington & Chelsea (RBKC) Adult Social Care (ASC) offers around 88 care home placements in the borough, and 309 placements out of the borough. The average weekly rates (defined through the West London Alliance) for local authority placements include:

- Residential £555 – £689 per week (minimum £28,860 per year)
- Residential for Dementia £675 – £783 per week (minimum £35,100 per year)
- Nursing home: Frail £814.25 – £895 per week (minimum £42,340 per year)
- Nursing home: for Dementia £819.25 – £895 per week (minimum £42,600 per year)

There are 79 placements for dementia, and 152 placements for the physically limited.

Reducing the need for entering long-term care is only likely to be a result for the patients who maintain behaviour change and activation for their own self-care, i.e. they choose to continue actively accessing services after they complete their sessions.

We have identified the proportion of referrals with improved activation and motivation scores (62%), which correlates to a c.12% reduction in hospitalisations (see section four). If we use the 12% as a proxy for reduction in long-term care needs, an estimate can be made of reduction in long-term care need.

It was not possible to ascertain the probability of a patient choosing to enter long-term care, as a result of their long-term condition. However, we can ascertain RBKC's total number of care placements for dementia and limiting long-term illnesses (LLTI) as a proportion of the RBKC population with those conditions. This provided an indication of the proportion of patients with those conditions entering care homes.

In summary, around 1 in 20 (5%) of over-65s with dementia in RBKC are in a care home, and around 1 in 59 (1.7%) of over-65's with a LLTI in RBKC are also in a care home. Using this data, an estimate of resource savings can be made: £33,000 in the pilot phase, and forecasted as £48,000 for the year ending March 2018 – equivalent to approximately one placement.

However, we have not currently included this provisional estimate within the SROI calculations above, as we feel more primary research data would be required. In addition, we would require more data from Adult Social Care services, to better understand the relationship between Self-Care social prescribing and effects on home-based social care needs.

7. Findings: Working with VCS providers



The Self-Care model has increased capacity for the health care system to offer support services that address non-medical health and wellbeing needs. VCS providers in the social prescribing directory have generally offered the right skills, experience, and capabilities to provide the key services they are contracted for.

However, capacity for some popular services can at times be outstripped by sharp increases in demand. This has also led to a reduction in the availability of re-referrals for some patients who may need that choice. HSCAs and Case Managers are updated by WLCCG and KCSC co-ordinators when this is the case.

For some other services, there has been lower demand than first hoped, e.g. T'ai Chi, and community lunches. These components of the contract were re-negotiated and no longer offered through Self-Care (Providers are always free to continue provision outside of the model).

Making the most of available capacity depends on two key characteristics of the model:

- Local VCS providers already deliver services as part of their ongoing activities in the community – (Self-Care supports only a small component of providers' existing service).
- Good contract administration by KCSC of the network of VCS providers, in conjunction with good HSCA line management by Age UK.

Self-Care co-ordinators at WLCCG and at KCSC have fostered a strong partnership working approach. Without this, the contract administrator (KCSC) would have reduced credibility to negotiate, drive, and where needed empower the VCS network in the local system. Whilst there are some elements of overlap and potential competition between providers, we observed that they recognised the strategic value of the model in terms of sharing best practices, organisational learning, and being more empowered as a 'bloc' to work with statutory services. In some cases, for smaller providers, building a track record with a prominent CCG has helped to build credibility with other funders. However, it was difficult to ascertain the long-term value of this across all providers, as these were exploratory considerations during the pilot phase.

Capacity

Effective use of capacity has partly relied on good communication between practices and providers, to avoid inappropriate referrals. However, some communication about services has been inconsistent from one practice to another. This must be better driven, and to clear agreed standards, by KCSC, WLCCG, and Line managers of HSCAs (through Age UK).

Whilst the services may have been identified with input from patient panels, the nature of demand-led service selection – and therefore the capacity that is brought in by provider – is reactive, rather than predictive. Services do not necessarily need to be pre-tested beforehand (e.g. by clinical trial), though it is difficult to test a new service for how it will cope with fluctuations in demand if it becomes more popular than first anticipated. In turn, this more acutely focuses the need for KCSC to ensure personnel across the network of VCS providers are deployed to join up capacity and resourcing. Compared to the outset of the project, KCSC has now more consistently tracked these to better match the needs of referred patients as quickly as possible.

Provider strengths

The core strength of the model is that VCS providers are already geared-up to deliver the services as part of their expertise and existing programmes of activity. In addition, the VCS organisations already work in partnerships with other organisations or programmes in the area, where resource-sharing can be seen as part of the norm. For example, being able to share physical space, materials, or equipment, has been a key strength and source of flexibility when working with VCS groups. At a local level this was brought to the fore in the aftermath of the Grenfell Tower tragedy in June 2017.

Furthermore, in comparison to other potential models, it is also a strength that the contractor organisation (KCSC) is from the voluntary and community sector, as they can be held accountable to VCS groups, as much as to WLCCG. This forms an effective bridging organisation that can be trusted by both sides, and empowers both sides within the contract structure. It also gives some license to KCSC to encourage learning and knowledge-sharing even though there may be elements of both competition and co-production between the provider organisations.

Overall provision

Based on observation of one-to-one and group activities, and personal feedback from patients, we believe that the VCS provision is generally person-centric, sensitive, and focused on the individual's situation, personality, and emotions. Service providers are patient and discreet, and patients have reported they feel enabled to progress at a pace that is appropriate for their condition. **Adapting the pacing and flexibility of the service is an important part of provision**, to help ensure patients are comfortable and feel positive about the experience of the service.

