



BRIGHTLIFE LEGACY REPORT
10. BRIGHTLIFE EVALUATION:
SOCIAL PRESCRIBING

*Evaluation
status report
(Three)*

The University of Chester Evaluation Team

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PART 1: Background

1.1 Aim

The aim of this report is to formally update the Brightlife Partnership Board regarding the progress and ongoing experience of Social Prescribers (SP) and to evaluate the continued development of this service.

1.2 Background

This report is the fifth in a series of reports relating to Social Prescribing that has been provided over the course of the evaluation (two of which have provided literature review and pen portraits, and three of which have been evaluation reports from interviews). This strand of the evaluation adopts a purely qualitative approach aiming to understand the experience of the Brightlife Team who are directly involved in the delivery of the Social Prescribing initiative.

Data was collected via a focus group interview conducted in July 2017 with four members of the social prescribing team. The SPs were all female with an average time in post of 10 months. To protect anonymity, participants will be referred to as either Social Prescriber (SP) 1, 2, 3 or 4, however these numbers do not identify individuals, nor the geographic locations in which they work.

In keeping with the test and learn ethos, findings and recommendations have been reported to the Partnership Board and Brightlife Management Team verbally on an intermittent basis, with this report providing the formal feedback mechanism. However, there are no new emerging themes from the data in this current report. Therefore, rather than conducting further interviews/focus groups of Social Prescribers 'learning events' have been suggested as an alternative.

PART 2 Results

A summary of the key findings is provided below. It should be noted that some quotations used to illustrate key points in the focus group discussion are the perceptions of the SPs; these observations have been reported in this document, however are not substantiated with evidence.

Five main themes emerged from the analysis, very similar to those in the previous social prescribing reports:

- SP role and development
- Role boundaries
- Referrals and signposting
- Questionnaire and discharge challenges
- Activity provision.

2.1 Social prescribing role and development

The SP's perceptions of the role were consistent with the findings from interviews in May 2016 and November 2016. SPs reported feeling more comfortable and established in the role and observing successful outcomes for participants. Equally, a perception of benefitting from a better familiarity within assigned geographical locations:

'I think we are all a lot more established now in the communities than we were... I know when I go around [location deleted for confidentiality], lots and lots of people know me, and I go into the local libraries and the health centres, and I bump into some of the GPs and health professionals and certainly, Brightlife's name is a lot more round there now than it was' (SP3).

Furthermore, SPs perceive an increase in public awareness of the role and of Brightlife:

'People are remembering us because we are out there in the community all of the time when we are not socially prescribing, when we are out there in the community, either attending groups or in the library, or different community venues and events and things like that, so certainly people are thinking about Brightlife a lot more now I think than they were six or seven months ago' (SP3).

During time in post, SPs have been encouraged by observations of perceived positive outcomes in participants. They believe the work has been key in aiding participants in attending activities; one reported observing participants who now have the confidence to join in with activities, have increased self-confidence and overall happiness:

'...because she knows people and feels confident and you can just see it in her face, her demeanour' (SP1).

SPs shared experiences of a number of cases, reflecting on the variation observed within the work areas. One SP discussed examples where social isolation 'crept up' on an individual following bereavement or change, describing observations of the person coping by themselves for a while but then losing confidence to move forward. Another SP spoke of examples of recently bereaved people who had become socially isolated following a decrease in family support due to demands of other responsibilities. SPs also raised concerns about carers at risk of social isolation following the death of the person they had provided care for, one paraphrasing a recent encounter:

'I am a carer for my husband, what do I do when he goes? I won't have that job anymore' (SP2)

Although Brightlife have agreed referral pathways, the SPs discussed there was no formal definition or criteria to determine who was at risk of social isolation, particularly amongst partners and referrers. SPs explained the subjective nature meant they heavily relied on experience and perceptions; thus, the importance of building a good rapport with potential participants was necessary:

'...every situation, everybody you see is completely different, absolutely there's no two-people's situation the same' (SP1).

SPs also perceived some people's personalities mean they were at risk of social isolation. Equally, some people could be quite resistant to social prescribing, stating they considered those who have enjoyed an independent lifestyle or who have never partnered (by choice or not) as potentially being at risk. SPs also discussed the risk of social isolation in people who were very reliant on networks for support:

'...whether it's a neighbour or a friend or family members, when that network suddenly goes they are suddenly at massive risk' (SP3).

