Faculty of Health and Social Care
The Centre for Ageing Studies
University of Chester

BRIGHTLIFE LEGACY REPORT
5. BRIGHTLIFE EVALUATION: SOCIAL PRESCRIBING

Evaluation status report

The University of Chester Evaluation Team

Originally June 2017

Table of contents

List of Tables

PART 1 Background

1.1 Aim

The purpose of this report is to update the Brightlife Partnership on the implementation of the Social Prescribing pilot and help inform the next phase of development. It is the third in a series of reports relating to Social Prescribing

This strand of the evaluation adopts a purely qualitative approach aiming to understand the experiences of the Brightlife Team who are directly involved in the delivery of the Social Prescribing initiative. The aim is to identify and understand challenges and enablers faced by staff during their involvement with the Social Prescribing intervention.

PART 2 Methods

2.1 Semi-structured interviews

To identify and understand the issues involved in designing and implementing social prescribing semi-structured interviews were commenced with the three social prescribing team members. The interviews were conducted in November 2016, six months after the first wave of interviews in May 2016. Interviews were undertaken by co-researchers.

Table 1: Interviewee details

Role	Time in post	1st interview	Follow-up interview
Social Prescribing Co-ordinator	12 months	May 2016	November 2016
Social Prescribing Co-ordinator	12 months	May 2016	November 2016
Social Prescribing Co-ordinator	7 months	May 2016	November 2016

To protect anonymity, the Social Prescribers will be referred to as either SP One, Two or Three, however these numbers do not correlate with the table above and the geographic locations they work in have not been identified. Individuals taking part in Social Prescribing will be referred to as Social Prescribing participants (SPPs).

2.2 Data Analysis

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

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

PART 3 Results

Five main themes emerged from the analysis; 1. the perceptions about the Social Prescribing role, 2. role boundaries and supervision, 3. referrals, 4. use of the questionnaire and 5. activity provision. A summary of the key findings is provided below.

3.1 The Social Prescribing role

The Social Prescribers' (SPs) perception of the role was consistent with findings from the interviews in May 2016; the primary aim of the role being to help reduce social isolation in older adults (aged over 50) by signposting and encouraging SPPs to engage in activities in their local area. SPPs are encouraged by the SP to engage in activities they have previously enjoyed or to develop new interests.

The SPs perceived offering participants a non-medical intervention regularly leads to improvements in health, levels of self-worth, self-confidence and levels of motivation. In addition, participants had also developed new friendships and experienced an increase in their social networks. One SP commented:

> ***We are connecting communities as well, so people within the community also become responsible for others because we are developing those friendships (SP1).***

Numerous examples were provided of Social Prescribing making a difference to people's lives. For instance:

1. One SP described a man aged 91 who previously wouldn't come out of his room[1] but is now coming down for coffee and going with the SP to walking football.
2. Another described a woman who said the 'drop-in' has been ***'an absolute tonic'*** and who thanks the SP weekly for making such a difference to her life. The same woman said previously she didn't think she'd ever dance again and, even though she had only danced a few steps, was going home to tell her family what she had achieved.

Perceptions of health improvement and increased social networks were based on anecdotal reports, which suggests there is a requirement for SPs to gather more formal evidence to support these claims. Some of this information is captured in the evaluation via the Common Measurement Framework and will be explored during qualitative interviews, however SPs could gather SPPs comments or write-up case studies, for example.

Having gained more experience, one SP said ***"the person-centred approach"*** is what makes the role successful. She went on to comment:

> ***I know we have our forms and what have you but not being overly structured in how we address the individual…it is very much about active listening and then responding and reacting to what the client…sort of being driven by the client and what their needs are rather than trying to make what we have fit. It's very much a person-centred approach (SP1).***

3.2 Role boundaries and supervision

In comparison with the interviews in May 2016, SPs were now much clearer about the boundaries of their role. One SP described how when she first started there was a tendency to perform a befriending role rather than Social Prescribing per se. During

[1] Unable to clarify living arrangements, although quotation suggests living in sheltered accommodation

the early stages of the project there were also fewer SPPs, which enabled more time to be invested with individuals. This SP is now trying to retain a sense of professional distance between herself and participants making clear the role is to introduce them to activities, rather than befriend.