Having the services available on a directory and having exposure to the session workers' expertise also helped to increase patient awareness of health support options available through community-based services. In some cases, this resulted in forward referrals to other services after the sessions were completed, for example to occupational therapy.

Provision for highly frail and housebound patients has been enhanced through traditionally 'centre-based' services being able to provide some home visits. For example, CAB Westminster and Age UK advice and information service is so well-used because they are spending more time than anticipated meeting patients at their home.

We also recorded Net Promoter scores as part of the research, to indicate how likely patients are to recommend them to other people. On a scale of 0 to 10, where 0 is "Very Unlikely" to recommend, and 10 is "Extremely Likely" to recommend, **patients give an average rating of 8 out of 10** (from a sample of 134 responses). This provides an indication as to most patients' perception of the *quality and appropriateness* of service(s) provision.

Furthermore, around three-quarters of HSCAs and Case Managers responding to surveys either 'strongly agreed' (50%) or 'somewhat agreed' (25%) that referrals were seen to in a timely and efficient manner during the past six months.

7. Findings: Working with VCS providers

Challenges of service delivery

The nature of older patients with higher levels of frailty and complexity can sometimes add complications to provision arrangements. For example, some patients suffer from memory loss, have emergency hospital admissions, or they don't hear when a provider arrives at their home because they suffer from poor hearing or they are asleep. It has been important that VCS providers have some existing track-record with this group and are sensitive to these issues and how to manage them.

Providers have generally taken care to 'get things right first time' with the patients. It has often fallen on providers to spend time chasing up patients. Providers also spend time chasing-up when more detailed or more accurate case information is required from Case Managers and HSCAs.

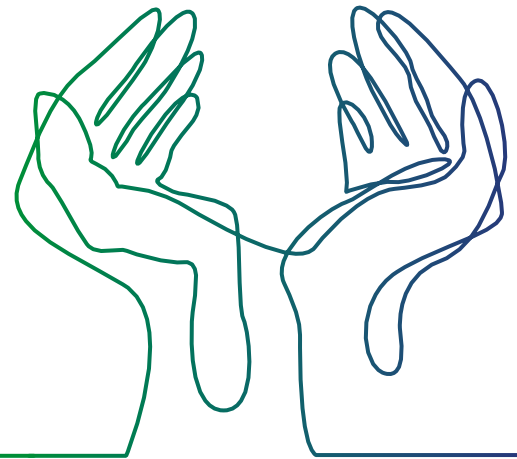
There have sometimes been misconceptions or misunderstandings amongst some HSCAs and Case Managers, about the practicalities or exact purpose of a service. This has created inappropriate or avoidable demand in some cases. In these instances, it has fallen mostly on VCS providers to identify a better alternative service or pathway during or before the patient's first session: for example, in one case, recommending de-cluttering and walking support instead of exercise at home.

Around one in ten patients gave a net promoter score of below 5 out of 10. Partly this has been due to some patients having misconceptions about service providers, and this is best addressed during practice consultations. Feedback we received also indicates that some patients can be put off if: i) they have not understood that their VCS provider is from a particular ethnic background that they may have some subconscious negative preconception about, or ii) they feel the service is beneath their socio-economic status/wealthier standing e.g. "that kind of group isn't for people like me".

Many patients are also not used to attending provision outside of the medical model and their knowledge of what is available outside the medical model can be limited. Many patients have an expectation, built up over many years, that their problems will be dealt with by the care system and clinical professionals. This can be hard to break down, and is reflected by many patients being of an age and level of need where they feel more comfortable in one-to-one services, than group activities. Patients can also be very anxious or embarrassed about being in a group with their condition in 'full view'.

Importantly, KCSC and WLCCG shifted the way in which the Self-Care directory information was communicated and structured, to be specifically about the services, rather than about the providers. This has been crucial in enabling HSCAs and Case Managers to recommend appropriate activities, rather than inadvertently bias choice towards selecting providers. This also helps KCSC to spread demand between different providers, and manage capacity.

8. Programme fit in the local system



Partner commissioners in local authorities who are on the local 'Transformation Steering Group' are also interested in the potential of the Self-Care social prescribing model. For example, delivering home visits effectively, whilst helping residents feel more included.

The Transformation Steering Group praised the flexibility of KCSC and the providers, stating that if Council services did what was set out in the contract they wouldn't have been able to achieve as much – indicating that KCSC and the Provider network are able to “go over and above.”

Transformation Steering Group members stated that before Self-Care, the equivalent Case Managers and HCSAs at that time were taking two hours to get to know one patient, but didn't have the time to follow-up with in-depth work. Now, they know they have six weeks to test different provision and support through Self-Care with the input of VCS providers rooted in the area.

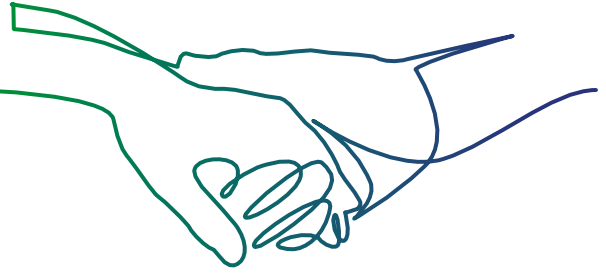
The Transformation Steering Group stated key outcomes that are most important for their work. Firstly, whether the patient group feel safe and supported to stay *independent in their home*, and secondly, whether they feel supported to increase their social inclusion. This was seen to be important in terms of specific behaviours linked to future health outcomes: for example, have they left the house more; have they walked for ten minutes; have they talked to more people?

