CLAREMONT

June 2019

islington giving

A review of Claremont's Social Prescribing Project

About this report

This report is intended to be of interest to health providers, other public bodies and voluntary organisations wanting to meet the health and wellbeing needs of people they work with.

Social Prescribing is a growing national movement of localised schemes that harness the assets and knowledge of local communities. Although gaining traction and credibility there are difficulties in accurately measuring the impact of Social Prescribing both in the short and long term. The aim of this report is to contribute to the conversation about Social Prescribing by sharing insights and data from one of the oldest Social Prescribing projects in London.

What is Social Prescribing?

'Social Prescribing is a means of enabling GPs and other frontline healthcare professionals to refer patients to a link worker - to provide them with a face to face conversation during which they can learn about the possibilities and design their own personalised solutions, i.e. a 'social prescription'- so that people with social, emotional or practical needs are empowered to find solutions which will improve their health and wellbeing, often using services provided by the voluntary and community sector'. The Social Prescribing Network website, 2019

About Claremont's Social Prescribing project

The Claremont Project in the heart of Islington offers a diverse range of creative activities for local people over the age of 55 so that they can flourish as individuals, friends, and communities.

Claremont's Social Prescribing project reaches isolated, often vulnerable, residents and has demonstrated an ability to reduce isolation, increase social connections, improve people's psychological well-being and support residents to become more involved in local activities. It has also shown an ability to sustain this engagement over the longer-term. The model demonstrates a successful partnership between frontline health services, other local referrers and a voluntary sector service for older people, with lasting benefits for some of Islington's most isolated residents.

Residents are referred to a Social Prescribing Manager who works with them to unearth their interests and any barriers there may be to accessing Claremont's diverse range of activities. Some residents quickly integrate themselves into the wide-ranging offer at Claremont, whilst for others, it takes sustained effort to engage and participate. Similarly, some referring partners instantly engaged with the project and others have needed more support to become active referrers.

More information

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Introduction

Social Prescribing at Claremont, funded by Islington Giving, has been running for seven years (2012-2019), and is currently funded until April 2022. Claremont's Social Prescribing Manager reaches out to GP surgeries, health professionals and others who are often among the few contacts very isolated older people have. They are then able to "prescribe" Claremont's highly supportive 6-week introductory programme.

Islington Giving has invested in this initiative as it directly contributes to our Confronting Isolation programme priorities, both in building relationships between people and improving access and take-up of social activities. In addition, the collaboration between health professionals (particularly GPs), residents and the voluntary sector mirrors Islington Giving's cross sector approach and fundamental principle of partnership working.

For Claremont this project enables staff to embody their relational approach, putting the time and energy into engaging and proactively supporting isolated older residents who have limited social networks, or opportunities to live fulfilled lives.

Over the last seven years we have developed a delivery model and learnt lessons along the way. This report intends to share learning with a wider audience.

About the project

The Social Prescribing project targets vulnerable, isolated Islington residents aged 55+. Many would be otherwise unlikely to access activities and opportunities. The project works with GPs, health care professionals, and locality navigators, who connect residents to local support and services.

'Social prescriptions' provide access to social, physical and therapeutic activities. The project offers participants 6 weeks of free sessions at Claremont. After this, participants can become a long-term member of Claremont. Classes usually incur small fees of around anything up to £5, but these are waived for people unable to pay.

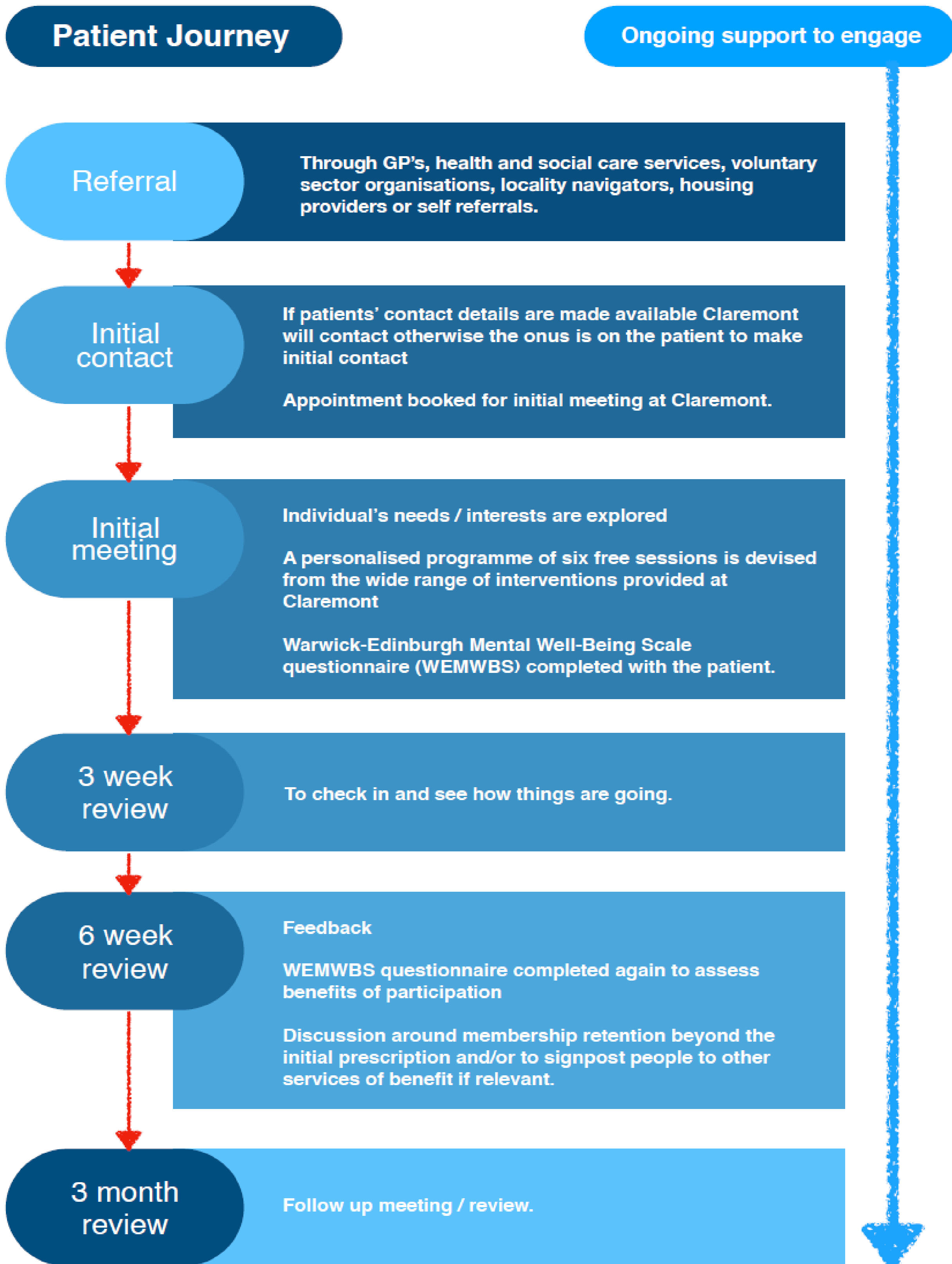
People receiving social prescription are supported on arrival at Claremont with:

- an initial assessment (to tailor the programme to their needs and interests),
- a follow-up assessment after 3 weeks,
- an end of programme assessment.

The project introduces residents to Claremont where a diverse range of activities are available at different times of the day during the week. These include dance classes, writing groups, arts and crafts activities, tai chi, physical exercise and falls prevention classes, psychotherapy (one-to-one, group and art therapy) and a choir.

It reaches highly isolated, often vulnerable, residents. Using a standardised measure – the Warwick Edinburgh Mental Well-Being scale - it has demonstrated an ability to reduce isolation, increase social connections, improve people's psychological well-being and support residents to become more involved in local activities. It has also shown an ability to sustain this engagement over the longer-term.

June 2019



- At relevant points feedback is given to referral agencies re: patients' engagement
- Patients may not all complete their 6 free sessions in 6 weeks. The timeline is a guide. There is flexibility about how and when people engage dependant on the individual's circumstances.

Key learning

- Engaging and establishing long term relationships with people who are traditionally very isolated and hard to engage requires dedicated time and effort.
- Establishing relationships with GPs and referrers has been key to take up and sustainability and as above takes dedicated ongoing time and effort.
- Given the points above, regular communication is key – with patients, referrers and funders to keep all parties engaged and benefiting.
- Flexibility is a pre-requisite. Referrals through Social Prescribing are reaching people in need of social and/or emotional support, including residents with multiple, complex and chronic mental health needs. Claremont has needed to remain flexible and adapt accordingly (e.g. allowing 'time out' periods and opportunities for residents to re-engage when ready).
- Significant measured improvement (using the Warwick Edinburgh Mental Well-Being Scale) has been seen in people's well-being when they attend Claremont for 6 weeks regardless of whether they are taking part in activities or simply coming to watch activities or drop in for a chat, as illustrated in Adam's case study below.
- Those who complete the initial 6-week programme are very likely to remain engaged with the Claremont.
- Most of the older people who have benefited to date are women. More work needs to be done to encourage and support referrals for men.
- The highest proportion of those engaged in the programme are under the age of 70. Mobility problems are part of the reason why older residents are not well represented. Claremont is continuing to work to involve more residents over age 70.

What next?

Claremont, Islington Giving and others (please click here to review research and evidence on Social Prescribing) are convinced that this approach works. Gains in well-being scores and retention rates at Claremont provide evidence of its effectiveness. After embedding the programme successfully at Claremont for a number of years we want to be part of the conversation around the future for Social Prescribing and how to sustain the contribution of the voluntary sector in delivering for health.

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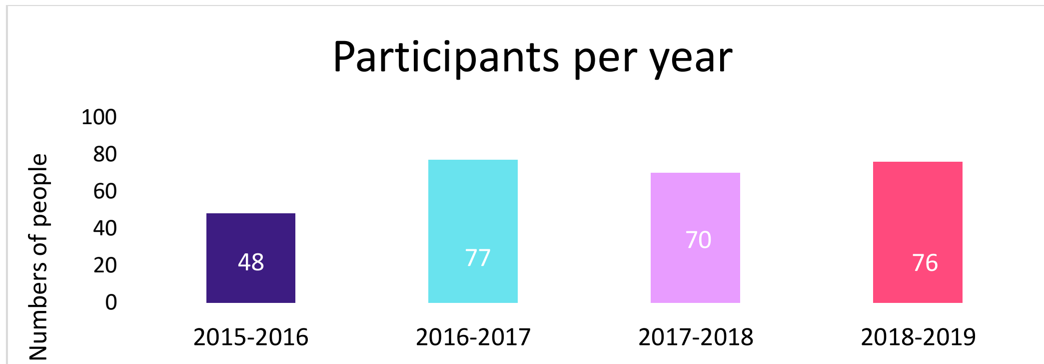
A review of quantitative and qualitative data from May 2015-April 2019

Numbers of participants

From May 2015 - April 2019 Claremont's Social Prescribing project reached 271 isolated people.

