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# BRIGHTLIFE LEGACY REPORT
# 15. SOCIAL PRESCRIBING

*Literature Review*
*Summary Report*

The University of Chester Evaluation Team

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# Introduction

A review of social prescribing delivery models was conducted by University co-researchers, who undertook both the search for, and review of, relevant literature. An iterative approach to the review was adopted with key learning being communicated during the process, which contributed to a revision to the Brightlife social prescribing model. Additionally, the whole evaluation team also worked concomitantly with Brightlife social prescribing staff, in learning sets, to encourage reflexivity and critical debate. The aim was to facilitate Brightlife revising the social prescribing model it had been operating and develop a sustainable social prescribing service.

Rather than provide an in-depth academic discussion about social prescribing, this document summarises the main findings of the co-researchers' review of the key published reports. This paper includes information regarding:

- the background of social prescribing
- the main approaches to social prescribing
- the link worker role
- eligibility and referral
- evaluation

# Background

In response to the increasing pressures on the National Health Service (NHS) in terms of funding, workforce challenges, and increasing patient demand, the NHS Long Term Plan highlights the importance of new ways of working (NHS 2019). Social prescribing is not a new concept, indeed occupational therapy has utilised non-clinical interventions for many years and the Bromley by Bow Centre launched its social prescribing service in 1997 (Independent Nurse 2015). However, given that estimates propose 20% of patients who visit their GP are presenting with social rather than purely health related problems (The Social Prescribing Network 2016) social prescribing may be an effective way of relieving pressure on already stretched GP practices. Consistent with this, Matthew Hancock, Secretary of State for Health and Social Care, has strongly supported an increase in social prescribing services (The Guardian 6.9.18) and the NHS Comprehensive Model of Personalised Care advocates social prescribing with the aim of 900,000 people having access to social prescribing by 2023/2024 (NHS 2019).

# Definition of social prescribing

While there is clear political support for social prescribing services to be widely available, it is important to highlight that, at the time of writing; there was no commonly agreed model. A review of social prescribing services conducted in 2016 by Bickerdike et al. (2017) found a variety of approaches; however, in its pure form social prescribing typically involves GP practices referring patients who are directed to non-clinical services for support in addressing their needs and wellbeing (Bickerdike et al. 2017).

The following definition was developed at the 2016 Social Prescribing Network Conference:

*"A means of enabling GPs and other frontline healthcare professionals to refer patients to a link worker - to provide them with a face to face conversation during which they can learn about the possibilities and design their own personalised solutions, i.e. 'co-produce' their 'social prescription'– so that people with social, emotional or practical needs are empowered to find solutions which will improve their health and well-being, often using services provided by the voluntary and community sector." (Social Prescribing Network Conference Report, 2016, page 19)*

This definition emphasises the link worker role, however, the Kings Fund (2017) provides a more concise definition:

*"Social prescribing, sometimes referred to as community referral, is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services." (Kings Fund 2017)*

A key difference between the definitions is that the Kings Fund's definition recognises that not all social prescribing services will utilise link workers.

While definitions may vary, common features of social prescribing services are typically:

- An aim to improve health and wellbeing
- GP and primary healthcare staff refer to locally based non-clinical services
- Non-clinical interventions/services are delivered by public sector, third sector or voluntary organisations
- Services are client centred

Direction to appropriate services is often performed by link workers who should have extensive knowledge of services available in the local area.

## Social prescribing models

This paper does not facilitate an in-depth discussion of all social prescribing models and will instead offer summaries of the most common approaches. Research into social prescribing conducted by Kimberlee (2015) defines three common social prescribing models, light, medium, and holistic (See Figure 1).