The SPs also perceive participants' mental and physical wellbeing are intrinsically linked, and have observed improvements in some participants partaking in social prescribing activities, for example:

'When you manage to get a [positive] outcome for someone with such complex health issues, you know actually to see them chatting and smiling and saying 'I have never had so much fun, I have never laughed so much in years', that has got to be a great outcome hasn't it?' (SP1)

Previous reports noted perceptions of health improvement and increased social networks were based on anecdotal reports, and requested SPs gather more formal evidence to support these claims. It was noted SPs are now completing contact sheets at each visit to record outcomes. SPs are also writing case studies for the purposes of feedback to the Social Prescribing Working Group which, along with the contact sheets, will provide supportive evidence of improvements and quotations from participants. It was also noted SPs consider the support and monitoring data provided by the Brightlife Data Analyst was invaluable, particularly for fieldwork.

2.2 Role boundaries

Very little was discussed in this focus group regarding role boundaries, however SPs did identify some related issues. In the previous round of interviews, SPs identified the need for, and challenges of ensuring personal safety when visiting participants. SPs described the importance of keeping a professional distance from participants and to employ strategies to ensure SP physical safety. There was a shared perception by SPs that since employment of the most recent SP Manager, improvements had been made with respect to assessing the level of need of new participants to identify those with complex needs, or who may pose a threat to SP safety. The importance of understanding the needs of new participants with mobility and/or mental health conditions were discussed as part of SPs forming an effective work plan whilst maintaining SP safety.

However, one example shared at this focus group suggested the level of need information is not always accurate, with SPs recalling a potentially unsafe situation involving a male participant with a record of violence. However, upon meeting this person (working in a pair of SPs) the man was found to be very pleasant and unlike the potentially challenging profile that was supplied. Although risk assessments and the lone working policy was not discussed during this focus group, a recommendation has been suggested to consider these important areas.

In addition to the variation in level of need accuracy, it was acknowledged that it was difficult for SPs to pre-determine the profiles of self-referred participants. SPs also perceived there to be a reduction in inappropriate referrals, and this had helped manage staffing when visiting participants for the first time.

The SPs all agreed the role involved highly emotive and difficult situations, and on occasion it was necessary for additional support to be available for SPs to debrief:

'We do talk about [support] in supervisions don't we and team meetings. We talk about it so... and that's all you need to do really. You just need to know that there is somebody that you can just talk to when you come across those situations' (SP1).

All SPs acknowledged a noticeable improvement in support provide by the newly appointed SP Manager and spoke very highly of the role in the Social Prescribing Working Group. When the SPs were asked if they had confidence in the SP Manager, all replied with positive enthusiasm:

'Oh yes very much so...Absolutely, 100% I have' (All SPs).

It was not discussed if SPs had received formal training on how to maintain professional boundaries and avoid becoming emotionally involved with participants, as highlighted in the first report in September 2016. At the time of the second wave interviews (November 2016), there had not been sufficient time to embed the recommendations of the previous report. However, the new SP Manager has now introduced regular supervision and the above feedback on support is very encouraging.

2.3 Referrals and signposting

In the previous (second – November 2016) social prescribing report, it was noted in the period between the first and second interviews (May 2016 and November 2016), the referral route to Social Prescribing had changed significantly. Initially, the Brightlife pathway required referrals from GP practices, which SPs continue to receive. However, an increase in referrals from a range of additional organisations including churches, charities supporting individuals with Parkinson's or dementia, the Citizen's Advice Bureau, hospital discharge teams, social workers and the Fire Service had commenced. The Brightlife team have since forwarded data of participant numbers from each referral pathway.

Table 3 lists the number of referrals received from GPs, churches, Fire service and Charities across the Brightlife region and demonstrates the majority of referrals for the 12-month period between June 2016 and June 2017 have consistently been from GPs and Charities.

Table 1 Participant referral data

Referrer	Number of referrals (June-Dec 2016)	Number of referrals (Jan-June 2017)
GPs	31	26
Churches	1	2
Fire service	2	2
Charities	30	32

In this focus group, the SPs agreed most referrals are now coming from the Health Sector, although there have not been any via the Egton Medical Information Systems (EMIS). The SPs all commented they perceive a trend of participants with more complex needs being referred, many with mental health conditions (for example Schizophrenia, Bipolar). SPs again stressed the importance of referrers providing an indication of the participants' level of care needed to ensure the best outcome for the participant, and for SP safety. It was not discussed how best practice for SP safety could be established.

