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## Measuring the economic impact of Wellspring Healthy Living Centre's Social Prescribing *Wellbeing Programme* for low level mental health issues encountered by GP services

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*We have seen how hard it is to engage some people, and how much patience and time some people need. In health we are often quick to judge, slow to listen, and feel too busy to care in the way we would want to. Having \*\*\*\*\* (a local social prescribing project) as a partner in our striving to deliver good care for our registered population is like having an extra pair of arms. The team are amazing in their resourcefulness and we are very much richer for the work they are doing.*

(A local GP who refers to a social prescribing project)

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## Executive summary

### *Introduction*

Social prescribing projects from the third sector can present a lot of qualitative evidence to demonstrate the transformative effect their intervention has on beneficiary' lives. Their impact should not be underestimated. However, the challenge for third sector organizations is to systematically collect quantitative evidence of the positive impact they have on people's lives. This requires the development of tools to capture their value.

It has been made clear that there is a growing crisis in primary care and with GP services in particular. According to the chair of the Royal College of General Practitioners general practice needs extra investment and at least 10,000 more GPs by 2022 to meet the population's growing and increasingly complex health needs (Gerada, 2013).

Links between primary health care services and third sector organizations are often underdeveloped and require considerable time and patience to develop and evolve (South, 2008:310). The social prescribing projects that are evolving and which have been identified and discussed in this report represent a considerable pioneering achievement and are a testament to the level of partnership work undertaken by GP practices and third sector organizations.

It is very clear from the literature review and the interviews/focus groups undertaken in a scoping exercise for this report that there is no single, agreed, understanding of what constitutes social prescribing. This report addresses this problem and outlines three different models of social prescribing to help describe the types of social prescribing services delivered: Social Prescribing Light, Social Prescribing Medium and Social Prescribing Holistic.

Social prescribing *holistic* projects like Wellspring Healthy Living Centre's Wellbeing Programme are adopting a holistic and preventive approach to health needs and seek to work with beneficiaries with long-term conditions. They encourage beneficiaries to play a central role in managing their own care. This intervention has emerged from an organic partnership that has developed between them and local GPs. Both perceived there was a need to utilize alternative approaches to promote beneficiary wellbeing.

We have found only one randomised control trial to assess the cost effectiveness of social prescribing. It looked at an intervention we would describe as social prescribing medium. Its conclusion was that beneficiaries of the project were seen to be less depressed and less anxious, but their care was more costly compared with routine care and their contact with primary care was not reduced (Grant et al, 2000:419).

### Method

This research evaluates the impacts of the *holistic* social prescribing, Wellbeing Programme delivered by the Wellspring Healthy Living Centre. As a *holistic* social prescribing approach it is representative of many third sector led interventions seeking to support local primary care services. It offers GP-referred patients 12 weeks of one to one support followed by 12 months of group support around a particular activity. Socio-economic impact was measured through *Social Return On Investment* approach using a pre and post intervention interview methodology using the Wellspring Wellbeing Questionnaire tool. This tool was used to help *Prove Our Value*. The tool was developed to include validated items that would be recognised by commissioners as suitable for providing evidence of impact.

### Impact

Data collected using the Wellspring Wellbeing Questionnaire suggests that three months after a beneficiary's induction on the intervention beneficiaries show statistically significant improvement in: PHQ9 scale for depression ( $p < 0.001$ ), GAD7 scale for anxiety ( $p < 0.001$ ), the Friendship Scale for isolation ( $p < 0.001$ ), the ONS Wellbeing measures (item range  $p < 0.05$  through to  $p = 0.001$ ), perceived economic wellbeing ( $p < 0.001$ ) and the International Physical Activity Questionnaire items for *moderate exercise*.

Analysis of GP contact times also suggest that for 60% of beneficiaries there is a reduction in their GP attendance rates in the 12 months post intervention compared to the 12 months period prior to referral. For 26% of beneficiaries it stayed the same and for 14% it actually increased.

A key outcome highlighted by social prescribing practitioners is that they perceive their intervention is not simply about achieving positive outcomes like: improved well-being, a return to work or training etc. Instead it is about addressing embedded and unaddressed/undiagnosed issues like: agoraphobia brought on by abusive neighbours, relationship breakdown, addiction etc. It can also be preventative in the sense that it helps to prevent beneficiaries spiralling down to worse scenarios.

### Cost-effectiveness

In a recent review of the economic costs involved in mental health prevention the importance of intervening to prevent worse outcomes cannot be underestimated (Platt et al. 2006). Simply looking at non-fatal suicide events it is estimated that costs are averted to £66,797 per year/person of working age where suicide is delayed. Figures vary depending on the means of the suicide attempt. 14% of costs are associated with A&E attendance and medical or surgical care; but more than 70% of costs are incurred through follow-up with psychiatric inpatient and outpatient care (Knapp et al, 2011:26).

Commissioners should be aware of the additional economic value provided through social prescribing projects like the Wellbeing Programme. These include: harnessing volunteers, beneficiaries returning to employment and training and resuming child care responsibilities and community capacity enhanced. Savings are also made through beneficiaries being guided into appropriate services and supported to address the variety of problems and issues they present with in general practice. These include addiction problems, debt management issues, anger management etc. This report outlines the significant costs averted as a result of the Wellbeing Programme.

A recent report of the government's Work Programme's first year shows that 19% of participants have spent 26 continuous weeks off benefit (DWP, 2012:5). Some of the Wellbeing Programme's added value comes from getting people back into work. 17% (n=9) of beneficiaries who at baseline described themselves as looking for work, long term sick, in education or training or on bail, actually found employment suggesting that the adoption of *holistic* social prescribing approaches are performing a return to work service as effective as the Work Programme.

Having established the social impact of the Wellbeing Programme we calculate a Social Return On Investment ratio of £2.90:£1. This means that for every pound of investment in the intervention, £2.90 of social value is created. We feel this is a very parsimonious reflection of the actual value created. Health economists like Knapp et al (2011) suggest quantifying these impacts across all beneficiary life years, whereas we are just reflecting on one year of value.

### *Conclusion and Recommendations*

Data monitoring methodologies are under developed across the third sector. This includes many projects that deliver social prescribing. Wellspring Healthy Living Centre have put considerable effort and time into developing data monitoring and evaluation processes to ensure they are well placed to *Prove Their Value*.

If policy makers and commissioners want to develop the scope and scale of primary care services it has been recommended that they will need to put in place innovative measures that could build on partnerships to address complex needs. Third sector partners like those discussed in this report have been shown to have the ability to help Clinical Commissioning Groups and the Department of Health to rebalance the way health services are delivered to address long term conditions that are a growing drain on health resources.

The Nuffield Trust has recommended that NHS England should work with CCGs, GPs, patient groups and professional bodies to create a national framework for primary care. The framework should set out the outcomes and overall vision for primary care, both in relation to service provision and the wider role of primary care in the health and social care system.



They recommend that this needs to be worked out locally with extensive public and patient engagement (Smith, 2013:15). Third sector organizations have a clear opportunity to be part of this process. New models for primary care could include social prescribing projects that seek to address the growing burden of mental health in the UK.

Right from the beginning of the *Proving Our Value* project the University of the West of England, Bristol and Wellspring Healthy Living Centre agreed that we would adopt a Social Return On Investment methodology to assess the value created by the intervention. As a framework it provides useful guidelines to third sector organisations that would enable them to understand the process. By pursuing this approach third sector organizations will get more than an understanding of the value they create. It empowers them to see competing theories of change. It involves stakeholders in mapping out impact, attributing value and collecting evidence. And for the third sector organization they have an audit tool which enables them to understand where most of their value is created. We think this makes the methodology more suited to the third sector to *Prove Their Value*.

Arguably the Social Return On Investment cost effectiveness method varies little from traditional cost-benefit analysis; the traditional tool of choice for economists. However the differences between the two approaches are largely in the style of each approach, rather than substance (Arvidson et al 2010:7).

Getting a perspective on costs and value are key to developing a business case to ensure the third sector organization's sustainability in the future. Prior to this there had only been one attempt to undertake a cost-benefit analysis of the social prescribing approach (Grant et al, 2000) and this was an extremely limited study.

The *Proving Our Value* project comes at a pertinent time. Research cited by the British Academy suggests that as little as 20% of the influences on health are to attributable to clinical care and the quality of care. Instead health behaviours account for 30% of influences and the physical environment for 10%. But by far the most important influence on our wellbeing comes from socioeconomic factors: 40% of all influences (British Academy, 2014:3). This is important. Social prescribing projects are working in communities that face some of the toughest challenges, including: deprivation, unemployment, health inequalities and dilemmas posed by the co-existence of diverse cultures.

Since the recent reforms in local governance and the Health and Social Care Act (2012) local authorities have become major players in health. The recent transfer of responsibility for public health to local government and the creation of health and wellbeing boards add to their influence. Despite a considerable reduction in their resources, there now exists a real opportunity for local authorities and local communities to make a difference. With shrinking resources and an impending crisis in GP provision (Gerada, 2013) there are now calls for the

development of new approaches to meet local health needs and this includes the need for more investment in preventative interventions to address health need according to a recently published Kings Fund report (Addicott et al, 2014). Social prescribing projects like the Wellbeing Programme can be a useful additional tool for commissioners to invest in to address the increasing burden of patients presenting with low level mental health issues.

## Introduction

The principle aim of this research was to measure the social and economic impact of Wellspring Healthy Living Centre's (WHLC) Wellbeing Programme (WP); a social prescribing (SP) project. In the broadest sense a SP project provides non-medical solutions to wellbeing challenges presented by beneficiaries in primary care settings.

*Wellspring's Wellbeing Programme is an early-intervention strategy, based on the social-prescribing model (WHLC, Accessed 29<sup>th</sup> October 2013)*

Our involvement in the *Proving Our Value* project emerged from conversations that developed between the University of the West of England, Bristol (UWE) and WHLC. The two institutions already had a good track record of partnership working. Previous collaborations included Professor Norma Daykin's *Arts Programme* (2008/9) which was developed with WHLC service users. This research project focused on measurable outcomes relating to beneficiary wellbeing, participation and feelings about the local neighbourhood.

Subsequent to this the Principal Investigator and two other researchers from UWE undertook an evaluation of the Big Lottery funded South West Wellbeing (SWWB) project, of which WHLC was a SWWB consortium partner. Key to this work was offering encouragement to consortium members to build their capacity to develop consistent and replicable registration information and linking this to evaluative tools. In this case our SWWB questionnaire (Jones and Kimberlee, 2009), included many validated items on wellbeing. These items were also subsequently incorporated into the new economics foundation (nef) national wellbeing evaluation. We helped to develop and embed the SWWB database which was used by the WHLC and consortia partners to track beneficiaries on the SWWB programme. This database was used for all SWWB projects. It provided them with management information at an instant. It was the culmination of a partnership with the social enterprise company Co-opportunity and is now used extensively by third sector consortium members. WHLC have always been a beacon for embracing management information systems to assist their learning to deliver effective services. This research envisaged that the database currently utilized could be a potential model for other third sector organizations in the health and community sectors to use.

Our evaluation of the Big Lottery funded SWWB programme (Jones and Kimberlee, 2011) demonstrated that through a holistic service approach work in one area (e.g. wellbeing) delivers wider health benefits for service users (e.g. changed diets, enhanced social capital scores etc.). However the economic value of these gains, have hitherto, been insufficiently quantified. Given that a recent review of economic indicators suggested that there were

insufficient validated indicators to reliably measure social prescribing performance (McDaid, 2008) our partnership evolved to attempt to fill this gap.

### *Social prescribing*

But what is a social prescribing approach? One of the initiatives that have developed out of this research, which has brought added value to the *Proving Our Value* portfolio, was that the Principal Investigator was invited by the Bristol CCG to undertake a scoping exercise of existing SP projects and make recommendations on how to develop SP across the authority. To this end the Principal Investigator convened three focus groups with: SP practitioners and service users (8 participants), Bristol City Council/Public Health employees (6 participants) and with GPs (4 participants). This was supplemented with interviews with 20 individual self defined SP projects across the city (Kimberlee, 2013). This scoping exercise enabled the researchers to explore the range of SP practice locally.

What is clear from this scoping exercise and the literature review is that there is no single, agreed understanding of what constitutes SP. Or what interventions/approaches can be called SP. In a lot of the literature including local policy documentation around the modernising mental health agenda SP is often used interchangeably with social intervention (Bristol NHS, 2012). In fact the term SP is applied to a variety of different interventions aimed at promoting well-being and/or health.

Nevertheless our partners for the POV research (Care Forum) have worked hard with a range of SP practitioners from different third sector organizations in Bristol to create a space to provide organizations with an opportunity to reflect on their practice and develop a definition of their work:

*Social prescribing provides a pathway to refer clients to non-clinical services, linking clients to support from within the community to promote their wellbeing, to encourage social inclusion, to promote self-care where appropriate and to build resilience within the community and for the individual (Social Prescribing in Bristol Working Group, 2012).*

This is a good definition and one that took the Social Prescribing in Bristol Working Group considerable time to develop. After all, SP is a complex intervention with many parameters.

But, for understanding of SP delivered by the third sector the definition of SP needed more development. At a general level SP has emerged as a mechanism for linking people using primary care with support in the community (Brown et al., 2004, Scottish Development Centre for Mental Health, 2007:12). It is actually sometimes referred to as community

referral. SP projects usually have a referral system in place and the SP element is often, but not exclusively delivered by the third sector. The driver is the limited time that GPs have to explore with patients the underlying psycho-social issues affecting their health (Grayer et al 2008). In adopting this approach there is some evidence to suggest that addressing psychological problems and low levels of wellbeing among frequent attenders in general practice helps to reduce GP attendance (Dowrick et al. 2000; Heywood et al. 1998).

So, SP involves the creation of referral pathways that allow primary health care patients with non-clinical needs to be directed to third sector organizations. Such schemes typically use community development workers or health workers with local knowledge or with skills to *navigate* resources locally. SP interventions are therefore formally linked to primary health care settings. SP interventions assist individual beneficiaries who present with social or psychological needs to access health resources and social support outside of the NHS. But they may also assist with patients who may present with a somatoform disorder i.e. where a patient has a mental disorder characterized by symptoms that suggest physical illness or injury. These are symptoms that cannot be explained fully by the patient. Or, where the GP believes, a non-medical approach could achieve better outcomes. These patients usually have not received a formal mental health diagnosis before. In fact they may not be suffering from a mental health disorder at all. But they are patients who present symptoms to GPs for which there are no obvious medical solutions.

SP therefore strengthens links between health care providers and third sector service providers. In these services there are potential solutions: to *the wider determinants of mental health, for example, leisure, welfare, education, culture, employment and the environment* (Scottish Development Centre for Mental Health, 2003:5). But these links between primary health care services and the third sector still remain underdeveloped, but they actually require considerable time and patience to develop and evolve (South, 2008:310).

In many SP projects the focus is often on vulnerable and at risk groups and people with enduring and long term mental health problems (Frasure-Smith 2000, Greene 2000, Harris 1999). But what characterises SP more than anything else is that they are services that are seen as offering a *holistic* approach (Brandling and House, 2007) to a beneficiary. And in many ways SP is also providing a route to reduce social exclusion, both for disadvantaged, isolated and vulnerable populations in general, and for people with enduring mental health problems (Evans, et al., 2011). Until the arrival of SP, Popay (2007) argued that: GPs had limited responses to the social issues often presented in surgeries. If they did refer it was often without a supportive framework to achieve a successful outcome (Brandling and House, 2009).

In their essence SP offers a local solution galvanising local resources to help their beneficiaries:

*Social prescribing creates a formal means of enabling primary care services to refer patients with social, emotional or practical needs to a variety of holistic, local non-Clinical services (Brandling and House, 2007).*

In the Netherlands the Dutch College of General Practitioners are actually adopting SP approaches as a first response. They recommend that drug treatment should not be the first step for patients exhibiting only depressive symptoms, a move that professional associations believe could substantially reduce the Netherlands' 1,000,000 antidepressant users (Sheldon, 2012:345). SP therefore aims to provide a referred patient with a *holistic* package of support tailored to their individual need. Practitioners often highlight that beneficiaries would primarily be around the diagnostic clusters 1-8 (i.e. enduring mild to moderate anxiety or very severe and complex) rather than cluster 10-21 (for psychosis or an organic disorder) when classified using standard measuring tools (See DoH Mental Health Clustering Booklet 2011-12 in McKee, 2011); although in practice all SP projects work with clients beyond the 1-8 clusters.

SP packages can often be delivered through or alongside other opportunities e.g.: arts and creativity, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help etc. This could involve the SP health worker offering an array of support around issues as diverse as: quitting smoking, addiction, relationship problems through to practical things like advice around: housing, debt, legal advice, benefits or parenting problems. The Health Workers at the WHLC offer additional skills around complementary therapies including Reiki.

#### *Different models of social prescribing*

Following the scoping exercise of local SP provision it was clear from discussions with providers, practitioners and local authority employees that there was no clear agreement as to what they mean by SP. A recent attempt to try and describe different SP models and approaches simply outlines the complexity without trying to distil them into types (Friedli, 2007:11-12). Focus group discussions tended to reach a reasoned understanding of what constitutes SP but only after considerable deliberation. But even then people did not necessarily agree on all aspects of SP or whether their experience of SP matched any broadly agreed criteria. To capture the range of diverse approaches to SP offered by third sector organizations across the local area the Principal Investigator devised different models

to describe the SP services currently on offer to beneficiaries. This was an attempt to capture and present the range of SP offerings available to inform our understanding of where WHLCs WP fits in the spectrum of SP on offer. Most of the offerings do not conform to the definition of SP suggested by Brandling and House (2007). This model of SP we call: *Social Prescribing Holistic* (Kimberlee, 2013). SP interventions in this category share certain clear features:

- There is a direct primary care **referral**, usually from a GP practice, to an external SP provider. This is often formalised in terms of a letter, form, an on-line application or even a telephone call.
- The SP provider has a clear **local** remit and draws on local knowledge of local services to connect beneficiaries to important sources of support and aid.
- The SP intervention has been developed and sustained jointly over time and in its present form represents a product of joint **partnership** work between the primary care provider and the SP provider.
- The SP provider addresses the beneficiary's needs in a **holistic** way. A patient may be referred to a SP project to improve diet, but in doing so the SP project will look at all needs and may offer support in terms of any issue discovered e.g. budgeting, nutrition, loneliness etc.
- There are **no limits** to the number of times a beneficiary is seen on a SP project. Time parameters may be set but the number of sessions offered can be more or less depending on the needs discovered in the holistic approach.
- SP projects seek to improve beneficiary' **well-being**. They may not necessarily initially be concerned with addressing mental health issues (although some are). Most beneficiaries who attend SP projects have undiagnosed mental health issues. Although in adopting a holistic approach the SP project may delineate the mental health needs of the beneficiary and these will be addressed or sometimes a beneficiary will be referred on to other mental health services.

In the city of Bristol there are 57 GP surgeries (Shepherd, 2010) of which 12% (n=7) are known to practice some form of SP. There are probably more but there may be some not yet known to the research team. All the projects would describe themselves as SP. However they do not necessarily contain all the elements outlined above in the SP *Holistic* model. They contain some elements and may even be in a transition to another model.

### *Social Prescribing as Signposting*

In this model the SP project is doing little more than signposting beneficiaries onto appropriate networks and groups who may assist an individual beneficiary to address their wellbeing needs. All SP models have an element of signposting in their delivery. GPs can directly refer to the project and leave the patient to their own devices to access and follow through on the local wellbeing offerings available. Or the SP project may seek to address beneficiary needs independent of the GP and will simply share the space of the practice but not necessarily have any regular or formal link with GPs. The activities that they may be referred too could include: a gym, a cooking project, peer support or a variety of counselling opportunities etc. The practice may not have a strong direct relationship with the SP project and their maybe little follow-up and/or feedback. The projects will have only minimal evaluation of outcomes. Local examples of this model would include the Social Mirror Project, in Knowle West and the Well Aware project delivered by the Care Forum.

