Collaborative Evaluation & Research Centre

Supporting Innovative Research and Evaluation

Latrobe Health Assembly Social Prescribing Project Evaluation SUMMARY 2023/2024

ACKNOWLEDGEMENTS

The Collaborative Evaluation and Research Centre (CERC) Federation University Gippsland, acknowledges Aboriginal and Torres Strait Islander people as the traditional owners and custodians of the land, sea and nations and pay our respect to elders, past, present, and emerging. The CERC further acknowledges our commitment to working respectfully to honour their ongoing cultural and spiritual connections to this country.

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SUMMARY OF FINDINGS

SOCIAL PRESCRIBING PROJECT EVALUATION 2023/2024

INTRODUCTION

Social Prescribing (SP) is a modern approach to primary care in which healthcare professionals may offer non-medical referrals to patients with the aim of addressing social determinants of health that are influencing the health of their patients (Moore et al, 2023)[1]. More than just 'signposting' to appropriate support services, referrals are being made to this new role known as Social Prescribing, where the '*link worker*' or '*Community Connector*' can help connect patients into social networks and help to overcome existing barriers that potentially contribute to poor health outcomes (Sharman et al, 2022)[2]. Non-medical interventions, such as involvement in community groups, art, music, exercise, and volunteering, or socio-economic support services such as housing, employment, and legal assistance (Brandling & House, 2007)[3] have been seen to help improve overall health outcomes and potentially reduce demand on GP and hospital interventions (Polley et al., 2017)[4]. Multiple Social Prescribing models exist around the world, including in the United Kingdom, USA, New Zealand and more recently in Australia, with variances noted in delivery and evaluation techniques (Ayorinde et al, 2024[5]; Annear et al, 2019)[6]. Despite the value of the role being widely disseminated, continuity and standardisation of practice is lacking. Research about Social Prescribing has demonstrated the diverse nature of the role, including the various names by which the worker identifies (Moore et al, 2023)[4] Professional identity and role definition is vague, with practice currently dependant on many variables, such as funding expectations, available resources, staff skill levels, and mixed participation from both referring practitioners and public consumers (Moore et al, 2023[4], Sharman et al, 2022[5]). Such variance within the role has led to disparate practice outcomes, where some link workers are restricted to simply 'signposting', directing patients towards community activities or supports; where others are able to spend more time accompanying clients to activities and supporting them to establish new connections. Therefore, evidence suggests that formulating an ideal role description and capacity is difficult due to the authentic nature of this contemporary position (Moore et al, 2023)[4].

The previous evaluation report developed by the CERC, explained the initial development of the Social Prescribing pilot program for the Latrobe Valley. The pilot was originally established in Churchill and was located at the Churchill Health Centre and Churchill Neighbourhood House. The 2022/2023 report provided details of the evaluation, reflecting the reach and impact of the pilot using a mixed methods

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[1] Moore, C., Unwin, P., Evans, N., & Howie, F. (2023). "Winging It": An Exploration of the Self-Perceived Professional Identity of Social Prescribing Link Workers. *Health & Social Care in the Community*, *2023*(1), 8488615.

[2] Sharman, L. S., McNamara, N., Hayes, S., & Dingle, G. A. (2022). Social prescribing link workers—A qualitative Australian perspective. *Health & social care in the community*, *30*(6), e6376-e6385.

[3] Brandling, J., & House, W. (2007). Investigation into the feasibility of a social prescribing service in primary care: a pilot project.

[4] Polley, M., Chatterjee, H., & Clayton, G. (2017). Social prescribing: community-based referral in public health. *Perspectives in public health*, *138*(1), 18-19.

[5] Ayorinde, A., Grove, A., Ghosh, I., Harlock, J., Meehan, E., Tyldesley-Marshall, N., ... & Al-Khudairy, L. (2024). What is the best way to evaluate social prescribing? A qualitative feasibility assessment for a national impact evaluation study in England. *Journal of Health Services Research & Policy*, *29*(2), 111-121.

