Richmond Group of Charities: Doing the Right Thing

Social prescribing: Options for outcome measurement

A summary

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1. About this paper

This is **a summary of Richmond Group thinking** about options for outcome measurement within social prescribing. It is based upon available literature, conversations with both colleagues and partners, and conversations with expert academics and practitioners.

The original purpose of the work was to inform discussions and decisions about outcome measurement for social prescribing with our collaborative partners in Somerset. As such, the recommendations serve a particular place and context and may or may not be the best options for use in other areas or other types of service.

However, we wanted to pull together our thinking as the Richmond Group **to contribute to wider discussions about social prescribing**. Our wider learning about social prescribing has been pulled together into a slide deck[1] and a webinar.[2]

2. About social prescribing

'Social prescribing' (as described by the NHS and others) **links people into personal networks as well as practical and emotional support within communities and the voluntary sector**. This is often via their GP, nurse or other primary care professional.

The aim of social prescribing is to help people live their lives as well as possible, with a focus on supporting them to take control of and to improve their health, wellbeing and social welfare.

Services are normally time-limited (but with some flexibility). There is **no definitive model** of developing and implementing social prescribing. Each area has different infrastructure, assets and relationships upon which to build.

However, we have identified five essentials of social prescribing:[3]

1. **Buy-in from referring professionals.** With recognition that collaboration and communication across and within sectors is a necessity and may require additional link workers, which is a skilled role that must be appropriately paid.
2. **A person-centred approach.** With appropriate time given to conversations focused on how people want their lives to be, what strengths they have, and what goals they can work towards to live as well and independently as possible.
3. **Connections.** To personal and community networks as well as to practical emotional support within communities and the

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[1] https://bit.ly/2tkDZku

[2] https://bit.ly/2DFsqKP

[3] A high-resolution version of this infographic is available here: https://bit.ly/2SQNWVu. Please feel free to use it.

voluntary sector.

4. **A transfer of resources.** From the statutory to the voluntary, community and social enterprise (VCSE) sector in parallel with these connections. This is essential for the sustainability of these approaches.

5. **Community-building service development.** With attention given to building on existing assets, generating social capital and creating local responses to unmet needs and goals.

3. What do we want social prescribing to achieve?

- The **primary aim** of social prescribing is to help **people** live their lives as well as possible.

- A **secondary aim** of social prescribing might be to have an impact on **system outcomes**, e.g. reduce demand for medical services.

4. What are we looking for in an outcome measure?

We are looking for one or more measure that fulfil/s the following functions:

- At an **individual level to tell a story about a person** using social prescribing in Somerset.
    - To understand a person and their situation.
    - To understand whether a person and/or their situation has changed.
    - To continuously improve a person's support.

- At a **group level to tell a story about social prescribing in Somerset**, e.g. "on average, this group of people were at X on a scale and now they are at Y" or "on average, this group of people used 10 of resource type A and now they use 5".
    - To understand whether the service is achieving what it was set up to achieve.
    - To continuously improve the service.
    - To contribute to local and national learning about this type of service.

While the collaboration is open to the possibility of exploring particular research questions through researcher-led projects, the priority is to identify **outcome measures that can be incorporated into practice and administrated by frontline staff**.

5. How do we weigh-up the options?

There are a number of ways we can approach this, but there does seem to be Richmond Group consensus about the important criteria for us to consider.

Recognising that each of these concepts is a spectrum, an outcome measure **needs to be**:
- **Useful**: Provides data / information that can be used for a positive practical purpose. (NB. The Data Protection Act requires this).
- **Valid (internal)**: Measures what it is supposed to measure.
- **Reliable**: Gives us the same result over and over again (assuming the thing being measured isn't changing).
- **Responsive**: Is sensitive to change.
- **Ethical**: Does no harm to (or even complements) the service and a person's experience of it.
- **Simple**: Is easy for both people using the service and staff to understand and use.
- **Unburdensome**: Is not onerous for organisations to facilitate or for staff to administrate.