To be effective SP very much depends on staff having good knowledge of what services are available in their local community. Mapping local, community groups and services into electronic health directories to facilitate signposting and referral helps SP projects to develop their knowledge base of what is available (Coulter 2013:16). However to be effective SP projects tend to also employ local, trained, community health trainers to assist in the development and implementation of a signposting project. As well as providing a variety of support services alongside the database they also take up the opportunity to improve beneficiary lifestyle by linking advice and practical support around health issues like smoking, stress, diet, alcohol, physical activity and obesity etc. This approach has been developed by HealthWORKS in Newcastle. A recent evaluation of this project revealed that: 70% of all referrals did engage with a link worker of which 91% set goals. Of those that were set goals 41% achieved their goals, but 59% did not. Monitoring data shows 69% of patients, based on completed records, experienced an increase in Short Warwick and Edinburgh Mental Well Being Scale (SWEMWB) score and that 64% have achieved an increase in confidence in managing their long-term condition (ERS, 2013:54).

### *Social Prescribing Light*

This is perhaps the most common form of SP. These are community and/or primary-care based projects which refer at risk or vulnerable patients to a specific programme to address a specific need or to encourage a patient to reach a specific objective e.g. exercise on prescription, prescription for learning and arts on prescription (see Aldridge and Lavender, 2000; Friedli and Watson, 2004; Tyldesley and Rigby, 2003; and Millin, 2003). Again locally third sector organizations delivering such models include a 'Wellbeing (Social) Prescription' walking project run at the Whitchurch GP surgery in Bristol. The initiative is new and only recently developed in response to a local need to address social isolation through walking.



As such SP Light projects would not necessarily have evolved through a partnership with a GP service and there would not necessarily be a feedback loop to monitor progress and would remain singular in the need addressed.

### *Social Prescribing Medium*

The best example of this approach in the South West can be found at the College Surgery Partnership in Cullompton, Devon. It was developed by senior partner Michael Dixon who had been a GP in Cullompton for 26 years. He had been chair of NHS Alliance, representing primary care, PCTs and practice based commissioners since 1998. He is a Senior Associate of the King's Fund and Honorary Senior Fellow in Public Policy at Birmingham University. Like other SP initiatives their SP project includes the employment of a Health Facilitator. This role developed out of an exercise on prescription scheme (SP Light) developed by local surgeries and the local Council ten years before.

The health facilitator sees referred patients. Using Life Check and other tools the facilitator provides advice on exercise, nutrition, diet etc. The facilitator would promote self-care using an on line Thought Field Therapy programme (rather like CBT) and also signpost to third sector organizations or self-help groups e.g. for specific disease areas – like patients with heart disease, diabetes and fibromyalgia or for specific needs - e.g. a Knit and Natter group for people who are socially isolated. Although the project has a clear local remit in that it works within a distinct geographically defined neighbourhood and it is the product of joint partnership work with third sector partners. It does not obviously seek to address the beneficiary' needs in a *holistic* way instead it aims to address certain needs or behaviours identified by the GP.

### *Social Prescribing Holistic*

This model is sometimes known as the Bromley-By-Bow Model. In essence it is a flexible model and represents the development of a project that had previously delivered at a lower level of SP. Thus these SP projects tend to evolve organically over time. They have also evolved in partnerships between a GP surgery and a third sector organization. They are innovative and are seen by local practitioners to be a catalyst for enabling health providers to think much more creatively and holistically about addressing people's wide-ranging mental health and social care needs within a non-stigmatising and empowering approach (CSIP 2009:9). They have frequently emerged to meet an acknowledged local need e.g. somatoform patients, vulnerable families, high attendees, people with certain mental health issues. They have also emerged because the GP practice accepts that an alternative solution should be considered to address a perceived health need or issue that they themselves cannot immediately address in the normal appointment time. In acknowledging the issue they also accept that the SP project offers a potential solution to the issue.

These projects, like WHLC WP are frequently built over a long time. They are not a quick fix or a bolt-on. They are a reasoned intervention developed through partnership. For example the Bromley-By-Bow SP approach evolved out of the development of a local Healthy Living Centre built in 1999. The approach sought to break down barriers that had traditionally separated services in a bid to meet the diverse needs of their patients. Primary Care services are run as a GP partnership and their other services operate as a charity with their own distinct but connected governance arrangements. GPs have a referral letter on their desk top and they tick what a client needs are perceived to be e.g. anything from dietary advice through to welfare advice, housing advice etc. (Beavers, 2013:5). GP Dr Everington from the local CCG argued that:

*From a GPs perspective it broadens the armoury of what they can prescribe, gives an alternative to a drug prescription and also reduces GP's workload.*  
(Beavers, 2013:5).

In the South West there have been attempts to develop SP holistic projects. WHLC's SP project represents the most comprehensive local project pursuing a *holistic* approach in Bristol. The project is based in Barton Hill, Bristol at the WHLC which was founded by local residents in 2004. It evolved from several initiatives aimed at addressing beneficiary well-being developed through the centre. WHLC serves one of the most deprived communities in England. Wellspring is based in the Lawrence Hill ward of Bristol. It is one of Bristol's most deprived wards with six of the seven Super Output Areas in the worst 10% nationally on indices of deprivation. Local residents of this ward are reported to have the least 'satisfaction with life' in their neighbourhood in Bristol and were the least 'happy' (Bristol City Council, 2013:11, Accessed 20<sup>th</sup> May 2013). Given the extent of deprivation it is clear from research that there is likely to be under registration at GP practices. For example in Manchester it is known that only 78% of names and addresses held on general practice registers can be matched with equivalent records held on the council tax system (Pollack et al 2012b, 344).

All holistic SP projects are characterised by direct referral routes from GPs. These referral routes will have been developed over time. The mode of referral can vary. One project has a flagging system on the GPs' computers across three surgeries while another has a specific form with suggested activities to be considered. Letters of introduction have also been used. Actual utilisation of the prescription by the beneficiary is in all cases voluntary. Which underlines a central tenet of SP: beneficiary engagement with the process is important and SP exists to encourage beneficiaries to seek solutions and develop self-management techniques.

The promotion of patient self-management and resilience is crucial to SP. It endeavours to ensure that the beneficiaries have the skills to look after themselves. In some ways SPs have parallels with the House of Care model developed and tested by the Year of Care programme in 2011/2 by Diabetes UK and the Department of Health (DoH). This was piloted on more than 3000 practitioners and 60 trainers working in 26 communities around England (Coulter, 2013). It was about developing personalised care planning. It involves clinicians and patients working together using a collaborative process of shared decision-making to agree goals, identify beneficiary support needs to develop and implement action plans and monitor their progress. In the programme the intervention is a continuous process, and not a one-off, bolt on event (Coulter, 2013).

But, why is SP delivered by third sector partners becoming important? We argue that there are three distinct pressures leading to the health sector services increasingly utilising SP. These are: the increasing pressure on GP services, the growing burden (and cost) of mental health and the modernisation of mental health services.

#### *GP Practice under strain*

There is mounting evidence to suggest that primary care services are under increasing strain. GP surgeries are facing an increase in the numbers of patients attending their surgeries. They are presenting with complex needs and in reality GPs are not necessarily equipped to handle all the social and psychological burdens they present. The service itself is also changing. It has come a long way from a model where patients were examined in their own living room. GPs now usually practice in stand-alone surgeries and healthy living centres which offer an ever broadening range of services. Which services they develop and offer can vary across GP practices. But these changes and pressures coupled with complex reforms have led Clare Gerada the Chair of the UK's College of General Practitioners (CGP) to conclude that GP is in crisis! (Gerada, 2013, Accessed 8th October 2013). Survey work commissioned by the College and undertaken by the Kings Fund reveals that:

- 85% of GPs believe their service is in crisis;
- nearly, 50% think they can no longer guarantee safe patient care;
- 50% felt their job had got more stressful;
- most GPs are conducting 40-60 patient consultations each day and working 11 hour days in the consulting room;
- and, most GPs predict that patients will have to wait longer for an appointment in the future.

(Gerada, 2013, Accessed 8th October 2013)

Additional stresses are being caused with pressures to extend hours of opening. And there are increasing numbers of people reporting that they are sick. In 1995 patients visited GPs

on average 3.9x a year; this has now increased to 5.5x a year. GP attendances have climbed from 17.8m in 2004-5 to 21.7m in the first 11 months of 2012-13, pushing annual tally to more than 24m. (Campbell 2013:4). With the increasing attendance GPs are having a reduced impact in terms of effective diagnosis of mental health conditions. It is reported that GPs are only recognising between a fifth and a half of the psycho-social issues patients that present with in GP (Gulbrandson, et al 1997). Psychosocial problems are increasingly common in primary care consultations. Social difficulties are often portrayed initially by patients as either physical or psychological problems, such as chronic pain or mood disorder (Cawston, 2011). And Popay et al (2007a) found that in total three quarters of social problems elicited in GP consultations were initially portrayed as either physical or psychological complaints. The most common social problems elicited by the GPs were difficulties relating to welfare benefits and housing (Popay et al, 2007a). It is not always easy for patients to distinguish between medical and social problems, and hence both types of problems may be brought to a GP consultation (Cawston, 2011).

With an aging population this burden is only going to increase and it is anticipated that consultation rates will rise by 5% over the next 20 years. GPs also perceive that their patients are demanding better services and expect more. In particular younger patients are seen as less likely to grin and bear their ailments compared to older generations (Everington, 2013). And unlike other health services primary care has no waiting list or referral criteria—they are forced to deal with the *here and now* in all its ramifications on a daily basis (Hardy, 2013:347).

With pressures on GPs growing some GPs are advocating and developing new approaches to developing their service delivery. This fresh approach includes SP. Dr Sam Everington, Chairman of Tower Hamlets CCG, has argued that GPs need assistance to manage their workload (Beavers, 2013:5) and believes that GPs should be offered more incentives to develop partnerships to make their services work more effectively. The Chair of the CGP recently argued that GPs need all providers of health and social care, within a geographically aligned area to come together and pool resources (Gerada, 2013, Accessed 8th October 2013). This includes making use of third sector organizations according to a retired GP from Bethnal Green Health Centre writing in the BMJ who argued it requires commissioners and GPs to undertake a:

*a radical rethink on service provision, with perhaps less emphasis on classification and more on collaborative working practices (Hardy, 2013:347)*

Part of this push to encourage primary care services to develop collaborative working is the realization that the burden of managing long-term conditions calls for a holistic approach.

There are 15 million people in the UK living with a long-term condition. Typically this can include people who are repeat attendees in surgeries for which SP is increasingly seen as a potential solution. Recent Kings Fund Caring Research has led to a call for GPs to be more proactive and preventive in their approach. Improving care for people with long-term conditions must involve a shift away from a reactive, disease-focused, fragmented model of care towards one that is more proactive, holistic and preventive, in which people with long-term conditions are encouraged to play a central role in managing their own care (Coulter, 2013:2).

The increasing burden on GP services is therefore making SP approaches potentially attractive to some GPs.

### *Increasing burden of mental health*

Mental illness is a growing problem in the developed world. In the US the Center for Disease Control and Prevention, report that 25% of people in the United States have a mental illness (Centre for Disease Control and Prevention, 2012). One in four people in the UK are also known to suffer a mental health problem in the course of a year. It is also acknowledged that within primary care around 30% of all consultations and 50% of consecutive attendances concern some form of psychiatric problem, predominantly depression or anxiety (Kessler et al, 2001; Scottish Executive, 2005).

The number of people with mental health problems subject to community treatment orders in England has also risen by almost a third in the year immediately following the 2010 recession according to the Care Quality Commission. Their second annual report on the use of the Mental Health Act in England, *Monitoring the Mental Health Act in 2010/11*, said the number of people subject to the act was 5% higher than in the previous year—rising from 19,947 on 31 March 2010 to 20,938 on 31 March 2011 (O'Dowd, 2011). Every year over 9,000 people in England and Wales who are held under the Mental Health Act are put in police cells despite codes of practice saying that this should occur only in exceptional circumstances. The police have powers under section 136 of the Mental Health Act 1983 to take individuals who are suffering from mental health issues in a public place to a 'place of safety' for their protection, and so they can be medically assessed (HM Inspectorates of Constabulary and Prisons, 2013).

Patients with multiple health problems are rapidly becoming the norm not the exception, and the NHS is not set up to treat them properly, according to a study carried out in Scotland. Examining a dataset of 314 medical practices representing 1.75 million patients, data on 40 morbidities (i.e. an incident of a disease), were extracted. Although multiple morbidities were recognised as being more common among older people, the team found that there were more in absolute terms in those under 65—210 500 versus 194 966 in

people over 65. By the age of 50, half the population had at least one morbidity and by 65 most had more than two. People living in deprived areas were more likely to experience multi-morbidity, even though the population of such areas was on average younger. Young and middle aged people in the most deprived areas had rates of multi-morbidity equivalent to those of people 10 to 15 years older in the most affluent areas. More than a third of those with multi-morbidity had a mental health problem, with women more likely than men to combine a mental and a physical health disorder (Hawkes, 2012a:345).

*“The NHS has too many people addressing part of the problem” he said, “which is a recipe for fragmentation, poor coordination and inefficiency.” What patients needed was a long term relationship with somebody they knew and trusted—“it could be a specialist, it could be a nurse, but most often it will be a GP.”*

There are also over 3 million adults of working age who are not in work and receiving incapacity benefits in the UK, and poor mental health was the most significant reason for their incapacity (ESN, 2011:25). According to the World Health Organization (WHO) by 2020 depression will be a leading cause of disability globally, second only to ischemic heart disease (Dewa and McDaid, 2011). Anti-depressant prescriptions in the UK are on the increase. 23 million prescriptions were issued last year. An increase of 40% over four years. Mental health problems can lead to or be a cause of other problems e.g. addiction, isolation, unemployment.

Patients presenting with complex mental health needs challenge traditional delivery in general practice:

*They challenge the single disease framework by which most healthcare, medical research, and medical education is configured. Existing approaches need to be complemented by support for the work of generalists, mainly but not exclusively in primary care, providing continuity, coordination, and above all a personal approach for people with multi-morbidity. This approach is most needed in socioeconomically deprived areas, where multi-morbidity happens earlier, is more common, and frequently includes physical and mental health comorbidity. (Hawkes, 2012a:345)*

The burden of mental health to society and the economy should not be underestimated. However the definition of what constitutes a mental illness is often one of opinion. These opinions are sometimes drawn from a small group of psychiatric experts who author the Diagnostic and Statistical Manual of Mental Disorders (DSM), used to categorise mental illness. The DSM mental health model, like a lot of approaches is a reductionist biological one: behaviours are sometimes explained as a *chemical imbalance* and therefore open to drug treatment. This leads to a constant redefining and developing of medical descriptions of behaviour to serve a drug industry, for which mental ill health is the *profit nirvana of life* (Spence, 2012:3135). Such pressures means that mental health is now high on the government's agenda. The *No Health without Mental Health*, document published by the Department of Health (2011) urged the development of a cross government approach to address the issue with a focus on outcomes for people with a mental illness as a way of developing and promoting solutions to reduce the burden. Although the picture varies across Europe, the emphasis in mental health services are now moving towards the development of a more person-centred approach, based on principles of SP (ESN, 2011:8).

#### *Costs of mental health*

The cost of mental health problems to the economy in England have been estimated at £105 billion, and treatment costs are expected to double in the next 20 years. Mental health problems cost the UK government billions every year, and the costs are set to rise over the next 15 years. Depression and anxiety in England alone are predicted to cost £24.4 billion by 2026 (Knapp et al 2011). In 2011/12, NHS Bristol spent just over £50 million on mental health services for the city – the largest spend by the former Primary Care Trust on non-acute hospital services (NHS Bristol, 2012:4). The cost of cardio-vascular diseases in the EU was estimated in 2007 as €36 billion (Leal, 2006) this compares to the cost for depression alone of €136.3 billion (McDaid, 2005:5). It is estimated that the economic costs of mental health are €2000 per annum for each European household (ESN, 2011:8). Mental illness is one of the biggest causes of misery in our society. It imposes heavy costs on the economy. Some 2% of the UK's GDP; according to research conducted by Professor Layard (2005).

Over the last four decades of rising life expectancy, the proportion of men who are economically inactive owing to long term ill health in the UK workforce has risen sharply, from under 5% to over 15% at the beginning of the 21st century. What this means is that the working population in 2008 faced the latest recession from a very different starting point from that faced in 1980, when the male economic inactivity rate was around 6% Bartley (2012). Economic inactivity is the status of not looking for a job at all and is different from unemployment. People are unemployed if they have no job but are actively seeking work, and this is usually on record. The two should not be confused. There are several reasons for economic inactivity. For men, the most common reason is long term sickness.

For women, traditionally it has been caring for the home and family. As the economic inactivity rate has risen among men, the rate among women has fallen. Bartley's (2012) cross sectional study shows that around half of men with long term ill health in 2009 were economically inactive compared with less than 5% in 1973. When the economy began to improve the employment rate increased, even for those with long term illness, in the professional and managerial occupations; but in the less advantaged socioeconomic groups the employment rate did not increase and the rate of permanent sickness (rather than unemployment) remained high. It may be that the demands of work have changed over time in such a way that it is now harder for people with some non-life threatening conditions (such as depression, anxiety, or autism spectrum disorders) to find and keep work. In the UK between 1996 and 2006 the numbers claiming incapacity benefit for mental health problems rose from 26% to 43% of all claimants and poor mental health was a factor in 70% of all claimants' cases (DoH, 2011). According to the Centre for Mental Health in the UK, at any one time one worker in six will be experiencing depression, anxiety or problems relating to stress. The total cost to employers is estimated at nearly £26 billion each year. That is equivalent to £1,035 per year for every employee in the UK workforce (Sainsbury, 2007). Additionally, the annual health service cost of people who frequently attend a GP for medically unexplained symptoms amounted to £3.1 billion in 2008-09 (Birmingham et al. 2010).

Making changes to improve access to services could help to reduce stigma and improve identification and recognition, which may lead to early intervention and more appropriate treatments resulting in significant savings (NIHCE, 2011:5). Mental health promotion and prevention appear to be more cost-effective than tackling mental ill health after it has occurred (ESN, 2011:26). And Lord O'Donnell the chair of the ONS argues that health budgets should be reallocated to focus on mental rather than physical health: *if the United Kingdom is serious about enhancing wellbeing. Depression reduces life expectancy as much as smoking* (Hawkes 2012b). With an increase in the burden of mental health and a clear recognition that the costs of this burden are rising SP is seen as a potential preventative solution to promote wellbeing.

### *Modernising mental health services in Bristol*

With the responsibility for the commissioning of healthcare services transferred to the Bristol Clinical Commissioning Group (CCG) on 1 April 2013, issues raised by the city's modernising mental health agenda in the city posed fresh challenges and uncertainties. A decision to re-commission mental health services followed serious concern expressed by GPs and service users about existing mental health services over a number of years. Part of the process has subsequently seen the development of a new overarching model of care. This new model seeks to relocate services closer to individuals and the communities where they live. The suggested model proposed multiple access points in accessible and non-



stigmatising settings. This model was widely supported amongst the stakeholder groups that were consulted (2012b:15) and it will be introduced across the city in 2014.

As part of the modernisation of mental health services a Recovery Pathway was outlined (as opposed to a chaotic or crisis pathway) which will see the needs of individuals with on-going mental health needs supported. SP provision was seen as an additional feature of local recovery services. The new approach aspires to meet the needs of individuals facing mental health challenges. It will provide a recovery plan informed with input from the service user, their carer, the GP and supporting mental health specialists, social care and third sector agencies. SP is seen as part of this pathway (Bristol NHS, 2013:13). And identified as an intervention that can be an:

*early intervention with an emphasis on promotion, prevention, early intervention, recovery/resilience and grassroots community provision (NHS Bristol, 2012:6)*

## The Wellbeing Programme at Wellspring Healthy Living Centre

WHLC has been delivering its social prescribing WP for four years. The initiative has been funded by various sources but predominantly by the Henry Smith and Tudor Trust. WHLC uses their funding to cover the costs of the service delivery. The programme aims to support adults who live in the Barton Hill area of the Lawrence Hill ward. The ward itself remains one of the most deprived in Bristol. It is ranked as the 336th (out of 32,486 wards) most deprived ward in the country. It is in the lowest 1% on income and employment indices and in the lowest 7% on health indices (UK Local Area, 2014). Also in a recent assessment of Quality of Life data it was seen as the ward with the highest level of risk for mental health in a *Mental Health Needs Assessment for Adults* (Van De Venter, et al 2011:11). The risk indicators were based on analysis of employment, education and training, housing, access to fresh food, physical activity, long-term limiting illness, social networks and support, access to green space, crime and discrimination and harassment. The impact of this on the community is far-reaching, affecting every aspect of people's lives and limiting not only their life chances, but also those of family members.