The Group stated that their interest in Self-Care is whether the testing approach helps patients to develop secondary behaviours that may impact on existing provision, e.g. day-centre visits, exercise to maintain mobility, which in turn helps them sustain independence and avoid the need for long-term care or nursing homes.

In conjunction with this, a number of patients in the target Tier groups might have personal budgets for their care from the local authority. These patients could be supported by Self-Care to purchase some of these interventions through their personal budgets, including paying for transport to access services.

There may also be a wider role for other stakeholders in the system, in particular, social housing providers, but this requires careful consideration. Some social housing landlords already work in partnership with VCS providers listed on Self-Care. Therefore, a balanced and targeted approach is needed: on one hand there may be a degree of duplication if social housing providers are promoting and offering similar services to tenants (but don't require a referral). On the other hand, housing providers may be offering their own activities that may sit well within the Self-Care directory. For example, Genesis (soon to merge with Notting Hill housing), and Peabody offer opportunities for older residents to share skills and experiences with other older residents (the V50 Project, co-funded by NESTA).

9. Recommendations



We feel the Self-Care model overall is an increasingly effective way of working towards the 'six core elements of the Whole Systems Model of care' (see Appendices part A).

Self-Care has helped to begin the transformation of provision and cross-sector collaboration between aspects of health and social care, and the VCS sector. However, this will take time to be more fully embedded in practice and mindsets of health and social care professionals, and much work still needs to be done, especially as the target patient groups will grow in number and have changing needs. This implies the model needs to be prepared for higher demand and ever-changing needs in the foreseeable future. Therefore, it should be managed as a live, dynamic model.

We recommend that future planning and considerations for the Self-Care model are underpinned by Envoy's separate analysis of process effectiveness. Part E of the Appendices can also provide a helpful reference point in this case (Strengths, Limitation, Opportunities, Challenges) derived from our process effectiveness analysis. We recommend a number of immediate actions, and medium to long-term actions, as follows:

Immediate actions

For KCSC

- Build information adequacy guidance and compliance, for both referral information (SystemOne) and Charity Log.

- Develop appropriate minimum service quality and information/feedback standards, using input of practice staff, clinicians, providers and patient feedback e.g. from Envoy surveys, Charity Log.
- Tighten full cost recovery with VCS providers and new services, through: i) slight adjustments between up front block components and later spot payments, ii) a simple, fair approach for unit costs to include resource required for ongoing learning network costs, and iii) a simple and fair approach for discontinued services who have had to resource setting-up and administrative costs, but who have not been provided with a minimum number of referrals within a set period e.g. first four months.
- Plan for expanding services more formally to Tier 1, where there is a greater potential for preventative effects on poor health.
- Better record the rate at which GP consultations are avoided. This could be achieved by linking patient ID number to self-care feedback at GP level.
- Improve reach and build capacity to deliver more services to more patients, but without sacrificing quality of patient experience and impact on quality of life. For example, group activities are not necessarily the ideal solution, compared to slightly extending the initial number of one-to-one sessions whilst reducing re-referrals.

For WLCCG

- Consider options for increasing from six initial sessions to eight sessions, but reducing re-referral options, e.g. 2–3 re-referral sessions only. Or introduce flexibility, e.g. offer 6 to 10 sessions only.
- Expand services more formally to reach 'high-risk' Tier 1, and consider targeting priority BAME patients.
- Ensure better integration and synthesis of information between 'SystmOne' and 'Charity Log' for input back to patient Care Plans.
- Build feedback loops by sharing relevant findings with wider WLCCG internal and external partners, other CCGs, and professional bodies, e.g. Royal College of General Practitioners.
- Increase marketing internally at practices and within MCMW, and market more broadly to local tenants through other new partners, e.g. social housing landlords who want to sustain tenancies.

For frontline staff

- HSCA and Case Manager to build their confidence and compliance with using Charity Log at practice-level as much as possible. HSCAs and Case Managers to remain responsible for attending refresher sessions, feedback meetings, and provide learning and information updates.

Medium to long term actions

For KCSC

- Ask new VCS providers to demonstrate evidence of the health and wellbeing impact of their service before being selected for the directory.

- Patients could be offered a bundle of complimentary activities from the directory within their sessions quota, and a 'Patient Exchange' function could be introduced, where unused sessions from patients who drop out are offered to other existing service-users where most needed.
- Explore how 'Personal Budgets' can be best allocated, with support and input from Transformation Steering Group.
- Proactively balance the contract structures for certain services, for example by having a small up-front component in block structure, and thereafter spot contracts.

For WLCCG

- Roll-out communications for awareness-raising amongst the rest of the clinical and reception staff about the success and impact of Self-Care services in supporting patient goals.
- PAMs survey wording can be inappropriate for various conditions – this may need a simpler alternative version to be in place, rather than having no follow-up measures at all.

For frontline staff

- Patient perceptions and concerns about the socio-economic background of other service users, and ethnic background of providers need to be addressed at initial consultation by Case Manager or HSCA, as this will help to flag risk of patient drop-out.
- Consider implications if affordable transport provision increases in the local area, the potential impact on demand should be planned for carefully.

Appendices

Part A

Six core elements of the Whole Systems model of care

Part B

SROI: Accounting for Impact

Part C

SROI calculation sources

Part D

Survey design

Part E

Strengths, Limitations, Opportunities, Challenges

Part F

Key references

Part A

Six core elements of the Whole Systems model of care

The Whole Systems model of care specifies six core elements for care planning and provision. The six elements are integrated into My Care, My Way, and therefore also apply to Self-Care social prescribing.