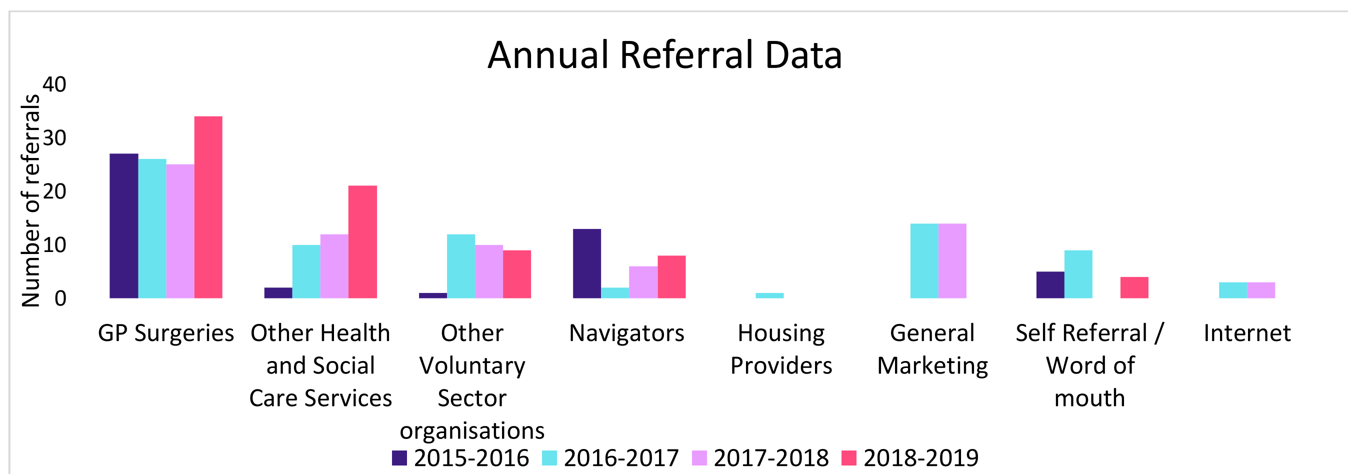


Claremont report that 70-80 participants feels like an optimum number of participants per year given their capacity to introduce new members into their weekly activity programmes and Claremont's Social Prescription Manager's (18 hours a week post) time to engage often isolated residents.

Who prescribed?

The Social Prescription Manager at Claremont undertook a considerable amount of outreach work to engage health care and other professionals to actively refer to the project. This involved talking directly to GPs at team meetings, attending Practice Managers Forums, advertising in weekly GP Bulletins, checking in with GP surgeries to remind them of the offer and promoting the project to other voluntary, community and public services.

Across four years (2015-2019) 43% of those referred were from GP surgeries, 16% from other health and social care providers, 12% from Islington's health navigators and 11% from voluntary sector and community services. The remaining referrals were through internet searches (1%), self-referrals / word of mouth (7%), and from general marketing (10%). The chart and table below depict the referral pathways over the last four years.



	Percentage of people			
Referrer	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**
GP Surgeries	**56%**	**34%**	**36%**	**45%**
Other Health & Social Care Services	**4%**	**13%**	**17%**	**28%**
Other Voluntary Sector organisations	**2%**	**16%**	**14%**	**12%**
Navigators	**27%**	**3%**	**9%**	**10%**
Housing providers	**0%**	**1%**	**0%**	**0%**
General marketing / leafleting	**0%**	**18%**	**20%**	**0%**
Self-referral / Word of mouth	**11%**	**11%**	**0%**	**5%**
Internet	**0%**	**4%**	**4%**	**0%**

Referrals from GP's decreased after the first year as the Social Prescribing Manager focused on a broader range of referrals to ensure those who could most benefit were reached.

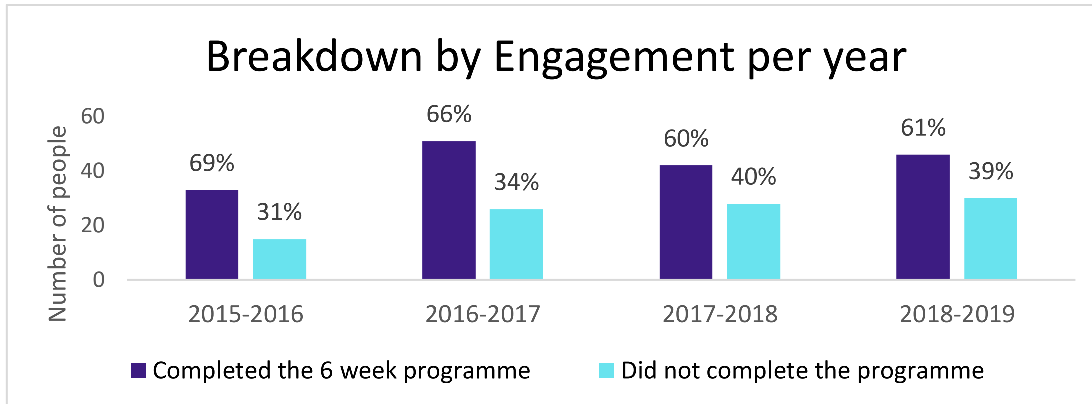
GP referrals then remained consistent in the subsequent two years and increased again in 2018-2019 to just under half of all referrals. This was made possible through directly speaking with GP's at weekly team meetings, integrated networks and regularly updating surgeries through an online newsletter. With appropriate permission, case studies and information on participant engagement and wellbeing were also shared.