[6] Annear, M., Lucas, P., Wilkinson, T., & Shimizu, Y. (2019). Prescribing physical activity as a preventive measure for middle-aged Australians with dementia risk factors. *Australian Journal of Primary Health*, *25*(2), 108-112. https://doi.org/10.1071/PY18171

approach. The evaluation contained data collected between the period July 2021 to March 2023, and included 47 referred clients during this time. Deciding to extend the pilot for another funding period, the program was relocated to a larger health organisation in the area; Latrobe Community Health Service (LCHS), widening the potential reach and scope of referring practitioners. In addition, a new Community Connector was employed and saw her first referred client in February 2023. CERC was again commissioned to evaluate the second iteration of the program. Recognising that a short cross-over period did occur as the Churchill program ended and the new program was established at LCHS, it has been agreed (LHA and CERC) that this report will only report on data collected from the new LCHS site and regarding work carried out by the new Social Prescribing Community Connector.

Note: In this report, the person employed to do the Social Prescribing role will be referred to as '*Community Connector'*.

EVALUATION OVERVIEW

This evaluation aimed to assess the process, the outcomes and the impact of the Social Prescribing pilot being delivered within the LCHS network across the Latrobe Valley and surrounding areas. It hoped to identify the benefits and challenges of delivery, the reach of the program, and determine how the program was received by the community and local health professionals.

RESEARCH QUESTIONS

The overall evaluation of the pilot project addressed the following research questions:

1. What was the impact of the Social Prescribing model on primary health providers in the Latrobe Valley?
2. What was the impact of the Social Prescribing model on referral recipients?
3. What were the perceived benefits and challenges to introducing a program for Social Prescribing in the Latrobe Valley?

DATA COLLECTION AND TOOLS

The evaluation of the Social Prescribing pilot used a Mixed Methods approach to examine the impact, outcomes, and processes of the program in Latrobe. Data was collected between February 2023 and April 2024 from a variety of sources, including clients participating in the program, referring practitioners and the Community Connector (Figure 1).

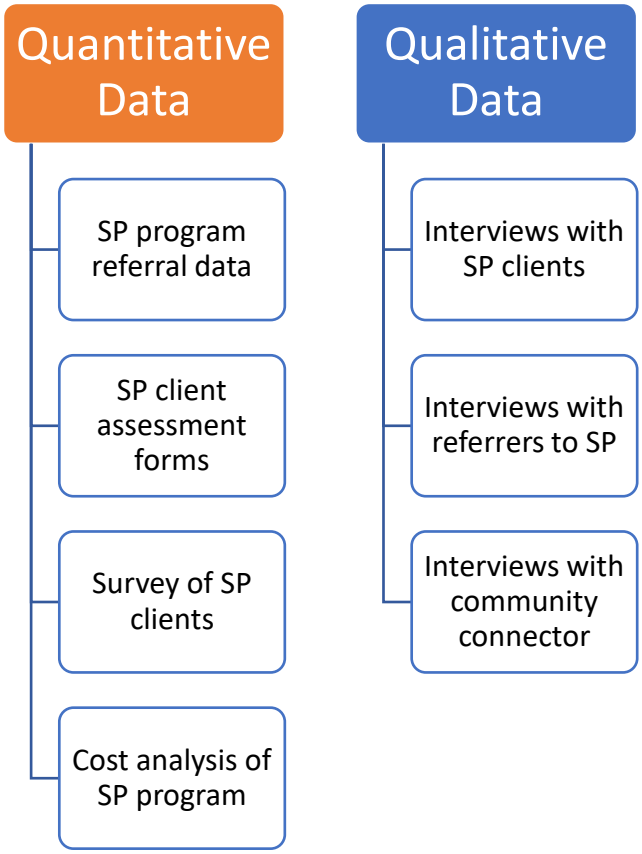


Figure 1: Data collected for evaluation

LATROBE HEALTH ASSEMBLY
SOCIAL PRESCRIBING PILOT PROGRAM 2023-2024

Latrobe Community Health Service

- 47 Client Referrals (Feb 2023-April 2024)
- 9 different referral sources (67% from GPs)
- 191 Client Visits
- First visits: 90% >30 mins duration, 45% >60 mins
- 2-18 visits per client (Average 6 visits per client)
- 277 client phone calls, 164 texts, 105 emails