The six elements specify that all models of health care provision should:

1. Be centred around the holistic needs of the service users and their Carers, involving them in all decisions while providing with simpler access and a shared care plan.
2. Be personalised and tailored to changing health as well as social needs, covering planned as well as reactive needs and one that empowers self-care.
3. Have a clear point of accountability (both for clinical and non-clinical outcomes) with a core team that reflects user's needs.
4. Be supported by a number of local operational whole-systems bases, where joint teams work on a day-to-day basis coordinating the care and tracking outcomes.
5. Help co-ordinate the services (via the base) as needed from different organisations, on behalf of the service users and their Carers.
6. Be brought together by an accountable partnership of organisations commissioned to deliver a single set of outcomes with shared systems and incentives.

(summarised from WLCCG Business Plan and service specifications for Whole Systems, 2015)

Part B

SROI: Accounting for Impact

To avoid over-claiming of value, the SROI analysis measured impact with a range of adjustments. This was also informed by triangulating different primary data (patient surveys and interviews) with secondary research elements to help establish impact credibly.

We identified '**attribution**', which is a measure of the proportion of outcomes that is directly attributable to Self-Care, i.e. the Self-Care service model can take credit for. It acknowledges that, although the calculations already consider the outcomes that would have occurred without Self-Care (through deadweight estimations – see below), the remaining outcomes are nonetheless due to the work of a number of different people and organisations, and are not solely due to Self-Care. In this SROI, attribution was determined through surveys of patients, cross-referenced with interview feedback.

We also assessed '**displacement**', which is a measure of whether some of the outcomes observed have not actually been created, but have been moved elsewhere. One example is where a fall in crime is recorded, but some or all of the reduced crime has actually relocated to another area. For the outcomes in this SROI, displacement is not deemed to be an issue; one client's improvement in health and well-being does not come at the expense of another individual.

SROI also requires assessment of impact '**drop off**', if claiming future longer-term outcomes beyond a year. This is because some outcomes may last longer for individuals over multiple years, but not necessarily to the same magnitude, i.e. the strength of impact drops off in year two and year three, after an intervention. However, as the impacts on patients are short-term i.e. less than one year, the drop off in our calculation is effectively 0%.

The specific adjustments are summarised as follows:

- **Attribution:** Is calculated from self-reported patient survey responses. In terms of scaling, a 5-point scale for level of attribution agreement was used ('None of it', 'A little of it', 'Some of it', 'Most of it', 'All of it') for different outcome categories, and stakeholder responses were converted to 0–1 scale (0–100%). The average results provided attribution score of c.23% for subjective patient outcomes.
- **Displacement:** we deemed this to be 0%, because improving the activation and health of the patients should not negatively impact other material stakeholders.
- **Drop-off** of impact and discount rates: The benefit period for patients does not exceed one year in our model, and therefore a drop-off rate and a discount rate for future impact is not required for our calculations.

Deadweight considerations

'Deadweight' is a measure of what would have happened in the absence of the intervention being evaluated. It is a similar concept to *counterfactual*, and acknowledges that observing and measuring change does not in itself tell us that the change only happened because of the intervention.

Within our analysis, we focus on how the issue of deadweight affects healthcare resources in the following ways:

- Without the 'in-practice' role of HSCAs and Case Managers, GPs would have to use more hours dealing with non-medical consultations that could otherwise be referred through social prescribing.
- Without the 'in-practice' role of HSCAs and Case Managers, GPs would have to use more hours *researching* appropriate support services in the community, in addition to consultation hours.
- A proportion of MCMW patients would have been referred to other services by HSCAs and Case Managers that are not on the social prescribing directory, and so those patients may have experienced similar outcomes.
- Without the social prescribing model and directory, HSCAs and Case Managers would have fewer options available for patients, and would have to use more hours on research and applications support for those referred patients, *in addition* to the consultation hours they also provide.
- Currently hospitals don't refer their patients to social prescribing services, but may refer to other services to help with recovery, e.g. British Red Cross wheelchair loan.

We assume in our modelling that whilst some patient needs become more familiar to staff, who are then able to deal with them more efficiently, over the long-term this is balanced out by: i) new patients with new needs accessing Self-Care, and ii) staff churn and the resulting loss of expertise.

Our model also assumes that the proportion of patients who may have improved without any support from GPs or social prescribing or any additional services, is cancelled out by the proportion of patients whose health would have deteriorated without their social prescribing referral.

We have used a 16% deadweight / counter-factual measure to further reduce the amount of impact claimed, based on interview feedback about the likelihood that outcomes would have happened anyway, and cross-referenced with patient survey feedback for those who felt the service did not add to the wellbeing outcomes they had experienced anyway. This is effectively a proportion of 1 in 5 patients who may have experienced the same outcomes anyway, minus an assumed proportion (20%) to account for patients who are housebound and bedbound. Housebound and bedbound patients are unlikely to access similar services or support offered outside of Self-Care.

