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BRIGHTLIFE LEGACY REPORT

2. SOCIAL PRESCRIBING

Review of existing evaluations

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Introduction

Social Prescribing (SP) is a relatively new intervention. As such, the evidence available in relation to best practice is limited. In particular, there is a lack of empirical peer reviewed research. However, a number of social prescribing pilots have been undertaken and evaluated. The findings from these evaluations have been reviewed and a summary is provided below. The review focussed on definitions, models, referral routes, activities, evaluation methodologies and outcomes measures. The final section summarises the key issues identified and recommendations made in existing SP evaluation reports.

Definitions

There are a range of definitions of SP within existing evaluation reports. There is varying emphasis on improving mental health, reducing so-called 'inappropriate' use of health care services and targeting areas of deprivation or particular population groups. A common factor throughout is the referral of primary care patients to voluntary and community sector organisations for practical and/or social support, although statutory services do feature where appropriate (Brandling & House, 2007; Dayson, Bashir, Bennett, & Sanderson, 2016). In contrast, the guidance for SP provided by the Care Services Improvement Partnership (CSIP) North West Development Centre suggests that SP relates to primary care-based projects, such as exercise on prescription (Friedli, n.d.). However, the report also state SP can be used as a gateway to community resources and may be beneficial for ***"for groups whose needs may be best met from within the voluntary and community sector (VCS)"*** (Friedli, n.d., p. 5).

The definition used by the University of Bath describes social prescribing as ***"a formal means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local nonclinical services, and provides a framework for developing alternative responses to meet need"*** (Brandling & House, 2007, p. 3). The report argues SP aligns with ambitions to ***"improve health and reduce health inequalities"*** (Brandling & House, 2007, p. 4). Furthermore, there

appears to be an emphasis on reducing the number of "***high resource users of GP, A&E and secondary care services"*** (Brandling & House, 2007, p. 5).

Brandling and House's (2007) definition was also used in the pilot report by Age Concern Yorkshire and Humber (Age Concern Yorkshire and Humber, n.d.; Kimberlee, 2013) and the report conducted by Kimberlee (2007) at the University of Bristol. However, greater emphasis was given to mental health and long term conditions in these reports. The Dundee pilot also focussed on mental wellbeing and was piloted in an area of deprivation (Friedli, Themessl-Huber, & Butchart, 2012). There was a particular emphasis on addressing the wider determinants of ***"mental health inequalities"*** (Friedli et al., 2012, p. 12) associated with deprivation and disadvantage. Similarly, the Care Services Improvement Partnership (CSIP) North West Development Centre also suggests that SP helps improve health, wellbeing and quality of life, reduce inequalities and regenerate deprived communities (Friedli, n.d.). The Age Concern report for Yorkshire and Humber also emphasised social exclusion (Age Concern Yorkshire and Humber, n.d.).

The Rotherham evaluation defines social prescribing as ***"a catch-all term for non-medical services that aim to prevent worsening health for people with long-term health conditions"*** with the overall aim of ***"reducing the number and intensity of costly interventions in urgent or specialist care"*** (Dayson et al., 2016, p. 1). The report goes on to describe SP as ***"a mechanism for General Practitioners and other primary care services to link patients with sources of social, therapeutic and practical support in their locality"***. The providers of this support are primarily drawn from the voluntary and community sector. There is also particular emphasis on targeting ***"marginalised and disadvantaged groups"*** (Dayson et al., 2016, p. 1).

The Newcastle social prescribing evaluation report did not provide a definition of social prescribing, however there was an explicit emphasis on patients with long term health conditions and mental health service users (ERS Research and Consultancy, 2013).

Community Action Southwark define SP as "***the referral of an individual by a health professional to an organisation providing non-clinical activities in the***

community with the intention of helping the individual to better manage their condition" (Community Action Southwark, 2015, p. 1). The report goes on to state SP has the potential to ***"tackle isolation and loneliness, empower patients and encourage self-management of long-term conditions"*** (Community Action Southwark, 2015, p. 3). The explicit aim of the Cheshire Brightlife SP service is to address social isolation among older adults.

Models

With regard to models of social prescribing, there is a range from informal, information sharing approaches at one end of a spectrum through to highly formalised referral processes and one-to-one support provided to clients at the other (Friedli, n.d.).

