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## Appendix 1: Methodology

### Evaluation questions

This evaluation was designed around seven evaluation questions.

How the MSP service can learn, adapt and improve – explored in Section 3 of this evaluation and in the Recommendations in Section 7

- What are the critical success factors and barriers to make MSP most effective?
- How might MSP be improved both for people effected by cancer and the wider system?

The outcomes and impact of the service for clients and for the wider system – explored in Sections 4 and 6 of this evaluation

- To what extent does MSP have a positive impact on people affected by cancer?
- What are the benefits of a cancer specific social prescribing service?
- To what extent does MSP enable the effective implementation of key health and wellbeing policies and practices? (E.g. stratified cancer follow up pathways, Cancer Recovery Package and patient experience)

An economic assessment of the service – explored in Section 5 of this evaluation, and in further detail in Appendix 4

- Using the Return on Investment methodology, assess whether MSP provides a return on investment for different stakeholders.
- To what extent does MSP reduce demand of unscheduled health care (e.g. GP appointments, A&E, calls to CNS)?

### Theory of Change and Phase 1

The evaluation was intended to build from the evaluation of the pilot phase of MSP (Frontline, 2017). Where comparable tables and figures could be generated, Phase 1 and Phase 2 statistics were compared and thus Phase 1 data was used as a triangulation point throughout the analysis. Recommendations from the Phase 1 evaluation were explored in creating the SROI and in interpreting changes within the service. This evaluation also followed the Theory of Change of the service (see Figure A1.1). The Theory of Change particularly influenced the structure of evidence around how the service achieved its impact (Section 3).