The implementation of an online referral form improved the process as often people who are advised to self-refer are not always likely to make the initial contact without extra support. GP's reported that they preferred a formal referral process where they are 'prescribing' classes to patients. Regularly speaking with practice staff also resulted in more referrals. Many staff members in GP surgeries are the main point of communication with older and more isolated people. Informing the practice staff about Claremont and the importance of Social Prescribing meant they could offer a non-medical, informal suggestions to older adults.

Referrals from other health and social care services increased considerably over the last three years reflecting efforts to engage new services, re-engage previous services and work more collaboratively with Islington health and social care services. Many Islington services can only offer short term provision, and often have a waiting time so Claremont's free on-going membership beyond the Social Prescription programme appeals to referrers. The only significant decline in referrals were from the Health Navigators, through word of mouth and from general marketing. See Appendix 1, Table 1 for a more detailed breakdown by each referrer across the 4 years.

Levels of engagement

From 2015-2019 64% (172 out of 271) of those referred completed the 6-week programme.

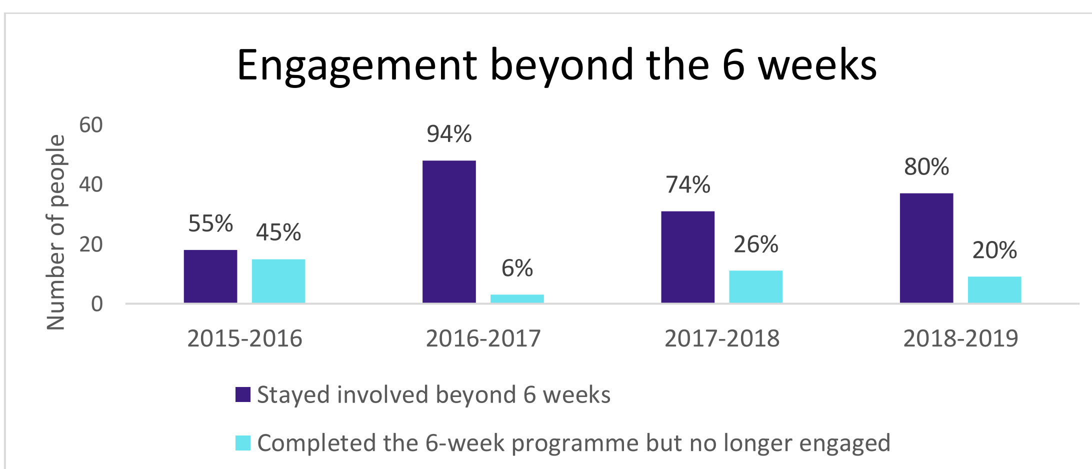


As you can see from the chart above, the proportion of people completing the 6-week programme remained broadly consistent across the four years.

Claremont could however only proactively contact patients where contact details were made available. It is not known how many referrals were made, where the onus is on the patient to make contact, which did not result in the resident contacting Claremont.

The proportion of people who didn't complete the six-week programme was around a third in 2015-16 and 2016-17 and rose slightly to 40% in 2017-18 and 39% in 2018-19. It is hard to explain precisely why there was a slight increase in those not attending all the initial six free sessions, but it possibly is correlated with reaching particularly isolated individuals who are more difficult to engage with. As relationships have been built with referrers and confidence in Claremont and the project has increased, Claremont have seen more referrals for people who are isolated and / or with complex needs.

78% (134 of the 172) of people who completed the programme continued accessing services at Claremont beyond the initial 6 free sessions. Although the proportion of people who stayed engaged beyond the six weeks fluctuated, the high retention rates clearly demonstrate the potential of this approach for achieving sustainable improvements to the lives of those experiencing loneliness and isolation.



It is difficult to explain the hike in people staying connected to Claremont in year two. It could be due to the increase in the Social Prescription Manager's hours from 12 to 18 hours a week in May 2016, meaning more time was devoted to engaging with potential and new members. However, the hours then stayed at 18 hours a week and the proportion of people who stayed engaged, although showing an increase on 2015-16, dipped. However, given the relatively modest number of people in total, these changes are not statistically significant. A small number of people who became seriously ill, for example, would markedly skew the results.

There was a significant drop in self-referrals between 2015 and 2019. In the first two years of the programme 11% of people self-referred. This dropped to 0% in 2017-2018 and 5% in 2018- 2019. There could be a correlation between those referring themselves and long-term engagement, with those being formally referred perhaps tending to be harder to engage. On the other hand we also know that some proportion of those self-referring had come to the service through informal NHS referral or suggestion. As the programme developed, it became much better at uncovering original sources of referral, which also explains the much lower rate of self-referral.