Appendices

Part C

SROI calculation sources

Outcome	Proxy value	Source of proxy value	Average amount of change in outcome or incidence	Evidence of change	Literature reference for change indicator
GP practice level					
GP hours diverted: social prescribing consultations	£60.39 per hour	WLCCG average annual cost, including London weighting, NI and pension: 2017/2018	0.25 hours x 2 consultations	Actual number of social prescribing consultations not requiring GP time	Consultation time length based on MCMW business case
GP hours avoided from reduced need			0.25 hours x 15 consultations	Case Managers and HSCA survey response, combined with WLCCG data for average half year number of GP visits per My Care, My Way patient	Consultation time length based on MCMW business case
Case Manager & HSCA research and support hours diverted: social prescribing consultations	£23.40 per hour	Mean of WLCCG HSCA and Case Manager annual cost, including London weighting, NI and pension: 2017/2018	0.75 hours x 2 consultations	Case Managers and HSCA survey response, combined with Actual number of social prescribing consultations	Research time length based on Case Manager and HSCA survey response and qualitative interviews
Case Manager & HSCA research and support hours avoided from reduced need			0.75 hours x 15 consultations	Case Managers and HSCA survey response, combined with WLCCG data for average half-year number of GP visits per My Care, My Way patient	Research time length based on Case Manager and HSCA survey response and qualitative interviews
Hospitals level					
Reduced A&E incidence	£142	WLCCG acute hospital incidence and costs per MCMW patient, Apr 2016–March 2017	0.116 reduction	PAM score correlation, for patients using relevant service category	Insignia Health (PAM scoring system)
Reduced hospital spells	£1,734	WLCCG acute hospital incidence and costs per MCMW patient, Apr 2016–March 2017	0.116 reduction	PAM score correlation, for patients using relevant service category	Insignia Health (PAM scoring system)

Outcome	Proxy value	Source of proxy value	Average amount of change in outcome or incidence	Evidence of change	Literature reference for change indicator
<i>(Hospitals level continued...)</i> Reduced outpatient visits	£72.34	WLCCG acute hospital incidence and costs per MCMW patient, Apr 2016– March 2017	0.116 reduction	PAM score correlation, for patients using relevant service category	Insignia Health (PAM scoring system)
Other statutory agency level					
Avoided need for entering long term care placement with local authority	£42,341	Annual care placement cost for Royal Borough of Kensington & Chelsea, Nursing home for Frail	0.017 reduction	Number of placements in local authority care for dementia and long term limiting illness as proportion of local population with those conditions	Adult Social Care (ASC) and Health Scrutiny Committee – Report of Interim Executive Director for ASC May 2017, combined with ONS data/RBKC factsheet extrapolated to 2017/18
Housing re-let cost avoided	£2,909	Average cost for social housing tenancy failure (The Ferry Project, <i>Octavia View SROI</i> , reference to Office for Deputy Prime Minister estimate 2005), linked to 2% inflation	0.017 reduction	Number of placements in local authority care for dementia and long term limiting illness as proportion of local population with those conditions	Adult Social Care (ASC) and Health Scrutiny Committee – Report of Interim Executive Director for ASC May 2017, combined with ONS data/RBKC factsheet extrapolated to 2017/18
Patient level					
Reduced physical pain/discomfort (improved mobility)	£20,000	Full QALY from National Institute of Health and Clinical Excellent, and British Medical Association, <i>Exploring the cost effectiveness of early intervention and prevention</i> (2017)	0.028 reduction	Patient survey indicator based on EQ-5d questionnaire and linked to corresponding QALY average improvement scores	Devlin, Shah et al, <i>Valuing health-related quality of life: An EQ-5D-5L value set for England</i> , in Health Economics journal (2016)
Avoided depression	£20,000	Full QALY National Institute of Health and Clinical Excellent, and British Medical Association, <i>Exploring the cost effectiveness of early intervention and prevention</i> (2017)	0.056 improvement	QALY linked to Patient survey indicator based on PHQ9 questionnaire and linked to corresponding QALY average improvement scores, with EQ-5d equivalent thresholds	Jia & Lubetkin, <i>Incremental decreases in quality-adjusted life years (QALY) associated with higher levels of depressive symptoms for US Adults aged 65 years and older</i> , in Health and Quality of Life Outcomes (2017)

Appendices

Outcome	Proxy value	Source of proxy value	Average amount of change in outcome or incidence	Evidence of change	Literature reference for change indicator
(Patient level continued...) Improved self-efficacy/self-worth*	£704	Sub-proportion of Mental Wellbeing QALY; Mental wellbeing comprising 0.352 of a Full QALY (Centre for Mental Health, <i>The economic and social costs of mental illness</i> , 2003)	0.03* improvement	PAM score change	New Economy Manchester (2012) <i>Social Value: Understanding the wider value of public policy interventions</i> (2012)
Retaining independence*	£352	Sub-proportion of Mental Wellbeing QALY; Mental wellbeing comprising 0.352 of a Full QALY (Centre for Mental Health, <i>The economic and social costs of mental illness</i> , 2003)	0.11* improvement	Patient survey indicator based on ASCOT questionnaire and linked to corresponding QALY average improvement scores	Based on ranking of older service user outcomes from Bield, Hanover, and Trust housing, <i>SROI on Stage 3 housing adaptations and Very Sheltered Housing</i> (2012)
Reduced social isolation/loneliness*	£1,173	Sub-proportion of Mental Wellbeing QALY; Mental wellbeing comprising 0.352 of a Full QALY (Centre for Mental Health, <i>The economic and social costs of mental illness</i> , 2003)	0.02* reduction	Patient survey indicator based on 'Warwick-Edinburgh Mental Wellbeing Scale' questionnaire and linked to corresponding QALY average improvement scores	New Economy Manchester, <i>Social Value: Understanding the wider value of public policy interventions</i> (2012)
Feeling more valued by others*	£235	Sub-proportion of Mental Wellbeing QALY; Mental wellbeing comprising 0.352 of a Full QALY (Centre for Mental Health, <i>The economic and social costs of mental illness</i> , 2003)	0.044* improvement	Patients reporting outcome in survey and linked to corresponding QALY average improvement scores	Assumed sub-proportion based on New Economy Manchester, <i>Social Value: Understanding the wider value of public policy interventions</i> (2012)
Carer level	Not included	Not included, low referrals	Not included, low referrals	Not included, low referrals	Not included, low referrals

* Average amount of change pro-rated by proportion of population in each service category to whom change applies

Part D

Surveys

There is a significant methodological difference between i) survey questions asked at the beginning and end of the programme, with respective results between the two compared; and ii) survey questions where respondents are asked how they feel now, and also asked to recall how they felt previously (this can be termed as a *Retrospective Post-then-Pre* approach).