The Rotherham Social prescribing service is considered to be a mainstream health service, although Voluntary Action Rotherham are the accountable contract holder and responsible for micro-commissioning of social prescribing activity. The Rotherham SP evaluation also highlighted an additional service being piloted in 2015-16 that was referred to as ***"a sister social prescribing service for people with mental health conditions"*** (Dayson et al., 2016, p. 2). In the Rotherham social prescribing model, volunteers would initially accompany some participants to the groups they had been referred to.

The Yorkshire and Humber pilot was focussed on ***"older people with mild to moderate depression or who are lonely and socially isolated"*** (Age Concern Yorkshire and Humber, n.d., p. 6). The project was implemented across 12 GP practices in Yorkshire and Humber using existing Age UK resources. Four practices piloted a ***"social prescribing clinic"*** at regular intervals and ***"six practices made referrals via a telephone call or fax"*** (Age Concern Yorkshire and Humber, n.d., p. 6). It was not clear what process was adopted by the other two practices. The local Age UK teams then conducted an in-depth assessment either in person at the person's home or GP surgery, or by telephone.

The Bath feasibility report identified six models of social prescribing. These are 1) information only, 2) information and telephone line, 3) primary care referrals, 4) in-

practice clinics (generic), 5) in-practice clinic (specialist) and 6) referral centre (Brandling & House, 2007). Information includes display boards with a directory of services. The telephone line allows people to self-refer to the SP service. Primary care referrals involve practitioners making referrals on behalf of patients. Clinics involve either 1) referral workers triaging and signposting patients or 2) ***"offer***[ing] ***specific services such as Citizens Advice"*** in some cases (Brandling & House, 2007, p. 4). The referral centre is community based, receives referrals from a range of organisations and provides a one-to-one service (Brandling & House, 2007).

A particularly useful typology was developed at the University of the West of England. A distinction is drawn between signposting, light, medium and holistic social prescribing (Kimberlee, 2013). Signposting involves directing patients to relevant local organisations without formal processes. SP Light involves referring ***"at risk or vulnerable patients"*** to specific projects or organisations to address particular issues (Kimberlee, 2013, p.18). SP Medium focusses on promoting self-care among patients and signposting to relevant self-help groups. The main difference between medium and holistic SP is that the former seeks to ***"address certain needs or behaviours identified by the GP"***, whereas the latter seeks ***"to address the beneficiary needs' in a holistic way"*** (Kimberlee, 2013, p.20). Holistic social prescribing, therefore, addresses need from the perspective of the patient, which often cannot be addressed within ***"normal appointment time"*** (Kimberlee, 2013, p.20). Holistic social prescribing also involves formal referral processes. Kimberlee (2013) highlights holistic social prescribing projects have tended to develop organically and flexibly overtime in response to particular local need. With regard to the scale of social prescribing projects some areas have piloted borough wide projects, while others have implemented pilots on a much smaller scale, such as within two or three general practices.

The Newcastle SP project was piloted by six GP practices and five VCS organisations. Each VCS organisation identified a Link Worker who would receive referrals from health professions (ERS Research and Consultancy, 2013). One organisation HealthWORKS was the 'lead provider', Northumbria University provided design expertise and Newcastle City Council's shadow Wellbeing for Life Board provided

overall governance. The delivery team responsible to the steering group was made up of a Strategic Linkworker, Project Coordinator, Project Linkworker and Project Manager (ERS Research and Consultancy, 2013).

The Community Action Southwark SP briefing outlines three models based on GP referrals. These are: 1) GPs refer directly to VCS organisations, 2) GPs refer to a single link worker who assesses need and supports the client to access VCS services or 3) a multi-agency approach where GPs refer to specialist organisation for example, Diabetes UK for specific support.

Referral routes, procedures, eligibility criteria and feedback

Little information is provided in most existing evaluation reports about referral routes, procedures and eligibility criteria. In general, referrals are made by primary care practitioners and GPs in particular (Community Action Southwark, 2015). However, there appears to be some consensus across evaluation reports that other organisations are not excluded from referring, and people can also self-refer if they are aware the project is in place. Few of the evaluation reports referred to feedback mechanism between GPs and social prescribers in relation to patient progress and those that did found there were no formal mechanisms in place.