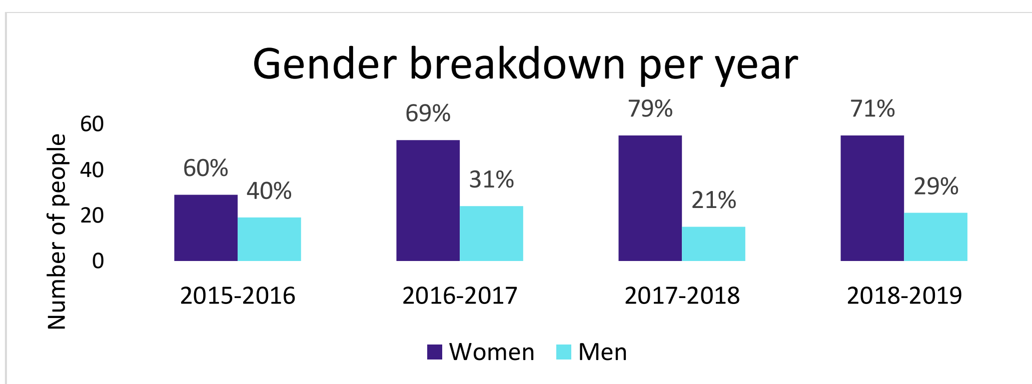
Who engaged?

People who engaged with the project had a range of needs including long term health conditions, mobility issues, social isolation and loneliness, depression, anxiety, terminal illness, grief and mild to moderate mental ill-health.

There has also been a correlation between some social factors and health issues for some individuals, for example some people referred had stress related issues like housing or debt that they believed had led to other health problems like depression, isolation, high-blood pressure and type 2 diabetes. Therefore, working with other services has been beneficial to supporting people with multiple needs. Social Prescribing appears to work as non-medical support for both medical and non-medical issues.

Gender

From 2015-2019 71% (192 out of 271) of people who engaged were women and 29% (79 out of 271) were men.

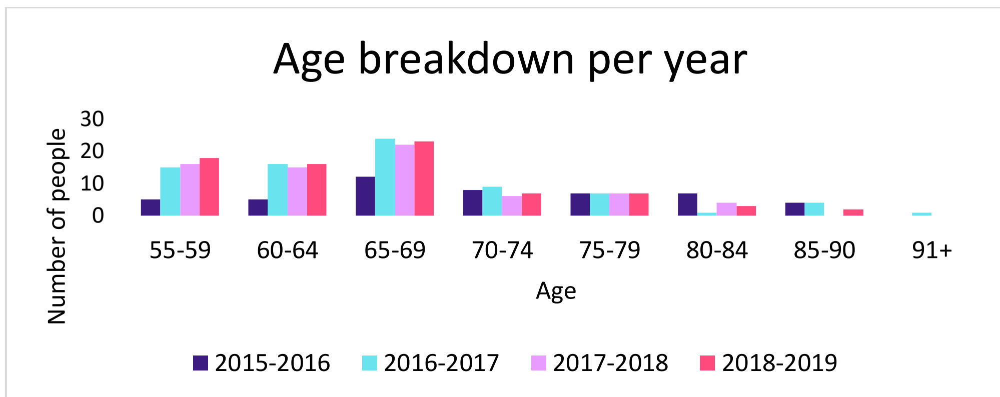


As you can see from the chart above, despite proactively trying to engage more men there has been a steady increase in the number of women engaged with the project and a decrease in the number of men (with the exception of 2018-2019). Claremont has historically had lower proportions of men than women. Though initial engagement and staying engaged in the early weeks can be difficult, men are more likely to stay engaged in the longer-term. More women are referred from GP surgeries and other NHS services, whereas more men are referred from

bereavement services or post-stroke related services. Once men have been referred, they often engage in classes that relate to physical exercise like Tai Chi or Men's Walking Football. Older men often attend larger events that are more sociable like coffee mornings and music events that offer a more flexible, 'drop-in' environment.

Age

Across the four years, 69% (187 out of 271) of those who engaged were 55-70 years old and 31% (84 out 271) were over 70 years of age.



	Percentage of people			
Breakdown by age	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**
55-59	**10%**	**20%**	**23%**	**24%**
60-64	**10%**	**21%**	**21%**	**21%**
65-69	**25%**	**31%**	**31%**	**30%**
70-74	**17%**	**12%**	**9%**	**9%**
75-79	**15%**	**9%**	**10%**	**9%**
80-84	**15%**	**1%**	**6%**	**4%**
85-90	**8%**	**5%**	**0%**	**3%**
91+	**0**	**1%**	**0%**	**0%**