Two of the SPs described becoming increasingly aware of the need to keep a professional distance between themselves and SPPs. Whilst retaining professional distance had presented challenges, all three SPs suggested they had made improvements in this regard. For example, one SP described a participant who could be particularly challenging. To protect herself, she arranged to meet in a public place. She said:

> ***Sometimes it is about managing risk. For example, this particular lady (sic) can be a bit accusative so I meet her in a public place…you can always adapt and find some way of working with somebody that has got complex needs (SP2).***

Another example related to a man who, not being able to get an appointment with a female GP (reason unexplained), asked the SP (a female) to visit him at home. The SP described feeling uncomfortable and refused his request as it was beyond the scope of the role. The individual concerned became agitated at this refusal. While the SP manager has begun to provide further support on role boundaries via regular supervision, it is suggested in order to provide greater clarity perhaps a formal Brightlife policy would assist SPs.

The SPs, as previously stated, are aware of the role boundaries and employ strategies to ensure they stay safe. All three indicated they find mutual support among one another:

> ***I am the sort of person who needs to offload so I feel I can do that with my colleagues. As you know, the job can be quite isolating so I have kind of made a conscious effort. We were talking about where I have my base. I have made a conscious effort to go into the office and so I feel that I am***

more part of the team. The other social prescribers are fantastic and I feel that I can discuss issues with them (SP3).

As of September 2016, the SPs had not received formal training on how to avoid becoming emotionally involved with SPPs or attended regular supervision to share their concerns and receive support. This was highlighted as a priority in the first report in September 2016. At the time of the interviews reported here, there had not been sufficient time to embed the recommendations in the previous report. However, the new Social Prescribing Manager has now introduced regular supervision.

3.3 Referrals

In the period between the first and second interviews (May 2016 and November 2016) the referral route to Social Prescribing 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 have commenced, although routes for such referrals vary between the three areas. One SP estimated receiving referrals from thirty-two different local organisations. The monitoring data collected by Brightlife indicates the majority of referrals across all three areas are received from the health sector (*n*=73), followed by self-referrals (*n*=71), charitable organisations (Health and Well-being Co-ordinators) (*n*=51) and the Local Authority (*n=31)* (Brightlife, 2017). The SPs suggest they are receiving referrals from a wider range of organisations due to better local establishment and promotion of Brightlife. For example, organising promotional days at GP surgeries, attending flu clinics, having banners and adverts in place, making links with a wide variety of other relevant organisations, charities and health professionals and distributing Brightlife's promotional items appears to improve referrals.

The SPs receive referrals by a number of routes; telephone, e-mail and self-referrals. In the case of telephone referrals, the SP will mostly complete the referral form during the conversation. E-mail referrals are integrated into the Egton Medical Information System (EMIS) used by GP practices and have therefore simplified the referral

pathway in primary care. The SPs emphasised the importance of a simple referral pathway and removing any perceived barriers to referring participants.

All the SPs reported an increase in self-referrals. There was a perception, on the whole, individuals who self-refer are already motivated to engage, are more easily signposted to activities and more likely to be able to travel independently. Perceptions about individuals who self-refer were based on anecdotal reports suggesting there is a need to gather further evidence about the differences between SPPs based on their referral pathway. This information could be obtained by analysing monitoring data.

Although on first acquaintance individuals who self-refer may not necessarily present as being socially isolated, the SPs find all participants have ***'a story to tell'*** and the self-referral is potentially effective in preventing future social isolation in some of these SPPs. As one SP reflects:

> ***They might look like a clear sign-posting but they have all got a story [about] why they come to the drop-in and you don't necessarily find that out immediately. I think it has identified those who potentially could be at risk of becoming lonely or isolated (SP1).***

The SPs also receive referrals from existing SPPs who know other individuals who they feel could benefit from Brightlife. In those situations, the SPs do not directly approach the individual but suggest the referrer provide contact details so the person could self-refer, if they wished.

Inappropriate referrals were reported to be low. Where inappropriate referrals had been received this was largely due to the individuals having complex needs, for example serious mental health issues, or living outside of the pilot project areas. The geographic boundaries have caused some difficulties, in particular for the SP in the Chester area where not all wards are covered by Brightlife. There are 15 wards in Chester, and Brightlife operates in four of these; Boughton, Upton, Lache and Blacon. Professionals working in Chester, in particular, GPs, may not be aware of the project geographical boundaries and, therefore may be unsure of who is and is not eligible to be referred into the service.

