SOCIAL PRESCRIBING IN THE EAST MIDLANDS

2019 Survey Results and Regional Case Studies

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TABLE OF CONTENTS

EXECUTIVE SUMMARY - EMAHSN

Within the East Midlands in 2018, a variety of Social Prescribing models were organically growing – each being individually shaped by different local resources and approaches. The East Midlands Academic Health Science Network (EMAHSN) noted the emerging evidence of the impact of Social Prescribing services on improved patient outcomes, reduced GP attendance frequency and reduced prescribing. In order to identify how best EMAHSN resources could be best utilised to facilitate Social Prescribing it was key to understand the current services and models in place across our region.

EMAHSN commissioned The University of Leicester (UoL) in January 2019, to review current Social Prescribing activity across the region. The research involved the creation of exemplar case studies from each of the counties in the East Midlands and the development of a survey tool designed to identify the range of Social Prescribing schemes in use and their core components. This report outlines the results of the research.

This commission coincided with the publication of the NHS Long Term Plan which commits to building an infrastructure for Social Prescribing, with creation of new Social Prescribing link workers, and a referral system to these services. Social Prescribing link workers are now an integral part of the multi-disciplinary teams in Primary Care Networks (PCNs), and are part of the additional roles in the five year framework for GP contract reform, as well as being included in the Network Direct Enhanced Service Contract for 2020/21.

The survey tool

This report and survey tool offers a unique insight into the local Social Prescribing service provision and models in the East Midlands. The questions used in the survey were carefully developed and designed by the UoL research team and EMAHSN with input from over 100 attendees of an EMAHSN Social Prescribing Event held in May 2019 and from a series of interviews.

The bespoke survey questions (which do not include the case studies aspect of this report) will be made available for colleagues in the East Midlands and through other regional AHSNs for independent use to support continued benchmarking of Social Prescribing services. Stakeholders can use the survey which has been designed to enable the independent collection of data at an organisational level (for example STP or ICS) or regional level. An example of the survey questions can be found in Appendix 1.

Data collection

EMAHSN distributed the survey in a targeted way across the regional STP and ICS areas, to those who manage and deliver social prescribing services and received 57 responses. This report therefore only represents a snapshot of the services provided across our region, as some service providers may not have participated or not fully completed the survey. However, the results act as a useful representation and tested the survey which is now available for independent use by these partners.

Key findings

The survey was developed from information obtained from the case studies, as well as the pilot feedback, it aimed to be comprehensive, including topics related to the structure and delivery of social prescribing across the region. From those that responded a number of key findings emerged:

- There were inequalities in the provision of social prescribing between the counties, with only four out of the six delivering social prescribing at the time of the survey.

- Many social prescribing schemes were in their infancy with only half being in operation for less than a year and had taken a relatively small number of referrals.

- ***For existing social prescribing schemes there are a broad range of referral pathways into the service, primarily from GPs, but also the police, community pharmacists, the fire service and social care.***

- For a number of schemes, referral systems were not linked with GP systems and some still used paper-based methods.

- ***Referrals more often focused on anyone deemed appropriate and relatively few schemes offered support to young people and in particular those under the age of 16.***

- The majority of organisations delivered a variety of training to link workers, however only one offered public health training. This is significant because social prescribing is part of the public health agenda.

- Clinical supervision was given to link workers in just over half of schemes, in spite of NHS England guidance which states that it should be regularly available.

- Just over one quarter of organisations offered training to local agencies delivering social prescribing services.

- Only half of the schemes had been evaluated. Loneliness and isolation and return on investment were the most frequent outcomes measured in evaluations.

Thematic analysis

A thematic analysis of the qualitative responses to the survey was conducted in order to establish frequent barriers and enablers experienced by providers, as well as key lessons.

- Barriers were funding, relationships between different organisations and sectors, the ability of the third sector to cope with referrals, and public perception of social prescribing.

- ***Three key lessons emerged. These were understanding the importance of voluntary organisations within this service delivery, constructive and positive relationships between the different sectors and organisations involved in the service, and robust referral criteria.***

- Enablers were funding, strong partnership working, and recognition of the ability of social prescribing to reduce the burden on healthcare services.

Case study findings

The report contains five case studies from Derbyshire, Nottinghamshire, Leicestershire, Lincolnshire and Northamptonshire. These provided detailed insight into a variety of models, as well as the unique benefits and challenges brought by each.