Generally, when referrals have come from GPs, SPs perceive the level of need provided is adequate, however SPs explained the level of need is often underestimated by specialised health professionals who are dealing with one health issue of a patient. SPs have assumed in these cases, the level of need is likely to be above that provided. Likewise, although the numbers of self-referral participants were reported as decreasing, SPs noted assessment of the level of need was not known until a good relationship and rapport had been developed. The level allocated to an individual indicates the amount of support required as detailed in the table 4 below:

Table 2: Level of need requirements

Level	Requirement
Level 1	Participants primarily require signposting to activities, either by telephone or during a face to face meeting.
Level 2	Participants require a face to face meeting and support to attend activities.
Level 3	Participants require ongoing and more intensive support.

SPs clarified at Level 1, the work is usually restricted to signposting to appropriate agencies, and perceive they have taken a step back from previously reported befriending of participants. They also stated there is a clearer understanding of the role boundaries now.

SPs stated many GPs have reported improvements in patient wellbeing and are now readily making referrals as a result of the SP intervention. SPs noted quite a number of referrals that do come from GPs are for patients who are affected by anxiety and depression.

In areas where there is a Wellbeing Co-ordinator, SPs found people are being signposted to specialist support groups, and then referred to the SP for mainly social aspects. Where there is no Wellbeing Co-ordinator, the SP is making the link with the relevant specialist support group. When referrals come via community matrons who support people with long-term health conditions, the SP is able to work with the matron in making joint visits to assess the social needs of potential participants. SPs then work with participants to build confidence and motivation to reconnect with the community. There was no mention of the process of how SPs communicate the process of discharging the participant from social prescribing.

One SP also explained a number of referrals have come from the hospital social work team, who oversee discharge from hospital and can identify people who could be at risk of social isolation. This SP reported good outcomes from these referrals.

Another SP reported a Health Centre Practice Manager in one of the Brightlife areas has initiated a meeting with the SPs and is interested in continued involvement between the Practice and Brightlife. The Clinical Commissioning Group (CCG) was also reported by one SP as recently taking a more pro-active approach. SPs perceive the positive outcomes achieved from the work is clearly being recognised by the community and health providers, with one SP stating:

‘People are seeing the outcomes and I think one of the care facilitators who refers onto me quite a lot (and they all go to the MDT meetings) said that I am the only organisation that actually gets the services, you know, gets people seen fairly quickly, spends time with people. They can see outcomes, that I am reliant and [have] got a good reputation, you know, all those kinds of things’ (SP1).

In previous reports, the SPs referred to an eligibility criteria to take part in a Brightlife activity; they reported the criteria had relaxed between the 1st and 2nd interviews (May and November 2016) so participants need only meet one criterion now rather than the previous two. SPs reported this has facilitated access to a greater number of older people. SPs in the focus group continued to use the word ‘criteria’, however it is unclear if they were referring to a screening tool for social isolation, or to the established level of need scale. They stated potential participants need only meet one criterion to be eligible and this was currently working in practice. In the SPs’ experience, they have observed people who are socially isolated always meet at least one of the eligibility criteria. Further discussions are required to clarify this point.

2.4 Questionnaire and discharge challenges

In the last report (June 2017), questionnaire completion had improved significantly between the interviews in May and November 2016. This was reflected in both the number of questionnaires completed and the quality of data collected; there were fewer unanswered questions. Feedback from the focus group suggested CMF completion continued to be problematic. SPs raised concerns the CMF may not accurately reflect the outcomes or progress made from baseline questionnaires, with one SP explaining that participants experiencing a low mood or deterioration in health on the day of the survey could devalue a positive social prescribing experience. One SP reflected on a recent participant who had a positive experience with Brightlife, but had concurrently experienced poor health and a change in family support, which resulted in negative reporting on her CMF. SPs reported they sometimes find themselves explaining the purpose of the CMF to participants, including the importance of an accurate reflection of their experience and reassuring those with

memory loss. SPs also reported they know of occurrences where family or carers have completed CMFs on behalf of a participant.