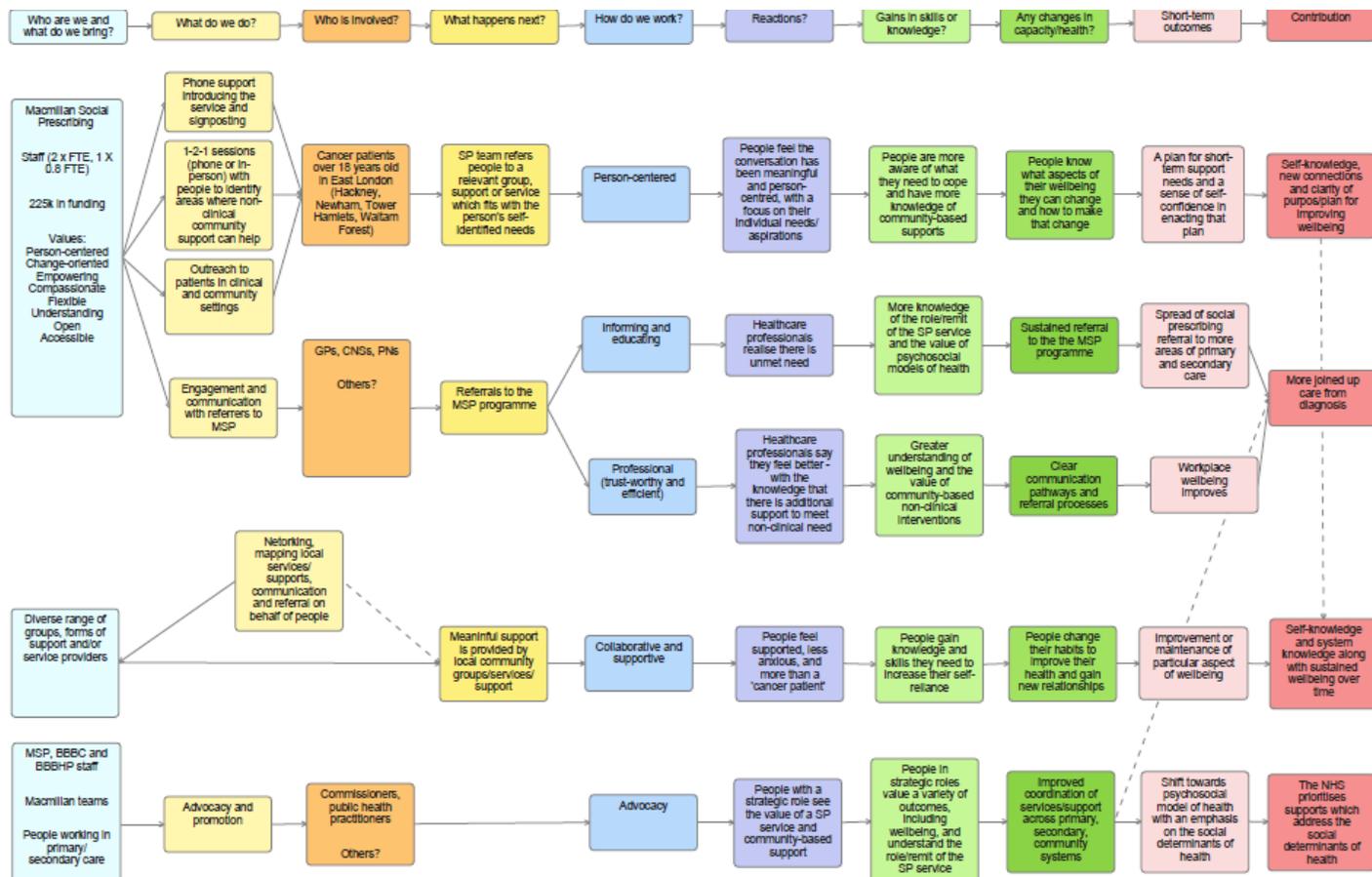


Figure A1.1: Theory of Change for MSP

## Data collection

The evaluation took a mixed method approach. The data sources included a wide range of qualitative and quantitative data (see Table A1.1). Most of the data was collected by members of the MSP team in the course of their routine case work, with the exception of stakeholder interviews and focus groups, which were run by independent evaluators. Surveys were sent to clients and were responded to anonymously.

Table A1.1: Data sources used in this evaluation

Data type	When taken	Client numbers	Completion rate
<b>MyCAW questionnaire – themes, severity of concerns</b>	In the first session and in the last session (L3 clients) or over the phone after discharge (L2 clients)	327 – pre	87% of Level 2 and 3 clients
		105 – pre and post	28% of Level 2 and 3 clients
<b>ONS questionnaire</b>	In the first session and over the phone	101 – pre	27% of Level 2 and 3 clients

	after discharge (L2/3 clients)	40 – pre and post	11% of Level 2 and 3 clients
<b>Level 1 client satisfaction and outcome survey</b>	Survey sent to clients after support given	128 (combines Phase 1 and 2 as date not recorded)	11% of Level 1 clients (across Phase 1 and 2)
<b>Level 2 and 3 client satisfaction and outcome survey</b>	Survey sent to clients after support given	75	20% of Level 2 and 3 clients
<b>Case notes</b>	Client case notes sampled from open cases over a 12 month period (at Level 2 and 3)	147	39% of Level 2 and 3 clients
<b>Database – demographics, referrals and signposts, safety netting</b>	Ongoing record of casework and information.  Sampled from July 2017 – April 2019	1,328 Lowest figures for completion of a single data field is 975 (whether clients lived alone)	73% - 100% of all clients
<b>Focus groups</b>	In March-April 2019, all participants having completed MSP sessions	17 participants over 2 focus groups	1% of all clients
<b>Stakeholder interviews</b>	In June 2019	7 in-depth semi-structured interviews	2% of all referral partners (of varying interaction)
<b>HCP survey (used for SROI attribution only)</b>	Phase 1 of MSP	18	5% of all referral partners (of varying interaction)
<b>Client interviews</b>	Summer 2018	2 in-depth semi-structured interviews	<1% of all clients
<b>Yoga impact survey</b>	March – July 2019, after the end of a term of yoga	11	8% of all clients referred to yoga

**Structure of MyCAW and ONS Wellbeing Questions**

**MyCAW**

Please write down one or two concerns or problems which you would most like us to help you with.

Concern or problem 1: Not bothering me at all (0) – Bothering me greatly (6)

Concern or problem 2: Not bothering me at all (0) – Bothering me greatly (6)

Wellbeing: How would you rate your general feeling of wellbeing now? (How do you feel in yourself?) As good as it could be (0) – As bad as it could be (6)

### **ONS Wellbeing**

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

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.

