



BRIGHTLIFE LEGACY REPORT

1. SOCIAL PRESCRIBING

*Organisational
process data*

The University of Chester Evaluation Team

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Table of Contents

1	Background	3
2	Methods.....	3
2.1	Interviews	3
2.2	Data Analysis	3
3	Results.....	4
3.1	Definitions	4
3.2	Referrals	4
3.3	Participant profile and role boundaries.....	6
3.4	Activity for participants	9
4	Discussion and conclusion	11
5	Recommendations.....	13
	References.....	14

1 Background

The purpose of this report is to update the Social Prescribing Working Group about progress in the implementation of the Social Prescribing pilot and to inform the development of the service in the next phase.

In order to inform this strand of the evaluation, a detailed review of existing social prescribing evaluation reports was completed. The aim was to understand what previous evaluations have identified as important considerations and what lessons can be learned. This review is available as a separate document; however, the findings were used to inform the analysis below.

2 Methods

To identify and understand the issues involved in designing and implementing social prescribing semi-structured interviews were undertaken with the four social prescribing team members. Interviews were undertaken by one member of the University team accompanied by a different co-researcher at each interview. The following table lists interviewees.

2.1 Interviews

Role	Time in post	Follow-up interview
Social Prescribing Manager	Less than 1 month	November
Social Prescribing Co-ordinator	6 months	November
Social Prescribing Co-ordinator	6 months	November
Social Prescribing Co-ordinator	Less than 1 month	November

For the purposes of protecting anonymity, the social prescribing manager and co-ordinators will be referred to as either Social Prescriber One, Two Three or Four, however these numbers do not correlate with the table above.

2.2 Data Analysis

The audio files were transcribed verbatim and thematic analysis undertaken to identify and report the patterns that emerged using an adapted framework (Braun and Clarke, 2006), as follows:

- Familiarisation with the data
- Search for themes
- Review themes
- Define and name themes
- Produce the completed analysis

3 Results

Four main themes emerged from the analysis; 'definitions', 'referrals', 'participant profile and role boundaries', and 'participant activities'. A summary of the key findings is provided below.

3.1 Definitions

The Social Prescribers are clear about Brightlife's aims in seeking to reduce social isolation by connecting socially isolated individuals with their communities. The Social Prescribers see the role as facilitating socially isolated individuals to activities where they can meet others in their geographic area, form friendships, and thereby regain confidence and self-worth. This was summarised by the following participant, who said:

I see it as a non-medical intervention for older people who are at risk of, or are currently, socially isolated, i.e., not getting out for one reason or another, whether that's access, accessibility, mobility difficulties, poverty or because they're recently bereaved or they've lost their confidence; a multitude of reasons. So, we're there to really facilitate them getting back in to the community and building their confidence (Social Prescriber Two).

An additional benefit identified by Social Prescribers was the potential for reductions in medical interventions and use of health care services.

3.2 Referrals

The process of referrals was discussed in some depth with the social prescribers. The model adopted by Brightlife was initially based on referrals being made by General Practitioners (GPs) in health centres to a locality-based Social Prescriber. In practice this system has proved difficult to implement. There were several reasons why this was the case. It was unclear how aware GPs were of Brightlife's aims and the programme's potential benefits to a patient's health and well-being. Practice Managers

were acting as 'gatekeepers' so that Social Prescribers were unable to communicate directly with GPs as the following participant describes below:

[It] is being blocked by the practice managers who are saying no, they've got enough to do, they're overworked anyway, etc., (Social Prescriber Two)

Having a simplified referral form available to GPs on the Egton Medical Information System (EMIS) was viewed as one way to increase direct GP referrals as well as making connections with other local organisations such as churches, the Salvation Army and social services. Well-being Co-ordinators were particularly helpful but, in some instances, there was a duplication of services. Self-referrals were a feature in all four areas.

Social Prescribers emphasised the importance of being proactive in raising awareness of the role among local agencies. Where social prescribers were proactive in connecting with the diverse range of primary care health professionals there was a greater number of referrals. In particular, negotiating office space or contact time with services was felt to be advantageous. For example, one Social Prescriber commenting on an increase in referrals states:

I think that's just come about because I've made myself known ...It's such a busy practice, people are in and out, it's difficult to kind of target them so it's just about me being there all the time (Social Prescriber One).

What evolved was a pragmatic approach that sought to balance the intended outcomes from social prescribing with the practicalities of implementation. While Social Prescribers endorse taking a pro-active approach they also suggested that, as a result, communication with services had been unstructured and disorganised. The number of criteria a participant needs to meet in order to be eligible for a Social Prescribing referral has been relaxed as has the requirement to be a patient at particular health centres.

