

LEEDS BECKETT UNIVERSITY

EVALUATION OF CONNECT FOR HEALTH

Interim report

May 2017

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1. Introduction

Social prescribing is a process of connecting primary care patients to support within the community. It allows primary care practitioners to refer patients to various sources of non-medical support which can complement existing interventions to help improve the health and wellbeing of those in need (Branding and House, 2009). Moreover, social prescribing offers a way to address some of the wider determinants of health through routine clinical services (South et al., 2008).

Connect for Health is a social prescribing service providing access to groups and activities to people within the South and East region of Leeds. The service is commissioned by Leeds South and East Clinical Commissioning Group and operates at three levels:

- I. Providing information by phone or email to individuals about existing support in their local community.
- II. One to one meetings with Wellbeing Coordinators to gain a better understanding of a person's health and wellbeing needs, and to provide information and advice on local groups and services.
- III. Providing additional support to those who require it, such as those with depression and anxiety, vulnerable adults or those who have little knowledge of how to access community groups and services in their local community.

The evaluation of the Connect for Health Social Prescribing service is being undertaken by Leeds Beckett University. This interim report provides indication of the effectiveness of the service to date drawing on questionnaire data and interviews with clients and key stakeholders.

The overarching aim of the evaluation as a whole is to provide a rigorous and accurate evaluation of the social prescribing service. This includes:

- To assess if the service is beneficial for the local population
- To assess if the service is cost-effective
- To assess if the service is contributing to address health inequalities within the Leeds South and East CCG locality
- To provide high quality evidence to help fill the identified evidence gap nationally to aid in the commissioning of social prescribing services

2. Methodology

2.1 Approach

To date, data collection has comprised of two elements:

1. Qualitative data gathering, using a combination of interviews and focus groups, with Connect for Health clients and stakeholders, including Connect for Health staff.
2. Baseline and exit questionnaires completed with clients referred to Connect for Health social prescribing service.

2.2 Ethical considerations

Approval for all aspects of the work has been provided by Leeds Beckett University after NHS Yorkshire and Humberside Commissioning Support Unit determined that the work classified as a service evaluation.

2.3 Timings

Individual interviews were conducted between July 2016 and December 2016. The focus groups took place on the 6th July 2016. Transcription and analysis was conducted immediately afterwards.

2.4 Interviews and focus group

A total of nineteen Connect for Health clients were interviewed by telephone between July 2016 and April 2017 in order to gather their views of the service. Interviewees were identified from the quantitative questionnaires based on those that had agreed to be contacted for a telephone interview. Clients who took part in an interview were offered a high-street voucher to recognise their contribution to the evaluation. In addition, two stakeholder interviews were conducted. One individual was employed by a voluntary sector organisation and one was a Wellbeing Coordinator at Connect for Health. Finally, a focus group was conducted with seventeen individuals employed at Connect for Health to ascertain the perspectives of those working both at operational and strategic levels.

All interviews and the focus group were recorded and transcribed. Transcriptions were then analysed thematically by the research team to generate salient themes that emerged from the data. Results are organised in accordance with the sub-categories from the quantitative data, and findings are illustrated with direct quotations from clients and staff. The quotations have been left anonymous to protect participants.

2.5 Questionnaires

In order to measure change in wellbeing, mental and physical health, social isolation and loneliness as well as ability to manage long term conditions, a questionnaire was administered by Connect for Health Well-being Coordinators to clients at baseline (during the initial assessment) and administered again when individuals 'exited' the service (described throughout as 'follow-up' or 'post-stage').

The questionnaire completed by clients at baseline and follow-up included seven statements designed to measure the wellbeing of participants. Responses to each statement were assigned a value from 1 to 5, with the least positive option scoring the lowest and the most positive option scoring the highest. For each participant the response scores were added

together to give a total 'wellbeing' score. The maximum possible score was 35 and the minimum was 7.

The questionnaire also included three questions related to relationships and social networks. The response to these three questions were scored, and a total 'social network' score calculated for each participant. Once again, the least positive option scored the lowest and the most positive option scored the highest. The maximum possible score was 15 and the minimum was 3.

95% confidence intervals of the average change in 'wellbeing' and 'social network' scores from baseline to post stage were calculated. Paired (related samples) t-tests were also used to assess whether there was a statistically significant difference in average scale scores from baseline to post stage. A confidence interval provides an indication of the range within which the true effect is likely to be. The width of a confidence interval is affected by the size of the sample, with smaller samples tending to have larger confidence intervals than bigger ones. A confidence interval of a mean difference that does not pass through 0 is indicative of a statistically significant change.

For all inferential tests a p value of 0.05 or less was taken to be statistically significant. In some cases, percentages may not add up to exactly 100% due to rounding.

3. Findings

3.1 Demographic data from questionnaire respondents

In total, 173 participants provided demographic information. The sex, age, and ethnicity of individuals are detailed below.

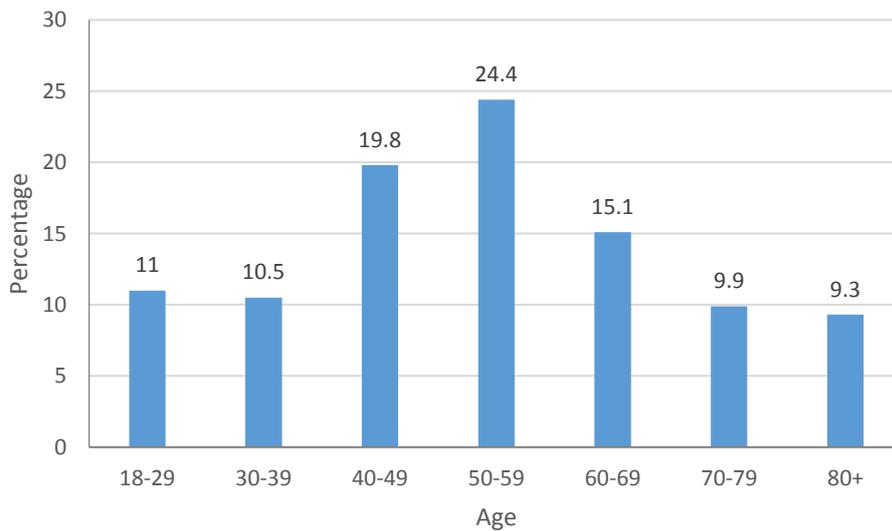
Sex ($n=170$)

Overall, 62% of participants were female and 38% male.

Age ($n=172$)

In total, 172 participants provided a date of birth which was used to calculate each person's age at analysis. The mean age of participants was 53.5 years ($SD=17.4$ years), with the oldest individual being 93 years old and the youngest 18 years. Figure 1 shows that the largest proportion of individuals (24%) were aged between 50-59 years old. Fifty nine percent of participants were between 40-70 years old and approximately 41% were under 50 years old.

Figure 1: Age of participants ($n=172$)



Ethnicity ($n=172$)

Table 1 shows that approximately 87% of participants were White British, and a further 5% White Irish ($n=9$). Only 14 individuals were of a non White ethnicity.

Table 1: Ethnicity of participants

	Frequency	Percent
White British	149	86.6
White Irish	9	5.2
Mixed White & Black Caribbean	2	1.2
Mixed White & Black African	2	1.2
Asian or Black Asian	2	1.2
Mixed White & Asian	1	0.6
Black African	2	1.2
Black Caribbean	1	0.6
Black other	1	0.6

Other	3	1.7
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3.2 Wellbeing

In total, 158 participants provided complete wellbeing data at baseline and post stage.

The average wellbeing score at baseline was 18.47 (SD=6.0). The highest score was 33 and the lowest was 7. At the post stage the average score was 22.55 (SD=5.78) with the highest score being 35 and the lowest 7.

The average change in score was 4.08 (SD=5.34) with a 95% confidence interval of 3.24 to 4.92, which is indicative of significant change. This is supported by the results of a paired t-test, which suggested there was a statistically significant improvement in well-being from baseline to post stage ($t=9.60$, $df=157$, $p<0.001$). The size of the improvement was large ($d=0.8$).

Out of the 158 participants:

- 124 (79%) had an improved wellbeing score from baseline to post stage
- 27 (17%) had a decrease in score
- 7 (4%) had no overall change.

Analysis of change in wellbeing score by sex

As can be seen from Table 2, average wellbeing score improved significantly from baseline to post stage for both males and females. There was no significant difference between males & females in terms of improvement in wellbeing ($t=0.29$, $df=154$, $p=0.78$).