In the Dundee pilot and Bristol social prescribing projects (see above) all clients are referred directly by GPs (Friedli et al., 2012; Kimberlee, 2013). The Dundee pilot report outlined that following a GP referral, clients would be contacted by a 'link worker' who would assess their needs and identify appropriate activity. Clients could receive up to four consultations with a link worker (Friedli et al., 2012).

In the Newcastle project the majority of patients were referred by GPs and some by other primary care professionals. Referrals were made directly to one of five 'Linkwork Organisations' where the patients' needs would be assessed and a plan put in place within the organisation's existing provision or the individual would be referred to another organisation (ERS Research and Consultancy, 2013). Patients with long term health conditions (*n* = 150) and mental health services users (*n* = 50) were the primary target group. Secondary criteria were ***"smokers, BMI over 30, postcode, demand,***

BME" (Newcastle West Social Prescribing Project, n.d.). Factors ***"included social isolation; mild to moderate depression; receptiveness to suggestions and ideas; and being ready to be motivated"*** (ERS Research and Consultancy, 2013, p. 35).

The Bath feasibility study was concerned with reducing use of primary care services by so-called 'high resource' users. As such, the criteria developed by the participating general practices related to frequency of attendance in primary care, the number of hospital referrals and/or a mental health diagnosis.

The Dundee pilot used the following inclusion criteria:

- Poor mental well-being affected by their social circumstances e.g. socially isolated, recently bereaved, lone parents, low income.
- Mild to moderate depression and anxiety.
- Long term physical/mental conditions.
- Frequent attenders in primary care (Friedli et al., 2012, p. 15)

Patients were excluded if:

- People experiencing acute episodes of psychosis
- People with primary issues of drug and alcohol misuse (Friedli et al., 2012, p. 15).

It was argued in the final report that ***"social prescribing can be particularly useful for those patients with long-term conditions, people with long-term mental health problems, and those in vulnerable and at-risk groups"*** (Community Action Southwark, 2015, p. 2).

Range of activities

A wide variety of services and activities have been accessed through social prescribing projects including, for example, advocacy, information and advice, befriending, counselling, transport, handyman services and exercise classes. The Rotherham evaluation reports states ***"the high demand for services such as befriending and community transport highlights the importance of services that aim to reduce dependence and social isolation"*** (Dayson et al., 2016, p. 6).

The Dundee pilot report grouped activities in to four categories. These are:

- Structural and environmental issues e.g. money/debt, employment and training, housing support, anti-social behaviour.
- Lifestyle issues e.g. drug and alcohol misuse, physical activity, condition management.
- Social isolation and other psychosocial and emotional needs e.g. counselling, volunteering, adult learning, social activities.
- Family and relationship problems e.g. mediation, children's services (Friedli et al., 2012, p. 5).

The Southwark pilot states ***"The five most in-demand services were information and advice, community activity, physical activities, befriending, and enabling"*** CAS, p.8).

Evaluation methodologies

Existing SP projects have sought a range of different outcomes through SP projects. As such, a range of measures and a variety of methodologies have been used.

Case studies

The Rotherham evaluation, conducted by researchers at Sheffield Hallam University, included three case studies of services provider organisations. These are 1) British Red Cross, 2) Active Regen and, 3) the South Yorkshire Centre for Inclusive Living. Interviews were conducted with key management and staff (7), volunteers (2) and services users (6) (Dayson et al., 2016).

The University of Bath conducted a case study of three general practices in one geographical area (Keynsham). They conducted semi-structured interviews with high resource services users (11), surgery staff (8) and VCS stakeholders (2). They also collected information from a database of local VCS organisations (Brandling & House, 2007).

The University of the West of England report investigated existing social prescribing services in the Bristol area. Three focus groups were undertaken, one with social

prescribing practitioners and service users (8 participants), one with Bristol City Council/Public Health employees (6 participants) and one with GPs (8 participants). Interviews were undertaken with representatives of 14 provider organisations, seven GP practices, one Bristol City Council/Public Health employees and three Bristol Clinical Commissioning Group representatives. In total 36 participants were involved (Kimberlee, 2013).

The Dundee evaluation was a case study in one medical practice in Dundee. Sources of data used were GP social prescriptions (N=123), pre and post questionnaires (N=16), patient interviews (N=12), GP interviews (N=2), link worker interviews (N=3) and link worker notes and reflections (Friedli et al., 2012).

