

# Evaluation of Doncaster Social Prescribing Service: *Understanding outcomes and impact*

December 2016



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# Contents

<b>Executive Summary</b> .....	<b>i</b>
<b>1. Introduction</b> .....	<b>1</b>
1.1. Methodology.....	1
1.2. Report structure.....	1
<b>2. An overview of the Social Prescribing Service</b> .....	<b>2</b>
2.1. What is social prescribing? .....	2
2.2. The process of delivering the Social Prescribing Service.....	3
2.3. Clinical perspectives on the Social Prescribing Service .....	5
<b>3. An overview of Social Prescribing Service Clients</b> .....	<b>8</b>
3.1. Referrals in and out of the Social Prescribing Service .....	8
3.2. Personal characteristics.....	8
3.3. Understanding referrals .....	10
3.4. Views about the Service .....	12
<b>4. Outcomes and Impact of the Social Prescribing Service</b> .....	<b>15</b>
4.1. Quality of life surveys .....	15
4.2. Use of primary, secondary and social care services .....	19
4.3. Qualitative findings .....	21
<b>5. Understanding the costs and benefits of the Social Prescribing Service</b> .....	<b>23</b>
5.1. Understanding the cost-effectiveness of the Social Prescribing Service .....	23
5.2. Wider social and economic benefits .....	25
<b>6. Conclusion</b> .....	<b>26</b>
<b>References</b> .....	<b>29</b>

# Executive Summary

This report has provided the main findings of an evaluation of the Doncaster Social Prescribing Service. It answers some important questions about the implementation, outcomes and impact of the service between August 2015 and July 2016.

## ***What is social prescribing?***

Social prescribing is a catch-all term for non-medical services and referral pathways developed as part of publicly funded health and social care services. It aims to prevent worsening health for people with long term health conditions and reduce the number and intensity of costly interventions in urgent or specialist care. Social prescribing works by enabling GPs to link patients with sources of social, therapeutic and practical support provided by voluntary and community organisations in their local area. There is significant policy support for Social Prescribing from the Department of Health and NHS England who have both promoted referral to the voluntary and community sector as a way of making general practice more sustainable.

In Doncaster the Social Prescribing Service is delivered through a partnership between South Yorkshire Housing Association (SYHA) and Doncaster CVS. The Service's Advisors receive client referrals from GPs, community nurses and pharmacists and provide them with support to access a range of voluntary, community and statutory services that meet their needs. It is funded through the Better Care Fund and is a key feature of local health and social care integration and transformation programmes.

## ***How many people in Doncaster have benefited from social prescribing?***

Between August 2015 and July 2016 more than 1,000 local people were referred to the Social Prescribing Service by their GP, community nurse or pharmacist. Following these referrals 588 people engaged with a range of voluntary, community and statutory sector services for the first time. The Service was accessed by more women than men, and a majority of clients were aged over 60. Social Prescribing also supported significant numbers of people with a disability and caring responsibilities.

## ***Why is the Social Prescribing Service needed?***

Most people were referred to Social Prescribing to help with the effects of long term physical and mental health conditions. Almost everyone who has come into contact with the Social Prescribing Service reflected positively on its addition to health and social care provision in Doncaster. It is particularly valued for the personal and flexible way it provides support with many people highlighting the importance of one-to-one contact at home as a vital first step in establishing the trust and confidence of vulnerable people. GPs emphasised how important it is to help patients with non-medical needs that affect their health whilst patients themselves generally felt better supported and more confident about managing their health, and were more aware of the range of services and support that could be accessed in the voluntary and community sector.

### ***What are the benefits of the Social Prescribing Service?***

The Social Prescribing Service appears to have had a positive impact on people's health and well-being: almost half of the people referred to the service saw an increase in their health related quality of life (HRQL), and the evaluation also identified improvements in people's, social connectedness and financial well-being in the 3-6 months following their engagement with the Service. However, the Social Prescribing Service has not had a discernible impact on secondary care as the majority of people referred are not regular attendees at Accident and Emergency and have not had many recent inpatient stays. There may be more immediate benefits of Social Prescribing for GPs though, as a majority of people reported fewer GP appointments following their engagement with the Service. In addition, if the Service can prevent people with poor mental health and well-being from requiring more intensive support in the future statutory mental health services will benefit as well.

### ***Does the Social Prescribing Service provide good value for money?***

In short, yes. In health terms the Social Prescribing Service is estimated to have led to an additional 91.7 Quality Adjusted Life Years (QALYs) in the 3-6 months following engagement. This provides a cost per QALY of £1,963; much lower than the NHS cost-effectiveness threshold of £20,000-£30,000. This QALY gain equates to health benefits worth £1,834,000 and means that for every £1 of health and social care funding spent supporting vulnerable people, the Social Prescribing Service produced more than £10 of benefits in terms of better health, at least in the short term. In addition to quantifiable health benefits the Service created a range of wider social and economic benefits in the areas of volunteering, employment, and leveraged funding.

# Introduction

The Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University has undertaken an evaluation of the Doncaster Social Prescribing Service as part of a wider programme of evaluation and capacity building being carried out through the Doncaster Academic Partnership. The Service has been delivered since 2014 in partnership between South Yorkshire Housing Association (SYHA) and Doncaster Council of Voluntary Service (CVS).

This final evaluation report provides key findings on the outcomes and impact of the Service between August 2015 and July 2016. An earlier interim report (April 2016) provided emerging findings about the process of delivering the Service and qualitative outcomes for service users.

## 1.1. Methodology

The evaluation employed a mixed quantitative-qualitative methodology:

- Semi-structured qualitative interviews were undertaken with Service staff, key stakeholders from across health and social care, and beneficiaries of the Service
- 292 service users completed a self-evaluation questionnaire upon completing the Service
- 215 service users completed a quality of life survey when they first engaged with the Service (baseline) and a follow-up survey after between three and six months.

The evaluation also utilised Service monitoring data collected by SYHA and Doncaster CVS and comparator quality of life survey data collected as part of the Doncaster Academic Partnership.

## 1.2. Report structure

The remainder of this report is divided into the following sections:

- Chapter 2 provides an overview of the Social Prescribing Service
- Chapter 3 highlights the key characteristics of clients of the Service
- Chapter 4 provides analysis of outcomes and impact for service users
- Chapter 5 discusses the costs and benefits of the Service
- Chapter 5 is the conclusion, which draws out the key findings from the evaluation.

# An overview of the Social Prescribing Service

This chapter provides an overview of Social Prescribing and the Doncaster Social Prescribing Service. It draws on a review of relevant policy and research literature and interviews with key stakeholders in the Service to discuss what Social Prescribing is and how it has been delivered in Doncaster before highlighting some of the key findings and learning from the process of delivering the Service between August 2015 and July 2016.

## 2.1. What is social prescribing?

Social prescribing is an overarching term for non-medical services and referral pathways developed as part of publicly funded health and social care services. They generally aim to prevent worsening health for people with long term health conditions and reduce the number and intensity of costly interventions in urgent or specialist care. In the UK in recent years a number of locality based social prescribing services have been developed by health and social care commissioners to provide a mechanism for General Practitioners (GPs) to link patients with sources of social, therapeutic and practical support provided by voluntary and community organisations in their locality (Dayson, 2016; Kimberlee, 2015). These social prescribing services have been developed in a policy environment which places greater emphasis on integrated preventative healthcare interventions for people from marginalised and disadvantaged groups (HM Government, 2010) alongside a pressure to reduce public sector budgets and implement market based approaches to delivery (Eikenberry, 2009; Evans et al, 2005). The Department of Health (HM Government, 2006) has advocated social prescriptions for almost ten years whilst more recently NHS England (2014) has promoted non-clinical interventions from the voluntary and community sector as a way of making general practice more sustainable.