A number of difficulties were reported by SPs when discharging participants. Concerns were raised in the previous report (June 2017) regarding difficulties experienced when completing the discharge form if an individual has a change in circumstances. In the focus group, SPs perceived the difficulties in completing discharge forms could be as a result of the following:

- Participant is referred at a point when their health is deteriorating regardless of SP interventions. These participants can remain with the SP for a considerable time and not be discharged.
- Participant is moved into care or have been so unwell that is it inappropriate to complete discharge; it was not explained why it was inappropriate. Sometimes the SP can pre-empt this and plan to complete the exit evaluation, however in other cases the change in circumstances can be sudden.
- Participant does not want to engage in discharge.
- Participant does not respond to a letter from SP asking to be part of the evaluation – the letter states if there is a lack of response within 2 weeks, the assumption will be they do not want to be part of the evaluation. SP then discharges the participant.

The SPs also reported difficulties in completing exit evaluations when a participant has either begun with a Royal Voluntary Service Buddy or has begun an activity with one of the commissioned services. SPs explained in some circumstances, rather than the responsibility for the CMF and exit evaluation being passed to a commissioned service provider, it remained with the SP regardless of whether they are actively working with the participant or not. Difficulties were also expressed regarding discharge of participants, particularly related to timing of discharge and with participants who were involved in multiple activities. SPs advised a solution was being discussed within the Brightlife team. Subsequently, discussions have been held with the evaluation team and a proposed trial of 3 months will begin in March, whereby participants will be discharged more timely.

2.5 Activity provision

The provision of activities was perceived to have improved by all the SPs. Directories of both commissioned and non-commissioned activities were reported as being used to good effect. Some Community Compass activities, particularly in the Malpas area, have become self-sustaining, which is a successful achievement. However, there was some confusion about identifying which activities were commissioned by Brightlife and which were non-commissioned. The SPs also raised concern about sustainability of activities for one provider, and the lack of information regarding future planning for some involved:

'I have got two ladies who come to my drop-in that went to the [deleted for confidentiality] classes and they have finished now and they absolutely loved them, they thought they were fantastic, they have got the enthusiasm and the motivation, which we wouldn't want to lose but even the [deleted] instructor, the tutor, didn't know what was happening next' (SP2).

The 'Storyhouse' event in Chester was considered by the SPs to be very successful and raised awareness of the diverse and ground-breaking work that Brightlife was undertaking. One SP described its impact:

'I think that really gave us, a kind of kudos really. I think it really got people that came to the drop-in on the back of going there and people that already knew about Brightlife that had been there and said you know it was just amazing, I think it's really given us more credibility really' (SP2).

The challenges with recruiting volunteers, and in particular buddies, in one of the Brightlife project areas was raised by the SPs. However, on a more positive note, collaborative work with community connectors was felt to have been a success. The community connectors have dropped leaflets in Lache, Chester and Malpas. SPs also reported an initiative of one of the community connectors who set up an IT activity in one area.

SPs reported they now utilise an activity feedback form to record any change in the processes, such as if a commissioned activity is purported to be different from its original description.

PART 3 Discussion and Conclusion

3.1 Discussion and Conclusion

The perception of the SP role in the focus group was consistent with the findings from the previous interviews conducted in May 2016 and November 2016. Initially viewing the role as linking people to social groups, the SPs now believe the main focus is to reconnect people with the community, signposting to (and where necessary) supporting people in joining groups or activities where they can meet others. Although very little was discussed regarding SP role boundaries, there was recognition that fundamental to inspiring participant confidence and motivation to reconnect with the community, is the need for SPs to build rapport with the participants.

SPs also reported feeling more established within the assigned geographical areas and comfortable in the role, and attribute some of this to the employment of a new social prescribing manager. SPs perceived positive outcomes such as increased self-confidence and overall happiness for participants engaged in socially prescribed activities. They have also perceived a strong link between mental and physical wellbeing in the participants. SPs reported being recognised by the public in the community, both on and off duty, and perceive there to be an increased public awareness of the SP role. Provision of activities was considered to have improved by all the SPs and directories of both commissioned and non-commissioned activities were being used to good effect. SPs noted some activities had become self-sustaining, however sustainability remained a sizable concern for SPs across all areas.

Despite these positive outcomes and increased experience in the role, SPs reported difficulties in providing a formal definition or suggesting clear criteria of who was at risk of social isolation. Furthermore, in subsequent discussions, SPs have indicated many partners and referrers do not have a clear understanding of social isolation and a wider, shared understanding of social prescribing needed. SPs noted new participants now need meet only one of the eligibility criteria to take part in a Brightlife activity, however it is unclear if they are referring to a specific criterion that indicates the level of social isolation, or the level of need requirements. SPs perceived the current procedure was working in practice, however further clarification is required to establish

what is being used. There remains a large amount of variation in participant circumstances, and the subjective nature of the work often means that SPs remain heavily reliant on personal experience and perceptions of people to provide appropriate referrals. Many successes are due to building a good rapport with participants to understand the short and long term needs of individuals. Although this is often very time intensive, this person-centred approach has proved very effective and has enabled SPs to develop a deeper understanding of the range of people potentially at risk or affected by social isolation.