Wellspring's SP WP is characterised by the following:

1. Holistic: person-centred and non-prescriptive with consideration of an individual's physical, mental and spiritual needs and wellbeing
2. Co-production: recognising and supporting clients to manage their own recovery. They are encouraged and to be active, not a passive recipient, in their recovery.
3. Key-worker model and goal setting: the client, together with their key worker, identifies and sets realistic goals. The worker then supports the client to achieve these goals.
4. The use of a range of therapeutic tools: cognitive behaviour therapy techniques, motivational interviewing, counselling skills, and brief intervention techniques for substance misuse
5. Addressing the wider, social determinants of health: referral to agencies that can address those issues that contribute to poor mental health, such as housing or debt.
6. Partnership working and embedded referral pathways: appointment slots are available with information and advice agencies, specifically for clients of Wellspring's SP programme. When a client discloses psychological or substance misuse issues that are outside the expertise and remit of Wellspring's SP programme, the worker will make a referral to an appropriate agency e.g. Kinergy, Womankind, Nilaari, Avon and Wiltshire Mental Health Partnership (AWP). If the client accesses these higher-tier interventions, but still needs support for wider, social issues, then Wellspring's SP programme can continue to engage with the client.

7. Asset-based approach: a) referral to activities and services, in the individual's local community, that support good mental health, e.g. peer-support groups, arts-based activities, physical activities, complementary therapies, volunteering, training and employment opportunities; b) facilitation and support for peer-support groups and activities based in the community e.g. Time Out Groups; c) Volunteer Befrienders who themselves have experienced poor mental health, but who are ready to support others in their recovery. Such support can include accompanying someone to an activity, shopping together or meeting for a cup of tea.
8. Based on Five Ways to Wellbeing: connect, be active, take notice, keep learning and give.

The WP service consists of two elements: Branching Out and Time Out. It is based on the principles of improving wellbeing and social wealth and is designed to hold hope and ambition for people, together with the expectation that their lives can improve.

*Branching Out - 1:1 intervention:* Based on the key-worker model to develop a strong, trusting and functioning relationship. Over an average of 9 weeks, clients, together with their support worker, set health and wellbeing goals in an action plan. Beneficiaries will then be supported to achieve these goals and to access activities and support in the community: for example Time Out (peer-support groups) and therapeutic activities, such as creative arts, physical activities, cooking courses or complementary therapies. Beneficiaries will be referred to the appropriate organisation for specialised or higher-tier mental health or substance misuse services, e.g. Womankind, Kinergy, Nilaari, or AWP. If wider determinants of health, such as housing, employment or debt present as hindrances to the wellbeing of the individual, then the Branching Out worker will support the individual to address these issues. If requested by the participant, the support worker will allocate a befriender to also support them to access activities or to meet for a cup of tea.

*Time Out Group - Peer-support groups:* The support worker facilitates weekly group get-togethers. This is an important strand of the project as it provides an opportunity for social contact and friendships to form, thereby enhancing the opportunity for mutual support and reducing social isolation. This helps build resilience, personal responsibility and social wealth back into the community. Each week the focus of the group will be an agreed-upon activity that supports mental wellbeing, e.g. crafts and arts, relaxation techniques, healthy eating and cooking, gift making, a physical activity or bingo.

Engagement with the project is not compulsory. We do not know how many Beneficiaries are necessarily referred by a GP and then subsequently fail to take-up the offer. We do

know from other research on a SP project that roughly 64% attend a SP project more than once (e.g. 64% see Freidli, 2012:17).

WHLC have been active in trying to develop a mechanism to assess the value of their work and in particular the impact of their WP. As a third sector organization they exist for *social purposes to meet a broad range of social needs which would otherwise go unmet* (South West Observatory, 2008). It is widely recognised that as well as meeting social needs the third sector are part a fundamental part of the economy and represent a growing business sector. As with private businesses, they contribute to the local and regional economy by generating income, attracting investment, maintaining and creating jobs and spending money on goods and services. Heady and Cops (2008) at a Researching the Voluntary Sector Conference called *Measuring effectiveness – the way forward* provide good reasons why charities and other third sector organisations like WHLC should focus more on the impact of the their work:

*charities rarely measure the social impact of their work. But without data on their impact, charities miss the opportunity to improve their services, and with it, the lives of the people they help.*

With this research WHLC looked to extend their evidence base of impact and *Prove their Value*.

## The methodology

WHLC and the researchers spent considerable time looking at different ways to measure the impact of the WP on beneficiaries' lives. Our preliminary scoping study led us to discuss the feasibility of undertaking a RCT study involving two surgeries in the local area. Clearly one of the surgeries would act as a comparative control group to WHLC. However this was ruled out primarily because the funding available from the SWF was insufficient to support such an approach. We estimated that such a study would have required three times the budget on offer. We also felt a study based around GP practices and an RCT approach would run the risk of sample contamination (See Middleton et al, 2003). We therefore opted to undertake a mixed methods approach. This involved focus groups and 1 to 1 in-depth semi-structured interviews with stakeholders and old beneficiaries to develop an appropriate tool to use with a cohort of new beneficiaries in a longitudinal study over 12 months.

### *Ethics*

We applied to the NHS Research Ethics Committee (NRES) for ethical approval in July 2011. Based on the information we provided, NRES decided that the project was not considered to be health research based on the protocol we sent. It was perceived to be a service evaluation and therefore did not require ethical review by NRES. Ethical approval was subsequently applied for and given by UWE's Health and Life Sciences Faculty Research Ethics Sub-Committee in October 2011.

Participants in this research were invited to participate and were not obliged to participate. Everyone had the right to refuse participation. Every participant was asked to provide written informed consent prior to commencement of any research activity. This applied to old and new beneficiaries of the service and stakeholders. The Information and Consent Forms were agreed with WHLC. Additionally new beneficiaries if they were registered with a GP at WHLC were asked to provide written consent for the researchers to collect their GP and prescription data (see Appendix 1). These were to be released to the researchers 12 months after their referral and would include their attendance and prescription records twelve months before and after their referral to the WP programme. All data provided would be anonymised using a pre-existing beneficiary id number used and developed for the purpose of our South West Wellbeing (Jones and Kimberlee, 2009) evaluation (ethics approval for database set up for the SWWB evaluation: Well-being in the South West: A Healthier Way to Live, HSC-07-072; project code: P36E356R). This database has previously supplied us with anonymised data for service evaluation purposes. Procedures were agreed with the Strategic Business Manager at Wellspring General Practice Services at WHLC. Participants were free to withdraw from any aspect of the research at any stage. This was confirmed on the information sheet and reiterated by the researchers and the Wellbeing workers on every research occasion.

### *Aim*

The aim of the research was to assess the impact of the WP delivered at WHLC in Bristol. The WP is defined as a holistic social prescribing programme. As part of the *Proving Our Value* portfolio we sought to take a pragmatic approach in the development of indicators for appraising the economic impact of third sector organizations and their activities. We concentrated on the specific use of the service. The focus on social purpose gives a particular direction to our study, notably the focus on recording social and economic outcomes rather than the means by which these outcomes were achieved. We opted for a SROI approach right from the start in the knowledge that this was an effective way of recording value for third sector organizations (Cabinet Office 2009). Carrying out an SROI analysis consists of a number of stages. The first two stages involve establishing the scope of the research and identifying key stakeholders to be involved and mapping acknowledged outcomes through an impact map.

### *Establishing scope and identifying key stakeholders*

Guidance on conducting SROI puts great emphasis on stakeholders' involvement than do standard cost benefit analyses (Arvidson, 2010:6). This enables researchers to be able to more effectively map outcomes. Following consultation with the WHLC Management Board which includes former WP users; the CEO at WHLC was asked to identify and develop a list of local stakeholders to the WP and a list of old beneficiaries to enable us to develop an impact map of the outcomes stemming from the intervention. The interview schedule used with the stakeholders is outlined in Appendix 2. The interview was devised to provide the research with a qualitative insight into the impact of the WP. It assisted us in identifying the desired wellbeing and economic outcomes that were perceived to be achieved by the programme; as well as potential deadweight and attribution indicators (please see Glossary on p113). Overall 20 stakeholders participated in 1 to 1, in-depth, semi-structured interviews. This included:

- three members of staff at WHLC,
- three referring GPs,
- a referring District Nurse,
- a funder of the intervention,
- a community service manager,
- two GP practice managers,
- two social workers,
- three mental health workers,
- four city council officials.

Previous WP beneficiaries were also invited to voluntarily attend focus groups via an agreed letter distributed by the WHLC to old beneficiaries who had already completed the BO component of the programme and were either participating in a Time-Out group or in full recovery. The researchers constructed an invitation letter. This was distributed and returned to WHLC who organised the timing of the focus groups to suit the beneficiaries. Adopting this approach ensured that the names and addresses of old beneficiaries remained unknown to the researchers. Thus, ensuring anonymity and confidentiality as agreed in our ethics application. Participation was voluntary. We undertook three focus groups with between 6-9 beneficiaries/group. There was an all-male group, a female group and a mixed group. 24 old beneficiaries participated in total. The nature of the WP, the duty of care of the WHLC and the long term relationship developed with beneficiaries ensured that extra care was taken to ensure that participants thoroughly understood the aims of the project and the importance of anonymity. All beneficiaries were given a consent form to sign. All data opt out options were explained. Beneficiaries were told that they were free to withdraw at any stage.

### *Mapping outcomes*

Engagement with stakeholders and old beneficiaries was crucial to ensuring that we understood what the key outcomes were of the WP. There was a broad consensus that the WP helped to reduce GP surgery attendance. This was because the programme helped to address and improve mental health. As a result of their engagement with the WP, beneficiaries were perceived to have primarily reduced their levels of:

- Depression
- Anxiety

GPs were also likely to highlight that WP was also good when working with patients presenting with somatoform symptoms.

*I think it is most effective with patients who present with physical (e.g. pain) problems and other issues for which there is no obvious medical cause rather than those with alcohol dependency or drug dependency. (GP stakeholder)*

Other outcomes highlighted by both stakeholders and old beneficiaries as stemming from the WP intervention were:

- Reduced isolation
- Anger Management
- Increased Physical Activity
- Advice Information and Guidance
- Improved employment/volunteering opportunities
- Listened too
- Safe space
- Suicide prevention
- Reduction in alcohol and drug consumption
- Bereavement
- Avoid downward spiral to moderate severe and severe depression
- Less of a burden on family and carers
- Increased confidence

There were some differences. Interestingly the stakeholders were more likely to suggest that the programme would help with broader community development issues:

- Promoting Resilience
- Developing social capital
- Community capital

The old beneficiaries in the focus groups were less likely to suggest these broader community outcomes as being achieved as a consequence of their experience on the WP.

#### *Evidencing outcomes to giving them a value*

Although we had sufficient evidence for a SROI analysis from both stakeholders and old beneficiaries on the efficacy of the programme we were tasked with the responsibility of developing a tool to assess these benefits to help other third sector organizations *prove their value*. In deciding to develop a tool we had to think about the policy context in which organizations like WHLC operate and anticipate what type of evidence commissioners might require.

The Darzi Review (2008) *Our NHS, Our Future* had outlined the importance of getting local service users and carers to have their say over mental health services. Importantly the review argued that change should be clinically driven to meet local need. If this is the case it



would be important for the tool to include validated robust items that could assist clinicians and commissioners to understand the impact of the WP. Mental health services in the city were under review (Bristol Clinical Commissioning Group, 2013) and were very likely to be reconfigured by the time the research was complete. If this was the case then third sector organizations would need to *prove their value* by providing outcome evidence to suit commissioner needs. The modernising mental health reforms meant an introduction of a consistent methodology for the contracting and payment of mental health services and for benchmarking and tracking impact needed to be in place. SP projects like WHLC WP and those of other providers were going to have to demonstrate the type of beneficiary they were working with in terms of the new Payment by Results (PbR) clusters underpinning the new commissioning ethos (McKee, 2011). The objective of these reforms was to have currencies and local prices established and for such services during 2012-13. The local prices would be agreed by commissioners and providers. Thus this evaluation had to make sure that the tool would provide users with evidence to support their engagement with beneficiaries in the targeted clusters if they were going to get their service commissioned.

There were also broader changes occurring in the NHS. The Health and Social Care (2012) introduced by the Coalition Government had made it clear that judging care by outcomes is one of its top priorities for the NHS. The original White Paper (2011): *Equity and Excellence: Liberating the NHS*, set out an Outcomes Framework by which performance could be managed. The reforms had promised opportunities for *Any Qualified Provider* to be given chance to be commissioned to deliver NHS care. This meant that the tool required validated measures to evidence base impact against both the outcomes framework and the mental health clusters.

However, the tool not only had to deliver evidence that would be acceptable to potential commissioners it also had to be suitable to be used with beneficiaries who were already vulnerable. It could not be too onerous. It had to be fairly brief to sit alongside potential care plans negotiated with beneficiaries and it also had to have the potential to be used as a tool with beneficiaries to their measure progress during their 1 to 1 sessions with the SP health worker who would administer the tool.

WHLC had recently decided to use PHQ9 and GAD7 tools to assess depression and anxiety so it was important to continue using these items as they seek to assess and identify the key issues highlighted by the old beneficiaries and stakeholders. Both are seen as popular validated tools to use in primary care settings for assessing depression and anxiety (Spritzer et al, 2006). And both would provide evidence for commissioners in terms of mental health clusters and so were included in the Wellspring Wellbeing Questionnaire (WWQ).

Many of the other outcomes identified by the stakeholders and old beneficiaries were pointing towards beneficiaries' improvement in wellbeing. But wellbeing is a complicated

concept and frequently used interchangeably with the term *quality of life*. Cronin de Chavex et al (2005) stress both terms lack a clear conceptual base with little consensus across disciplines as to how to identify wellbeing or measure it. The Stiglitz Report (Stiglitz et al., 2009) surveyed a range of academic research and initiatives developed throughout world and recommended the following dimensions of wellbeing: Material living standards (income, consumption and wealth), Health, Education, Personal activities including work, Political voice and governance, Social connections and relationships, Environment (present and future conditions) and Insecurity, of an economic as well as a physical nature. This highlights the broad factors that can impact on individual's sense of subjective wellbeing. The New Economics Foundation (nef) have also highlighted a dynamic model of wellbeing which clarifies the relationship between functioning and hedonic approaches to wellbeing by showing how having good overall feelings (and a positive evaluation of those feelings) is dependent on functioning well, and on having the external and internal resources to do so (Michaelson, 2012).

The most widely used measure of mental wellbeing in the UK is the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) which is increasingly used in evaluations to measure beneficiary well-being (See e.g. Jones and Kimberlee, 2009). However, as yet there is not an established time series of SWEMWBS scores at present to develop a national understanding of a population's wellbeing (DoH, 2013:3). Secondly, we considered that it is perhaps inappropriate to use SWEMWBS on a holistic SP intervention evaluation because on presentation the potential beneficiary would not necessarily have been diagnosed as having a mental illness but would instead be perceived to have been displaying behaviour which was inimical to their wellbeing. And thirdly, the PHQ9 and GAD7 would be more effective in assessing a beneficiary's level of depression and anxiety.

However, when we were developing our tool the ONS was asked by Prime Minister David Cameron (2010) to develop a tool to measure happiness. This was done as part of the ONS's *Measuring National Well-being Programme*. There are now four questions used in the ONS's Well-being Index which are now going to be answered annually by 200,000 people in the government's Integrated Household Survey (IHS). As such it is four questions validated against the general population. The four questions are seen as a way of assessing the subjective well-being of individuals, by measuring what *people think and feel about their own lives* (Self et al, 2012:31). It is one of three wellbeing measures recommended by nef (Michaelson, 2012:11). And as such it is also useful in that it will allow users to compare their beneficiary scores with demographic and local authority scores to once again demonstrate the profile of their beneficiaries compared to a large national dataset. This is useful for third sector organizations when presenting evidence to local commissioners.

We also felt that it was important to capture the extent to which WP addressed two additional outcomes identified in the old beneficiary and stakeholder focus groups and

interviews which may not be easily encapsulated by the ONS questions. Namely: loneliness and physical activity.

The literature on social isolation shows that it is often the self-assessed feelings of being isolated that are more important for our health and wellbeing than the number of social contacts (Hawthorne, 2000). In the 1960s and 1970s, research by Townsend revealed that there were two different, but related aspects of loneliness: perceived social isolation and perceived emotional loneliness. These two dimensions of social isolation have been widely confirmed by other researchers (Hawthorne, 2000). And as such both are addressed by the Friendship Scale; which we included in our tool.

In terms of assessing physical health we have used the validated International Physical Activity Questionnaires (IPAQ) before (Jones and Kimberlee, 2009). The purpose of the IPAQ is to provide a set of well-developed instruments that can be used internationally to obtain comparable estimates of physical activity (IPAQ, 2013: Accessed 20<sup>th</sup> November 2013). This item was also important because in asking on how many days a week the beneficiary undertook to do moderate exercise (e.g. brisk walking, gardening, housework like cleaning) for 30 minutes or more users of the tool will be able to directly assess beneficiary performance against a key NHS target of 5 x 30 minutes a day of moderate exercise a week.

Our interviews and focus groups with old beneficiaries and stakeholders highlighted differences in terms of perceived outcomes. Stakeholders were more likely to suggest that the programme helped with broader community development issues in terms of promoting resilience and developing social and community capital. Old beneficiaries were less likely too. Given that there was less of a consensus here we had less of a focus on these issues but still felt it important to include items that could address these issues. We were mindful of the need to keep the WWQ as short as possible because of the vulnerability of the beneficiaries particularly at baseline. But we included two items from the IHS that asks about an individual's perception about their local neighbourhood in terms of whether they think it is a good place to live and whether they were satisfied.

Finally, as personal wellbeing is associated with income we decided to ask a question about personal finances. So we included an item in the WWQ on the subjective assessment of a beneficiary's personal finances that has been previously included in the UK's Family Expenditure Survey in the past and has been recommended as a good item to use particularly in areas of deprivation (McKay et al, 2003:11).

All of these items were included in the WWQ which new beneficiaries were asked to complete at baseline and at the end of the BO programme 3 months later. Additionally, when beneficiaries enter the WP they also completed the WHLC Registration Form (Appendix 3). This is compulsory for all beneficiaries and users of WHLC services. The form requests consent for release of anonymised information for evaluation purposes. This form generates a unique personal identifier. The identifier was used on the WWQ tool and also

given to Wellspring GP surgery for collection of the GP data noted above. The data from the registration form and the wellbeing tool was stored on the WHLC database. Access to the data on the database was password protected. Only the wellbeing workers and the CEO at WHLC had access to the data on the database. However they were able to provide the researchers with anonymised excel reports of beneficiary progress.

At three months following beneficiary enrolment on the WP in addition to completing the WWQ tool again beneficiaries were invited to come to a 1 to 1, in-depth, semi-structured interview with either a male or female researcher in a private room independently booked by the researchers at WHLC. We had funding to conduct 40 beneficiaries, almost a third (31%) of the cohort. In the interviews we were able to look at their experiences of the programme and explore areas of impact not necessarily covered by the WWQ. The interview schedule can be found in Appendix 4. The final version of the WWQ tool in Appendix 5.

