Path to fit for the future: Social Prescribing extension project

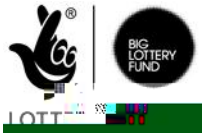
Evaluation report

Andrea Wigfield
Sarah Alden
Erika Kispeter
With contribution from Tom Clarke

CIRCLE

fit as a fiddle is a programme run by Age UK and funded by the Big Lottery Fund as part of the Wellbeing programme
www.ageuk.org.uk

www.fitasaf



Executive Summary

The fit for the future 'social prescribing' extension project evaluation was interested in the potential impact on the outcomes of older people that are referred to the project by health care professionals. It focuses on additional survey data collected by three of the 11 local Age UK Partners which took part in the programme: Nottingham and Nottinghamshire; Newcastle; and West Cumbria. Each area received additional funding to deliver fit for the future activities for newly recruited older people, specifically

as fit for the future, alongside the potential resource savings to the health and social care sectors. However, more research is needed in this area.

Introduction and background

This report, undertaken by CIRCLE, University of Leeds, provides an additional evaluation based on Age UK's fit for the future programme, which was part of the Big Lottery Funded 'fit as a fiddle portfolio 2013-*нлмр'*.

The fit for the future programme is a person-centred programme with the overall objective of supporting the physical health and mental well-being of older people living with at least one long-term health condition, with a primary focus on those with declining health and/or mental well-being. The fit for the future programme was delivered in 11 local Age UK areas and the evaluation included a three phase survey of participants, completed at three timepoints (at the start of their involvement in the programme; three months; and nine months after86(t)-4(e)8-2(e)8>2(s)11(t)-4(ar)8(t)-4( )63(o)7(f)5( )63(t)-4(h)5(e)8>2(in)5(t)-4e(rvo)7(r

reuarfteo lad dtiotnaly( )-712(f)5(u)-4(n)5(d)-4(ed)3( )1763(t)-4ot deliver

l P Œ } µ v š } Œ • } •] Œ o] ‰ v P [

This report is interested in understanding the potential value of 'social prescribing', in light of an increasing recognition that the 'social' as well as the 'medical' aspects of long term conditions, need to be tackled (Nesta, 2013:6). For the purposes of this report, social prescribing is defined as:

> ^ u v • } (v o] v P ‰ Œ] u Œ Ç Œ • Œ À] • š } Œ (Œ ‰ š] v
> or practical needs to a range of local, non-clinical services, often provided by the voluntary and community s š } Œ (Age UK, 2011:4)

These measures are viewed as complementary to medical services, enabling a more 'holistic' approach to managing the health and well-being of the population (Dayson and Bashir, 2014). The main assessed benefits of social prescribing have been described as:

> ^ Better social and clinical outcomes for people with long-term conditions (LTCs) and their carers.
> More cost-efficient and effective use of NHS and social care resources.
> Á] Œ U u } Œ] À Œ • v Œ • ‰ } v •] À ‰ Œ } À] Œ • X _
> (Dayson and Bashir, 2014:i).

Research has also indicated that adopting a social prescribing model can improve community cohesion, mental well-being, and help to reduce social exclusion (Age UK, 2011:4). Further, a recent study found that nine out of ten GPs felt that their patients would benefit from social prescribing (Nesta, 2013). In 2011 Age UK completed a small pilot, working with 12 General Practices and six local Age UKs across the Yorkshire and Humber area, which included referrals to the previously-fit as a fiddle portfolio of activities. Qualitative findings showed improvements in local community linkage and to the emotional well-being of older beneficiaries, alongside enabling clinicians to make more effective use of their time (Age UK, 2011).

However, despite these recorded benefits social prescribing has not yet experienced widespread coverage. For example in the Nesta study referred to above, despite 90% of GPs recognising the benefits of social prescribing, less than 20% actually offered this (Nesta, 2013). Further, whilst the number of localities experimenting with social prescribing trials has been increasing, these have generally been small scale, and effectiveness or cost benefit have not been conclusively demonstrated (Centre for Reviews and Dissemination, 2015; Williams, 2015).

The Rotherham Social Prescribing Project, an evaluation of which was undertaken by the Centre for Regional Economic and Social Research, represents the first large scale trial of

social prescribing of its kind (a total of 1,607 beneficiaries). The evaluation of the Rotherham Social Prescribing Project found that health care costs had been reduced by around a fifth, and that patients who had been referred reported improvements in well-being, thus illustrating the potential cost benefit and effectiveness of social prescribing (Dayson and Bashir, 2014). However, despite these promising findings some issues have been identified, such as the risk of bias due to patients not being randomly selected, and importantly it also lacked a control group. It was also felt that detecting significant changes was adversely affected by the short timeframe before follow up (at six and 12 months) (Centre for Reviews and Dissemination, 2015).