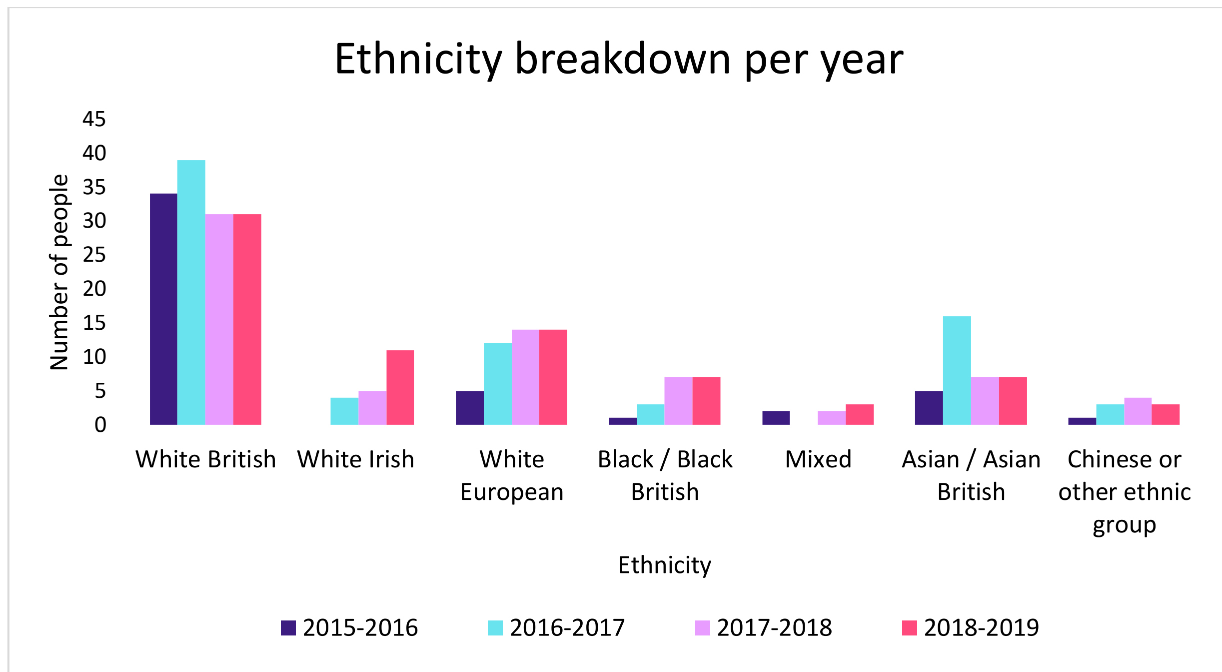
The project hoped to attract people over 70 but there has been an increase in participants under 70 across the four years.

It continues to remain difficult to reach those who are over 70 in Islington. Those isolated and over 70 often have mobility issues or are not accessing any services. To address this Claremont worked with Red Cross Community Connectors (as they often do home visits) and other Islington services that can offer free travel. Many individuals over 70 have preferred to initially speak on the phone. This reinforces the importance of a flexible timeframe as individuals often decide to engage once regular contact has been made and they begin to feel comfortable.

With some people over 70 a family member who can't always be nearby has been involved with the arrangement of an initial meeting, and in these cases they have engaged quickly and continuously. People over 70 often engage in strength and balance (osteoporosis and fall prevention) classes, helping increase mobility through physical exercise, and decreasing the isolation that stems from spending time alone indoors. Some more medically frail participants prefer sit-down yoga classes or seated social events.

Ethnicity

Across the four years 50% of participants (135 out 271) were White British and 50% (136 out of 271) were from Black and Minority Ethnic (BAME) communities. According to the Office for National Statistics 2011 Census, this is reflective of Islington's population with 52% of residents reporting to be from BAME communities.



Breakdown by ethnicity	Percentage of people			
	2015-2016	2016-2017	2017-2018	2018-2019
White British	71%	50%	44%	41%
White Irish	0%	5%	7%	15%
White European	10%	16%	20%	18%
Black / Black British	2%	4%	10%	9%
Mixed	4%	0%	3%	4%
Asian / Asian British	11%	21%	10%	9%
Chinese or other ethnic group	2%	4%	6%	4%

The chart and table above show that people from White British backgrounds were overrepresented in the first year but decreased considerably over the next three years making the project much more representative of Islington's diverse population.

Location

Across the four years 94% (256 out of 271) of participants were Islington residents. 46% (125 out of 271) were from N1 (Canonbury) where Claremont are based and most of the outreach work was carried out. The project is hyper local which is unsurprising given that the Social Prescribing Manager invested considerable time and effort into making local connections.

New referrals from other parts of the borough can be anxious about the distance and travelling on public transport. Some people have been particularly isolated because they find public transport challenging or overwhelming. It does seem more likely that a new referral will engage more quickly if they live within walking distance or one bus journey away.

	Percentage of people			
Breakdown by postcode	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**
N1 – Canonbury	48%	49%	44%	44%
N4 – Finsbury Park	4%	3%	10%	0%
N5 – Highbury	6%	4%	10%	15%
N6 – Highgate	2%	0%	0%	0%
N7 – Holloway	11%	9%	14%	13%
N10 – Muswell Hill	0%	1%	0%	0%
N13 – Enfield	0%	1%	0%	0%
N15 – Tottenham	0%	1%	0%	0%
N16 – Stoke Newington	0%	1%	0%	1%
N19 – Hillrise	21%	17%	7%	20%
EC1R – Finsbury Park	2%	1%	4%	1%
EC1V - Finsbury Park	2%	5%	0%	1%
EC1Y - Bunhill	0	3%	4%	3%
EC2Y - Barbican	0	1%	0%	0%
N11 - Friern Barnet	0	1%	0%	0%
NW5 - Camden	0	1%	0%	1%
WC1X - Camden	4%	0%	4%	1%
EC1A - City of London	0	0%	2%	0%

Other postcodes with a higher proportion of participants were N19 (Hillrise, 16% - 43 out of 271) N7, (Holloway - 12% - 32 out of 271) and N5 (Highbury, 9% - 24 out of 271). Holloway and Highbury are less surprising due to their proximity to Claremont. It is interesting that Hillrise had the second highest number of participants even though it is in the north of the borough. It could be explained by the fact that St John's Medical Practice, The Rise Group Practice and Archway Medical Centre have all formally referred and also let patients know about the project for 'self-referrals' in a more informal way.