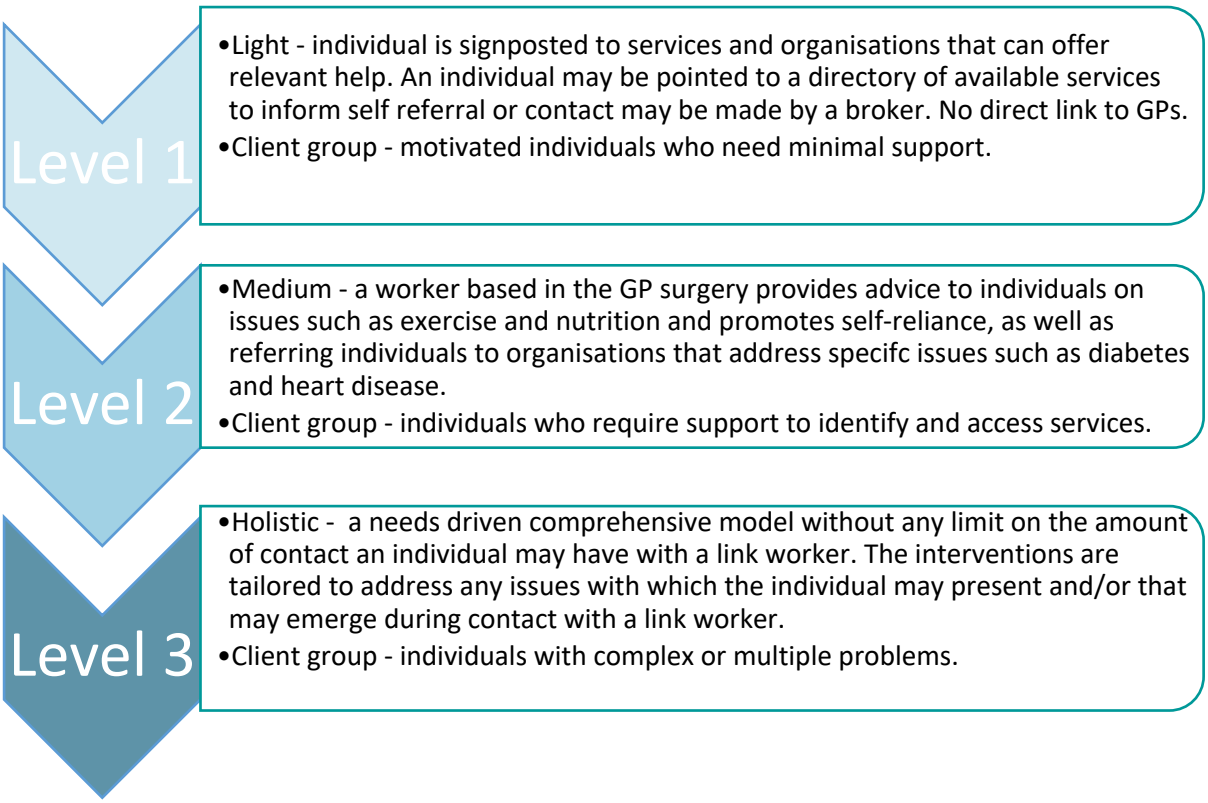


**Figure 1 Social prescribing models (Kimberlee 2015)**

Dayson (2017) reports a model of social prescribing that further builds on the holistic approach described above calling this model "social prescribing plus". The features of this model include multiple referral pathways from a variety of health settings, and a range of available prescribed services and activities that are specifically developed for the scheme. The Rotherham Social Prescribing service typifies this approach as a product of the CCG working strategically with the voluntary sector covering the whole CCG area of Rotherham. The service has access to a large network of different groups and organisations, facilitating patients with a wide choice of activities (Local Government Association, 2016, page 10).

The Social Prescribing Network (Social Prescribing, 2016, page 20) characterises social prescribing as having two dominant models:

1. General Practice based with inbuilt social prescribing

2. CCG/local authority wide model that provides a service to GPs rather than being an intrinsic part of a GP practice.

Dayson also describes a model of social prescribing in which initiatives are delivered at smaller geographic scales, involving GP practice and a neighbourhood or local community organisation.