Evaluation sources

- Referral and client visit forms
- 7 Referring Practitioner interviews
- 9 Client interviews
- 3 Community Connector interviews

Additional care option

"...it's nice to be able to offer something which isn't just a pill or a potion" Referring Practitioner

Connector support

"I dont think I would have gone if I didnt have her with me..." Client

First impressions

"I'm really trying to make that first experience, a really good one… because that sets the tone for the rest..." Community Connector

Successful Connections

"I absolutely love it and I've got to know some fabulous people... so it has made a huge difference in my life" Client

Social Prescribing was designed to improve mental and physical health through addressing isolation and social disconnection. The Community Connector role aimed to support vulnerable people to overcome barriers and make sustainable connections within their local community. Improved social connection has built confidence, improved self-esteem and provided purpose, while shifting the focus away from poor health.

"...the more normal you can make your life, the less likely the symptoms are to bother you."

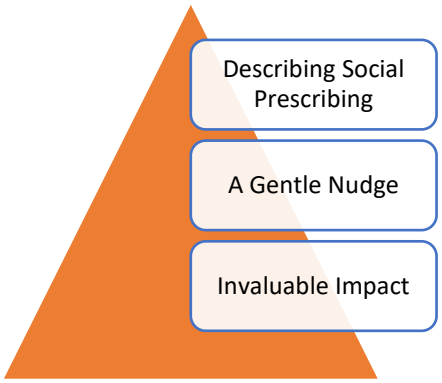
OUTCOMES & RECOMMENDATIONS

- **TIME and SCOPE** - the Community Connector role requires the resources to provide truly holistic support.
- **RESEARCH and KNOWLEDGE** - are required to produce appropriate opportunities for connection that meet clients' needs.
- **PROGRAM AWARENESS** - improved program promotion is required to maximise impact on the Latrobe community

KEY FINDINGS

SOCIAL PRESCRIBING CLIENTS

Three key themes were identified through analysis of individual interviews with clients participating in the social prescribing program (Figure 2). These themes described how each of the individual utilising the program valued the service in different ways. They highlighted key characteristics of the community connector that saw them engage, yet also explained how the service did not address all their needs. Many saw the program as 'a gentle nudge' to support them to reconnect and others highlighted the invaluable impact their participation in the program had made in their lives and wellbeing.

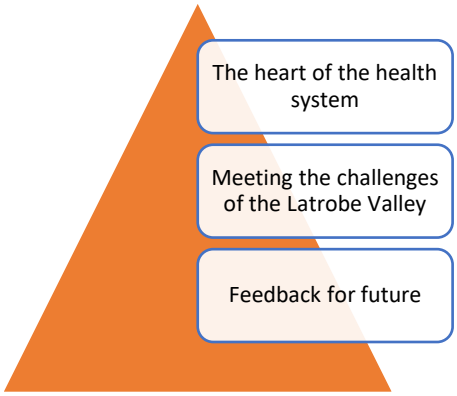


"I don't think I would have gone if I didn't have her with me…she was very happy to take the lead and ask a lot of questions and speak on my behalf…because I have a lot of social anxiety. It was a really lovely experience." C4

Figure 2: Thematic analysis of client interviews

REFERRING PRACTITIONERS

Individual interviews with referring practitioners also highlighted three key themes, giving insight into the impact of the program on the individual, the health system, and for the Latrobe Valley community (Figure 3). There was complete consensus regarding the importance of a program such as Social Prescribing, to help address social needs and community connection, in order to maintain and improve health within the Latrobe Valley community.



"So, I think it is another option in terms of medicine, not forgetting that medicine is not all just pills and potions. We know that. It really is lots of other things and I think this (Social Prescribing) is filling a role that we as GPs, struggle to provide." P4

Figure 3: Thematic analysis of practitioner/personnel interviews

THE COMMUNITY CONNECTOR

The community connector identified three priority areas early in her role and strived to further develop the role and community engagement:

1. *"Making sure my* [Social Prescribing service] *information is out there."* Increasing awareness of Social Prescribing within LCHS to increase the number of appropriate referrals and clients.
2. *"Streamline referrals."* Ensuring the referral process was easy and simple for practitioners and clients to reduce wait time and increase accessibility to the service.
3. *"Making sure that I'm up to speed with what's out there"* regarding community activities, social services, and referral points, ensuring that all participants receive the best possible service and community connection.