The Newcastle evaluation was based on a documentation review, feedback from 11 health care professional involved in the pilot and the views of nine patients who received support through social prescribing (Newcastle West Social Prescribing Project, n.d.).

Outcome measures

The outcomes measures used in existing evaluations are varied depending upon the aim of the SP service. The Cheshire Brightlife intervention aims to prevent or reduce social isolation and improve general well-being. From the literature reviewed, there are no previous evaluations that have measured reductions in social isolation, however several have used measures of well-being. The following section describes the well-being measures used and the findings based on these measures. This is followed by a brief overview of other measures used in existing evaluations.

Well-being outcomes

In Rotherham the evaluators developed a well-being tool using a five point scale rating scale across ***"eight measures associated with … self-management"*** (Dayson et al., 2016, p. 18). The scale ranged from 1 = not thinking about it/ not doing anything, to 5 = as good as it can. The measures were feeling positive; lifestyle; looking after yourself; managing symptoms; work, volunteering and other activities; money; where you live and family friends. 1,843 participants provided base line data and 1,068 participants provided follow-up data. Statistical testing was applied to the data using 95% confidence intervals and the McNemar test (Dayson et al., 2016).

The evaluation report states that ***"82 per cent of service users experienced positive change on at least one outcome measure"*** (Dayson et al., 2016, p. 20). The authors suggest that the progress made by participants over a short period of time shows the potential of social prescribing. A further positive outcome was among participants with low baseline scores showing the most progress (Dayson et al., 2016). Interestingly, participants referred to VCS organisations made better progress (84%) than referrals to non-VCS organisations (74%) or where individuals only received signposting information (66%) (Dayson et al., 2016). It should be noted more complex cases are likely to be referred to statutory agencies that VCS organisations, which may impact the likelihood of improvement.

The case study element of the Rotherham evaluation identified four outcome themes. These are ***"increased well-being, reduced social isolation and loneliness, increased independence*** [often related to transport], ***and access to wider welfare benefits"*** (Dayson et al., 2016, p. 24). In particular, volunteers accompanying service users to activities had two broad benefits. The first was increased confidence using public transport or transport schemes. The second was reduced anxiety related to starting a new activity and meeting new people (Dayson et al., 2016).

The research conducted by Kimberlee (2013) at the University of the West of England found that few providers routinely collected monitoring information. As such it was difficult to compare across different social prescribing projects. Measurement frameworks included:

- Inventory for Brokerage Service Outcomes Star (IBSO)
- Patient-Health Questionnaire-9 (PHQ-9),
- Generalised Anxiety Disorder-7 (GAD-7)
- Office of National Statistics Well-being Indicators

The Age UK Yorkshire and Humber pilot (55 participants), the Dundee evaluation (16 participants), Newcastle evaluation (16 participants) all used the Warwick Edinburgh Mental Well Being Scale (WEMWBS). Each evaluation reported an improvement,

however the sample size of each was small. The Dundee evaluation also used the Work Social Adjustment Scale (WSAS).

The Age UK Yorkshire and Humber pilot report that ***"the Social Prescribing pilot project was too short in timescale to be able to provide robust evidence of an impact"*** (Age Concern Yorkshire and Humber, n.d., p. 10).
Based on qualitative interviews with health care professionals and patients, the Newcastle pilot reported GPs highlighted both ***"measurable improvements"***, such as reduced blood pressure, and other less tangible improvements, including increased confidence and self-esteem (ERS Research and Consultancy, 2013, p. 37). GPs also reported patients, in general, were positive about their experiences of the programme. Patients themselves reported social prescribing had helped to improve their health and/or wellbeing (ERS Research and Consultancy, 2013). The monitoring information focussed on goal setting and 79 of the 87 patients who met with the link worker set goals. The majority of goals related to physical health or mental well-being, with 41% of patients achieving the goal.

The Dundee evaluation found that half of those referred (N=61) attended at least one consultation with a link worker and all of these individuals attended at least one activity (Friedli et al., 2012). Based on the WEMWBS and WSAS, the 16 people that completed the entire programme all made a ***"significant ($p<0.05$) improvement in mental well-being and functional ability"*** (Friedli et al., 2012, p. 19). The qualitative interviews (N=16) identified a range of benefits including raising awareness about different activities, increased confidence to attend activities, meeting new people and getting out of the house, and renewed motivation to make positive changes (Friedli et al., 2012).