## Link workers

Social prescribing services often involve the input of "link worker"[1]; link workers can be described as intermediaries who receives referrals from health and social care professionals and directs service users to services, offering additional support to those who need it. The link worker is often viewed as a key factor in the success of social prescribing, especially where service users have complex needs or require support to access appropriate services (Bertotti et al. 2018; Impetus 2015; Kimberlee 2016); indeed Kimberlee (2015) categorises social prescribing models based on the level of input from link workers.

Polley et al. (2017) highlight the complexity of the link worker role stating:

*"The link worker role demands a broad range of skills, as well as the ability to work independently and proactively with people" (page 36).*

According to Laing et al. (2017) link workers need to be able to engage, empathise, listen, empower and motivate individuals without being judgemental, noting that link workers for the Newcastle "Ways to Wellness" social prescribing service were drawn from differing employment backgrounds, including, community development work, health promotion, and welfare rights advice. Link workers may also need skills specifically relevant to working with the target population. As an example, in the City and Hackney social prescribing service, which targeted service users with mild to moderate mental health problems, link workers had psychology, psychotherapy and coaching experience, as well as advanced listening skills (Bertotti et al. 2018).

The training required by link workers should logically be related to the service aims and the target group. For example, link workers employed on the "Ways to Wellness" scheme, which took a holistic approach with service users with long-term and multiple health conditions, underwent a 10-day training programme (Laing et al. 2017). Although, Laing et al. report link workers indicated that their initial training sessions were insufficient in preparing them for the complexities of the work.

Volunteers may be a valuable resource in delivering social prescribing services; Friedli, Jackson, Abernethy, Stansfield (2009) advocate utilising volunteers in social prescribing services, suggesting they fulfil tasks such as signposting, administrative support and programme coordination. Volunteers may also work as link workers; the Brighton and Hove service uses trained volunteers as link workers in its Community Navigator Social Service programme (Impetus 2015: 2017). However, there is no consensus regarding the feasibility of engaging volunteers as link workers. Attendees of a workshop during the 2016 Social Prescribing Network Conference report that given the demanding person specification it is:

*"Unrealistic to think volunteers could take on such a linking role" (Social Prescribing Network Conference Report 2016, page 23).*

[1] A profusion of job titles are used for this role: these include link worker, health advisor, health trainer, care navigator, community navigator, community connector, social prescribing coordinator, wellbeing coordinator, social facilitator, and community care coordinator.

However, given that the Brighton and Hove Community Navigators, who were volunteers, had high-level skills with most having work experience in counselling, healthcare, teaching and social services, this view may be specious.

Considering the plethora of social prescribing models, it is logical that there is also wide variation in how link workers fulfil their role. For example, where people are motivated to address issues and services are available, they may need very few meetings with a link worker (Polley et al., 2017). The Brighton and Hove Community Navigator Social Service reports for the period April to September 2017 it provided 5.2 average hours of support time, with 3.3 sessions per person on average, and 13 weeks average case length (Impetus 2017). However, the service also reports seeing an increasing number of complex cases, which require more support with an average of 9.5 support hours. Short-term intervention is common with Kensington and Chelsea, which offers participants six sessions (Kensington and Chelsea Social Council and NHS West London CCG, 2018), and Luton community navigators arrange a 12-week prescription (Local Government Association, 2016).

In other services, link workers spend consultation time with a person, together exploring needs and goals, which may require a number of visits before the person is confident to act on his/her own. City and Hackney service users had six sessions of up to 40 minutes with link workers to discuss and co-produce a wellbeing plan leading on to referral to services (Bertotti et al., 2018). A long-term approach is exemplified by the Newcastle "Ways to Wellness" programme (Laing et al., 2017) where the majority of service users have more than one long-term health condition and other problems such as low confidence and social isolation. The service involves assessment and six-monthly re-assessment as well the development of a bespoke action plan and the promotion of self-care, and service users are supported to access community services. Link workers are able to maintain contact with a service user based on their need; this could potentially be for up to two years. In an evaluation of the Gloucestershire CCG Social Prescribing Service, Kimberlee (2016) found 103 days to be the mean time a service user was engaged with the service with the longest recorded period being 280 days. The average recorded number of contacts with a service user was five; although one received 37 contacts.

