

# Community Webs Final Evaluation Report

January 2018



  
**BRISTOL  
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## Foreword

On my first day in Bristol, I went out to explore my new city. As I got off the bus, a woman was sitting on a bench and called me over to ask me for directions to a particular street. I apologised for not being able to help and had to admit I was new to Bristol. She asked about my partner, my new house and where I had come from. We talked for nearly an hour, in which time I heard all about her daughters, their troubled marriages and her neighbours' allotment. She told me about some lovely walks near my house and suggested somewhere I could go for lunch during my exploring. When we finally said our goodbyes, she got on a bus and left the city centre. It wasn't until a few months into this role that I realised that the woman with such fantastic knowledge of Bristol probably hadn't needed directions but it started a conversation that kept us both buoyant for the rest of the day.

Unsurprisingly, most people don't want to be isolated or lonely but it can often be self-perpetuating. The more isolated you are, the more confidence you lose and the harder it is to make meaningful social contact. Bristol Ageing Better has funded over 50 very different projects across the city, and the one common factor is that each of them creates some kind of space for people to interact and make social connections. For some people, it might be chatting to a man on a bus, for others it might be volunteering in their community or taking part in an art class. For some people, we might need to work with them to work out what has kept them lonely and isolated for so long; this could be physical barriers, such as a disability, or something less tangible such as confidence, anxiety or sensory impairment.

The *Community Webs* project came about following evidence from the Citizens' Advice Bureau "A very general Practice" report that suggested that GPs spent 18% of their time dealing with non-health issues that ranged from relationships and housing to employment issues and debt. After talking to GPs and receptionists, it also became clear that while a lot of the issues were not health related, the underlying issues were connected to depression, isolation and loneliness. Working with Better Care Bristol (through Bristol CCG and Bristol City Council), we commissioned this project to take these non-health issues off GPs' desks and provide meaningful support to the patient.

I am pleased to welcome the publication of this report and to see the effect that the project has had on lonely and isolated older people in Bristol. The Link-Workers have been able to provide the right level of support to people most in need, offering a listening ear and a good understanding of the services on offer that could help.

The Jo Cox Commission on Loneliness uses the tag line "start a conversation" and I think it perfectly encompasses both a goal for lonely and isolated people but also a responsibility for all of us.

**Adam Rees**  
Bristol Ageing Better Programme Director

... for each age group, social isolation was a more prevalent referral reason than any other.

## Executive Summary

### Community Webs

*Community Webs* supports, enables and equips GP patients to access social activities and non-medical support services available in their local community. It is led by Southmead Development Trust and The Southville Community Development Association. The project is staffed by a Project Coordinator with two *Community Webs* Link-Workers who are based within a cluster of GP practices and receive direct referrals from GPs and practice staff. The project has been running in Bristol in the North (covering 3 practices) and in the South (covering 3 practices). Bristol Ageing Better (BAB) and Better Care Bristol (BCB) are the joint funders of the project.

*Community Webs* is part of ongoing developments – taking place both in Bristol and nationally – to improve how health, social care and community services work together. *Community Webs* builds upon best practice in social prescribing and the creation of community-led alternatives to medical care. The service intends to contribute towards current debates on supporting positive mental wellbeing, building community assets, reducing social isolation and ageing better.

The evaluation of *Community Webs* used both qualitative and quantitative methods to understand the process of delivery, short-term outcomes for clients and key costs linked to the project. The evaluation was a collaborative effort, involving staff from Southmead Development Trust, Bristol City Council, and the University of the West of England – with volunteer support from Bristol Ageing Better Community Researchers.



Bradgate Surgery



Malago Surgery



Ridingleaze Surgery



Bedminster Family Practice



Gaywood Surgery



Avonmouth Surgery

The project has been running in Bristol in the North (covering 3 practices) and in the South (covering 3 practices)

## Client profile and patterns of referral in to the service

In the period 1/3/2017 to 1/11/2017:

- 318 referrals were made into the service from six GP practices in north and south Bristol
- The average rate of referrals from GPs was 38 per month (range: 29-47 per month)
- Average attendance rate was 71.8%
- The average age of those referred was 54 years, with 187 clients aged 50 or over (58.8%)
- 214 clients were female (67.3%), 104 clients were male (33.7%)
- 94% of clients were from a White British/Other group, and 6% were from a BAME group
- Clients tended to be resident in areas of high social deprivation, with 22% resident in the top 10th areas of multiple deprivation
- The leading reasons for practitioners making referrals were social isolation (29.5%), low confidence and self-esteem (26.2%) and practical support needs (including welfare benefits, housing and form filling) (22.8%)
- During initial interviews clients often reported a wide range of additional needs not recorded at the point of referral by GPs and practice staff
- At the point of enrolment with the service, a majority of clients score highly for loneliness, e.g. for De Jong Gierveld Loneliness Scale the mean score was 4.67 and modal score was 6.0 (n=129). There are no significant differences in loneliness scores between men and women, the area of the CW scheme, age or race/ethnicity
- For mental wellbeing, using the Short Warwick-Edinburgh Mental Well-being scale (SWEMWBS), the mean score at entry was 16.69 (n=131), which is substantially lower than the UK average of 23.6

## Experiences of *Community Webs* and linked activities

Clients were supported to access an average of six community activities, groups or services. Clients took up an average of two of these in the three months following the initial meeting.

The most common type of support that was accessed after referral was relating to practical support needs (26%), followed by mental health support (21%).

During the three month period, *Community Webs* Link-Workers provided support to clients, often to help maintain confidence and commitments to engage with activities in the community. Difficulties, including those linked to finances and transport, were a barrier to engaging with community activities.

91% of respondents felt that the *Community Webs* service addressed their social support needs.

75% of respondents felt that the service addressed their practical support needs.

54% of respondents reported that they have continued to attend community activities at three months after discharge from *Community Webs*.

When asked “what are the good aspects of our *Community Webs* service?”, the main themes that came out were:

1. Knowledge of the local area and support available
2. Having unhurried time to talk and someone to listen
3. Help to make sense of the confusing nature of statutory services, benefit systems etc.
4. Non-judgemental
5. The introduction of hope

GPs and practice staff are overwhelmingly positive about the *Community Webs* service. Out of the 33 GPs who completed the satisfaction questionnaire 8 months after the project began, 100% who gave an opinion stated that they were ‘very satisfied’ or ‘satisfied’ with the service (21% stated ‘not applicable’ or ‘don’t know’ due to not feeling that they had made sufficient use of service to be able to judge).

Interview data with the project delivery team suggests that ‘low confidence and self-esteem’ in the context of wider social disadvantages make it difficult for clients to develop skills around self-directed and independent personal care. The team adopt a wide-range of personally tailored strategies to support clients. At exit, 100% of clients who responded felt that they had done things differently to take control of their own health and wellbeing since referral to the team, and 100% of these clients felt that they would continue to do these things.

### Associations between participation in the service and client outcomes

Overall, the data collected from baseline, exit and follow-up questionnaires suggest a positive set of client outcomes that address key priorities for Bristol Ageing Better and Better Care Bristol (BCB).

Using well-established measures for loneliness and social isolation, there was a significant reduction in both. In terms of loneliness, using the De Jong Gierveld Loneliness Scale, scores went from an average value of 4.67 to 3.99 from entry to exit<sup>1</sup>. UCLA Social Isolation Scale scores showed a similar positive change.<sup>2</sup>

Clients’ wellbeing (using the Short Warwick-Edinburgh Mental Wellbeing Scale) also increased from baseline, from an average of 17.4 to 20.49.<sup>3</sup>

The impact of *Community Webs* seems to be sustained into the medium term. Follow-up questionnaires (n=41) completed at three months post-exit showed continued improvement for measures of loneliness and mental wellbeing.

Clients’ improvements for these measures were impacted both by the 1:1 Link-Worker support and community engagement itself – the importance of the former being attributed to clients having someone to talk to, and someone who they felt listened to them.

Community engagement by clients showed some increase in membership of organisations like political parties, religious education, sports clubs etc. Most people are not members of any organisations. At entry patients were members of an average of 0.31 organisations, at exit 0.54 and three months post-exit 0.8.

- 
- 1 At the point of service exit, there was a statistically significant decrease in De Jong Gierveld 6-Item Loneliness Scale from baseline (M=4.67, SD=1.62) to exit (M=3.99, SD=1.79),  $t(69) = 1.42, p < 0.000$ . The eta squared statistic (0.30) indicates a large effect
  - 2 (Baseline M=8.83, SD=2.33; Exit M=7.98, SD=2.15;  $t(5.23) = 0.85, p < 0.000$ ). The eta squared statistic (0.37) indicates a large effect.
  - 3 There was a statistically significant improvement in the SWEMWBS from baseline (M=17.4, SD=6.40) to exit (M=20.49, SD=5.13),  $t(-7.46) = 3.35, p < 0.000$ . The eta squared statistic (0.57) indicates a large effect.

A similar pattern emerged in terms of volunteering, with volunteering per person rates rising from: 0.36 at entry, to 0.44 at exit, to 0.46 at three months post-exit. Similarly the intention to volunteer in the future has grown with 24% (n=30) on entry, 27% (n=25) on exit and 32% (n=13) at three months post-exit. However this is in the context of very few clients volunteering for any organisation.

Clients appear to be willing to engage with other services in the medium term (measured 3 month after exit) at least without resorting to the GP for non medical reasons, and there is also some suggestion that clients are more likely to attend a group/service/activity to enable reduced isolation and better mental well-being changes to continue. The sStatistical analysis carried out to date on the loneliness and mental well-being scales underlines that these changes are significant. It is therefore postulated that these major changes are likely to continue or be sustained if clients are able to continue taking control of their own lives.

### Recording information on GP service use, community agency engagement, and service costs

A major challenge for projects such as *Community Webs* is understanding the effects on partner agencies and the wider community context.

*Community Webs* piloted a range of strategies to record information and to support the work of GP services. This involved testing out methods for distinguishing patient clinical and non-clinical needs and building upon the medical record coding systems used by GP practices. The team also analysed the perspectives of clients on their use of GP and community services. This showed, for example, that clients are more likely to directly access community groups compared to NHS services post-participation in *Community Webs* (from 22% at baseline to 39% at exit).

*Community Webs* also undertook extensive work to test strategies for compiling intelligence and building relationships with community groups. This involved matching ‘community asset mapping’ results to client goals, and collaboration with other initiatives (such as WellAware) to share information.

Analysis of project budget suggests average cost per patient (n=318) referred to the *Community Webs* service was £268.77. Of these, average cost per patient (n=239) who took part in the *Community Webs* intervention was £357.57. These costs include costs linked to both the start-up and wind-down of the 12 month project.

## Lessons learnt, what worked well, and what can be improved

This report builds on an interim evaluation of the process of project delivery. The overall view of *Community Webs* from patients, GPs/practice staff, key stakeholders, community organisations and project staff respondents has been positive.

*Community Webs* is considered to be an essential service which is running well and is helping to meet a range of non-medical needs. There are however limitations noted with the project – related to bureaucracy and operational issues. Themes were identified under the interview topic areas of planning and implementation, management and operation (divided into successes and challenges), perception of project need and perception of project impact.

## Strengths and limitations of the evaluation

This evaluation builds upon a wide range of insights of front line staff, clients and stakeholders in partner agencies. It draws upon the expertise of academic researchers, community researchers and service evaluation specialists. It includes both quantitative and qualitative evidence. This is a rapid evaluation that did not have the opportunity to fully follow up on all participants at three month or six months post enrolment. Due to ethical and data protection constraints the evaluation did not analyse patient medical records. The evaluation did not estimate the monetary-equivalent value of the project's impacts.

Data was collected from interviews (17) patient exit questionnaires (93), patient 3-month evaluation questionnaires (41) and monthly project worker reflective logs (March 2017-November 2017).

## Learning and recommendations

There is a wide range of areas of learning to arise from *Community Webs*. These are summarised below:

- Agree the model between all the relevant stakeholders at the outset with no major changes except where it is an enhancement to project work
- Develop plans for long-term sustainability for successful projects at inception
- Increase project length to enable sufficient time for asset mapping, for the service to embed and for evaluation of long-term outcomes
- Adapt the project to increase staffing and length of project input to enable handholding for patients to access services and to engage in the community, as well as enabling Link-Workers to fully address the patient needs
- Ensure there is early clinical engagement
- Provide Linkworkers with access to EMIS
- Provide Linkworkers with sufficient room space at GP practices for appointments
- Include a lead-in time of two months for the project to allow for relationship building, asset mapping and project promotion
- Ensure Linkworkers have the full skillset required for the role
- Linkworkers need a trusted directory/database of services and source of information that is up to date, clear and easy to use.
- Good knowledge and skills around mental health for project staff and staff from community organisations
- Review, and where possible reduce, paperwork needing to be completed by clients – ensuring that all evaluation is of benefit to the client and does not compromise the intervention

## Introduction

This report presents an evaluation of *Community Webs* at the final stage of the project. It gives an overview of the origins, development and key characteristics of the project alongside an account of the current research, policy and practice context. Drawing upon multiple research methods the findings are framed in relation to the main objectives of the report. The final sections discuss the implication and limitations of the evaluation, then set out key conclusions and recommendations for further work in this field.

### Overview and background of *Community Webs*

*Community Webs* is a test-and-learn pilot funded by Bristol Ageing Better (BAB) and Better Care Bristol (BCB). BAB is funded by the Big Lottery Fund to develop and deliver a programme that identifies the best ways of reducing the isolation and loneliness of older people. BCB is a local programme that aims to improve the way health services

and social care services work together. It involves Bristol CCG and Bristol City Council pooling budgets and resources to drive transformation of care and reduce inequalities by establishing integrated local services.

The *Community Webs* project has been set up to test the idea of primary care services working with community assets at a neighbourhood level to best support adults, particularly with regard to their non-medical social needs. One of the aims of the project is to reduce use of GPs for non-medical issues. This would have the potential to free up GP time and alleviate the burden to the health system by creating capacity to deal with patients with medical needs who may otherwise present to A & E.

The project has undergone several changes since it was originally planned. The tender for the project was won by a cluster group of practices in the south of Bristol, Greater Bedminster area. Initially the project was to be managed by a *Community Webs* Project Lead, employed by the Bristol Clinical Commissioning Group (BCCG), however it was not possible to recruit to the role. It was felt that this was partly due to the dual skill sets required of project management along with patient-facing signposting and navigation experience, which on reflection was considered to be an unlikely skill mix.

In their original application to Big Lottery, BAB proposed a project called 'GP Case Finding' with the aim of using GPs and primary care to find the most isolated and lonely older people, and to refer them into support services. As part of the BCB transformation board, BAB identified the links and potential duplication of GP Case Finding and *Community Webs*. Therefore BAB made the decision to offer support and alignment of their work streams to *Community Webs* and provide match funding, despite the remit being expanded to the over 18's – with BAB and BCB becoming equal partners in the project.

Match funding was provided by BAB on the condition that the money was put out to the third sector to deliver and report on the project and they also specified inclusion of the cluster group of practices in the Northern Arc, North Bristol who were the only other appointable expression of interest for *Community Webs*, in order to be able to compare models. North Bristol became the second site and the project lead role was split into two new roles – a *Community Webs* Coordinator to oversee the project in both areas and a *Community Webs* linkworker in the South and one in the North.

Better Care Bristol were committed to running a Test and Learn project board for *Community Webs* and the Integrated Nursing pilots that would look at strategic learning from both. As part of the match funding it was agreed that it would be easier for BAB to undertake the commissioning of *Community Webs* and manage the contract, whilst both BAB and BCB would retain input via the Test and Learn Project board. Due to departures in the BCB team, no one from Better Care was able to chair this board as planned, and the BAB Programme Director temporarily took on this role. In the spring of 2017, Better Care decided to end this group.

BAB put the management of *Community Webs* out to tender and awarded the contract to Southmead Development Trust (SDT), as a partnership with The Southville Community Development Association (SCDA) who were part of the initial South Bristol bid. The project started in January 2017 with referrals being received from March 2017.

Following feedback from stakeholders the number of GP practices involved in the North was changed from three (proposed in SDT's bid) to seven and therefore the beneficiary



numbers were increased. SDT/SCDA revised their proposal to incorporate two different models of service in order to deliver the service for all of the practices. This resulted in a holistic model with up to four supported referral sessions with a linkworker in the south and a light-touch signposting model with a maximum of two sessions with a linkworker in the north.

Once the project started receiving referrals there were issues raised with the light-touch model and its suitability to provide sufficient support to patients, especially with the conditions that the project was focussing support on. In response to this the project team decided to reduce the number of practices involved in the north back to three in order to be able to deliver the more intensive holistic model.

The *Community Web* linkworkers undertake holistic guided conversations to work out with the patient what their needs are and to set goals. The linkworkers provide supported referrals to services in the community for patients to access support to meet their individual needs.

## Research, policy and practice context

Projects like *Community Webs* fit into a genre of projects that are commonly referred to as social prescribing. There are currently many varied social prescribing interventions being commissioned around the UK and beyond. In many ways they are seen as a non-medicalised response to the exponential rise in demand for NHS services<sup>4</sup>. This rise is partly due to the fact that one in five presentations in primary care have no medical condition for GPs to address<sup>5</sup>. Social prescribing provision includes universal provision in every GP practice across a Clinical Commission Group's (CCG) area: including Gloucestershire, Rotherham and Bradford. Funding arrangements include sole CCG commissioning (e.g. Waltham Forest), joint commissioning with public health (e.g. Gloucestershire) public health (e.g. Shropshire) and a range of charitable funding including the Big Lottery (e.g. Bristol) and a small-scale philanthropic funded project in Herefordshire. Social prescribing is becoming increasingly accepted as a 'tried and tested' solution to improve patient flow in the NHS according to the '*General Practice Forward View*'. In fact the development of social prescribing is one of the ten key outcomes specified in the five-year *General Practice Forward View*<sup>6</sup>.

4 Kimberlee, R. (2015) What is social prescribing? *Advances in Social Sciences Research Journal*, Volume 2, No1.

5 Citizen's Advice (2016) A very general practice: How much time do GPs spend on issues other than health? [https://www.citizensadvice.org.uk/Global/CitizensAdvice/Public%20services%20publications/CitizensAdvice\\_AVeryGeneralPractice\\_May2015.pdf](https://www.citizensadvice.org.uk/Global/CitizensAdvice/Public%20services%20publications/CitizensAdvice_AVeryGeneralPractice_May2015.pdf)

6 NHS England (2016) *General Practice Forward View*, <https://www.england.nhs.uk/publication/general-practice-forward-view-gpfv/> Accessed 22nd January 2018



## Project summary

In its final form *Community Webs* is a person-centred supported referral/signposting service, staffed by a Project Coordinator with two *Community Webs* Linkworkers who are based within a cluster of GP practices and receive direct referrals from GPs/practice staff. The project is running in Bristol in the north (covering 3 practices) and in the south (covering 3 practices). The aim of the service is to address non-medical needs that patients at the surgery present to their GP or to practice staff.

Referral criteria for access to *Community Webs*, termed the 'basket of conditions', are as follows:

- Social isolation/loneliness
- Practical support needs (including benefits, letter writing, housing, debt etc.)
- Over-reliance on NHS services
- Bereavement
- Need for improved self-care (e.g. diet and exercise)
- Low confidence and self-esteem (including mild-moderate depression/anxiety)

From the outset it was made clear that this was to be a guide, and that referrals were also open to any other patients whom GPs/practice staff felt would benefit from non-medical sources of support, as long as they did not come under the exclusion criteria of being:

- Under the age of 18
- A threat to themselves/others
- In a crisis situation
- Suffering from uncontrolled mental health issues or addictions
- Suffering from dementia



## Aims

The aim of the project is to provide patients with appropriate support to deal with non-medical issues through coaching and referrals to organisations in the local community (or beyond, as appropriate) and to reduce their use of GP time for non-medical issues.

In a recent review undertaken by the Social Prescribing Network (SPN) (2017)<sup>7</sup> for the Department of Health the SPN identified that 74% of local Sustainability and Transformation Plans (STP) have identified social prescribing as a key outcome in their forward plans.

Little is known about the economic case for social prescribing. In essence social prescribing represents a complex community intervention, which poses challenges for evaluators in that the challenge of evaluating effectiveness and cost-effectiveness stems from the impetus to generalise complex health interventions to another setting. Given the heterogeneity of the target population, however, achieving this goal could be difficult; and yet evidence-based practice in public health is the basis for policy development and implementation. To date there have been at least two systematic reviews of social prescribing. One review looked at 15 evaluation reports on social prescribing from 2000 to date<sup>8</sup>. They concluded that most evaluations presented positive conclusions but were limited because of a lack of controls, inconsistent design, short follow-up durations and an absence of standardised and validated measuring tools. They report that only four of the studies attempted any cost analysis but the authors drew little conclusion as to what the relevance of the cost analysis showed. A more recent review looked at 86 evaluation reports going back to 1993. They similarly undertake an interesting overview of the

broad range social prescribing interventions including those with no discernible direct link to primary care<sup>9</sup>.

These reviews say very little directly about the linkworker social prescribing model that is proving popular amongst CCGs and other commissioners and which is the model utilised in the *Community Webs* project and the preferred model of the Department of Health. To specifically explore the impact of linkworker based social prescribing schemes, the SPN reviewed 94 social prescribing project reports and identified 15 papers that met the linkworker model. Seven papers looked at the effect on demand for general practice, reporting an average 28% reduction in demand for GP services following referral. Results ranged from 2% to 70%. Five studies looked at the effect on A+E attendances reporting an average 24% fall in attendance following referral. Results ranged from 8% to 26.8%. Five studies looked at the effect on demand for other secondary care services. Three reported a fall in emergency hospital admissions in the months following referral (6%, 7% and 33.6%) and two studies measured secondary care referrals after social prescribing. Eight studies attempted some form of cost-effective analysis. This revealed savings made in things like demand reduction as key to assessing social prescribing's effectiveness; with estimates varying from a Return on Investment (ROI) of £0.33 per patient per £1 per annum annually to a return of £11 per patient per £1 per annum. Using a broader multi-

7 Polley, M.,<sup>1</sup> Bertotti, M.,<sup>2</sup> Kimberlee, R.,<sup>4</sup> Pilkington, K.,<sup>4</sup> and Refsum, (2017) A review of the evidence of social prescribing and demand reduction. <http://westminsterresearch.wmin.ac.uk/19223/1/Simon%20Stevens%20approved%20v1%20%20Evidence%20summary%20of%20SP%20on%20healthcare%20demand%20and...pdf>

8 Bickerdike, L., Booth, A., Wilson, P., Farley, K. and Wright, K. (2016) Social prescribing: less rhetoric and more reality. A systematic review of the evidence, *BMJ Open*, Volume 7, No 4.