Table 2: Wellbeing score by sex

	Mean Baseline (SD)	Mean Post (SD)	Mean Change (SD)	95% CI	T (df)	Sig
Males (n=62)	18.92 (5.59)	23.16 (5.71)	4.24 (5.99)	2.72 to 5.76	5.58 (61)	$p<0.001$
Females (n=94)	18.15 (6.30)	22.14 (5.88)	3.99 (4.95)	2.98 to 5.0	7.81 (93)	$p<0.001$

Analysis of change in wellbeing score by age

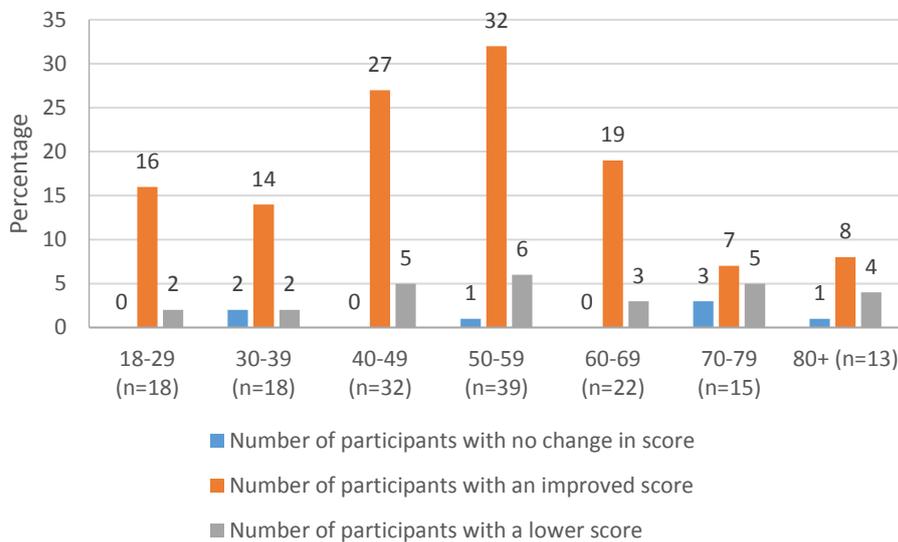
Analysis revealed there to be a significant negative relationship ($r=-.272$, $p=0.001$) between age and change in wellbeing from baseline to the post stage. This indicates that younger individuals tended to have greater improvement in wellbeing than older people. To explore further the relationship between age and wellbeing, individuals were assigned into 2 groups i) under 50 years, ii) 50 years and older. An analysis of change in wellbeing scores over time was then conducted. Table 3 shows average wellbeing score improved significantly from baseline to post stage for both age groups. Additional analysis revealed that average improvement was greater in the under 50 years old group than the 50 years & over group (4.94 vs 3.39), but the difference was not statistically significant ($t=1.81$, $df=155$, $p=0.07$).

Table 3: Wellbeing score by age group

	Mean Baseline (SD)	Mean Post (SD)	Mean Change (SD)	95% CI	T (df)	Sig
Under 50 (n=68)	17.69 (5.57)	22.63 (6.0)	4.94 (5.08)	3.71-6.17	8.02 (67)	p<0.001
50 & over (n=89)	19.03 (6.32)	22.43 (5.65)	3.39 (5.49)	2.24-4.55	5.83 (88)	p<0.001

Figure 2 provides a breakdown of the number of participants whose wellbeing score increased, decreased or remained the same from baseline to post stage by 10 year age grouping.

Figure 2: Number of participants with increases, decreases or no change in wellbeing score at post stage



In agreement with the quantitative data an improvement in wellbeing was reflected in the qualitative interviews with individuals describing feelings of optimism and a more positive outlook as a result of being referred to Connect for Health. For one individual, resolving immediate issues, such as securing a permanent home, not only resulted in increased aspirations for the future, but also more palpable outcomes such as securing employment:

“You know obviously [the support workers] could see I had goals and I couldn’t get to them because of the situation I was in. Now I’m getting closer to them because the situations I had are no longer there anymore. I’m not homeless. I couldn’t sleep ...I really was on egg shells because I was still in that jail environment, you know prison mentality. If they [Connect for Health] hadn’t of stepped in when they did I probably would have been back in jail. The progress that I’ve made since I kind of first met her [support worker] she’s been all like encouraged my experiences and things. Like my life has got flipping a hundred times better just with them sessions. My whole outlook has changed because I’ve got a job since then.” (Male client)

Similarly other individuals reflected on how Connect for Health had impacted their wellbeing as a result of being able to access relevant and helpful services. For one male, accessing activities such as swimming and a woodwork workshop provided him with a greater sense of

independence and made him feel useful, something that he felt had been absent since becoming a wheelchair user:

“I’d been feeling very depressed, I’ve been in the building trade for fifty years very active, doing all my own repairs at home I was a joiner. And then I’m suddenly stuck in a wheelchair. And it was more frustration. In my mind I could still do the job but physically I couldn’t. And everything was load onto my wife. You know she was having to do things that I used to do I had to sit and watch her ...and it just got me down. Still does at times... they [Connect for Health] just gave me suggestions on things to do like one thing I’ve always enjoyed is swimming. And I haven’t done it for years. And it was you know accessing things like that. There is a workshop where people go to do wood work. Because they were disabled and that and it’s all sorts of little things, gardening. I feel a bit better in myself knowing that there are things out there that I can do. And I’m not just stuck at home and can only go into town when the wife can has got time to do it you know.” (Male client)

Having the opportunity to attend support groups allowed individuals to gain more of a balanced perspective by being able to share experiences with others going through similar difficulties. This resulted in some individuals feeling much more hopeful about their own lives:

“Since I went to that group I could see what other people are actually having difficulty in life with, and you do not assess yourself the same. It actually made me realise that life is not all about yourself. You find here that everybody has got different problems. You find that yours is not even as serious as the other person that you are talking to.” (Female client)

Being given the time and support from the Wellbeing Coordinators to discuss their issues and concerns led to individuals feeling comforted and reassured:

“After meeting (worker) you come home and you feel a bit relieved.” (Female client)

“I think that’s what it is all about, getting it off your chest the problems that you have within that hour. And if you’ve gone away from that hour and things have been solved at that meeting its good.” (Male client)

3.3 Health

Participants were asked to what extent they had problems today with the following:

- Mobility (walking about)
- Self care (washing or drying)
- Usual activities (work, study, housework, family, leisure activities)

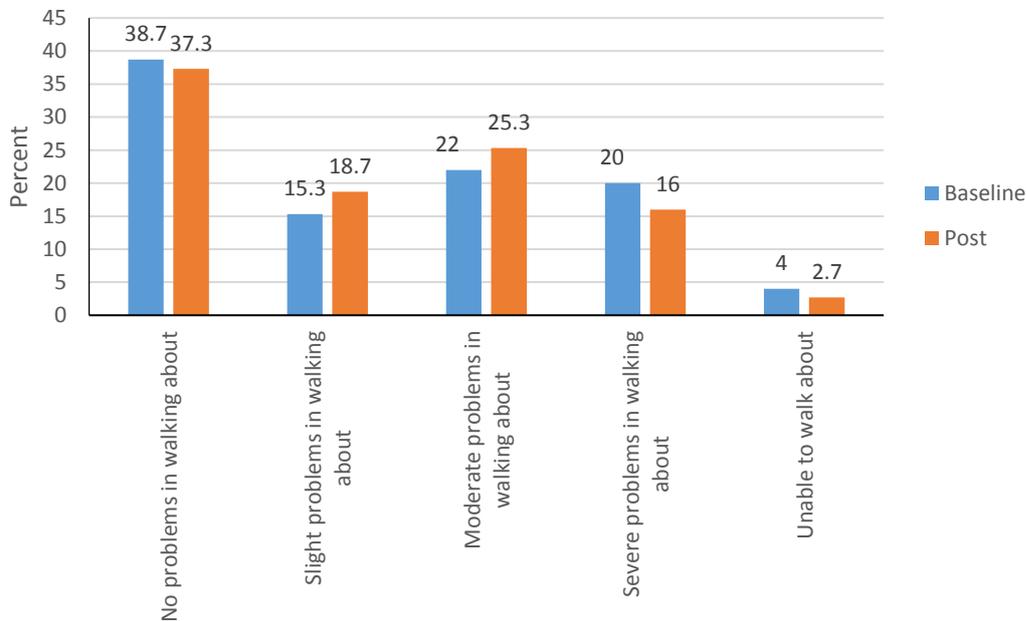
In addition, participants also indicated their current level of pain/discomfort, and how anxious or depressed they felt today. The following results are based on those individuals who provided complete data at both baseline and post stage.

Mobility (n=150)

The extent to which participants had problems with mobility is shown in Figure 3. The largest proportion of participants at both stages of the research had no problems walking about. However, there was a slight decrease in the proportion of individuals reporting no problems from baseline (39%) to post stage (37%). The largest decline between time points was found in the proportion of participants who had severe problems walking. A fifth of participants

(20%) reported having severe problems walking at baseline compared to 16% at post stage. The proportion of individuals reporting 'slight' problems increased from 15% at baseline to 19% at the post stage.