In Doncaster the Social Prescribing Service is delivered through a partnership between South Yorkshire Housing Association (SYHA) and Doncaster CVS. The Service was initially commissioned through the Community Fund Prospectus Innovation Fund<sup>1</sup> in 2014/15 and then re-commissioned as a mainstream service in 2015/16 (from August 2015). The Service's Advisors receive client referrals from GPs, community nurses and pharmacists and provide them with support to access a range of voluntary, community and statutory services to meet any additional needs that are identified. It is funded through the Better Care Fund and is a key feature of Doncaster Metropolitan Borough Council (DMBC) and NHS Doncaster Clinical

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<sup>1</sup> The Community Fund Prospectus was evaluated through the Doncaster Academic Partnership in 2015. An report from that evaluation is available here:

<http://www4.shu.ac.uk/research/cesr/sites/shu.ac.uk/files/eval-doncaster-community-fund-prospectus.pdf>

Commissioning Group's (CCG) health and social care integration and transformation programmes.

## 2.2. The process of delivering the Social Prescribing Service

Through interviews with key stakeholders and clients of the Social Prescribing Service a number of key findings associated with the process of delivering the Service were identified.

### ***Personal nature of the Service***

In interviews with both staff and clients it was highlighted how important the personal nature of the Service was. Advisors talked about the significance of seeing people in their own home, both in terms of building rapport and trust, but also in terms of seeing how people are coping in their existing home environment. Advisors felt that clients were more likely to 'open-up' to them and discuss problems and concerns if they were in their home environment.

Clients suggested that having someone sitting with them in order to discuss referral options meant it was far more likely that they would follow-up on referrals and make the changes suggested to them. Clients also discussed the significance of having the personal contact:

*"It's personal isn't it? You don't build up a relationship, but it's like much easier to talk to somebody face to face than it is to fill a form in. And you can explain better how you're feeling, you know, that's the main thing. It's a personal contact. Plus, you know, the first time, I probably hadn't seen anybody for a week. And I know there are a lot of people a lot worse off than that. It can be a killer, it can." (Social Prescribing Client)*

The face-to-face element of the project was also highlighted, as it presents a contrast to so many other services, which are conducted online, or over the phone. All the advisors, and clients, stated that it wouldn't work as a service without the face-to-face contact. One advisor stated that providing a home-visiting element enabled the Service to access clients that other services struggled to reach.

*"The fact of having that one person that actually goes out and listens to you, and then comes back and says 'well there's this, or there's this, or there's that, you can choose, but this is what this is...'you can't kind of capture that" (Social Prescribing staff member)*

### ***Changing nature of referrals***

It was reported that the nature of referrals had changed since the pilot phase. Cases had become more complex, often with multiple issues which need a number of individual referrals. There were more clients with severe or complex mental health issues, as outlined below:

*"I think we've had more complex referrals in, I do, I think when we first started, we would have very, perhaps the simpler referrals. We'd go out and it would be somebody that's isolated and they'd go to a group, that would be one of the things, or organise a befriender, or whatever, or it would be benefits and you'd, you know, it would perhaps be just a couple of issues, but we do seem to have more with perhaps more complex mental health issues, I feel. There's more mental health, and just more complex issues in general." (Social Prescribing staff member)*



A second member of the Social Prescribing team reiterated this issue:

*"We have criteria on this contract that wasn't there before. And the two exclusions are we don't work with people who have acute episodes of psychosis, or primary issues with drug and alcohol, which is massive. So we still get referrals, even though we've talked to GPs. So, we then have to spend quite a bit of time assessing before we pick that up where that person is in the system... So, as the project's got more popular, and more demand, the criteria is being questioned in a lot of ways and we are working our way through that." (Social Prescribing staff member)*

When asked why this might be, a number of reflections were made. It was suggested that more GPs were starting to understand and trust the Social Prescribing Service, and therefore may be referring more cases of greater complexity. It was also suggested that the withdrawal/reduction of other support and welfare services had led to increased need in the community which is not being picked-up on elsewhere. A further suggestion was the increased pressure to care for people in the community, and provide services in community settings, freeing up places in care homes, residential homes or hospitals and that this had led to increased need and isolation in certain circumstances.

The complexity of the referrals had an impact on the way that the Service was monitored against the targets in the contract. Only one referral per client was 'counted' as an output for monitoring purposes, but the complexity of the cases meant that advisors often made multiple referrals for each person being referred into the Service:

*"People with complex needs will probably need more referrals and more time spent with them, and if you're going on a purely financial, target driven thing...we wouldn't do that, because that's not giving them the best possible service. You know, if I'd only done one referral for X, well I don't know which one I'd have chosen, but she'd have still been stuck in that house and not doing anything perhaps" (Social Prescribing staff member)*

### **Changing context - increasing need?**

A number of interviewees talked about how quickly things were changing, in particular referring to welfare services, welfare benefits and housing. Such changes were discussed in terms of generating greater levels of need, with fewer support services to prevent people 'slipping through the net'.

*"What we're finding, we're going out and we're finding people who I think have fallen through the net. We all talk about people who have fallen through the net, but I think there's a bigger increase now" (Social Prescribing staff member)*

It was suggested that services like Social Prescribing were essential in terms of ensuring people could be referred into a support service which could deal with multiple issues.

### **Volunteers**

The Service has a number of volunteers that support the delivery of the Service. Whilst it was considered essential that paid advisors conducted the visits, and made the referrals into other services, volunteers were able to undertake subsequent support visits, and support clients to be able to start accessing other services and groups. It was argued that this volunteering activity added significant value to the

Service, rather than reducing the workload on advisors. Staff reflected on what this element brings to the project:

*"So that is a really nice element that you can, you know, you've got somebody for the people that are struggling in confidence, they have got somebody that is there and will go and support them to attend these groups, so that after three or four times, they are quite familiar with it and able to go themselves" (Social Prescribing staff member)*

### **2.3. Clinical perspectives on the Social Prescribing Service**

During the stakeholder interview process the Evaluation Team engaged with a number of clinicians (GPs and nurses) to gather their experiences of and perspectives on the Social Prescribing Service. A summary of the findings from this process is provided in the following sections.

#### ***The potential of Social Prescribing***

When discussing the role of Social Prescribing with clinicians, some reflected on their understanding of the role of the Service in supporting patients with non-medical needs that are impacting on their health, for example:

*"I think a lot of patients end up being diagnosed with anxiety...when in actual fact what they have is a fairly normal response to a fairly, you know, grotty social situation. So address the social situation and then I think it has a knock-on effect into their physical and mental health as well." (Clinician)*

And:

*"We have an awful lot of patients on benefits. We have an awful lot of patients who have low self-esteem. And actually you tackle those you increase the likelihood of those approaching returning to a workforce, or actually entering a workforce if they've never actually worked previously" (Clinician)*

One clinician reflected on the vital role of Social Prescribing, particularly within areas of deprivation:

*"The benefits of SP are so vast, living in an area of deprivation, I think realistically at least 50-60 per cent of our patient population could probably benefit from some form of Social Prescribing." (Clinician)*

#### ***Education and information: promoting the Social Prescribing Service to health professionals***

When exploring rates of referral, some interviewees suggested that some practices and individual clinicians didn't make full use of the Service due to lack of understanding about what Social Prescribing is and what it can offer patients. One GP suggested that more information and promotion was needed. It was also suggested that if Social Prescribing does continue, it would be beneficial to include information about the Service in monthly training sessions which are available to GPs.

One interviewee had spent some time learning more about the Social Prescribing Service, and on this basis felt that the Service will only grow in importance and "be a more integral part of primary case provision." (Clinician)

If the profile of the Service could be raised, Clinicians felt that referral rates would increase, and in turn, demand for primary care services would eventually fall.