Impact on demand for hospital care

The Rotherham evaluation followed 559 patients out of the 1500 that participated using ***"patient-level Hospital Episode Statistics (HES) provided by their local CSU (Commissioning Support Unit), to analyse patients' use of hospital resources, including unplanned care"*** (Kinsella, 2015, p. 6). They found that over a 12 month period there was a 20% reduction in Accident and Emergency attendance, a 21% reduction

in outpatient appointments and a 21% reduction in inpatient admissions (Dayson et al., 2016).

Economic and social cost-benefits

The Rotherham evaluation used the above findings as well as those relating to well-being to estimate economic and social cost-benefit. They suggest that the SP intervention saved between £1.14 and £3.38 for every £1 spent (Dayson et al., 2016). However, the authors were clear that due to the small sample size these results are not statistically significant.

The Bristol evaluation reported a Social Return on Investment of around £1.20 but suggested this would probably be higher in subsequent years once the early challenges of setting up were overcome (Kimberlee, 2013). The report by Kinsella, which reviewed the evidence of effectiveness of SP, argues that the economic and social benefits are difficult to demonstrate, stating that due to the nature of the interventions it may take several years for impact to embed (Kinsella, 2015).

Reduction in 'high resource' users

The University of Bath examined the impact of social prescribing on ***"primary care high resource users"*** (Brandling & House, 2007, p. 6). Eleven interviews were undertaken with patients identified as high resources users. The reports states that ***"they could see the potential benefits"*** of Social Prescribing including ***"an alternative that was easily accessible, reducing the waiting time for a GP appointment and the option to have a longer appointment to discuss issues at a much deeper level"*** (Brandling & House, 2007, p. 12).

The Newcastle evaluation initially intended to utilise Reporting Analysis Intelligence Delivering Results (RAIDR) information through the PCT/CCG, however practical barriers prevented access to this information (ERS Research and Consultancy, 2013). Nine patients were interviewed regarding their experiences of the project. The evaluation, which interviewed nine participants, stated the ***"majority of patients consulted believed their experience of the project had helped, or was continuing to help to improve their health"*** (ERS Research and Consultancy, 2013, p. 50).

Service and community change/improvement

The Dundee pilot adopted a Contribution Analysis Theory of Change framework (adapted from Wimbush, 2009) for evaluation. The premise was that engagement, awareness raising and capacity building would lead to changes in behaviour and practice in service delivery and within the community (Friedli et al., 2012).

There is little available evidence in support of SP as an effective intervention (Centre for Reviews and Dissemination, 2015; Community Action Southwark, 2015; Kinsella, 2015). The studies that are available tend to have methodological weaknesses, such as or non-validated tools or small sample sizes. This suggests more robust evaluations are required to make the case for SP as an intervention (Centre for Reviews and Dissemination, 2015; Community Action Southwark, 2015; Institute for Voluntary Action Research, 2014; Kinsella, 2015).

Methodology recommendations

The Rotherham evaluation made several recommendations for future evaluative work. The first was tracking people longitudinally over a period of 2-3 years to understand the extent to which the benefits for people either drop-off, are sustained or enhanced. The second recommendation was the use of control or comparison groups to improve statistical reliability (Dayson et al., 2016). Finally, the report suggested including ***"the impact on GP time, use of social and residential care and the introduction of a standardised measure of health-related quality of life"*** (Dayson et al., 2016, p. 39).

Brandling and House (2007, p. 18) state that it would be "***interesting to separate groups by size and by the services they provide, to determine whether responses about social support through social prescribing can be clustered differently according to the role of organisations and their structure"***.

A review by Wirral Public Health states the following tools have been suggested as potentially useful measures: ***"the General Health Questionnaire (GHQ) Social Functioning (SF) or Patient Health Questionnaire (PHQ) scores, the ONS4 personal wellbeing questions, the Lubben Social Network Scale (LSNS) or the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)"*** (Kinsella, 2015, p. 9).

Key issues and recommendations from existing reports

The recommendations from existing reports can be grouped into three broad categories; services users, professionals coordinating and delivering the services, and the administrative and operational processes. These are summarised below.