The case studies demonstrated that there is no 'one-size-fits-all' approach to how social prescribing services are delivered and managed, and that there are multiple models and delivery formats that can be successful.

In particular, however, good integration between sectors and adequate support for voluntary organisations receiving referrals appeared to be key in allowing schemes to run efficiently.

Recommendations

- Areas (ICS/STP or at a regional level) to consider using the survey tool to gain an insight into their Social Prescribing services, and to identify and share examples of the different types of models existing locally.

- ***Areas (ICS/STP or at a regional level) to consider using the survey tool to benchmark the development of their Social Prescribing services and to track changes and new service developments over time. Commissioners / Funders / Service Managers / PCN Networks to consider undertaking an annual survey of their social prescribing services.***

- The results of the survey should be shared to support the understanding of service models, as well as the sharing of good practice and networking support.

1. INTRODUCTION

SOCIAL PRESCRIBING

Around 20% of patients consult their GP for psychosocial problems (Low Commission, 2015), whilst 15% visit for welfare and benefits advice (Torjesen, 2016). However, despite this it has been argued that psychosocial issues and long-term conditions can be better managed in the community (Carrier & Newbury, 2016). Social prescribing is 'a mechanism for linking patients with non-medical sources of support within the community' such as charities, the voluntary sector, and community groups (Adbowale et al., 2014), all of which can offer an alternative to the traditional medical models and reduce the burden on the NHS. This is also in line with the National Institute for Health and Care Excellence (NICE, 2016) guidance, which endorses community engagement as a strategy for health improvement.

Social prescribing schemes often employ a link worker who uses a range of techniques such as shared decision making, personalised care, and planning support to empower patients to connect to community groups and other agencies for social (i.e. debt, benefits, employment advice and training) and emotional support (i.e. local voluntary groups and befriending services) (NHS England, 2019a). Social prescribing interventions are often targeted at people in socioeconomically deprived areas, broadening the options available for primary care when patients present with needs related to wider social determinants of health (Friedli, Jackson, Abernethy & Stansfield, 2008). Our research has found that these patients are often the most frequent GP attenders with the greatest complex needs (Lynch & Jones, 2019).

BENEFITS OF SOCIAL PRESCRIBING

The evidence base for the benefits of social prescribing is growing, despite some methodological limitations such as a lack of controlled study designs (Bickerdike, Booth, Wilson, Farley & Wright, 2017). Reviews so far have suggested that there are a range of psychological benefits for patients accessing social prescribing including empowerment, increased self-esteem, confidence and sense of control, improved mood and psychological/mental well-being, and reduced symptoms of anxiety and depression. As a result of social prescribing patients can also become more active in managing their conditions leading to less reliance on the NHS, particularly for marginalised groups such as mental health service-users and older adults at risk of social isolation (Thomson, Camic & Chatterjee, 2015). In addition to this, accessing a broad range of community-based services can help patients to self-manage long-term chronic conditions and reduce health inequalities, particularly for vulnerable and socially deprived groups who face barriers to accessing appropriate health services (Carrier and Newbury, 2016, Trappenburg et al., 2013).

Social prescribing has also been found to have a positive impact on the wider health care system. Evaluations of social prescribing schemes have found reductions in A&E attendance and demand for GP services (Kimberlee et al., 2013), as well as a reduction in secondary care referrals (Brandling et al., 2011). Our own research, an evaluation of a 5-month social prescribing pilot across 3 GP practices in South Wales, demonstrated a reduction in GP consultations and prescriptions and found a direct cost saving of £8,109 (or £77.22 per frequent attender) (Jones & Lynch, 2018). In terms of the wider determinants of health, social prescribing results in higher rates of employment and has a mean social return on investment of £2.3 per £1 invested in the first year (Polley, Bertotti, Kimberlee, Pilkington & Refsum, 2017).

SOCIAL PRESCRIBING AS A NATIONAL PRIORITY

Social prescribing is a current priority for the UK's Health and Social Care Secretary. As a result of this NHS England is leading a dramatic expansion of social prescribing as a way of relieving the pressure on primary care services and improving patients' chances of recovering from ill-health. Social prescribing is referenced in the long-term plan, with NHS England currently in the process of recruiting and training 1000 social prescribers or 'link workers' by 2021. In addition to this, more link workers will be recruited incrementally over the next 5 years with an overall aim of 900,000 patient referrals by 2023/24. Recruiting link workers is a 'priority target' of the government's personalised care plan, with link workers set to be embedded in the newly formed primary care networks (PCNs).