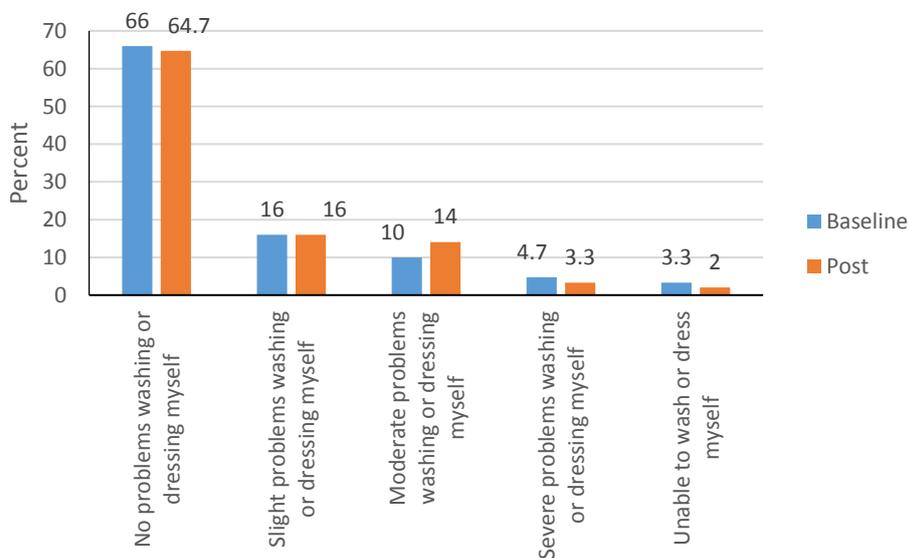
Figure 3: Problems with mobility at baseline & post stage



Self care (n=150)

As Figure 4 shows, there was relatively little change over time in the extent to which participants had problems with self care. The proportion of individuals experiencing moderate problems with self care increased between the 2 time points. Approximately, 10% of participants had moderate problems with washing or dressing at baseline compared to 14% at post stage. There were slight decreases over time in the proportion of participants who had 'severe' problems with self care, and those unable to wash/dress themselves. At both stages approximately, two thirds of individuals had no problems with washing/dressing.

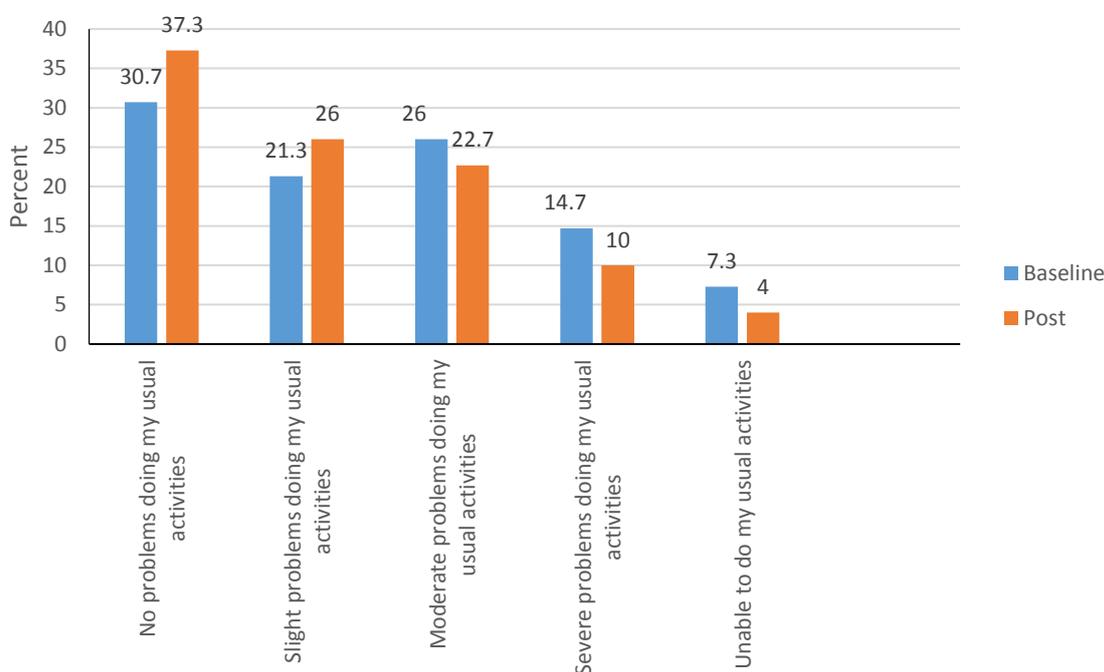
Figure 4: Problems with self care at baseline & post stage



Usual activities (n=150)

As can be seen from Figure 5, the proportion of individuals who had 'severe' problems performing usual activities decreased from 15% at baseline to 10% at post stage. There was also a decrease over time in the proportion of participants who had 'moderate problems' and those unable to perform usual activities at all. The proportion of individuals reporting 'no problems' increased from 31% at baseline to 37% at post stage. A larger proportion of participants also reported having 'slight problems' at post stage (26%) than at baseline (21%).

Figure 5: Problems with usual activities at baseline & post stage



Consistent with the quantitative data around usual activities, many of the individuals interviewed felt that they were better able to carry out their usual activities (e.g. housework, family or leisure time) as a result of receiving support from Connect for Health. Although this was not always in relation to physical barriers but often in relation to practical barriers. Being directed to services that they had previously been unaware of was in itself an immense source of support:

“Well what it was I asked my own GP about a wheelchair for my husband. And then they rang me a few days later and asked if they could come and see me. And when they came they were very knowledgeable, very helpful the advice they gave me things that I didn’t even know existed.” (Female client)

“There’s a lot of advice out there that I didn’t even know existed. You know like the police you can contact the police you know because he’s got dementia and they can record that he’s a dementia person there’s all things I’d never even heard of.” (Female client)

Being unable to carry out usual activities can undoubtedly impact on quality of life, and as such this was a pertinent theme throughout the interviews. For example, agoraphobic tendencies, anxiety, lack of social networks or practical care issues had previously prevented some clients from performing everyday tasks such as shopping or partaking in social activities:

"I mean I've even you know a few months ago started going shopping by myself again because I used to have a lot of panic attacks. And I've been fine whilst I've started driving again because I stopped driving for about six months as well I just totally lost confidence. Before I started Connect for Health I couldn't even...I wouldn't have been able to get in the car and go anywhere. Because that fear was so massive." (Female client)

"It was daunting for me cos I don't go out of the house, so when I do I suffer a lot of stress and anxiety. I was a bit upset at the beginning but they made me feel really...they made me feel secure and comfortable." (Female client)

"I've got free time now like I know it sounds silly but like Tuesday and Fridays I know I can go shopping Friday. Today it's my day I do a bit of housework and I can go out shopping and I can go out in comfort." (Female client)

For one lady receiving practical support within her caring role led to a better quality of life overall:

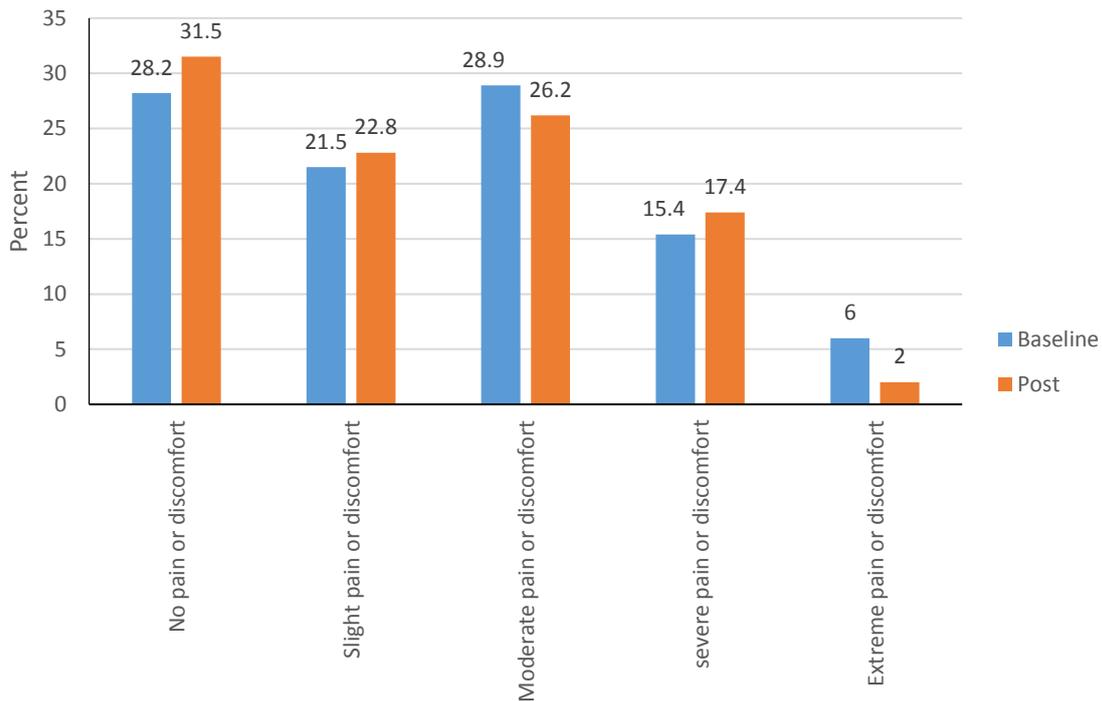
"I had chance of going away for a week and I hadn't had a holiday for three year and I rang the green up myself the day centre where he goes. And they said there were no vacancies they rang me back ten minutes later I got him in... [Worker] pushed it like to get him onto respite for me and to get him into Green day centre." (Female client)

"Yeah she organised that [disabled parking badge] for me. You know there are all these they might seem little things to people but they're big things to me. It's given us both some quality of life." (Female client)

Pain/discomfort (n=149)

Figure 6 shows the amount of pain/discomfort reported by participants. The proportion of individuals who experienced no pain or discomfort at all increased from 28% at baseline to 32% at post stage. Conversely, there was a decrease over time in the proportion of respondents reporting 'extreme' pain/discomfort. At baseline, 6% of individuals reported having 'extreme' pain/discomfort compared with 2% at the post stage.