Service users

The Rotherham evaluation found service users who had engaged fully with their prescribed activities were likely to gain the most benefit. In this respect, the authors highlight the importance of the referral process in ensuring the right people are channelled towards the right activities (Dayson et al., 2016). Similarly, the Dundee evaluation found individuals who attended at least one meeting with a Link Worker tended to engage more fully with the activities. It was also important that activities were tailored to patients' preferences. Therefore, having a wide range of activities available was beneficial. However, it was also important to beneficiaries that they were not pressured to engage (Dayson et al., 2016). Some patients benefited from a high degree of support in the first instance but gradually grew in confidence (Dayson et al., 2016).

The Newcastle evaluation reported the emphasis on clients with LTCs and mental health needs meant Link Workers faced a number of challenges, including:

- Having limited information on the patient condition and circumstances
- Clients potentially not being forthcoming with details of their LTC, wider issues and aspirations of engaging with the link worker
- The link worker being unaware of any risks of working with the client
- A number of patients referred had no intention of changing their behaviour and typically denied they had a problem
- Even where patients acknowledged they "had a problem" many did not have a desire to seriously want to address it

(ERS Research and Consultancy, 2013, p. 18).

Factors reported as likely to improve engagement rates included:

- Health and care professionals knowing and applying selection criteria in order to identify only those patients for whom SP is appropriate
- Link worker making first contact through home visit

- Link worker contacting referrer to gain better knowledge and understanding of patients' needs, wants and anticipated outcomes

(ERS Research and Consultancy, 2013, p. 58).

The report further states ***"it is important that organisations that refer patients to a social prescribing Link Worker explain fully to the patient the reason for this and the possible benefits"*** and ***"resources are in place to support patients with mental health issues"***

(ERS Research and Consultancy, 2013, p. 68/69).

The Age UK Yorkshire and Humber (n.d.) pilot scheme highlighted a limited engagement from the BME population. The report also suggested a large proportion of older adults in care homes suffer with depression, however this population group was not included in the pilot (Age Concern Yorkshire and Humber, n.d.).

Professionals

The University of Bath feasibility report included an additional piece of research examining the views of key voluntary and community sector personnel. Constantine (2007, as cited in Branding and House, 2007) recommends services should be user-led and VCS organisations should be involved in the design process. Similarly, the Newcastle evaluation suggest in developing future projects it is important to ensure the involvement and commitment of key strategic partners alongside partners that understand the project management and service delivery (ERS Research and Consultancy, 2013). Constantine (as cited in Branding and House, 2007) also emphasises the need to establish good working relationships between referrers and VCS providers, as referrers' interactions with clients can influence the engagement of the client. Finally, the report highlights concerns among VCS providers about having sufficient funding, given increased referrals and the sustainability of services (Constantine, 2007, as cited in Brandling & House, 2007).

A common theme across evaluations was the usefulness of having social prescribers in primary care settings (Community Action Southwark, 2015). Projects where this was built in already found it was a good way of engaging both staff and patients. In Newcastle, health care professionals suggested this would be a useful approach and

plans for implementation were being developed (ERS Research and Consultancy, 2013).

Several reports highlight the importance of the individual link worker in working with participants, and statutory and voluntary organisations (Brandling & House, 2007; Community Action Southwark, 2015; Friedli, n.d.). The Dundee evaluation found the skill of the individual link workers was a key aspect in successful pilots (Friedli et al., 2012) suggesting time should be taken to ensure the link workers/coordinators have the right skills mix. As such, they state ***"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, p. 69).

A recurring theme for primary care professionals across evaluations was, prior to social prescribing, knowledge about the range and quality of activities and support services available was patchy. The social prescribing service provided an up to date list, which could be more easily accessed by GPs and patients (ERS Research and Consultancy, 2013; Friedli et al., 2012). However, the Southwark evaluation suggested while GPs are often enthusiastic about SP 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). Moreover, as SP often involves a broad range of partners, the Southwark report recommends developing a strong brand to raise the profile of the project and draw organisations together. Finally, cooperation between sectors and organisations was viewed as important as some people may have limited experience of SP and its benefits. They suggest the link worker or coordinator can have an important role in ***"championing social prescribing, and liaising between health professionals and VCOs"*** (ERS Research and Consultancy, 2013, p. 3).

The Bath feasibility study identified a number of issues based on existing knowledge. These are:

- Resource implications of increased referrals from primary care for voluntary organisations
- Ensuring joint ownership of schemes across the sector
- Addressing cultural differences between the sectors
- Addressing differences in working practices and styles
- Ensuring that everyone involved is clear about the purpose and value of the work (Edmonds, 2003, p2).
- Prioritising services where need is identified, for instance high resource users
- Equitable access
- Developing the confidence of local practitioners in the service
- Flexibility
- Service evaluation (Brandling & House, 2007).