Policy guidance states that social prescribing connector schemes are to be locally and collaboratively commissioned by partnerships of primary care networks, clinical commissioning groups (CCGs) and local authority commissioners, working with the voluntary, community and social enterprise (VCSE) sector and patients, their families, and their carers. However, whilst social prescribing link workers will be attached to general practices and PCNs they may be employed by local social prescribing connector schemes, typically hosted within the VCSE sector. In addition to this, connector schemes may also be hosted by other agencies, depending on local partnerships (NHS England, 2019a).

Despite the guidance on social prescribing, there is variation regarding how the different models can be translated into practice within the PCNs. For example, whilst link workers should be attached to general practices and PCNs, they can also be employed by local schemes hosted within the voluntary sector or other agencies depending on local partnership arrangements (NHS England, 2019a). The variation among different models can be attributed to social prescribing schemes being driven by the specific demand and types of referrals to existing community/voluntary sector organisations, which differ across localities. At one end of the spectrum there are narrow interventions that focus on the prevention/progression of chronic diseases (i.e. diabetes), which primarily involve targeted life-style interventions (e.g. nutrition, physical activity or medicines management). At the other end of the spectrum, there are a large number of schemes which focus on the social determinants influencing health outcomes and social connectivity activities (e.g. groups and social support) (Killingback, Tsofliou & Clark, 2017, Catalan-Matamoros, Gomez-Conesa, Stubbs & Vancampfort, 2016). These schemes tend to employ different techniques to support behaviour change (e.g. motivational interviewing, goal setting and coaching), as well as using connective activities in order to support individuals (e.g. community groups and social support).

CURRENT STUDY

EMAHSN commissioned UoL to identify the range of social prescribing schemes that are currently being employed across the East Midlands and understand their core components, referral pathways, and local partnerships.

AIMS

- To develop a survey tool which identifies the range of social prescribing schemes and their core components across the East Midlands.
- To identify areas of best practice through exemplar case studies for each region.

2. METHODOLOGY

CASE STUDIES

Qualitative interviews (*n*=12) were conducted with key stakeholders involved in social prescribing across the East Midlands region. Participants were purposefully sampled (Patton, 2015) for their involvement in the design and/or delivery of social prescribing programmes. Interviews were transcribed verbatim and interviews and key documents such as evaluation reports were triangulated and analysed in order to identify the core components of the social prescribing models and develop in-depth case studies (Yin, 2012). Case studies are presented in section 3. Further analysis was conducted to compare and contrast the core components of each case study and these are presented in table 1.

SOCIAL PRESCRIBING SURVEY SCOPING TOOL

Key policy documents were reviewed (NHS England, 2019b,c,d) in order to identify guidance on models of social prescribing and their core components. The results of this and the core components identified in the interviews with key stakeholders were used to develop a pilot survey scoping tool.

A co-production engagement event was held in May 2019 in Derby, hosted by EMAHSN. A range of practitioners involved in social prescribing attended the event, including representatives from the third sector, primary care, clinical commission groups, pharmacists, DWP workers, and patient representatives. The aim and purpose of the project was introduced and participants (*n*=80) were asked to fill out a paper copy of the pilot scoping survey tool. Participants were asked to discuss and feedback on:

1. *Comprehension*
    - Are the questions relevant/appropriate?
    - Are the questions easy to understand?
2. *Content*
    - Are the any topics/questions that need to be included?
    - Are there any topics/questions that are not relevant?
3. *Usefulness*
    - How would you use the results?

The survey tool was then revised by the research team to incorporate the feedback. The final survey tool (Appendix 1) was a 43-item questionnaire which included checkboxes and free text questions. It covered topics including; demographic information, PCNs, social prescribing priorities, referrals, current social prescribing services, workforce development, agency training, clinical supervision, strategic partnerships, evaluation, outcomes, and future activity. The survey was administered from the 1st of November 2019 to the 16th of December 2019. A comparison of the East Midlands by region is presented in section 4. Thematic analysis of the qualitative comments is presented in section 5. The total responses breakdown is presented in Appendix 2.