The impact

All participants were asked to complete a Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) questionnaire before and after embarking on the 6-week programme. WEMWBS ‘before’ and ‘after’ scores were collected from 132 out of 271 (49%) who completed the 6-week programme between May 2015 and April 2019.

The average ‘before’ score was 44.6 out of 70.00. The average ‘after’ score was 52.7 out of 70.00. Research suggests that the national average score for mental well-being is a score of 53. It is difficult to say exactly why the scores are below the national average. If those referred are coming from particularly isolated backgrounds, this isolation and lack of social connection can have a negative effect on well-being. As a result, when social connection increases there is a correlation with an increase in reported well-being.

The scores showed an average 8.1 point increase in WEMWBS scores from the beginning of the social prescription programme to after completion of the programme. It is accepted in the field that a change of 2.77 or more is a meaningful change in psychological well-being. A difference of 8.1 points indicates substantial changes in well-being.

The table below illustrate the point difference for each question. The greatest point changes were reported against feeling optimistic about the future and feeling cheerful, confident and good about myself, which indicate a significant difference in engaging with self and with the world.

	Point difference			
Question by theme	**2015-16**	**2016-17**	**2017-18**	**2018-19**
I've been interested in new things	11	17	11	16
I've been able to make up my own mind about things	13	6	10	11
I've been dealing with problems well	20	11	11	10
I've been feeling useful	20	11	10	21
I've been thinking clearly	23	11	10	11
I've had energy to spare	15	16	11	16
I've been feeling loved	16	8	10	10
I've been feeling relaxed	18	19	16	18
I've been feeling interested in other people	13	20	13	27
I've been feeling close to other people	23	22	17	14
I've been feeling good about myself	28	26	13	28
I've been feeling optimistic about the future	27	29	17	18
I've been feeling cheerful	32	34	16	25
I've been feeling confident	32	35	25	31

See Appendix 1, Tables 2,3, 4 and 5 for a more detailed breakdown of the Warwick-Edinburgh Mental Well-Being Scale questionnaire (WEMWBS) including scores by each question for each year and the point difference for each of the four years.

Case Studies

The three case studies below further demonstrate the engagement with, and impact of, the project. All the names in the case studies that follow have been changed to protect people's anonymity.

Adam's Story

Adam was referred by a mental health worker at Sir Jules Thorn Trust at St Pancras Hospital after finishing an inpatient stay there. Initially Adam was very excited about Claremont as he is very interested in the arts, although with a long existing anxiety disorder he has difficulty engaging in groups for long periods of time.

At first, he could not bring himself to go into any of the classes, he had too much anxiety and felt everyone was watching him. Despite that he would come in at least once a week, to discuss his anxieties and how he is dealing with them, quite often brought to tears as he recounted his life experiences. He would not only come in for a chat but would also have a look as the classes were going on, although he would not get involved in them himself.

During the fifth week of his six-week programme he decided he was able to attend a Funky Disco Dancing class and managed to stay through the entire session. He was quite pleased with himself but the following weeks his anxiety got the better of him and he came in for a chat instead. Despite not attending the class he was able to bring himself to say hello to the tutor after the class finished and also greeted some of the members of the class he had seen the previous week.

Adam still comes in regularly to watch other members to participate in activities and to drop into the office and say hello or have a chat. He has expressed multiple times in conversation over the last few months how much it means to him to have access to a place like Claremont and how supported he feels by that. Adam treasures and is proud of his membership card to Claremont.

Technically Adam didn't engage in the Social Prescribing activities, but he has engaged with the service in a different way and has also made personal connections with other members despite not attending any of the activities. Adam often says that Claremont **"is another home for me."**

Marina's Story

Marina was referred by a practice nurse at St John's Medical Centre in Archway. Marina lived alone and wasn't involved in many activities. She was immediately excited about the line dancing class. Marina attended the classes regularly without missing one for the entire six weeks and has continued attending the classes since as a regular member.

In the first weeks Marina was quite shy, but as the weeks went on, she engaged with the other members. At the six week review she explained how happy she

was to have the line dancing class and she continues to be happy with it as the months go by. Marina said she has made friends and she is quite pleased to find everyone is very friendly.

She was invited to join in activities by other members and was quite pleased they were keen to involve her. After nine months she continues to be involved at Claremont as a regular member and has also been developing relationships with other members outside of Claremont. At Christmas and Easter, she rang to share holiday greetings and has shared on multiple occasions that she is happy for Claremont to be part of her home.

Alex's Story

Alex is a 90-year-old man who has lived and worked in Islington since fleeing the war in Cyprus 50 years ago. Up until his involvement at Claremont his community involvement was limited to his family and a Greek club in Islington.

He came to Claremont quite shy to speak English and wary to share any personal information. By the end of the six-week programme he shared his difficulty and sadness taking care of his son who has a severe mental health issue.

He has enjoyed coming to Claremont to have a break from these stresses and feels much more a part of the community. After 5 months he still comes regularly, much more open, engaging with the other members, and smiling and cheerful.

If you are interested in discussing this report further please contact Nikki Wimborne at nikki.wimborne@cripplegate.org.uk or on 020 7288 6942.

Summary

Claremont's Social Prescribing project is one of the oldest Social Prescribing initiatives in London engaging 271 Islington residents over the last four years.

Claremont has benefitted from the increased membership, health and social care services have benefitted from having a trusted and high-quality service to refer to and local residents have benefited from the activities on offer, social connections and networks.