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

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

### **Data analysis**

Each data source was first examined individually, through the following methods:

- Qualitative data - thematic analysis of the focus groups and interviews. Close reading of case notes to elicit strategies, interventions and outcomes within the text. Nvivo used for analysis of use of key words and frequencies of language use, for example clusters of emotive words.
- Quantitative data – summary tables and visualisation of key trends, then a further statistical analysis of correlation and significance. Significance measured through a paired two-tailed Student's t-test for means.

Using the structure of the evaluation questions, themes drawn from the individual data sources were then triangulated with each other. At this stage, further investigations were performed to uncover further patterns and test emerging trends: for example, referral organisations were re-categorised by sector at this stage, to understand further MSP's position within the healthcare and voluntary sectors.

Finally, a comparison to Phase 1 data was made to establish the stability of the results and to identify any evidence of change within the service.

### **Outline of SROI approach**

There is an emerging body of cost-benefit studies regarding social prescribing (Polley, et al 2017), with various different emphases in assigning outcomes and values. This cost-benefit analysis is a Social Return on Investment, following the method outlined in 'A Guide to Social Return On Investment', particularly its seven principles of an SROI study (The SROI Network, 2012). Its SROI self-assessment tool was used to check progress against these seven principles.

In designing an SROI specifically for this social prescribing service, this work has particularly been informed by initial preparation work by Kimberlee (2019) and the methodology of a recent SROI on the British Red Cross (2019) Community Connectors programme.

## Purpose and approach

The purpose of this assessment was to ‘assess whether MSP provides a return on investment for different stakeholders.’

The approach was designed to acknowledge two factors:

- The difference in support received by clients at different levels of the service
- Trying to understand the value of MSP for wider services and system as well as the value to clients

Three impact maps were used, representing the client journey from initial contact to action (as seen in Figure A1.2). This was chosen to incorporate impacts from Level 1 clients. The three impact maps are:

- Direct benefits attained through the nature of the sessions (as attested to in the ‘connection to yourself’ and ‘appreciation’ mechanisms) - Impact map 1
- The benefit of linking clients to other services, which would not otherwise have happened (as attested to in the ‘awareness’ and ‘action’ mechanisms) – Impact map 2
- The overall impact of clients taking action and the MSP supporting this action, leading to relief from depression and anxiety (as attested to in the overall impacts of the service on wellbeing – Section 4) – Impact map 3



Figure A1.2: Three maps of impact

## Assumptions and method of calculation

Within each impact map, every effort was made towards providing conservative assumptions: for example two pieces of evidence were needed for each impact to be considered; the method

avoided double-counting any impact within the same “family”; and thresholds for outcomes to be met were considered carefully.

Assigning values for these impacts followed the wellbeing valuation methodology of SROI calculation (HACT, 2014; Cabinet office, 2009; HM Treasury, 2013) – for consistency, where possible using the HACT (2014) database and method.

Reliance on this method, without using stakeholder surveying to establish own values, led to several gaps in suitable proxies for the outcomes identified. These gaps were most prominent in impact map 2, linking to hospital transport, practical support, wider advice and complementary therapies. Proxies in impact map 1 for treatment compliance, access to knowledge and information, feeling in control and mental health escalation avoidance were either missing or underestimated. Furthermore, it is clear that more work is needed within the wider literature on the methodology of valuing the bridging and linking role of social prescribing services.

Deadweight (19% - from client survey), displacement (0% - evidence of MSP creating demand for new services), drop off (0% - not applicable as values calculated for one year only) and attribution (100%, 10% and 10%) were calculated based on 7 stakeholder interviews, the response of 17 focus group participants and a Phase 1 stakeholder survey of 18 participants. Ideally, there would have been more continuity and breadth within this consultation – to mitigate this, motivation from the wider evidence base of this evaluation was used to test attribution assumptions particularly.

Ten tests for sensitivity of the SROI were performed:

- SROI only based on Impact map 1
- Impact map 1 – Changed parameters for knowledge shared, autonomy and suicide prevention
- Impact map 2 – Accounting for physical activity
- Impact map 3 - Different wellbeing thresholds
- Impact maps 2 and 3 – Changing attribution
- All impact maps – Discounting based on problem alleviation rate
- All impact maps – Difference in attribution needed to set SROI ratio to £1
- All impact maps – Number of financial proxies dismissed for SROI ratio to move to £1
- All impact maps – Comparison to WEMWBS valuation
- All impact maps – Re-calculating ratios compared to the total cost of service

The tests suggest that the SROI calculation has a good level of internal validity, without high sensitivity to changes across a range of assumptions. Within the range of tests, the SROI ranged from £0.82 to £3.35, with a median of £2.08. It is also consistent with a different methodology of valuation.