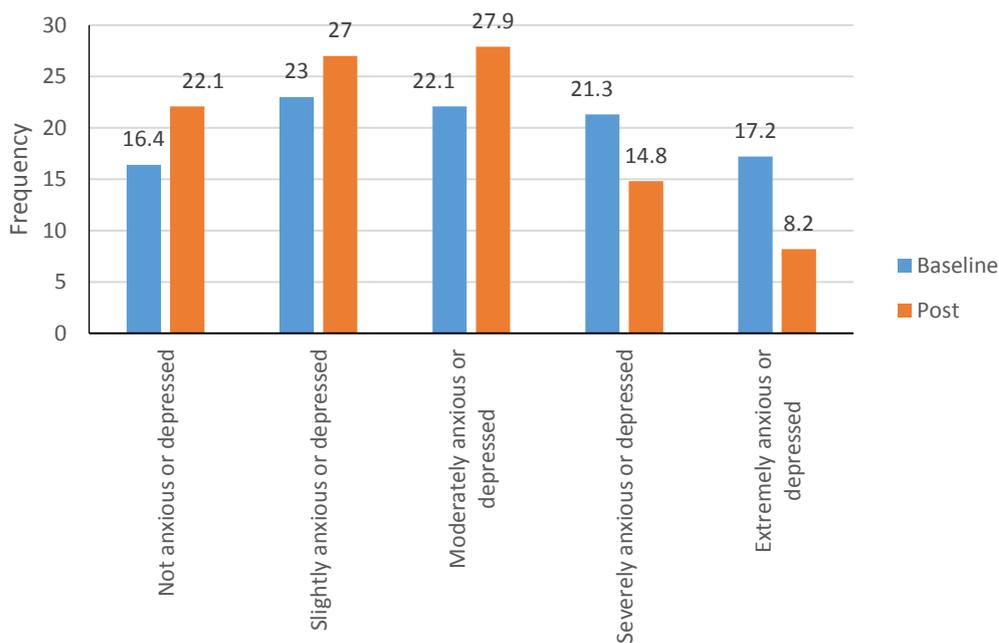
Figure 6: Level of pain/discomfort at baseline & post stage



Anxiety/depression (n=122)

Figure 7 shows sizeable decreases from baseline to post stage in the proportion of participants who reported being severely or extremely anxious/depressed. At baseline, 38% reported being either 'severely' anxious/depressed (21%) or 'extremely' anxious/depressed (17%). At post stage, 22% were 'severely' anxious/depressed (17%) or 'extremely' anxious/depressed (8%). The proportion of individuals who were not feeling anxious/depressed rose from 16% at baseline to 22% at post stage.

Figure 7: Level of anxiety/depression at baseline & post stage



Additional analyses were conducted using a Wilcoxon Paired Signed-Rank Test to assess whether there was any statistically significant change in individuals' responses from baseline to post for these 5 aspects of health. For the analysis of the responses for pain/discomfort and anxiety & depression, the categories of 'severe' ('severely') and 'extreme' ('extremely') were merged into one combined group.

Analysis revealed that between baseline & post stage there was:

- No significant change in the extent to which participants had mobility problems ($z=-1.03$, $p=0.30$) ($n=150$)
- No significant change in the extent to which participants had problems in washing & dressing ($z=-0.1$, $p=0.92$) ($n=150$)

Conversely,

- The severity of problems in doing usual activities at post stage was significantly lower than at baseline ($z=-2.93$, $p=0.003$) ($n=150$)
- Levels of pain at post stage were significantly lower than at baseline ($z=-1.62$, $p=0.11$, ($n=149$)
- Levels of anxiety at post stage were significantly lower than at baseline ($z=-3.67$, $p<0.001$) ($n=122$).

Analysis of change in the 5 aspects of health by sex

When changes between stages were analysed by sex the results showed that both males and females experienced a significant decrease in the severity of problems performing usual activities (females $z=-1.96$, $p=0.05$, $n=94$; males $z=-2.35$, $p=0.02$, $n=54$). However, significant decreases in both pain and anxiety were found for females only (pain $z=-2.02$, $p=0.04$, $n=94$; anxiety, $z=-3.53$, $p<0.001$, $n=77$). Conversely, the analysis further found that males experienced a significant decrease over time in the extent to which they had problems in washing & dressing ($z=-1.98$, $p=0.05$, $n=54$).

Health rating ($n=146$)

Participants were asked to rate their health today on a scale of 0 to 100, where 0 was the 'worst health you can image' and 100 was the 'best health you can imagine'.

The analysis revealed a statistically significant improvement in health from baseline to post stage ($t=5.711$, $df=146$, $p<0.001$) (95% CI: 6.58-13.54). The average health rating at baseline was 42.82 (SD=20.62) compared to 52.88 (SD=21.54) at the post stage. The size of the improvement in health rating was medium ($d=0.5$).

Out of the 146 participants:

86 (59%) had an improved health rating score from baseline to post stage

31 (21%) had a decrease in score

29 (20%) had no overall change.

Analysis of change in health rating by sex

As can be seen from Table 4, average health rating improved significantly from baseline to post stage for both males and females. The increase amongst males was notably higher than in females, but the analysis suggested that the difference was not statistically significant ($t=1.86$, $df=412$, $p=0.065$) (95% CI: -.42 to 13.67). However, when change in health rating by sex was examined using a different test (non-parametric), improvement amongst males was found to be significantly greater than amongst females ($U=1843$, $p=0.015$). Change in health rating scores were double checked using a non-parametric test as the change scores were found to have a degree of skewing. Change in health rating by sex was the only analysis for which non-parametric & parametric tests (t-tests) gave differing results.

Table 4: Health rating by sex

	Mean Baseline (SD)	Mean Post (SD)	Mean Change (SD)	95% CI	T (df)	Sig
Males (n=54)	44.72 (19.84)	58.37 (21.86)	13.65 (22.52)	7.50-19.79	4.46 (53)	$p<0.001$
Females (n=90)	42.08 (21.06)	49.10 (20.66)	7.02 (19.52)	2.93-11.11	3.41 (89)	$p=0.001$

Analysis of change in health rating by age

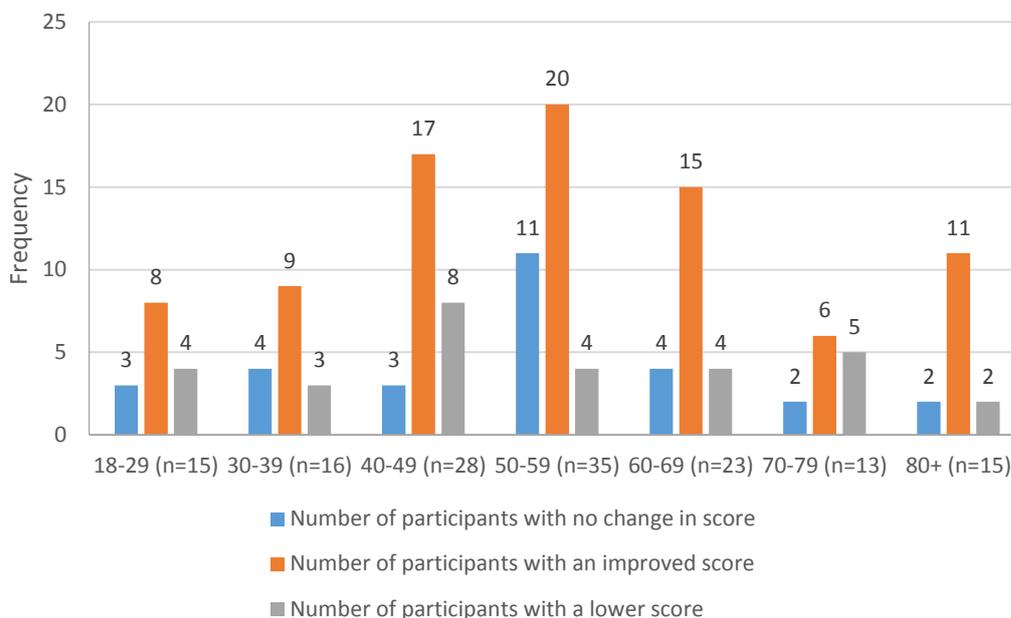
Table 5 shows that average health rating improved significantly from baseline to post stage for both age groupings (under 50 year old and 50 & over). There was found to be no significant difference in average health rating change over time between the 2 groups ($t=0.03$, $df=143$, $p=0.98$) (95% CI: -7.26 to 7.04). Further analysis also suggested that there was no significant relationship between change in health rating and age ($r=-.035$, $p=0.67$).