9 Thomson, L., Camic, P and Chatterjee, H (2016) Social Prescribing: A Review of Community Referral Schemes, [http://create.canterbury.ac.uk/15655/1/Social\\_Prescribing\\_Review\\_2015.pdf](http://create.canterbury.ac.uk/15655/1/Social_Prescribing_Review_2015.pdf) Accessed 22nd January 2018.

## Evaluation methodology

### Overview

This evaluation uses both qualitative and quantitative methods. With input from stakeholders during *Community Webs* project board meetings and evaluation meetings, a logic model was developed setting out the components of the project and the theory of how the project would work, which provided an evaluation framework which the plan was based on<sup>11</sup>. Stakeholders gave input to the plan, which was incorporated. The plan was a working document and has been updated on an ongoing basis to reflect input from new stakeholders involved in the project.

### Participant questionnaire data collection and analysis

The evaluation team devised client forms for data collection:

- a referral form
- an assessment form with a goal-setting section/action planning
- an exit questionnaire
- a three-month post-exit questionnaire.

The long version of the BAB monitoring form CMF (Common Measurement Framework) was also formatted for use with the *Community Webs* project. This includes the Short Warwick- Edinburgh Mental Wellbeing Scale (SWEMWBS), De Jong Gierveld Loneliness Scale, the UCLA Loneliness Scale and questions around volunteering and social

stakeholder perspective analysis to capture the social value for all stakeholders in social prescribing delivery suggests a Social Return on Investment of £2.30 per £1 invested in the first year. Unit cost per patient for the linkworker model revealed a cost range of £153 to £270 per patient<sup>10</sup>.

Moving forward the linkworker model at the centre of the *Community Webs* approach is likely to be expanded nationwide. Prior to the turn of the year the Department of Health announced a £5.1m Health and Wellbeing Fund offer to the Voluntary and Community Sector to work in partnership with primary care (CCGs, Public Health, not for profit organizations) to develop social prescribing in CCG areas where it remains non-existent or underdeveloped. And the SPN and NHS England announced in January 2018 at a 'historic' meeting that they will work together to develop universal social prescribing provision in all CCG areas by 2020.

10 ibid

11 Available on request.

contact<sup>12</sup>. This questionnaire is completed at three points: with the assessment at the start of project contact, once input has ended (exit) and at follow-up three months after the last contact with project staff. The assessment, exit and follow-up forms include the validated tool MYCAW to measure levels of concern with an identified problem<sup>13</sup>.

CMF data was initially inputted into an Excel spreadsheet by the *Community Webs* staff, then exported into an SPSS (a statistical software package) data analysis template developed by Richard Kimberlee. The data was coded, checked and cleaned, then analysed with the use of descriptive and inferential statistics.

Consent was gained from patients for GP's/ practice staff to pass on patient details for *Community Webs* referral, and project information sheets were sent out by *Community Webs* staff with initial contact letters. At the first session, opportunities were provided for any questions about the project and consent forms were then signed. These research ethics procedures were consistent with the process approved by UWE Research Ethics Committee for the evaluation of the Bristol Ageing Better programme (HAS.16.11.045).

#### Qualitative data collection and analysis

Data was collected from interviews (17) patient exit questionnaires (93), patient 3 month evaluation questionnaires (41) and monthly project worker reflective logs (March 2017-November 2017). Semi-structured interviews were carried out between July and October 2017 with the following people

in each area: GP's/Practice Staff, a Care Coordinator/ Community Resource Lead, a client and members of staff from community organisations. In addition project staff (the coordinator and linkworkers) and five key stakeholders were also interviewed.

Interviews were conducted by the Public Health Evaluation Assistant (Bristol City Council), Bristol Ageing Better Community Researchers and a Southmead Development Trust volunteer. Interviewees, apart from the project staff and key stakeholders, were selected on a purposive basis based on those who had experience of the project and to ensure representation across roles and from both areas of Bristol in which the project is running. Qualitative findings were analysed thematically. Interviewers went through the interview guides together prior to the interviews to try and ensure a consistent approach. Interviewers carried out data analysis separately and checked each other's coding. There was a high degree of concordance on themes identified.

In the quotes included in this report, interviewer comments, pauses and non-verbal responses have been removed and some text has been condensed for ease of reading. Some respondents amended wording for clarity before inclusion in the report. In this report we use the terms 'clients' and 'patients' interchangeably to refer to the users of *Community Webs*.

<sup>12</sup> <http://bristolageingbetter.org.uk/evaluation-tools/>

<sup>13</sup> <http://www.bris.ac.uk/primaryhealthcare/resources/mymop/sisters/>



## Aim and objectives of the evaluation

The aim of this evaluation is to assess the short term outcomes for participants and to examine the implementation process. The objectives are as follows:

1. To examine the profile of *Community Webs* clients and patterns of service use.
2. To examine clients' perceptions of referrals to community groups, services and activities.
3. To explore patient experience of and satisfaction with the linkworker service and referral support.
4. To explore GP and practice staff experiences of and satisfaction with the linkworker service and referral support.
5. To assess the impact on clients' social isolation, wellbeing and other key outcomes.
6. To gain feedback on client perspectives of self-care, approaches prompted, attempted and/or sustained.
7. To explore mechanisms for gathering data of GP service usage and monitor early/possible effect on GP service usage by referred patients, to identify future potential for the service to reduce this longer-term.
8. To identify mechanisms for capturing information about local voluntary and community sector services, for longterm use by GP and practice staff, for non-medical referrals and for patient self-referral.
9. To understand what *Community Webs* components and processes are working well and what can be improved ('lessons learnt') – from a variety of perspectives: patients, GPs, practice staff, organisations that the linkworkers are referring to, project staff and stakeholders.
10. To assess the costs associated with the delivery of the project.

## Findings

### Objective 1: Client profile and patterns of service use

This section is concerned with understanding the characteristics of Community Webs clients and their take-up of the service.

#### Client referrals, take-up and patterns of referral to the service

During the period of 1st March 2017-1st November 2017, 318 referrals were made into the service. Of those referred:

- 79 referrals did not engage (including those we were unable to contact by phone or post, or who DNA multiple times)
- 393 = total number of supported referrals to groups, services and activities
- 4 per client = average number of 1:1 sessions
- Average DNA rate: 28.15%
- 187 clients were over 50 (58.8%)
- 214 clients were female (67.3%), 104 clients were male (33.7%)
- 54 = average age.

**Table 1: GP Surgery referrals**

GP surgery	Number of referrals
Bradgate Surgery	117 (18 did not engage)
Malago Surgery	61 (15 did not engage)
Ridingleaze Surgery	48 (4 did not engage)
Bedminster Family Practice	36 (18 did not engage)
Gaywood Surgery	35 (18 did not engage)
Avonmouth Surgery	21 (6 did not engage)

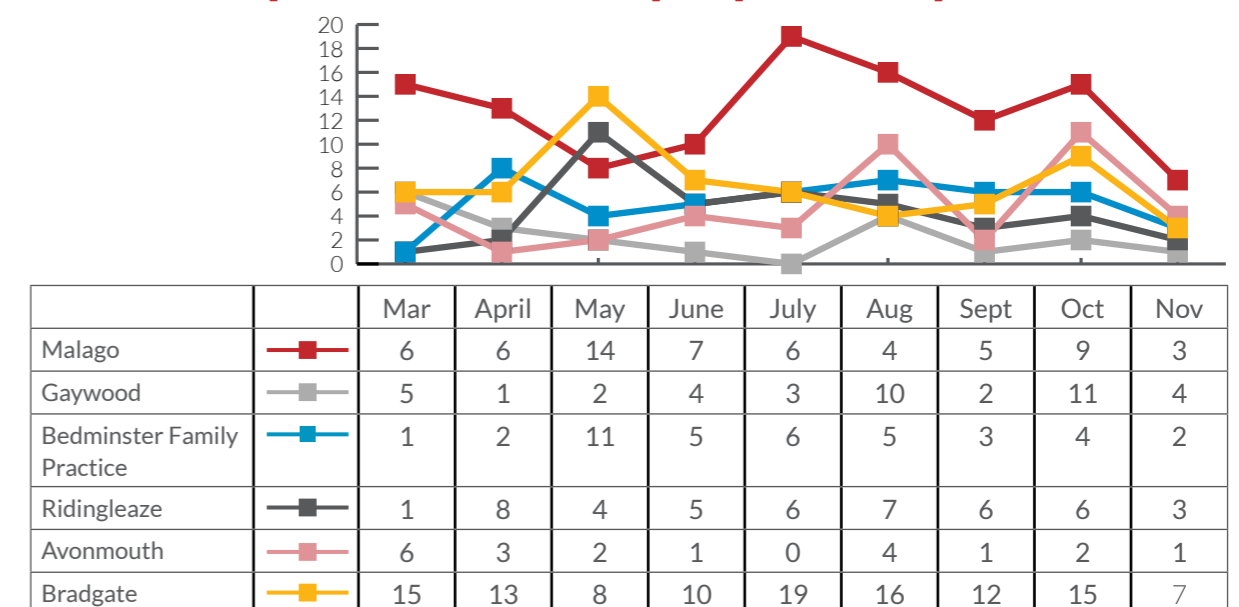
#### Patterns of referral to the Community Webs service from GP practices

The chart below shows the pattern of referrals from GP practices to the Community Web service. Some practices are referring at higher rates. For the eight main months of delivery (March-October) the average rate of referrals was 38 per month. Although there were fluctuations in referrals from individual GP practices, the pattern was largely stable with a range from 29-47.

It is interesting that in both the north and the south there is one GP practice in each cluster which has referred more than double the number of patients as each of the other two practices in the area. After discussion with linkworkers, GP practice managers and other stakeholders, reasons for this assumed to be:

1. Patients who are highly suitable for *Community Webs* tend to migrate towards particular GPs, who work out of these practices.
2. GPs working in these practices already operate more holistically, tend to be younger and more open to change, have bought into the model and are passionate about it.
3. At least one GP in these practices is passionate about the model, and this disseminates amongst the other GPs working alongside them.
4. The linkworker sees GPs at these practice more regularly than at the others, serving as a constant reminder.
5. Many more GPs (c.13) based at Bradgate (yet only 5 are referring). There tends to be only 1 GP working at Avonmouth at any given time.

**Number of patients referred per practice, per month**



Furthermore, in the north there is one surgery that is lagging considerably behind the other two in terms of referral rates. We have chosen not to address this due to our current long waiting list and not wishing to promote the service further due to lack of capacity, however reasons for this have been considered as being:

1. Other Public Health initiatives were in place when we began *Community Webs*, leading to potential confusion for GPs.
2. *Community Webs* did not achieve particularly strong outcomes with Avonmouth clients compared to the expectation of referring GPs. This was because the referrals were mainly housing-related, and other entrenched issues which needed more intensive input and longer-term support than the CW service could provide short-term.

Linked to this, there is clearly a great amount of untapped need in primary care as, apart from the linkworkers attending weekly coffee mornings with some GPs, the team has not promoted the service to any great extent. This is because the team did not want to raise unrealistic expectations of numbers of beneficiaries amongst GPs. Due to making a decision not to use volunteers, the capacity of the project's linkworkers has remained constant at 12 per week, with the majority of clients taking the full four sessions offered. Therefore, as the waiting list has been constant throughout (approximately 15 in each area, which equates to 4-6 weeks), an exact time is difficult to calculate due to clients finishing intervention at different times – the linkworkers are stretched over capacity.

14 See Appendix 2

After conversation with GPs and Community Resource Leads in each area the team concluded that up to one month was the time that people felt it was acceptable to wait to see a linkworker – particularly due to the fact that the linkworker would be supporting the individual to access other services if they had additional support needs (which often had three-month waiting lists) rather than providing the support to the individual themselves. Interestingly however, no clients have ever passed comment on the length of time that they have had to wait to see a linkworker suggesting that a) in the current climate they are used to all services having long waiting lists and that b) expectations to be seen within a very short space of time are perhaps not held to as great an extent as the team initially assumed.

It is also apparent that there are certain GPs who refer more patients than others into the service. If we look at a breakdown of individual GP referral rates, we can see that out of 56 potential referring GPs, only 22 have referred more than 3 patients<sup>14</sup>:

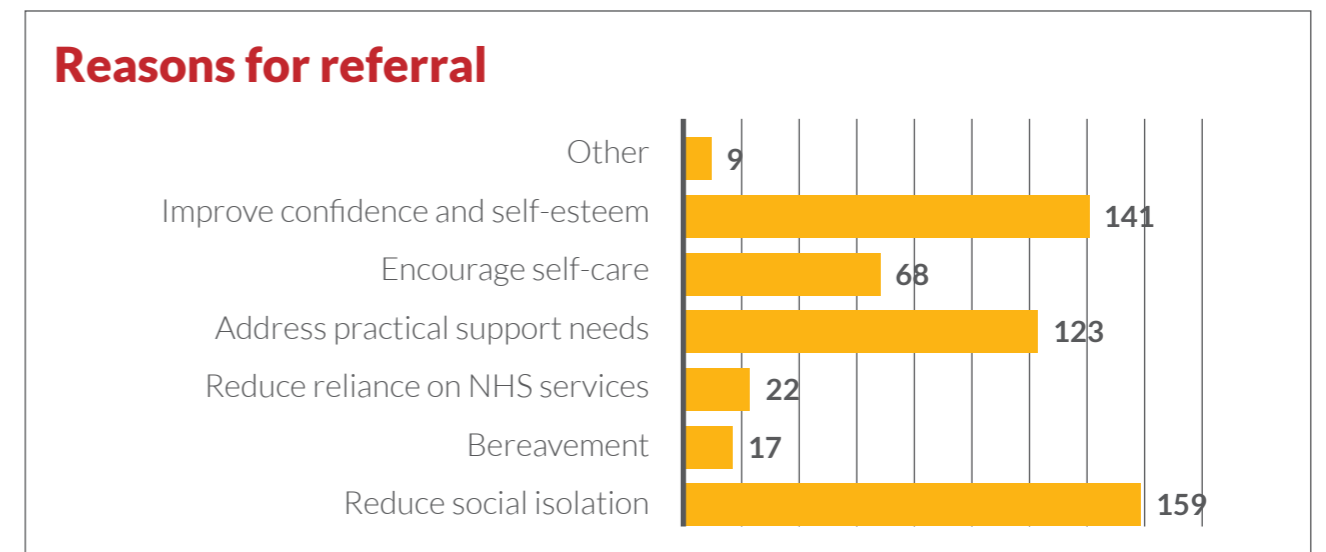
It is encouraging that only five GPs haven't referred into the service at all. These reasons will be explored with the GPs themselves, but they could be amongst those who stated on their feedback forms that they had not referred due to 'not being in a position to do so' or 'not seeing any appropriate patients'. The latter reason is surprising, and suggests that perhaps further discussion could be had with GPs around the value of linkworkers being a single-point of access for all non-medical support needs rather than having patients having to fit into very strict criteria to be referred.

The fact that the highest referring GPs work at the highest referring practices suggests that it is these GPs' referral rates that are creating such a disparity between practices, rather than particular GP practices as a whole being more on board than others. Indeed, in one high-referring practice, two GPs account for 51% of all referrals from that practice (despite it having eight GPs).

**Reasons for referral**

The main breakdown of reasons for referral are as follows:

- 159 social isolation (29.5%)
- 141 low confidence and self-esteem (26.2%)
- 123 practical support needs (including welfare benefits, housing and form filling) (22.8%)
- 68 poor self-care (e.g. diet and exercise) (12.6%)
- 22 over-reliance on NHS services (4.1%)
- 17 bereavement (3.2%)
- 9 other (1.6%)



As can be seen above, the most frequent reason for referral was to reduce social isolation. However it is important to note that most referrals had more than one reason for referral. Although the initial 'basket' proposed by GP practice managers included bereavement, we did not get many referrals solely for this issue. It is thought that this is because GPs were mostly aware of specific services that support people with bereavement, and it was more the social isolation that was a symptom of bereavement that people were noted as needing support with. Indeed, this would also be true of all of the other referral categories, when it comes to them being symptoms of things like bereavement.

It is important to note that the reason the GP gave for referring the patient sometimes did not correspond with the support needs spoken about by the patient themselves when the linkworker asked them why they think they were referred to *Community Webs* and what they would like support with:

**Table 2: Engagement and referrals**

Reason for referral	Percentage of total reasons for referral	Percentage of reasons for referral for those who did not engage
<b>Reduce social isolation</b>	29.5%	33%
<b>Improve confidence and self-esteem</b>	26.2%	19.5%
<b>Address practical support needs</b>	22.8%	28.9%
<b>Encourage self-care</b>	12.6%	10.3%
<b>Reduce reliance on NHS services</b>	4.1%	5.2%
<b>Bereavement</b>	3.2%	2.1%
<b>Other</b>	1.6%	1%

We can see that there was no clear correlation between those who did not engage and their reason for referral

Table 3 (below) shows the disparity between patient needs perceived by referrers and needs as perceived by patients themselves.

**Table 3: Engagement and referrals**

Reason for referral exactly the same according to referrer and client	Reason for referral the same, but referrer had included additional referral reasons	Reason for referral the same, but client noted additional referral reasons/support needs	Reason for referral completely different according to referrer and client
20%	32%	40%	8%

This data could only be collected for those who actually engaged in the service and were met by a linkworker (n=239).

It is not surprising that once a relationship was built between the client and linkworker (due to the luxury of time that the linkworker has compared to the GP), additional support needs were mentioned by the client. What was surprising was that 32% of referrals had additional reasons for referral than the client disclosed at initial assessment. Through further exploration, some of these appear to be linked to social isolation/loneliness and the difference in GP and patient perception of this. 24% of clients referred due to social isolation did not cite this as a reason for referral themselves. Reasons for this discrepancy could be linked to GPs seeing something as a problem which the client sees as the 'norm' and something that they are happy with. This was particularly true of older clients, who still saw the service as valuable for addressing these needs (despite them not explicitly stating them).

*“Very helpful with regard to lonely, elderly patients with poor self-confidence and isolation.” (GP)*

The linkworkers also noted that there still appears to be a stigma around social isolation. In addition, some clients noted that their GP would like them to be more socially involved in order to help their mental health, but clients did not currently see this as an option or as the main problem. Indeed, it is interesting that many clients substituted the referral reason of 'reduce social isolation' for 'improve confidence and self-esteem'.

Interestingly, 7% of clients cited social isolation as a reason for referral despite this not being noted by their GP.



### Box 1: Understanding people's needs

An illustration of the disparity between perceived needs and actual needs is an elderly gentleman who was referred to us with 'practical support needs'. His GP cited that the patient did not know how to cook and therefore did not have a very good diet, so would benefit from attending a local cooking class. In building a relationship with this 78 year old gentleman, the linkworker gleaned that the reason why he didn't know how to cook was because his wife had recently left him after 48 years of marriage. She had done all of the cooking, looked after everything around the house and this gentleman had never had to learn how to look after himself. As a result of her leaving him, the gentleman had begun drinking heavily and had attempted suicide 3 times. A cooking course would be helpful, yes, but the gentleman had more pressing concerns that he wanted support to

address. This resulted in supporting the gentleman to: access ROADS drug and alcohol service (spending time breaking down the barriers that he had to accessing them), attend a mental health peer support group, attend Better Breathing and Balance and Strength classes at The Greenway Centre and gradually begin to expand his social networks. He still struggles with cooking but instead of not eating he now comes to The Greenway Café every day for lunch where he feels comfortable, has got to know lots of people and knows that he is cared about.