Recognising that each of these concepts is a spectrum, an outcome measure **would ideally be**:
- **Free**: Without cost to use (licenses, access to data, training, and so on).
- **Recognised**: Well known within the health and care sector.
- **Respected**: Carries weight within the health and care sector.
- **Valid (external)**: Results can be generalised to other settings.

- **Associated:** There is evidence (or emerging evidence) that the outcome being measured has a relationship with another outcome.

6. A few points to note

- It can be very challenging to control for fluctuating and deteriorating conditions.

- Anything that relies on self-reported measures is difficult for people with declining cognitive conditions. Alzheimer's Society recommends anything relying on a self-completed questionnaire be avoided for people with dementia.

- Social prescribing brings together a lot of different people and organisations. This means it can be relatively easily influenced by local and national policy and practice change. E.g. something like changes to benefits or changes to local services could have an impact on referral numbers, people's needs and goals, and what it's possible for a social prescribing service to achieve.

- Cross-sector conversations about outcome measurement need to be realistic, with all partners – within the statutory and VCSE sector alike – held to the same standards and expectations. Otherwise there is a risk that social prescribing is set up to fail.

OPTIONS: OUTCOME MEASUREMENT AND ASSOCIATED TOOLS

7. Achievement of / progress made toward self-identified outcomes

How far a person feels they have moved towards addressing a concern or reaching a goal that they set at the beginning of an intervention, compared to where they are at the end of an intervention.

Measuring self-identified outcomes focuses on what's important to people. Richmond Group charities report these measures to be comfortable to use, to drive person-centred practice, and to capture the results of complex and holistic interventions. However, scientific validity is difficult to establish and there is potential for perverse practice, e.g. encouraging people to set 'easy' goals or identify 'easy' concerns to address.

Some Richmond Group charities strongly advise against using self-identified outcomes within outcome-based contracts because of the risk that gaming dilutes good practice, as well as the "huge challenge" of knowing what good looks like. There is consensus that it's impossible for 100% of people to fully achieve their goals / completely mitigate their concerns, but beyond that, we don't know what a good result (and therefore a sensible target) looks like.

Tools for measuring self-identified outcomes:

- <u>Measure Yourself Concerns and Wellbeing (MYCaW)</u>[4]: 1-2 concerns/problems plus 1 wellbeing question – all with a 7-point scale. Concerns and wellbeing are assessed at the point of identifying concerns (Time 1) and at the end of intervention (Time 2). MYCaW is free to use, practitioners report it to be simple to administrate, and the Social Prescribing Network promotes it. However, the MYCaW wellbeing score is less responsive to change than the MYCaW concern score.

- <u>Goal Based Outcomes (GBO)</u>[5]: Up to 3 goals assessed against a self-reported 10-point scale. Goals are assessed at the point of goal-setting (Time 1) and at the end of intervention (Time 2). GBO is free to use and practitioners

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[4] Joliffe, R. et al (2014). The Responsiveness, Content Validity, and Convergent Validity of the Measure Yourself Concerns and Wellbeing (MYCaW) Patient-Reported Outcome Measure. *Integrative Cancer Therapies.* Vol 14, Issue 1, pp.26-34.
http://journals.sagepub.com/doi/abs/10.1177/1534735414555809

[5] Law, D. & Jacob, J. (2015). *Goals and goal based outcomes: Some useful information: Third edition.*
www.corc.uk.net/media/1219/goalsandgbos-thirdedition.pdf CAMHS Press

report it to be simple to administrate. However, GBO has only been tested with children and young people and little (if any) benchmarking data is available for adults. That said, British Red Cross and Age UK report their own similar approaches to work well with adults with long-term conditions. A Department of Health (as it was at the time) methodology has long been available to help with this.[6]

Self-identified outcomes seem to be the best approach to measuring outcomes at an individual level in order to tell a story about a person. **Self-identified outcomes are useful and fulfil one of the key functions we seek from an outcome measure.**

It could be sensible to use the 'concerns' section of the MYCaW tool but substitute the wellbeing section with a tool that is more sensitive to change.