The SPs also highlighted the eligibility criteria to take part in a Brightlife activity has been relaxed between the 1st and 2nd interviews (May and November 2016) so SPPs have to meet one criterion rather than the previous two; this facilitated access to a greater number of older people. Reflecting on experience, the SPs reported while an individual may be referred on the basis of meeting one criterion, in practice further conversation frequently reveals that individuals meet more than one; this is especially the case with individuals who have self-referred.

A further policy change between May and November 2016 allowed individuals receiving palliative care to be considered as potentially eligible. The policy change was welcomed by SPs who argued if an individual receiving palliative care wanted to engage with Brightlife and could be supported to do so, they should be able to participate. However, SPs were aware there were limitations to the role and the extent of help they could provide. In such cases where the support required was beyond the scope of the Social Prescribing role, it was suggested the best option for the individual was to refer them to another service or back to the original referrer.

Regarding participants' medical fitness to take part in activities, SPs suggested medical fitness was more easily assessed when referrals came from GP surgeries or other health and welfare agencies. In situations of self-referrals, SPs found most individuals were happy to share their medical history during the first meeting. In situations of particularly complex needs, the SPs were occasionally unable to accommodate the individual in a Brightlife programme; likewise, for individuals who live outside the designated areas. The recognition some older people would be better supported through alternative services is further evidence that SPs are clearer about the boundaries of the role, as discussed in the previous section.

Concerns remain over determining whether new SPPs should be allocated to Level One, Two or Three to determine the appropriate degree of intervention. The level allocated to an individual indicates the amount of support required. Level One participants primarily require sign posting to activities, either by telephone or during a face to face meeting. Level two participants require a face to face meeting and support to attend activities, either and Level Three ongoing and more intensive support. The SPs reported judging level of need could be challenging, particularly with self-referrals

where additional needs might be revealed further along the referral pathway. One SP was also concerned over the level of consistency across the team in ascribing levels commenting:

> ***This is something that we need, I think, to discuss more with the manager, because there was, with all the social prescribers, inconsistencies in what we perceived to be a level one, a level two, so I do think we need to highlight a little bit more (SP1).***

The SPs suggested discussing level of need with the Social Prescribing Manager would assist consistency and we understand this is now taking place with the introduction of regular supervision. An independent audit of level of need allocations may also provide greater clarity on consistency across the team.

Concerns were also expressed over difficulties experienced when completing the discharge form if an individual has a change in their circumstances, for example, one SP commented:

> ***Discharge forms are quite difficult because many of my clients have been discharged because they have moved into 24-hour care or they have passed away. So, yes, I think simplifying that process will help (SP2).***

No clear procedure for discharging SPPs from Brightlife services is available, therefore guidelines would assist how this might be accomplished. Greater consideration in maintaining manageable caseloads as the number of SPPs increase is also necessary. Governance and ethics, to ensure transparent distribution of resources also needs to be considered as part of this management process.

3.4 Questionnaires

Reflecting on the interviews in May 2016, the SPs reported confusion over who should initiate filling in the questionnaire had been resolved and there was an understanding that all questions must be answered. 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

are fewer unanswered questions. Initially, completing the questionnaire was often left to the second meeting, however more recently SPs had begun to introduce the questionnaire during the first visit, after the participant had the chance to ***'tell their story'***. Some SPPs were content to complete the questionnaire themselves, however often it was found to be more effective to read the questions aloud and complete the answers on the SPPs behalf.

While most SPPs were pleased to answer the questions, each SP had developed an individual approach to asking the more sensitive questions. For example, one SP commented:

> ***I always explain beforehand how valuable this is and thank them. I explain about the research and let them know beforehand if the question is quite sensitive but it is relevant to the research and that some of them are kind of repeated aren't they? Again, that is relevant to the research. I just emphasise how grateful we are for them taking part because it will help shape the future of older people (SP3).***

In order to increase the response rate, SPs found it helpful to explain some questions might be perceived as sensitive and emphasised the value of the questionnaire responses in gathering information to help other older people. Despite this clarification, it was reported some SPPs had difficulty understanding the research aspect or were suspicious of it. There were also some very vulnerable older people, such as those with dementia, who could not always respond to the questions. In such cases, it was found to be helpful to have someone else present who was known to the individual to assist with completion of the questionnaire.