### ***The point at which Clinicians refer into Social Prescribing***

When considering the point at which the Social Prescribing Service could be used most effectively by GPs, one interviewee suggested that she had initially thought that the Service would be a last resort, but her experience of the Service had altered this view:

*"I think it should be an avenue of first resort, because there is so much they can work on." (Clinician)*

### ***The role of the Social Prescribing advisors***

Clinicians who had experienced the Social Prescribing Service spoke very highly of the advisors, in terms of their knowledge, but also their skill in communicating with patients so that patients are at their ease. For example:

*"The sensitivity and the way she questioned, the way she teased-out information establishing what those needs were was just fantastic." (Clinician)*

And:

*"The worker is absolutely key...it is so important to have that skilled, if you like, gatekeeper" (Clinician)*

Clinicians also praised the information they receive back from Social Prescribing advisors:

*"The quality of the feedback from the SP Service is very thorough and invaluable. Because of the skills of the worker, the patient feels at ease, and often there are quite significant revelations and disclosures in the course of their interaction." (Clinician)*

### ***The home visit***

One clinician pointed to the vital role that the home visit played in the Social Prescribing Service, and how this contrasted to what a GP appointment could achieve:

*"Home visit-based service, rather than sitting in a room in a GP surgery, and I think that has massive value, because you see what the environmental issues are, you see the housing conditions, the social area that they're in. And also I think they feel comfortable to discuss, you know, what's brought them to that point. So the quality of the feedback is absolutely fantastic. I think being listened to, and the time that is allowed for that interaction. We have 10 minutes, 15 minutes at a push."*

The personal nature of the Service, and the way in which it enabled staff to get a better understanding of a patient's personal circumstances, was considered a major strength of the Social Prescribing model.

### ***Capturing the value of the Service***

One clinician made an important point about how to capture and measure the value of the Social Prescribing Service, and cautioned that it was vital that all stakeholders

take seriously the qualitative evidence emerging about the impact on individual patients:

*"I know it's very difficult to get objective, quantitative data, I don't think it necessarily lends itself, you know, looking at all the benefits of Social Prescribing in all the forms it takes, I think it's very much a qualitative impact, and what my worry is, is that when it comes to commissioning, a lot of those qualitative affects don't get taken into account." (Clinician)*

# An overview of Social Prescribing Service Clients

Overall, 1,058 people were referred to the Social Prescribing Service between August 2015 and July 2016. This chapter draws on routinely collected monitoring data and self-evaluation questionnaires to provide an overview of these clients and their experiences of using the Service. It provides an overview of referrals *in to* and *out of* the Service and highlights: the personal characteristics of clients such as their gender, employment and disability; their support needs and reason for referral; and their views about how they have benefitted from the Social Prescribing Service.

## 3.1. Referrals in and out of the Social Prescribing Service

Of the 1,058 people referred to the Service between August 2015 and July 2016 there were onward referrals of 695 clients to 1,795 services provided by a range of voluntary, community and statutory organisations. Of these referrals 588 clients engaged with 1,144 services. This means that around 56 per cent of referrals *in to* the Service resulted in positive engagement with other services, and 64 per cent of referrals *out of* the Service resulted in positive onward engagement.

The types of services and organisations referred to ranged from large local voluntary organisations such as Alzheimer's Society, Age UK and SYCIL; to small community organisations and groups such as PFG and local community centres; and statutory services provided by DMCB, the CCG and RDASH.

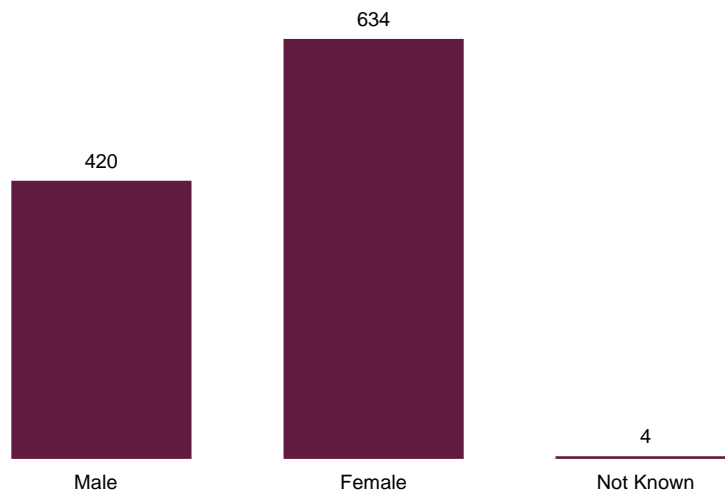
## 3.2. Personal characteristics

Figures 3.1-3.4 highlight some of the key personal characteristics of clients of the Social Prescribing Service. From these charts a number of features stand out.

### **Gender**

A significant majority of clients - 60 per cent - were women.

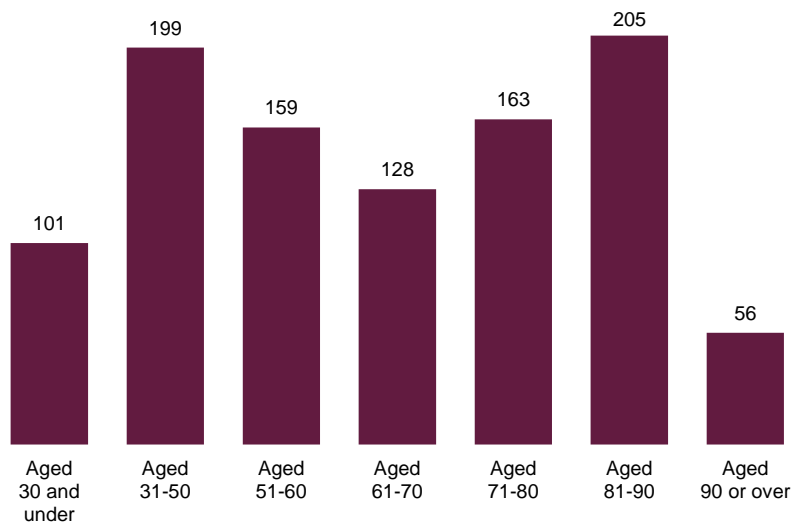
**Figure 3.1: Gender of Social Prescribing Service clients**



**Age**

The Service benefitted a large proportion of older people: more than half of clients were aged over 60, with around a quarter aged over 80. This reinforced by data on the employment status of clients (not presented) which shows that close to half of clients were retired.

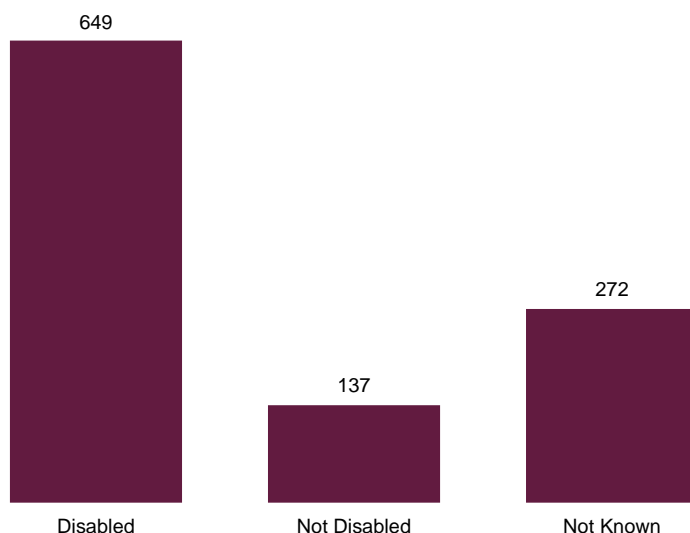
**Figure 3.2: Age profile of Social Prescribing Service clients**



**Disability status**

A significant majority of clients - almost two-thirds - identified as themselves as disabled. In addition, data on the employment status of clients (not presented) shows that around a fifth of clients were economically inactive due to long term illness or disability.

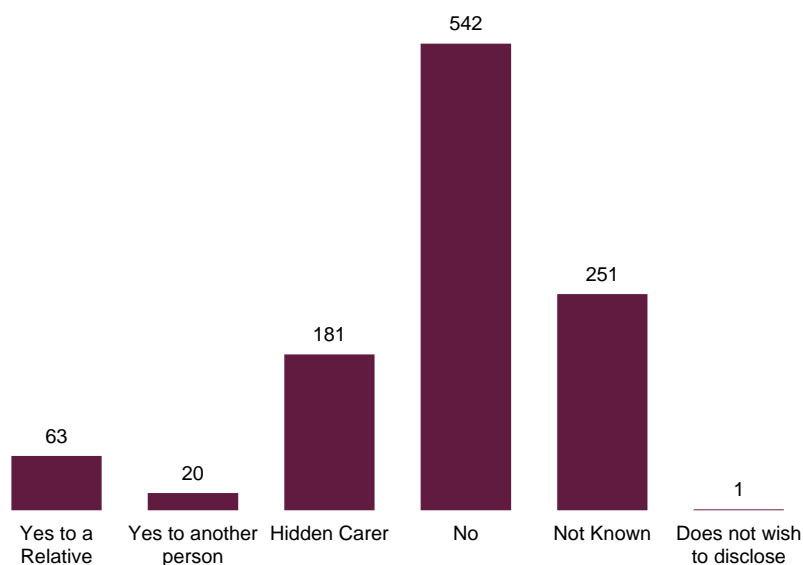
**Figure 3.3: Disability status of Social Prescribing Service clients**



### ***Carer status***

Just over a quarter of Social Prescribing clients were carers. This included a significant proportion who were classified as 'hidden carers'.