There seems to be an emerging consensus that social prescribing should focus on supporting people to identify and work toward achieving their goals. Local areas should consider how best to go about this. There is a lot of learning about this within the Richmond Group charities, including British Red Cross and Age UK.

8. Improved Wellbeing

People understand 'wellbeing' as confidence, a sense of self-worth and a good quality of life. We all have an instinctive idea of what 'wellbeing' means, but **a definition is now enshrined in primary legislation through the Care Act 2014**.[7] This definition includes personal dignity, control over day-to-day life, participation in work, education, training or recreation, and positive domestic, family and personal relationships. We should avoid revisiting a discussion about what 'wellbeing' means.

Measuring wellbeing focuses on people's emotional as well as practical needs. People broadly understand the concept, it's a common focus for statutory partners, and it's a recognised frame of reference within national policy. However, demonstrating attribution can be burdensome, and securing before and after measures can be problematic.

Tools for measuring improved wellbeing:

- Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWS): 7 statements, 5-point scale. Measures current mental wellbeing (time frame of the previous two weeks). Free to use, translated into a number of languages, recognised and used by some services in Somerset. Richmond Group charities report people with and without cognitive impairment can find the statements difficult to understand. Some Richmond Group charities report the 5-point scale to be insufficiently sensitive to capture the impact of short-term interventions.

- ONS Subjective Wellbeing: 4 questions, 10-point scale. Free to use, recommended by What Works Wellbeing, extensively tested to ensure members of the public understand the questions, Richmond Group charities report staff feel more comfortable with its approach of asking people how they felt yesterday rather than asking how they feel today. No identified cons so far.

- Well-being Star™: 8 outcome areas, 5-point scale. There are over 20 different versions for different groups of people, which can frustrate administration and data aggregation. Richmond Group charities report staff feel uncomfortable asking people about pre-defined aspects of their lives, which an intervention is not necessarily designed to respond to. Licences must be purchased and all workers must complete minimum training with an associated per-person cost.

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[6] Department of Health (2009). *Working Together for Change: Using person-centred information for commissioning*. www.thinklocalactpersonal.org.uk/_assets/WTFC_Final.pdf

[7] *Care Act 2014*, s.1. www.legislation.gov.uk/ukpga/2014/23/contents/enacted

- WHO-Five Well-being Index (WHO-5): 5 statements, 5-point scale. Free to use, available in many languages, can generate a percentage score. Agreeing / disagreeing with 'I statements' is difficult for people with cognitive impairment.

A number of Richmond Group charities report having switched to the ONS Subjective Wellbeing tool after trialling another tool. This preference seems to be based on: a) being free to use, b) questions that make (relative) sense to people with a range of needs, c) staff feeling (relatively) comfortable using it, and d) its 10-point scale being sensitive enough to capture changes over short-term interventions.

There seems to be an emerging consensus that the ONS Subjective Wellbeing tool is a sensible option to pursue.

9. Increased activation[8]

Activation refers to the knowledge, confidence and skills a person has to manage their health.

Measuring activation recognises the choices and actions people take contribute to their outcomes, and is a concept that is currently being promoted within the NHS. However, the terminology of 'activation' is clunky, and approaches to measurement are focused on a medical understanding of health rather than a more holistic understanding of health, wellbeing and social welfare.