Reflecting on questionnaire completion, SPs described how the questions encourage SPPs to think about the situation and what they might change, as illustrated in the following quotation:

> ***Some of the questions … are bringing things to the forefront aren't they, really if you think about it? What is one of the questions? Do you look forward to every day? Well it makes you think doesn't it? It makes you***

think well 'I don't really, I don't look forward to every day'. I do actually see it like that and nobody has actually said to me that I am evaluating their life but I think it is a real sort of wakeup call really (SP3).

Another SP suggested responding to the questions prompts individuals to evaluate their lives, to reminisce and to remember aspects they had previously enjoyed, activities they had been able to participate in and such reflection can in itself be confidence building, motivational and cathartic. The SPs went on to comment SPPs have observed how much they have appreciated having someone actually listen and take an interest in them as individuals. The SPs therefore feel listening helps with confidence building and added this also increases the SPPs confidence in being involved with Brightlife as a whole.

The completion of consent forms was also highlighted as a challenge, particularly as a number of SPPs had asked why they needed to complete a consent form for each intervention they participated in. Although the rationale was explained, SPs suggested often participants did not understand the methodological reasoning. In the interim period between the November 2016 interviews, the process of questionnaire (CMF) completion and consent has been rationalised. SPs will now complete pre and post questionnaires with SPPs who are no longer required to complete an additional questionnaire if they attend a Brightlife commissioned activity.

3.5 Activities

The provision of activities within the different Brightlife areas is variable. All three SPs recognise they cannot rely exclusively on Brightlife commissioned activities to accommodate social prescriptions. Indeed, in Chester no commissioned activities were available at the time of the interview (November 2016).

Well established drop-in sessions where the SP had a strong presence in the local community are considered a good way of introducing older people to Brightlife and building up a relationship that can lead to engagement in other activities. The drop-in sessions also provide an opportunity for the SP to interact with individuals who have been referred into an activity at a later date, as explained in the following quotation:

Making sure that all the commissioned activities are ready to go so that the social prescriber can … go back in two weeks and say 'oh I have a befriender' (SP1).

Cheshire Wildlife Trust provided a range of activities such as bird watching, painting, nature walks and bee keeping. While these activities have been enjoyed by some, the SPs suggest these activities are not suitable for individuals with mobility issues and/or limited access to transport. This also applies to many of the non-commissioned activities, including the Malpas walking group. The lack of suitable activities presents challenges when trying to encourage individuals to engage in Brightlife. Community Compass and the drop-in sessions are therefore considered to be particularly important in Malpas; noteworthy activities included seated exercise, creative writing and craft sessions.

Strong local knowledge is essential when signposting SPPs to potential activities; the Salvation Army's community programme is considered to perform much worthwhile work with older people. Non-commissioned activities seem to be particularly well mapped in Winsford, however mapping and capturing appropriate activities is a significant challenge in larger geographical areas.

As Brightlife is based on a person-centred model it is important the SPs can draw on a wide range of activities. This was recognised in the first Social Prescribing report produced in September 2016 and the SPs continue to draw on pro-active approaches when seeking a diverse range of activities. For example, one SP describes the necessity of tailoring activities towards individual needs, commenting:

A lot of people that I come across in a situation where they need to be working with an organisation that is a bit more specialised for their needs. So, I work very closely with the Cheshire Carers', the Alzheimer's, the Parkinson's, all those kinds of organisations really. So, it is linking people with the communities (SP3).

The Local Information System for Scotland[2] (ALISS) for mapping activities provides a useful tool in seeking appropriate activities in different geographical areas. However, it is of limited value if it is not updated regularly, which suggests there is a need to develop a formal, rather than ad hoc, process for updating the ALISS. ALISS also requires internet access, which is not always available when visiting SPPs. The use of electronic tablets is currently being trialled to determine if this is a more feasible option. For now, SPs face continual technological challenges to maintain detailed and updated information on current activities across a large urban area, including those areas where there are no commissioned activities. In practice the SPs construct their own directory of activities, often distributing leaflets to SPPs as tangible material to reflect on following a SP visit.