Processes

Several reports recommend service users and stakeholders, in particular the CCG and public health, are involved in the development of the SP service to promote shared ownership of the project as well as increase uptake (Institute for Voluntary Action Research, 2014; Kinsella, 2015).

The Newcastle Evaluation report argues having an inclusive steering group was beneficial, although it also slowed down progress. Furthermore, in designing governance structures it is important to ensure the reporting mechanisms are clear, the structures are resourced effectively and flexibility is designed in to reflect emerging priorities (ERS Research and Consultancy, 2013, p. 65). The report also recommends:

- Learning from previous initiatives and national guidance is reviewed and embedded
- Robust project management is resourced to ensure that plans are implemented in a timely and effective manner, and
- Systems are implemented to mitigate the impact of staff turnover

(ERS Research and Consultancy, 2013, p. 66).

In relation to the operation delivery of SP, Friedli (n.d. p. 53) state ***"the main barrier was a lack of capacity to co-ordinate referrals and record activity and outcomes, and so bring coherence to the local schemes"***. In this regard the Newcastle evaluation argued ***"central coordination of referrals and management is important"*** (ERS Research and Consultancy, 2013, p. 69).

The recommendations for development were:

- Development of a social prescribing care pathway flexible enough to meet the needs of different geographic and demographic area profiles;
- Improved social prescribing co-ordination to manage the efficiency and effectiveness of the service across the locality and between referrers, providers and patients; and
- Social marketing of social prescribing to promote benefits and increase use

(Friedli, n.d., p. 53).

Due to the limited time available to GPs, several reports recommend there are quick and simple systems in place for GPs to make referrals (Southwark, Wirral). Moreover, it would be beneficial if referrals could be made through their online system EMIS (Southwark). Finally, time should be taken to understand the potential demand for the service and the capacity of local VCS organisations to respond, including organisations funded through the programme and those that are not (Community Action Southwark, 2015; Kinsella, 2015).

Conclusion

Social Prescribing is a relatively new health and social care intervention, consequently there is a dearth of evidence, in particular empirical peer reviewed research. This notwithstanding, there are clear messages from the evaluative evidence with recommendations regarding definitions, models, referral routes, activities, evaluation methodologies and outcome measures.

With regard to definitions of SP, existing evaluations have largely centred on primary care patients receiving non-medical interventions. The Brightlife model is innovative as it encapsulates a broader social orientation which is in line with the overarching Brightlife philosophy of reducing social isolation among older adults. This differing emphasis on social aspects is both a strength and a challenge, which requires continuous monitoring as part of the Test and Learn process.

Brightlife have adopted a model of SP aligned with the holistic distinction in Kimberlee's (2013) typology, which emphasises a person centred approach to addressing social isolation. Referral routes adopted in existing SP services are dependent upon the definition and model adopted. As such, there is an emphasis on primary care referrals, in particular GPs. The Brightlife model adopted, as indicated above, takes a broader social approach and consequently referrals are received from a wider range of organisations.

A plethora of activities have been available in existing SP services, for example befriending, physical activities, and advice services. Brightlife have also commissioned a broad range of activities not too dissimilar to what already exists in the literature. As part of the Brightlife evaluation a co-researcher has developed pen portraits of the pilot areas adopted by Brightlife, which include detailed information regarding the demography of the areas. This could be utilised alongside the asset mapping information to aid the commissioning of future services.

In relation to measuring well-being one of the limitations of existing evaluations is the relatively small sample sizes typically between 16 and 87 participants. Whilst the commonly cited Rotherham evaluation recruited over 1800 participants, this study

failed to adopt a validated measurement tool. As such, it is difficult to draw any realistic conclusion regarding the effectiveness of SP as an intervention. This limitation reinforces the necessity of adopting a robust study design incorporating validated data collection tools and recruiting sufficient participants.

The existing evaluations highlight factors likely to improve services user engagement, insights for professionals and embedding the right processes in design. These recommendations offer valuable insights to be considered, however it should be noted that the existing SP services reviewed here all have varied aims and objectives and are located within a broad health framework.

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