Tools for measuring increased activation:

- Patient Activation Measure (PAM): 13 statements, 5-point scale, four activation levels along a 100-point scale). Promising emerging evidence of an association between PAM score and primary and secondary care usage. The questionnaire is intended to be completed by a person on their own. People who are less activated are less likely to complete the questionnaire (self-selecting sample). People with dementia are also less likely to complete the questionnaire. Richmond Group members report finding it difficult to translate PAM's medical terminology to holistic situations like social prescribing, e.g. it asks only about medication and not about equipment, physiotherapy, and other non-drug therapies. Some local 'link workers' report finding the PAM to be quite useful, but they are adapting their administration on a case-by-case basis (e.g. selecting which questions to ask). It is not possible to access the calculation the PAM uses to turn a person's response into a score from 0-100, as the developer will not release it. It is therefore impossible to understand how changes to its administration might affect its validation. In the short-term, NHS England seems willing to cover the cost of licences, but longer-term costs are unknown (price on application).

Despite significant investment in the PAM by NHS England and others, we have struggled to find much support for using the PAM as an outcome measurement tool for social prescribing.

10. Reduced demand for medical services

Measuring system outcomes has proven to be burdensome, resource intensive and problematic for Richmond Group charities and the wider VCSE sector. Matched control groups are very difficult to identify and to source data for, and both Richmond Group charities and independent experts have struggled to control for important variables such as living status. The University of Westminster has published a review of available evidence.[9]

Measurable outcomes might include:

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[8] Armstrong, N. at al (2017). *Independent evaluation of the feasibility of using the Patient Activation Measure in the NHS in England: Final report.* https://lra.le.ac.uk/bitstream/2381/40449/2/PAM%20learning%20set_final%20evaluation%20report_final.pdf University of Leicester

[9] Polley, M., Bertotti, M., Kimberlee, R. & Pilkington, K. (2017). *A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications.* www.researchgate.net/publication/318826738_A_review_of_the_evidence_assessing_impact_of_social_prescribing_on_healthcare_demand_and_cost_implications University of Westminster

- Reduced A&E attendance. There is some, albeit limited, evidence that social prescribing services *may* reduce A&E attendance. Increasing activation seems to be associated with reduced inefficient use of A&E, though this is less pronounced for older people (possibly because high activation cannot negate frailty), which is important to note in the context of Somerset's higher-than-average ageing population. Some Richmond Group charities report people living alone to be more likely to attend A&E than people who live with others.

- Reduced emergency admission to hospital. There is some, albeit limited, evidence that social prescribing services *may* reduce emergency admission to hospital. Few, if any, social prescribing services have set out to achieve this outcome.

- Reduced GP attendance. At least seven papers have looked at the effect of social prescribing on demand for general practice, reporting an average 28% reduction in demand for GP services following referral. Results range from 2% to 70%. Unless a social prescribing service reduces GP attendance to the sum of *an entire* GP's workload, the service is making general practice *more efficient* rather than releasing a cost saving. It may be possible to reinvest the saved opportunity costs into an activity that subsequently results in a measureable cost saving.

The available evidence points toward reducing GP attendance as the most sensible system outcome to capture and measure. We need to be careful about equating this to financial outcomes, and particularly ensure we distinguish between efficiencies and cashable savings.

11. Capturing and sharing data

In order to report on the activity, outputs and outcomes of social prescribing, services need a digital tracking system. This needn't be expensive off-the-shelf software and we have thus far found it unnecessary to buy any.

The **relevant data is usually already captured** and stored in a data warehouse or lake. Collaborating with the relevant data analytics lead/s and developer/s from the outset of setting up a social prescribing service can save a lot of time and money later on.

NHS Digital has created national SNOMED codes [systematically organised computer processable collection of medical terms] for social prescribing **to be used within GP IT systems**. These need to be used within primary care so that social prescribing cases can be easily identified and tracked:

- 871691000000100 | Social prescribing offered (finding)
- 871711000000103 | Social prescribing declined (situation)

Establishing data sharing protocols with health services and other statutory services can be very helpful, but it takes time. Some statutory and VCSE partners elsewhere in the UK hold **honorary contracts** with the statutory services with which they are based in order to enable data sharing.

CHLOË REEVES
chloe@londonroadpp.com