**Table 1: Old beneficiary and stakeholder identified outcomes and their coverage in primary research methods with new beneficiaries**

| <b>Outcome</b>   | <b>Covered</b>                             |
|--|--|
| Depression   | WWQ  |
| Anxiety  | WWQ  |
| Reduced isolation  | WWQ  |
| Anger Management   | 1 to 1 in-depth semi-structured interviews |
| Increased Physical Activity                                    | WWQ  |
| Advice Information and Guidance                                | Outcomes recorded on database              |
| Improved employment/volunteering opportunities                 | Outcomes recorded on database              |
| Listened too   | Outcomes recorded on database              |
| Safe space   | 1 to 1 in-depth semi-structured interviews |
| Suicide prevention   | 1 to 1 in-depth semi-structured interviews |
| Reduction in alcohol and drug consumption                      | 1 to 1 in-depth semi-structured interviews |
| Bereavement  | 1 to 1 in-depth semi-structured interviews |
| Avoid downward spiral to moderate severe and severe depression | WWQ  |

|                                       |  |
|---------------------------------------|--|
| Less of a burden on family and carers | 1 to 1 in-depth semi-structured interviews |
| Increased confidence                  | 1 to 1 in-depth semi-structured interviews |
| Promoting Resilience                  | 1 to 1 in-depth semi-structured interviews |
| Developing social capital             | WWQ  |
| Community capital                     | WWQ  |
| Reduced isolation                     | WWQ  |

## Evidence of impact of the Wellbeing Programme

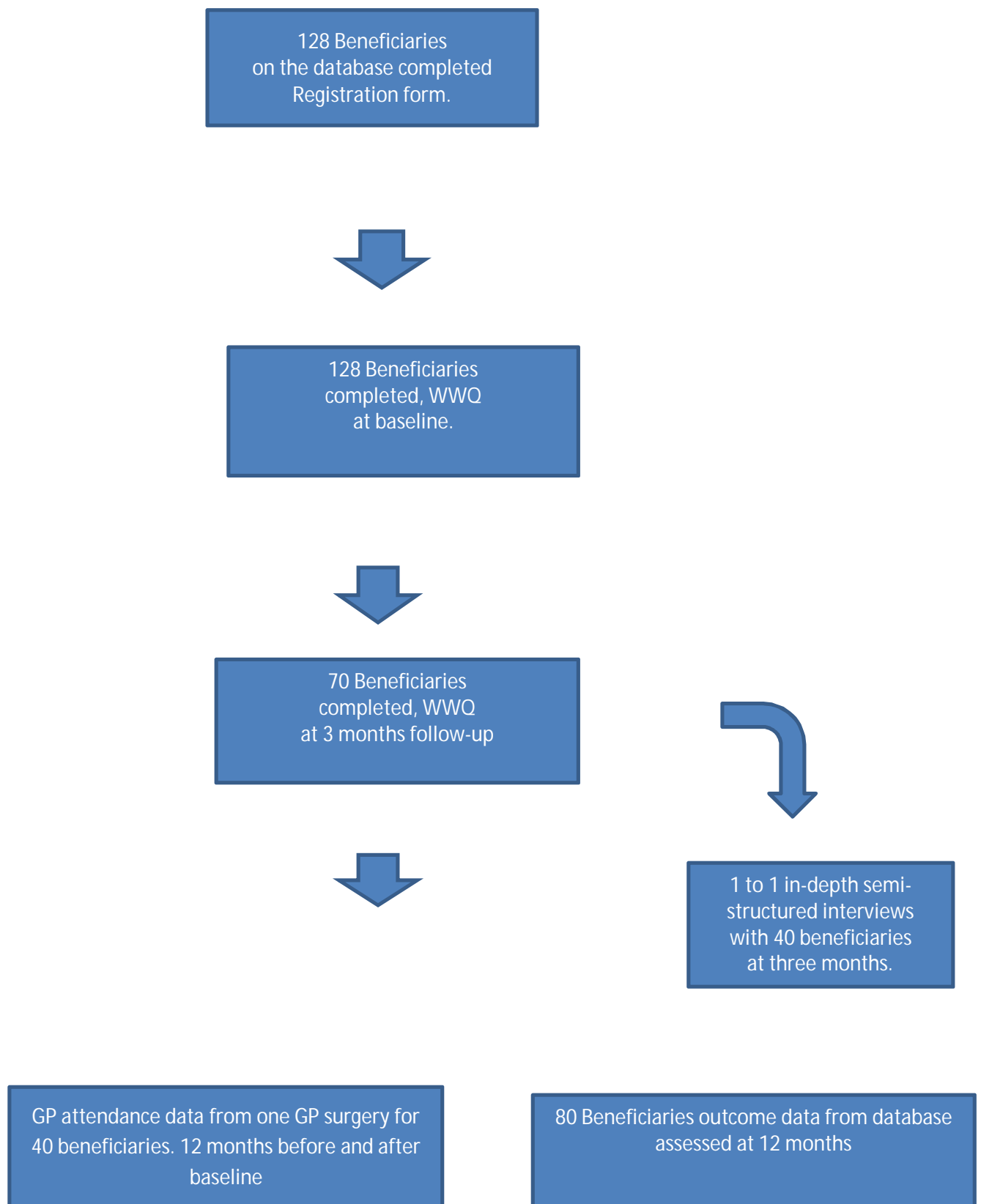
The WHLC Wellbeing database shows that there were 128 beneficiaries who participated on the BO programme for the year running from May 2012 to April 2013. This is the year of our analysis. Beneficiaries come on to the programme at different points; as and when they are referred. All WHLC beneficiaries are asked to complete a Registration form (See Appendix 3). On this form they are asked to give their consent to share anonymised responses for evaluation purposes. These details are recorded anonymously against a Personal Identification Number (PIN).

It is from this database that we get a sense of the demographic profile of people who present. The median age of beneficiaries was between 36-40 years of age. There were 12.5% (n=16) aged over 55. But most were of working age. 51.2% (n=66) were male. 83% (n=103) defined themselves as white. 11.3% (n=14) were black or black British. 3.2% (n=4) were Asian or Asian British and 2.4% (n=3) mixed. 33.6% (n=43) were in receipt of some disability benefit. 91% (n=115) said their first language was English. Other first languages included: French, Polish, Somali, Arabic, Mandinka and Portuguese.

In terms of their accommodation 37.7% (n=43) lived in either council owned or housing association property; 32.5% (n=37) were living in private rented accommodation and 23.7% (n=27) owned their own home. 6.1% (n=7) described themselves as either homeless or living with friends. The majority of the beneficiaries lived alone (37.9%, n=44). Very few were in traditional familial households which included a partner and children (22.4%, n=26). 12.9% (n=15) lived as a single parent and 14.7% (n=17) lived solely with a partner. 41.6% (n=47) said they were in full time work. 40% (n=45) were looking for work. The rest were either long-term sick, retired or in full time-education or training. 98% (n=112) were referred to the project by their GP from 5 different GP practices in Bristol.

From the database we can also learn a little about the client attendance on BO. Figure 1 below summarises the number of participants involved in each part of the study.

**Figure 1: Outline of sampling of New Beneficiaries for the Wellbeing Programme**



Below we look at the data collected through the WWQ tool. In order to undertake a statistical analysis of the data collected scores have been aggregated to enable us to look at the distance travelled by the beneficiaries on the programme. With more resources we would have been able to undertake a case by case analysis but that wasn't feasible within the timescales set for reporting. It reports on baseline and three month follow-up scores but we also provide quotes from the in-depth semi-structured interviews we conducted.

128 beneficiaries completed the WWQ at baseline and 70 completed the tool at follow-up three months later when their time on BO had finished. The disparity between 128 and 70 reflects beneficiary flow. There were still beneficiaries on the BO programme at the time when we were contractually obliged to look at the data in order to meet *Proving Our Value* report schedules.

**Table 2: Baseline and three months later scores on the PHQ9 scale for depression**

|                     | None<br>(0-4) | Mild<br>Depression<br>(5-9) | Moderate<br>Depression<br>(10-14) | Moderately<br>Severe<br>Depression<br>(15-19) | Severe<br>Depression<br>(20-27) | Mean  | Range |
|---------------------|---------------|-----------------------------|-----------------------------------|---|---------------------------------|-------|-------|
| Baseline<br>(n=128) | 3%<br>(n=4)   | 9%<br>(n=11)                | 12%<br>(n=15)                     | 25%<br>(n=32)                                 | 52%<br>(n=66)                   | 18.54 | 27    |
| Interim<br>(n=70)   | 32%<br>(n=21) | 26%<br>(n=18)               | 29%<br>(n=20)                     | 8%<br>(n=6)                                   | 6%<br>(n=5)                     | 4.61  | 27    |

A paired samples t-test was conducted to evaluate the impact of the intervention on beneficiary scores on the PHQ-9 scale. There was a statistically significant decrease in PHQ-9 depression scores from baseline (M=18.38, SD=6.42) to three months after (M=8.43, SD=6.33),  $t(69) = 11.39, p < 0.001$ . The mean decrease in PHQ-9 depression scores was 9.95 with a 95% confidence interval ranging from 8.208 to 11.692. The eta squared statistic (0.65) indicates a large effect.

There is clear improvement in beneficiary scores on depression. As a project the intervention seeks to promote beneficiary wellbeing needs in reality it works with people with quite severe mental health problems. It is clear at baseline that over half the beneficiaries could be diagnosed as having severe depression. The target beneficiary group for the programme was actually people with mild to moderate depression but the beneficiaries who are referred to BO by GPs are actually people with moderately severe to



severe levels of depression. Most beneficiaries of SP may not have had a mental health diagnosis.

*She (her GP) was going to refer me to a psychiatrist but it was going to take a long time to be honest so she said she would refer me to WellSpring. She said it could take weeks, maybe months to see a psychiatrist and even then it might not help me but that this women’s worker might, it might help with my isolation and depression (Beneficiary N20).*

**Table 3: Baseline and three months later scores on the GAD7 for anxiety**

|                  | None (0-4) | Mild Anxiety (5-9) | Moderate Anxiety (10-14) | Severe Anxiety (15+) | Mean   | Range |
|------------------|------------|--------------------|--------------------------|----------------------|--------|-------|
| Baseline (n=128) | 2% (n=3)   | 8% (n=13)          | 30% (n=38)               | 59% (n=74)           | 15.41% | 21    |
| Interim (n=70)   | 36% (n=25) | 31% (n=22)         | 23% (n=16)               | 10% (n=7)            | 7.21%  | 21    |

A paired samples t-test was conducted to evaluate the impact of the intervention on beneficiary scores on the GAD-7 scale. There was a statistically significant decrease in GAD-7 Anxiety scores from baseline (M=15.39, SD=4.67) to three months after (M=7.21, SD=5.34),  $t(69) = 12.83, p < 0.001$ . The mean decrease in GAD-7 Anxiety scores was 8.81 with a 95% confidence interval ranging from 6.901 to 9.442. The eta squared statistic (0.70) indicates a large effect.

These scores once again reveal the severity of mental health issues faced by WHLC’s SP beneficiaries. Almost 60% of those referred present with high levels of anxiety. At the end of BO over 60% have either mild or no anxiety.

One of the key issues faced by beneficiaries is social isolation. The registration forms reveal that 40% (n=44) live alone. We know from the one to one in-depth semi-structured interviews that beneficiaries have often been through considerable stress and dramatic life changes that could have left them bereft and alone.

*.....with me it was breakdown of a relationship, it got out of control, I was alone and about to be made homeless.....and then obviously ended up going out on sick leave from my full time job. And after the breakdown of my relationship,*

*down the line, I ended up resigning from a nice job in [deleted]. I got myself back into a safe environment through the help of \*\*\*\*\* and all the support from the guys down here. I am back in a safe environment now. I now live day to day, back in a happy place, got a part time job, so er, things are looking up.*  
(Beneficiary O5)

*It was like a spiritual thing that we did...which makes you think. It made more aware of the stressful situation that was on me and how to deal with it. Before I wouldn't have been able to deal with it. I would have just blown my top and deal with the consequences after it. It made me think more. Like instead of just sitting down and talking to a counsellor. You know you might as well talk to a hat and coat stand really.....do you know what I mean....I unloaded my loneliness and anger on \*\*\*\*\*. (Beneficiary N16)*

**Table 4: Baseline and three months later scores on the Friendship scale**

|                        | <b>Very Isolated</b> | <b>Socially Isolated</b> | <b>Some Isolation</b> | <b>Socially Connected</b> | <b>Very Connected</b> |
|------------------------|----------------------|--------------------------|-----------------------|---------------------------|-----------------------|
| <b>Baseline (n=87)</b> | 67.8%<br>(n=59)      | 17.3%<br>(n=15)          | 12.6%<br>(n=11)       | 1.1%<br>(n=1)             | 1.1%<br>(n=1)         |
| <b>Interim (n=48)</b>  | 35.4%<br>(n=17)      | 33.4%<br>(n=15)          | 18.7%<br>(n=9)        | 12.7%<br>(n=6)            | 0%<br>(n=0)           |
| <b>All Adults UK*</b>  | 2%                   | 5%                       | 9%                    | 25%                       | 59%                   |

\* See Hawthorne et al (2000)

A paired samples t-test was conducted to evaluate the impact of the intervention on beneficiary scores on the Friendship Scale. There was a statistically significant increase in connectedness in the Friendship Scale scores from baseline (M=8.63, SD=6.01) to three months after (M=13.17, SD=4.28),  $t(69) = 5.62, p < 0.001$ . The mean increase in the Friendship Scale scores was 4.54 with a 95% confidence interval ranging from 6.155 to 2.908. The eta squared statistic (0.4) indicates a large effect.

What the table shows is that people's sense of isolation has got less but there is still a considerable number of people who still feel very isolated at the end of the BO programmes, with 1 in 10 now saying they feel socially connected.

Looking at the Well-being measures we can see improvement on all four ONS indicators of wellbeing. There are improvements in beneficiaries' satisfaction with life, their happiness and an improvement in their belief that life is more worthwhile than it was at baseline. The

improvement on the how anxious item verifies the earlier gains demonstrated on the GAD7 indicator.

**Table 5: Baseline and three months later scores on the ONS Well-being indicators scale**

| <b>ONS Wellbeing Indicator</b>  | <b>Baseline (n=87)</b> | <b>Interim (n=48)</b> | <b>UK Adult average (ONS, 2012)</b> | <b>South West Region (ONS, 2012)</b> | <b>Bristol Region (ONS, 2012)</b> |
|---|------------------------|-----------------------|-------------------------------------|--------------------------------------|-----------------------------------|
| <b>Overall, how satisfied are you with your life nowadays?</b>                            | 2.63                   | 5.58                  | 7.4                                 | 7.52                                 | 7.3                               |
| <b>Overall, how happy did you feel yesterday?</b>   | 3.26                   | 6.06                  | 7.3                                 | 7.28                                 | 7.18                              |
| <b>Overall, how anxious did you feel yesterday?</b>                                       | 6.0                    | 3.56                  | 2.9                                 | 2.99                                 | 3.21                              |
| <b>Overall, to what extent do you feel the things you do in your life are worthwhile?</b> | 3.8                    | 6.02                  | 7.6                                 | 7.77                                 | 7.47                              |

Again these improvements were significant. The table below provides the t-scores and eta effect values. Interestingly, beneficiaries make between 2 and 3 point improvement on the ONS wellbeing indicators. Although looking at the table above their scores are still below the regional and local authority levels.

**Table 7: Baseline and three months later T-values for the ONS Well-being indicator scale scores**

| <b>ONS Wellbeing Indicator (n=48)</b>   | <b>Mean difference</b> | <b>T scores</b> | <b>Significance</b> | <b>Eta Values</b>    |
|---|------------------------|-----------------|---------------------|----------------------|
| <b>Overall, how satisfied are you with your life nowadays?</b>                            | -2.872                 | -7.880          | P= <0.001           | 0.60<br>Large effect |
| <b>Overall, how happy did you feel yesterday?</b>   | -2.851                 | -8.630          | P= <0.001           | 0.65<br>Large effect |
| <b>Overall, how anxious did you feel yesterday?</b>                                       | 2.894                  | 6.757           | P= <0.001           | 0.58<br>Large effect |
| <b>Overall, to what extent do you feel the things you do in your life are worthwhile?</b> | 2.255                  | -4.822          | P= <0.05            | 0.37<br>Large effect |

This greater sense of well-being is a theme that consistently came out of the one to one, semi-structured interviews:

*It's been absolutely brilliant. I have never felt better. It's really sorted out my mind. I have got a totally different outlook. Positive thinking. I have a real positive consistent outlook on life.....It feels like a miracle to me it really does.*  
(Beneficiary N15)

*I used wait for the doctor in the morning after work. I would sit in the car park until it was time. He sort of gave me a sort yourself out type of chat. I am not very good at taking pills but they really helped. They took the edge of things. It was like the security blanket, but I would also see \*\*\*\*\* and he turned me around.* (Beneficiary N14)

Another reported outcome of the BO programme is that beneficiaries now report increased physical activity rates. There has been considerable discussion as to whether addressing mental health can improve physical activity. And there is evidence to suggest that walking, and physical activity more generally, can be an effective way to enhance positive moods.

People with high levels of regular physical activity have been shown to have higher levels of positive emotions such as interest, excitement, enthusiasm and alertness compared to people with moderate and low levels of physical activity (Pasco et al, 2011).

What the WWQ tool reveals is an increase in beneficiaries' rates of physical activity. The Department of Health recommend at least 150 minutes of moderate-intensity aerobic activity such as cycling or fast walking every week (NHS Choices, 2013, Accessed 11<sup>th</sup> November 2013). The table below looks at physical activity rates of beneficiaries. It shows that only 17% of beneficiaries were meeting government guidelines of 5 x 30 minutes of moderate intensity activity at baseline. After three months this had almost doubled to 31%

**Table 8: Baseline and three months IPAQ measures for physical activity.**

|                     | <b>No days of physical activities (moderate intensity)</b> | <b>5 + days of physical activities (moderate intensity)</b> | <b>Mean day score</b> |
|---------------------|--|---|-----------------------|
| Baseline<br>(n=87)  | 4.6%<br>(n=4)  | 17.2%<br>(n=28)   | 3.06                  |
| Follow up<br>(n=48) | 2.1%<br>(n=1)  | 31.2%<br>(n=25)   | 4.10                  |

The table below also shows there has also been a slight, although non-significant increase in the number of people who are doing vigorous activity as well.

**Table 9: Baseline and three months IPAQ measures for physical activity.**

| <b>During the last 7 days, on how many days did you:</b>   | <b>Baseline Mean day score (n=87)</b> | <b>Follow-up Mean day score (n=48)</b> | <b>Eta score and effect</b> | <b>t-value Significance</b>        |
|--|---------------------------------------|--|-----------------------------|------------------------------------|
| <b>Walk for at least 10 minutes at a time?</b>   | 4.14                                  | 4.71                                   | Eta= 0.16<br>Large effect   | t=3.02<br>Significant<br>p= <0.004 |
| <b>Do moderate exercise (e.g. brisk walking, gardening, housework like cleaning) for 30 minutes or more:</b> | 3.06                                  | 4.10                                   | Eta =0.4<br>Large effect    | t=5.62<br>Significant<br>p= 0.001  |
| <b>Do vigorous physical activities like heavy lifting, digging, aerobics, or fast bicycling?</b>             | 1.23                                  | 1.56                                   |                             | Not significant<br>p=0.127         |

As previously noted we obtained permission from beneficiaries to look at their GP attendance and prescription data. There were five local GP surgeries referring to the WP. We were able to negotiate with the WHLC surgery a process of releasing anonymised data using the beneficiary PIN. This took a lot work for the surgery's GP Strategic Business Manager. Of the 128 beneficiaries on the data base 48 beneficiaries were registered at WHLC. This is 75% of all BO beneficiaries who are known to have been referred from a WHLC GP. Of these 40 beneficiaries had records 12 months prior to joining the BO programme and 12 months after. Looking at telephone contact 50% (n=20) had fewer telephone contacts in the 12 months after commencing the BO programme, 25% (n=10) had the same amount and 25% (n=10) had more telephone contacts.

**Table 10: Beneficiary telephone contact with GPs at Wellspring Surgery 12 months before and after commencing Branching Out**

| N=40  | Mean contact /patient | Mean contact/patient (excluding 2 outliers) | Median contact /patient | Range |
|---|-----------------------|---|-------------------------|-------|
| Number of GP contacts 12 months before BO enrolment | 2.48                  | 2.55  | 2                       | 1-10  |
| Number of GP contacts 12 months after BO enrolment. | 2.7                   | 2.0   | 1                       | 1-16  |

The mean values in the table above suggest that there were actually more telephone contacts overall from these beneficiaries in the 12 months after the intervention than in the 12 months before. The range scores show that some beneficiaries had 10 telephone calls prior to joining the BO programme but up to 16 in the 12 months after the programme. A closer examination of the data reveals that 2 of the 10 beneficiaries who had more telephone calls after commencing the BO programme made 16 calls each. Between them they accounted for almost a third of all calls from the 40 beneficiaries in the 12 months after commencing the BO programme. If we exclude these two then there is a marked difference in the mean scores. Examination of the PHQ9 scores and GAD7 scores suggest that they had made little improvement on the WP.