**Figure 3.4: Carer status of Social Prescribing clients**



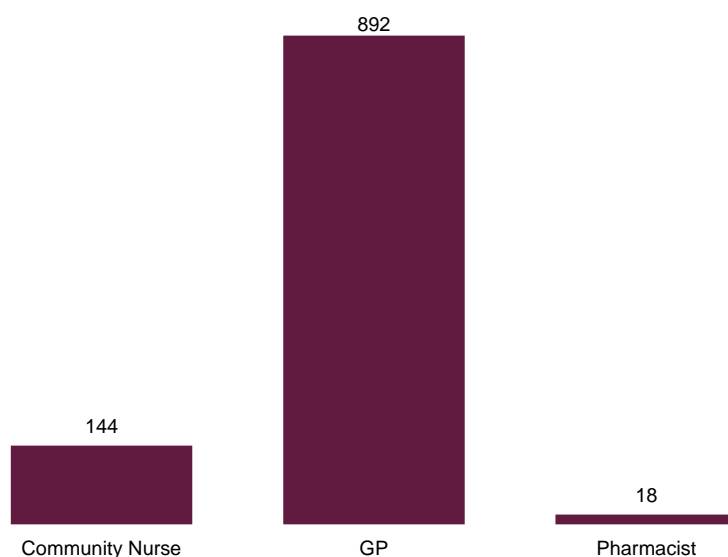
### **3.3. Understanding referrals**

Figures 3.5-3.8 highlight a range of data on the types of referrals received by the Social Prescribing Service. They cover sources of referrals, reasons for referral, support needs and support requirements.

#### ***Sources of referrals***

The vast majority of referrals - almost 90 per cent - came from GPs with smaller numbers of referrals coming from Community Nurses. At the outset it was hoped that pharmacists would provide an additional source of referrals but these did not come through as frequently as hoped, despite efforts by the Service to improve throughput.

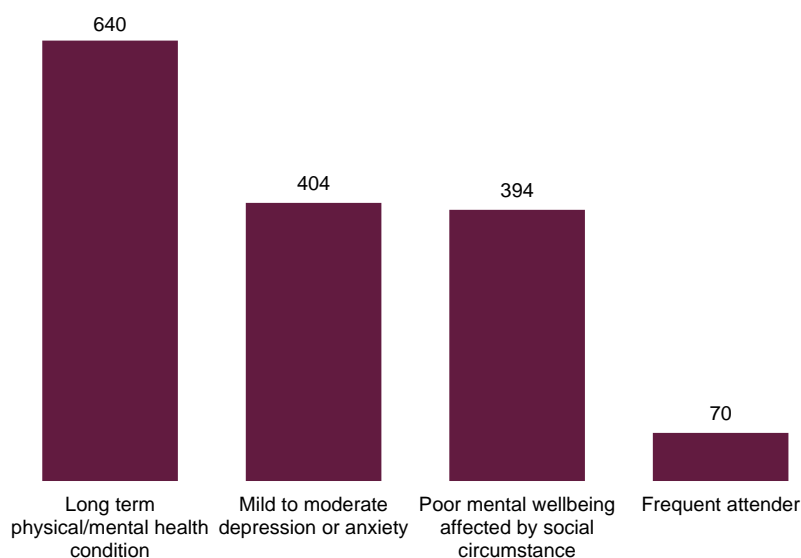
**Figure 3.5: Sources of referral to the Social Prescribing Service**



***Reasons for referrals***

Referrals were made to the Social Prescribing Service for a range of reasons, but the most common was to address the effects of a long term health or mental health condition, which provided a primary reason for referral in 60 per cent of cases. In addition, around 40 per cent of clients were referred for issues associated with mild to moderate depression or anxiety, with a similar proportion referred to address the consequences of address poor mental well-being.

**Figure 3.6: Primary reasons for referral to the Social Prescribing Service**

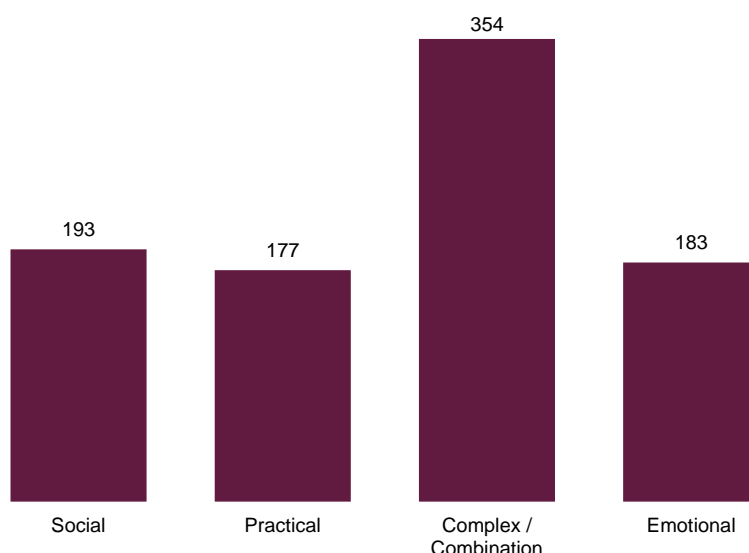


***Support needs and requirements***

Social Prescribing clients presented with a range of support needs, the most common of which were best classified as 'complex' and or multiple, which affected just over a third of clients. Relatively even numbers of clients - between 17-19 per cent - presented with social, practical or emotional support needs.

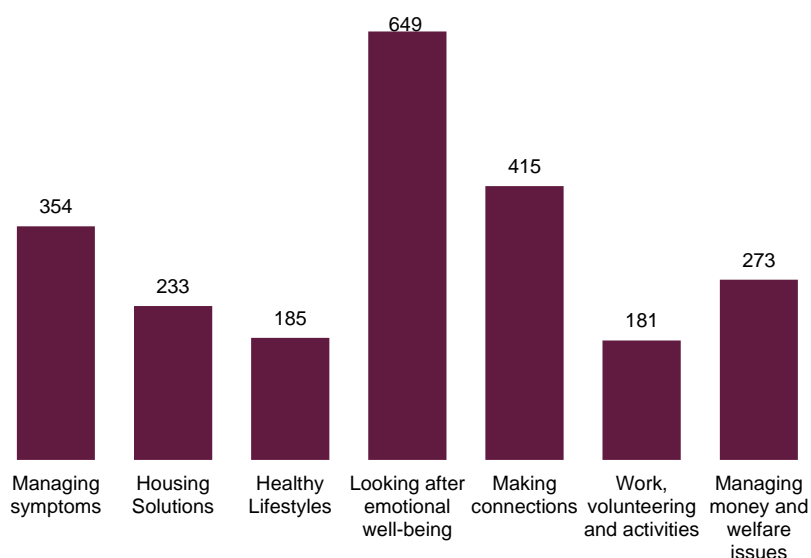


**Figure 3.7: Support needs of Social Prescribing clients**



Social prescribing clients were also asked to identify their own support needs in discussion with their GP based on eight categories associated with their ability to self-manage their own health and well-being. The most commonly identified category was 'looking after emotional well-being' (62 per cent) followed by making connections (39 per cent) and 'managing symptoms' (34 per cent).