3. CASE STUDIES

DERBYSHIRE: EREWASH VOLUNTARY ACTION (CVS)

BACKGROUND

Erewash Council for Voluntary Service (CVS) is a charitable organisation that was established in 1998. It promotes and assists with effective voluntary action in the borough of Erewash, a government district in eastern Derbyshire covering 42 square miles and with a population of approximately 115,500 residents (Erewash Borough Council, 2020). Erewash has a significant ageing population, with 19% of residents being of pension age (3% more than the national average) (Derbyshire County Council, 2020).

Erewash CVS is a company limited by guarantee, meaning that all profits are invested in projects to improve the local community. It has close links with the community of Erewash and is actively involved in assisting with its development in order to meet individual and community-level needs. A large part of this involves supporting local groups to achieve their aims, as well as representing them at local, regional and county events. The CVS currently supports around 450 local groups and 900 volunteers. As part of the 'Wellbeing Erewash' NHS vanguard project, social prescribing was introduced in Erewash through its Community Connectors scheme.

SOCIAL PRESCRIBING SCHEME

There are two social prescribing schemes currently delivered by Erewash CVS. One of these is a voluntary social prescribing project, the Community Connectors scheme, whilst there is also a more formal social prescribing service delivered by employed link workers. Both of the schemes are available for a wide range of individuals, and not just those suffering from medical conditions. For example, patients with unique social needs or suffering from loneliness may be referred.

Figure 1: Diagram showing the aims and intended outcomes of social prescribing.

Referrals to the social prescribing link workers (who administer social prescriptions tailored to individuals' needs) come from many sources. Many of these are medical professionals or healthcare organisations (GPs, pharmacies, hospital discharge teams and emergency services), however social care professionals, housing organisations, local authorities and job centres can also refer. Self-referral is also available and encouraged.

The aims for the recipients of social prescriptive programmes (Fig. 1) are as follows: to be more active, receive support for mental wellbeing, to be healthier, more socially connected, to live well and more independently, and to receive support with finances. This demonstrates that the social prescribing programme is not only concerned with helping individuals with medical conditions but improving the community's wellbeing and lifestyle activities more broadly.

SOCIAL PRESCRIBING LINK WORKERS

Funded by the local PCN, there are currently two social prescribing link workers in Erewash, one of whom is based at a GP practice and the other who works within the voluntary sector as a member of Erewash Voluntary Action. This allows the social prescribing team to access as many eligible individuals as possible, and not just those who have been identified as candidates for social prescribing by GPs or healthcare professionals in primary care settings.

COMMUNITY CONNECTORS PROJECT

The Community Connectors project is similar to social prescribing in the sense that it aims to connect individuals with a range of local services that are relevant to their specific needs and that will improve health and wellbeing. The project emerged from the 'Wellbeing Erewash' NHS vanguard programme, launched in October 2016, and was funded by the NHS as part of a trial of new models of health and social care. Prior to this a number of events were held in which delegates living and working in Erewash were asked about their views on health and wellbeing and for their visions of care provision in the area in 2020. The feedback from local delegates highlighted that individuals were unaware of the number of local services available and did not know how to access them. This led to the introduction of community connectors, volunteers who introduce individuals in the local community to services that may be of benefit to them.

COMMUNITY CONNECTORS

Community connectors are volunteers who work with individuals in order to direct them towards community services that aim to improve health and wellbeing. There are currently 91 active community connectors in Erewash, in the form of the following:

- Individual volunteers.
- Community group leaders.
- Members of residents' groups.
- Members of patient participation groups.
- Small businesses.
- Community champions.

SOCIAL CONNECTORS

In September 2018 and following interest from GP Partners, the community connectors model was applied to primary care settings with the introduction of social connectors, who perform the same duties as community connectors but are based in GP practices. Unlike community connectors, however, social connectors are not volunteers, but instead are frontline staff at GP surgeries who are supported by the link worker based at the practice. GP practices were identified as ideal sites for community connectors to work at because they see a large number of patients daily. Furthermore, approximately 25% of these patients attend due to loneliness rather than medical need and are therefore ideal candidates for a social prescribing-type intervention.

Monthly drop-in sessions with social connectors were introduced at GP surgeries in Ilkeston in October 2018 and Long Eaton and Sawley in February 2019. One-to-one face and telephone appointments were also introduced for all patients within the PCN. This service was introduced at a practice in Ilkeston in April 2019, and in Long Eaton in June 2019.