The paperwork required to be completed by Social Prescribers during the initial assessment with the participant was felt to be time consuming and cumbersome. Moreover, the language was viewed as too formal and not conducive to building trust and allowing the participant to 'open-up'. As a consequence, rather than follow the

assessment forms Social Prescribers tended to ask more general questions and complete the forms retrospectively, as summarised below:

We were given a pack but I felt that closed it down when you get all this paperwork. So, I tend to take in a notepad in, have a few prompts and then just ask them to tell me a little about them and that usually opens it up then, I can ask more questions about family, sort of try and identify how isolated they are or whether they've got carers going in. It just develops from that, you know, me asking them a little bit about themselves and family and what they used to like to do and what would they like to do now and...and then I kind of take it from there really. It's not...it's not overly structured (Social Prescriber One).

This practical change in approach appears to be an attempt to de-formalise the assessment experience to put the participant at ease during the first visit.

The evaluation questionnaire was felt to be very formal, long and to some extent intrusive although the Social Prescribers appreciated the need for base line information and knowledge of the participant's circumstances. Some of the questionnaires were not completed initially, but rather on a subsequent visit, which again appears to be in an attempt to de-formalise the process for what were considered to be vulnerable participants. However, questionnaires completed after the initial visit compromise the data as they do not reflect a true baseline measurement.

3.3 Participant profile and role boundaries

There has been some excellent work with individual participants who have benefitted from being part of the Brightlife programme. However, these individuals have not come from the expected routes of referral, which raises questions about how individuals are being recruited/referred as discussed above. At this stage in the project development the number of participants is small, which will need to be addressed if the targets and the intended outcomes achieved.

Due to the way the referral system is currently working many of the participants are known to other services, for example Social Services. As the Brightlife programme gains momentum it is intended that more participants will come from the very socially isolated backgrounds that Brightlife is targeting. To date, many participants appear to be from the older and more frail end of the spectrum. As such, many of the participants

have very complex health and social care needs that are beyond the scope of the social prescribing role, such as serious mental health issues, as described below:

People with a huge range of complex needs. When you go out to see them they might have dementia, eyesight problems, they might have never been out for years, they might have mental health problems, very, very poor mobility, they have lost their confidence, they have no motivation (Social Prescriber Three).

Similarly, the following quotation demonstrates some blurring of the boundaries around the responsibilities of the Social Prescriber suggesting they will address practical issues.

They [British Red Cross] see people for six weeks but they only see them for a six-week window and they may have other issues like debt and other problems to sort. If you look at someone's problems holistically they may have lots of practical issues that need to be sorted. So that six weeks is not long enough really. So, I have been looking at us picking up referrals on the back of those people (Social Prescriber Four).

Where it is the case that an individual has complex needs, Social Prescribers have sought to address both practical and emotional issues before they begin to focus on the participant's social isolation. In addition, in some cases, relatives of the participant are looking to the Social Prescribers to deal with these needs. This is resulting in the Social Prescribers being drawn into trying to offer a wide range of support, that has the potential to encroach into areas beyond the remit of the project such as social care. An example of a complex case is provided below.

A gentleman who has lived on his own for twenty years, he has got macular degeneration, so he has got problems with his eyesight. He has got dementia, he has got heart problems, he has got very, very bad arthritis, hasn't been out for a long time, has no confidence. So, he was quite complex in the sense that he has got a sister who lives in the kind of area, but no transport herself, so she gets across every now and again. I walked into that situation...and met the sister. He had just had a level access shower fitted through a Disabled Facility Grant, but couldn't use it. There was stacks and stacks of medication all over the place and the first thing the sister said was 'can you sort the shower out, can you sort his medication out, can you sort the garden out, we are having problems with the Carers, can you sort that out' (Social Prescriber Three)

She went on to describe the actions she took:

So, I had to go back to Social Services and speak to the occupational therapist and see if they could come out and do some work with him about supporting him with regard to using the shower. We had to get him in touch with the chemist, to sort out all his medication as he hadn't had a medication review. Put him in touch with kind of a gardener. As well, he was struggling, he was really struggling with his mobility, struggling to get in and out of the chair and again I got the occupational therapist to come out. So, there was a whole kind of host of things before we had talked about the companionship side (Social Prescriber Three).