**Figure 3.8: Support requirements of Social Prescribing Clients**



### 3.4. Views about the Service

Social Prescribing clients were asked three questions about how they felt engaging with the Service had benefitted their lives: were they more confident about managing their health condition; did they feel better supported to manage their health; and were they more aware of the services and support available in their community? An overview of responses to these questions is provided in figures 3.9-3.11.

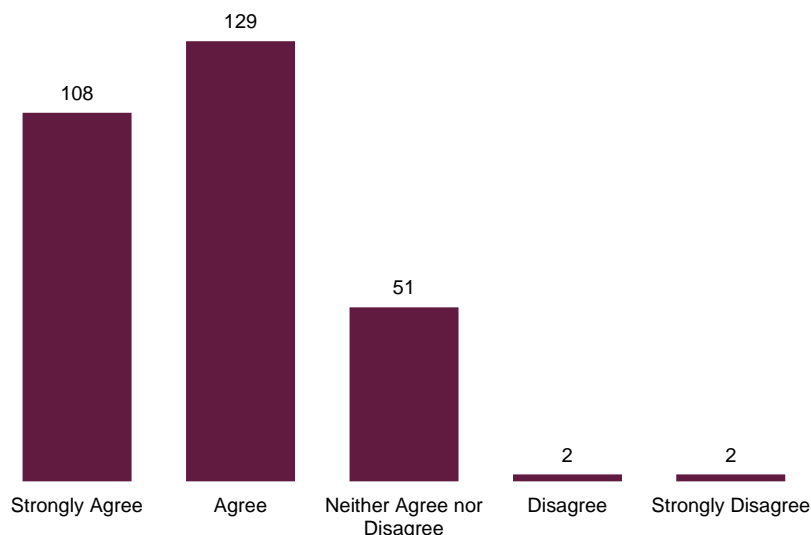
#### *Support to manage their health*

Social Prescribing clients were largely positive about the impact of the Service on the management of their health. More than 80 per cent felt that engaging with Social

Prescribing had made them more confident to manage their health condition and the same proportion said they felt better supported to manage their health condition following their engagement with Social Prescribing.

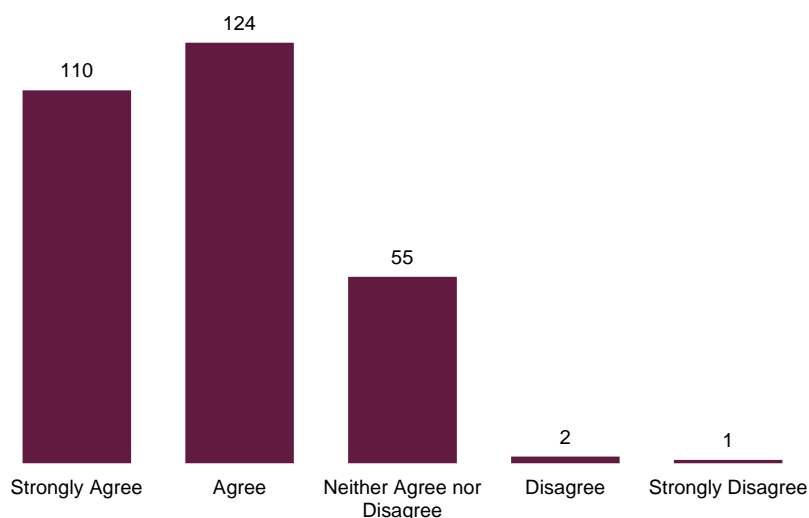
**Figure 3.9: Social Prescribing client's views about the effect of the Service on their confidence to manage their health condition**

*To what extent to you agree or disagree that you are more confident that you can manage you own health condition since engaging with the Social Prescribing Service?*



**Figure 3.10: Social Prescribing client's views about whether they felt better supported to manage their health**

*To what extent to you agree or disagree that you are better supported to manage your health condition since engaging with the Social Prescribing Service?*

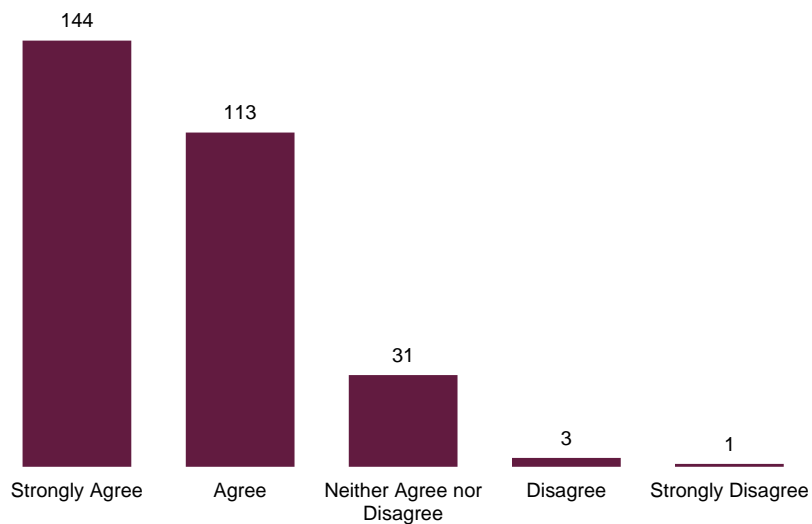


***Awareness of services and support in their community***

A large majority of Social Prescribing clients - 88 per cent - reported that they were more aware of the services and support available in their community following their referral to the Service.

**Figure 3.11: Social Prescribing client's awareness of services and support in their community**

*To what extent to you agree or disagree that you are more aware of services and support in your community since engaging with the Social Prescribing Service?*



# 4

## Outcomes and Impact of the Social Prescribing Service

This chapter discusses the outcomes and impact of the Social Prescribing Service from the perspective of its clients: patients who were referred to and engaged with the Service between August 2015 and July 2016. It draws on analysis of data from baseline and follow-up 'quality of life' surveys with 215 clients, and a series of qualitative client interviews, to understand the effect of engaging with Social Prescribing on outcomes such as health, social connectedness and financial well-being. It also utilises self-reported data on clients' use of various primary and secondary health services to understand any changes in their demand for and utilisation of health services<sup>2</sup>.

### 4.1. Quality of life surveys

Quantitative outcome data was collected using the 'Doncaster Outcome Tool' (DOT) that was developed as part of the Doncaster Academic Partnership. Overall, 254 Social Prescribing clients completed a baseline questionnaire following their initial engagement with the Service and at least one follow-up questionnaire during the period following that engagement. Analysis in this report focusses on changes between the baseline questionnaires and follow-up questionnaires completed between 3 and 6 months following first engagement with the Service (n=215).

The DOT questionnaire was also used to evaluate outcomes for service users across the Better Care Fund programme. An overarching finding from this evaluation was that there was very little detectable change in outcomes for Better Care Fund beneficiaries. Although this Better Care Fund data cannot be classed as a control group or matched comparator - referral was not randomised and the two groups are not exactly same - it still provides a useful reference point for the Social Prescribing Service as it enables the outcomes of clients engaging with the Service to be compared with those engaging in other health and social care services. As such, the data for 323 health and social care service users who completed a baseline survey and a follow-up survey after three months is reported through this section for comparative purposes.

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<sup>2</sup> It is important to note that patient self-reporting of health service use can be unreliable, but more accurate data on their actual use of services was not available for evaluation.

The DOT questionnaire includes questions about three types of outcome relevant to Social Prescribing:

- **Health:** the EQ-5D (3L) scale is used to provide a measure of 'health related quality of life' (HRQL). EQ-5D measures five components of health - mobility, self-care, usual activities, pain/discomfort and anxiety/depression - to provide an overall rating for an individual's HRQL.
- **Social connectedness:** a 'social isolation and loneliness' scale - from 'having as much social contact as I want' to 'having little social contact with people and feel socially isolated' - is used to provide a measure the amount and quality of social contact. The measure is based on the Adult Social Care and Public Health Outcome Framework (ASCOF/PHOF) indicator of social isolation and loneliness.
- **Financial well-being:** a scale that measures how well people are 'managing financially' - from 'finding it very difficult' to 'living comfortably' - is used to provide a measure of financial well-being. This measure is also used in the Office for National Statistics (ONS) Measuring National Well-being programme.