**Table 11: Beneficiary face-to- face contact with GPs at Wellspring Surgery 12 months before and after commencing Branching Out**

| N=37  | Mean contact /patient | Median contact /patient | Range | Mean contact/patient (excluding 2 outliers) |
|---|-----------------------|-------------------------|-------|---|
| Number of GP contacts 12 months before BO enrolment | 4.61                  | 3.51                    | 1-13  | 4.4   |
| Number of GP contacts 12 months after BO enrolment. | 4.51                  | 3.0                     | 1-18  | 3.71  |

The mean values in the table above suggest that there were slightly fewer face-to-face contacts overall from these beneficiaries in the 12 months after than the 12 months before. The range scores show that some beneficiaries had 13 face-to-face contacts prior to joining the BO programme but up to 18 in the 12 months after the programme. A closer examination of the data again reveals that 2 of the 10 beneficiaries who had more face-to-face contacts after commencing the BO programme had 17 and 18 face-to-face contact with their GP each. Between them they accounted for 15% of all the face to face contacts from the 37 beneficiaries in the 12 months after commencing the BO programme. If we exclude these two then there is a marked difference in the mean scores.

We know that the number of consultations for a typical practice in England rose from 21,100 in 1995 to 34,200 in 2008. The average patient had 3.9 consultations each year in 1995 rising to 5.5 consultations each year by 2008. Of these 82% of GP consultations were conducted in surgery premises, 12% were on the telephone, 4% were home visits and 3% were conducted at other locations (Hippisley-Cox et al, 2009:4-7). Looking at the BO patients attendance records it is clear that prior to coming on the BO programme almost a third (50%, n=17) of the patients whose records we looked at were having above national average GP consultations.

**Table 12: Summary of face to face attendance and telephone calls to WHLC.**

| Number of consultations After 12 months; excluding the two high users. | Face to Face (n=37) | Telephone (n=40) |
|--|---------------------|------------------|
| Fewer  | 60%                 | 50%              |
| The Same   | 26%                 | 24%              |
| More   | 14%                 | 26%              |

The table above confirms the views of stakeholders and the old beneficiaries interviewed at the start of the research and those also interviewed as part of a scoping exercise to understand what is meant by SP (Kimberlee, 2013) that beneficiaries of SP projects are consulting their GPs less.

At the time of reporting we were still awaiting clarification on prescription data from the WHLC database. So direct evidence of a reduction in anti-depressants cannot be immediately verified. However 6 new beneficiaries in the 1 to 1 in-depth semi-structured interviews had reported coming off anti-depressants.

At 12 months from baseline the WHLC's database was consulted to understand what changes had occurred in beneficiary's lives in the longer term and what engagement beneficiaries had with the broader WP programme. The table below shows that individual



beneficiaries are seen on average 7 times by the two workers. Although, the range of the number of sessions attended can vary; with one client being seen 22 times during the three months of BO.

**Table 13: Attendance on Branching Out sessions (n=128).**

|                      | <b>Number of Sessions</b> | <b>Mean number of sessions/client</b> | <b>Range of sessions/client</b> | <b>Modal sessions</b> |
|----------------------|---------------------------|---------------------------------------|---------------------------------|-----------------------|
| <b>Branching Out</b> | 945                       | 7.32                                  | 1 - 22                          | 3                     |

Beneficiaries have an opportunity to attend a variety of Time-Out Groups having gone through the BO sessions with the health workers. These sessions are various but they are also open to anyone to access from the community. Existing Time-Out Group users can include individuals that were previously BO participants. Or they may have been recommended by friends or other primary care service providers. As such they offer an additional medium SP opportunity at the WHLC. Out of 128 Beneficiaries only 22% (n=28) opt to go on to attend a Time-Out Group session.

**Table 14: Attendance on Time-Out Group Out sessions (n=28).**

|                                | <b>Number of Sessions</b> | <b>Mean number of sessions/client</b> | <b>Range of sessions/client</b> | <b>Median sessions</b> |
|--------------------------------|---------------------------|---------------------------------------|---------------------------------|------------------------|
| <b>Time-Out Group Sessions</b> | 391                       | 13.96                                 | 1 - 72                          | 13                     |

Time-Out Groups Sessions that could be enjoyed include:

- Kitchen on Prescription
- Knit and Natter
- Somali Health and Wellbeing group
- Support to Stop Smoking
- Time-Out for Men
- Time-Out for Women

We were able to examine the outcome data from the WHLC database of 80 beneficiaries who first came to the Wellbeing programme 12 months ago. The table below summarises

the employment outcomes that beneficiaries have achieved during this time. It shows that within 12 months of being on the programme 29% of beneficiaries manage to obtain employment, voluntary work or had accessed some form of education or training.

**Table 15 Employment outcomes of Wellbeing Programme participants at 12 months (n=80)**

| <b>Employment Outcome achieved</b> | <b>Percentage (Number)</b> |
|------------------------------------|----------------------------|
| <b>Full time employment</b>        | 8% (n=6)                   |
| <b>Part time employment</b>        | 4% (n=3)                   |
| <b>Voluntary Work</b>              | 9% (n=7)                   |
| <b>Education or training</b>       | 9% (n=7)                   |
| <b>Total</b>                       | 29% (n=23)                 |

In addition to achieving employment Table 16 below reports on advisory and counselling services accessed by beneficiaries within 12 months of starting on the WP. This includes 29% (n=23) of beneficiaries who have accessed Employment Links. Employment Links can provide advice, assistance and training to individuals to help them to access training, education and work opportunities. They also deliver a range of training interventions from sessions to build basic skills through to vocational courses.

Additional services beneficiaries were supported with while on the WP are outlined in the table below. In several cases the workers on the project will do more than signpost what is available. Part of the SP holistic approach is about working with beneficiaries to address all their needs. Through the programme they may come to recognise and confront the manifold problems they face which can include accepting they have a dependency on a substance. Workers can also play key advocate role for beneficiaries and could make and/or attend initial appointments to support the beneficiary.

**Table 16 Additional services accessed by beneficiaries of the Wellbeing Programme participants at 12 months (n=80)**

| <b>Additional services accessed</b>   | <b>Percentage (Number)</b> |
|---------------------------------------|----------------------------|
| <b>Referred to other agencies</b>     | 45% (n=36)                 |
| <b>Access to Employment Links</b>     | 29% (n=23)                 |
| <b>Access debt advice</b>             | 26% (n=21)                 |
| <b>Person referred to counselling</b> | 20% (n=16)                 |

|   |          |
|---|----------|
| <b>Person quits smoking for at least four weeks</b>       | 6% (n=5) |
| <b>Accessed a decision-making group</b>                   | 6% (n=5) |
| <b>Person support with drug/alcohol addiction issues</b>  | 6% (n=5) |
| <b>Person supported on to an Arts programme</b>           | 5% (n=4) |
| <b>Person supported on to the Freedom programme</b>       | 2% (n=2) |
| <b>Person supported to access Safe accommodation</b>      | 2% (n=2) |
| <b>Person supported to access Health Visiting service</b> | 1% (n=1) |
| <b>Person referred to language course</b>                 | 1% (n=1) |

## The cost effectiveness of the Wellbeing Programme

There has been very little research to explore the cost effectiveness of SP. The Amalthea SP Project based around 26 GP surgeries in the former county of Avon using the referral services of a Health Facilitator is the most recent investigation. This was very much a SP *medium* project i.e. not a *holistic* SP project. It worked with 90 beneficiaries who were referred to a voluntary organisation to manage their access onto a SP supplier from the third sector. It is one of only a few projects to have been comprehensively evaluated, using a RCT and an economic evaluation. The Amalthea Project and subsequent contact with the third sector resulted in clinically important benefits compared with usual general practitioner care in managing psychosocial problems; but at a higher cost. Beneficiaries of the project were seen to be less depressed and less anxious (as WP beneficiaries are) but their care was more costly compared with routine care and their contact with primary care was not reduced (Grant et al, 2000:419):

*Psychological interventions in primary care can, but do not necessarily, result in savings in mental health prescribing.*

However this cost-benefit study did not look at the long term savings made beyond a year and also failed to compare the costs to what would have happened if the patients had been referred to a specialist and secondary care (Thornett, 2000).

Are RCTs an appropriate way to measure the cost effectiveness of SP projects? Current policy guidance and recommendations suggests that it is important to assess potential saving of future costs (Freidli, 2007:9). SP fits in with the long-term strategic reorientation towards promoting health, independence and well-being, and in essence practitioners believe that by investing in SP now it will reduce the future costs of ill health. Thus there are several critics who argue that short-term economic evaluations of SP are limited and erroneous in concluding that it costs more than usual general practitioner care.

*Experience of the Hackney Well Family Service, a family support project we have developed jointly with the Family Welfare Association, suggests this is short-sighted. It fails to take into account the long-term benefits to the community, and the consequent reduced burden on all support services, when the cycle of deprivation can be broken (Goodhart, 1999:525).*

This need for taking a long term view on costs has long been advocated by SP practitioners arguing that outcomes are often slow to materialise when working with isolated and often poorly motivated clients (Care Forum, 2012). This is because SP beneficiaries frequently require a considerable amount of time to enable the SP worker to address their multi-faceted needs. *Holistic* projects do this. If beneficiary needs are not addressed and a person reaches a crisis point, it then becomes much more difficult and costly to restore their health, employment and social status, with a subsequent exacerbation of economic and health inequalities (Freidli, et al 2007:45).

Thus, these long term benefits need to be considered when assessing cost-effectiveness. The governments focus on outcome and impact, along with the concept of 'value for money', is growing even within *philanthropic* sector (Leat, 2006). Using the SROI methodology it is officially accepted is an appropriate method for assessing third sector value (Cabinet Office, 2009). It enables third sector providers and commissioners an opportunity to see the broader value that third sector organizations can bring. In essence SROI approaches compare the monetary benefits of a program or intervention with the program costs (Phillips, 1991). In this sense SROI represents a development from traditional cost-benefit analysis as practiced by Grant et al (2000) when they assessed the cost-effectiveness of the Amalthea SP project. Developed in in the late 1990's it aims to fully valorise all social impacts of any intervention (Emerson, 2000). This is a method for measuring and communicating a broad concept of value, which incorporates the social, environmental and economic impacts, generated by all the activities of an organisation (Greenspace Scotland, 2009). SROI therefore works to demonstrate the extent of this value creation by measuring a range of social, environmental and economic impacts, using monetary values to represent these impacts and enabling a ratio of benefits to costs to be calculated (Cabinet Office, 2009).

SROI developed from traditional cost-benefit analysis in the late 1990's (Emerson, 2000). The SROI approach captures the economic value of social benefits by translating social objectives into financial measures. In the previous chapter we outline the impact of the WP has had on beneficiaries using the WWQ and identified some of the outcomes that has been achieved in the 12 months after starting the BO component of the programme. Here we will valorise these impacts.

### *Suicide prevention*

One of the key messages that came through our 1 to 1 in-depth semi-structured interviews and responses to the WWQ was that for the majority of the beneficiaries they see an improvement in their mental wellbeing. Note individual beneficiaries may not have necessarily been diagnosed with a mental illness when they were referred to this SP project, but on arrival the GAD7 and PHQ9 items reveal considerable levels of anxiety and depression at baseline that are reduced during their exposure to the BO component. Our

qualitative interviews revealed that many beneficiaries who end up on the WP have faced severe challenges. We know from the WWQ that 77% (n=98) at base line were rated as either having moderately severe depression or severe depression on the PHQ9 scale. It is known that 90% of people who commit suicide suffer from a mental disorder and 60% suffer from depression (WHO, 2006:4). Our qualitative interviews with almost a third (31%, n=40) revealed beneficiary reflections on desperate circumstances and sometimes chaotic lifestyles. 13% (n=5) of those interviewed referred to feeling suicidal or having suicidal thoughts during the interview:

*I was at my wit's end. I was like. Things were so bad I could have topped myself. I just had nowhere to go. I had such a row with my partner, it was bad I just smashed things up.* (Beneficiary, N15)

*Sometimes I feel self-destructive but I think that is probably quite normal.* (Beneficiary, N25)

*If I hadn't started to talk about these things I don't think I would be here.* (Beneficiary, N11)

*Somebody I have met has brought me back to life. The woman downstairs (the doctor in the GP surgery) didn't give me any help.* (Beneficiary, N2)

Suicidal thoughts and being desperate were feelings that beneficiaries express. In times following the economic crash in 2008, individuals have come under increasing pressure. Stuckler et al (2013) point out that at a time of austerity suicide rates increase. Suicides were falling in the UK before the recession, they spiked in 2008 and 2009 at the same time as a sudden rise in unemployment. In Bristol the recorded standardised mortality ratio for suicides and undetermined death between 2007 and 2009 was 9.5/100,000 compared to the South West average of 8.4 (SWPHO, 2011, accessed 15th September 2013). As unemployment fell again in 2009 and 2010, so too did suicides. But, in the past few years, as austerity measures have begun to take effect, suicides have risen (Arie, 2013:10).

It is hard to definitely say whether the WP directly prevented a beneficiary from committing suicide. Interviewee N11 claims it definitely did. However, what we do know from recent research in the UK is that 45% of patients who complete suicide contact a primary care provider (e.g. their GP) in the month preceding their death (Dolton, 2013:347). The WP is a GP referral SP intervention. People are referred after primary care contact and it is clear that they have worked with so many people who were in desperate need. People like beneficiary N18:

A male 36, refused to leave room in mother's house for three months, struggling on anti-depressants, history of violence towards girlfriend, unemployed, doesn't see children, no friends, alcohol dependent. (Beneficiary, N18)

We know from our discussion above that the cost of mental health accounts for 2% of GDP according to Professor Layard (2005). A lot of this cost is in services expended to deal with attempted suicides. In their review of mental health costs for the NHS Platt et al (2006) have argued that the average cost of a completed suicide for those of working age in England is £1.67m (2009 prices). This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as lost output (e.g. employment), (both waged and unwaged), police time and funerals. But, there are also costs to the public purse from recurrent non-fatal suicide events. Overall it is estimated that costs are averted to £66,797 per year per person of working age where suicide is delayed. Figures will vary depending on means of suicide attempt. One recent English study indicates that only 14% of costs are associated with A&E attendance and medical or surgical care; with more than 70% of costs incurred through follow up psychiatric inpatient and outpatient care (Knapp et al, 2011:26).

In the scoping exercise to understand the range of SP provision all SP practitioners tended to argue that one of the real achievements of SP is supporting beneficiaries to ensure that their circumstances does not get any worse. Clearly our stakeholder interviews also acknowledged that suicide prevention for some beneficiaries are a real outcome of the work undertaken. Given that one interviewee directly attributed their suicide prevention to the WP the SROI will parsimoniously include the cost of preventing one suicide for one year. However, the number may be greater. We only interviewed 40 beneficiaries in our one to one in-depth semi-structured interviews. We discovered explicit suicide intentions in 5 beneficiaries, when the actual project dealt with 128 beneficiaries in a year.

#### *Mental health: Preventing psychosis*

Most, if not all of the beneficiaries on the WP would have been referred by their GP because they had been on anti-depressants for some time, and had enduring anxiety and/or had somatoform conditions (i.e. they present physical symptoms for which there is no identifiable physical cause). As far as we know the beneficiaries would not have had their depressive or anxiety symptoms formally diagnosed. At baseline PHQ9 scores reveal considerably high levels of depression. With these high scores interviewees reveal frequent accounts of psychotic behaviour or incidents. RCT research suggests that the transition from prodromal psychosis symptoms to full psychosis occurs for 35% of patients under standard care (Garety et al, 2006:45). What the WP achieves more than anything is that it works with beneficiaries with severe depression and at the end of three months a majority report

reduced levels of depression. We can therefore assume that potentially 35% of beneficiaries who show declining PHQ9 scores have been prevented from becoming a heavier burden on NHS services at least in the short term and associated savings can be calculated. The reduction in service costs is primarily due to the lower demand for inpatient care when specialist early intervention is provided. The annual direct cost per patient of this type of service in terms of input from an early intervention team plus other community psychiatric services and inpatient care has been estimated at £10,927 at 2008/09 prices (McCrone et al, 2011). 98 beneficiaries had moderately/severe depression scores at baseline but this declined to 11 at interim follow up. If we calculate the 35% figure then up to 30 beneficiaries have been prevented from being a heavier burden on the NHS. Without a thorough psychiatric examination (which was beyond the scope of the study) we cannot adequately know how many were psychotic. We know from our interviews we came across 4 interviewees who revealed occasions of psychosis prior to referral and all four show improvement. One interviewee's story (he smashed up his house) comes particularly to mind.

*I don't want to remember the past...it's not that I don't want to remember it....its like I got rid of it.... I was in my house.... I was on a tag everyday.... My Mum was an alcoholic, she was suicidal, my sister was in and out of psychiatric wards, she sliced herself on a daily basis she has also sat down and watched one of her kids.....because they were all saying that you are a criminal we are going to class yourself as a criminal when really I was a sick criminal and needed help for my condition but like they were diagnosing me but like none of them were giving me help. (Beneficiary N18)*

So for the SROI analysis we will assume 1 person has been saved from moving into requiring more services to deal with the drift into psychosis. But again this is a very parsimonious assumption. We only conducted one to one in-depth semi-structured interviews with 40 beneficiaries, a third of the baseline sample. Other compelling stories are likely to have been revealed if we had the resources to undertake more interviews.

### *Preventing Depression*

In 2011-12 14.03% of adults in Bristol were diagnosed with depression (NEPHO, 2013). For those identified as being at risk, the cost of six sessions of face-to-face Cognitive Behaviour Therapy (CBT) delivered within the NHS was £240 in 2008-09 (McDaid et al, 2011). It is accepted that by tradition CBT is offered for 12-16 1-hour sessions (Whitfield et al, 2000). The majority of WP beneficiaries were seen for just 7 sessions; roughly half the number of sessions required by CBT therapies. PHQ9 scores suggest that the number of people who had severe depression at baseline was 52%. This reduces to 6% at the end of BO. The



number of people with no depression increases from 3% to 32% i.e. 17 beneficiaries report no depression. Parsimoniously for these beneficiaries we can valorise depression reduced by highlighting savings for each of 6 CBT sessions.

#### *Reduced GP attendance*

We know that the annual health service cost of people who frequently attend a GP for medically unexplained symptoms amounted to £3.1 billion in 2008-09 (Bermingham et al. 2010). Reducing GP attendance particularly as the service is in 'crisis' is going to be of great benefit to GP practices. Expert opinion suggests that four GP visits at a cost of £38 per visit (Curtis 2009, updated for 2010/11 prices) were needed over a treatment period for such patients. These figures have been used in the local costing templates for people who have mild depression and people who have mild GAD scores to assist with estimating savings and resources released from implementing the guidance (NIHCE, 2011). We know that 60% (n=22) of the 37 beneficiaries for which we have 2 year attendance data are seeing their GP less. They have 0.7 less contacts each which we can valorise.

#### *Reduced prescription data*

It is clear that the costs of anti-depressants are a growing burden on the NHS. A recent report exploring a decade of prescription data found that in the year before new beneficiaries joined the programme just under 46.7 million prescriptions for antidepressants were dispensed in England in 2011, a 9.1% increase on 2010. This was the largest increase in the number of prescription items within all 200 therapeutic areas covered in the report (Health and Social Care Information Centre, 2012).

Estimates given in the costing tool for beneficiaries with GAD and panic disorder (NICE clinical guideline 113) identify that the cost of interventions involving drug treatment ranges from £189 to £449 per person. A mid-point value of £319 has been used to estimate potential savings in the NHS costing template (NIHCE, 2011:19). Costs for antidepressant prescribing rose by £49.8 million to £270 million, a rise of 22.6% on 2010. With prescriptions for fluoxetine, a selective serotonin reuptake inhibitor (SSRI), available as a generic and sold under the brand name Prozac, increasing by 0.1m (15.9%) (NHS Choices, 2012, accessed 22<sup>nd</sup> November 2013). The average monthly cost to the NHS of buying generic SSRI in England and Wales is £14/patient (Nice, 2004). Allowing for the growing costs of SSRIs this can parsimoniously be estimated to be £16/month; we can estimate savings for 6 beneficiaries over nine months of the WP following their experience of being on BO to be £844.