In summary, whilst social prescribing, both its use and efficacy, are still in early stages, findings indicate its potential contribution to make more effective use of health care resources and support medical interventions in increasing the health and well-being of patients.

analysedmanually to assess the main points and some key quotes are presented in the report to illustrate findings and to add specific detail to the discussion. It is important to note that the sample of participants and stakeholders identified for interviews may not necessarily reflect the views of all participants and stakeholders involved in the local Age UKs in each respective area.

Working with health care professionals

This section provides a short overview of the telephone interviews carried out with two HCPs whose General Practices are involved in referring patients to fit for the future programme: a GP based in Newcastle; and a Community Rehabilitation team leader in West Cumbria. The discussion that follows should be viewed as providing an illustration of how HCP's based in two of the three areas have worked with Age UK, and to consider the main benefits and challenges.

Both interviewees confirmed that their respective organisation's had got involved with Age UK to improve community links, reduce capacity, and for the benefit of the older person. Whilst both HCP's reported initially completing 'paperwork', the arrangement to refer patients was 'informal', and neither organisation kept records.

The main benefit of referring older people to fit for the future was perceived, by the HCPs, to be the provision of preventative support. This was particularly so for the Rehabilitation Service, whose team leader believed that referring patients at an early stage risk of falls to an Age UK falls group could help delay the onset of the older person developing more complex needs, thus reducing demand for medical services:

> It helps us out [referring to Age UK West Cumbria], otherwise those patients are more likely to get deconditioned and not get out as much and develop health problems which impacts on the rehab service, it is like a preventative service, really (HCP West Cumbria)

Alongside health benefits, both HCP's also referred to 'softer' outcomes, such as the role of fit for the future in preventing loneliness and social isolation:

> You are talking to somebody and they talk about being lonely, isolated, not having the confidence to go out, or being bored and unfulfilled and you become aware that they need structure in their life or social stimulation (HCP, seenting l92303 Tm TJ C01son.

detrimental impact on health provision, mainly due to capacity, as more patients will inevitably end up requiring health services:

> There is need for social and psychological type of services as health is as much to do with social and environmental factors as with medication and things like that. So I think this type of pilot is very much part of primary care (HCP Newcastle).

> / (• }] o € Œ • v [š ‰ Œ } À] U š Z v Z o š Z € Œ • Á] o o (o Sector not being funded, will have effect on health (HCP, West Cumbria).

In terms of the wider health and social care system, both HCP interviewees suggested that joined up working with Third Sector organisations such as Age UK saved resources by freeing up capacity, and it also enables clinicians and GPs to have more time to work with patients

The Survey Respondents

This section now considers the main characteristics of the respondents to the survey. A total of 305 older people completed Survey 1, and 247 completed both Survey 1 and 2. As can be seen from Table 1, the proportion of respondents are drawn fairly equally between the three participating local Age UKs. The number of responses for each survey question varies due to 'missing values', where participants have not provided an answer.

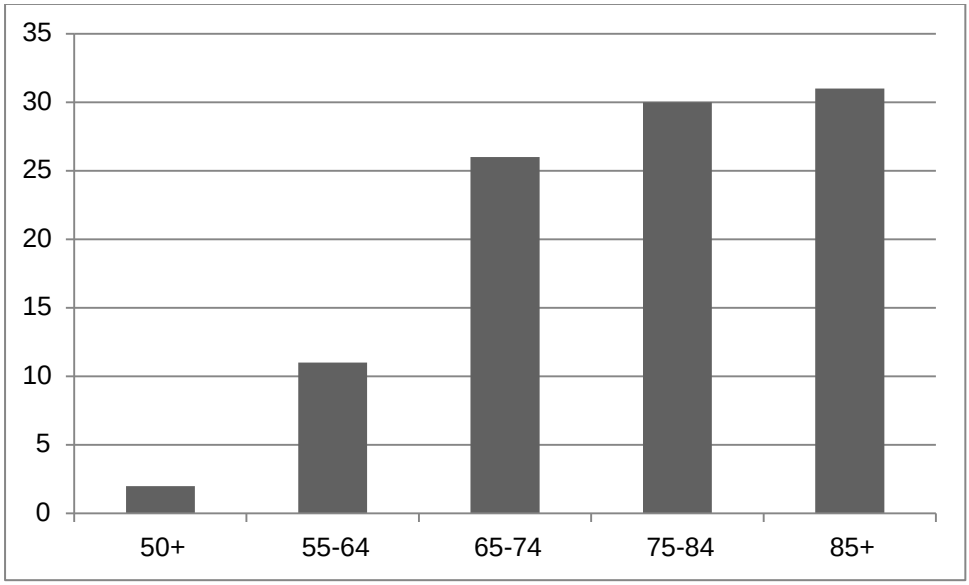
Table 1: Number of respondents (percentage)