Describing the role as '*the best job ever',* the community connector explained how the role was often very time consuming and involved a lot of research and preparation time to ensure clients had great first contact experiences.

> *"I'm really trying to make that first experience, a really good one… because that sets the tone for the rest of the future activity…just trying to make the experience as easy and fun as possible"*

This dedication to preparing for successful experiences therefore resulted in many continued social interactions and built confidence in the individuals the program was designed to support.

> *…one of the most enjoyable parts of it has been the fact that I've been able to leave my desk and participate with the clients. That's been really enjoyable, and it's enabled me to really close the circle… talk about an activity with the client, do the research and then go along and then see how the client reacts.*

COST ANALYSIS

The average cost per client contact hour was **$631.50 in Phase 2**, compared to $1,871 in Phase 1, a decrease of **$1,239 (196%) per contact hour**. This exceptional decrease was due to a combined increase in the number of client engagements and the longer duration of these engagements seen in Phase 2 (Table 1).

Table 1: Cost analysis outcomes Phase 2

Measure	Phase 1	Phase 2	Variance	% Change
Cost Per Client	$1,940	$1,764	-$176	-10.0%
Cost Per Visit	$496	$436	-$59	-13.6%
Cost Per Client Contact Hour	**$1,871**	**$631.50**	**-$1,239**	**-196.2%**

OUTCOMES

Relocating the pilot program into the Latrobe Community Health Service has not seen the dramatic increase in client referrals as expected. However, it did result in a wider range of health providers utilising the service as part of their practice. In comparison to the previous pilot period where only one referral came from a General Practitioner (GP); the new model saw 67% (n=28) of clients referred by GPs, located across various sites of the organisation. Referrals also came from nurse practitioners, dieticians, a refugee nurse, drug and alcohol and care coordination personnel; all grateful to have an additional referral option to address their client's social needs, in order to improve health outcomes:

> *"…it's nice to be able to offer something which isn't just a pill or a potion".* Practitioner (GP)

Cost analysis comparing the two phases of the project demonstrated that although client contact increased in Phase 2, the present model was not necessarily a cost-efficient solution to providing social support. However, evaluation participants suggested that with greater awareness, there was the potential for increased referral capacity, with a resultant improvement in cost effectiveness. Role efficiency throughout the project was adversely impacted by lower-than-expected referral numbers. The average cost per engagement (visit) was $436 in Phase 2, compared to $496 in Phase 1, a decrease of $59 (13.6%) per engagement. The average cost per client contact hour was $631.50 in Phase 2, compared to $1,871 in Phase 1, a decrease of $1,239 (196%) per contact hour. This exceptional decrease was due to a combined increase in the number of client engagements and the longer duration of these engagements seen in Phase 2.

Although not all clients participating in the program made sustained social connections, client engagement with the program improved, with the average number of visits increasing from 4 visits per client in the previous model, to 6 visits per client in the current model. Many anecdotal success stories were provided during the evaluation, from both clients and referring practitioners, including improvements that were seen in client confidence, physical activity, creative outlets, and opportunities to 'give back' to the community through volunteering, teaching, and supporting others. Clients reported making new friends, new contacts, and no longer feeling *'like everyone's a stranger'* within their own community. Whilst not all successes were able to be formally measured through data collection methods, these successes were noticed through improved mental health, improved self-esteem, and a more positive client demeaner as reported by the clients, the Community Connector, and the referring practitioners:

> *"I have done over 25 walks with them* [Heart Foundation Walking Group] *now. Absolutely love it and I've got to know some fabulous people through there. So, it has made a huge difference in my life."* Client

For others, engaging with the Social Prescribing program was not enough to help overcome the personal challenges they had in reconnecting with their community. For some, barriers such as pain, mobility, or financial concerns, could not be addressed by the Community Connector, and although these clients truly valued their association with the program, they were unable to fulfill their connection desires.