Both approaches have their advantages. The first approach is more common, particularly among social science research, and it does not rely on participants recalling how they felt some time in the past. The second approach can avoid *Response Shift bias*, which occurs when a participant uses a different frame of reference for understanding a question. For example, it might be that an individual thinks they are good at 'Dealing with Problems'. They then learn more effective ways of dealing with problems, and realise that they are actually not as 'good' as they thought they were. They might end up scoring themselves the same before and after the programme, even though they have improved, because their understanding of how to 'Deal with Problems' effectively has changed.¹⁵ As a general rule, the *Pre/Post* method may understate any change, while the *Retrospective Post-then-Pre* method may overstate it. When it is possible to take the different approaches together (e.g. PAM scores and additional Retrospective survey), they can give a better indication of change.

Patient survey

Survey versions can be made available on request. The full list of patient survey questions are summarised below. Some questions were not relevant or appropriate for specific services; other questions were specific to only one or two services. The pro forma was adapted to the outcomes relevant to the specific service themes (see section two of the report).

Certain questions are drawn directly from validated health questionnaires, in particular EQ-5d, regarding physical pain (using the scoring system designed by EuroQol Research Foundation), PHQ9 indicator relating to depression (developed by Columbia University and widely used in primary care settings), the Warwick-Edinburgh Mental Wellbeing Scale regarding isolation and loneliness, and ASCOT quality of life measures, regarding independence (developed by the University of Kent).






Patients were asked to provide responses to the questions for their situation now, and then to provide their responses for their situation before receiving the service. Each pro forma was pre-filled with a generic anonymised ID number linked to the service(s) accessed by that patient.

Response options about frequency were accompanied by colour-coded visual aids as follows:

Not at all  A little  Moderately 
Quite a lot  Extremely 

Response options about (dis)Agreement were accompanied by colour-coded visual aids as follows:

(Question statement...)

Strongly agree  Agree 
Neither agree nor disagree 
Disagree  Strongly disagree 

The wording of the questions and response scales remained consistent for all pro forma as follows below, *except for surveys with dementia patients*, which did not require reflective recall questions, and were simplified in question design to align with i) the objectives set out in the National Dementia Declaration from Dementia Action Alliance, and ii) British Medical Journal Open research by Spencer, K. et al (2017):

1. Please indicate if the survey is being completed either:

*About myself / On behalf of someone else
(please write your relationship)*

2. How likely would you be to recommend _____ service(s) to a friend/someone you know?
0–10 scale where 0 is 'Not at all likely' and 10 is 'Extremely Likely'

3. In general how would you rate your health?
Excellent / Very good / Good / Fair / Poor

4. Please think about any change in your health over the past year. To what extent do you think this change is because of the service(s) mentioned?
All of it / Most of it / Some of it / A little of it / None of it

¹⁵ For more information on the two approaches, see Program Development and Evaluation. Using the Retrospective Post-then-Pre Design, Quick Tips #27. University of Wisconsin-Extension, Madison, WI. © 2005
uwex.edu/ces/pdande/resources/pdf/Tipsheet27.pdf

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5. I feel motivated to take care of my own health and medication needs

Strongly agree / Agree / Neither Agree nor disagree / Disagree / Strongly disagree

6. I can live as independently as I want

[based on ASCOT]

Strongly agree / Agree / Neither Agree nor disagree / Disagree / Strongly disagree

7. My living conditions help me to live in dignity

Strongly agree / Agree / Neither Agree nor disagree / Disagree / Strongly disagree

8. There are enough people I personally feel close to

[based on De Jong Gierveld/SWEMWBS]

Strongly agree / Agree / Neither Agree nor disagree / Disagree / Strongly disagree

9. When accessing health care support I feel I'm valued just as much as other people like me

Strongly agree / Agree / Neither Agree nor disagree / Disagree / Strongly disagree

10. I use techniques I have learned to help me remember things more easily

Strongly agree / Agree / Neither Agree nor disagree / Disagree / Strongly disagree

11. How much do you feel in pain or discomfort

[based on EQ-5d]

Not at all / A little / Moderately / Quite a lot / Extremely

12. How much do you feel limited in what you can do [based on SF 12]

Not at all / A little / Moderately / Quite a lot / Extremely

13. How often have you been bothered by the following problem: Feel down, depressed or hopeless

[based on PHQ9]

Not at all / Several days / More than half the days / Nearly every day

14. How often have you been bothered by the following problem: Feeling anxious

[based on ICECAP-A & PHQ9]

Not at all / Several days / More than half the days / Nearly every day

15. In the past 3 months, indicate roughly how often you tended to visit your local GP clinic:

Once a week or more / Once a fortnight / Once a month / Less than once a month / Did not use

16. In the past 3 months, indicate roughly how often you needed emergency admission /A&E:

Once a week or more / Once a fortnight / Once a month / Less than once a month / Did not use

17. In the past 3 months, indicate roughly how often you needed other treatment e.g. specialist surgery, mental health unit:

Once a week or more / Once a fortnight / Once a month / Less than once a month / Did not use

Please describe any further reasons for this [open text]

[Welfare payments and Carer relief]

18. If relevant to you, did the service help you to access any extra financial welfare support e.g. benefit payments or allowance to support your situation?