It should also be noted that not all social prescribing services utilise link workers; Morton, Fergus and Baty (2015) evaluated a social prescribing model in Fife where health professionals working in secondary care referred service users directly to social activities/classes; six different classes were available. Referrals were made by psychologists, community nurses, occupational therapists and other allied healthcare professionals. The service was advertised on a website and individuals were able to self-refer to the activities.

## Referral and eligibility

Logically, referral mechanisms should be consistent with the service and the target population so will vary accordingly. In the main, referrals are made by a range of primary care healthcare professionals; typically, these are more likely to be formal written referrals. However, other referral sources include secondary care, community sources, and self-referral (Dayson, 2017). A guide to social prescribing commissioned by NHS England notes that:

*"Sometimes a link worker may also refer back to a health professional, if they identify someone who needs crisis support" (Polley, Fleming, Anfilogoff, Carpenter, 2017, page 42).*

Dayson (2017) proposes that identifying appropriate service users may be made based on clinical need, informal assessments or referrer discretion. Logically, social prescribing services

may have eligibility criteria defined by the aim of the programme and the target group. As examples, the Glasgow Deep Den project uses social prescribing to support patients with complex health needs who live in a disadvantaged location (Mercer et al.2017) and the "Ways to Wellness" programme in Newcastle focuses on people with long-term health conditions (Williams, 2013). The Kensington and Chelsea service again focuses on individuals with long-term health conditions but restricts the service to those aged 65 and over. This service also classifies individuals into three tiers:

Tier 1: one well managed long-term condition
Tier 2: two long-term conditions, mental health or social care needs
Tier 3: three or more long-term conditions, mental health or social care needs
(Envoy Partnership 2018, page 7)

Other social prescribing services are less specialised, addressing a wide range of psychosocial issues and accepting a more diverse range of service users. In such cases, a triage system may be useful to screen potential service users for eligibility and need. For example, Brighton and Hove staff visit potential service users in their home and conduct an in-depth goals based assessment (Impetus, 2015).

Polley et al. (2017) offer clear guidance on the information that should be included in a referral. This includes clarity regarding why the referral has been made, any risk factors, what the service user wants to address, and how and when feedback to the referrer should take place.

## Evaluation

A key issue regarding sustainability and future commissioning of social prescribing is how effective a service is in achieving its aims and objectives. At the time of writing, evaluations and reviews of social prescribing services were of mixed quality with a lack of clarity or robust evidence regarding the effectiveness of social prescribing (Dayson 2015; University of York 2015; Bickerdike et al. 2017). Dayson (2015) and the University of York (2015) argue that there is little in the way of supporting evidence of effect to inform the commissioning of a social prescribing programme. Although, Bickerdike et al. (2017) also highlight that, due to flaws in the evaluation designs, neither are they able to state that social prescribing is ineffective. A systematic review conducted by Bickerdike et al. (2017) highlights numerous issues with social prescribing evaluations. The authors note that there were examples of flawed study design with weaknesses including lack of validated psychometric measures, poorly timed review/follow-up of participants, and poorly controlled studies that were unable to assign outcomes to interventions due to participants undertaking multiple activities in parallel. Nonetheless, they highlight that:

*"Despite these methodological shortcomings, most evaluations have presented positive conclusions, generating a momentum for social prescribing that does not appear to be warranted." (p 15).*

However, it is important to highlight that social prescribing operates in a "real world" setting and, while well-designed, controlled studies are important for robust evaluation, individuals lead "messy lives" and have multiple needs that may need addressing in a variety of ways by

numerous agencies. Thus, it is useful to explore some of the reported outcomes from social prescribing services, while bearing in mind issues regarding the methodology adopted.