Lack of transport remains a challenge in all three locations, but especially in rural areas. The 'Community car scheme' in Malpas, 'Plus Bus' in Chester and 'Dial a Ride' in Winsford are useful services for older people without transport. It is hoped the Befriender scheme will assist with mobility issues and also reduce the challenge for SPs currently transporting participants to activities, thereby enabling them to focus on priorities more relevant to their role.

Sustainability of commissioned activities was also a source of anxiety for SPs, particularly when successful activities come to an end. In this regard, it was suggested sustainability and the continuity of activities should be considered as part of the commissioning process.

PART 4 Discussion and Conclusion

4.1 Discussion and Conclusion

While some of the issues identified in the report produced in September 2016 have been addressed, there are some that continue (Mead et al., 2016). Nonetheless, it does not appear any additional challenges have arisen since the last report.

[2] Now UK wide

There remains a clear understanding of the aims of the Social Prescribing project. In addition, there appears to be better reflection on the health benefits of social prescribing. SPs also appear to have an increased understanding of the professional boundaries of the role and have taken practical steps to ensure they work within them.

In comparison with the first report in September 2016, there is greater acceptance to utilise the scheme among local professionals and the organisations they represent. Previous evaluations have emphasised the importance of ensuring those agencies and professionals involved are clear about the purpose and value of the work (Community Action Southwark, 2015; ERS Research and Consultancy, 2013), this appears to have improved in the SP areas. The monitoring data also suggests there has been an increase in referrals from a range of organisations. In particular, the first report highlighted situating SPs in the primary care setting is key to generating referrals. Moreover, it is important for GPs to have quick and simple systems in place to make referrals (Community Action Southwark, 2015; Kinsella, 2015). The Social Prescribing referral form is now available via the online system EMIS in some GP practices. While GP engagement remains a challenge, there have been improvements in the number of referrals from Primary Care.

There have been substantial improvements in the way in which SPs approach questionnaire completion. While it is too early to compare the perceptions of SPs with the monitoring and evaluation data, early indications suggest the number of completed questionnaires and the quality of the data collected has improved.

Availability of commissioned activities SPs can refer participants to remains a challenge, although new providers have recently been commissioned in the Chester and Winsford areas. Transport and sustainability remain challenges for social integration in communities.

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

4.2 Recommendations

For:

- SPs to gather formal evidence regarding health improvement and increased social networks. For example, SPP commentary or case studies.
- The establishment of regular meetings to share best practice and ensure consistency of approach, whilst recognising this needs to be tailored to the locality
- A formal policy on role boundaries
- Analysis of monitoring data in relation to referral pathway and participant need, e.g. signposting or intensive support.
- Further guidance for local professionals on appropriate referrals, in particular geographic boundaries.
- A mechanism to ensure SPPs have received appropriate medical assessment and clearance if they have self-referred
- An independent audit of level of need allocations
- Further guidance on appropriate levelling of need
- Procedures and guidance to enable SPPs to be discharged from the service
- A formal process for continual update of the ALISS system.

For consideration to be given to:

- Sustainability of activities once a commissioned activity has been completed,
- Coverage of transport to reduce barriers for SPPs accessing activities
- Faster pathways for the commissioning of activities so SPs have activities available to offer SPPs
- Leaflets/marketing material of commissioned activities to be made available to SPs for distribution to SPPs.

.

4.3 Endorsements

- Provision of avenues of supervision within Brightlife to provide a safe place for sharing concerns and receive support
- The commissioning of the Befriending Service.

References

Brightlife. (2017). Social Prescribing: Qtr 4 Report April 2016 – March 2017. In. Cheshire West and Chester: Brightlife.

Community Action Southwark. (2015). Social Prescribing. In. London: Community Action Southwark.

ERS Research and Consultancy. (2013). Newcastle Social Prescribing Project: final report. In. Newcastle: ERS Research and Consultancy.

Kinsella, S. (2015). Social Prescribing: a review of the evidence. In. Wirral: Wirral Council Business & Public Health Intelligence Team.

Mead, R., Taylor, L., Whiteley, K., Marsland, J., Bailey, J., & Kingston, P. (2016). Social Prescribing: evaluation element organisational process data. In. Chester: Centre for Ageing Studies, University of Chester.