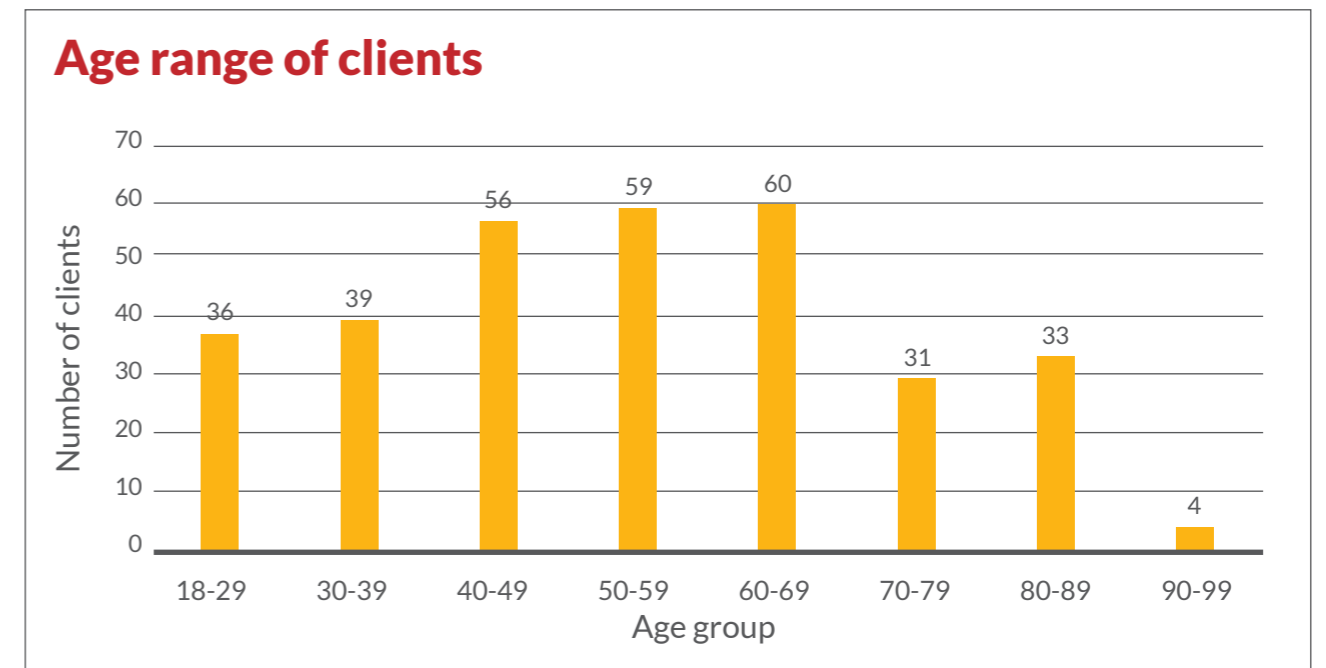
*"The most important thing is that you asked what MY needs were." (Patient)*

*"Someone listened, when the GP didn't." (Patient)*

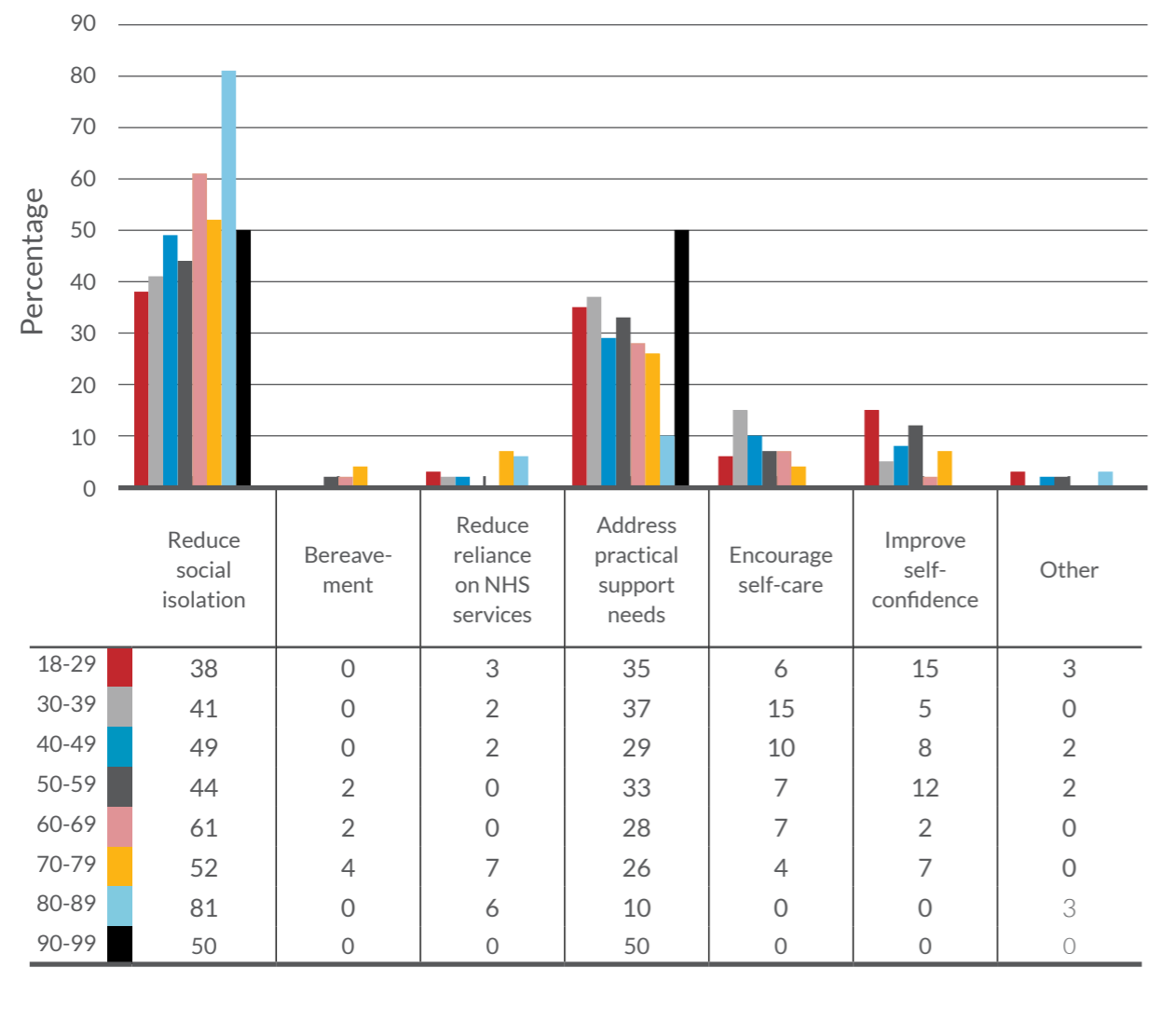
### Age range of clients

59% (n=188) of individuals referred into the service were over 50 (BAB's threshold) – a number that we expected to be greater due to the much-publicised idea of this age group being linked to isolation. However it is important to note the wide variety of reasons for referral for individuals. Of this age group, 58% were referred due to social isolation/loneliness – thus accounting for the majority of referral reasons. Indeed, for each age

group, social isolation was a more prevalent referral reason than any other. However attention should be drawn to the other referral reasons which it could be argued are caused by, or cause, social isolation – linked to, for example, addiction, bereavement, past trauma and unemployment. The reason for referral by percentage of each age group can be seen below:



### Reason for referral, broken down by age



Although those referrals of people over 50 only amounted to 58% of total referrals, this breakdown of reason for referral shows social isolation as being the main referral reason for an average of 58% of over 50s – greater than any other. This is likely to be even higher within the general population of the areas that *Community Webs* targeted – not least because of these people not going to their GP in the first place to be referred to the project. New projects that have begun delivery since the inception of *Community*

*Webs* (such as the Bristol Ageing Better funded Community Navigator project, which supports people over 50 who are socially isolated to engage in groups and activities by providing home visits), have increased the support that older people are able to access in addition to *Community Webs*. Community Navigators is a non-GP referral project and is looking to target the most isolated in society in a more creative way than social prescribing (in terms of the referral route in).

However moving forward, due to a wish for social prescribing models to be a ‘single point of access’ – particularly for GPs – linkworkers will be able to triage those over 50 whose referral reasons suggest social isolation so that these individuals can be seen directly by the Community Navigators. This will therefore increase the capacity of social-prescribing linkworkers to meet 1:1 with people who are not served by these any of these other services.

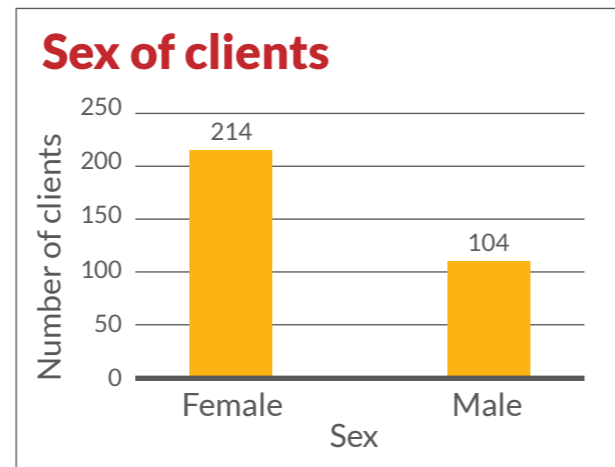
It has also been interesting to note that the asset mapping exercise identified a greater number of specific services, groups or activities that have been set up for older people compared to other age groups. This raises the question of whether, if these were not available, the proportion of over 50s who were referred due to social isolation or loneliness would be higher. *Community Webs* Staff are also aware, through talking to GP practice managers, that other initiatives (such as RSVP) are well known about amongst some GPs and, as such, these GPs are still likely to refer older, isolated people directly to befriending services such as these. The fact that each GP surgery has a worker specifically for their elderly patients will also have had an impact on referral rates for this age group, as well as the perceived higher resilience and self-sufficiency of the older generation. Indeed, linked to the latter, 18% of over 50s did not engage with the service after referral, compared to 27% of under 50s.



## Sex of clients

67% of those referred to *Community Webs* were female, compared to 33% who were male. The main reasons for this disparity are thought to be:

1. Research indicates that women are more likely to attend their GP for social needs than males, and are more comfortable with talking about mental health needs<sup>15</sup>.
2. Women are more dependent on welfare benefits than men and are more likely to be living in poverty<sup>16</sup>.
3. Women are more likely to be carers than men<sup>17</sup>.
4. Subconscious gender biases on behalf of referring partners – e.g. that women are in more need of social networks and support than males due to women being better known for having wider social support<sup>18</sup>
5. Women live longer than men and therefore more likely to become socially isolated due to old age and bereavement<sup>19</sup>
6. More women than men are frequent attenders at GP surgeries (for the above reasons<sup>20</sup>.



All of our referrals have come from GP practice staff – therefore this gender split is perhaps purely reflective of the needs of patients who are attending the surgeries. This suggests that there is a need to reach out to those who are not currently going to their GP to ask for help. The Bristol Ageing Better funded city-wide ‘Community Navigator’ project has this as their objective – finding those who are incredibly isolated and not even leaving their homes. However Community Navigators focuses purely on those over 50 and who are struggling with social isolation and/or loneliness. Therefore, moving forward, we need to continue to sustain and build on our links with other local and national initiatives/organisations – such as the Community Access Support Service which works to improve access to mental health services across the city of Bristol.

15 <http://www.time-to-change.org.uk/blog/why-dont-men-talk-about-mental-health-problems>

16 Bristol Fawcett Society ‘Cutting Women Out in Bristol’ (2014)

17 Bristol City Council (2015) Joint Strategic Needs Assessment

18 [http://userpage.fu-berlin.de/~health/support/knoll\\_schwarzer\\_in\\_weidner.pdf](http://userpage.fu-berlin.de/~health/support/knoll_schwarzer_in_weidner.pdf)

19 <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/nationallifetablesunitedkingdom/2015-09-23>

20 <https://academic.oup.com/fampra/article/17/4/298/445915>

Table 4: Race/ethnicity of clients

Race/Ethnicity	Percentage of Community Webs clients	Northern Arc average	Southville/Bedminster average	Bristol average
English/Scottish/Welsh/Northern Irish/UK	94%	82.90%	85%	77.90%
Any other White background	1.30%	5%	6%	5.10%
Arab	1.30%	0.20%	0.30%	0.30%
Mixed ethnic background	0.90%	2.90%	3.30%	3.60%
Pakistani	0.60%	0.40%	0.40%	1.60%
Caribbean	0.60%	0.90%	0.50%	1.60%
Irish	0.30%	0.70%	1.20%	0.90%
Indian	0.30%	1.80%	0.80%	1.50%
African	0.30%	1.80%	0.80%	2.80%
Any other ethnic group	0.30%	0.40%	0.40%	0.60%
Gypsy or Irish Traveller	0%	0.10%	1.00%	0.10%
Bangladeshi	0%	0.50%	0.40%	0.50%
Chinese	0%	0.40%	0.40%	0.90%
Any other Asian background	0%	1.20%	0.50%	1%
Any other Black/African/Caribbean background	0%	0.70%	0.50%	1.60%
Prefer not to say	0%	6.0	4.7	5.2

## Race/ethnicity of clients

As can be seen by *Table 4*, those who were referred into *Community Webs* and identify as English/Scottish/Welsh/Northern Irish are over-represented compared to the demographic of the localities in which the service was based<sup>21</sup>. This may be due to

the different age profile of the *Community Webs* clients compared to that of the locality. However we cannot exclude the possibility that lower take up by BAME groups, was a consequence of barriers to accessing the service or the design of the service.

21 <https://www.bristol.gov.uk/statistics-census-information/new-wards-data-profiles>

## Deprivation in the areas of clients' residence

The registration form did not ask clients to record their employment or income status. However, if area of residence is used as a proxy for client deprivation, the following table shows that clients were more likely to live in areas of high multiple deprivation.

**Table 5: Profile of database records on the Index of Multiple Deprivation (n=230)**

Percentile of deprivation	Percentage	Number
<b>Most deprived percentile</b>	22%	55
<b>2nd Percentile</b>	15%	37
<b>3rd Percentile</b>	15%	38
<b>4th Percentile</b>	17%	44
<b>5th Percentile</b>	5%	12
<b>6th Percentile</b>	5%	13
<b>7th Percentile</b>	9%	22
<b>8th Percentile</b>	4%	9
<b>9th Percentile</b>	0%	0
<b>10th Percentile</b>	0%	0

## Patterns of referrals to community groups, services and activities

The table below shows that the most used group of services was relating to practical support needs – unsurprising due to the fact that 39% of those referred had practical support needs.

**Table 6: Type of support provided**

	Type of group, service or activity	No. clients
<b>1</b>	Information, Advice and Guidance (e.g. debt, housing, benefits, legal). Includes linkworker filling forms	103
<b>2</b>	Mental health and loneliness support (e.g. Bristol Wellbeing Therapies, counselling, Community Navigators)	82
<b>3</b>	Other social (e.g. reading groups, history, knitting)	55
<b>4</b>	Employment or training support	34
<b>5</b>	Physical activity	28
<b>6</b>	Volunteering	26
<b>7</b>	Courses – e.g. cooking, woodland, art	22
<b>8</b>	Befriending	16
<b>9</b>	Gardening/nature	16
<b>10</b>	Physical health – e.g. diabetes support group	14
<b>11</b>	Carers support	9

Looking in more detail, the top 10 groups/ services/support that were referred into and accessed at least once were:

- Bristol Wellbeing Therapies (36)
- Community Navigators (31)
- North Bristol Advice Centre (17)
- West of England Works (15)
- RSVP (9)
- Changes Bristol (7)
- Greenway Gym (6)
- Child Poverty Action Group (5)
- LinkAge (5)
- Tea & Tech (5)

The large list of community agencies and activities clients were supported to access indicates the importance of adopting a holistic approach to social prescribing. There is not a one-size-fits-all approach and the skill of the linkworkers is to find something appropriate to the client's individual circumstances. This also indicates the importance of time being dedicated to asset mapping the local area:

*“When we first started, we did an initial ‘map’ of activities and support in the local area, but this needs to be kept updated and we often find ourselves having to look further afield. This takes time and needs to be factored into the role rather than just as an add-on – it’s essential to the success of the service.” (Linkworker)*

*“You know everything about everything.” (Patient 1)*

The extensive asset maps collated (on an ongoing basis) by the linkworkers also highlight the importance of a locality-based approach to social prescribing. One of the main barriers to engagement that clients raised with linkworkers was that things needed to be local otherwise they would not be able to attend due to poor transport links and lack of money to spend on transport – particularly accessible transport. Lack of community transport has been cited as being an issue in project localities – thus increasing the need for the linkworkers to ensure that they have an extensive asset map of activities/groups/support that are on the doorstep of each of the *Community Webs* surgeries.

*“I have been out on shopping trips to Aldi because you sorted out the transport, meeting other people. Before I wasn’t meeting anyone new at all really! I’d still like to do more, but it’s so difficult to get around with a wheelchair.” (Patient 2)*

## Objective 2: Clients’ perceptions of referrals to community groups, services and activities

*This section refers to Objective 2 of the evaluation:*

*To examine clients’ perceptions of referrals to community groups, services and activities.*

Each client who engaged with *Community Webs* was supported to access an average of six groups/activities/support services, but only actually accessed an average of two of these by the three-month evaluation questionnaire. The most common type of support that was accessed after referral related to practical support needs (26%), followed by mental health support (21%). It is believed that this is, in part, due to clients having a clear reason for accessing the former and being able to see a direct, immediate benefit. In the project team’s experience it has been harder to encourage people to engage with activities or groups that will not show a direct or immediate benefit to the individual, as opposed to ‘services’ that help them to address pressing practical needs or to achieve something of importance to them or their family – e.g. accessing welfare benefits or carers’ support. The main type of mental health support that *Community Webs* supported clients to access was Bristol Wellbeing Therapies, which invariably involved the linkworker making the initial telephone call with the client to book in an initial assessment appointment. This approach made it more likely that clients would engage with the support, rather than just a ‘signposting’ approach of giving clients a leaflet and ignoring the barriers to

access that the majority of clients have. In contrast, the majority of the other groups/activities/support services referred to (e.g. social groups) involve clients attending of their own accord and, without the initiative of, for example, getting their welfare benefits sorted, it was more difficult for clients to commit to attending something new. It is here that having staff that could go along with clients for the first time of trying a new activity would be highly beneficial – something that current capacity does not enable. It is also difficult to introduce a volunteer to a client purely for this role as they will have built a relationship with the linkworker.

A question that has been raised when thinking about evaluating social prescribing services is whether individuals benefit most from the 1:1 support of a linkworker or from the activities/groups/support services that they are supported to access. It is clear from the evidence gained for this report that both are needed for real and lasting change – particularly when people have complex lives. An overriding theme of the exit questionnaires was that the thing that people valued most about *Community Webs* was having ‘someone to talk to’ and ‘someone to listen’. Often this meant not just someone

who listened, but someone who really heard what the individual was saying and made them feel valued.

*“I found it so helpful that I was able to talk about my problems. There’s never enough time to speak to the GP. A lot of people can’t talk to someone and it’s the only way to sort things out, to get on with things.” (Patient 3)*

This is why follow-on support in terms of relationships with others is so important – not only so that individuals do not become dependent on the linkworker to fill this role in their lives, but so that people can link with others to form a lasting support network. In social prescribing, this is done through the guise of activities and groups of people who share a common interest, but ultimately this is about bringing people into relationships with others to enable them to continue the positive changes that they have made whilst being supported by a linkworker.

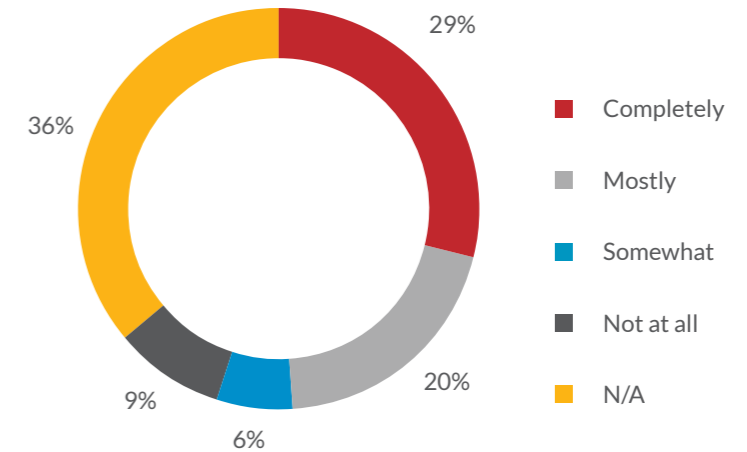
The project team has also found that many people have practical support needs that need to be addressed before they feel able to engage in groups, activities or support services that will enable them to take steps to improve their general wellbeing. If these practical support needs are not met, then attempts to address clients’ wider wellbeing will fall upon deaf ears and the individual will not feel listened to or heard. Linkworkers cannot enter into relationships with clients with their own agenda, or indeed with the agenda of their referrer. Clients need to know that they will be taken as they are with an asset-based approach – focusing on their strengths rather than purely negative aspects of their life that the linkworker will

be addressing as part of the holistic approach to their wellbeing. It is for this reason that clients are put at the centre of the service – asked from the outset what they want to achieve from the 1:1 sessions, what their priorities are, what their strengths are and what they feel that they have to contribute to society. In areas of deprivation where people have been told time and time again that they are worthless and will never amount anything, this approach can be invaluable.

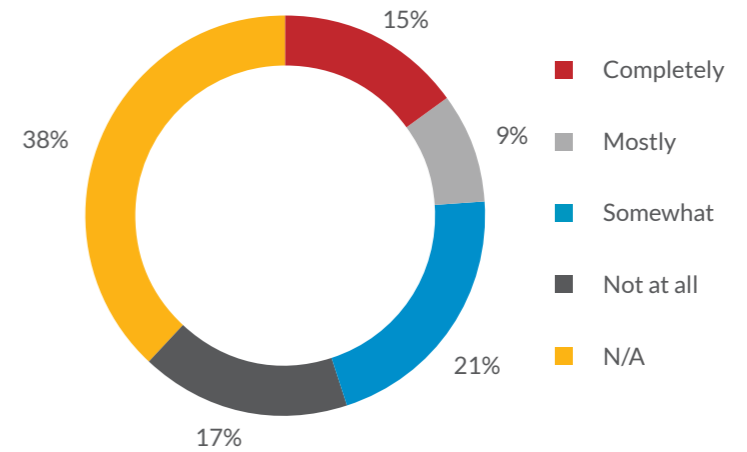
*“You explored my needs and interests. I was feeling I wasn’t good for anything. Now I feel I can take part. You listened to me and didn’t jump to conclusions or judge me like everyone else does.” (Patient 4)*

In order to assess effectiveness of the activities, group and support services referred into, we split patients’ non-medical needs into practical, emotional and social needs, asking patients during their three-month evaluation questionnaire: ‘to what extent do you feel that the groups/services/activities that Community Webs supported you to access addressed your practical, social and emotional needs?’