Table 5: Health rating by age group

	Mean Baseline (SD)	Mean Post (SD)	Mean Change (SD)	95% CI	T (df)	Sig
Under 50 (n=59)	42.15 (20.34)	52.25 (21.76)	10.10 (21.71)	4.45-15.76	3.58 (58)	$p=0.001$
50 & over (n=86)	43.20 (21.03)	53.41 (21.61)	10.21 (21.19)	5.67-14.75	4.47 (85)	$p<0.001$

Figure 8 provides a breakdown of the number of participants whose health rating increased, decreased or remained the same from baseline to post stage by 10 year age grouping.

Figure 8: Number of participants with increases, decreases or no change in health rating at post stage



3.4 Social networks (n=144)

The average 'Social networks' score at baseline was 9.26 (SD=2.65). The highest score was 15 and the lowest was 3. At the post stage, the average score was 10.33 (SD=2.44) with the highest score being 15 and the lowest 5.

The average change in score was 1.06 (SD=2.50) with a 95% confidence interval of .065 to 1.47 which indicates significant improvement in relationships & social networks. A paired t-test also revealed a statistically significant improvement in 'Social networks' from baseline to post stage ($t=5.10$, $df=143$, $p<0.001$). The size of the improvement was small/medium ($d=0.4$).

Out of the 144 participants:

75 (52%) had an improved 'Social Networks' score from baseline to post stage

29 (20%) had a decrease in score

40 (28%) had no overall change.

Analysis of change in 'Social networks' score by sex

Table 6 shows that average 'Social networks' score improved significantly from baseline to post stage for both males and females. Additional analysis revealed there to be no significant difference between males & females in terms of their improvement in 'Social Networks' score ($t=1.7$, $df=141$, $p=0.09$) (95% CI: -.12 to 1.58).

Table 6: 'Social networks' score by sex

	Mean Baseline (SD)	Mean Post (SD)	Mean Change (SD)	95% CI	T (df)	Sig
Males (n=53)	8.98 (2.85)	10.49 (2.67)	1.51 (2.71)	0.76 to 2.26	4.06 (52)	p<0.001
Females (n=90)	9.44 (2.54)	10.22 (2.32)	0.78 (2.35)	0.29 to 1.27	3.15 (89)	p=0.002

Analysis of change in 'Social networks' score by age

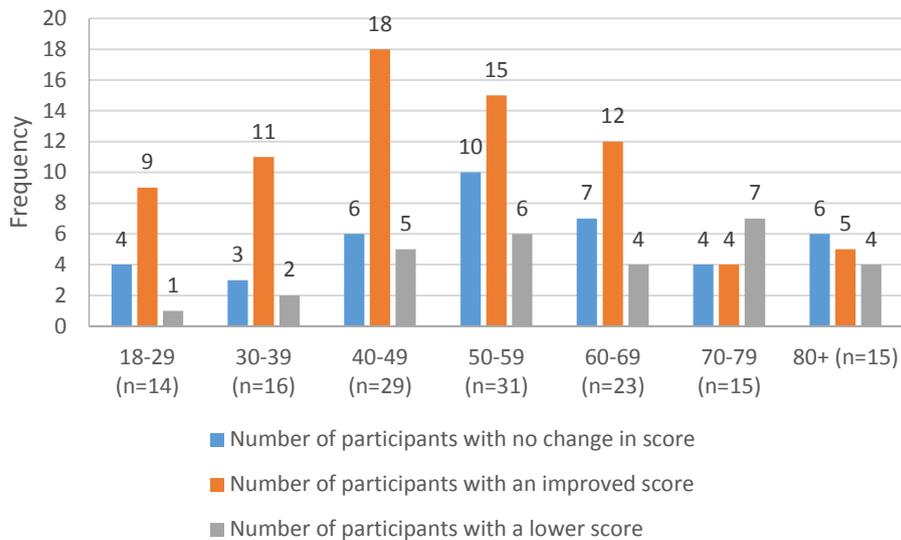
Table 7 shows average change in 'Social networks' score by age between time points. There was statistically significant improvement from baseline to post stage for both age groupings (under 50 years & 50 years and over). Average improvement in 'Social networks' score was significantly greater in the under 50 years old group than the 50 years & over group ($t=2.61$, $df=141$, $p=0.01$) (95% CI: .26 to 1.91). This finding was supported by further analysis which indicated younger individuals tended to have greater improvement in relationships and social networks than older people ($r =-.244$, $p= 0.003$).

Table 7: 'Social networks' score by age

	Mean Baseline (SD)	Mean Post (SD)	Mean Change (SD)	95% CI	T (df)	Sig
Under 50 (n=59)	8.61 (2.71)	10.31 (2.56)	1.70 (2.60)	1.02 to 2.37	5.0 (58)	P<0.001
50 & over (n=84)	9.71 (2.54)	10.32 (2.38)	0.61 (2.35)	0.10-1.12	2.37 (83)	p=0.02

Figure 9 provides a breakdown of the number of participants whose 'Social networks' score increased, decreased or remained the same from baseline to post stage by 10 year age grouping.

Figure 9: Number of participants with increases, decreases or no change in social networks score at post stage



Differences in baseline and post stage responses for the 3 individual questions concerning relationships and social networks

An additional analysis was conducted to examine separately, change in the responses to the 3 questions comprising the ‘Social networks’ score. The analysis revealed that responses were significantly more positive at post stage than at baseline for all 3 statements:

- I am content with my friendships and relationships (z=-2.94, p=0.003) (n=146)
- I have enough people I feel comfortable asking for help at any time (z=-5.17, p<0.001) (n=148)
- My relationships are as satisfying as I would want them (z=-3.0, p=0.003) (n=145)

Table 8: shows the percentage responses to each of the 3 statements related to relationships and social networks at baseline and post stage.

Table 8: percentage responses to each of the 3 relationships & social networks statements

	Baseline (%)					Post stage (%)				
	SA	A	N	D	SD	SA	A	N	D	SD
I am content with my friendships and relationships (n=146)	10.3	32.9	26	23.3	7.5	9.6	45.2	24.7	17.8	2.7
I have enough people I feel comfortable asking for help at any time (n=148)	10.1	32.4	20.9	29.1	7.4	13.5	52	18.2	14.9	1.4
My relationships are as satisfying as I would want them (n=145)	5.5	33.8	24.1	29.7	6.9	6.9	44.8	24.1	20.7	3.4

SA=Strongly agree; A=Agree; N=Neutral; D=Disagree; SD=Strongly disagree

Analysis by sex of differences in baseline and post stage responses for the 3 individual questions concerning relationships and social networks

When changes between stages were analysed by sex the results showed that amongst males the responses were significantly more positive at post stage than at baseline for all 3 statements.

- I am content with my friendships and relationships ($z=-2.72$, $p=0.007$) ($n=54$)
- I have enough people I feel comfortable asking for help at any time ($z=-3.63$, $p=0.001$) ($n=54$)
- My relationships are as satisfying as I would want them ($z=-2.87$, $p=0.004$) ($n=53$)

Amongst females, responses were significantly more positive at post stage than at baseline for:

- I have enough people I feel comfortable asking for help at any time ($z=-3.84$, $p<0.001$) ($n=93$)

However, between baseline and the post stage there was no significant change amongst females in responses to the statements:

- I am content with my friendships and relationships ($z=-1.61$, $p=0.11$) ($n=91$)
- My relationships are as satisfying as I would want them ($z=-1.17$, $p=0.241$) ($n=91$)

Analysis by age of differences in baseline and post stage responses for the 3 individual questions concerning relationships and social networks

Analysis revealed that the responses in the under 50 year olds group were significantly more positive at post stage than at baseline for all 3 statements.

- I am content with my friendships and relationships ($z=-3.09$, $p=0.002$) ($n=59$)
- I have enough people I feel comfortable asking for help at any time ($z=-3.89$, $p<0.001$) ($n=60$)
- My relationships are as satisfying as I would want them ($z=-3.16$, $p=0.002$) ($n=59$)

Amongst the 50 years old and older group, responses were significantly more positive at post stage than at baseline for:

I have enough people I feel comfortable asking for help at any time ($z=-3.47$, $p=0.001$) ($n=87$)

However, between baseline and the post stage there was no significant change in responses to the statements:

- I am content with my friendships and relationships ($z=-1.10$, $p=0.27$) ($n=86$).
- My relationships are as satisfying as I would want them ($z=-0.83$, $p=0.41$) ($n=85$).