#### *Improved Well-being*

It is very hard to valorise well-being. Let alone improved well-being. Our impact data reported above suggest that beneficiaries have statistically significant improvements on all

ONS wellbeing indicators. Our 1 to 1 in-depth semi-structured interviews with 40 beneficiaries also delivered strong testament to how far beneficiaries had come in terms of their improved sense of well-being:

*It's (the WP) absolutely brilliant. I have never felt better. It's really sorted out my mind. I have got a totally different outlook. Positive thinking. I have real consistent outlook on life.....It feels like a miracle. (Beneficiary N15)*

*\*\*\*\*\* (The Worker) there and I can see the light at the end of the tunnel. I feel so much better in myself (Beneficiary N33)*

*I found it (The WP) really useful...and I was quite surprised because I am 58 years old so I have tried everything and I have got the T-shirt. (Beneficiary N32)*

There is also additional evidence of improved financial well-being for beneficiaries. The WWQ included an item on perceived economic well-being.

**Table 17: Perceived economic well-being**

|                                 | <b>Living comfortably</b> | <b>Doing alright</b> | <b>Just about getting by</b> | <b>Finding it quite difficult</b> | <b>Finding it very difficult</b> | <b>Mean scores</b> |
|---------------------------------|---------------------------|----------------------|------------------------------|-----------------------------------|----------------------------------|--------------------|
| <b>Baseline (N=86)</b>          | 2%<br>(n=2)               | 17%<br>(n=15)        | 36%<br>(n=31)                | 20%<br>(n=17)                     | 24%<br>(n=21)                    | 3.41               |
| <b>3 month follow-up (N=46)</b> | 14%<br>(n=7)              | 19%<br>(n=9)         | 40%<br>(n=19)                | 21%<br>(n=10)                     | 6%<br>(n=3)                      | 2.78               |

These gains over a three month period show that there has been a change at the extremes. In particular there are less (29% compared to 44%) people who feel it is *quite* or *very* difficult to get by. And an improvement from 19% to 33% who feel they are *doing alright* or *living comfortably*. A paired samples t-test was conducted to evaluate the impact of the intervention on beneficiary' perception of their economic well-being and found that there was a statistically significant decrease in economic well-being scores from baseline (M=3.41, SD=1.24) to three months after (M=2.78, SD=1.20),  $t(45) = 4.49$ ,  $p < 0.001$ . The mean decrease perceived economic well-being in scores was 0.63 with a 95% confidence interval ranging from 0.348 to 0.913. The eta squared statistic (0.31) indicates a large effect.

Given the broad improvement in beneficiary sense of well-being it is important to capture this added value. On the follow-up well-being scores 48 beneficiaries reported improvement on all indicators. It is arguable to imply that BO is a multi-faceted intervention achieving a broad range of outcomes to achieve a sense of well-being. In the recent report for the DoH on the economic costs of mental health one case study was provided of a multicomponent intervention aimed at improving well-being for adults in the work place. It was estimated to cost £80 per employee per year (McDaid et al 2011b:22). We use this proxy but only for a three month period which is the duration of the BO part of the programme.

### *Reduced social isolation*

In the past we have used a befriending service charge as a proxy to cost the added value gained from socialising activities that help to end isolation (Shergold, Kimberlee and Musselwhite, 2012). It is clear from the evidence outlined above that many beneficiaries report improvements in connectedness. Table 4 shows that 67% (n=59) were already saying that they were very isolated at baseline. At follow-up three months later only 35% (n=17) were reporting being socially isolated. There are 30 people reporting real improvement in their sense of social connectedness. Our one to one in-depth semi-structured interviews with 40 beneficiaries revealed that they got a lot from the friendships they developed with the project workers.

*It would be a 'disaster' if the service was taken away. This has been an important service at this time in my life and I see it as invaluable. It could also be important to many others as there are so many people like me facing and feeling isolated, particular those living in flats in the area (Beneficiary, N28)*

*I was off my tree basically. I wasn't very happy at the time and he suggested that I come and see \*\*\*\*\*. He knew I wasn't very good at talking about my feelings and said so he said try this instead. Since then I know I have found a friend. (Beneficiary, N14)*

The importance of the befriending element of the WP cannot be underestimated. Research has shown that befriending can lead to positive outcomes and cost saving benefits for the NHS through the early intervention and prevention of complicated health issues as well as through reducing dependency on its resources (Mulvihill, 2011). Using the parsimonious assumption that the one-to-one BO sessions lasts roughly for 1 hour, beneficiaries have had 7 sessions on average and 30 beneficiaries report improvement in terms of their isolation we can calculate befriending costs for the support they received. This approach has been used before to calculate the befriending value of a Wheels-to-Meals scheme (SROI Network, 2012).

### *Increased physical activity*

Several beneficiaries have shown improvement in terms of their physical activity by achieving levels of moderate exercise as recommended by the DoH. We have therefore added the cost of physical activity or gym attendance for those beneficiaries. A proxy that has been used in SROI analyses before to valorise improved fitness (Capacity Builders, 2010). In doing this we have looked at the costs of attending a local Fitness Centre.

### *Getting back to work*

One of the key outcomes of the programme is helping beneficiaries to get back into employment again. At baseline 46% (n=52) of the beneficiaries said they were either looking for work, were long term sick, in education or training or on bail. The WP helped beneficiaries to look for employment opportunities. For some beneficiaries this was about accessing an advisory charity called Employment Links. This is a local organization which provides information, advice and support to people looking for work and/or training. Almost half of those not in employment 44% (n= 23) were signposted and/or supported to visit this agency. Of which 26% (n=6) went on to find full time employment and 13% (n=3) part-time employment. In total 39% (n=9) had found some form of employment. Additionally at least 7 beneficiaries had also taken on some voluntary activity.

A significant majority of WP beneficiaries had been long term employed. Other SROI studies have used benefits saved over the year to calculate value of return to work or actual salary gained (nef, 2008:35). In fact the advice to commissioners from the NIHCCE (2011) is that the biggest benefits and savings as a result of implementing psychological therapies like CBT, counselling etc. are likely to be made outside the health service. Improving access to services and providing choice and continuity of service is likely to result in people successfully completing treatment and allowing them to retain or regain employment. The effect of this is to deliver savings in the form of additional tax receipts and reduced welfare benefits payments (NIHCCE 2011:20). Unfortunately, we don't know the exact start point of beneficiary employment so this would be difficult to calculate benefit savings. However it is quite feasible that these beneficiaries would at some future point be faced with the requirement to enter the Work Programme. In 2011 the government introduced the Work Programme. This provides personalised support for claimants who need more help looking for and staying in work. Service providers have freedom to decide how best to support Work Programme participants while meeting minimum standards for delivering the service. A recent report of the programme's first year shows that 19% of participants have spent 26 continuous weeks off benefit (DWP, 2012:5). Having 17% (n=9) of beneficiaries who at baseline described themselves as looking for work, long term sick, in education or training or on bail, actually in employment suggests that the WP is performing a return to work service as effective as the Work Programme. Comparison to the Work Programme is

important because commissioners of programmes like the WP are frequently requesting evidence of an intervention's contribution to employment. It is also possible to estimate some benefit savings. If we assume that the 9 beneficiaries were in work for 6 months after baseline this would yield a Job Seekers Allowance and Council Tax saving of £142 per week (DWP, 2012). These benefit rates are based on a single person aged 25 and do not include dependents. The benefit savings are estimated to be £33,228. Again we stress that the JSA figure is the lowest benefit amount and therefore again represents a conservative figure. It is very possible that these beneficiaries are in receipt of other out-of-work benefits; they maybe even receiving the higher ESA rate and other pass-ported benefits.

### *Signposting*

Given the holistic approach adopted by the programme signposting to different services is crucial to ensure that the issues beneficiaries present with are addressed. A key skill of the project workers are their ability to work with beneficiaries and get them to accept positive steps to address key personal issues. It is a form of Motivational Interviewing, which is grounded in developing a respectful stance with a focus on building rapport and developing a trusting relationship. This requires the project worker to identify, examine and resolve their ambivalence about changing behaviour (Miller et al, 2009). A review of SP projects in Scotland has shown that vulnerable or disadvantaged patients may be unlikely or unable to access community-based opportunities without additional support (Friedli, 2007:37). Thus the project workers provide active support at a crucial time is a key component of developing recovery and starting the process of taking control.

A key issue revealed by beneficiaries was personal debt. At least 26% (n=21) of beneficiaries followed up at 12 months were getting support to access debt advice. Even before the current global financial crisis, it was estimated that 8% of the population had serious financial problems and another 9% showed signs of financial stress. These problems have wide-ranging implications and research has shown that debt is often linked to poor mental health. For the general population, contact with face-to-face advice services is associated with a 56% likelihood of debt becoming manageable (Knapp et al, 2011:24). On a holistic SP project the project workers are able to work with beneficiaries and get them to accept and own their debt problem and get them prepared for debt counselling. It is a valued and a time-saving first step that prepares beneficiaries to respond to support around debt advice.

The importance of signposting and supporting beneficiaries applies to getting beneficiaries into Employment Links to begin the process of returning to work. Considerable return to work success has been achieved. To other beneficiaries it was about accessing counselling (20%, n=16). In counselling the first 30 minute of a counselling service is usually a free introductory meeting designed to see if they can work comfortably together (Kate Murphy Counselling in Bristol, 2013, Accessed 13<sup>th</sup> November 2013). In having a local holistic

approach to SP strong links are already made with counsellors where the appropriateness of the service is already understood. This initial screening is less required and ease of access is made for on-going support beyond BO.

Supportive signposting was also undertaken with 6 beneficiaries who had addiction issues to address. We take account of the cost of addiction counselling in our SROI by looking at a local addiction counsellor fees.

Finally, the WP uses volunteers to deliver some activity particularly around the Time-Out groups. We estimate that five volunteers support the programme for 30 hours a week. This can be factored into the SROI calculation.

**Table 18: The costs of running the WP programme 2012-13\***

|                                 |                          |
|---------------------------------|--------------------------|
| Staffing Costs                  | 40,818                   |
| National Insurance              | 4,490                    |
| Room Hire                       | 6,334                    |
| Clinical Supervision            | 900                      |
| Mobile Phone                    | 720                      |
| Training                        | 300                      |
| Admin support (1 day/week)      | 3,968                    |
| Rent                            | 806                      |
| Service charge                  | 1,384                    |
| Child care support              | 900                      |
| Training for Befrienders        | 800                      |
| Room Hire at another GP surgery | 1,920                    |
| <b>Total Running Costs</b>      | <b>63,340</b>            |
|                                 | Management and overheads |
|                                 | <b>19,805</b>            |
| <b>TOTAL ANNUAL SPEND</b>       | <b>83,144</b>            |

\*Source Accountants Report

Below are the values calculated to support the social return on investment provided by the WP.

**Table 19: Proxy values created by the project**

| <b>Value</b>  | <b>Evidence Source for Proxy</b>   | <b>Amount £</b> |
|---|--|-----------------|
| Delayed Suicide for one year  | Knapp, M., McDavid, D., & Parsonage, M. (Eds.). (2011:25). Mental health promotion and mental illness prevention: The economic case. London: Department of Health.   | 66,797          |
| Prevention of referral of one beneficiary to secondary care psychiatric services. | The annual direct cost per patient of service to support patients with psychosis in terms of input from an early intervention team plus other community psychiatric services and inpatient care has been estimated at £10,927 annually at 2008/09 prices (McCrone, 2011).  | 10,927          |
| Return to work saving of Work Programme fees                                      | 9x £1,200 Job Outcome Fee service group B for JSA 25+ claimants.<br><a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209260/wp-costs-to-31-march-2013.pdf">https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209260/wp-costs-to-31-march-2013.pdf</a> . Accessed 6th September 2013.   | 10,800          |
| Return to work.   | Benefit savings for 9 beneficiaries over 6 months based on Council Tax and JSA rates for a single person aged over 25.<br><a href="http://www.dwp.gov.uk/docs/benefitrates2012.pdf">http://www.dwp.gov.uk/docs/benefitrates2012.pdf</a> , Accessed 22nd November 2013.   | 33,228          |
| Supporting into Debt advice   | 21 x £15 The cost of providing 1 hour of debt advice to 21 beneficiaries. Hourly rate charged by Bristol Debt Advice Centre. <a href="http://www.bdac.org.uk/services/debtadvice">http://www.bdac.org.uk/services/debtadvice</a> Accessed 5th September 2013.  | 315             |
| <b>Supporting into employment links</b>   | 23 x £14 The Cost of employment mentoring provided by Third Sector Solutions<br><a href="http://www.thirdsectorsolutions.net/services/support-services/personal-support.htm">http://www.thirdsectorsolutions.net/services/support-services/personal-support.htm</a><br>Accessed 6th September 2013.  | 322             |
| Supporting into counselling   | 16 x £35 the cost of preparing for counselling. Price charged by a local counsellor.<br><a href="http://www.katemurphycounselling.co.uk/phdi/p1.nsf/supppages/3849?opendocument&amp;part=4">http://www.katemurphycounselling.co.uk/phdi/p1.nsf/supppages/3849?opendocument&amp;part=4</a><br>Accessed 13th November 2013.  | 560             |
| Support into addiction counselling  | 6 x £35 for 1 hour of addiction counselling on a 12 week programme<br><a href="http://www.therapychippenham.com/addiction-counselling/">http://www.therapychippenham.com/addiction-counselling/</a><br>Accessed 14th November 2013   | 210             |
| <b>Reduced GP attendance</b>  | 17 x 0.7 X £38 for GP appoint costs for patients with high Gad scores, Personal social services research unit (PSSRU) available [online] from: <a href="http://www.pssru.ac.uk/uc/uc.htm">http://www.pssru.ac.uk/uc/uc.htm</a> . (Curtis 2009)   | 452             |
| Reduction in depression   | 17 x The cost of six sessions of CBT valued at £240 in 2008-09 (McDavid et al, 2011).  | 4,080           |
| <b>Reduced social isolation</b>   | Befriending services for 30 isolated new beneficiaries, for 7 sessions of 1 hour charged at the minimum wage rate. 71 x 10 x £6.19. £4,394.  | 1,230           |
| <b>Improved Physical activity</b>   | Gym membership at Lifestyles Fitness Centre. Assuming 10 sessions. Membership £25 + (£4.50/session x12) = £79 x 22 (12 weeks is the length of the BO programme)<br>Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity according to DoH.<br>At baseline 17 of beneficiaries said they were already achieving this level of activity. At follow up 34 were achieving this level of activity. Therefore 22 beneficiaries were reaching DoH recommendations on exercise.<br><a href="http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127931">http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127931</a> Accessed 1st November 2012. | 1,738           |
| <b>Improved well-being.</b>   | Improved well-being reported by 48 beneficiaries after 3 months. Use £80 x 0.33 months cost of a workplace intervention to promote well-being (McDavid et al 2011b:22).  | 1,267           |
| <b>Reduced anti-depressants</b>   | Cost of antidepressants..NICE (2004) Clinical guideline on costing depression, Secta<br><a href="http://www.nccmh.org.uk/downloads/DCHP/CG23CostReport.pdf">http://www.nccmh.org.uk/downloads/DCHP/CG23CostReport.pdf</a><br>Accessed 20th November 2013   | 864             |
| <b>Volunteer engagement</b>   | 5 x 30 x £6.12 The national minimum wage in 2012.<br><a href="https://www.gov.uk/government/news/national-minimum-wage-to-rise-from-1-october-2013">https://www.gov.uk/government/news/national-minimum-wage-to-rise-from-1-october-2013</a><br>Accessed 22nd November 2013  | 918             |
| <b>TOTAL RETURN</b>   |  | <b>£133,708</b> |

A lot of the values calculated for the SROI are calculated on the basis of a sample of people (e.g. the 40 beneficiaries who participated in the one to one in-depth semi-structured interviews). Below we scale up these values on the assumption that they represented only 31% of all the beneficiaries involved in the WP in one year. The 40 interviewed were the first 40 to complete the BO component of the WP. We are not aware of anyone refusing the invitation to participate and as such there is nothing special or unique about them that would necessarily differentiate them from the other beneficiaries.

**Table 20: Values scaled up to apply to whole sample**

| Value   | Source for Proxy   |                  | Amount<br>£     |
|---|--|------------------|-----------------|
| Delayed Suicide for one year  | Evidence from 1 to 1 in-depth semi-structured interviews   | £66,797<br>x 3.2 | 213,750         |
| Prevention of referral of one beneficiary to secondary care psychiatric services. | Evidence from the outcome information stored of the whole cohort on the WHLC at 12 months            |                  | 10,927          |
| Return to work saving of Work Programme fees                                      | Evidence from the outcome information stored of the whole cohort on the WHLC at 12 months            |                  | 10,800          |
| Return to work.   | Evidence from the outcome information stored of the whole cohort on the WHLC at 12 months            |                  | 33,228          |
| Supporting into Debt advice   | Evidence from the outcome information stored of the whole cohort on the WHLC at 12 months            |                  | 315             |
| <b>Supporting into employment links</b>   | Evidence from the outcome information stored of the whole cohort on the WHLC at 12 months            |                  | 322             |
| Supporting into counselling   | Evidence from the outcome information stored of the whole cohort on the WHLC at 12 months            |                  | 560             |
| Support into addiction counselling  | Evidence from the outcome information stored of the whole cohort on the WHLC at 12 months            |                  | 210             |
| <b>Reduced GP attendance</b>  | Based on the GP attendance records of 37 beneficiaries attending one GP surgery                      | £452 x<br>3.45   | 1,559           |
| Reduction in depression   | 17 x The cost of six sessions of CBT valued at £240 in 2008-09 (McDaid et al, 2011).                 |                  | 4,080           |
| <b>Reduced social isolation</b>   | Evidence from the outcome information stored of the whole cohort on the WHLC at 12 months            |                  | 1,230           |
| <b>Improved Physical activity</b>   | Based on self-report of (n=48) beneficiaries who completed the item on follow-up WWQ at three months | £1,738<br>x 2.66 | 4,623           |
| <b>Improved well-being.</b>   | Based on self-report of (n=48) beneficiaries who completed the item on follow-up WWQ at three months | £1,267 x<br>2.66 | 3,370           |
| <b>Reduced anti-depressants</b>   | Evidence from 1 to 1 in-depth semi-structured interviews   | £864 x<br>3.2    | 2,764           |
| <b>Volunteer engagement</b>   | Evidence from the outcome information stored of the whole cohort on the WHLC at 12 months            |                  | 918             |
| <b>TOTAL RETURN</b>   |  |                  | <b>£288,656</b> |



## Establishing impact

We have valorised the impact and scaled up the values to ensure they reflect the whole cohort. However we need to establish impact to reduce the risk of over-claiming. It is only by measuring and accounting for all of these factors that a sense of the impact that the WP is having can be understood. There are four aspects of establishing impact:

*Deadweight* – how much of the activity would have happened anyway.

*Attribution* – how much of the outcome was caused by the contribution of other organisations or people.

*Displacement* – what activities or services are displaced.

*Drop-off* – the decline in the outcome over time (only calculated for outcomes that last for more than one year).

### *Deadweight*

Deadweight is a measure to describe the amount of the outcome that would have happened anyway, even if the WP had not been available or if they had not been referred onto the intervention by their GP. In establishing deadweight, and through exploring deadweight during our interviews, it was believed that in most cases the beneficiaries would have done very little without some form of intervention in their lives. We have already highlighted in our discussions around the context to the project that these beneficiaries are already in a desperate situation when they come to the WP. Their GPs have already decided that they cannot provide any medical solution to meet their needs. In fact they could have been dependent on GP services for a considerable time. Our stakeholder interviews suggested that many had. It is only through SP that referring health professionals believe a solution will be found to meet these people's needs. Our interviews identified that having the personal support offered by the health workers as well as the options of joining the Time Out group were key factors in helping to build motivation and personal wellbeing in the beneficiaries. We have highlighted the depth of mental health problems found in the UK and the problem of actually accessing mental health services locally. In our scoping work for Bristol Clinical Commissioning Group we have also highlighted that there are insufficient *holistic* SP provision across the city and the Health and Wellbeing Board have now decided to invest and expand the service to other areas of inequality in the city (Kimberlee, 2013).

We have highlighted from the scoping exercise around local SP provision that all SP practitioners tended to argue that one of the real achievements of SP is supporting beneficiaries to actually ensure their circumstances does not get any worse. Clearly our stakeholder interviews also acknowledged that suicide prevention for some beneficiaries

was a very real outcome of the work undertaken. Health economists Knapp et al (2011) in their advice to the DoH argued that the economic case for intervening and developing mental health interventions should be expanded to deliberately restrict the burdening and increasing costs of mental health and their pharmacological solutions. Thus the premise here is that deadweight is not necessarily an issue. These beneficiaries are often desperate people. In fact there is evidence to suggest that the trends in wellbeing demonstrated here is sometimes counter to what is happening around them e.g. achieving a good return to work rate compared to the Work Programme and improving physical activity when around them we have shown that the city's Quality of Life survey suggests that rates of physical activity are actually in decline (Bristol City Council, 2013).