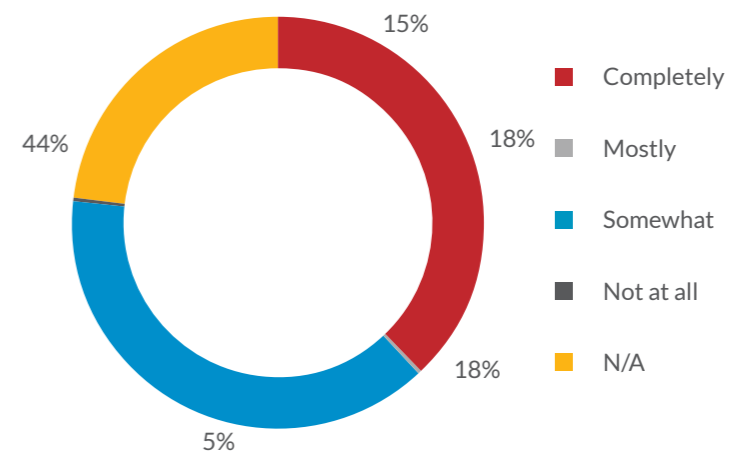
**To what extent did the services/groups/activities you accessed address your practical needs?**



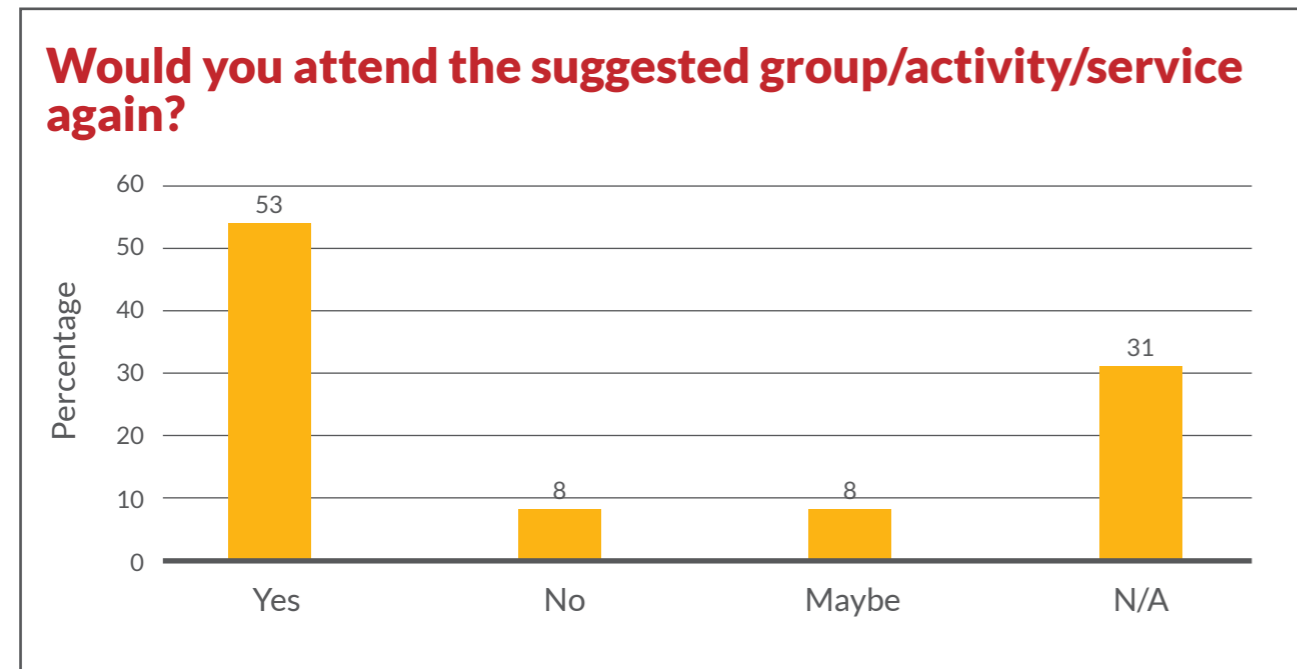
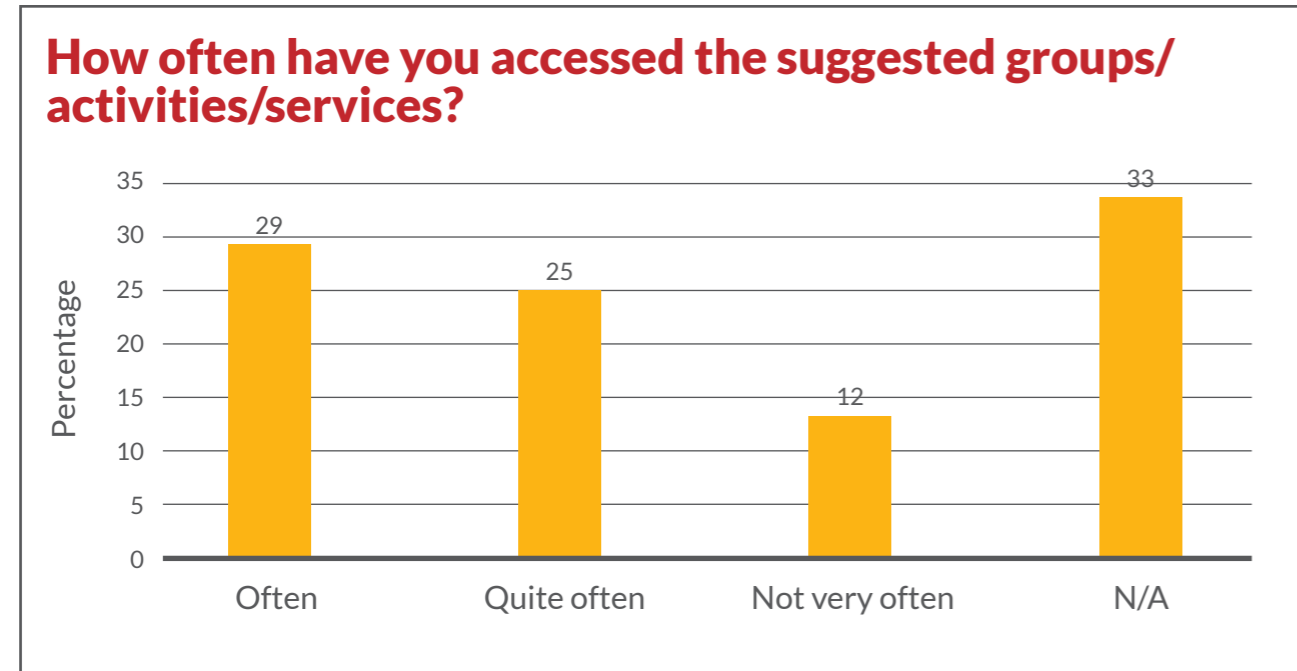
**To what extent did the services/groups/activities you accessed address your social needs?**



**To what extent did the services/groups/activities you accessed address your emotional needs?**



The positive responses on page 39 are really encouraging, particularly when looked at in conjunction with the following graphs:



The fact that, three months after meeting a linkworker, 54% of clients have continued to attend what they were supported to access ‘very often’ or ‘quite often’ suggests that clients are finding what these groups, activities and support services provide to be of benefit – supported by the evidence that the vast majority of people asked the question ‘would you attend the group/service/activity again?’ answered positively. The hope is that clients will be using these to address unmet needs that they would previously have attended their GP for, however as can be seen in objective 6, this is complex to measure. One of the concerns around a linkworker social prescribing model is that dependency would be transferred from the GP onto the linkworker. This is why these results are so encouraging, because they show that the linkworkers have been successful in supporting people to not only access but to sustain attendance at what, in social prescribing terms, are described as ‘non-medical sources of support in the community’.

It is also important to note that when it comes to attending a group, activity or support service again, and frequency of attendance, that some of those that clients were supported to access were relating to, for example, benefits advice, and therefore frequent attendance of these services would not be expected – unlike, for example, a local craft group. These figures all need to be taken in the context of groups, activities and support services often being able to address either practical, social or emotional support needs rather than all three. This was the reason for the negative responses when it came to these distinctions – no one responded negatively about the services themselves, it was more that the question wasn’t relevant and, rather than putting ‘n/a’ the respondents put ‘no’.

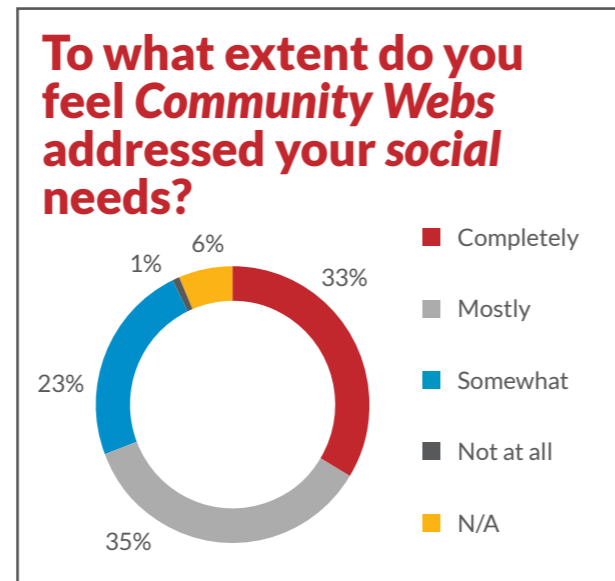
## Objective 3: Patient experiences of the linkworker service and referral support

*This section refers to Objective 3 of the evaluation:*

*To experience patient experience of and satisfaction with the linkworker service and referral support*

The charts below show the breakdown of how clients felt the service met their social, emotional and practical support needs.

91% of respondents felt that the service addressed their social support needs completely, mostly or somewhat – which is very encouraging for *Community Webs*. Some people (6%) felt that this was not applicable – mainly due to them accessing the service for practical support needs. It is also interesting how these figures correspond to reasons for referral – only 50% of clients were initially referred due to social isolation. This supports the view that social contact is incredibly important for one’s wellbeing and, even if one is not perceived to be socially isolated or see lack of social contact as a concern, any social improvement can be felt to be beneficial. In addition, addressing other support needs (practical and emotional) had the impact of people being able to focus on the social aspect of their life more, despite this not being the initial intention of them accessing *Community Webs*:



*“I didn’t need much help with social things, I see lots of people. But sorting out care for mum means I have more time to do things with friends which I’d neglected before, so that is much better.” (Patient 5)*

*“Keep up the good work. Doctors referred me and I thought it wasn’t relevant and not useful for me but actually turned out to be a great help.” (Patient 6)*

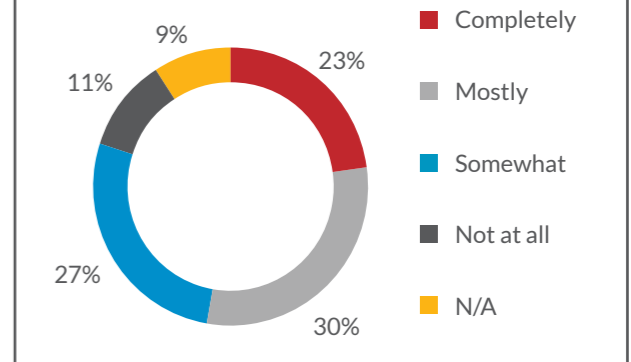
80% of respondents felt that the service addressed their emotional support needs completely, mostly or somewhat. The majority of responses were related to having someone to talk to and someone to listen:

*“We talked through my worries a lot. That’s what I really needed. I worry such a lot, and don’t know what to think. It’s really helped to tell you about what’s going on in my family.” (Patient 7)*

*“It got things off my chest, talking to you.” (Patient 8)*

However the above responses, representative of many, also raise the question of the role of a social prescribing linkworker. The team was clear that *Community Webs* was not a counselling service, however the linkworker was often the first person to whom clients disclosed major, difficult, personal and traumatic experiences. This required the linkworkers to be very skilled in these conversations, and very clear about their role. To ensure people were able to access the support that they needed, it was important that they were able to be honest with the linkworker. However this often lead to the linkworker having to ‘hold’ very difficult disclosures. To aid with this, the project coordinator provided weekly supervision to each linkworker and external group clinical supervision was also provided once a month. The project coordinator also ensured that the linkworkers knew that they could contact her at any time to offload any distress and ensure that they did not take troubling disclosures home with them.

### To what extent do you feel *Community Webs* addressed your emotional needs?



Work was also done with the linkworkers around the ‘Karpman Triangle’<sup>22</sup> which ‘shows the dance that occurs whenever we make someone else responsible for how we feel’ and which was found to be essential for preventing burnout.

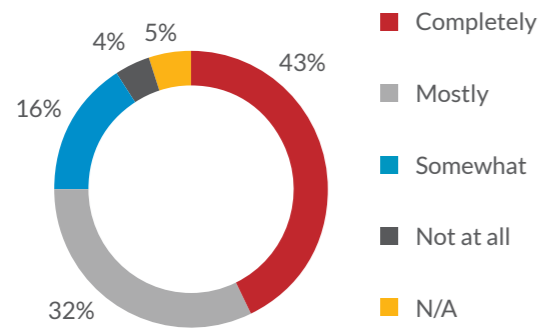
For those who responded ‘not at all’, these clients did not feel that they had emotional needs rather than having negative views of the service:

*“Good to plan together but I don’t really have those needs – I just wanted Slimming World and gym.” (Patient 9)*

*“Not really what I needed. I’m quite chipper.” (Patient 10)*

<sup>22</sup> <https://depressionsupportnetwork.wordpress.com/2008/03/27/the-drama-triangle-and-the-winners-triangle/>

### To what extent do you feel **Community Webs** addressed your practical needs?



75% of respondents felt that *Community Webs* addressed their practical support needs. This ties in with feedback from the linkworkers that people were more responsive to the service when they had practical support needs. These were short-term pieces of work which could have a clear outcome for clients – as opposed to work around emotional and social wellbeing which ultimately needed to come from the client and will take longer for clients to see benefits from.

The clients who responded negatively or ‘somewhat’ either:

- did not have practical support needs,
- had practical support needs that required a waiting time before the issue was resolved, or
- had very complex practical support needs that a 4-week injection of support would not be able to completely address.

When asked ‘*what are the good aspects of our service*’, the main themes that came out were:

1. Knowledge of the local area and support available
2. Having unhurried time to talk and someone to listen
3. Help to make sense of the confusing nature of statutory services, benefit systems etc.
4. Non-judgemental
5. The introduction of hope

*“You listened to me and didn’t jump to conclusions or judge me like everyone else does.” (Patient 11)*

*“You’re really helpful and kind. You get on and get me organised, even all the horrible things that I’m freaking out about!” (Patient)*

*“One ray of hope is like oxygen when you’re depressed.” (Patient 12)*

Patients most commonly described having someone to talk to as the main positive of the service. Being linked into community services which they were unaware of and going out to take part in activities when they had previously been socially isolated were other benefits experienced. Some patients described better wellbeing and transformative outcomes after accessing *Community Webs*.

From clients saying that ‘*it was nice to have someone to talk to*’ and ‘*it was nice to have someone to listen to me*’, we glean two things:

1. The importance of relationships to wellbeing and the impact on one’s physical and mental health when relationships are not present
2. What clients really yearn for is to have someone to truly ‘hear’ what they are saying – which is what clients seem to mean when they celebrate being listened to.

The holistic and person-centred nature of the service was also celebrated by clients:

*“Until now I’ve only had support on coping with my medical conditions, but with this service it has opened my eyes to the possibilities that are out there for me.” (Patient 17)*

*“You allowed me to talk about what I actually want, not what people think I want. You believed in me.” (Patient 18)*

*“With these meetings I have achieved more than I have over the last five years. As until now I haven’t spoken to or seen anybody to give advice and guidance on where to look. The service has provided somebody with whom to talk and given details on the different support groups available.” (Patient 13)*

*“Being able to talk to someone. [Linkworker] explored my needs/interests. I was feeling I wasn’t good for anything. Now I feel I can take part in cooking/reading/walking groups and engage more.” (Patient 14)*

*“It’s got me going out and doing other things. She’s really good... I was becoming a bit of a hermit. I’m mixing more now, going out and doing things.” (Patient 15)*

*“Even though it has only been a few visits I feel my life has purpose again and for that I thank you.” (Patient 16)*

This highlights the asset-based and person centred approach of the *Community Webs* service. The linkworkers focused on the positive parts of the client rather than the negativity that is prevalent in their lives. The initial conversation always began with the linkworker asking the client ‘*what’s good about your life at the moment, what are some of the positives?*’ rather than delving directly into the negatives (which is what many clients expect, and are a therefore little surprised by this approach). The linkworkers also challenged clients when it came to making changes – especially when clients did not see themselves as having anything to give to society.

Some of the ways in which *Community Webs* did this were:

- Thinking about ‘wellness’ not ‘illness’ – finding ways to stay well and to prevent becoming ill  
*Providing tailored and person-centred support because we start with the person not their condition or illness*
- Exploring causes not symptoms – thinking about why things happened in the first place rather than focusing on what has happened.  
*Addressing psychosocial or economic factors that impact on wellbeing*
- Harnessing personal and community assets – helping people and communities developing their own strengths and abilities to live independent and fulfilling lives
- Providing ‘additionality’ to primary care – making new and different resources available
- Promoting different perspectives, new ways of thinking and in turn new ways of doing
- Giving space for a collaborative exploration of any given opportunity to improve and maintain health and wellbeing – increasing the control that patients have over their lives, treatment and decisions  
*Doing ‘with’ not ‘to’ or ‘for’ a person*



## Box 2: Understanding people’s needs – A client’s perspective

“I have lived in the south of Bristol for nearly 40 years. The area is fine with no real social issues which bother me. I have a number of friends which I see intermittently and family as well. I have been struggling with a number of issues for some time and didn’t feel that I could really speak to anyone about them. When a practical problem arises I didn’t know how to sort it out and I think I was suffering from a lack of confidence (my interpretation from what she said). I was referred to the *Community Webs* project by my GP as a result of being in a state of shock and traumatised from a serious domestic incident and also from other previous bad thing that happened to me. I was in bad way, a sort of detached fog. [A linkworker] from the *Community Webs* project has helped me to realise that if I take things in ‘baby steps’ as she puts it that I can actually do more for myself than I had originally realised. I now feel more motivated and capable than before I met [the linkworker] – they have been great. I like their mind-set and they are easy for me to get along with. I am now thinking that I might try some voluntary work with a friend of mine who works at a hospice, as I am feeling like the strings holding me back have been cut.”

*“You’ve helped me understand things somehow, to get through the muddle. I’ve wanted to join the gym and talk to someone (do counselling) for ages – I now I need to – but it’s difficult to make yourself do it. I needed someone to help get me going, and you’ve done that. Thank you.” (Patient 19)*



## Objective 4: GP and practice staff perceptions of the service

**This section refers to Objective 4 of the evaluation:**

To explore GP and practice staff experience of and satisfaction with the Navigator service and referral support

GPs and practice staff are overwhelmingly positive about the *Community Webs* service – as evidenced by the sustained high level of referrals across all participating practices. Out of the 33 GPs who completed the satisfaction questionnaire 8 months after the project began receiving referrals, 100% who gave an opinion stated that they were ‘very satisfied’ or ‘satisfied’ with the service (21% stated ‘not applicable’ or ‘don’t know’ due to not feeling that they had made sufficient use of service to be able to judge). One thing that was highlighted in particular by GPs about the service was the direct benefit that they saw to patients, with comments from GPs such as:

*“Excellent service with very good feedback from the patients I referred.”*

*“Great service and great feedback.”*

*“Patients report high levels of satisfaction and are very happy.”*

*“Brilliant service for patients who seem very happy with it.”*

These comments all tie in with the overriding theme of GPs valuing the service because it allows them to use their time more appropriately. GPs realise the limitations of their ability to support patients in a fully holistic way, and appreciate that they cannot expect patients to concentrate on their health when they have pressing social issues (e.g. housing, debt) going on. There is a public perception that the NHS is focused on health, despite it being set up to address illness. However health is linked to a wide variety of things, and nowadays patients have a plethora of concerns that cannot be solved in a consulting room.

*“I have found it extremely useful to have a service such as yours to refer to. It has saved time allowing me to focus on clinical aspects of care more. Thank you and I do hope that this service can continue!” (GP 1)*

*“Provokes patients to think about their “real” needs as opposed to perceived worries.” (GP 2)*

It has been noted that this is largely due to the in-depth local knowledge held by the linkworkers – knowledge that GPs are unable to hold due to the vast amount of medical information that they need to be able to call upon, and due to the ever-changing landscape of the VCS. Linkworkers can keep on top of all of this, meaning that GPs can see them as a single-point of contact for all non-medical support needs.

*“I think [linkworker] has done a great job. She obviously knows the local area and systems. Her advice on benefits has been particularly high quality I have noticed. She has made lots of effort to meet the team and promote the service which has been excellent.” (GP)*

The fact that GPs value the service is evident by their fear of losing the service:

*“Community Webs has been helpful and I would be very sorry if we were to lose this service.” (GP 3)*

GPs need for the *Community Webs* project was put down to time saving and skills use as well as the inability to keep track of local resources that can help with patients’ non-medical needs and the lack of capacity for the handholding required to help patients access community services. Respondents also spoke of how because referring patients to *Community Webs* frees up GP time this provided benefits for the wider health service by increasing the capacity to deal with medical health issues.

*“I think it’s saving the GPs time and also their skillset. We as the tax payer here have invested so much money training these GPs up to be experts in what they do I wouldn’t want them to see it being it wasted by them having to discuss housing with someone when someone else can do it. I would want them to be diagnosing an illness that no one else can do.... that’s what they’re trained in.” (Key Stakeholder)*

*“Oh I just think it’s a gold service I really do I think it just opens up and it links to so many other things that we don’t get the time and we can’t keep up with everything that’s available in the local community centre ‘cos things change you know rapidly... it’s just another option that we’ve got we can’t possibly have that level of knowledge... you know generally in the practice you have an idea, you get emails from different organisations saying we’re doing this that and the other so I’m aware of some of them but obviously not all of them at all. You know probably 10% compared to what they’re [linkworkers] aware of.” (Practice staff)*

One respondent was of the view that the health service is increasingly the one place where people can get help but that it cannot improve health in isolation, so linking up with community provision is considered to be important.

*“We think it’s absolutely essential because the truth is that where I sit in a doctor’s surgery we know that patients struggle to get doctors’ appointments we also know that - we think that 20 per cent roughly of the appointments that we give are actually for patients that don’t need them, they just think they need them and they don’t know where else to go, so for us the power of this project is to place those patients where they need to be to create capacity behind them for the appointments that are now free for those who are truly poorly and the truly ill that need to see a doctor.” (Key stakeholder)*

*“It’s a terribly important step forward, the health service is not going to heal everybody’s ailments by itself and yet we’re the only port of call now with so many other more possibly better ports of call being withdrawn.” (GP 4)*

Many GP respondents commented on the improvements being made for individuals following referral to *Community Webs* – including prevention of homelessness, reduction in social isolation and improvements in mental health.