A major theme that was reflected in the qualitative interviews was that involvement with the social prescribing service had resulted in individuals feeling less socially isolated:

"I felt isolated, because my husband works away and the kids are at school. I felt very isolated and I knew that wasn't going to do me any good, so it was a case of I wanted to get into the community and meet people and things. So it was a case of oh well we'll see what groups there are and see how we can link it to your hobbies."
(Female client)

"I used work to hide. And it's when you stop you think great I've got all this time. But after a while...you can be married but you can be lonely. Because she (wife) works funny hours, I lost that day time interaction with people, and I think that's the problem." (Male client)

Clients described how the easy-going yet informative nature of the interactions with the Wellbeing Coordinators, had led them to be more open-minded with regards to suggestions that were made helping them to alleviate their social isolation:

"It was just a case of a conversation, a constructive conversation. Look if you do this, it might help you, get you out of the house, meeting other people, and sort of like engaging with yourself again. I find most people have become isolated, and it's trying to kill that isolation." (Male client)

Clients were provided with information about numerous groups that they could get involved with in order to help break the cycle of feeling confined to their homes:

"Before I got involved I was probably just stewing at home and watching too much television, and really getting myself worked up now and again about that I should be doing more for myself, and when I went to these meetings and we spoke about it and she started giving me information about a lot of things it did work well, it did a lot for me." (Male client)

"She got me involved in a walking group. She found me another number for a dancing group. She did really well for me to be honest. She was what I was looking for at the time, to get myself out of the property and do things." (Male client)

One individual poignantly described how her involvement with the social prescribing service had somewhat alleviated her intense feelings of loneliness after the death of her husband:

"There is something and somebody there. Before there was nothing. I was just pacing up and down, didn't know where to go. I only have one sister and I don't have any other relatives that are close. I'd looked after my husband, he was terminally ill. The other people that were coming in to help me with him all stopped, it just went blank, nothing and no-one. This Connect for Health I wish I'd of had it sooner. I needed some form of being able to get out and meet people. I mean I'm not completely 'cured' yet if you know what I mean? I still have really down days. But it's a start, I'm getting moving." (Female client)

The practicalities of being a carer had meant that some individuals had previously struggled to maintain any quality of life. Receiving practical support from the social prescribing service meant that those individuals were able to enjoy some of that social interaction once again:

"I go out the house more now. You feel like a prisoner when you don't do anything. Whereas now I've got the care, and my family I like a game of bingo so my daughter will say you go to bingo and I'll sit in with dad tonight. You know, so I'm getting some kind of life back." (Female client)

Reducing feelings of social isolation and increasing social networks also had a positive effect on how some individuals were able to deal with challenging times, which is indicative of the social prescribing services ability to empower individuals to take positive action:

"If I have a bad day because my depression is getting the better of me, then I ride it out. I don't feel sorry for myself like I used to go. It's like right chalk it down to experience, get on with it." (Female client)

"I don't feel as isolated and I kind of know that the onus is on me and I need to get out and stuff. I can't expect people or things to fall in my lap." (Female client)

From this reduced isolation clients often experienced an increase in confidence levels:

"It has given me confidence, shown me stuff that's around in my community, stuff I'm still doing as well. The main one was managing mental health, and I was really weary

about that but luckily she came with me as well. And I'm helping out with that a little bit and doing some coffee mornings." (Male client)

Notably, one individual described how an increase in confidence had given him the strength to remove himself from a contemptuous relationship:

"She help me get out of an abusive relationship, gave me confidence." (Male client)

The potential impacts of reducing social isolation were also reiterated by a substance misuse worker:

"There's no medication involved and it's about helping an individual who is relatively socially isolated develop more of a social structure, which can help them feel better about him or herself, be exposed to people with shared interests. That on its own can reduce anxiety and substance misuse." (Stakeholder in the voluntary sector – substance misuse worker)

Impacts on existing family relationships were also evident from the interview data. For example, family members noted positive changes made within the family unit as a result of their involvement in the social prescribing service. One individual described how her family members were less anxious regarding her wellbeing and state of mind, ultimately having an impact on their own wellbeing:

"I have two teenage daughters. I think it was very tough for them. They didn't understand other than the fact they could see mum was really upset and struggling with things. And they did help a great deal and they are still helping me although not as much as they did [Laughs]." (Female client)

"My partner was very worried and he had to take some time off work to look after me. I wouldn't answer the phone I wouldn't answer the door if anybody came to the door and I wouldn't go out of the house. And he slowly got me back into the car and driving again it was even just going 500 yards down the road and I'd say 'I can't do any more' and he'd just get back in the car. He'd swap seats with me and drive me home sort of thing and he'd always say you know 'well done for going so far we'll go a little bit further next time'. And now he's more or less just leaves me to it." (Female client)

Improvements in communication within relationships were also noted:

"My husband says he can notice a difference when I've been out and done something rather than staying at home all day. It's given us more to talk about as well." (Female client)

The positive social aspects described by the clients can be somewhat attributed to the ongoing communication and networking of the Wellbeing Coordinators, allowing for clients to be referred to a wide range of services and support networks. For example during the staff focus group the wellbeing staff described the extent to which they ensure that they are up to date with available services. The Wellbeing Coordinators indicated that they follow several channels of communication:

- Wellbeing Coordinators are allocated to clusters which allows them to network and keep up to date with available services in the area.
- Extensive research is carried out within geographical areas so that they are aware of any changes to services.
- 'Champions' are allocated to different health related areas (e.g. mental health) so that they are able to feedback information on services in the area.

“What we are doing now is we are putting champions in areas, so people are taking leads on...older people, mental health [etc.] so we’ve got specific areas that people can learn more about and then if one of our Wellbeing Coordinator has someone they don’t know where to send, they can go to that champion and they might have a better idea of where to turn to.” (Wellbeing Coordinator)

Staff also suggested that the Wellbeing Coordinators have worked hard to build a presence in various geographical areas, building relationships with a number of different services and organisations:

“Individually and collectively they [Wellbeing Coordinators] have worked really hard to get foot hold in their areas, becoming part of forums, neighbourhood networks, health and wellbeing partnerships... and they’re not easy to get into, particularly because it’s quite a difficult structure to understand, the health and the local area officer patches. It’s quite complicated and the team have worked really hard to become involved in those things. We fully recognise that our referrals won’t come easily necessarily through GP’s so we have to diversify our referral sources so the team have done an awful lot of work, on social media, face to face and being present and getting in various newsletters and forums to make sure they are as representative as they can be.” (Wellbeing Coordinator Manager)

As a result this has created a two-way communication stream whereby services refer to each other:

“We’ve had the time to go out and research our areas, and we’ve met managers or teams who think their services will be beneficial to our clients. And we’ve arranged to go to team meetings, explain our service to them so they are aware of us so they can refer to us and we can also refer to them.” (Wellbeing Coordinator)

An example of the effectiveness of this way of working was emphasised by one individual who perceived his circumstances to have changed once the social prescribing service became involved. He suggested that Connect for Health communicated effectively with the probation and mental health services ultimately allowing things to move more expeditiously:

“Everybody’s talking to one another, everybody’s communicating.” (Male client)

However notably many of the individuals interviewed had not been aware of the Connect for Health social prescribing service prior to being referred by the GP, suggesting that raising awareness may be a key issue, in particular for other vulnerable adults who may not necessarily have regular contact with a GP:

“I think it really needs to be you know [promoted]. I mean I know there’s these surgeries and I know there’s pamphlets in the doctors. Because I’ve noticed a couple when I’ve gone to the doctors previous you know Carers Support. Well you read them and you don’t take any notice you know what I mean? You know and it really threw me as I say the wheelchair and them ringing me and coming to see me. You wouldn’t have even known it existed otherwise.” (Female client)

“I pass their names on to a lot of people. Because I live in a multi-storey block of flats and there’s a lot of elderly here. And they don’t know what help they can get you know.” (Female client)

In addition a lack of awareness around what the service can offer may impact on whether individuals engage initially:

“I’d never heard about them before and didn’t look too much into it so I just thought I was going to be another version of Foundation. So my expectations of them was probably house me in a shared accommodation.” (Male client)

3.5 Use of primary care services

Use of GP services: baseline (n=154)

At baseline, around half of participants (51%) went to the GP less than once every month and a further 32% visited every 3 or 4 weeks. Just over 1 in 10 individuals (12%) went every 2 weeks and 5% visited at least once a week.

Use of GP services: post stage (n=164)

At post stage, individuals were asked about their use of GP services since participating in Connect for Health. A majority of participants (59%) reported using GP services about the same. The proportion of participants reporting increased and decreased use of GP services was similar. Just over a fifth (22%) had used services less, with 9% visiting 'a lot less' and 13% a 'bit less'. Conversely, 20% reported increased GP use, with 5% visiting 'a lot more' and 15% a 'bit more'.