If yes, please indicate payment support received £ [Pound numerical value] per year income*

Please describe any further reasons for this [open text]

19. If you have a carer or relative caring for you, to what extent was the service helpful in freeing up your carer/relative's time to arrange other things, or take a break?

Extremely helpful / Moderately / A little / No change

20. If you have further comments about the service(s) you received, please write here

[open text]

Case Manager and HSCA survey

The following questions regarding referred patients were configured onto online survey software and completed online by Case Managers and HSCAs.

Q1. Are you a HSCA or Case Manager?

I am a HSCA / I am a Case Manager

Q2. Which is the main practice or clinic at which you are based?

[open text]

Q3. In your opinion, approximately what proportion of patients referred onto Self-Care services go on to improve self-activation about taking care of their own health?

Tier 1 patients [0–100% scale]

Tier 2 patients [0–100% scale]

Tier 3 patients [0–100% scale]

Q4. In your opinion, roughly how long do you think this improvement – if any – generally lasts for patients referred onto Self-Care services?

Tier 1 patients

[Up to 1 month/Up to 3 months/Up to 6 months/Up to 1 year/1–2 years/Rest of their lives]

Tier 2 patients

[Up to 1 month/Up to 3 months/Up to 6 months/Up to 1 year/1–2 years/Rest of their lives]

Tier 3 patients

[Up to 1 month/Up to 3 months/Up to 6 months/Up to 1 year/1–2 years/Rest of their lives]

Q5. In your opinion, how would you rate the recent physical health and mental wellbeing of patients referred onto Self-Care activities, compared to before their referral: [Select a box]

	Much better	Somewhat better	About the same	Somewhat worse	Much worse
Tier 1 Physical health					
Tier 1 Mental wellbeing					
Tier 2 Physical health					
Tier 2 Mental wellbeing					
Tier 3 Physical health					
Tier 3 Mental wellbeing					

Q6. If the Self-Care directory information and referral model were not in place, how many more hours per week do you estimate your practice GP(s) would have to work on the non-medical needs of these related patients'?

Number of hours per week per GP [Number]

Number of GPs at practice [Number]

Q7. If the Self-Care directory information and referral model were not in place, how many more hours per week would You have to work on researching similar local voluntary and community services to refer patients to?

Hours per week [Number]

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Q8. Thinking about Self-Care services in general, please select one response that best describes how much you agree or disagree with each statement below: [Select a box]

	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
Referrals have been seen to in a timely and efficient manner during the past 6 months					
Appropriate feedback about patient progression is accessible for me					
Clear minimum standards are in place for services to ensure appropriate quality of patient experience					
Self-Care service providers often call me to request further information about referrals					
Clinical staff at the practice(s) where I work have a clear appreciation of the outcomes achieved by Self-Care services					
Clinical staff at the practice(s) where I work view Self-Care service providers as partners in their work					

Q9. In your opinion, how would you rate the possible preventive effects of Self-Care services on longer-term health conditions of referred patients?

Tier 3 patients

[No effect / Slight effect / Moderate effect / High effect / Very high effect]

Tier 2 patients

[No effect / Slight effect / Moderate effect / High effect / Very high effect]

Tier 1 patients

[No effect / Slight effect / Moderate effect / High effect / Very high effect]

Q10. What are the main types long term conditions being dealt with at your practice for +65 year olds? Please describe:

[open text]

Q11. In your opinion, approximately what percentage of referred patients do you feel have gone on to experience the following outcomes, after completing their Self-Care sessions? Please rate for each statement, and each Tier of patient.

Note you may leave blank or '0%' responses where appropriate: [Select a box]

	Tier 1 patients %	Tier 2 patients %	Tier 3 patients %
Stopped all need for visit or call to GP			
Stopped all need for emergency admission			
Stopped all need for tertiary care			
Slightly reduced need for visit or call to GP			
Slightly reduced need for emergency admission			
Slightly reduced need for tertiary care			

If you have an example, please describe below:
[Open text]

Q12. If you have any other important comments, please write them below:
[Open text]

Part E

Strengths, Limitations, Opportunities, Challenges

This section summarises key strengths, limitations, opportunities, and challenges of the Self-Care model in generating patient activation and bringing knowledge to patients about VCS services in the community. The summary tables are based on i) analysis of feedback from service providers, patients, and practice-based GP, Case Managers, and HSCAs, as well as ii) our research observations from several service sessions – including one-to-one befriending, and also group activities (Men's club, and cultural group activities for dementia patients).