To some extent Social Prescribers are fulfilling an unmet need within communities. As such, there is a potential risk that participants have not had appropriate medical clearance prior to participation. Moreover, the number of visits to and time spent with an individual was often beyond what was intended, as one participant states:

It can be quite a lengthy process before... and it can take weeks and weeks before you have really got people engaged and you are starting to kind of make some progress (Social Prescriber Three).

The intensive level of involvement with individuals is not sustainable once the programme gains momentum. In this regard, all the Social Prescribers highlighted the need for a buddying/befriending scheme.

The Social Prescribers are aware of the tension between the role as signposts/conduits to activities and the wider needs of their participants but find it difficult not to offer this wider level of support where the participant's other needs seem greater than, and may contribute towards, social isolation.

I have done more than I should in some ways, but what I am trying to do mainly is signpost people. But it is very, very difficult when you are going into a situation like that...You can't walk away, there are certain that you can't walk away from, you can't just completely ignore somebody in that situation...I have highlighted my concerns to the Care Agency and the occupational therapist and his sister, and I have recorded it. Because at the end of the day, what I feel is that we are going into these people's home. These people are very, very vulnerable people (Social Prescriber Three).

Being faced with such degrees of participant need, and not infrequently hearing heart-rending histories, Social Prescribers can find themselves becoming emotionally involved with participants, or experience conflict in terms of the time available to work with individuals to the detriment of their own emotional well-being.

The Social Prescribers are also finding the role overlaps with existing provisions already working within the same location. As a result, there is a complex environment with a cross-over of other social support roles such as Well-being Co-ordinators based in GP practices, Age UK, Snow Angels and the Salvation Army, all of whom also help socially-isolated individuals into activities. Reflecting on the overlap between roles, the following Social Prescriber commented:

We are not really doing anything, I hate to say, that unique because there are other people...They are not calling it Social Prescribing. I mean we are unique in a sense that is all that we provide and there is obviously a more academic side to it as well – that's quite unique. But there are other organisations that will help people to get into social activities so we need to be mindful of that really (Social Prescriber Four).

3.4 Activity for participants

Social Prescribers emphasised the importance of people having control over the types of activities they are referred to.

It is a person-centred approach. So, it is led by them to give that person a voice to decide what they would like to go out and do. It can be something really small, you know, just by connecting to their local community – going out into the community (Social Prescriber Four).

At times this required tailoring activities to participants' needs and beyond the scope of what was readily available. Thus, it was necessary to take innovative and pro-active approaches to seeking out activities. For example, one Social Prescriber had a participant with serious health problems that wanted to go swimming. When co-ordinating transport to the public pool did not work, she found a private pool that can be hired out and arranged for a befriender to pick him up and take him.

The mapping of existing activity in the three areas differed depending upon how long the Social Prescriber had been in post. Overtime this is likely to improve and the information become more comprehensive. There was also mixed use of the ALISS (A Local Information System for Scotland) system in terms of populating information and making use of the system for referrals. Operationally, the requirement for an internet connection was sometimes an impediment to using the ALISS system. In addition, the use of laptop was viewed as too formal and potentially off-putting for some participants. However, Social Prescribers were able to go back to participants once they had considered needs and researched what services could be appropriate.

There was some frustration that more services had not been commissioned prior to the pilot being rolled out as this limited the avenues available to the Social Prescribers.

The activities hadn't been commissioned. So, I was going to see people and saying there maybe this starting and...and it was...it was all a bit woolly (Social Prescriber One).

I was quite surprised that we haven't commissioned more and I understand there's been a few political issues and a few barriers (Social prescriber Two).

The commissioned services that are in place were perceived as working relatively well. Equally, it was recognised that time had been taken to assess the needs of older people accessing the service and that Social Prescribers should continue to seek to be responsive to the requests made by older people themselves. There was some concern about the lengthy commissioning process and a view that it could be simplified to speed up the process and become more responsive.

In particular, the need for befriending and transport services were felt to be high priority. While existing activities were available, often people needed one-to-one emotional and practical support to be able to access them. This was summarised best by the following participant:

I have to say every single one of my participants needs a buddy, every single one (Social prescriber Three).

Social Prescribers also emphasized necessity of activities becoming self-sustaining to ensure people were able to access them when the Brightlife project concludes. Finally, anecdotal evidence has highlighted that there are few activities tailored towards men.

4 Discussion and conclusion

There appears to be a good understanding of the aims of the Social Prescribing project, however there are problems with implementation. The model in place in Cheshire appears to be a blend of the signposting, light, medium and holistic approaches described by Kimberlee (2013), although in practice the 'type' of approach was not distinguished by the social prescribers.