These appointments are 15 minutes long and booked through the GP, and patients can have up to six sessions with their social connector.

In addition to this a monthly community coffee morning was set up at Long Eaton Health Centre in June 2019, and at a GP practice in Ilkeston in September 2019. These coffee mornings are themed, and topics covered to date have included 'carers', 'exercise and healthy eating' and 'community involvement'.

A number of the GP practices involved in the project actively advertise social connector appointments and drop-in sessions by sending texts to patients informing them of social connector events and appointments, whilst GPs can also directly refer patients they think would benefit from the scheme.

EVALUATION AND OUTCOME

The Community Connectors Project underwent an external evaluation in which a return on investment assessment was calculated. The total time invested by volunteers was £36,000 worth of hours (paid at the real living wage) per year and the financial value of referrals made was £71,971, giving the project a total annual cost benefit of £107,971. The cost of delivering the scheme was estimated to be £44,000 per annum, resulting in a return on investment of £2.50 return for every £1 invested. The evaluation concluded that 'without the connectors it is certain that people would *feel* – and would *be* – more isolated, and less supported, than would otherwise be the case'.

Since July 2017, the CVS have posted or shared 1,773 local activities on Facebook and have tweeted or retweeted 4,310 posts about local events and connector activity. In terms of actual connections made there have been over 3,300 recorded community connections so far, however the actual number may be much higher than this as many connections occur informally. In terms of social connectors, the project has only been running since September 2018 and therefore as of yet there is no data available regarding the number of people who have accessed and benefitted from the service.

During appointments with social connectors, patients only provide personal details if they would like to receive updates regarding available services. Furthermore, there are no follow-up consultations in order to assess whether people have accessed services, and if they have, whether or not these have proven helpful. Stella Scott, CEO of Erewash CVS, recognises that this is a key area for development for the programme and has requested for the organisation to gain access to the GP records system. By doing this it is hoped that outcomes of social connector appointments can be properly recorded and assessed. This includes financial evaluation, such as whether GP appointments and hospital admissions are reduced.

CASE STUDY: ELIZABETH[1]

The CVS have undertaken a number of case studies of patient experiences. One of these is the case of Elizabeth, an Erewash resident who suffers from fibromyalgia. A community connector met Elizabeth through a friend, and after hearing about her condition, asked her whether she was aware of the local fibromyalgia support groups. Elizabeth didn't know about the groups but was very keen to attend. The community connector attended the group with her for the first session, but ever since she has been attending alone. Elizabeth said:

[1] **Elizabeth is a pseudonym*

'I love talking to the others in the group who are in the same boat. It has been really good to hear how others manage on a daily basis and I've picked up some useful tips. It has really helped lift my mood and I feel much more confident going to the group.'

Elizabeth's testament shows that the referral she received from the community connector has led to improvements in her life, in terms of both psychological wellbeing and coping practically with the specific limitations of her condition.

KEY LESSONS/LEARNING POINTS

- The Community Connectors project demonstrates how social prescription services can be introduced to relevant individuals through volunteers who are active within the community and have extensive knowledge of local services. A particular strength of this method is that it allows more individuals to be reached than just those who attend the GP practice.

- The recent introduction of social connectors into GP surgeries is a positive development that will allow access to individuals who are frequent GP attenders and would strongly benefit from social prescriptions. Long-term, this will hopefully reduce the number of GP appointments booked by such individuals. In order to evaluate this, however, access is needed to the GP system to asses any changes in healthcare usage as a result of contact with the social connecters, and furthermore to evaluate any return on investment.

- Community and social connectors are able to informally provide feedback and act as evaluators of the service. This is because many are already active within the community and the services that may be used as forms of social prescription. Due to their continued presence, they are able to improve social prescribing in two ways; firstly, by promoting and directing individuals towards relevant services, and secondly, by identifying and reporting areas in which provision is absent or requires improvement.