*“I think it’s incredibly positive and really makes a huge difference to those people who like I say might not be able to support themselves in terms of getting themselves to Citizens Advice, can’t get that advice and potentially could end up really in a very bad way in terms of their mental health and in terms of their tenancy. They could end up homeless, you know, it really is a positive impact and just the knowledge that people have that they could potentially be referred to and it’s another safety net in a world where there are very few at the moment.” (Practice staff)*

*“... it was actually me who referred her into the scheme and she came to see me for something completely different. I helped her fill in a form poor thing and she’d just lost her partner and she was very concerned about financial ability so I referred her to [linkworker] and she’s attended appointments. She was taking anti-depressants at the time so you know life was really tough for her... she attends a local bereavement counsellor in the area that [linkworker] set up for her. She also attends another community-based project for isolated patients so, you know, that’s two community groups that she now goes to, she’s off the anti-depressants and she just looked really happy.” (Practice staff)*

Some respondents reported reductions in *Community Webs* patients accessing appointments in general or for non-medical issues based on observing the reasons for accessing GP appointments whilst patients were working with *Community Webs*, monitoring patients’ progress through the *Community Webs* service and anecdotal evidence. The project steering group meeting was told of a GP describing not receiving feedback from patients referred to *Community Webs* because he never sees them, which was seen as a light bulb moment for the GP - the implication was that this suggested *Community Webs* was working.

*“... the handful that have come back and said the agency has been helpful, have come back with - because I’ve sent them to [linkworker] and they’ve come back for the medical reason not for the social.” (GP 5)*

*“So it was interesting that [linkworker] and I sat down last week as I said and did this update and I was looking at the patients’ screens at the same time and it was really clear to see the majority of these patients either haven’t attended at all since seeing [linkworker] or have attended, but for medical only purposes. That was a very - that was a huge positive moment to be able to see, you know, the proof of that.” (Practice staff)*

Respondents described *Community Webs* as being a resource for GPs to use where such resources are few and far between or not available, as well as offering patients an alternative to visiting their GP.

*“Oh I think it’s great, I really do... it’s that light bulb moment, ah we’ve got this [Community Webs], fantastic because I didn’t have it or know what else to do. I’ve got my standard five things probably CRUSE for bereavement, Silverline for telephones for elderly people, you know you haven’t got many other things - there’s Princes Trust that’s it, nothing else to offer people and because they’re well known everyone’s patients have probably heard of them as well anyway so I’ve got nothing new to signpost them to that hasn’t got a huge waiting list.” (GP 6)*

*“I think it’s given us the awareness and the confidence to be able to say you know we’re trying to de-medicalise what’s going on, if that’s a word, but you know that we can offer something else and you know there are other ways of dealing with the issues that you’ve come with.” (Practice staff)*

## Objective 5: Associations between the service participation and client outcomes

*This section addresses Objective 5 of the evaluation:*

*To assess whether referral support had an impact on patients’ social isolation, wellbeing and other key outcomes.*

The client questionnaire used two scales to measure loneliness: the De Jong Gierveld 6-Item Loneliness Scale (Gierveld and Tilburg, 2006) and the University of California at Los Angeles (UCLA) 3-Item Loneliness Scale (Russell, 1996). On both scales at baseline

when the patients are referred to *Community Webs*, a majority score highly for loneliness. On the De Jong Gierveld 6-Item Loneliness Scale the mean score for those completing it was 4.67 and the modal score was 6 (n=129).

### Baseline De Jong Gierveld 6-Item Loneliness Scale

Pre-support, the questionnaire showed a clear skew to high scores for loneliness. Cross tabulation analysis suggest that there are no significant differences in loneliness scores between men and women, the area of the CW scheme, age or race/ethnicity.

**Table 7: Baseline De Jong Gierveld 6-Item Loneliness Scale (n=129)**

De Jong Gierveld Loneliness Scale Score	Percentage	Number
0	1.2	3
1	2.0	5
2	4.9	12
3	2.0	5
4	6.1	15
5	14.2	35
6	21.9	54

Least lonely      0      1      2      3      4      5      6      Most lonely

**Baseline UCLA Loneliness Scale**

There is less skew on the UCLA scale for loneliness. Thus the scores skew less to high scores. One of the main criticisms of the full UCLA scale is that it was developed in the USA with students – and therefore may not be suitable for a UK context or use with older adults. Again there are no significant differences in the UCLA loneliness scores between men and women, the area of the *Community Webs* scheme, age or ethnicity.

A third wellbeing measure included in the questionnaire is the Short Warwick-Edinburgh Mental Well-Being Scale (SWEMWBS). The scale was developed to enable the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. At baseline the mean score for those completing the questionnaire (n=131) was 16.69 which is lower than the UK average 23.6; suggesting that those referred are likely to report lower rates of wellbeing than the adult population as a whole.

**Table 8: Baseline UCLA Loneliness Scale**

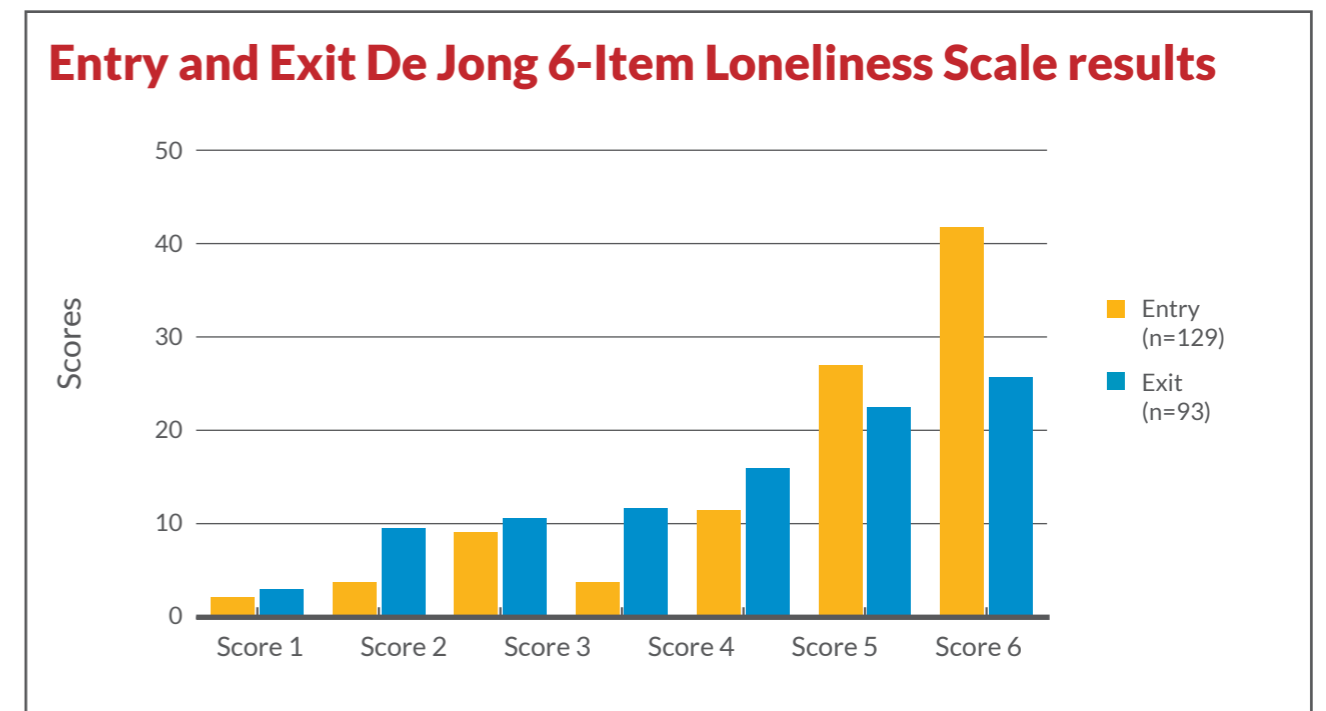
UCLA Loneliness Scale Score	Percentage	Number
4	1.2	3
5	3.6	9
6	4.0	10
7	4.9	12
8	5.7	14
9	7.7	19
10	7.7	19
11	8.9	22
12	8.5	21

Least lonely    0    1    2    3    4    5    6    Most lonely

**Entry and Exit De Jong Gierveld 6-Item Loneliness Scale**

When patients complete their time with *Community Webs* they are invited to complete the questionnaire again on exit. The table below compares the patient entry and exit scores on De Jong Gierveld 6-Item Loneliness Scale. The mean scores show an improvement in Loneliness Scale mean scores from 4.67 to 3.99. A paired samples t-test was conducted to evaluate the impact on loneliness.

There was a statistically significant decrease in De Jong Gierveld 6-Item Loneliness Scale from baseline (M=4.67, SD=1.62) to exit (M=3.99, SD=1.79),  $t(69) = 1.42, p < 0.000$ . The mean decrease in De Jong Gierveld 6-Item Loneliness Scale scores was 0.68 with a 95% confidence interval ranging from 0.282 to 0.805. The eta squared statistic (0.30) indicates a large effect.

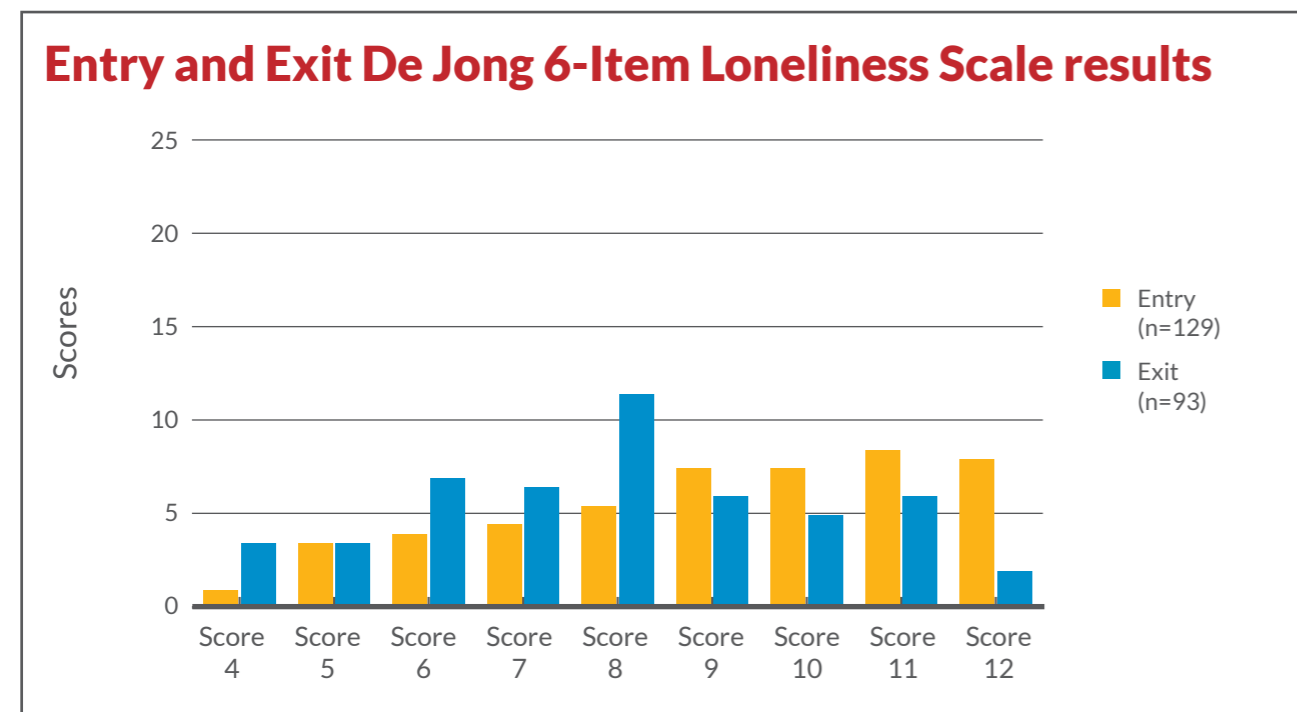


### Exit and Entry UCLA Loneliness Scale

Examining the UCLA Loneliness scale scores we see a similar change. The mean scores show an improvement in Loneliness Scale mean scores from 8.83 to 7.98. A paired samples t-test was conducted to evaluate the impact on loneliness. There was a statistically significant decrease in the UCLA Loneliness Scale from baseline (M=8.83, SD=2.33) to exit (M=7.98, SD=2.15),  $t(5.23) = 0.85$ ,  $p < 0.000$ . The mean decrease in UCLA Loneliness Scale scores was 0.85 with a 95% confidence interval ranging from 0.526 to 1.17. The eta squared statistic (0.37) indicates a large effect.

Looking at the SWEMWBS, we again see an improvement on all the wellbeing items at exit. A paired samples t-test was conducted to evaluate the impact on wellbeing. There was a statistically significant improvement in the SWEMWBS from baseline (M=17.4, SD=6.40) to exit (M=20.49, SD=5.13),  $t(-7.46) = 3.35$ ,  $p < 0.000$ . The mean increase in SWEMWBS Scale scores was 3.35 with a 95% confidence interval ranging from 4.248 to -2.462. The eta squared statistic (0.57) indicates a large effect.

The impact of the CW programme seems to be sustained into medium term. Follow-up questionnaires (n=41) have been completed at three months. These show continued improvement at least amongst those who completed the questionnaire at a three month follow up. However the sample size is too small to undertake any meaningful comparisons with baseline entry and exit questionnaires.



### Comparing means on scales to three-month follow-up

Looking at CW patients' community engagement data we again see some increase in membership of organisations like political parties, religious education, sports clubs etc. On the whole most people are not members of any organizations. At entry patients were members of on average 0.31 organisations, at exit 0.54 and three months 0.8. A similar pattern emerged in terms of volunteering with very few people volunteering for any organisation. With volunteering per person rates at: 0.36 at entry, 0.44 at exit and 0.46 at three months. Similarly the intention to volunteer in the future has grown with 24% (n=30) on entry, 27% (n=25) on exit and 32% (n=13) at three months.

**Table 9: Baseline UCLA Loneliness Scale**

Scale	Entry Mean (n=129)	Exit Mean (n=93)	3-Month Mean (n=41)
De Jong Gierveld 6-Item	4.67	3.99	3.46
UCLA Loneliness	8.83	7.98	7.59
SWEMWBS	17.04	20.49	22.07

## Objective 6: Clients' perspectives of self-care approaches

*This section addresses Objective 5 of the evaluation:*

*To gain feedback on client perspectives of self-care approaches that are prompted, attempted and/or sustained*

A theme evident during the linkworkers' 1:1 engagement with clients was the desire to be 'rescued' and a lack of desire and/or self-perceived ability to take control and ownership of their own health and wellbeing. This may be symptomatic of the areas in which the team are working, which are likely to be classified as 'areas of multiple deprivation', and contexts of significant social exclusion.

Self-care measures that have been taken up by *Community Webs* clients relate heavily to mental health difficulties – evidenced by the vast number who were supported to access Bristol Wellbeing Therapies (11% of those seen by a linkworker). The fact that 44% of all referrals were linked due to 'low confidence and self-esteem' helps to explain this high rate of onward referrals. The linkworkers found that they often saw people who disclosed previously undiscussed traumatic life experiences, for which they had never considered accessing help. Having the option to explore this further, through a supported referral, was seen as an achievable thing for people, however perhaps this was also due to the fact that it still fed into the idea of getting support from 'professionals' to 'fix' a problem, rather than using self-care skills.

This links to arguments that the term 'social prescribing' itself is problematic because it doesn't imply 'working with' rather it still sounds like 'doing to' or 'for'. So this language does not easily support a rebalancing of the relationship between patients and practitioners, nor does it create any sense of increasing patient autonomy and power, which is deemed a necessary step for real success. Marmot puts this well in *Fair Society, Healthy Lives* (2010)<sup>23</sup> where he in effect identifies social prescribing as an: 'approach [that] facilitates greater participation of patients and citizens and support in developing health literacy and improving health and wellbeing.'

The low self-esteem of the clients accounting for the majority of referrals linked to *Community Webs* is telling of the feelings of inability of many residents of areas of multiple deprivation to take control of their own health and wellbeing. This is why *Community Webs* was established to start with – because people did not have the confidence to make decisions affecting their wider wellbeing and don't feel like they are of any worth.

23 <http://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf>

*'She [linkworker] explored my needs and interests. We talked about what I actually want, not what people think I want. She believed in me. I was feeling I wasn't good for anything. Now I feel I can take part.'* (Patient 20)

The responses relating to the question 'where would you go if *Community Webs* wasn't available' (asked at exit and 3-months post-exit) are encouraging when looked at from this perspective. They show that after contact with *Community Webs*, clients are more likely to access places other than their GP for help and support – thus showing that their networks around self-care have grown. The growth of the 'other' category is also encouraging, as along with stating that this was chosen as an option 'to be referred back to *Community Webs*', clients also cited that this was to mean that they would find the resources within themselves to address their problem.

The data that the team have collected around self-care is encouraging, although limited due to the fact that the linkworkers only asked this set of questions to individuals who suffered from long term conditions – and even then the resulting data collection was patchy. However, from the responses that the team do have for entry and 3-month post-exit, we can ascertain that *Community Webs* has had a positive impact on primary care patients' approach to self-care, as 100% of clients who responded felt that they had done things differently to take control of their own health and wellbeing since referral to *Community Webs*, and 100% of these clients felt that they would continue to do these things.

*"Thank you for your help and support. I came away thinking I can do things on my own. It's good that the service is there, knowing it's there helps."* (Patient 21)

*"I'm starting to make changes for the first time."* (Patient 22)

Feedback from the linkworkers suggests that they often incorporate advice around self-care into their 1:1 work with clients – particularly for those who feel very 'stuck' and are highly reluctant to engage in other sources of support. This has involved suggestions around journaling, diet, exercise, basic mindfulness and coping strategies. One client voiced her appreciation of exploration of the latter:

*"I feel loads better, in the last 4-5 days I haven't self-harmed or anything. It really helped me to know I could come here and talk. Now I know I can call a phone help-line and speak to someone too."* (Patient 23)

*"He gave me options that I hadn't thought of and helped encourage me that I can do it."* (Patient 24)

Another client noted further self-care strategies they were now implementing as a direct result of the input of *Community Webs*:

*“I’ve made changes in my lifestyle – more balanced now. It’s difficult because my mother has dementia and needs caring for, but I’m sticking to not doing too much, so that I don’t get ill too. I feel happier, I’m sleeping better, my sons tell me how much better I look.” (Patient 25)*

Linkworkers have also used the Wellbeing College courses run by Second Step (part of Bristol Mental Health) to support people to access groups around self-care. They have found that most individuals are reluctant to access groups however, and two courses around coping strategies for common mental health problems were cancelled during the autumn term because of low numbers signing up. This had a negative impact on those clients who had signed up, as it had been a big step for them to access help in this way. In light of this, and to address the difficulty that many clients have in engaging in self-care (both due to low self-esteem and due to a lack of knowledge) Southmead Development Trust are currently engaging with the Recruitment and Student Liaison Coordinator from Second Step’s Wellbeing College to build on the partnership that we already have with Second Step and to potentially provide courses specifically for clients who have met with social prescribing linkworkers.

For the purposes of *Community Webs*’ referral criteria, the team incorporated ‘diet and exercise’ into self-care. *Community Webs* has supported 11% of clients to engage with physical activity through a variety of means. The team were keen not to just have a ‘one size fits all’ approach to physical activity, which is why clients who were inactive were given a number of different options to increase their activity levels – from formal exercise on referral programmes to specialist classes for older and frailer people, cycling courses, walking groups, couch 2 5K programmes, general exercise classes or community exercise groups to name but a few. The aim was to move away from the idea that physical activity is something that must be done in a gym, and our linkworkers worked with clients to find ways that they could incorporate physical activity into their daily routine. Although significant progress has often been slow (due, in part, to the complex nature of people’s lives and the other challenges people were working hard to address), it is encouraging that the number of people engaging in 30 minutes of exercise more than 3 times a week increased from 7% at entry to 48% at 3-months post-exit after *Community Webs*’ involvement. However it is important to note that the data sample for returned 3-month post-exit questionnaires was much smaller than that for entry, so these results may be skewed.



With regard to diet, 4% of clients were provided with 12 free weeks’ worth of Slimming World/Weight Watchers vouchers by linkworkers. The most encouraging feedback given around this particular intervention (in addition to the support provided by the linkworker) is not only the weight lost, but the social aspect of meeting with others in a similar situation each week.

*“I now feel happy. Having support from others who were struggling with similar things has helped to build my confidence again. The old me has come back.” (Patient 26)*

## Objective 7: Mechanisms for gathering data on GP service usage

*This section addresses Objective 7 of the evaluation:*

*To explore mechanisms for gathering data on GP service usage and monitor early/possible effect on GP service usage by referred patients, to identify future potential for the service to reduce this longer-term*

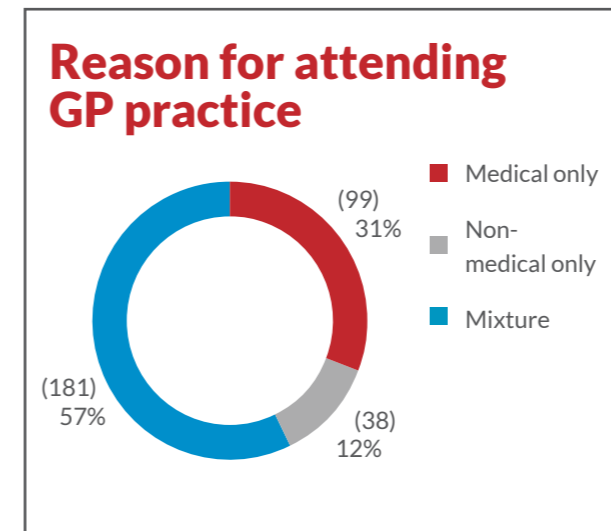
Early on in the pilot it became evident that GPs/practice staff do not currently have a way of recording presentations for non-medical issues, bar what the GP writes in patients' EMIS notes. This was surprising given that a figure of 20% is often given as being the percentage of patients who attend their GP practice with non-medical support needs – however the Citizens Advice Bureau study that this emerged from<sup>24</sup> based this on a survey of GPs rather than data from GP computer systems. Something that the team also did not know was whether these patients who presented with non-medical support needs also had medical support needs (in which case they would be coming to the GP anyway), or whether they were purely coming to the GP practice asking their GP to help them with things like welfare benefit forms.