Of those referred a high proportion (an average of 64%) completed the 6-week programme. Over 75% of people who completed the 6 weeks programme stayed involved.

With the investment of time and resources, to engage both referrers and local residents, and a flexible personalised approach Claremont's Social Prescribing project demonstrates the potential for this model to reach, engage and connect isolated people to community resources over a sustained period.

" I had not been out of the house for eleven years to socialise because I had been frightened of the outside world ... Claremont has given me a new lease of life ... if I feel a bad bout of depression coming on then I know if I can just get to Claremont then I will be okay here."

– J, a social prescription member

Appendix 1

Data tables

Table 1

	Number of people			
Breakdown by referrer	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**
Peabody Housing Trust	0	1	0	0
Other Voluntary Sector groups	1	4	8	7
Islington Bangladesh Association	0	8	0	2
Age UK locality Navigators	13	2	1	5
Stroke Navigator	0	0	3	0
Dementia Navigator	0	0	2	3
MacMillan Social Prescribing	0	0	2	0
Word of Mouth	0	7	0	0
Internet	0	3	3	0
Leaflet marketing (in GPs and libraries and pharmacists)	0	14	14	0
Self-referral	5	2	0	4
Other health and social care services	2	10	12	21
St Peter Street Medical Practice	2	1	1	3
River Place Group Practice	0	2	3	0
Miller Practice	1	1	0	1
Dr. Bowry	0	1	0	0
The Rise Group Practice	1	1	1	1
Pine Street Medical Practice	1	0	0	0
Islington Medical Centre	5	0	2	6
Clerkenwell Medical Centre	1	0	0	0
Roman Way Medical Practice	1	0	0	2
Bingfield Medical Centre	1	0	0	0
Highbury Grange Medical Centre	2	0	2	0
Amwell Group Practice	1	2	1	2
St Johns Medical Centre	7	8	4	4
Neaman's Practice	0	3	0	0
Ritchie Street Group Practice	3	4	3	2
Killick Street Health Centre	1	2	2	3
Mitchison Road Surgery	0	1	1	2
Hanley Road	0	0	1	0
Andover Medical Practice	0	0	1	0
Mildmay Practice	0	0	1	2
City Road Medical Practice	0	0	1	0
The Medical Centre	0	0	1	0
Elizabeth Avenue Group Practice	0	0	0	1
Stratham Grove Surgery	0	0	0	1
Goodinge Group Practice	0	0	0	4

Table 2

WEMWBS scores by question 2015-2016			
	Before	After	Difference
I've been interested in new things	112	123	**11**
I've been able to make up my own mind about things	125	138	**13**
I've been dealing with problems well	100	120	**20**
I've been feeling useful	109	129	**20**
I've been thinking clearly	111	134	**23**
I've had energy to spare	91	106	**15**
I've been feeling loved	122	138	**16**
I've been feeling relaxed	98	116	**18**
I've been feeling interested in other people	118	131	**13**
I've been feeling close to other people	111	134	**23**
I've been feeling good about myself	98	126	**28**
I've been feeling optimistic about the future	103	130	**27**
I've been feeling cheerful	108	140	**32**
I've been feeling confident	93	125	**32**

Table 3

WEMWBS scores by question 2016-2017			
	Before	After	Difference
I've been interested in new things	121	138	**17**
I've been able to make up my own mind about things	127	133	**6**
I've been dealing with problems well	110	121	**11**
I've been feeling useful	118	129	**11**
I've been thinking clearly	120	131	**11**
I've had energy to spare	92	108	**16**
I've been feeling loved	122	130	**8**
I've been feeling relaxed	105	124	**19**
I've been feeling interested in other people	120	140	**20**
I've been feeling close to other people	111	133	**22**
I've been feeling good about myself	108	134	**26**
I've been feeling optimistic about the future	109	138	**29**
I've been feeling cheerful	111	145	**34**
I've been feeling confident	105	140	**35**

Table 4

WEMWBS scores by question 2017-2018			
	Before	**After**	**Difference**
I've been interested in new things	83	94	**11**
I've been able to make up my own mind about things	86	96	**10**
I've been dealing with problems well	71	82	**11**
I've been feeling useful	69	79	**10**
I've been thinking clearly	69	79	**10**
I've had energy to spare	62	73	**11**
I've been feeling loved	75	85	**10**
I've been feeling relaxed	67	83	**16**
I've been feeling interested in other people	78	91	**13**
I've been feeling close to other people	73	90	**17**
I've been feeling good about myself	70	83	**13**
I've been feeling optimistic about the future	74	91	**17**
I've been feeling cheerful	77	93	**16**
I've been feeling confident	69	94	**25**

Table 5

WEMWBS scores by question 2018-2019			
	Before	**After**	**Difference**
I've been interested in new things	119	135	**16**
I've been able to make up my own mind about things	127	138	**11**
I've been dealing with problems well	118	128	**10**
I've been feeling useful	98	119	**21**
I've been thinking clearly	117	128	**11**
I've had energy to spare	81	97	**16**
I've been feeling loved	91	101	**10**
I've been feeling relaxed	96	114	**18**
I've been feeling interested in other people	85	112	**27**
I've been feeling close to other people	101	115	**14**
I've been feeling good about myself	82	110	**28**
I've been feeling optimistic about the future	97	115	**18**
I've been feeling cheerful	101	126	**25**
I've been feeling confident	101	132	**31**