Headline analysis of each outcome measure is provided in the following sections. For each outcome measure the following data is provided:

- the proportion (per cent) of Social Prescribing and Better Care Fund respondents providing a particular response at baseline
- the proportion (per cent) of Social Prescribing and Better Care Fund respondents providing a particular response at follow-up
- the change between baseline and follow-up of Social Prescribing and Better Care Fund respondents
- the difference in change between Social Prescribing and Better Care Fund respondents

### *Health outcome measures*

Table 4.1 provides an overview of the baseline and follow-up responses for each of the EQ-5D components for Social Prescribing clients and the wider Better Care Fund sample. It shows:

- **Mobility:** there was very little difference between baseline and follow-up scores for both the Social Prescribing and wider Better Care Fund samples. Overall, the Social Prescribing sample had fewer respondents with mobility problems at baseline than the Better Care Fund sample.
- **Self-care:** there was very little difference between the baseline and follow-up scores for the Social Prescribing sample but the wider Better Care Fund sample did see an increase in the proportion of respondents with 'no problems'. Overall, the Social Prescribing sample had fewer respondents with self-care problems at baseline than the wider Better Care Fund sample.
- **Usual activities:** there was a small overall improvement between baseline and follow-up in respondent's ability to undertake their usual activities in the Social Prescribing sample. In comparison, there was very little difference in the baseline and follow-up scores for the Better Care Fund. Overall, the Better Care Fund Sample had more respondents reporting difficulties with their usual activities at baseline than the Social Prescribing sample.
- **Pain/discomfort:** there was a small overall improvement between baseline and follow-up in respondent's experience of pain or discomfort in the Social

Prescribing sample. In comparison, there was very little difference in the baseline and follow-up scores for the Better Care Fund sample. Overall, the Better Care Fund Sample had more respondents reporting high levels of pain or discomfort at baseline than the Social Prescribing sample.

- **Anxiety/depression:** there was a large overall improvement between baseline and follow-up in respondent's levels of anxiety or depression in the Social Prescribing sample. In comparison, there was very little difference in the baseline and follow-up scores for the Better Care Fund sample. Overall, the Better Care Fund Sample had fewer respondents reporting high levels of anxiety or depression at baseline than the Social Prescribing sample.

**Table 4.1: Baseline and follow-up responses each EQ-5D component (percentage of survey respondents)**

	Social Prescribing			BCF Comparator			Difference in change
	Baseline %	Follow-up %	Change	Baseline %	Follow-up %	Change	
<b>Mobility:</b>							
I have no problems in walking about	33	32	-1	15	13	-2	1
I have some problems walking about	64	66	+2	83	85	+2	0
I am confined to bed	4	2	-1	2	2	0	1
<b>Self-care:</b>							
I have no problems washing or dressing myself	57	56	0	42	46	+4	4
I have some problems washing or dressing myself	38	41	+3	53	48	-5	8
I am unable to wash or dress myself	5	3	-2	5	6	+1	3
<b>Usual activities:</b>							
I have no problems with performing my usual activities	32	36	+4	15	16	+1	3
I have some problems with performing my usual activities	56	59	+3	60	61	+1	2
I am unable to perform my usual activities	12	6	-7	25	23	-2	5
<b>Pain/discomfort:</b>							
I have no pain or discomfort	30	39	+8	15	14	-1	9
I have moderate pain or discomfort	52	53	+1	54	58	+4	3
I have extreme pain and discomfort	18	8	-9	31	28	-3	11
<b>Anxiety/depression:</b>							
I am not anxious or depressed	23	31	+8	41	43	+2	6
I am moderately anxious or depressed	47	62	+15	47	48	+1	14
I am extremely anxious or depressed	30	7	-23	12	10	-2	21

**Social connectedness and financial management outcome measures**

Table 4.2 provides an overview of the baseline and follow-up responses for the social connectedness and financial management outcome measures for Social Prescribing clients and the wider Better Care Fund sample. It shows:

- **Social connectedness:** there was a large overall improvement of 19 percentage points between baseline and follow-up in the proportion of respondents in the Social Prescribing sample reporting they had 'enough' social contact. In comparison there was a much smaller increase of three percentage points in the Better Care Fund sample. Overall, the Better Care Fund Sample had had more respondents than the Social Prescribing sample reporting they had 'enough' social contact at baseline.
- **Financial management:** there was a large overall improvement of 21 percentage points between baseline and follow-up in the proportion of respondents in the Social Prescribing sample reporting they were 'not struggling' financially. In comparison there was a smaller increase of seven percentage points in the Better Care Fund sample. Overall, the Better Care Fund Sample had had more respondents than the Social Prescribing sample reporting they were 'not struggling' at baseline.

**Table 4.2: Baseline and follow-up scores for the well-being outcome measures (percentage of survey respondents)**

	Social Prescribing			BCF Comparator			Difference in change
	Baseline %	Follow-up %	Change	Baseline %	Follow-up %	Change	
<b>Social connectedness:</b>							
Enough social contact	46	64	+19	62	65	+3	16
Not enough social contact	54	36	-19	38	35	-3	16
<b>Financial management:</b>							
Not struggling	49	70	+21	68	75	+7	14
Struggling	51	30	-21	32	25	-7	14

#### 4.2. Use of primary, secondary and social care services

Social Prescribing clients who completed the baseline and follow-up questionnaires were also asked to provide a figure for the number of primary, secondary and social care service engagements they had in the past three months. These responses can be compared to provide the client's perspective on their use of services immediately prior to and following their referral to Social Prescribing<sup>3</sup>. An overview of responses is provided in table 4.3. For **secondary care services**, it shows:

- **Accident and emergency attendance:** 19 per cent of Social Prescribing clients had attended Accident and Emergency in the three months prior to their referral to the Service. At follow-up, seven per cent of clients reported a reduction in the number of attendances, one percent reported an increase and 92 per cent reported no change.
- **Inpatient stays:** 20 per cent of Social Prescribing clients had stayed in hospital as an inpatient in the three months prior to their referral to the Service. At follow-up, nine per cent of clients reported a reduction in the number of stays, three percent reported an increase and 90 per cent reported no change.

<sup>3</sup> It is important to note that patient self-reporting of health service use can be unreliable, but more accurate data on their actual use of services was not available for evaluation.



**Table 4.3: Change in use of primary and secondary care services between baseline and follow-up**

	Clients using service in 3 months before referral		Increased since referral		No change since referral		Reduced since referral	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
<b>Secondary care:</b>								
Accident & Emergency attendance	19	9	2	1	197	92	16	7
Inpatient stay	20	9	3	1	193	90	19	9
<b>Primary care:</b>								
GP appointment	183	85	32	15	36	17	147	68
Nurse appointment	48	22	24	11	149	69	42	20
Contact with a mental health worker	10	5	2	1	203	94	10	5
Psychotherapy appointment	2	1	2	1	211	98	2	1
<b>Social care:</b>								
Contact with a social worker	7	3	0	0	208	97	7	3

For **primary care services**, it shows:

- **GP appointments:** 85 per cent of Social Prescribing clients had attended a GP appointment in the three months prior to their referral to the Service. At follow-up, 68 per cent of clients reported a reduction in the number of appointments, 15 per cent reported an increase and 17 per cent reported no change.
- **Nurse appointments:** 22 per cent of Social Prescribing clients had attended a nurse appointment in the three months prior to their referral to the Service. At follow-up, 20 per cent of clients reported a reduction in the number of appointments, 11 per cent reported an increase and 69 per cent reported no change.
- **Mental health services:** five per cent of Social Prescribing clients reported having contact with mental health services in the three months prior to their referral to the Service. At follow-up, five per cent of clients reported a reduction in the number of contacts, one per cent reported an increase and 94 per cent reported no change.
- **Psychotherapy appointments:** one per cent of Social Prescribing clients had attended a psychotherapy appointment in the three months prior to their referral to the Service. At follow-up, one per cent of clients reported a reduction in the number of appointments, one per cent reported an increase and 98 per cent reported no change.