Strengths of the model

- Contracting a well-positioned co-ordinating VCS organisation that is accountable to *both* VCS organisations as well as to the CCG has been key, to:
 - i) enable agile and flexible commissioning, whilst supporting some frontline administrative functions
 - ii) enable GP practices and patients to reach more VCS services appropriate to their needs (and thus work more effectively with their time)
 - iii) generate trust between providers, health services, patients, and stakeholders, and
 - iv) foster cross-sector collaboration to better join up resources.
- The role of the HSCA and being based at a clinic/surgery practice, is crucial in assisting broader patient choice; HSCAs are equipped with richer information and knowledge about options across the local system that can more appropriately meet patients' non-medical health and wellbeing needs. Line management by an external specialist VCS organisation such as Age UK has supported frontline administration. This might potentially reduce human resource tensions if clinical managers were previously having to line managing them.
- New partnership working and cross-sector collaboration between health, VCS, and statutory services, has improved capacity across the health and social care system to meet patient needs more appropriately.
- There have been some significant resource savings to care services, especially GP time and Case Manager time spent on care co-ordination, planning, and research.
- It has enabled broader reach to patients in need, for VCS services that support frontline health care.
- It enables patients, especially those who are housebound or bedbound, to live as independently as they wish for longer; and better support patients to decide to move to long term care on their own terms, or in some cases to die in the place they wish.

Limitations of the model

- Tier 3 are often 'too far progressed' with their conditions to transform their health, even though activation or motivation might improve in the short-term.
- Tier 1 are not always offered services, creating a gap in a preventive approach; there may be more sustained resource savings from targeting longer-term outcomes for this group, as indicated by HSCAs and Case Manager survey, before their condition escalates to Tier 2.
- Six sessions are not enough in many cases to encourage sustained change in habits – although it is difficult to balance the 'introductory taster' rationale to the service vs becoming perceived as a frontline service. Evidence suggests ***Eight consecutive sessions*** to be more effective to embed behaviour change for the majority of patients (*Handbook of Psychotherapy and Behaviour Change*, M. Lambert, 2013).
- Clear minimum standards are not in place for:
 - Quality of service provision/care
 - Information adequacy provided on referral forms, or Charity Log (and subsequent usage of this for patient Care Plans)
- Patients could be offered a bundle of different complimentary activities within their sessions, and a 'Patient Exchange' function could be introduced, where unused sessions from patients who drop out are offered to other existing service-users where appropriate.
- Contract and payment structure (e.g. block payment in advance, or 'pay-per-play' spot contract) with each VCS provider can influence their up-front resource and capacity risks.
- It is a demand-led model rather than clinically tested services, and so there is some churn when low service demand leads to discontinuation; in which instance, a clear criteria or policy for discontinuation needs to be fully understood and agreed by all partners.
- Charity Log is inconsistently utilised by HSCAs and Case Managers; there does not appear to be strong line management of this at practices, or compliance in place, about regular use/practice-setting. Some of this is down to churn of staff, and some wider lack of confidence across all staff about its use.

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- There is significant variation in effective communication and feedback between certain practices and providers about patient situation, and patient progression.
- There can be information overload for both patients and HSCAs and Case Managers, when they are getting to grips with all the services and how they really work, and given the plethora of other care pathway information and service contact details they receive. However, HSCAs and Case Managers still hold a responsibility to attend to refresher meetings, feedback meetings, and learning and information updates.
- The range of services and how they are delivered may need to be refined with regards to reaching older patients from broader BAME and LGBT backgrounds.

Opportunities for the model

- Self-Care is clearly a new innovative delivery model that works in many instances, and potentially reduces duplication between health and social care, and VCS providers
- It can support reduction in wellbeing inequality, and especially improve patients' sense of being valued by the care system.
- Can help explore new co-investment models with other statutory services e.g. Transformation Steering Group, or making use of **Personal Budgets**.
- Increases awareness and education amongst clinical staff about cross-sector collaboration, and the effect of VCS services on supporting patient outcomes; Self-Care is helping to slowly build culture change amongst clinical and health professionals about this collaboration and also about non-medical and social variables affecting health and wellbeing.
- In terms of some forms of medication (e.g. anti-depressants, pain management medication), Self-Care can help to identify alternative options to avoid inappropriate medical interventions.
- Self-Care can help diversify client groups (e.g. more men, BAME patients, LGBT patients), and also supports the socialising and destigmatising of certain conditions such as dementia or mental health.

- Correct and appropriate quality of information could potentially be shared between referrers and providers (two-way), to reduce waste and optimise activities that best meet Care Plan goals; this would also be enhanced by sharing parts of the patient Care Plan where appropriate and consented to.
- Improve ongoing feedback and communication between providers and practices; this requires appropriate use of Charity Log (and better integration with System One).
- Improved word-of-mouth and awareness-raising about services to target clients.
- Continuous improvement practices for CCG, KCSC and VCS providers, especially through shared learning, action-setting, and target-setting, which they remain responsible for.

Challenges for the model

- There will likely be ongoing changes to criteria for provider selection as the model grows, and both demand levels and needs change.
- Having to balance demand-led vs evidence-led services; both have their advantages and disadvantages.
- Transport / Mobility barriers and under-funding are prevalent in the local system.
- Patient perceptions about socio-economic class (their own vs service target group) and ethnic background can sometimes become a barrier, or lead to reluctance to engage.
- The need to reduce patient drop-out.
- Awareness vs misconceptions amongst rest of clinical and reception staff about the success and impact of Self-Care services in supporting patient goals, which is linked to required improvements to feedback-sharing between SystmOne and Charity Log.
- PAMs survey wording can be inappropriate for various conditions – this may need a simpler alternative version to be in place, rather than having no follow-up measures at all.
- Effective compliance regarding line management of HSCAs by Age UK, to reduce potential for conflict of interest with Age UK services.

Part F

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1. T'ai Chi 2. Link Up service & Men's activities group 3. Creative group 4. Massage therapy 5. Chair-based exercise 6. Information & Advice 7. Dancing & exercise 8. Local VCS groups

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