It is quite conceivable that a few may have had help and support from elsewhere that may have yielded the same effect. Given that most live alone and others report that their family/partner told them to go to the GP or seek advice suggests otherwise. As a result, in the absence of a clear comparator it is important to try and use a 'best estimate' (Cabinet Office, 2009:56) to assess deadweight. Let us assume that 12 beneficiaries could have improved all things being equal and apply a 10% deadweight reduction. This is similar to a 12% deadweight figure used in a SROI study of clients using an advisory employment and housing service from backgrounds that are similarly disadvantaged and traumatised as those reported by the beneficiaries of the WP (Bates et al 2013:13).

### *Attribution*

Attribution is an assessment of how much of an outcome was caused by the contribution of other organisations or people external to the programme. This is difficult to judge as details of the support offered to the client outside of the WP were limited. A question was asked, which was used as the basis for our attribution calculations, around what approaches had been made to other support agencies. A few of our interviews said things like God or their partner had helped, but it is hard to quantify these impacts especially when for some beneficiaries if a partner exists they were often vital in getting them to the WP to get their issues addressed as they couldn't cope or support them anymore. And anyway they may not have been of any help:

*I don't want to remember the past...its not that I don't want to remember it...its like I got rid of it....I was literally suicidal. I was in my house. I was on a tag everyday...I was suicidal. My Mum was an alcoholic, she was suicidal, my sister was in and out of psychiatric wards, she sliced herself on a daily basis she has also sat down and watched one of her kids. As I have got older I have also got*

*suicidal because I used to help them and say it was not worth killing themselves, because in the end on the inside I was worse...so all the dirt has rubbed off on me...so over a period of years I have started to neglect myself.....I have got a big family I have got five kids a mum who has had six kids, my brothers and sisters they have all had kids; one of my brothers lost five kids to social services, I have never had any help in my life because I come from a travelling family ....the only person who could understand myself was \*\*\*\*\* because they were all saying that you are a criminal we are going to class yourself as a criminal when really I was a sick criminal and needed help for my condition but like they were diagnosing me but like none of them were giving me help but like with probation they say like yes you have got problems and we are giving you help but they just put me on tag and say sit in the house. So I am sat in the house and I have got all these probation letters around me ...and I don't know what to do...I want to do something with it and I don't know and my mum she is dyslexic and she never know what it is about ....but here it has been about helping me and starting that process of getting beyond all this crap. (Beneficiary N2)*

You will note from our valorisations of outcomes we have only valued the cost of getting the beneficiary to other support in the community i.e. the value of getting people to accept their problem and getting them motivated to do something about the challenges they face. We believe this is a very parsimonious approach to adopt. However it is clear that after leaving BO the other agencies referred too could have been very instrumental in achieving other outcomes like a return to work. So around the values gained around employment (i.e. benefits saved and the Work Programme avoided) we will attribute a 30% deduction to reflect other people's support in returning to work. A similar attribution was given around employment by Bates et al (2013:26).

### *Displacement*

Displacement is another component of impact and is an assessment of how much of the outcome displaced other services. Our interviews and focus groups with stakeholders and new beneficiaries revealed very limited evidence of displacement. Their loneliness, absence from or lack of work and the lack of suitable mental health services to suit their needs suggest very little displacement. There are no other services locally that would seem to address their multiple needs. In fact getting support for all of their needs is unique to the holistic SP approach. Nevertheless it is a standard SROI approach to assume some displacement. Nef and others are currently working on specific guidance on displacement in

relation to employment support and recommended displacement rates for state outcomes of similar projects range from 20 – 60%. We will opt for a median estimate of 40% (Bates, 2013:26).

**Table 21: Deadweight, attribution and displacement values applied to scaled up values in**

| <b>Adjustment</b> | <b>Calculation</b>                  | <b>Adjusted Value</b> |
|-------------------|-------------------------------------|-----------------------|
| Deadweight        | £288,656 - 10%                      | £259,791              |
| Attribution       | £259,791 - (30% of 10,927 + 10,800) | £253,138              |
| Displacement      | £253,138 - (40% of 10,927 + 10,800) | £244,448              |
| SROI              |                                     | <b>£244,448</b>       |

**Having established the impact of the WP we calculate a Social Return on Investment ratio of £2.90: £1**

This means that for every pound of investment in the WP, £2.90 of social value is created. We feel this is a very parsimonious reflection of the value created. Health economists like Knapp et al (2011) suggest quantifying these impacts across all beneficiary life years, whereas we are just commenting on one year.

*Drop off*

Discounting is usually applied to those values that could be projected for longer than one year. The interest rate to be used to discount the value of future benefits should be 3.5% as recommended in the Treasury’s Green Book. For the wellbeing benefits identified in the analysis we could reduce the value by a still quite conservative 10% drop-off rate. Our thinking is that almost without exception the beneficiaries and particularly the GPs we spoke to felt the WP considerably improved the health and wellbeing of beneficiaries who were on the programme. Our data using validated items shows that over time the majority of beneficiaries make positive improvement to their lives having come from situations and experiences that in essence were life threatening in several cases. However, some set back by encountered by a few especially if unanticipated outcomes occur. Continued use of the WWQ tool will help WHLC and other services to revisit the drop-off discount.

## Conclusions & Recommendations

This research has shown there is a growing crisis in primary care and with GP services in particular. It has been suggested that GP in the UK needs more investment to recruit at least 10 000 more GPs by 2022 in order for the NHS to meet the population's growing and increasingly complex, health needs. This is according to the chair of the Royal College of General Practitioners (Gerada 2013). However if policy makers and commissioners want to develop the scale of their primary care service to address this need, now is the time to adopt more imaginative and innovative approaches utilising the combined resources that new partners can bring (Addicott, 2014). Third sector partners like those discussed in this report have shown they have the ability to help CCGs and the DoH to rebalance the way health services are delivered to address (in particular) long term conditions that will be an increasing drain on future NHS resources.

To help make this happen, research undertaken for the Nuffield Trust has recommended that NHS England should work with CCGs, GPs, patient groups and professional bodies to create a national framework for primary care. The framework should set out the outcomes and overall vision for primary care, both in relation to service provision and the wider role of primary care in the health and social care system. They argued that it should not specify the details of how the vision might be achieved, nor the organisational form to be used. Instead they recommend that this needs to be worked out locally with extensive public and patient engagement (Smith, 2013:15). Third sector organizations will have a clear opportunity to be part of the process.

New models for primary care could include SP projects that are seeking to address the growing burden of mental health in the UK. *Holistic* SP interventions are interventions that have grown organically over time and they represent a local partnership approach between GP services and third sector providers to respond to known local needs. The benefits of a *holistic* SP intervention have been highlighted in this report. These benefits have been acknowledged by GPs themselves who see for themselves the impact that *holistic* SP approaches can have in alleviating them of some of their more burdensome patients for which they have been unable to provide a clear medical solution.

Preparing for this challenge has been a long term ambition of WHLC. Their WP like other *holistic* SP projects has taken a lead in accumulating evidence to demonstrate their impact and *prove their value*. The partnership between UWE and WHLC has developed over several years. At the forefront has always been our drive to develop effective methods to assess impact to enhance the quality of service delivery for future beneficiaries. This is important because a lot of their service users are amongst the vulnerable people who live in our nation. Their third sector/GP partnership offered the potential to look at the value of what can be achieved in adopting SP. Having knowledge of impact and what can work has

enabled the WP to be developed over time. This research demonstrates that the WP can deliver improved wellbeing, lessen depression and anxiety, ameliorate isolation, lessen GP attendance, enhance physical health and improve employment chances for the majority of their beneficiaries. The lessons learnt through this research are broad. WHLC and the Board are aware of the depth of challenges their clients present with in practice. WHLC can also see that the WP is having impacts beyond what they anticipated. This is not simply about improved wellbeing but also includes unanticipated impacts like increased physical activity and enhanced employment prospects.

The tool that we developed for the programme will have benefits in the future. The diagnostic PHQ9 and GAD7 measures will help service providers to reflect on the range of issues that beneficiaries present. They can be used diagnostically to discuss progress. Being able to classify types of depression and anxiety could also lead the service to consider tailoring their work to support different beneficiaries. At the start of the research WHLC anticipated that they would be working with beneficiaries in the lower ranges of PHQ9 scores; but the tool has enabled them to see that predominantly the beneficiaries that are referred by GPs are more likely to have Moderate to Severe Depression. The Friendship Scale scores has helped the project to document the extent to which beneficiaries live isolated lives. WHLC in fact has contributed to the: *Addressing Loneliness in Bristol* conference in Bristol in November 2013. This was a multi-agency conference aimed at developing a partnership approach to address social isolation. At the conference they would have heard a call from Guy Robertson the Director of Positive Ageing Associates in his keynote speech that:

*...the evidence base is currently underdeveloped; many interventions have not received a robust evaluation ...and for those that have, many interventions have failed to demonstrate a quantifiable impact. (Robertson, 2013)*

WHLC are now collecting robust evidence of their impact. The data from the ONS items on the tool will also help WHLC to get an understanding of beneficiaries' wellbeing. It enables them to undertake comparative analyses with national datasets. There is publically available demographic ONS Wellbeing scores on gender, ethnicity and age splits. And also scores provided at a regional, local authority and ward level. This will provide good information not only for understanding the beneficiary but collectively it could be used to profile their users to future commissioners and for promotional activity. The tool provides important quantitative data, something which the third sector has been broadly accused of lacking.

Right from the beginning UWE and WHLC agreed that we would adopt a SROI approach to assess the value created by the WP. As a framework SROI provides useful guidelines to third

sector organisations that would enable them to understand the SROI process. By doing a SROI like WHLC, third sector organizations will get more than an understanding of value at the end of the process. It empowers them see competing theories of change. It involves stakeholders in mapping out impact, attributing value and collecting evidence. And for the third sector organization they have an audit tool which enables them to understand where most value is created. We think this makes the methodology more suited to the third sector as the sector itself is entirely built on citizen participation and it is unsurprising that successive governments have endorsed its approach (Cabinet Office, 2009). Arguably this cost effectiveness technique varies little from traditional cost-benefit analysis. The tool of choice for most traditional economists and consultants who are recruited to assess financial impact and value. However the differences between the two approaches *are largely in the style of each approach, rather than the true substance* (Arvidson et al 2010:7). Like cost benefit analysis there will always be an issue with finding suitable proxies, however this research benefitted from the pioneering work undertaken by Knapp et al (2011) in developing robust costings in the area of mental health. These costings informed this research together with official valuations from the NHS and other official sources e.g. DWP. All of which are easily available to the public and third sector organizations.

A key driver in the development of this research proposal from the beginning was a considered anticipation by all partners that the results of the research will help WHLC to understand the economic value of their work. Getting a perspective on costs and value are key to developing a business case to ensure any organization's sustainability in the future. Prior to this there had only been one attempt to undertake a cost-benefit analysis of social prescribing project (Grant et al, 2000) and this was an extremely limited study. The scoping analysis of SP projects reported in this document shows that the SP project explored in this cost-effectiveness study could only be described as a SP *medium* project at best and therefore limited in its relevance today. The research reported here moves our understanding of the social value of SP interventions forward.

Now knowing the SROI that is yielded by the WP WHLC can use this evidence to demonstrate their value to external stakeholders and commissioners. Funding has recently been gained to support Somali, Polish and West Indian people living in the community to address their wellbeing needs. Evidence from here has also been included in discussions with Bristol City Council's Economic Development Unit about trying to work in partnership with local stakeholders to develop a local Enterprise Zone. WHLC could develop a strong referral pathway and target people who are long term unemployed who would like to return to work but have complex social issues that need addressing.

This POV research therefore comes at a pertinent time. This is true nationally as well as locally. Research cited by the British Academy suggests that as little as 20% of the influences on health are to attributable to clinical care and the quality of care. Instead health

behaviours account for 30% of influences and the physical environment for 10%. But by far the most important influence on our health and wellbeing comes from socioeconomic factors – 40% of all influences (British Academy, 2014:3). This is important. SP projects like WHLC's WP are working in communities that face some of the toughest challenges of all communities, including: deprivation, unemployment, health inequalities and the challenges posed by the co-existence of diverse cultures. There are increasing calls for local solutions to be found to these challenges. But these solutions need to evolve from the collection of systematic evaluation approaches utilising cost-effectiveness methods. Without such approaches scarce resources will be insufficiently utilised, allowing health inequalities to persist or increase (Maynard, 2014).

Since the recent reforms in local governance and the Health and Social Care Act (2012) local authorities have once again become major players in health. The recent transfer of responsibility for public health to local government and the creation of health and wellbeing boards will add to their influence. Despite a considerable reduction in their resources, there now exists a real opportunity for local authorities and local communities to make a difference. With shrinking resources and an impending crisis in GP provision (Gerada, 2013) there are new calls for the development of new approaches to meet local health needs (Addicott et al, 2014). In a recent Kings Fund report, Addicott et al (2014) urge GP practices to invest in more preventative interventions to address health need. They are urged to:

*move away from the current model of small independently minded practices towards new forms of organisation that enable practices to work together and with other providers to put in place the integrated services that are required. We believe that different funding streams should be used more flexibly to enable this to happen, creating the possibility of practices receiving more resources as funds are released from other areas of cares..... Other providers, including NHS trusts, should also have the opportunity to work with practices in developing this approach (Addicott et al, 2014:2-3)*

As the hollowing out of universal state provision continues there are and will be opportunities that could allow third sector providers an opportunity to deliver services to promote wellbeing in innovative ways and in partnership with others to deliver more *holistic* approaches to support local communities. This research has looked at this need and has developed an approach and evidence that will allow other third sector organizations to step up to the plate and prove their value.



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# Abbreviations

|      |   |
|------|---|
| AWP  | Avon and Wiltshire Mental Health Partnership          |
| BMJ  | British Medical Journal                               |
| CBT  | Cognitive Behavioral Therapy                          |
| CCG  | Clinical Commissioning Group                          |
| CEO  | Chief Executive Officer                               |
| CGP  | College of General Practitioners                      |
| CSIP | Care Services Improvement Partnership                 |
| DoH  | Department of Health                                  |
| DSM  | Diagnostic and Statistical Manual of Mental Disorders |
| DWP  | Department of Work and Pensions                       |
| ESN  | European Social Network                               |
| GAD  | Generalized Anxiety Disorder                          |
| GP   | General Practice/Practitioner                         |
| IHS  | Integrated Household Survey                           |
| IPAQ | International Physical Activity Questionnaires        |
| nef  | new economics foundation                              |
| NHS  | National Health Service                               |
| NIHR | National Institute for Health Research                |
| NRES | NHS Research Ethics Committee                         |
| ONS  | Office for National Statistics                        |
| PBR  | Payment by Results                                    |
| POV  | Proving Our Value                                     |

|         |   |
|---------|---|
| PCT     | Primary Care Trust                                |
| PHQ     | Patient Health Questionnaire                      |
| PIN     | Personal Identification Number                    |
| RSVP    | Retired & Senior Volunteer Programme              |
| SOA     | Super Output Area                                 |
| SP      | Social Prescribing                                |
| SPO     | Social Purpose Organizations                      |
| SROI    | Social Return On Investment                       |
| SSRI    | Selective Serotonin Reuptake Inhibitor (SSRI)     |
| SWEMWBS | Short Warwick & Edinburgh Mental Well Being Scale |
| SWF     | South West Forum                                  |
| SWWB    | South West Wellbeing                              |
| UWE     | University of the West of England                 |
| WHLC    | Wellspring Healthy Living Centre                  |
| WWQ     | Wellspring Wellbeing Questionnaire                |

# Glossary

|                      |   |
|----------------------|---|
| <b>Attribution</b>   | Attribution is an assessment of how much of the outcome was caused by the contribution of other organisations or people. Attribution is calculated as a percentage.   |
| <b>GAD 7</b>         | Generalized Anxiety Disorder <sup>7</sup> is a self-reported questionnaire for measuring of generalized anxiety disorder. It contains seven questions which measure the severity of the disorder. Respondents are asked to indicate whether this is experienced: 'not at all,' 'several days,' 'more than half the days,' and 'nearly every day.' A total GAD 7 score is calculated from their responses. |
| <b>Deadweight</b>    | Deadweight is a measure of the amount of outcome that would have happened even if the activity had not taken place. It is calculated as a percentage.   |
| <b>Displacement</b>  | Displacement is another component of impact in a SROI analysis and is an assessment of how much of the outcome measured displaced other outcomes.   |
| <b>Eta Scores</b>    | In statistics eta scores are often provided to indicate the strength of a phenomenon. Statistical differences are then indicated as small, moderate or large effect.  |
| <b>Morbidity</b>     | A morbidity is an incidence of ill health e.g. a patient with anxiety and depression could be described as having two morbidities.  |
| <b>Paired t-test</b> | Is a statistical technique used to compare the values of means from two samples/tests; e.g. before and after an intervention. It provides a probability value which if significant we can assume the effect/impact of the intervention did not occur because of chance factors.   |

**PHQ9** PHQ9 is a self-reported questionnaire for measuring depression. It contains nine questions which measure the severity of the disorder. Respondents are asked to indicate whether this is experienced: 'not at all,' 'several days,' 'more than half the days,' and 'nearly every day'. A total PHQ9 score is calculated from their responses.

**Randomised Control Trial** RCTs are the 'gold standard' method of measuring the effectiveness of a medical intervention within a patient population. It commonly involves comparing an experimental group who receive an intervention with one that does not.

**Statistically significant** Statistical significance is the probability that an effect of an intervention is seen as not being due to just chance alone.



# Appendix 1: Information and consent forms

## Evaluation of Wellspring's Wellbeing Programme

Dear

\*\*\*\*\* (Chief Executive Officer at Wellspring Healthy Living Centre) recently wrote to you to explain we are conducting a cost benefit and impact evaluation of the Wellbeing Programme at Wellspring. You have been identified as a potential stakeholder to their centre and work. We would therefore like to invite you to take part in our research. This research is being carried out by researchers at the University of the West of England, Bristol (UWE). Please read the following information carefully. If you have any questions, you will find our contact details at the end of this letter.

What is this research about?

The purpose of this research is to evaluate the Wellbeing Programme at Wellspring. In particular we have been asked to 'Prove the Value' of the Wellbeing Programme to help funders to decide whether it is a worthwhile investment. In order to do so, we would like to get some information from you. We are inviting you to take part in our research.

Who is conducting the research?

The research team includes Dr Richard Kimberlee and Dr Rachel Manning, from UWE, and also members of Wellspring staff. The research is being funded by the South West Forum, a charity that supports and promotes voluntary organizations like the Wellspring Healthy Living Centre. South West Forum is supported by the Big Lottery.

If I take part what will it involve?

If you agree to help us we will ask you a series of standard questions in an interview. It will take between 30 and 45 minutes of your time. We would like to do this face to face but if it is inconvenient to you we can also interview by telephone or skype. The questions are designed to enquire about the impact of the Wellbeing programme. It will also provide you with an opportunity to discuss your work with the Wellspring Healthy Living Centre.

Confidentiality of information

Everything you say will be treated in confidence. Your answers will provide us with data. All data and consent forms will be kept confidential and stored in a locked filing cabinet at UWE. Your anonymised answers from the interview will be transcribed by the researchers.

Your identity will remain anonymous. Any identifiable information, such as your age, occupation, role will be removed from the typed up notes and also from any reports or publications that are produced using the data we collect.

#### Withdrawal of data

You are free to withdraw from the research at any time. NAME will explain this in more detail. If you wish to withdraw your contribution, please contact the researchers (contact details below). However, please note that, due to the nature of the anonymised process, once this data has been collected, and your contribution anonymised, this will no longer be possible. So if you wish to withdraw your data, you will need to do so within 2 weeks of the interview taking place.

Please keep this information in a safe place.

If you have any questions about this research, please contact:

Dr Richard Kimberlee  
Faculty of Health and Life Sciences  
University of the West of England  
Coldharbour Lane  
Bristol  
BS16 1QY  
Tel: 0117 3281124  
Email: Richard.Kimberlee@uwe.ac.uk

or

Dr Rachel Manning  
Faculty of Health and Life Sciences  
University of the West of England  
Coldharbour Lane  
Bristol  
BS16 1QY  
Tel: 0117 3283956  
Email: Rachel.Manning@uwe.ac.uk

Participant consent form: Evaluation of Wellspring's Wellbeing Programme

The purpose of this form is to ensure that you have received all the necessary information concerning the research project and wish to take part. Please read the following statements carefully. If you agree that all points of information have been covered please sign and date

the sheet in the space provided below. If you are unclear on any point please ask NAME or contact us.