For **social care**, it shows:

- **Social services:** three per cent of Social Prescribing clients had reported having contact with a social worker in the three months prior to their referral to the Service. At follow-up, three per cent of clients reported a reduction in the number of contacts, none per cent reported an increase and 97 per cent reported no change.

### 4.3. Qualitative findings

The interviews with key stakeholders and clients of the Social Prescribing Service revealed a number of key findings associated with outcomes for clients that support the findings from the quantitative data analysis but also provide added depth about client's experiences of engaging with the Service.

#### **Reduced social isolation**

Clients discussed the ways in which the Service had changed how well they felt that they could cope with situations, in that they didn't feel isolated or alone with their problems any more. People talked about feeling like they had someone they could turn to, and could contact them. For example:

*"Either you let yourself go, or you start to come back... I've basically up until then, I'd basically been one who did do things for myself... when I came out of hospital I wouldn't have felt like doing anything...and it was only this contact that I got, that helped me to... it's just seeing the help that you get, somebody's out there battling for us." (Social Prescribing Client)*

One client had even started volunteering for the Service, which was providing her with important social links, but also made her feel that she was giving something back.

*"One of the things that we talked about was my volunteering, that I am doing now with Social Prescribing, so that's wonderful... it's great for me, because it makes me feel a load better, and hopefully it's helpful to other people" (Social Prescribing Client)*

#### **Changing perceptions of GP appointments**

One client in particular felt that the Social Prescribing Service had made her almost forget her GP as she felt so well supported through the Social Prescribing Advisor, but also the services onto which they had been referred.

*"I don't think I went to the GP a lot, no, because quite honestly, with the lady that was coming, you nearly forget the GPs there to go to. You do, I never give it a thought, because they were coming." (Social Prescribing Client)*

A second client felt that she was attending her GP less, because she was less anxious:

*"I probably go [to the GP] less now, because I'm not sat here worrying about things as much, I'm more active, and getting out there and doing things." (Social Prescribing Client)*

#### **Helping clients cope with stress and anxiety**

Clients talked about not knowing where to turn, and having reached points of high stress and anxiety prior to their referral into the Service. However, the Service helped to put their mind at rest, making them feel like someone was 'doing something' for them, reassuring them that help was available, and even that the Service had 'saved' them.

*"I was in a really bad way, and I'm not saying that it's all down to SP, because it isn't, because I've used my own strengths as well, but I really wouldn't like to think where I would have been if I hadn't had had the help." (Social Prescribing Client)*

### ***Helping clients navigate through complex situations***

Clients talked about how significant it had been for the advisor to visit them, and help them to navigate aspects of their life. Examples including managing debt and housing issues, for example applying for home adaptations to enable them to live more independently. One client referred to the gap left by the local Citizen's Advice Bureau closing, highlighting the increased levels of need which this had left, suggesting this Service went some way to fill this gap. A number of clients talked about the fact that they wouldn't have known where to turn, and what to do about their situations:

*"We wouldn't have known where to go if it hadn't come up, whatsoever. It would have been delving into the unknown. Your GP doesn't come out to you to see whether there's anything, and nobody comes out from them to tell you, you know, to say what you can do and what help you get. I think you'd have been floundering as to what you could do, I think you'd have just been sat in a corner, wondering what to do with yourself." (Social Prescribing Client)*

### ***Helping clients to avoid crisis***

Advisors talked about how the Service helped people in all kinds of situation to avoid dipping further into points of crisis, reaching people when they were almost at a point where they could no longer cope. For example, helping to prevent debt or housing related issues from escalating helped prevent clients from having to be referred into processes of debt collection or legal action through the courts. Helping to advise clients on home adaptations helped to avoid more serious health emergencies relating to accidents.

# Understanding the costs and benefits of the Social Prescribing Service

This chapter provides an assessment of the economic and social cost-benefits of the Social Prescribing Service. The economic benefits are estimated based on a simple cost-effectiveness analysis that utilises the health related quality of life (HRQL) data discussed in chapter 4. Some of the wider social benefits are identified from qualitative data provided by the Service providers.

## 5.1. Understanding the cost-effectiveness of the Social Prescribing Service

The National Institute for Health and Care Excellence (NICE) guidelines on the methods to be used in the economic evaluation of health interventions preference cost utility analyses (CUAs). In CUA, the consequences of interventions are measured in Quality Adjusted Life Years (QALYs) which combine length of life with a utility value for health related quality of life (HRQL).

As discussed in chapter 4, The DOT questionnaire captured data on respondent's health related quality of life (HRQL) using the EQ5D tool which enables an assessment of the cost-effectiveness (CUA) of the Service from a health perspective. The following sections present analysis of the HRQL of survey respondents and use this to produce a CUA for the Social Prescribing Service.

### *An overview of the HRQL of Social Prescribing beneficiaries*

Overall, 48 per cent of Social Prescribing clients recorded an overall increase in their HRQL whilst only 11 per cent recorded an overall deterioration. By comparison, 34 per cent of the Better Care Fund sample recorded an overall increase in HRQL whilst only 11 per cent recorded an overall deterioration Table 5.1 provides an overview of the overall HRQL scores at baseline and follow-up for Social Prescribing and BCF Comparator samples. Figures are also provided for 25<sup>th</sup>, 50<sup>th</sup> and 75<sup>th</sup> percentiles of both samples. It shows that there was an overall improvement of 0.156 between baseline and follow-up in the average (mean) HRQL score for the Social Prescribing sample. This compares to only a very small improvement of 0.014 for the Better Care Fund sample. However, the Social Prescribing sample had considerably higher levels of HRQL at baseline compared to the Better Care Fund sample<sup>4</sup>.

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<sup>4</sup> It should be noted that the national average (mean) HRQL score is 0.856, meaning that both samples reported lower HRQL than the general population.

**Table 5.1: Baseline and follow-up scores for the overall HRQL score**

	HRQL						
	Social Prescribing			BCF Comparator			Difference in change
	Baseline	Follow-up	Change	Baseline	Follow-up	Change	
Sample mean	0.437	0.592	+0.156	0.368	0.382	+0.014	0.142
25 <sup>th</sup> Percentile	0.159	0.516	+0.357	0.055	0.082	+0.027	0.330
50 <sup>th</sup> Percentile	0.516	0.639	+0.123	0.516	0.516	0.000	0.123
75 <sup>th</sup> Percentile	0.725	0.812	+0.087	0.690	0.691	+0.002	0.085

### ***A cost utility analysis of the Social Prescribing Service***

The NHS values a QALY at between £20,000 and £30,000. This is the threshold for cost-effectiveness recommended by NICE. Taking the lower threshold value, this means that a £100,000 intervention can be considered cost-effective if it generates five additional QALYs. The cost utility data from the DOT survey can be used to estimate the overall cost utility of the Social Prescribing Service if it is assumed that the changes in HRQL identified through the survey can be generalised across the whole population of beneficiaries. This is summarised in table 5.2 below which indicates that the Service is estimated to have led to an additional 91.7 QALYs: a cost per QALY of £1,963.

**Table 5.2: An overview of the cost utility (cost per QALY) of the Social Prescribing Service**

Full Sample	
<b>Inputs</b>	
Total annual cost of Social Prescribing	£180,000
Total no of interventions*	588
Cost per intervention*	£306
<b>Outcomes</b>	
Mean HRQL change	0.156
Est total additional QALYs	91.7
Est cost per QALY	£1,963

\*'Intervention' refers to the number of people referred to the Social Prescribing Service who went on to engage with other voluntary or community sector services

If the estimated total QALY gained across the whole Programme is converted into a monetary value using the NHS threshold of £20,000, then **the value of the benefits gained amounts to £1,834,000**. This means that **for every £1 of the £180,000** funding spent supporting vulnerable people, the Social Prescribing Service produced **more than £10 of benefits** in terms of better health.

Overall the Social Prescribing Service **appears to be a very cost-effective intervention** when the cost per QALY of less than £2,000 is compared to the NICE threshold of £20,000. However, in interpreting these findings about cost-effectiveness it is important to recognise that data only provide an indication of short

term benefits. The changes in HRQL were measured after between 3 and 6 months following first engagement with the Service and as such, we do not know the extent to which these changes might have been sustained over a longer period (i.e. 12 months or longer) or how much of the change is due to a Social Prescribing 'effect'.