Table 9 provides a breakdown of GP service use across the 2 time periods. It shows that:

- Out of the 7 individuals who were visiting the GP at least once a week at baseline, 5 were using services about the same amount at post stage. One was using services less, and the other person more.
- Out of the 19 individuals who were visiting the GP at least once a fortnight at baseline, 11 still did so at post stage. Five had increased frequency of visits and 3 had visited less.
- Out of all 26 individuals who visited the GP either weekly or fortnightly at baseline, 4 used GP services less at post stage (3 females & 1 male used the GP less. The male and 1 female used the GP a lot less).
- 14 out of the 74 individuals (19%) who were visiting the GP less than once a month at baseline reported using GP services more at the post stage. Ten used GP services 'a bit' more and 4 'a lot' more.
- Out of 31 individuals who used GP services a 'bit less' or a 'lot less' at post stage, 16 reported visiting their GP less than once a month at baseline. A further 11 reported visiting their GP every 3 or 4 weeks at baseline.

Table 9: GP service use at baseline and post stage

		Baseline			
		GP visit at least once a week (n=7)	GP visit every 2 weeks (n=19)	GP visit every 3 or 4 weeks (n=48)	GP visit less than every month (n=74)
Post stage	GP services used a lot more (n=8)	0	1	3	4
	GP services used a bit more (n=20)	1	4	5	10
	GP services used about the same (n=89)	5	11	29	44
	GP services used a bit less (n=20)	1	1	6	12
	GP services used a lot less (n=11)	0	2	5	4

Figure 10 provides a breakdown of GP usage at post stage by sex. Analysis revealed there to be no significant sex difference in the use of GP services at the post stage ($U=3055.500$, $p=0.92$).

Figure 10: GP usage at post stage by sex

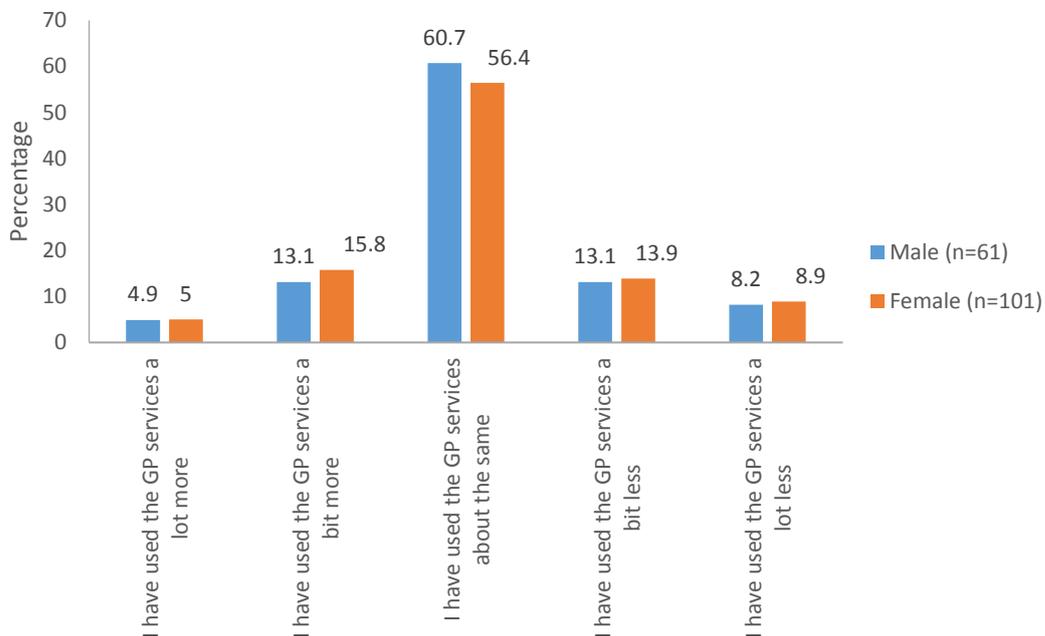
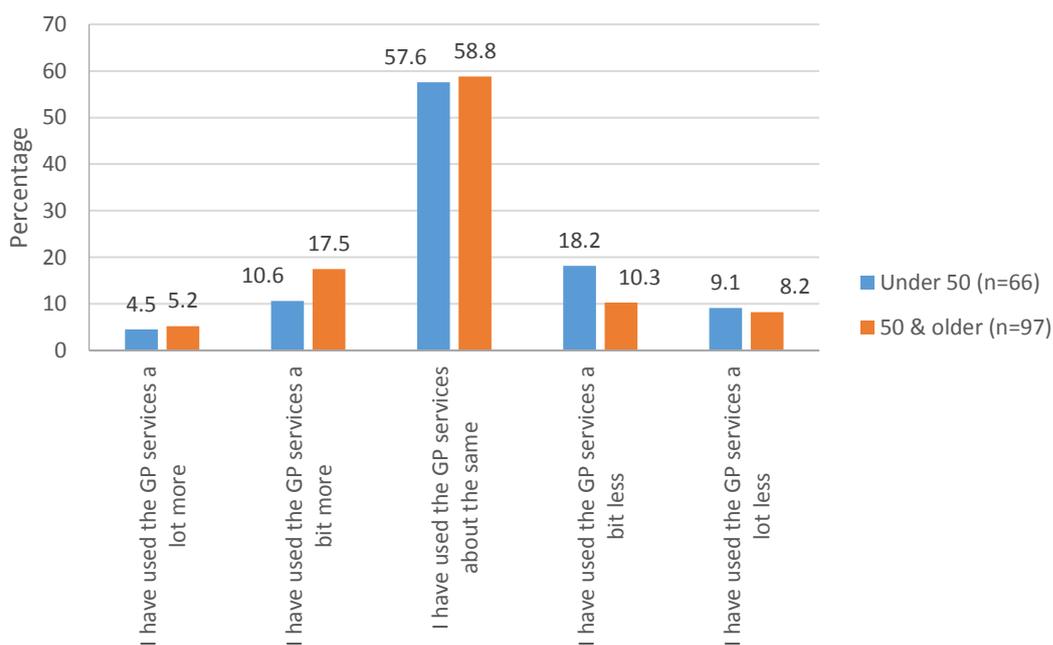


Figure 11 provides a breakdown of GP usage at post stage by age. Analysis revealed there to be no significant age difference in the use of GP services at the post stage ($U=2815.0$, $p=0.14$).

Figure 11: GP usage at post stage by age



The qualitative interviews resulted in mixed responses in relation to GP use. For example some individuals stated that their contact with the GP had reduced since their involvement with the social prescribing service due to a more positive state of mind:

“I cut down by seeing them because obviously well basically because I seemed better in myself. You know, and more happy because you know the progress that I’ve made.”
(Male client)

However, although other individuals stated that their GP use had not changed (i.e. they continued to see the GP the same amount of time), this was not necessarily a reflection of their wellbeing. In fact all of the individuals that were interviewed had experienced improvements in their wellbeing regardless of their GP use. For example, one individual whose contact had not changed stated that her continued contact with primary care services was due to an existing condition, vestibular migraines which subsequently affected her speech and overall quality of life. Consequently she had regular neurologist and hospital appointments. However when reflecting on how the social prescribing service had impacted her wellbeing the impacts had been extremely positive. In particular the non-medical nature of the support she had received only served to increase her positive state of mind further:

“It’s made me more aware of things that are out there, than I did before. The community groups, community events, things like that. And there are people out there to talk to, rather than medical people. Last year I seemed to spend a hell of a lot of time talking to the doctor, the neurologist ...asking me the same questions all the time and not getting to the bottom of it ...and it was frustrating and scary. But actually speaking to somebody afterwards that wasn’t from a medical background and said ok this is what we can offer you in support, kind of gave it a new spin. Once I’d identified my isolation, what I could do about it, cos I never knew this book at the library existed [book with information about community groups]. Finding out that there are activities out there that can help me and to meet people ...it’s baby steps. I might not feel up to going [to a group] tomorrow but I will go next week, and it gives me something to look forward to.” (Female client)

Another individual stated that his GP use had not changed, yet his wellbeing had greatly improved:

“No I still see them frequently because I’m on medication, so they keep an eye on my heart rate and stuff. ...[but] I’m a lot happier and settled now I suppose. Not as stressed and stuff like that. Because when I was homeless I was very stressed.”
(Male client)

These outcomes suggest that the social prescribing service is enhancing primary care services by providing people with additional support. During the staff focus group staff commented that the social prescribing service compliments primary care in several ways by:

- Providing people with additional support that other services may not be able to
- Helping to stop the smaller issues becoming larger issues
- Helping to put people in touch with services that they may not have been aware of if they had only visited the GP
- Being more able to interact with clients and get a better understanding of their practical needs (e.g. smoke alarm fittings, help with care issues)
- Providing a holistic service that other services do not have capacity to provide