## **Valuation**

The running costs of the service for a year are £188,000 per annum. Excluding evaluation cost and expense of micro-commissioned projects (not measured here), in the 22-month period of July 2017 –

April 2019 this equates to £304,751. This resulted in a Net Present Value of £386,803 and an SROI of £2.27. For full calculations, please see the accompanying spreadsheet and Appendix 4.

Table A1.2: Valuation and attribution for each impact map

	<b>Total impact for clients</b>	<b>Attribution of impact map</b>	<b>Total impact attributable to MSP</b>
Impact of in-session support	£440,658	100%	£440,658
Impact of onward referral and signposting	£801,945	10%	£80,194.47
Impact of relief from depression and anxiety	£1,707,024	10%	£170,702.40
<b>Total</b>	<b>£2,949,627</b>		<b>£691,555</b>

Considering whether this social value had a benefit for stakeholders other than MSP clients, 11 outcomes were identified which had potential benefit for the NHS. These ranged from outcomes supporting timely and informed medical support for more effective treatment; acting as protective factors for disease recurrence; ensuring timely mental health support at an appropriate level; and supporting stress reduction, thus aiding cancer recovery. Three of these 11 relevant outcomes had a suitable proxy for the calculation of potential costs averted from NHS services (see Table A1.3 below). Once these figures have been weighted for attribution, a conservative figure for the value of this service for the NHS is therefore **£347,094**.

Table A1.3: Outcomes relevant to the NHS - see Appendix 4 for full references and discussion.

	<b>Amount</b>	<b>Number</b>	<b>Total</b>	<b>Relevance for NHS</b>	<b>Cost valuation available</b>
<b>Impact map 1</b>					
Suicide prevention	£66,797	5	<b>£333,985</b>	Costs averted due to delayed suicide	<b>Yes – Costs averted by delayed suicide for a year for people of working age. Knapp et al (2011)</b>

Knowledge and skills - info and widening options	£51	32	£1,632	Timely and informed medical support for more effective treatment	Yes - Time gained by NHS administration staff due to increased knowledge of local services available. NEF Consulting (2018)
<b>Impact map 2</b>					
Support groups	£1,551	74	£114,774	Health service savings for support groups - timely mental health support at an appropriate level	Yes - Annual estimated health service savings for support groups. McDaid and La Park (2017)

**Appendix 2: Level 1 clients**

To better understand clients’ reasons for refusing face-to-face Level 2 support, a sample were e-surveyed. There were two main reasons for clients to remain at Level 1. The majority (72%, 39 out of 54) who stayed at Level 1 felt that the telephone conversation had met their needs. 6 of the respondents (11%) were not eligible for further support, due to being out of the borough.

Clients at Level 1 were more likely to be male, White British, referred from an outreach session and to be having treatment. 25% (n=711) were resident outside of the four boroughs. Level 1 clients were just as likely to be working, much less likely to have breast cancer, and least likely to be in the 41-60 age bracket.

One potential implication of this is that clients may benefit more from later engagement in their cancer pathway (post-treatment, or nearing the end of intensive chemotherapy) or sessions and activities outside working hours. In Level 1 feedback, one of the recurring themes was lacking the time to engage in the suggested activities, for example: *“At the time I was recovering from high dose chemo so was not fully able to converse. I was called some weeks later and emailed some information of local support groups.”* (Survey respondent)

## Appendix 3: Tables

### Section 2

Table 2.1: Referral sources into MSP, Phases 1 and 2

Source of Referral	Phase 2 – July 2017- April 2019		Phase 1 – Jul 2015-Jun 2017	
	Community Partner (inc social prescribing)	54	4%	36
Outreach	668	50%	396	53%
Primary Care	194	15%	75	10%
Secondary Care	274	21%	155	21%
Self-Referral	138	10%	81	11%
<b>Grand Total</b>	<b>1328</b>	<b>100%</b>	<b>743</b>	<b>100%</b>