A particular challenge highlighted in both previous evaluations and interviews with Social Prescribers was ensuring buy-in to the scheme among local professionals and the organisations they represent (Brandling & House, 2007; Community Action Southwark, 2015; ERS Research and Consultancy, 2013). Previous evaluations have emphasised it is important to ensure those involved are clear about the purpose and value of the work (Community Action Southwark, 2015; ERS Research and Consultancy, 2013). Several reports recommend that participants and stakeholders, particularly the Clinical Commissioning Group and Public Health, are involved in developing the Social Prescribing service to promote shared ownership of the project as well as increase uptake (Brandling & House, 2007; Community Action Southwark, 2015; Dayson, Bashir, Bennett, & Sanderson, 2016; Kinsella, 2015). A potential advantage that could be used to promote Social Prescribing is that knowledge about the range and quality of activities and support services available can be patchy. Previous evaluations have shown that the Social Prescribing service provided an up to date list that could be more easily accessed by GPs and patients (ERS Research and Consultancy, 2013; Friedli, Themessl-Huber, & Butchart, 2012).

A common theme in existing evaluations and supported by interviews was the usefulness of having Social Prescribers in primary care settings. Previous projects that found it effective in engaging staff and patients (Community Action Southwark, 2015; ERS Research and Consultancy, 2013). Due to the limited time available to GPs, several reports recommend that there are quick and simple systems in place for GPs to make referrals (Community Action Southwark, 2015; Kinsella, 2015). The possibility of referrals being made through the GP online system EMIS was raised by one Practice Manager locally and suggested in the Southwark evaluation report (Community Action Southwark, 2015). While GPs are often enthusiastic about Social

Prescribing it can take time for them to consistently make referrals (Community Action Southwark, 2015). As such, **“resourcing significant engagement with GP practices throughout any future social prescribing services will be vital to delivering a successful service”** (ERS Research and Consultancy, 2013, p. 75).

Several reports highlight the importance of the individual link worker/co-ordinator in both working with participants and statutory and voluntary organisations (Community Action Southwark, 2015; Friedli, n.d.). The Dundee evaluation found that the skill of the individual link workers was a key aspect of the pilots success (Friedli et al., 2012), suggesting that time should be taken to ensure the link workers/coordinators have the right skills mix. On this basis, existing reports suggest that it is important to resource and facilitate link worker training, briefings and networking to share best practice, improve coordination and deliver consistent outcomes for patients (ERS Research and Consultancy, 2013). The co-ordinators have an important role in **“championing social prescribing, and liaising between health professionals and VCOs”** (Community Action Southwark, 2015, p. 3).

The funding provided to Voluntary and Community Sector (VCS) organisations was highlighted as a challenge due to the short-term and unstable nature of funding to the sector (Brandling & House, 2007; Community Action Southwark, 2015). Increasing the number of participants utilising these services may also place increased pressure on them (ERS Research and Consultancy, 2013). As such, previous evaluations recommend that time should be taken to understand the potential demand for the service and the capacity of local VCS organisations to respond, including those that may be funded through the programme and those that are not (Community Action Southwark, 2015; Kinsella, 2015). A related issue of concern highlighted in interviews was the sustainability of the intervention beyond the term of the Brightlife project.

At the time of interview, the Social Prescribing co-ordinators had been in post for a relatively short period of time. Set within this context, the Social Prescribers were experiencing a number of challenges implementing the project. However, this stage of project development presents an opportunity for such challenges to be addressed.

Based on the evidence available evidence a number of recommendations are provided in the following section.

5 Recommendations

For Social Prescribers to be given,

- Guidance as to how best to work with other individuals and organisations in their area who are offering similar support
- Guidance on providing a consistent approach whilst appreciating approach needs to be tailored to locality
- Guidance on how far they should go in meeting a participant's wider health and wellbeing needs beyond social isolation
- A mechanism to ensure participants have received appropriate medical assessment and clearance.
- Training on how to avoid becoming emotionally involved with participants
- Provision of avenues of supervision within Brightlife to provide a safe place for Social Prescribers to share the concerns and receive support
- Guidance on completing the evaluation questionnaire

For:

- Greater awareness raising among GPs and other professionals of Brightlife's benefits
- To broaden participant profile base beyond those already in contact with services
- A pro-active approach to asset mapping to be taking including the use of the ALISS system and the Cheshire West and Chester Local Offer database.

Endorsements

- The commissioning of Befriending Service and Transport services
- Simplification of referral forms
- Simplification of assessment paper work including more open/general questions

References

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