	Survey One	Survey Two
Newcastle	103 (33.8)	80 (32.4)
Nottinghamshire	100 (32.8)	78 (31.5)
West Cumbria	102 (33.4)	89 (36)
Total	305	247

Age and gender of participants

Table 2 provides information relating to the gender of the older people who responded to this question. Just under two thirds were women; this leaning toward female respondents reflected participation in the Fit for the Future programme overall and in fact, the proportion of women was even higher for the original survey respondents, at 74.7%. All three areas had

Figure 1 Age breakdown of participants (percentage)



Disability and Long term health conditions

Long term conditions

Just over 90% of respondents have a long term health condition, with just over a third (31.7%) reporting three or more, which broadly follows the numbers identified in the original surveys (see Table 3).

Table 3 Number of long term health conditions

Number	Frequency	Percent
none	30	9.8
1	106	34.8
2	72	23.6
3	68	22.3
4	23	7.5
5	4	1.3
6	1	0.3
7	1	0.3
Total	305	100.0

The most common LTC was arthritis, reported by nearly half of the sample (48.2%), with heart conditions being reported by just under a third (29.6%) (Figure 2 provides a percentage breakdown of each).

The types of disabilities reported are listed in Table 4. Of those who reported a disability, in comparison to the original survey participants, the extension respondents were slightly more likely to report a physical disability and less likely to have a chronic illness, but overall, the differences were slight.

Table 4: Respondents with different types of disability (percentage of total sample)

Disability	Percentage
Physical disability	76.1 (40.6)
Chronic illness	20.2 (10.8)
Deafness / serious hearing impairment	12.3 (6.5)
Blindness / serious visual impairment	13.5 (7.2)
Serious mental health condition	12.9 (6.9)
Other disability	9.2 (4.9)
Substantial learning difficulty	0.6 (0.3)
Substantial learning disability	0

Living arrangements and caring responsibilities

Respondents were asked whether they lived alone or with one or more other person. Over half (55.8%), lived alone (Table 5). The original report (Wigfield et al, 2015) observed a difference between the living arrangements of male and female respondents, showing that a larger proportion of female respondents lived alone, consistent with national trends (ONS, 2014). The extension survey found a similar pattern, with 44.7% of men and 64.5% of women reporting that they lived alone, which in fact starker than the original survey, as the same number of women lived alone (64.5 %), compared to 54% of men.

Table 5: Living arrangements

	Frequency	Percent
Live alone	168	55.8
Live with someone	133	44.2
Total	301	100

In total 16.4% of respondents were carers (slightly higher than the proportion reported by the original survey respondents, at 13.8%). Of these, a similar proportion of men and

Impact on older people

The data analysed compares the changes reported between survey one and survey two, with the total number of respondents who completed both surveys being 247, as previously stated. The effect that gender[5], age and caring responsibilities have on the variables where a change was identified are also considered and discussed, where appropriate. The data is considered in comparison to timepoints one and two of the original survey, which was also completed at the start, and three months after involvement in Fit for the Future.

The differences between the findings in this survey are compared to the findings for the future survey, but it needs to be borne in mind that we are unable to provide direct comparisons to the original Fit for the future survey. This is because we do not know the specific referral routes of the original sample, and therefore cannot manipulate the data to exclude those referred by HCPs. That is, we are aware that some of the participants in the original Fit for the future survey were referred by HCPs, so we are unable to provide any comparison. So whilst the results across the 'original' and 'extension' surveys are compared and contrasted (both the overall findings and those based in the three individual areas), direct comparison was not possible.

Differences on the basis of ethnicity, religion or sexuality are not considered due to the limited variation in the data. For example the overwhelming number of respondents (97.5%) identified themselves as White British and all as heterosexual; for religious belief 98% either identified themselves as Christian (75%), or of following no religion (23%); Tables with information for each of these characteristics can be found in Appendix 1. Table 6 provides the percentage of positive change for the key variables assessed.