Table 2.2: Borough of residence of clients, compared to East London population size (Phases 1 and 2)

Borough of Residence	Proportion of East London Population	Phase 2 July 2017- April 2019		Phase 1 July 2015 – June 2017	
		City Hackney	23%	191	14%
Newham	29%	327	25%	146	20%
Out of Borough		241	18%	114	15%
Tower Hamlets	26%	262	20%	188	25%
Waltham Forest	23%	307	23%	166	23%
<b>Total</b>		<b>1328</b>	<b>100%</b>	<b>743</b>	<b>100%</b>

Table 2.3: Level of support received by clients (Phases 1 and 2)

Level of Support	Phase 2	Phase 1

	July 2017- April 2019		Jul 2015- Jun 2017	
<b>Referral</b>	224	17%	77	10%
<b>Level 1</b>	727	55%	408	55%
<b>Level 2</b>	204	15%	114	16%
<b>Level 3</b>	173	13%	144	19%
<b>Total</b>	<b>1328</b>	<b>100%</b>	<b>743</b>	<b>100%</b>

N.B – Clients are logged regarding the highest level of support they received. A Level 3 client here has also received Level 1 and 2 support.

### Section 3

Table 3.1: Expressing emotion. Number of case notes (of 147) and number of references within case notes to emotive words.

Words associated with...	Number of case notes	Number of references	Percentage of case notes
<b>Direct reference to emotion</b>	126	695	86%
<b>Anxiety</b>	95	297	65%
<b>Sadness</b>	91	234	62%
<b>Happiness or enjoyment</b>	74	137	50%
<b>Difficulty</b>	76	117	52%
<b>Death</b>	47	97	32%
<b>Anger</b>	31	45	21%
<b>Shame or burden</b>	25	39	17%
<b>Suicide</b>	13	19	9%

Table 3.2: Categories of concern (Phase 2). Including average rating on MyCAW, the percentage of these concerns rated 'serious' (5 or 6 out of 6 on MyCAW), and the number of referrals/signposts for this category in Phases 1 and 2.

Categories	Total	Percentage prevalence	Average severity	Percentage 'serious'	Number of referrals/signposts	Referrals in Phase 1
Advice, including financial support	176	23%	5.21	77%	1 <sup>st</sup>	106 (3 <sup>rd</sup> )
Emotional wellbeing	170	22%	5.00	68%	5 <sup>th</sup>	155 (1 <sup>st</sup> )
Physical concern and treatment options	120	15%	5.06	70%	3 <sup>rd</sup>	91 (5 <sup>th</sup> )
Physical activity	84	11%	4.67	62%	2 <sup>nd</sup>	114 (2 <sup>nd</sup> )
Work and learning	67	9%	4.82	66%	7 <sup>th</sup>	93 (4 <sup>th</sup> )
Socialising	59	8%	4.22	41%	6 <sup>th</sup>	52 (6 <sup>th</sup> )
Practical support and other	51	7%	4.82	68%	8 <sup>th</sup>	26 (8 <sup>th</sup> )
Support groups, relationships	51	7%	4.63	56%	4 <sup>th</sup>	39 (7 <sup>th</sup> )
	778					

Table 3.3: Number of referrals and signposts for each level

	Phase 1	Phase 2			
		Level 1	Level 2	Level 3	Total
Number of referrals	718	296	207	309	812
Number of signposts	1228	835	566	559	1960
Total number of referrals and signposts	1946	1131	773	868	2772
Number of people	667	711	198	148	1057
Average number of referrals	1.1	0.4	1.0	2.1	0.8
Average number of signposts	1.8	1.2	2.9	3.8	1.9

<b>Average of referrals and signposts</b>	2.9	1.6	3.9	5.9	2.6
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Table 3.4: Categories of signposts or referrals (Phase 2)

<b>Referral/signpost category</b>	<b>Number</b>
<b>Advice services, including financial support and food referrals</b>	601
<b>Physical activity</b>	545
<b>Treatment and health options, including addressing physical concerns and complementary therapies</b>	323
<b>Support groups</b>	301
<b>Emotional wellbeing</b>	212
<b>Socialising and activity groups</b>	199
<b>Yoga</b>	146
<b>Learning, volunteering and return to work</b>	133
<b>Case work and information</b>	114
<b>Practical support</b>	103
<b>Cancer centre (unspecified)</b>	54
<b>Other</b>	22

## Section 4

Table 4.1: Change in problem severity after MSP work. Displaying difference in averages and in percentage of problems that are 'serious' (rated 5 or 6 out of 6).