The program has been described as '*invaluable*', '*life changing'* and making *'a huge difference',* with the key contributing factor being that of '*time*'. The Community Connector had the privilege of time,

scope, and resources, to spend appropriately addressing the needs, desires, and challenges of the client, of which the referring practitioners stated, they did not have:

> "*I know what (the clients) really need, but I don't have the time and it's out of my scope.*" Practitioner

Authentic and truly personalised support was now being achieved through the Community Connector, as practitioners were unable to spend time researching, planning, and preparing clients for positive social connection experiences. Therefore, the role of Social Prescribing was described as helping to '*bridge some of the gaps'* within healthcare.

The main reason given by participants for low referral rates, was that the publicity and promotion of the Social Prescribing pilot had been insufficient, or perhaps ineffective. Clinician awareness and understanding of Social Prescribing was limited, and many participants stated they only learnt about the program by chance, many months after it commenced in the organisation, through speaking with the connector in the corridor. For those practitioners who did embrace and value the service, they were also afraid that, like many other transient funded support programs introduced into the Latrobe Valley, the full potential of Social Prescribing may not be achieved. Innovative and novel programs like Social Prescribing need appropriate marketing and time to become established and accepted, within the health system and the community. Therefore, evaluating the success of such programs before they are fully established, working at full capacity, and recognised within the community, may have been premature:

> *"…it's going to be something that's going to (SIC) take 5-6, however many years, to really get it established and for people to feel confident… for GPs, and practice managers, and practice nurses to understand it... this will take time." Practitioner*

Regardless of these challenges, the clients, referring practitioners and the Community Connector, all see both the need and a future, for the Social Prescribing program in the Latrobe Valley. The Community Connector describes the role as '*the best job I have ever had'* and believes '*being embedded in a large health service*' has '*worked really well'*. The second iteration of the pilot has provided opportunity to trial different connection strategies and build resources and social networks which will lead to a more effective and efficient service. As a result, the future of Social Prescribing in Latrobe '*is really exciting!*'

Thanks to this program I have joined the heart foundation and the local stroke support group. I would not have had the confidence in myself to have initiated either had it not been for the assistance and support I received from this program… This program has enabled me to make friends and develop meaningful and enduring friendships. This is a huge development for me because prior to this program I knew no one and would not have been able to accomplish what I have. I stayed home all the time and neither saw nor (SIC) engaged in conversation with anyone. I truly am very grateful to participate in this program and am all the better for it… This program is a vital link for people like myself whom otherwise would have remained disengaged and unable to make such steps to improve my quality of life.' Anonymous.

KEY RECOMMENDATIONS

1. The Social Prescribing program should continue to provide a community connection service within LCHS in the Latrobe Valley, with increased referral pathways. Referral agency should be expanded to include any healthcare provider within the organisation, local community service providers, Neighbourhood centres and include client self-referral.

2. Increased publicity and marketing of the service is required to ensure practitioners are aware and understand the scope, capability, and capacity of the Community Connector role, as well as how to refer into the program.

3. Further evaluation of the Social Prescribing program should be prolonged to allow time for program and role establishment.

    a. The Community Connector role is unique and will develop according to the population it serves and the needs of the population. Therefore, it will take time and increased client numbers to determine an appropriate workload and service capacity, whilst maintaining a quality and effective service. Until maximum capacity is achieved, true cost effectiveness cannot be determined.
    b. Community and provider acceptance and uptake will only occur after adequate exposure and information about the program. Further promotion and access to Social Prescribing resources both within and external to the organisation will mean the community will become more familiar with the service.
    c. Further development of data collection tools is required to measure program impact effectively and appropriately.

4. The Community Connector should have a stable and permanent location, to allow storage of resources, promotion of community activities and contacts, as well as maintain a familiar place of exposure for the community and other healthcare providers. The current transient nature of delivery has not been efficient, nor has it provided a welcoming, confidential and familiar place to meet with clients.

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