Table6: Older people with a positive outcome observed

Outcome	Verification Method	% of older people with positive outcome Survey 1 - 2	Sample Size
Older people feel more positive about themselves.	7-item Warwick-Edinburgh Mental Well-being Scale	39,2	199
Older people feel less lonely.	Loneliness Survey Question	17.5	229
Older people feel less isolated.	Isolation Survey Question	14.8	229
Older people are satisfied with their life	Life Satisfaction Score	36.9	233
Older people have increased the number of minutes of physical activity they do per week as per the Department of Health physical activity guidelines.	Walking Survey Question	35	216
	Hard breathing Survey Question	34.7	216
	Muscle Strengthening Activity Survey Question	28	211
Older people have an improved body mass index (BMI).	BMI Survey Question	30.4	148
Older people have an improved waist circumference.	Waist Circumference Survey Question	15,7	83
Older people have reduced their average alcohol consumption per week	Alcohol Consumption per wee Survey Questions	32	50
Older people have reduced the numbe of cigarettes they smoke per day.	Cigarette Consumption per da Survey Questions	41.7	24
Older people have increased their daily consumption of fruit and vegetables.	Fruit & veg intake per day Survey Questions	31.7	234
Older people feel more supported to manage their LTCs.	Feel supported to manage LT Survey Question	18.2	214
Older people feel more in control of their own care as relevant to their specific LTCs.	Feel in control of ID 84>> BDC		

the four variables relating to social networks produced a significant result for the extension survey (Table 10).

d o ìW Z v P]v šZ À o µ }( ]v] š}Œ• u •µŒ]vP] o}v o]v ••
~]v š Œ‹µ Œš]o Œ v P •

s Œ] o	^µŒ À
	K v

A significant rise in the proportion of those eating ‘five or more’ portions of fruit and

Table 14

Table 17

Table 13: D] v µ š • • ‰ v š }] v P š] À] š] • š Z š u l Z Ç } µ Œ š Z • } u
(interquartile range)

	^ µ Œ À Ç K v	^ µ Œ À Ç d Á } *n* À o µ		*Statistically significant change*[F]
Newcastle	0 (32.50)	20 (160)	61	Yes
Nottinghamshire	0 (71.25)	30 (142.50)	70	No
West Cumbria	10 (60)	10 (60)	88	No

can be seen in Table 10.2. Also, the overall number of respondents who were recorded as overweight, based on their BMI score, was low (n = 36). It is worth noting that the BMI of overweight participants showed a significant decrease in the original surveys between timepoints 2-3, suggesting overall changes to BMI due to weight loss may take longer to take effect, though we cannot assert this with any certainty.

d o ïW K o Œ ‰ }‰ov Pvu švžš }(šZš]ŒEuo}ZvPošZ -}v]š]}v•
u] v ~]vš Œ‹µ Œš]o Œ vP •

s Œ] o	^µŒÀ K v	^µŒÀ d Á}	*n* À o	*Statistically significant change*F
I am fully informed about issues relating to my long term health conditions	2 (1)	2 (1)	214	No.

When individual areas were isolated, the only difference observed was that West Cumbria showed a statistically significant decrease in participants reporting falls between timepoints 1-2 in the original survey, which was not found in the extension survey.

Older people participating in fit for the future were asked about the number of unplanned visits to GPs, hospitals and other health professionals. As the reported numbers were very small, we combined the three categories and analysed how the number of visits to health profes

outside contact. Furthermore, it may be that HCPs such as a local GP are a trusted source of information, potentially encouraging

References

Age UK & Age Concern 2011. *Social prescribing: A model for partnership working between primary care and the voluntary sector* London, Age UK.

Centre for reviews and dissemination 2015. *Evidence to inform the commissioning of social prescribing,* York, The University of York.

Dayson, C. & Bashir, N. 2014. *The social and economic impact of the rotherham social prescribing pilot,* Sheffield, The Centre for Regional, Economic and Social Research.

Nesta. 2013. *More than medicine: New services for people powered health* [Online]. Available: http://www.nesta.org.uk/sites/default/files/more_than_medicine.pdf [Accessed 12 February 2015.

Wigfield, A., Kispeter, E., Alden, S. & Turner, R. 2015. *Age uk's fit for the future project: Evaluation report,* Leeds, CIRCLE.

Williams, R. 2015. Why lunch at a rugby club is the best medicine. *The Guardian*, London, n.p.

Appendix One Characteristics of respondents (percentage)

Table 1: Ethnicity

Ethnic background	Percentage
White British	97.5
Irish	1.0
Gypsy or Irish Traveller	0.0
Other White	1.0
Indian	0.0
Pakistani	0.0
Chinese	0.0
Other Asian	0.0
Mixed white and Black Caribbean	0.0
Mixed white and Black African	0.0
Mixed white and Asian	0.0
Other mixed background	0.0
Caribbean	0.5
Other Black, African, Caribbean	0.0
Arab	0.0
Any other ethnic background	0.0
Total	100.0

Table 2: Religion

Religion or belief	Percentage
No religion	23
Christian	75
Buddhist	0
Hindu	0

Muslim	0
Sikh	0
Other religion	2
Total	100

Table 3: Sexual orientation

Sexual orientation	