Category	Average of Pre	Average of Post	Difference	Percentage serious - pre	Percentage serious - post	Sample size	Statistical significance (p value)	Clinical significance
<b>Emotional Wellbeing</b>	4.85	3.04	1.81	66%	21%	47	Yes p=1.86874 E-08	Yes
<b>Physical Activity</b>	4.38	2.58	1.79	46%	21%	24	Yes p= 0.000408648	Yes
<b>Work and learning</b>	4.55	2.77	1.77	55%	14%	22	Yes p= 7.1612 E- 05	Yes
<b>Advice</b>	5.28	3.65	1.63	80%	33%	54	Yes p=1.14413 E-07	Yes
<b>Physical and treatment</b>	5.06	3.48	1.58	71%	35%	31	Yes p= 6.28178 E-05	Yes
<b>Support groups and relationships</b>	4.05	2.67	1.38	33%	10%	21	Yes p= 0.008768255	No
<b>Social</b>	3.85	2.55	1.3	30%	10%	20	Yes p= 0.011545925	No
<b>Practical support and other</b>	4.56	3.89	0.67	56%	33%	18	Yes p= 0.029258036	No
<b>Grand Total</b>	<b>4.72</b>	<b>3.16</b>	<b>1.57</b>	<b>60%</b>	<b>24%</b>	<b>237</b>	<b>Yes</b> p= 1.69205 E-28	<b>Yes</b>

Table 4.2: ONS wellbeing scores before and after MSP work (40 Level 2 and 3 clients)

	Life satisfaction	Worthwhile	Feeling happy	Feeling anxious*
<b>Before</b>	4.71	5.35	4.54	5.43
<b>After</b>	5.51	6.44	5.14	3.90
<b>East London weighted average</b>	7.60	7.70	7.49	2.94

<b>Average improvement after MSP</b>	0.80	1.09	0.60	1.53
<b>Statistical significance</b>	No	No	No	Yes
<b>P value</b>	0.111439934	0.084420477	0.237142022	0.016342609
<b>Percentage improved</b>	55%	56%	48%	60%
<b>Moved categories (positive)</b>	16	16	14	17
<b>Stayed in same category</b>	18	15	11	15
<b>Moved categories (negative)</b>	6	8	14	8

\*All out of 10. For anxiety, a low score is positive.

N.B. There is a statistically significant difference for change in general wellbeing as rated on the MyCAW scale. The p value is 1.5174E-08.

In all cases, a two-tailed t-test for paired samples for means has been used.

## Section 6

Table 6.1: Referrals or signposts to external organisations, by type of organisation

<b>Referrals or signposts</b>	<b>Number</b>	<b>Percentage</b>
<b>NHS service</b> <ul style="list-style-type: none"> <li>- 176 for Barts Health Trust workshops for complementary therapies</li> <li>- 88 for talking therapies</li> <li>- 73 for complementary therapies</li> <li>- 58 for support groups</li> <li>- 33 for hospital transport</li> </ul>	491	17%
<b>Advocacy or advice charity</b>	412	14%
<b>Other charity, charitable trust or NFP</b>	368	13%
<b>Cancer charity</b>	306	11%
<b>Social enterprise</b>	254	9%
<b>Information, casework, online platform or no direct contact (online or telephone)</b> (N.B. this includes more examples than those recorded on the database, inflating the number of referrals/signposts compared to Table 3.3)	252	9%
<b>Community centre</b>	246	9%

<b>Statutory body</b>	191	7%
<b>Network</b>	112	4%
<b>Unknown - but support or activity group, or exercise on referral scheme</b>	87	3%
<b>Leisure trust</b>	56	2%
<b>Unknown</b>	37	1%
<b>Company, housing association, membership organisation</b>	33	1%
<b>Learning organisation</b>	26	1%
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