In order to gain some clarity on this, the team decided to include a question on the referral form of 'why did this patient attend the GP practice today? Medical, non-medical or a mixture.' All of those referred to *Community Webs* would have non-medical support needs, however it is interesting that, as the chart below shows, the majority also had medical support needs (therefore a 'mixture'):

Yet stating that these patients would come to the GP anyway regardless of having an intervention like *Community Webs* or not and would therefore not save GP time misses the point. Having somewhere else to direct these patients for their non-medical support needs frees the GP consultation time up to focus on the medical side of things that the GP is trained to deal with.

*"I have found it extremely useful to have a service such as yours to refer to. It has saved time allowing me to focus on clinical aspects of care more. Thank you and I do hope that this service can continue!" (GP 6)*

GPs realise the limitations of their ability to support patients in a fully holistic way, and appreciate that they can't expect patients to concentrate on their health when they have pressing social issues (e.g. housing, debt) going on.



The team have ensured that the referral code '8T09' is used on EMIS when a patient is referred to *Community Webs*. However, as the above chart shows, this does not record whether a patient attended with non-medical reasons – merely that they accepted the support of *Community Webs*. There will be a great number of patients who this misses – either because they were not offered the service or because they refused a referral. Again, there is no data on this latter point but it would be interesting to know how many patients did indeed refuse a referral. From our interviews with GPs, one GP suggested that it was approximately 50% of those that she suggested the service to.

The team have the potential to use the 'Search and Report' function of EMIS to look at GP practice attendance for those who have been referred to *Community Webs*, however as one can expect this will not tell the whole story – particularly so early on in the life of a project.

There are many reasons why GP attendance for particular patients may have increased or decreased, such as:

- Newly diagnosed medical conditions
- Medication reviews
- Improvement or decline in long-term condition
- An increase or decrease of support from family, friends or carers
- A change in GP staff who patients may have built positive or negative relationships with

The only way of knowing for certain whether there has been a reduction in patients attending the GP practice with non-medical support needs is by reading through each patient's individual EMIS notes – something that the evaluation team was unable to do in the timescale and resources of the project. This also relies on the GPs recording comprehensively the reasons why the patient attended the practice – a big ask when their time is already stretched and EMIS notes are very minimal.

It is for this reason that the team asked recipients of the *Community Webs* service at exit and three-months post-exit the following question: 'If you were in a similar situation again to that which you were in when you were referred to *Community Webs* and *Community Webs* wasn't available, where would you go for help and support?' Knowing that all respondents would previously have gone to their GP (hence them being referring to *Community Webs*), the results are encouraging:

<sup>24</sup> [https://www.citizensadvice.org.uk/Global/CitizensAdvice/Public%20services%20publications/CitizensAdvice\\_AVery-GeneralPractice\\_May2015.pdf](https://www.citizensadvice.org.uk/Global/CitizensAdvice/Public%20services%20publications/CitizensAdvice_AVery-GeneralPractice_May2015.pdf)

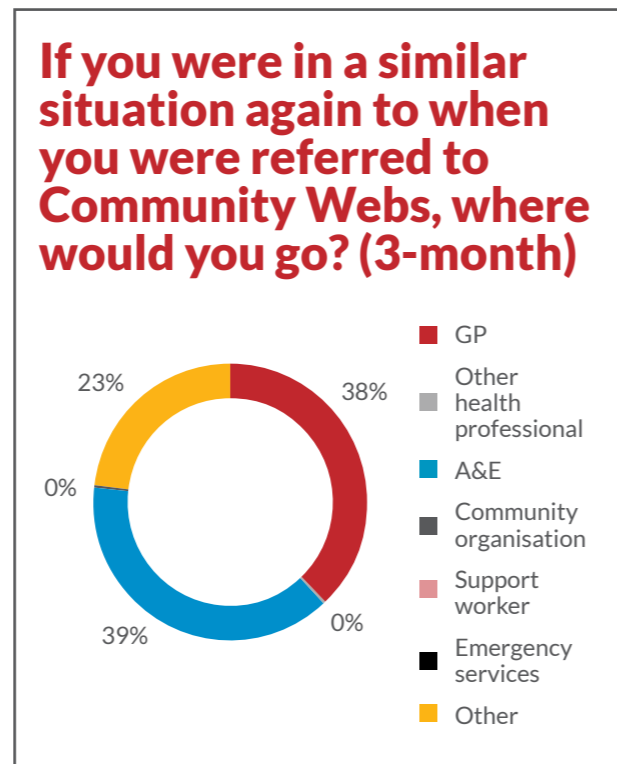
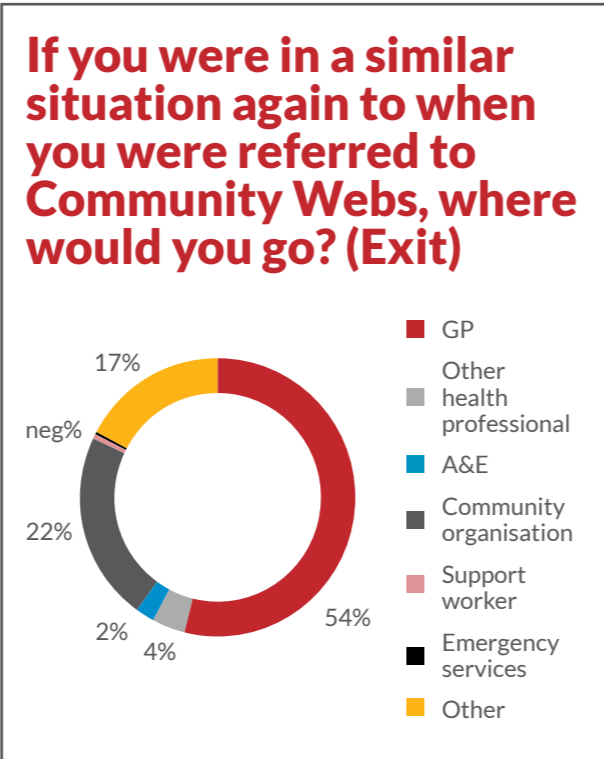


It is very positive that at exit 22% of respondents cited that they would go straight to a community organisation, and by 3-months post-exit this had increased to 39%. In addition, it is worth exploring the 'GP' and 'other' response. All of those who answered 'other' noted that this meant that they would contact the *Community Webs* linkworker directly. The vast majority of those who stated 'GP' did so because they felt that this would ensure that they were referred back to the *Community Webs* linkworker or to a similar service (should this service not be available, as the question suggested). The sustained behaviour change seen by the 3-month chart is really encouraging. This is highlighted by a response by a GP when a practice manager asked him how he thought the service was going as:

*"I'm not too sure. I was hoping to ask [patient x] how he was finding it, but I haven't seen him recently – he used to come in all of the time."* (GP 7)

The GP then realised what he was saying, and confirmed that he did indeed think that *Community Webs* was working well.

The referral data certainly shows that there is a clear need and appetite (amongst both GPs and patients) for a service like *Community Webs*.



## Objective 8: Mechanisms for gathering data about community service usage

*This section addresses Objective 8 of the evaluation:*

*To identify mechanisms for capturing information about local voluntary and community sector services, for long term use by GP and practice staff, for non-medical referrals and for patient self-referral*

One of the first tasks of each of the linkworkers when they came into post was to 'asset map' activities, groups and support services in the local area. Initially this was done around the 'basket of conditions' which fed into the referral criteria (bereavement, practical support needs, mental health, exercise etc.) However once the linkworkers began seeing patients it soon became clear that the asset mapping would need to reach further than this and be a continuous activity. This was due to:

- The holistic, person-centred approach that the service took. Linkworkers did not rely on the reason for referral as being what the person actually wanted support with, and found that this could be different to what the GP suggested. This approach is highly valued – one client stated on his exit questionnaire that *'the most important thing was that you asked what MY needs were.'* Therefore people who accessed the service had a wide variety of support needs which often could not be predicted.
- The team took referrals based on whether someone was registered with a particular GP practice, rather than where they lived. This meant that those referred sometimes lived at quite a

distance from the referring surgery – something experienced in particular in Southville whereby many patients lived in Knowle West.

- The VCSE is rather 'fluid' and, as such, groups come and go – particularly when they rely on small 'pots' of funding or enthusiastic individuals to run them. It is interesting to note that we have found that the groups that are the most reliable long-term are those run by people within the community rather than by external organisations. However it is still important to check that these groups are still running at the same time/day. This is where the linkworker being truly embedded within the community really helps, as it means that they become the person who is told about any changes to activities, or any new groups that are set up.

However, this also shows it may be unrealistic for practice staff to have a resource that is kept up-to-date and is comprehensive enough for the vast variety of patients that visit the practice every day. This is why having a 'go-to' person such as a linkworker as a single-point of access at a GP practice is so valuable. Some additional things that we have trialled through this pilot however have been:

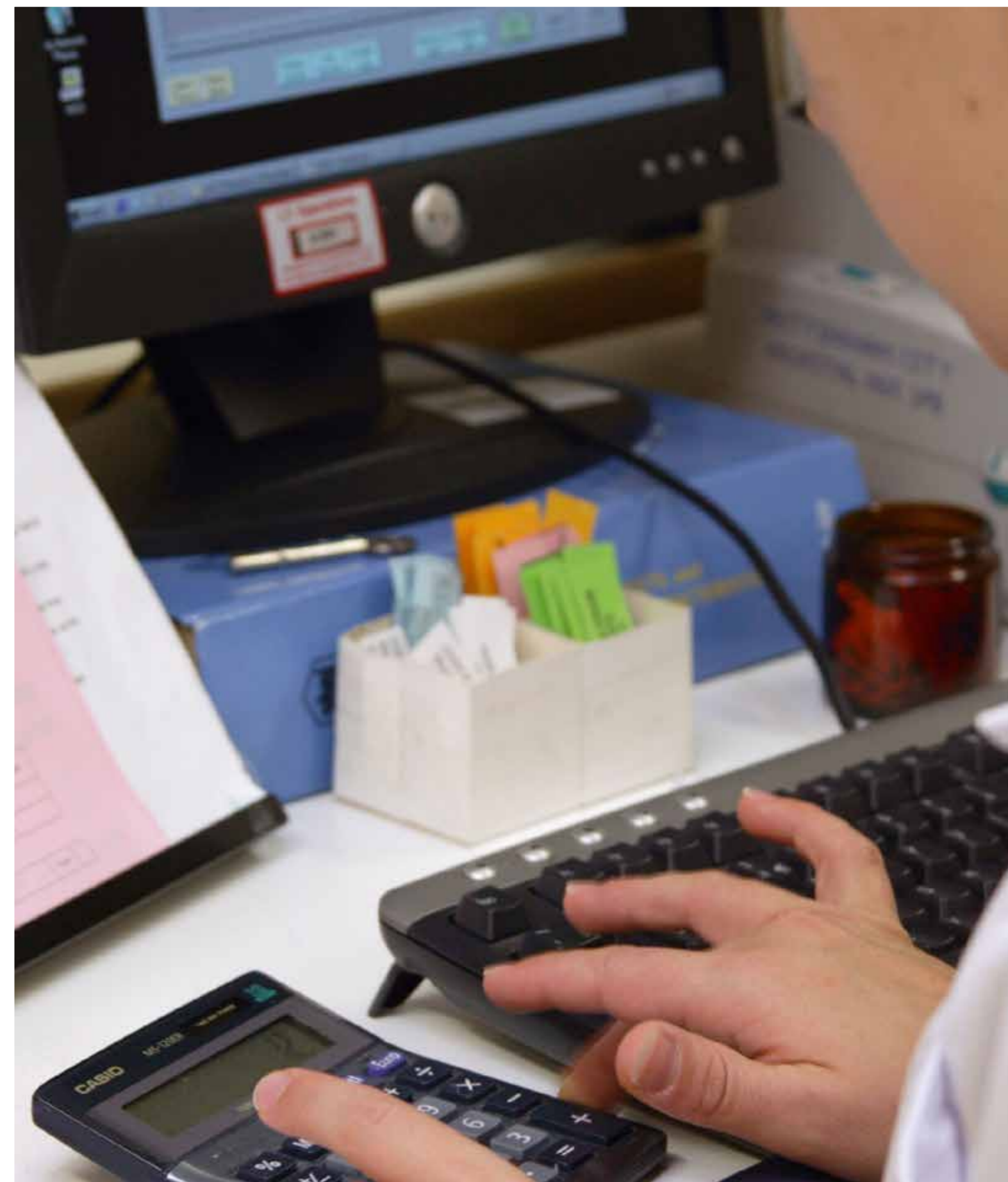
- The linkworkers providing reception staff with a 'folder' of the most often used activities/group/support, broken down into categories. This has worked well at The Greenway Centre in Southmead and at Malago surgery in Southville/Bedminster, however it is difficult to keep updated in its paper format. There would need to be a dedicated person within the surgery who would keep this updated
- Being involved in the redesign and development of 'WellAware' – an online database. Despite this not being as comprehensive as one would wish, we are working closely with The Care Forum to improve this and to input asset mapping data that we have collected onto this
- Working closely with other 'navigators' and with Public Health to reduce the repetition of asset mapping and to pool resources/energy
- Using a 'shared folder' through SDT's computer system so that all health and wellbeing staff can access the asset mapping documents and update as/they see fit. This mitigates against paper versions becoming outdated and new versions needing to be printed as soon as something is changed

- Ensuring good links with Community Resource Leads to ensure that they are able to build on the good links with local community organisation, feel able to contact social prescribing linkworkers when they have queries about patients and have good supplies of leaflets and posters for boards in the reception area.

### Mechanisms for gathering data on usage of social care packages

Of the people who completed the 3-month post-exit evaluation questionnaire (where questions regarding receipt of care packages were asked), only 1 respondent was receiving support to live at home in February 2017, and they were still receiving this support after the *Community Webs* intervention. No other respondents were receiving support from social care in February 2017, and only 1 of these changed to receiving support to live at home after the *Community Webs* intervention.

Therefore there has been no significant change in care packages accessed – mainly due to the lack of clients receiving care packages in the first place. The fact that one client was able to get support to live independently at home since referral to us is encouraging, as it supports the idea of social prescribing as enabling people to access appropriate forms of support to improve their quality of life. It is also worth noting that the linkworkers made 5 referrals to Care Direct which may result in four more changes to social care packages accessed by clients after *Community Webs* input.



Data was collected from interviews (17), patient exit questionnaires (93), patient 3-month evaluation questionnaires (41) and monthly project worker reflective logs

## Objective 9: Lessons learnt from the perspectives of key stakeholders

**This section addresses Objective 9 of the evaluation:**

To understand what Community Web components and processes are working well and what can be improved ('lessons learnt') – from a variety of perspectives: patients, GPs, practice staff, organisations that the linkworkers are referring to and project staff

**The full process evaluation report, published in September 2017, is available on request**

The overall view of *Community Webs* from patients, GPs/practice staff, key stakeholders, community organisations and project staff respondents is positive. *Community Webs* is considered to be an essential service which is running well and is helping to meet a range of non-medical needs. There are however limitations noted with the project - related to higher level management, bureaucracy and operational issues. Themes were identified under the interview topic areas of planning and implementation, management and operation (divided into successes and challenges), perception of project need and perception of project impact.

### Planning and implementation

#### Successes

Reported successes pointed to aspects of planning and implementation before the start of the project and at the early stages which were considered to be effective. The following themes were identified:

- Beneficial early clinical engagement
- Positive higher management approach
- Good understanding of the project

#### Beneficial early clinical engagement

Many respondents highlighted the importance of involving GP practices from the start of the project as part of the planning process, stating that this was a key factor in the engagement of practice staff and in the later success of the project.

*“The main point that I would suggest and I think has been a strength of Community Webs, is that we promised that there would be clinical engagement with the plan right at the beginning so that our three surgeries’ doctor teams would be aware of the project, would be prepared to listen to what the project was going to deliver and commit to giving the pilot a trial all of those commitments to clinical engagement have made this successful.” (Key stakeholder)*

*“It’s been wonderful, it really has the way that it’s just been embraced by the practices, for previous social prescribing projects it’s taken much longer for it to become embedded and this has been done straight away. I personally think that’s because the Practice Managers were on board from the outset, well before the outset even.” (Project staff)*

#### Positive higher management approach

Other features of the planning stage which respondents considered beneficial was the approach of higher management in allowing local areas to develop the project themselves and in setting up regular project meetings from the start of the project. Most of the key stakeholders felt that these meetings have been beneficial to the project for monitoring and in allowing issues to be discussed and worked out.

*“Two way – very conciliatory, very keen to work with us very keen to get the model right, there wasn’t any pushback, so much a sort of a test and learn process.” (Key stakeholder)*

**Good understanding of the project**

There was a good level of awareness about the aims of the *Community Webs* project amongst stakeholders which suggests that activities undertaken at the implementation stage to provide information about the project and to promote the project (including attending practice meetings to give presentations, having GP champions and networking meetings with local community and voluntary organisations) were effective.

**Challenges**

Highlighted challenges indicate difficulties with the early management of the project and the number of stakeholders involved, with themes identified as difficulties agreeing the model and excessive bureaucracy.

- Difficulties agreeing the model
- Excessive bureaucracy

**Difficulties agreeing model**

The issue of difficulties agreeing the model extended from higher management deciding the overall model of *Community Webs* to coming to an agreement with GP practices on how the model would operate at practice level.

*“...At that time [planning stage] with Better Care we had a good relationship and actually it, it was clear on what outcomes both of us wanted. I think that’s changed slightly since then and it’s obviously become more difficult as staff have moved on and we’ve included more and more partners... messages start to get a little bit blurred then when we’re not all specifically talking about the one project.”* (Key stakeholder)

*“So yes, it’s been difficult in trying to get everyone on board and understanding what the purpose is and agreeing the model that we were commissioned to do that we said we would do, that we were having to change and then change back to something else and yes we’re testing and learning which is fine but we’ve had to adapt quite a lot.”* (Key stakeholder)

*“...There were quite a few difficulties in the north around agreeing the model, agreeing which surgeries would be involved.”* (Project staff)

Part of the problem in agreeing a model at the higher management level stemmed from wanting to maintain *Community Webs* as a project which is distinct from social prescribing, in line with the original commissioning objectives. The key stakeholder involved in commissioning the service reported that the aim of *Community Webs* was to meet the purely non-medical needs of people who frequently visit GP surgeries, as opposed to what was considered as social prescribing, which is meeting the social aspects of clinical needs. Whilst there was recognition of potential overlap, as the project has continued they see *Community Webs* as having developed into an exclusively social prescribing project from ground level and suggested that this may be a factor in its reported success.

**Excessive bureaucracy**

The length of time it took for the project to get started initially from the design stage was reported as problematic.

*“What did not go well at the time to make it happen was that with the high level, essentially and this isn’t a criticism but it’s just an observation that the clinical commissioning group and the Better Care fund and all of the*

*high powered agencies that were trying to make this happen they took so long to get around to agreeing and giving it a green light that it took a long time to get this thing off the ground and going.”* (Key stakeholder)

Once the project had been commissioned a delayed start was planned which a member of project staff noted enabled more asset mapping/relationship building to take place. However paperwork finalisation to cover the requirements of the commissioning organisation was described as time intensive and evaluation data requirements due to the number of management organisations involved were considered as leading to an overload of forms for patients.

*“...The other thing that is quite difficult around the stakeholders higher up is that because of the - their expectations of the project they’re needing a lot of evaluation data as it were, which inevitably bring a lot of forms with it. My priority is the patients, sometimes there have been questions around how ethical that actually is if it’s not really benefitting the patients so the [linkworkers] have had a lot of forms to complete which takes valuable time.”* (Project staff)

## Management and operation

### Successes

Day to day management and operation of the project is reported as going well with three themes described:

- Successful running of project
- Ease of referral process
- Highly regarded project staff

### Successful running of project

All respondents considered that the project is running successfully with some pointing to the high number of referrals into the project and waiting lists as indicative of this.

*“I think it was a difficult project to implement, so actually the fact that it’s delivering now and delivering well is a good - very good - sign. I think it was quite a challenge for the group to put it into place and to get something that both met what they want to deliver from it and what we were commissioning ‘cos I think they were slightly different but I think we’re probably at a point where both have been achieved.” (Key stakeholder)*

*“We’re very lucky that we have GP’s that are very keen to take on board and try new things so it was accepted from launch and it’s been very successful there have been lots of referrals into the Community Webs we’re quite high referrers into it, we have a little waiting list.” (Key stakeholder)*

### Ease of referral process

One of the factors highlighted by several respondents, which may have contributed to the positive reception of the project, is the ease of referral.

*“I found it really easy it so it’s straightforward to do it in our system EMIS webs that’s one of the things I like about it and the reason I do refer is that I can complete a referral in about 30 seconds and so it’s quick from that point of view.” (GP)*

*“Totally easy, just an email, a couple of forms a little bit of information to back up from the clinical record - but yeah, no really simple.” (Practice staff)*

### Highly regarded project staff

The other factor which came across strongly from respondents was the high regard in which they held project staff. Project staff were widely praised for being helpful, flexible, skilled, knowledgeable, dedicated and acting as excellent champions for Community Webs.