### Consent statement

I have read and understand the information presented in the Information Sheet. I have had the opportunity to discuss it with NAME and to ask any questions. I understand that:

- My participation is entirely voluntary
- I am free to refuse to answer any question during the interview
- I am free to withdraw from the research project at anytime

I agree to take part in the research and I give my permission for anonymised data from my interview to be used for the 'Proving the Value' project.

### Participant information

Name:.....

Signed: .....

Date: .....

If you have any questions about this research, please contact:

Dr Richard Kimberlee  
Faculty of Health and Life Sciences  
University of the West of England  
Coldharbour Lane  
Bristol  
BS16 1QY  
Email: Richard.Kimberlee@uwe.ac.uk  
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University of the West of England  
Coldharbour Lane  
Bristol  
BS16 1QY  
Email: Rachel.Manning@uwe.ac.uk

Appendix: Old beneficiary letter and consent form

Dear Beneficiary

We are conducting an evaluation of the Wellbeing Programme at Wellspring and would like to invite you to take part in this. The research is being carried out by researchers at the University of the West of England, Bristol (UWE). Please read the following information carefully. If you have any questions, you will find our contact details at the end of this letter.

**What is this research about?**

The purpose of this research is to evaluate the Wellbeing Programme at Wellspring. In particular we have been asked to 'Prove the Value' of the Wellbeing Programme to help funders to decide whether it is a worthwhile investment. In order to do so, we would like to talk to people who have used this Programme. We are inviting people to take part in group discussions about their experiences of the Wellbeing programme and how they feel about it, and perceptions of how it works, and how they feel about it.

**Who is conducting the research?**

The research team includes Dr Richard Kimberlee and Dr Rachel Manning, from UWE, and also members of Wellspring staff. The research is being funded by South West Forum, a charity that supports and promotes voluntary organizations like Wellspring Healthy Living Centre.

**If I take part what will it involve?**

You will meet with other people from the Wellbeing Programme at the Wellspring Centre to discuss your experiences of the Wellbeing programme. You will be asked questions about your experiences before, during and after your time on the programme. The group discussion will be tape recorded, and should last around 1 hour, depending on how much you have to say. Only the research team will hear the group discussion. In any reports resulting from this research, your name and any other identifying information will not be included.

**Confidentiality of information**

All consent forms will be kept confidential and stored in a locked filing cabinet. Your group discussion will be transcribed by the researchers. The recording will be stored on a password protected computer and any typed up notes from the discussion will be kept in a locked filing cabinet. You will remain anonymous; any identifiable information, such as your name, age, or where you live will be removed from the typed up notes and also from any reports or publications that are produced using these data.

### **Withdrawal of data**

You are free to withdraw from the research at any time. We will explain this in more detail at the start of the discussion group. If you wish to withdraw your contribution after the discussion group, please contact the researchers (contact details below). However, please note that, due to the nature of typing up group discussion, once this data has been done, and your contribution anonymised, this will no longer be possible. So if you wish to withdraw your data, you will need to do so within 2 weeks of the discussion group taking place.

Please keep this information in a safe place.

If you have any questions about this research, please contact:

Dr Richard Kimberlee  
Faculty of Health and Life Sciences  
University of the West of England  
Coldharbour Lane  
Bristol  
BS16 1QY  
Tel: 0117 3281124  
Email: [Richard.Kimberlee@uwe.ac.uk](mailto:Richard.Kimberlee@uwe.ac.uk)

or Dr Rachel Manning  
Faculty of Health and Life Sciences  
University of the West of England  
Coldharbour Lane  
Bristol  
BS16 1QY  
Tel: 0117 3283956  
Email: [Rachel.Manning@uwe.ac.uk](mailto:Rachel.Manning@uwe.ac.uk)

## Evaluation of Wellspring's Wellbeing Programme

Dear Beneficiary

Your Wellspring Project worker (David Martin) would have told you that we are conducting an evaluation of the Wellbeing Programme at Wellspring Healthy Living Centre and would like to invite you to take part in this. The research is being carried out by researchers at the University of the West of England, Bristol (UWE). Please read the following information carefully. If you have any questions, you will find our contact details at the end of this letter.

### **What is this research about?**

The purpose of this research is to evaluate the Wellbeing Programme at Wellspring. In particular we have been asked to 'Prove the Value' of the Wellbeing Programme to help funders to decide whether it is a worthwhile investment. In order to do so, we would like to get some information from you. We are inviting you to take part in our research.

### **Who is conducting the research?**

The research team includes Dr Richard Kimberlee and Dr Rachel Manning, from UWE, and also members of Wellspring staff. The research is being funded by South West Forum, a charity that supports and promotes voluntary organizations like the Wellspring. The South West Forum is supported by the Big Lottery.

### **If I take part what will it involve?**

If you agree to help us and take part we will ask you to fill in a questionnaire now, in 3 months time and after 15 months. The questionnaire will ask you questions on your wellbeing. David will help you to fill in the first questionnaire but researchers from the UWE, with your permission, may help you fill in the other two questionnaires.

We are also asking to see some specific data held by your GP. This is data on your:

- Prescriptions
- Attendance at the surgery
- Referrals

We will not see any case notes or know about any discussions you may or may not have had with your GP. If you agree, the surgery's Strategic Business Manager, will provide this information to the researchers in an anonymised form using a special id system that prevents researchers knowing your identity. This data is being collected to enable us to make calculations on costs only. It is being collected to assess the economic impact of the Wellbeing Programme.

### **Confidentiality of information**

All data and consent forms will be kept confidential and stored in a locked filing cabinet at UWE. Your anonymised data and questionnaires will be transcribed by the researchers. You will remain anonymous. Any identifiable information, such as your age, will be removed from the typed up notes and also from any reports or publications that are produced using these data.

### **Withdrawal of data**

You are free to withdraw from the research at any time. David will explain this in more detail. If you wish to withdraw your contribution at anytime, please contact the researchers (contact details below). However, please note that, due to the nature of the anonymised questionnaire, once this data has been collected, and your contribution anonymised, this will no longer be possible. So if you wish to withdraw your data, you will need to do so within 2 weeks of the questionnaire completion taking place.

### **What will happen if I decide not to be involved with the research?**

Nothing. Your entitlement to services and support provided at the Wellspring Healthy Living Centre will continue as normal.

Please keep this information in a safe place.

If you have any questions about this research, please contact:

Dr Richard Kimberlee  
Faculty of Health and Life Sciences  
University of the West of England  
Coldharbour Lane  
Bristol  
BS16 1QY  
Tel: 0117 3281124  
Email: [Richard.Kimberlee@uwe.ac.uk](mailto:Richard.Kimberlee@uwe.ac.uk)

or Dr Rachel Manning  
Faculty of Health and Life Sciences  
University of the West of England  
Coldharbour Lane  
Bristol  
BS16 1QY  
Tel: 0117 3283956  
Email: [Rachel.Manning@uwe.ac.uk](mailto:Rachel.Manning@uwe.ac.uk)

If you have any questions about the database that will confidentially store your anonymised surgery and questionnaire data please contact:

Ian Lawry  
Chief Executive Officer  
Wellspring Healthy Living Centre  
Beam Street  
Barton Hill  
Bristol  
BS5 9QY  
Tel: 0117 304 1416  
Email: [ian.lawry@wellspringhlc.org](mailto:ian.lawry@wellspringhlc.org)

## **Participant consent form: Evaluation of Wellspring's Wellbeing Programme**

The purpose of this form is to ensure that you have received all the necessary information concerning the research project and wish to take part. Please read the following statements carefully. If you agree that all points of information have been covered please sign and date the sheet in the space provided below. If you are unclear on any point please ask David or contact us.

### **Consent statement**

I have read and understand the information presented in the Information Sheet. I have had the opportunity to discuss it with David and to ask any questions. I understand that:

- My participation is entirely voluntary
- I am free to refuse to answer any question on the survey
- I am free to cancel the release of any GP data anytime
- I am free to withdraw from the research project at anytime

I agree to take part in the above project and I give my permission for anonymised data on my prescriptions, attendance at the GP surgery and referral destination information to be given.

### **Participant information**

Name:.....

Signed: .....

Date: .....

If you have any questions about this research, please contact:

Dr Richard Kimberlee  
Faculty of Health and Life Sciences  
University of the West of England  
Coldharbour Lane  
Bristol  
BS16 1QY

or Dr Rachel Manning  
Faculty of Health and Life Sciences  
University of the West of England  
Coldharbour Lane  
Bristol  
BS16 1QY



Email: [Richard.Kimberlee@uwe.ac.uk](mailto:Richard.Kimberlee@uwe.ac.uk)

Email: [Rachel.Manning@uwe.ac.uk](mailto:Rachel.Manning@uwe.ac.uk)

## **Participant consent form: Evaluation of Wellspring's Wellbeing Programme**

The purpose of this form is to ensure that you have received all the necessary information concerning the research project and wish to take part. Please read the following statements carefully. If you agree that all points of information have been covered please sign and date the sheet in the space provided below. If you are unclear on any point please ask.

### **Consent statement**

I have read and understand the information presented in the Information Sheet. I have had the opportunity to discuss it with the researcher and to ask any questions. I understand that:

- My participation is entirely voluntary
- I am free to refuse to answer any question during the discussion group
- I am free to withdraw my contribution from the group discussion (within two weeks – see the Information Sheet for further details)

I agree to take part in the above project and I give my permission for the group discussion to be audio-tape recorded and used for research purposes.

### **Participant information**

Name: .....

Signed: .....

Date: .....

If you have any questions about this research, please contact:

Dr Richard Kimberlee

or Dr Rachel Manning

Faculty of Health and Life Sciences

Faculty of Health and Life Sciences

University of the West of England

University of the West of England

Coldharbour Lane

Coldharbour Lane

Bristol

Bristol

BS16 1QY

BS16 1QY

Email: [Richard.Kimberlee@uwe.ac.uk](mailto:Richard.Kimberlee@uwe.ac.uk)

Email: [Rachel.Manning@uwe.ac.uk](mailto:Rachel.Manning@uwe.ac.uk)

# Appendix 2: Stakeholder interview schedule

## Stakeholder Interview Schedule

Names

Activity

Your organization

Building owned by who?

How and when did you get involved with the Wellbeing Programme Project?

What do you think are the Aims of Wellbeing Programme?

What activities have you seen?

What impact do you think it has?

What are the benefits?

What are the negative or unintended consequences?

- Critical of Mental Health services
- Critical of CBT
- Helping others
- What other groups they go to

What would they do if the Wellbeing Programme wasn't here?

What are the costs involved?

How much would people pay?

# APPENDIX 3: WHLC REGISTRATION FORM

# Wellspring Health & Wellbeing Programme

## Registration Form

CLIENT ID: \_\_\_\_/\_\_\_\_

DATE: \_\_/\_\_/\_\_

|   |                      |
|---|----------------------|
| <b>NAME:</b>  | <b>Date of Birth</b> |
| <b>ADDRESS:</b><br><br><b>NUMBER</b><br><br><b>STREET</b><br><br><b>TOWN</b><br><br><b>POSTCODE</b> | <b>Home Tel</b>      |
|   | <b>Mobile</b>        |
|   | <b>Work Tel</b>      |
|   | <b>E-mail*</b>       |

**How did you hear about us?**

Word of mouth or through a friend

|   |  |
|---|--|
| GP/ Nurse/ NHS Practitioner                       |  |
| School/ Children's Centre/ Community Organisation |  |
| Website   |  |
| Newspaper/ Newsletter/Poster/Leaflet              |  |
| Project Worker or Volunteer                       |  |
| At a project event / open day                     |  |
| Other (Please say):                               |  |

\*Please indicate if you would prefer not to be contacted by us

|  |  |
|--|--|
| <b>Who referred or recommended you to this activity?</b> |  |
| I referred myself  |  |
| A local community group                                  |  |
| A GP or other health professional                        |  |
| Someone working for this project                         |  |
| Another professional e.g. youth or community worker      |  |
| Other (Please say):                                      |  |

|                |  |        |  |
|----------------|--|--------|--|
| <b>Gender:</b> |  |        |  |
| Male           |  | Female |  |

|                          |  |                     |  |
|--------------------------|--|---------------------|--|
| <b>Race / ethnicity:</b> |  |                     |  |
| Asian or Asian British   |  | Mixed               |  |
| Black or Black British   |  | White British       |  |
| Black - Caribbean        |  | White Other         |  |
| Black African - Somalian |  | Other (Please say): |  |
| Black African - Other    |  | Don't wish to say   |  |

Continued overleaf...

|                             |  |
|-----------------------------|--|
| <b>Your first language:</b> |  |
| English                     |  |
| Other (Please say):         |  |

|  |  |    |  |                       |
|--|--|----|--|-----------------------|
| <b>Do you consider yourself a disabled person?</b>                           |  |    |  | Continued overleaf... |
| Yes  |  | No |  | Do                    |
| Please give details if you wish:   |  |    |  |                       |
| <b>Are you receiving benefits because of a health problem or disability?</b> |  |    |  |                       |



|     |  |    |  |                   |  |
|-----|--|----|--|-------------------|--|
| Yes |  | No |  | Don't wish to say |  |
|-----|--|----|--|-------------------|--|

|                            |  |                   |  |
|----------------------------|--|-------------------|--|
| <b>Sexual orientation:</b> |  |                   |  |
| Heterosexual               |  | Bisexual          |  |
| Lesbian                    |  | Gay               |  |
| Other                      |  | Don't wish to say |  |

|  |  |                                      |  |
|--|--|--------------------------------------|--|
| <b>Which of the following best describes your current situation?</b> |  |                                      |  |
| Live alone   |  | Live with partner                    |  |
| Live with partner and children                                       |  | Live with a relative (e.g. a parent) |  |
| Live with children   |  | Live with parent and children        |  |
| Other (Please say):  |  | Don't wish to say                    |  |

|   |  |    |  |                   |  |
|---|--|----|--|-------------------|--|
| <b>Are you a carer for someone with disability or health needs?</b> |  |    |  |                   |  |
| Yes   |  | No |  | Don't wish to say |  |
| If Yes please give details:   |  |    |  |                   |  |

|                                |  |                     |  |
|--------------------------------|--|---------------------|--|
| <b>Accommodation:</b>          |  |                     |  |
| Own home                       |  | Private rented      |  |
| Council or housing association |  | Nursing/Residential |  |
| Other (Please say):            |  |                     |  |

|  |  |                            |  |
|--|--|----------------------------|--|
| <b>Which of the following best describes your current situation?</b> |  |                            |  |
| At school  |  | Further Education/Training |  |
| Retired  |  | Employed                   |  |
| Seeking to work  |  | Self employed              |  |
| Full time looking after home or family                               |  | Other (Please say)         |  |

|                                |                |
|--------------------------------|----------------|
| <b>Emergency Contact Name:</b> | <b>Tel No:</b> |
|--------------------------------|----------------|

We operate a secure system of holding information. The Company will only use personal data in connection with its charitable purposes. It does not make personal data available to any other organisation or individual without prior consent. Anonymised information in this form will be used in summary monitoring and evaluation reports. These reports enable us to be accountable to our funders and the communities we serve. Further details on our Data Protection Policy are available from Wellspring Healthy Living Centre.

I consent to Wellspring HLC Ltd holding information in accordance with the Confidentiality and Protection statement.

Signature\_\_\_\_\_

Date\_\_\_\_\_

Wellspring is a membership organisation and members are called Friends of Wellspring. Please tick if  
you would like to be a Friend of Wellspring. For more information please ask a member of staff

# APPENDIX 4: the new beneficiary interview schedule

**Main schedule/questions/topic guide:**

Initial contact:

Can you tell me how you first heard about Wellbeing/Branching Out?  
What was life like for you before you became part of Branching Out?  
Why did you decide to join the Wellbeing/Branching Out programme?  
How long ago did you first come here?  
Have you used any similar services anywhere before?

Experience of the service:

What was your experience like of being on the Branching Out programme?  
What were the best things about the programme?  
Was there anything that you didn't enjoy or were difficult for you?  
Is there anything that you would change about your experience of Branching Out?

Impact of the service:

What impact did the service have for you?  
Is life for you any different after coming to Branching Out?  
How do you think you have benefitted from the Branching Out programme?  
Did they provide you with any advice on other services to access?  
Did they refer and or go to any other service....HOW MANY TIMES WHERE AND WHAT for.  
What aspects of your life have changed following your involvement in Branching Out?  
Follow up about how they feel on;  
a day to day basis,  
life at home,  
are they employed (Check confidence on getting a job if u/e)  
Social life? Managing day to day tasks and problems?  
Any others e.g. well-being?). Why do you think this is?  
Physical health...any noticeable changes  
Exercise...walking more

Any other aspects of health

What aspects of Branching Out contributed to this?  
What do you think life would be like for you now if you hadn't used the Branching Out service?  
If the Branching Out service wasn't available to you, what do you think you might have done instead? (Document particularly evidence around suicide, drug and alcohol abuse)

What aspects of the Branching Out programme helped you the most?  
How did it help you?  
What do you feel you have achieved as a result of this service?  
What do you think has been the broader impact of the service?  
Has it had any impact on your family? (Has partner got a job since programme)

Looking at your neighbourhood

How do you feel about the people in your neighbourhood?  
Have you had any help from anyone else apart from the programme e.g. friend  
Try and quantify this % for vicar, friend, neighbour,

Economic value of the programme.

Do you know how this project is funded?  
If you were asked to pay a contribution would you/are you able too?  
Check at the start of the programme  
Now?  
If they were offered a grant?

Looking forward:

Are there any challenges that you feel you still face in your daily life?  
How might these be overcome?  
Has your experience with Branching Out helped with thinking about this?  
In terms of future plans, is there anything in particular that you'd like to achieve in the next years?

# APPENDIX 5: The Wellspring Wellbeing Questionnaire (WWQ)

Id Number \_\_\_\_\_/\_\_\_\_\_

## 1, During the past four weeks:

Has it been easy to relate to others:

Always      Most of the time      About half the time      Occasionally      Not at all

I felt isolated from other people:

Always      Most of the time      About half the time      Occasionally      Not at all

I had someone to share my feelings with:

Always      Most of the time      About half the time      Occasionally      Not at all

I found it easy to get in touch with others when I needed to:

Always      Most of the time      About half the time      Occasionally      Not at all

When with other people, I felt separate from them:

Always      Most of the time      About half the time      Occasionally      Not at all

I felt alone and friendless:

Always      Most of the time      About half the time      Occasionally      Not at all

## 2 Overall, how satisfied are you with your life nowadays? Where 0 is not satisfied at all and 10 is completely satisfied.

0   1   2   3   4   5   6   7   8   9   10

Overall, how happy did you feel yesterday? Where 0 is not at all and 10 is completely.

0   1   2   3   4   5   6   7   8   9   10

Overall, how anxious did you feel yesterday? Where 0 is not at all and 10 is completely.

0   1   2   3   4   5   6   7   8   9   10

Overall, to what extent do you feel the things you do in your life are worthwhile? Where 0 is not at all worthwhile and 10 is completely worthwhile.

0   1   2   3   4   5   6   7   8   9   10

3, During the last 7 days, on how many days did you walk for at least 10 minutes at a time?

1      2      3      4      5      6      7

During the last week on how many days a week did you do moderate exercise (e.g. brisk walking, gardening, housework like cleaning) for 30 minutes or more:

1      2      3      4      5      6      7

During the last 7 days, on how many days did you do vigorous physical activities like heavy lifting, digging, aerobics, or fast bicycling?

1      2      3      4      5      6      7

4, Taking everything into account, what do you think of this area as a place to live?

A very good  
place to live

A fairly good  
place to live

Neither good  
nor bad

A fairly bad  
place to live

A very bad  
place to live

5, Overall, are you satisfied with your neighbourhood?

Yes

No

Don't Know

6, How well would you say you yourself are managing financially these days? Would you say you are

Living  
comfortably

Doing  
alright

Just about  
getting by

Finding it  
quite difficult

Finding it  
very  
difficult

7, What benefits do you receive?

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