## **5.2. Wider social and economic benefits**

In addition to quantifiable health benefits it has been possible to identify a range of wider social and economic benefits from the Social Prescribing Service in the areas of volunteers, employment (through links with youth employment initiatives), and leveraged funding.

### ***Volunteers***

The Social Prescribing Service utilised 12 volunteers between August 2015 and July 2016 who contributed 1,370 hours to the Service. This time from volunteers has a value, which, if equated to the National Living Wage of £8.45, has been worth £11,577 to the Service. Volunteers have carried out a number of roles, including supporting service users to access groups and organisations by providing transport or helping them access public transport; and befriending, to increase people's confidence, by staying with them until they have and integrated fully into the group or activity. Another aspect of Social Prescribing volunteers' befriending role was to visit very lonely and isolated older people who cannot get out of the house, providing company. Five of the Service's volunteers were initially users of the Service who got involved in volunteering once their own needs had been addressed.

A number of volunteers have moved back into employment since being involved the project. This includes one who found work as a German teacher, another as a chef, and several others in full and part time administrative roles. Although it cannot be said for certain that these people would not have found work without volunteering for the Service, a number have reported that Social Prescribing provided them with an important stepping stone back into the world of work.

### ***Linking with youth employment initiatives***

The Social Prescribing Service has linked-up with Talent Match, a major Big Lottery Fund youth employment initiative, to provide work placements through its job creation scheme. To date three unemployed young people have worked on placement with the Service as Support Workers. This has provided an additional £21,000 funding to the project through the Talent Match Wage Fund. In addition, both young people who undertook work placements with the Service have found employment: one has been employed by the project as a Social Prescribing Advisor and one found work as a receptionist in a GP surgery.

### ***Leveraging funding from additional sources***

The Social Prescribing Service has also enabled funding to be levered in from other sources. This includes an Awards For All Grant from the Big Lottery fund for £6,200 to purchase computers, iPads and other IT equipment for the Service. In addition, SYHA has obtained funding from the Paul Hamlyn Foundation to offer a 'Moments of Joy' programme in partnership with DARTS, which will offer workshops in music and dance specifically for Social Prescribing Service Users once a week.

## Conclusion

This report has provided the main findings of an evaluation of the Doncaster Social Prescribing Service that is being delivered by South Yorkshire Housing Association (SYHA) and Doncaster CVS on behalf of Doncaster MBC and NHS Doncaster CCG as part of their Better Care Fund programme. The evaluation was undertaken as part of the Doncaster Academic Partnership and focussed on the first full year of Social Prescribing Service delivery as a mainstream commissioned service (August 2015-July 2016). The main findings are as follows.

- 1) The Service reached more than 1,000 people referred by their GP, Community Nurse or Pharmacist between August 2015 and July 2016 and enabled almost 600 local people to access support within the community**

Overall, 588 clients were supported to engage with voluntary, community and statutory services. This means that more than half of referrals *in to* the Service resulted in positive engagement with other services, and that almost two-thirds of referrals *out of* the Service resulted in positive onward engagement with support in the community. The Service was more likely to be accessed by women compared to men, and a majority of clients were aged over 60. The Service also benefitted significant numbers of people with a disability and caring responsibilities.

- 2) People were generally referred to the Service to help mitigate the effects of long term health and mental health conditions, including mild to moderate depression or anxiety and poor mental well-being**

Addressing the effects of a long term health or mental health condition provided a primary reason for referral to the Service in more than half of cases. In addition, around two-fifths cent of clients were referred for issues associated with mild to moderate depression or anxiety, with a similar proportion referred to address the consequences of poor mental well-being.

- 3) The Service is valued by all of its key stakeholders for the way it provides an additional support option for people engaging in with health and social care services**

All stakeholders in the Social Prescribing Service viewed it as a positive addition to health and social care service provision in Doncaster. It was particularly valued for the personal and flexible way it provided support to clients and a number of stakeholders highlighted the importance of the one-to-one contact with clients in their homes as vital first step in establishing people's trust and confidence. Clinicians emphasised the importance of supporting patients with non-medical needs that are impacting on their health and felt the Service model could be embedded more broadly across health and social care. Patients themselves generally felt better supported and more confident about managing

their health, and more aware of the range of services and support that could be accessed in the voluntary and community sector.

**4) Almost half of Social Prescribing clients demonstrated an improvement in their health related quality of life (HRQL) in the period following their referral to the Service**

There were small but limited changes in the 'mobility', 'self-care', 'usual activities' and 'pain/discomfort' components of Social Prescribing clients' HRQL, but significant improvements in the 'anxiety/depression' component. Importantly, patients with the lowest HRQL demonstrated the greatest improvements. This compares favourably with a wider cohort of Better Care Fund beneficiaries whose HRQL did not change much at all during a similar timeframe<sup>5</sup>.

**5) Social Prescribing clients demonstrated significant improvements in their social connectedness and financial well-being in the period following their referral to the Service**

A majority of clients reported that they had insufficient social contact and were struggling financially at the point when they were referred to the Social Prescribing Service but this reduced significantly in the period that followed. This compares favourably with a wider cohort of Better Care Fund beneficiaries whose social connectedness and financial management was generally better than Social Prescribing clients' at baseline but did not change as much at all during a similar timeframe<sup>6</sup>.

**6) The ability of the Social Prescribing Service to impact on secondary care use appears limited, but there may be significant benefits to primary care, in particular to GPs and mental health services**

A key overall aim of the Better Care Fund, through which Social Prescribing is funded, is to reduce secondary care use. This includes a commitment to cut unnecessary or unplanned inpatient stays and Accident and Emergency attendances significantly by 2020. However, the majority of people referred to Social Prescribing do not appear to be high users of secondary care and as a result only limited reductions in inpatient stays and Accident and Emergency attendances have been identified<sup>7</sup>.

The greater immediate benefits of Social Prescribing may be to GPs, as more than two-thirds of clients reported fewer GP appointments following their engagement with Social Prescribing, potentially reducing the pressure on Practices. In addition, the Service is supporting high numbers of people with poor mental health and well-being who are not currently receiving support from statutory mental health services. If the Service can prevent these clients from requiring statutory support in the future agencies such as RDASH<sup>8</sup> and the CCG will see benefits as well.

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<sup>5</sup> It should be noted that the wider Better Care Fund cohort reported lower overall HRQL than Social Prescribing cohort but higher levels of mental health, social connectedness and financial well-being.

<sup>6</sup> As above

<sup>7</sup> Note that this finding is based on client's self-reported use, not care data, and should be treated with caution.

<sup>8</sup> Rotherham, Doncaster and South Humber NHS Trust (RDASH) provide statutory mental health services in the borough.



**7) In health terms the Doncaster Social Prescribing Services appears to cost-effective, but it also provides wider benefits in terms of social value**

The Social Prescribing Service is estimated to have led to an additional 91.7 Quality Adjusted Life Years (QALYs). This provides a cost per QALY of £1,963 and equates to health benefits worth £1,834,000, which means that for every £1 of the £180,000 funding spent supporting vulnerable people, the Social Prescribing Service produced more than £10 of benefits in terms of better health.

In addition to quantifiable health benefits it has been possible to identify a range of wider social and economic benefits from the Social Prescribing Service in the areas of volunteers, employment, and leveraged funding.

**8) Although the benefits of Social Prescribing can be captured through quantitative measures, these data can disguise the full social value of the Service which can only be realised by taking into account qualitative evidence as well**

Key stakeholders in the Social Prescribing Service, notably including clinicians, were keen to emphasise the far reaching benefits of referring patients to the Service and the importance of the client level 'stories' that emerge from the process of engagement. It was argued that commissioners should take this wider evidence into account when deciding on the future of the Service, particularly given the challenges of demonstrating its impact on Better Care Fund secondary care targets. The qualitative evidence collected through this evaluation have confirmed and added richness to the quantitative findings.

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# Sheffield Hallam University

*Evaluation of Doncaster Social Prescribing Service: understanding outcomes and impact*

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