While many of the issues identified in previous reports have been addressed, some continue, including challenges with completing the CMF questionnaire. SPs have adopted the use of contact sheets and writing case studies in order to gain more detailed feedback in addition to the CMF. It is anticipated these documents will provide real (rather than anecdotal) evidence of participant benefits. Interestingly, SPs have observed some potentially false negative feedback being reported by participants who are experiencing a 'bad day' due to a decline in health or change in circumstances on the day of questionnaire completion. Whilst it is too early to compare data from the new monitoring methods, early indications suggest the SPs perceive the detail in contact sheets and case studies could provide a better reflection of any benefits participants may be experiencing, particularly when used in conjunction with the CMFs. In addition to the difficulties noted with participant completion of CMFs, there was also some discussion about the inconsistencies of data when carers have completed the survey on behalf of the participant. SPs also raised concerns of retrospective completion of CMFs. The inclusion of quotations from the participant to illustrate evidence of recorded outcomes could be very helpful, however they acknowledged a potential conflict with role boundaries in completing this task.

In previous interviews, SPs described the need and challenges of keeping a professional distance between themselves and participants. All SPs acknowledged the role involved potentially highly emotive and difficult situations which could be best managed by providing SPs with details of patient mobility and mental health conditions and the level of need assessment, prior to the meeting new participants. SPs shared that on occasion it was necessary for additional support to be available to SPs to

debrief and the Social Prescribing Manager had introduced regular supervision and feedback meetings for support. SPs all agreed that the employment of the new Social Prescribing Manager had also led to an improvement in assessing the level of need of new participants, which have aided in minimising inappropriate referral, manage staffing, and ensuring SP safety.

SPs reported most referrals are now via the Health Sector, observing a trend of participants with more complex needs, many with mental health conditions (for example Schizophrenia, Bipolar). There has also been an increase in referrals from a range of additional organisations including churches, charities supporting individuals with Parkinson's or dementia, the Citizen's Advice Bureau, hospital discharge teams, social workers and the Fire Service. SPs all emphasised the importance of referrers providing an indication of the level of care required to ensure the best outcome for the participant and for SP safety. SPs perceive GPs are currently providing the best indication for level of care for referrals, whereas specialists generally underestimated due to a focus on only one health issue in patients. Self-referred participants are decreasing, however are still proving difficult to assess, with SPs relying on experience to best judge the level of need required. It is unclear what tools SPs use to assess the level of need in new self-referred participants.

Difficulties with discharging participants remains a concern with SPs reporting health deterioration and lack of engagement in evaluation as the main concerns in the focus group. These difficulties have been reported by SPs at Brightlife team meetings and a solution is currently being considered by the Head of Brightlife.

One other initiative shared by SPs was that Brightlife have considered the option of videoing 1:1 interviews, so participants with deteriorating health and/or memory will be able to tell their story. It is thought this will also help participants to reflect on their experience and potentially see the value of the project from a personal perspective.

Based on the available evidence and progress from the previous reports, a number of recommendations are provided in the following section.

3.2 Recommendations

For:

- SPs to continue to gather supportive evidence regarding health improvement and increased social networks via contact sheets or case studies.
- The continuation of regular meetings to share best practice, ensure consistency of approach, and provide feedback opportunity and support to SPs.
- Continued analysis of monitoring data in relation to referral pathway and participant level of need and guidance on appropriate levelling of need.
- Review of lone working policy and risk assessments to ensure SP safety.
- Further guidance for local professionals on appropriate referrals, in particular geographic boundaries.
- A mechanism to measure/screen if participants have received appropriate medical assessment and clearance if they have self-referred.
- Clarification of level of need allocations.
- Procedures and guidance to enable participants to be discharged from the service.
- Clarification of terminology for 'criteria' for being considered socially isolated and 'level of need'.

For consideration to be given to:

- Sustainability of activities once a commissioned activity has been completed.
- Leaflets/marketing material of commissioned activities to continue to be made available to SPs for distribution to participants.

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