*“Fantastic, yes fantastic. I had a tricky one once that on paper looked like if you saw them on your own you might be in danger so I checked that out first so I phoned her and she answered quite quickly... she was happy to take him. So I think as long as one can be flexible that’s always very helpful.” (GP)*

*“Very helpful, very keen, very enthusiastic and really good advocates for what we are trying to do with this scheme.” (Key stakeholder)*

## Challenges

Challenges experienced in the management and running of the project were connected to problems with higher management, operational issues and patient follow-up:

- Higher-level management issues
- Operational issues
- Limited patient follow-up information

### Higher level management issues

Whilst aspects of the higher management approach were considered appropriate (as described in the planning and implementation stage), the limited involvement of BAB and BCB (CCG) on an ongoing basis and lack of communication (particularly on BCB’s part during project planning and initial implementation) was cited as detrimental by a number of respondents although one respondent stressed that communication had been poor in the other direction from project level to higher level management at times. BAB staff were clear from the start that their involvement would be limited to monthly phone check-ins with the project coordinator as they don’t attend the operational steering group of their projects – something that other stakeholders were unaware of and which, on reflection, may have been useful.

Contrary to the perception of flexibility to develop the model, another respondent thought a test and learn approach had not been adopted and that higher management had been rigid in their aims, especially regarding lack of consideration of project sustainability. The contrast in needs and expectations between higher stakeholders was also considered problematic.

*“Okay, so in terms of Better Care Bristol I don’t think we’ve had any meaningful interaction with them at all... they are a key player, they just haven’t engaged. There may be a whole ream of reasons behind that, I know there’s been a lot of people movement behind that so structurally they may not have had the personnel and the time-capacity to really get engaged.” (Key stakeholder)*

*“I think there was learning... Better Care Bristol and Bristol Ageing Better had different priorities and it would have been useful to thrash those out. To be honest they would have been except Better Care Bristol sold as there was no staff there... Better Care Bristol and BAB haven’t really turned up to steering group meetings to date I don’t think that matters but I guess communication could be better.” (Key stakeholder)*

However it is worth noting that attendance at steering group meeting and contact outside of the monthly check-ins with the coordinator was not something that was agreed by BAB from the start of the project. Email and phone contact was also utilised by the BAB programme manager to support the project coordinator, all of which were found to be useful by the project coordinator for addressing issues and occasional firefighting.

### Operational issues

#### Lack of practice space for linkworkers

Respondents described a number of operational issues which they felt hindered the running of the project. Lack of practice space for linkworkers was one of those mentioned. Linkworkers have been allocated rooms in different practices on set days and this has not always been sufficient for the number of appointments required for patients especially when requests for rooms were made outside of the specified times and when extra rooms were needed to catch up with appointments during the period when there was no linkworker in the north.

*“The only thing that I worry about is that the [linkworkers] getting space within the practice. So they’ve been allocated rooms on different days and that’s been absolutely fine but I know that when they were trying to catch up once [linkworker] had left, they were asking for rooms on different days and there were times that we had to say I’m really sorry but we don’t have the space. Well it’s a bit disappointing because we all try and do the best for the patient.” (Practice staff)*

#### Loss of linkworker

One of the linkworkers left the project in the early stages and this was cited as an issue by a couple of respondents, although it was only considered a minor setback and it wasn’t viewed as having an ongoing impact due to the fact the coordinator took up the linkworker’s work.

*“It’s running successfully. We have had the hiccup where one [linkworker] left but [project coordinator] stepped in and it felt seamless from my perspective. I don’t feel there was any issue with her going or anything that got dropped. Or, we’ve certainly had no negative feedback at all.” (Key stakeholder)*

### Paperwork

The amount of project paperwork needed for reporting requirements was perceived negatively when planning the project, as previously described, and this is carried over into delivery of the project with the number of forms to be completed being considered as onerous by project staff.

*“I enjoy the face to face with the people but I think administratively it’s been quite heavy but I understand the need for that because we need to feedback: BAB needs to know, GPs needs to know, the CCG needs to know exactly what we do. I think some of the paperwork we need to review.” (Project staff)*

### Time limitations

Time limitations were mentioned by project staff as a challenge partly due to the extra input required to address Did Not Attend (DNA) rates but also due to administration levels. There were additional tasks for the role carried out in workers’ own time such as picking up information about services, which is indicative of the dedication to the service described. This was noted as a feature of trying to manage all the required tasks of the roles within contracted hours. With the staffing hours available (22.5 for both linkworkers) and the fact that there is a waiting list (despite each linkworker seeing an average of 4 clients per day) there isn’t capacity in the service to

increase numbers seen and this is given as reason for not carrying out further promotion of the project and suggests a level of need for the service which would require more staffing to be able to address.

*“It’s been good [level of use of the project], I mean at the start it was a variety of GPs referring, now it is more so that the same few... so the same two or three that are referring. But then saying that I’m personally not pushing it as much as I could because we don’t have the capacity to have more referrals than we’re getting...” (Project staff)*

### Limited patient follow-up information

A key aspect of project delivery which was felt to be lacking by project staff and some practice staff was patient follow up after being seen by the linkworkers and this encompassed feedback to GP’s/practice staff and follow-up with community organisations that patients have been referred to. One GP referred to receiving patient summaries at the beginning of the project that had now tailed off and another suggesting they hadn’t received any written information. Not having access to EMIS (a patient electronic record system used in GP practices), was considered to be a factor in the difficulties with follow-up. Where practices had Community Resource Leads (who signpost patients to local organisations for non-medical support) or Care

### Did Not Attend rates

An operational challenge that project staff experienced was the high level of patients not attending appointments in the early stages of the project. Although the numbers of patients who don’t engage at all is fairly low there are a high number of patients who don’t attend appointments when they are arranged for the first or second time and once starting with the *Community Webs* service they may have further non – attendances.

Due to the complexities of *Community Webs* patients’ lives they often cancel due to other issues which blocks appointments that could be used for other patients and means that the length of time clients are in the service has extended. *Community Webs* staff have made a concerted effort to contact patients by writing, phoning, sending reminder texts etc. and have been flexible with the referral process so as not to exclude patients but this has meant lots of effort and time has been spent trying to engage patients at the start of the project which has reduced capacity for follow up with GPs and referral agencies at the end of project input.

Coordinators (who support patients discharged from hospital) they acted as intermediaries and transferred *Community Web* patient updates to EMIS, this wasn’t so much of an issue and some respondents reported that follow up was good.

*“I can’t say I’ve heard too much from [linkworker’s] point of view but it is still early days. I’m trying to think, I don’t think I’ve had anything written... no I suppose the fact that we are not getting that feedback is really to stop overloading us I guess... however I’m a bit a nosey and would like to know what happened, if they’ve been helped.” (GP 8)*

*“Okay, what, I could do better on which is poor, is feedback to GPs but that’s partly because of the lack of EMIS which is now coming up as something we really should have...” (Project staff)*

### Suggestions for improvement

Respondents gave a number of suggestions for improving the project and addressing some of the challenges noted. Most of the recommendations centred on the need to continue, extend and expand the project to give a longer time for changes to be embedded, to see more people and to offer capacity for linkworkers to help patients with community engagement and to provide the handholding considered necessary to effectively support Community Webs patients who often have complex multi-factorial issues.

*“In terms of redesign, what I think is a major weakness of this whole approach is that... we haven’t got the ability yet to have somebody hand-hold people to places so if they are not very confident, if they are... a bit shy, socially inept sort of thing, they’re not gonna go. If somebody could accompany them... I think that would be a major bonus to this.” (Key stakeholder)*

Operational suggestions included:

- Direct EMIS input for linkworkers
- Review of paperwork
- Linkworkers to return to GP practice meetings and feedback on patients



*“Now I feel I can take part in cooking/reading/walking groups and engage more.” (Patient 14)*



## Objective 10: Service costs

*This section addresses Objective 10 of the evaluation:*

*To assess the costs associated with the delivery of the project*

The total cost of this pilot including set up costs from January 2017 to January 2018 was £83,506. This figure includes in-kind contributions from SDT and GP practices in terms of room hire and management support. These figures were included in our initial bid, as although the linkworkers were based at GP practices for part of their weeks, SDT and SCDA still had to provide desk-space for these employees. Time needed and given by GP practice managers and other practice staff was minimal (only 1 attended steering group meetings and meetings outside of this time did not exceed 2 hours over the lifetime of the project). We have included an additional £500 to cover practice staff costs. The breakdown of these figures is shown in Table 10.

From this table it can be seen that the most expensive quarter related to the setting up of the project – in part due to the need to purchase core items such as laptops during this period. There were also additional management costs during this time. The ‘activity budget’ was fully utilised in Q3, otherwise the costs would have continued to reduce then become constant during the project. The latter quarter had reduced costs due to the winding down of the project and therefore less use of meeting rooms during this time (as some steering group meetings were cancelled and fewer meetings were undertaken overall).

This equates to the following unit costs:

- 318 patients were referred to the Community Webs service over the lifetime of the project. Therefore the ‘average cost per patient referred to the *Community Webs* service’ was £268.77.
- With respect to the 239 patients that were actually seen and supported by a linkworker, the ‘average cost per patient who took part in the *Community Webs* intervention’ was £357.57.
- Each patient was supported for an average of 8 hours (4 hours face-to-face, 4 hours research, planning, contacting, evaluation, admin etc.), resulting in an hourly cost to the service of £44.70 per person (£85,459/1,912 hours for 239 patients).

There were some costs associated with those 79 patients who did not engage as the linkworker will have spent time trying to contact them and reporting back to their GP. This would have been an average of 15 minutes per client (as each client was phoned 3 times, sent 2 letters, had their data inputted onto the spreadsheet and a report sent to their GP). This equates to an additional 19.75 hours: a small proportion (about 2%) of the total staff hours for the project delivery.

**Table 10: Project costs**

	Q1	Q2	Q3	Q4	TOTAL £
<b>Direct Project costs</b>					
Project Co-ordinator/Management	6,851	5,835	5,835	6,316	24,837
Link Worker (Bedminster)	2,869	3,274	3,270	3,261	12,682
Link Worker (Northern Arc)	2,869	3,349	1,585	3,448	11,292
Recruitment	900	365	0	0	1,265
Activities	0	0	4000	0	4,000
Office space	1,500	1,500	1,500	1,500	6,000
Volunteer expenses	0	0	0	0	0
Training	1,350	0	0	270	2,070
Travel	72	120	268	41	501
Events/conferences	0	0	0	0	0
Computer & internet	1,347	180	150	150	1,827
Phone	264	203	135.3	135.3	737
Meeting rooms	1,482	1,170	850	850	4,352
	<b>19,504</b>	<b>15,996</b>	<b>17,594</b>	<b>14,508</b>	<b>67,601</b>
<b>Overhead costs</b>					
Management & overheads at 15%	2,609	2,609	2,609	2,609	10,435
<b>Total project cost</b>	<b>22,113</b>	<b>18,605</b>	<b>20,202</b>	<b>19,139</b>	<b>79,999</b>
<b>Additional costs</b>					
Meeting rooms and desk space	1,100	1,100	1,100	1,100	4,400
SDT Volunteer Coordinator (1 day per month=12 days)	285	285	0	0	570
GP practice staff	125	125	125	125	500
<b>Total additional costs</b>	<b>1,510</b>	<b>1,510</b>	<b>1,225</b>	<b>1,225</b>	<b>5,470</b>
<b>Total project cost</b>	<b>23,623</b>	<b>20,115</b>	<b>21,427</b>	<b>20,364</b>	<b>85,459</b>

Note: Figures are rounded to the nearest £

### **NB**

The evaluation has not estimated the value of the benefits of the service. Other data in this report suggests that there will be value linked to *Community Webs* for GP services, the wider health and social care system, voluntary and community organisations, clients and their families or dependents.

## Discussion

Data collected through the delivery of *Community Webs* indicates that the project has a high level of referrals with a waiting list in both areas. Aspects of the project that were beneficial in the planning and implementation stages included early clinical engagement, regular project group meetings and project promotion amongst practices and community organisations. Issues were experienced in the early stages with higher management disagreement on the model for the project and with bureaucratic processes. One of the aims of the evaluation was to identify any issues with the delivery of the project. The day to day operation of the project is reported to be very good with an easy referral process and a high calibre of project staff. However restricted room availability for linkworker appointments, lack of follow-up to GPs, and issues with the numbers of patients not attending appointments are some of the problems that have been flagged up.

An aspect of the evaluation was to assess whether the project is acceptable to patients and to GPs. The response to the project is overwhelmingly positive with the findings suggesting that both patients and GPs are benefiting from having access to *Community Webs*. For patients in getting their social needs met appropriately and for GPs having the option of accessing non-medical support for patients with social needs. Respondents working in community organisations have also pointed to benefits of *Community Webs* for their organisations and the wider community from increased use of their services and from the opportunities to enhance the community through community engagement.

Gaining awareness of the high numbers of community organisations operating in local communities has been an unexpected outcome of the project for some respondents and the development of positive relationships between GP practices and organisations in the VCS has been considered as a positive outcome of the project over and above those originally intended. The extent of change reported for patients has exceeded expectations and some respondents have observed that consideration needs to be given to whether helping more people but to a lesser degree or helping fewer people but with a greater impact should be the aim, as the latter is more likely to be long lasting.

Although the project was generally viewed favourably there were suggestions given for improvement around operational issues such as linkworker access to EMIS and better patient feedback to GPs along with suggestions for higher management related to extension of linkworker input and continuation of funding for *Community Webs*. There may be work to be done around identifying which patients are declining the service, increasing the numbers of referrals from under-represented groups to reflect the local population and finding out the reasons for GPs not engaging with the project. Due to the respondents participating in the evaluation being those who had used the service it is not possible to find out this information which would reveal gaps in provision and would be useful for planning project delivery.

A suggestion given by one GP who experienced half of suggested referrals declining the offer, was to compare patients who accept a *Community Webs* referral with those who don't by differentiating them via a code in EMIS, to see what the characteristics

are of each group. This kind of information on what patient groups are accessing *Community Webs* would be required in order to fully assess the reach of the project and to determine whether there is potential for long term impacts on health inequalities.

Some common points came up from respondents on the nature of the issues which *Community Webs* patient present with and the wider political, environmental and societal factors considered to be influencing the levels and types of non-medical issues that patients consult GPs for.

One of the observations of the interim evaluation was that trying to differentiate between medical and non-medical issues is problematic as they are inextricably linked and so require a holistic approach. This is seen to be offered by GPs working with *Community Webs* staff to jointly provide support to patients to try and meet all their needs, which releases GPs to deal with medical issues and potentially frees up more time for them to do this. The difficulties in separating these issues is reflected in data available on the levels of medical or non-medical presentations which several respondents mentioned means that the true picture of this may not be known with the current system. Reasons for GP presentations would generally be written in note form on EMIS as there is no separate code. Furthermore reporting on consultations includes all patient visits to GP surgeries which might include medicine reviews or repeat prescriptions, so where information on the number of visits is obtained there is no way of knowing what they are for without going through each individual patient's record.

When thinking about the need for *Community Webs*, reference has been made to a reduction in advice provision and other support by BCC and other organisations. Benefit reforms and the negative financial repercussions of the recession were other political impacts described. The high criteria for access to secondary mental health care and the loss of hospital consultant input for people with mental health conditions and disabilities were also considered to lead to increasing numbers of patients visiting their GPs. Changes to communities such as closure of former community spaces and dispersed families were viewed as leading to high levels of social isolation. Furthermore, what respondents identified as the major issues in the areas where *Community Webs* is running is reflected in the reasons for referral to the project with social isolation being the most common reason, followed by mental health and practical issues such as welfare benefit and housing problems. This all paints a picture of the extent and breadth of issues, which whilst they might exacerbate a medical condition, have a root cause that is behavioural or social, and end up being presented at GP practices which, as respondents pointed out, GPs are unable to deal with adequately.

It has been identified in the NHS Five Year Forward View that the NHS cannot improve health outcomes in isolation particularly in the context of rising needs and reduced funding and that there is a need to work with patients and the VCS, which is recognised as having staff with a depth of skills and local knowledge providing vital services in the community. The *Community Webs* project (which comes under the umbrella of social prescribing) offers links to such services and provides an example of how the VCS and primary care can work together to relieve

pressure on the health service and to provide much needed support especially for those patients facing difficulties from the impact of wider societal factors. When GP respondents were asked what they think would happen if *Community Webs* was no longer available, in testament to the dedication of GPs and practice staff, they said they would return to trying to deal with these types of non-medical issues themselves as best they can but that they did not have the knowledge, time, capacity or resources to do so effectively.

It is encouraging that clients who have engaged with the *Community Webs* service had, on the whole, a statistically significant improvement in their Short Warwick-Edinburgh Mental Wellbeing Scale from baseline to exit, and again to 3-month. This positive change was also replicated with regard to clients' scores on the UCLA loneliness scale and the DeJong Gierveld social isolation scale. As the exit scales were often taken before clients had begun any significant engagement with community groups, activities or support we are led to believe that clients' wellbeing is often positively affected by the 1:1 support of a linkworker rather than just by the actual 'social prescription' – thus showing the importance of the linkworker model. It is believed that both are needed for real and lasting change – particularly when people have complex lives. An overriding theme of the exit questionnaires was the thing that people valued most about the service was having 'someone to talk to' and 'someone to listen'. Often this meant not just someone who listened, but someone who really heard what the individual was saying and made them feel valued.

*"I found it so helpful that I was able to talk about my problems. There's never enough time to speak to the GP. A lot of people can't talk to someone and it's the only way to sort things out, to get on with things."* (Patient 27)

This is symptomatic of our society today that people are craving someone to talk to and shows that one of our inherent human needs is to be in relationship with others. This is why follow-on support in terms of relationships with others is so important – not only so that individuals do not become dependent on the linkworker to fill this role in their lives, but so that people can link with others to form a lasting support network. In social prescribing, this is done through the guise of activities and groups of people who share a common interest, but ultimately this is about bringing people into relationships with others to enable them to continue the positive changes that they have made whilst being supported by a linkworker.

The project has also shown that many people have practical support needs that need to be addressed before they feel able to engage in groups or activities that will enable them to make steps to improve their general wellbeing. If these practical support needs are not met then attempts to address their wider wellbeing will fall upon deaf ears and the individual will not feel listened to or heard. Linkworkers cannot enter into relationships with clients with their own agenda, or indeed with the agenda of their referrer. People need to know that they will be taken as they are with an asset-based approach – focusing on their strengths rather than purely negative aspects of their

life that the linkworker will be addressing as part of the holistic approach to their wellbeing. It is for this reason that clients are put at the centre of the service – asked from the outset what they want to achieve from the 1:1 sessions, what their priorities are, what their strengths are and what they feel that they have to contribute to society. In areas of deprivation where people have been told time and time again that they are worthless and will never amount anything, this approach can be invaluable.

*"You explored my needs and interests. I was feeling I wasn't good for anything. Now I feel I can take part. You listened to me and didn't jump to conclusions or judge me like everyone else does."* (Patient 28)

The focus on *Community Webs* on volunteering and engaging in society is further thought to have been behind the positive change in clients' wellbeing, social isolation and loneliness scores. It is worth exploring whether statistically those who engaged in volunteering had a greater positive change in their scores, however due to the fact there are many factors at play any correlation would be difficult to prove. Client feedback has however shown that volunteering and contributing to society in a positive way has invariably increased feelings of self-worth, as well as increasing social networks. As humans, we need to be needed and when we don't feel that we have a role in the world or anything to give to others, this has a detrimental effect on our wellbeing. It is therefore likely that reducing clients' social isolation and loneliness had a knock-on, positive impact on clients' wellbeing due to the importance of relationships and human

connection to individuals. However, as noted, there are often many long-held barriers that individuals (and particularly *Community Webs* clients) have to being able to engage in their community – thus showing the importance of the initial 1:1 work undertaken with a linkworker to be able to break down some of these barriers and increase community engagement.

More detailed analysis would be necessary to establish if the improvements in mental well-being and reduced social isolation can be sustained after the linkworkers have disengaged with the clients and the clients are more self-motivated to help themselves. Currently the indication is that 3 months after exit the clients are still experiencing being in a 'better place', although the data is limited to make these claims with any high degree of confidence. However, when the statistical findings from the two loneliness scales and the well-being scale are viewed in relation to the outcome from Objective 2 the data strongly suggests that the engagement by the clients with support and services to meet their social, practical and emotional needs has had a positive impact. Clients have responded positively to using a group/service/activity again even after 3 months suggesting that they see a benefit in doing this even though they might not need to understand what the motivation is. It is necessary to guard against identifying client improvement particularly in the early phase being attributed to the clients taking a greater role in how well they live their lives rather than becoming initially dependent upon the linkworker. However as Objective 2 records the linkworkers have been successful in encouraging clients to attend and keep attending non GP interventions such as community support.

This is also borne out by the findings of Objective 7, which shows that clients would be more inclined to find other services as opposed to their GP.

### Limitations

A number of limitations of this evaluation need to be recognised:

- Two interviewers completed the interviews and carried out the data analysis which could lead to inconsistencies which would have a bearing on the data collected. Interviewers did however go through the interview guides together prior to the interviews to try and ensure a consistent approach. Interviewers carried out data analysis separately and checked each other's coding.
- Purposive sampling was used for the evaluation to include those who had used the Community Webs service, to cover both the north and south of Bristol and to represent a range of roles, so it is possible that those who did not engage with the service would have had different opinions about the project.
- Some of the respondents were linked to the provider organisation or key stakeholder group and had prior working relationships with project staff which may have influenced the responses given.
- The project process is for exit interviews to be given to respondents at the penultimate session for self-completion and returned to the linkworker at the last session, however

due to the number of forms that were not returned and last appointments being missed, the linkworkers have completed some forms with patients which limits the validity of responses.

- The three-month evaluation interviews were conducted by the service coordinator, which could be seen to have created a danger of a more positive spin being put on the questionnaires. However we are confident that the responses to evaluation questionnaires were all recorded as given by the participants, and the service coordinator has ensured that all documentation is kept should questions arise.
- Through discussion with clients who completed exit questionnaires, and GPs who completed the feedback questionnaire, some of the questions were thought to be difficult to understand by a few individuals. This may therefore mean that the responses given by these individuals are not truly reflective of the response that they meant to give. This is where doing the exit questionnaires with clients was in fact a benefit, as it meant that the linkworker could explain the questions to the client.