3.6 Reflections on the service

Although the above examples reflect how the social prescribing service has been able to make substantial changes to people's lives, the service is perceived by staff as being more of an enabling service. For example reflecting on how the service empowers individuals to 'take action' the Wellbeing Coordinators described the process as being very much collaborative. That is that together the staff and clients establish the best course of action based on the individual's situation:

"We try and empower people to take action, you know to physically go down to [an activity], or to get information, to ring people up...part of the assessment process is to stress that's it's very much a collaborative process." (Wellbeing Coordinator)

"It's very much an enabling process to enable the person to address the issues that are relevant, the non-medical issues...and so to fit all that together and come up with an action plan." (Wellbeing Coordinator)

This collaborative process enables individuals to feel confident enough to take responsibility for their own wellbeing, as well as allowing them to recognise that they themselves are perfectly able to make changes in order to improve their health:

"I mean it I've only been in a wheelchair a year. And so it's taken me the best part of that year to realise the situation. I hadn't thought about it but the wife said I was getting a bit grumpy and all this lot and it didn't sink in for a long while, but I had changed. To me I felt the same. It's been very good. It's helped me a lot. Just from that one interview. ..It's settled my mind a little bit, I've got to accept the fact that I can't do it and but there are other things I can do instead." (Male client)

This cooperative way of working was echoed throughout the client interviews. For example all of the individuals spoke highly of the wellbeing staff, referring to their approachability, trustworthiness and exemplary communication skills, resulting in them feeling valued and listened to:

"And to be taken notice of. And to be looked on as a person as an individual as opposed to 'oh just somebody else'." (Female client)

"It's that being able to talk to somebody, and somebody being willing to listen, I think that's the crux of it, and not being judgmental." (Male client)

Clients felt that they were working together with the Wellbeing Coordinators for a common benefit, and that the Wellbeing Coordinators were not just going through the motions, but actually getting to know them as individuals so that the support they received was helpful and relevant:

"She took the time out to learn about me and to actually help me and look for things that I needed and not just general, not just in general if that makes sense? I just felt like I could trust her so much. And I knew that she was working for me instead of telling me what was best telling me what I should be doing. There wasn't any of that she just made suggestions and then asked me how I felt about it." (Female client)

Clients also described a consultative nature to the service. Rather than being dictated to, clients felt assured that the process was very much about working together to decide on the best course of action:

"I was free at any time to say 'no I'm not comfortable with this I don't like it' and she was very adamant that it would not affect me if she'd arranged it all and I'd have gone and then come back and said 'no I can't do this' she'd have been fine with that. It was kind of all along how I felt and she made that very clear that any time that I

didn't feel comfortable with anything that she maybe suggested or got me to have a look at, if I didn't like the idea it was no problem." (Female client)

"She was absolutely fantastic. And she's right down to earth and you know you feel comfortable with her and you can be yourself do you know what I mean? It's not as though she's trying to boss you about or anything you know. And she'll say 'you know like they've on this available where you can go for coffee mornings or they do trips.'" (Female client)

Clients valued the fact that the service was not delivered by health professionals such as dietitians, but rather someone who could perhaps look at their issues more objectively:

"She's absolutely brilliant. She's the one that really put me back with my head in the right place. She wasn't a dietitian and that. Cos worst thing you do... cos I'm over weight 'oh if you lost that weight you know'. And I think you don't know their situation. See I've found when I'm depressed I eat." (Male client)

For some, being able to be open and honest about their own feelings and needs was a new experience:

"I mean it was I think what I loved a lot about it was the free the ability to say what I thought. I felt comfortable enough to actually say 'this is what I want' whereas I'd not had that before." (Female client)

"She just made me feel really so comfortable and safe. And I just felt like I could trust her because I told her a lot about myself in the first session and even she sort of said afterwards 'wow I didn't expect you to tell me so much'. And I did and I just felt able to talk to her because she was like I say I can't speak highly enough of her. She was a lovely person to talk to."(Female client)

Notably, the service had been particularly helpful to male clients in that it allowed some to feel more able to express their emotions without having to live up to a gender stereotype:

"At first when she (worker) mentioned mental health I thought I'm not one of those, but when I look back it's a massive problem...mental health issues for men are massive. I'm not saying women don't have the same problems, but if you see a woman crying you don't think oh soft sod." (Male client)

For some, this feeling of being able to speak more openly about particular issues seemed to stem from the fact that their interactions was with a female worker. Some clients felt that they were better able to relate to women, and perceived that female workers could offer more compassion and empathy at that time:

"It's funny cos they've got all women, I don't know if that helps. All the women that I've spoken to have all been passionate about their job and I think that's a big thing as well. Cos you know sometimes when people are talking to you and you think they are talking to you but no they are bored to death. And they must hear the same story over and over again, but it's how they relate to you." (Male client)

"I just seem to have a better response talking to females to be honest. I can't put my finger on it as to why that it. It just seems to be a little calmer in coming back to me and things like that...I do get on with males as well but a female seems to be more helpful." (Male client)

"It was a young lady, she was really nice...I discussed how low I was feeling and what caused it." (Male client)

One client suggested that had it been a male worker he was consulting with, he may not have been as open to discussions:

"I would have been a bit more wary as to how open I would have been with a male." (Male client)

Feeling comfortable with the worker they were consulting with, and having open conversations helped some clients to lessen the stigma of mental health in their own mind:

"There was a few things that I could have done, like the shed thing where men meet up but there was none in my area. Then there was a couple of courses in Garforth, over mental health issues. And I suppose that terrified me in a way because when people say mental issues people think straight away that...well I do, I'm not going gah gah, I'm not dribbling in a corner. But after a while I know what they meant, try to stimulate yourself, which I've tried to do myself. I thought right I'm getting in a massive rut here, I've got to fight to get out of this rut." (Male client)

Some clients also spoke of the flexibility of the service and how this had been useful in relation to fitting meetings around their schedule:

"She told me that was only allowed to see me for six sessions or something like that, so I decided that I wanted it every fortnight, to three weeks maybe, just to make it last a bit longer. Cos she was helping. And then sometimes when I just wasn't feeling it I'd cancel it and meet up the next week." (Male client)

However a number of clients stated that it would be useful to have a greater number of one to one sessions should they need to:

"I think it probably could have been longer. I think it should be more like help until they think they are done. Cos when I first met her I was really down, but towards the end I was much better but I still could have done with one or two more." (Male client)

"The time wasn't really enough. I wish if the time was a bit extended. I requested more time. It's not enough time to sort out everything that a person would actually want to do. What I wanted we couldn't really sort out everything." (Female client)

4. Summary of findings

This evaluation report provides good evidence of outcomes and learning for the Connect for Health programme. The evaluation has sought to provide both a viewpoint of Connect for Health from the perspective of those directly involved in delivering and those receiving support from the service, alongside client questionnaire data. As an evaluation team, we feel that the evidence gathered from this interim report demonstrates the services valuable contribution to improving the health of those who need it.

The findings have highlighted many positive health and social outcomes for individuals engaged with Connect for Health, ranging from a greater engagement with activities and social groups, to individuals securing volunteering and paid employment opportunities. The findings from the questionnaires revealed a statistically significant improvement in health and well-being scores from baseline to post stage in clients. The proportion of those that reported being either 'severely' anxious/depressed or 'extremely' anxious/depressed at baseline reduced by 16% at post stage, with a 6% increase from baseline to post stage in the proportion of individuals that were not feeling anxious/depressed. Such outcomes can only be an indicator of how the service may also lead to further health outcomes longer-term.

Clients were able to access relevant activities as a result of the strong connections that Connect for Health have built up within the Leeds South and East region ensuring that clients are referred to community groups or services that best match their needs. Indeed findings from the questionnaire data showed a statistically significant improvement in relationships and social networks from baseline to post stage in both male and females, with significantly greater improvements in the under 50 years old group than the 50 years & over group. Further exploration will be needed to understand the client's experiences once they exit the social prescribing service.

The evidence presented here suggests that clients welcomed the holistic approach of the service which allowed them to address a multitude of issues over a period of time. Spending time getting to know their clients and working from a more flexible approach allowed the Wellbeing Coordinators to develop trusting relationships, which ultimately seems to be critical factor for the on-going engagement of clients. Clients appeared to appreciate the consistency of the service as well as follow ups to ensure their progress.

Importantly this evaluation has highlighted the importance of increasing awareness of the service as well as clarity about how it can support individuals. Although the Connect for Health Social Prescribing service is only in its infancy it would be useful to consider on-going strategies that will help target those individuals harder to reach. The majority of the data analysed in this evaluation came from white British individuals (86.6%) and 62% being female. Equally, many individuals had been previously unaware of the service and its function. There is a need for greater promotion of the service to ensure on-going referrals from professionals as well as clients themselves.

References

Branding, J. and House, W. (2009) social prescribing in general practice: adding meaning to medicine. British Journal of General Practice. 59 (563), 454-456.

South, J, Higgins. T. J, Woodall. J and White, S. M. (2008) Can social prescribing provide the missing link? Primary Health Care Research & Development. 9 (4), 310-318.