Kimberlee's (2016) evaluation of the Gloucestershire CCG social prescribing service is not included in Bickerdike et al.'s (2017) systematic review and it adopts a more robust methodology utilising validated psychometric scales. As measured by the **"**Short Warwick and Edinburgh Mental Wellbeing Scale", there was a statistically significant increase in service user wellbeing as measured on the scale. There was also evidence of reduced emergency hospital admissions and GP appointments for social prescribing service users. Kimberlee also examines return on investment suggesting that for each £1 invested a return of £1.69 is achieved (health £0.43, social £1.36). However, it should be considered that this includes falls and suicide prevention returns, which is problematic as prevention can only be estimated and not measured.

Morton et al.'s (2015) evaluation of Fife social prescribing was also not included in Bickerdike et al.'s review, because it did not involve primary care. Morton et al. report positive outcomes in terms of reduced anxiety and depression, improved mental wellbeing and self-efficacy (measured using validated scales) and positive feedback from service users and referrers.

The Brighton and Hove Community Navigators evaluation report, which takes a less academic approach utilising self-report and non-validated surveys, proposes a number of positive outcomes for the service**.** (Impetus 2015). In a survey of GP and practice, staff 87% stated they thought the service improved patient wellbeing. Similarly, 84% of patients self-reported improved wellbeing; this figure rose to 95% for patients with mild to moderate mental health issues. The report also includes positive feedback from Community Navigators (link workers) and service user case studies. Based on assumptions extrapolated from the evaluation of the Penwith and Cornwall social prescribing service evaluations, Impetus suggests a net cost saving of £1365 per service user for the service being delivered and states that if the service was scaled-up for the whole city:

*"1.36 million per year of GP time could be put to more effective use by providing the Community Navigation service as part of the Primary Care offer in Brighton and Hove" (Page 37).*

Bertotti et al. (2018) suggest that social prescribing is beneficial for individuals who need support and motivation noting that service users reported increased self-esteem and motivation to address their health and wellbeing.

It is important to consider, therefore, that lack of evidence in the effectiveness of social prescribing services may be related to the design of both services and their subsequent evaluations, rather than the impact of social prescribing per se. Moreover, it may be unrealistic to expect to be able to implement controlled or quasi-experimental evaluations; the paradox is that such approaches produce robust findings that can be utilised to inform the future development of social prescribing.

## Discussion

The initial concept of social prescribing was a service where clients visited a GP, or a worker located in a GP surgery, and where appropriate, were prescribed a social rather than a clinical intervention. The intervention would be for a fixed period and the client would be reviewed after that period to assess the outcome of the social prescription. However, in practise, social prescribing evolved into a complex service with myriad different delivery models. Indeed, as this short summary of social prescribing highlights, there is a lack of consistency regarding what social prescribing is, what it delivers, to whom, when, for how long, and the role of the link worker.

Numerous models of social prescribing exist, which render it difficult to evaluate services and compare their effectiveness, efficiency and value for money, creating difficulty for commissioners. Conversely, it can be argued that it is the bespoke nature of social prescribing that makes it attractive to service users and providers. Taking a middle ground, Polley et al. (2017) propose a balance between optimum contact time with service users and arbitrary lengths of service. Nevertheless, if social prescribing is to become an established mainstream service it is necessary for commissioners to have a clear vision of the service they require. It is also important that referrers do not utilise social prescribing as a "catch-all" or "last resort" service for use when clinical interventions have failed or are not readily accessible. To facilitate effective and efficient service delivery, commissioners need to be clear regarding services expectations, supplying guidance on:

- Eligibility criteria for the service and assessment processes
- Service user contact time, e.g. length of meetings and number of meetings per service user
- Maximum cost of intervention per service user
- Assessment and monitoring processes and tools; wherever possible, to facilitate robust evaluation, validated measures should be utilised at consistent points during engagement with service users

Additionally, considering the key role link workers have in social prescribing services it is essential to properly explore what skills, knowledge, and competencies are required to be effective in this role (Bertotti et al 2018).

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