### Conclusions

*Community Webs* is viewed as being acceptable to GPs and patients as an appropriate service to support patients with their non-medical needs. From our findings the perception is that *Community Webs* is beneficial for patients and GPs - in particular through its person-centred methods which have resulted in significant improvements to patients' health and wellbeing. Patients of the service have been provided with the right information to help them to access social, emotional and practical support. They have been able to make positive choices regarding their broader health and wellbeing needs and taken steps to improve their situation.

*'She [linkworker] explored my needs and interests. We talked about what I actually want, not what people think I want. She believed in me. I was feeling I wasn't good for anything. Now I feel I can take part.'* (Patient 29)

GP's and practice staff have demonstrated trust in the voluntary and community sector, and in social prescribing in particular, by continuing to refer their patients into the service. Positive feedback has been given of the service by all referring partners.

*"... The general consensus amongst the GPs is that it's been very positive. It's worked its way into their prescribing if you like, they find it very easy to use the service and with very good outcomes."* (Practice staff)

Numerous lessons have been learnt about primary care engagement, working flexibly, relationship building, using volunteers and the actual role of a social prescribing service in the current landscape. Evidence has also been collated about the need for and use of groups, services and activities across North Bristol and Greater Bedminster.

Social prescribing provides both a platform and a vehicle to drive forward integration agendas and the 'prevention early intervention and self-care' arm of the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Partnership (BNSSG STP). Indeed, in the 'Five Year Forward View' Simon Stevens (Chief Executive, NHS) highlighted a growing understanding of the need for health services to provide a service focused on the individual, their aspirations, their needs, their assets and their context within the community - identifying a need to move from 'a factory model of care and repair' to one that focuses on much wider community engagement.

It is also evident that there is no 'one size fits all' even where a social prescribing service like *Community Webs* has been located in one specific geographical area - again highlighting the importance of the holistic, person-centred approach taken by the service.

This reports highlights the value of exploring both the individual and community 'assets' not 'deficits' in any given context. Social prescribing appears to have great potential to add to patient choice, freedom and autonomy but only if the appropriate investment is made to create the infrastructure to make this happen. Contrary to some held beliefs, social prescribing is not simply a response to austerity in the public sector. It is about

changing the way services and communities and civil society work together. This pilot has shown what can be achieved by re-thinking a patient journey, and challenging the idea that patients should play a passive role. The *Community Webs* team embraced the opportunity to provide GPs with an increase in the number of 'tools' in their toolkit. But, perhaps more importantly, the team sought to show the patient that there are other options out there. These are options that do not need a diagnosis, do not need costly medication and which, if the patient is willing to engage in and take a risk on, can have a profound effect on their quality of life.

We are all very focused on the life expectancy of individuals, seeing this as the marker of a healthy society. This is not necessarily where our focus should be. Our focus should be the quality of the years that an individual is alive, and making sure that people have the opportunity to reach their full potential – whatever that may be. Again, this links back to choices. Where you are born shouldn't influence your future, but too often it does. The Marmot Review (*Fair Society, Healthy Lives*) highlights that health is only 30% clinical – the rest is social. The most important factors for health/wellbeing are: a decent home, a decent job and strong familial and community relationships.

Relationships are key to any social prescribing service. The relationship that the linkworker builds with the client enables the client to feel able to build trust, accept support, challenge themselves and make changes to their lives. However it is important that this relationship does not create dependency, which is why the linkworker does not allow themselves to be pushed into a 'rescuer' role with the client adopting a 'victim' mentality. Instead, they

adopt an adult-adult relationship that is focused on change. This initial relationship can often involve challenging disclosures which is why the establishment of trust is so important, as these disclosures enable the linkworker to support the client to access the most appropriate form of support.

The statistical analysis on loneliness and wellbeing backs up the qualitative data collected on continuing attendance at group/service/activity (*Objective 2*) and the answer to the question 'If you were in a similar situation again to that which you were in when you were referred to *Community Webs* and *Community Webs* wasn't available, where would you go for help and support?' (*Objective 9*). This suggests that the client improvements seen to date are likely to be as a result of the clients being helped to take more control of their own lives and not as a result of becoming dependent on linkworkers. The real value of the time that linkworkers can spend with patients and the asset based, person-centred approach that *Community Webs* took is that patients are seen in the context in which they live their lives and an understanding is created around how this context impacts on both wellness and illness. Seeing patients as assets who have something to give to society (often at odds to long-held beliefs of the individuals themselves) goes a long way to empowering patients to be able to take control of their own health and wellbeing and, ultimately, their lives. This will inevitably have a knock-on impact on patients' physical health – thus showing social prescribing services like *Community Webs* as being preventative (in terms of future physical health deterioration and associated healthcare needs) as well as just re-directing primary care patients who have non-medical support needs.

*"They'll come to the GP asking various questions, when you dig deep, you find out it's not really a health issue but if we're not careful could become a health issue."* (GP)

In the publication 'A Glass Half Full', Jane Foot and Trevor Hopkins make the case that:

*"As well as having needs and problems, our most marginalised communities also have social, cultural and material assets. Identifying and mobilising these can help them overcome the health challenges they face... The more familiar 'deficit' approach focuses on the problems, needs and deficiencies in a community such as deprivation, illness and health-damaging behaviours. It designs services to fill the gaps and fix the problems. As a result, a community can feel disempowered and dependent; people can become passive recipients of services rather than active agents in their own and their families' lives."* (Foot and Hopkins, 2010, p7)

Much of social prescribing seeks to put individuals in the driving seat - creating the opportunity for real and lasting behaviour change because it involves learning and making choices.

However, as highlighted by Trevor Hopkins, there is a concern that as social prescribing gains political parlance without real culture change it simply risks becoming a buzzword, lacking any real substance.

The development of the *Community Webs* service had Michael Marmot's vision at its core – particularly with regard to the social determinants of health.

*"There's good evidence that if people are disempowered, if they have little control over their lives, if they are socially isolated or unable to participate fully in society, then there are biological effects."*

*"Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health... When we consider these social determinants of health, it is no mystery why there should continue to be health inequalities. Persisting inequalities across key domains provide ample explanation: inequalities in early child development and education, employment and working conditions, housing and neighbourhood conditions, standards of living, and, more generally, the freedom to participate equally in the benefits of society."*

Ultimately, however, it is participating in society that has a long-term benefit for people – with the initial injection of 1:1 support from a linkworker enabling this. Finding people to talk to, build relationships with and share experiences with is essential for our wellbeing. Life is about relationships and shared experiences, and when this is not an option for people their wellbeing will inevitably be negatively affected. This long-term sustained change cannot be held by a linkworker, or indeed any ‘professional’. It can only be formed by sustained integration in society and one’s community.

### Learning and recommendations

There is a wide range of areas of learning to arise from Community Webs. These are summarised below:

- Agree the model between all the relevant stakeholders at the outset with no major changes except where it is an enhancement to project work.
- Develop plans for long-term sustainability for successful projects at inception.
- Increase project length to enable sufficient time for asset mapping, for the service to embed and for evaluation of long term outcomes.
- Adapt project to increase staffing and length of project input to enable handholding for patients to access services and to engage in the community and to enable linkworkers to fully address patient needs.
- The number of sessions per client should be extended to 6 with the professional staff given the flexibility to extend that if required.
- Ensure that the GP practices fully understand the objective of the scheme, the referring criteria and are committed to its success. This requires early preparatory work, ideally with people involved who already are known and trusted by the GP practices.
- Grant linkworkers access to EMIS.
- Grant linkworkers sufficient room space at GP practices for appointments.
- Include a lead-in time of two months for the project to allow for relationship building, asset mapping and project promotion.
- Ensure linkworkers have the full skillset required for the role.
- Linkworkers need a trusted directory/ database of services and source of information that is up to date, clear and easy to use.
- Good knowledge and skills around mental health for project staff and staff from community organisations
- Review, and where possible reduce, paperwork needing to be completed by clients – ensuring that all evaluation is of benefit to the client and does not compromise the intervention.
- Both internal and external supervision is essential to the linkworker role.

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## Appendix 1

# Community Webs Referral Form

Patient Name: \_\_\_\_\_ EMIS Number: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Patient's tel. number: \_\_\_\_\_

Referrer's name, role and surgery: \_\_\_\_\_

If person being referred needs support to discuss referral or has communication challenges, access needs etc. please detail below and provide details of person who is able to provide support (name, relationship, contact number): \_\_\_\_\_

### Reason for referral (please tick all that apply)

Any other comments regarding referral: \_\_\_\_\_

- |  |                          |   |                          |
|--|--------------------------|---|--------------------------|
| Social isolation/Loneliness  | <input type="checkbox"/> | Need for improved self-care (e.g. diet and exercise)                        | <input type="checkbox"/> |
| Practical support needs (e.g. benefits, letter writing, housing, debt, etc.) | <input type="checkbox"/> | Low confidence and self-esteem (including mild-moderate depression/anxiety) | <input type="checkbox"/> |
| Over-reliance on NHS services  | <input type="checkbox"/> |   |                          |
| Bereavement  | <input type="checkbox"/> |   |                          |

What reason did the patient give for attending the GP practice today? (Please tick one)

- |                                |                          |  |                          |
|--------------------------------|--------------------------|--|--------------------------|
| Non-medical only               | <input type="checkbox"/> | Medical only but I feel they need wider holistic support | <input type="checkbox"/> |
| Mix of medical and non-medical | <input type="checkbox"/> |  |                          |

How motivated do you consider this person to be to engage with the service?

1  2  3  4  5

Not motivated at all

Highly motivated

I have obtained verbal consent from the patient to refer them to you, to pass on their contact details and to give you limited access to their medical records.

Consent code: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### What is Community Webs?

Community Webs "aims to align assets in a community (GP practices, voluntary sector etc.) so people can be supported to access community resources independently. This will help to relieve some of the pressure on health and social care services; aid the identification of complex, 'at-risk' individuals; reduce the likelihood of individuals accessing social care when not necessary, and prevent expensive and potentially harmful over-medicalisation of social problems."<sup>25</sup>

### Who is the service for?

The referral criteria for both areas will be open (anyone whom GPs feel would benefit from non-medical sources of support), but as guidance will include:

- Social Isolation/Loneliness
- Practical support needs (e.g. letter writing for welfare cases, benefit help, housing, debt, work etc.)
- Over-reliance on NHS services
- Bereavement
- Need for improved self-care (e.g. diet and exercise)
- Low confidence and self-esteem (including mild-moderate depression and anxiety)

### Who is not suitable for the service?

- Patients who are:
- Under the age of 18
- A threat to themselves or others
- In a crisis situation
- Suffering from uncontrolled mental health issues or addictions
- Known to have pre-existent or recurrent safeguarding issues

During the first appointment, the Navigator and client will engage in a guided conversation around the patient's needs/wants/barriers, using motivational interviewing techniques and completing an assessment form which will incorporate measurement scales. Using a person-centred approach the client will have the opportunity to discuss their current challenges and circumstances, and any barriers they may have with regard to being able to access or engage in community activities. The client will set goals that they wish to use the service to achieve.

Practical support needs will be identified and followed up by the Navigator. This may include linking with local befriending schemes, and using volunteers to help clients to access local groups and activities and to provide companionship to clients with the aim of reducing social isolation and breaking down social barriers.

29 [https://www.bristolccg.nhs.uk/media/medialibrary/2016/03/govbody\\_29March2016\\_Item15.pdf](https://www.bristolccg.nhs.uk/media/medialibrary/2016/03/govbody_29March2016_Item15.pdf), p.40.

## Appendix 2

### Referring GPs

GP ID	Surgery	No. of referrals	Comments
GP1	Bradgate	48	also sits at Avonmouth and Ridingleaze
GP2	Ridingleaze	34	
GP3	Malago	17	
GP4	Ridingleaze	15	
GP5	Bradgate	12	
GP6	Malago	12	
GP6	Bedminster Family Practice	10	
GP7	Bedminster Family Practice	9	
GP8	Bradgate	8	
GP9	Bradgate	8	
GP10	Gaywood	8	
GP11	Malago	8	
GP12	Avonmouth	7	
GP13	Bradgate	7	
GP14	Ridingleaze	7	
GP15	Bedminster Family Practice	6	
GP16	Malago	6	
GP17	Avonmouth	5	also sits at Bradgate and Ridingleaze
GP18	Bradgate	5	
GP19	Bradgate	5	
GP20	Gaywood	5	
GP21	Bedminster Family Practice	4	
GP22	Avonmouth	3	
GP23	Bedminster Family Practice	3	
GP24	Bedminster Family Practice	3	
GP25	Bradgate	3	

GP ID	Surgery	No. of referrals	Comments
GP26	Bradgate	3	
GP27	Gaywood	3	
GP28	Gaywood	3	
GP29	Malago	3	
GP30	Malago	3	
GP31	Bedminster Family Practice	2	
GP32	Bedminster Family Practice	2	
GP33	Bradgate	2	
GP34	Bradgate/Avonmouth	2	
GP36	Gaywood	2	
GP37	Gaywood	2	
GP38	Malago	2	
GP39	Ridingleaze	2	
GP40	Avonmouth	1	
GP41	Avonmouth	1	
GP42	Bedminster Family Practice	1	
GP43	Bedminster Family Practice	1	
GP44	Bradgate	1	
GP45	Bradgate	1	
GP46	Gaywood	1	
GP47	Malago	1	
GP48	Malago	1	
GP49	Malago	1	
GP50	Ridingleaze	1	
GP51	Ridingleaze	1	
GP52	Bedminster Family Practice	0	
GP53	Bedminster Family Practice	0	
GP54	Bedminster Family Practice	0	
GP55	Gaywood	0	
GP56	Ridingleaze	0	



## Appendix 3

### Community Webs – Process and model

#### 1 Referral to *Community Webs*



- From GP Practice Staff
- 'Basket' of criteria for referral
- Referral form embedded in EMIS and self-populated, then sent to secretary/care coordinator (using EMIS Task) who forwards to *Community Webs* Navigator

#### 2 Patient meets with *Community Webs* linkworker (Session: 1: 1-1.5hrs, after appointment booked by navigator via telephone)



- Guided conversation around patient's needs/wants/barriers, use motivational interviewing techniques (1.5hr)
- Complete evaluation scales (Warwick-Edinburgh Mental Wellbeing Scale, ONS, BAB CMF)
- Think together about goals, social needs, life at present etc.
- Identify any practical support needs – contact relevant organisations together to make referrals
- Begin to construct action plan of support, begin supported

#### 3 Patient meets with *Community Webs* linkworker (Sessions 2-4: 1hr, as needed)



- Construct action plan of support together
- Check up on whether referrals have been actioned
- Ensure practical support needs have been/are being met (benefits, debt, form filling, housing, home repairs, food etc.)
- Supported referral to organisations/groups/activities

#### 4 Non-medical sources of support within the community (Determined by client needs/wants/goals)



- **Level 1:** Community group, practical support, befriending? (linkworker will asset-map local area and build strong links)
- **Level 2:** Structured programme, e.g. Wellbeing Arts, Growing Support
- **Level 3:** Psychological/Counselling support

#### 5 Outcomes (Assessed through exit survey & during follow-up telephone call after 3 months)



- Patient feels able to access, and is accessing, appropriate support from within the community
- Patients feels empowered
- GP isn't patient's first port of call
- Improved wellbeing
- More appropriate use of GP time

## Appendix 4

### Case studies



#### Client A: Female, 42

**Reason for referral by GP:** *Low confidence and self-esteem, need to improve self-care (diet and exercise)*

**Reason for referral by client:** *Practical support needs (court case), domestic abuse, trauma, physical health problems, depression and anxiety*

Client 'A' was referred to *Community Webs* with anxiety, depression and a desire to lose weight. On first meeting a linkworker 'A' was very distressed and described her most pressing problem as an upcoming court case against a previous partner who raped her and behaved abusively towards other family members. 'A' spoke about the trauma of her ordeal and having to appear as a witness in court, alongside fears of being targeted by the perpetrator's friends. She also spoke about her health problems: fibromyalgia, prolapsed bowel, and recovery from bowel cancer the previous year, combined with depression and anxiety – none of which she had had an opportunity to discuss before. The linkworker supported 'A' to contact Next Link to enrol in the Freedom Programme (tailored support for survivors of domestic abuse). They offered her a community support worker, who could meet on a regular basis and accompany 'A' to the court hearings. In discussing her physical health and weight concerns, the linkworker talked through various options with 'A', who decided to attend a local Slimming World group. The linkworker gave her access to 12 free sessions, increasing motivation to attend. 'A' reported

finding the weight-loss group really friendly and supportive, and decided to keep attending (self-funded) once her introductory sessions were completed. In her next session with the linkworker, 'A' again discussed difficulties with day-to-day life. The linkworker helped her look at ways of coping with intrusive thoughts and friends and family when she's distressed, and taking time for self-care. 'A' expressed an interest in resuming old hobbies, and was keen to join the Wellbeing Arts class run at The Greenway Centre, now comfortable at this location. She was also keen to resume swimming, which was set as a goal for that week. 'A' didn't manage her first swim (due to anxiety about exposing her body and going to a new place) so planned another attempt and the second time succeeded, much to her astonishment and delight. 'A' continued to enjoy Slimming World, attended some of the Wellbeing Arts sessions, enrolled in the Greenway Gym's exercise on referral scheme, and felt supported by Next Link. She still has the court case to come (it was postponed), causing ongoing stress, but now has sources of support and positive change, from new friends and activities in the community, and from support workers at Next Link and the Freedom Programme.



#### Client B: Female, 54

**Reason for referral by GP:** *Practical support needs – help getting work*

**Reason for referral by client:** *Practical support needs (debt), poor self-care, low confidence and self-esteem*

Client 'B' was referred to *Community Webs* by her GP, and from her referral it was initially thought that she would be suitable for the West of England Works programme. However as she was enrolled on a course, she was unable to access their support.

'B' arrived at her first meeting with the *Community Webs* linkworker late and confused, talking in a rush and clearly very anxious. She talked about being concerned about how she was managing life, having recovered from breast cancer in recent years, separating from her husband, getting into significant debt, and since then struggling with chronic fatigue. She was working with a debt charity, who were supporting her to manage her debts and make repayments, however she was struggling with day-to-day money management.

The linkworker actioned a supported referral to Money Smart Mentors (North Bristol Advice Centre), and 'B' had productive meetings with them to learn how to make budgeting spreadsheets and use online budgeting tools to track her spending. The linkworker also spoke with 'B' about ways of cost-cutting around food shopping and recipes using cheaper ingredients, as 'B' was accustomed to living with more generous finances. 'B' came to subsequent meetings with reports of the bargains and cost-savings she'd achieved, as well as new recipes she had tried. 'B' was interested in trying yoga or tai chi, but worried about not being able to afford the classes. The

linkworker found a low-cost Tai Chi class in Southmead (£2 / session) and suggested this to 'B', which she now attends and finds relaxing and very supportive. 'B' was keen on volunteering, and together with the linkworker looked at getting involved in the Growing Support gardening group (set up through the *Community Webs* enabling fund), as well as volunteering in a charity shop she enjoys frequenting. 'B' did not yet feel ready to commit to volunteering as she frequently has episodes of exhaustion, however she found it useful generating ideas of goals for the future, instilling a sense of hope and possibility.

'B' used our sessions to gain support to complete her introductory computer course (including being open with her tutor about when she's struggling – rather than dropping out, and making time-tables to plan her study sessions and revision, and work at times of day that suit her). 'B' also addressed sleep hygiene with the linkworker and the benefits of regular sleeping and eating patterns, as she was used to keeping very erratic hours. 'B' began keeping an appointments diary, logging her activity, both to keep track of her achievements and to see where her difficult times arise.

Once 'B' had completed her computer course the linkworker referred her to the West of England Works team to link up with support around moving towards work, as B was keen to build on the success and routines we had begun to establish in her life.



### Client C: Female, 65

Reason for referral by GP: *Reduce frequent attendance at GP practice*

Reason for referral by client: *Stress and anxiety, practical support needs*

At the first meeting with a *Community Webs* linkworker, 'C' stated she had been feeling stressed, anxious and constantly overwhelmed. She spoke mainly about the condition of her home, particularly her bathroom, which she said was unusable due to a flooding four years ago and subsequent mould and damp issues; she had been using her neighbours bathroom to wash. Her struggle to resolve this issue with her housing provider had been significantly impacting her mental health and ability to cope with day-to-day life (as well as the stress of not having a useable bathroom).

During 'C's first two appointments with the linkworker she spoke constantly about this issue and the dealings she had had with various staff at the housing association and tradesman over the last four years. 'C' stated that she had little faith in anyone sorting the issue for her as she had been let down so many times in the past and didn't know what to do. The linkworker listened to her story and gathered information about what had happened over the last four years.

The linkworker's first action was to contact CHAS (Bristol) an independent housing advice service. CHAS suggested following the formal complaints procedure for the relevant housing association. In 'C's third appointment the linkworker was able to assist her with the online complaints form that she was unable to do herself due to a lack of computer literacy. 10 days later the linkworker chased the complaint with the housing association who had

not responded. The housing association advised the linkworker to take some photos of the bathroom and send these photos to them, which the linkworker did on behalf of 'C'. Further to this, the housing association agreed to attend a joint home visit with C and the linkworker and apologised for their delay in resolving this complaint.

The linkworker was able to support 'C' (who had grown increasingly frustrated) at the meeting with the housing manager. It was agreed at this meeting that the necessary work would be carried out on 'C's property and also further 'snags' within the property would also be resolved. The plan of works was promptly confirmed in writing.

During 'C's work with the *Community Webs* linkworker, 'C's primary goal had been to request that the housing association restore the condition of her property so she could have a useable home and be relieved from this source of stress. Fortunately 'C' and the linkworker were able successfully achieve this. However, an issue that was also raised by 'C' was her struggle to cope emotionally with traumatic events that had happened in her past. 'C' was reluctant to seek further help, as previous help hadn't benefited her much. However the linkworker had built trust and a relationship with 'C', and together they were able to action a supported referral to WOMANKIND who offer a free helpline and professional counselling support.

## Notes

Horizontal lines for taking notes.





**Bristol**

**Clinical Commissioning Group**

Bristol Ageing Better (BAB) is a partnership working to reduce social isolation and loneliness among older people and help them live fulfilling lives.

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