LINCOLNSHIRE: VOLUNTARY CENTRE SERVICES, WEST LINDSEY

BACKGROUND

Gainsborough is a town in the district of West Lindsey, Lincolnshire, which in 2016 had a population of approximately 20,000 people (West Lindsey District Council, 2018). As a district West Lindsey is currently accommodating an increasing aging population, as well as facing high levels of obesity and diabetes (West Lindsey District Council, 2018). A number of rural areas around Gainsborough lack strong transport links, and one in four adults living in in the town do not have access to their own form of transport. This creates issues with isolation, making social prescribing a much needed and valuable service in the area.

Voluntary Centre Services (VCS) is a charity with divisions across Lincolnshire which supports local community groups and voluntary organisations. In 2017, West Lindsey VCS ran a pilot project delivering social prescribing in the Lincolnshire West CCG area. This ran for five months, from June to October. The pilot was successful, and the scheme has continued ever since. The social prescribing model that was developed was closely aligned with the aims of the Lincolnshire health and care strategy for integrated neighbourhood working, which is a new scheme of care delivery across the county that involves collaboration across a number of sectors including health, voluntary, and charitable organisations.

SOCIAL PRESCRIBING SCHEME

Social prescribing is delivered from a specially created ‘central referral hub’ at the VCS’ offices in Gainsborough. Following referral clients have face-to-face appointments with a link worker who discusses their needs and suggests appropriate services. Link workers use a variety of techniques during these sessions, including motivational interviewing and reflective questioning. After the client has had a face-to-face appointment there are follow-up consultations either face-to-face or over the phone as often as is required. There is no time limit placed on how long clients can receive social prescribing appointments for, however if an individual has not accessed the service within eighteen months of referral their case is archived. If the same client later decides that they would like to receive social prescribing re-referral is not required, and their file is simply reactivated.

The VCS is housed in a large multi-agency building which also contains Citizens Advice, a job centre and Social Services. This proximity to a range of other organisations is particularly helpful, as social prescribing clients can easily access and often be accompanied by link workers to relevant services.

COMMUNITY CAFES

Community cafes are themed events in which representatives from health and community sectors offer advice to individuals. A key aim of the cafes is to educate individuals about ways to successfully prevent and manage illness and spread important self-care messages, and thus they are potentially helpful in reducing GP appointments and hospital admissions. There were two community cafe events during the pilot period, and since then they have been running monthly.

The cafes cover a wide range of topics and are often closely linked to awareness days or weeks for specific conditions. For the first cafe event the theme was diabetes, in which the

VCS collaborated with partners from Diabetes UK in order to offer advice and raise awareness.

COMMUNITY SURGERIES

Community surgeries are similar to the appointments available at the central referral hub and involve one-to-one sessions in which clients are offered advice and guidance about local organisations that are relevant to their needs and interests. During the pilot scheme, community surgeries were delivered weekly for a period of six weeks.

MENTAL HEALTH SCHEME

Expansion of the social prescribing scheme is currently taking place with the development of a specialised mental health service, funded by the local NHS Foundation Trust. This is going to be delivered from a hub at an acute mental health setting in Lincoln in which patients who feel that they are experiencing a mental health crisis will be triaged. Those who do not meet the clinical criteria for acute mental illness will be referred to the social prescribing service.

REFERRALS

Individuals are referred to the service from a wide range of organisations, including Gainsborough neighbourhood team, JobCentre Plus, Victim Support and Social Services. Once clients are working with the VCS the most frequent types of referrals are to small community organisations or the Lincolnshire wellbeing service, which offers a range of in-home services to help individuals live independently. Link workers will accompany the client to these organisations if they don't feel comfortable attending on their own.

Referrals also come from a hot desking system at the local hospital in Gainsborough. Since 2017 a workspace has been established in the hospital where all health and social care staff across Gainsborough are able to hot desk and share information. As well as social prescribing staff, the office is used by social workers, occupational and physiotherapists, and district and community nurses. This set-up has proven very successful in raising awareness and increasing social prescribing referrals:

'…it's fantastic, you end up with those corridor conversations… it's (about) being able to physically sit in those rooms and say, we can help with that. We can help with that. Because of course we started in 2017 in a context of 'what's social prescribing? Why would I refer into the community? Why would that help me? I'm a fully qualified nurse, thank you very much, I don't need a lunch club. You know, why would we be doing that.' So, actually, that's been the success of it, physically sitting there.'

FUNDING

The pilot phase of the scheme was funded by public health within the local authority. Since then funding has been received from Lincolnshire West CCG and the Better Care Fund. It is currently being funded by the CCG and a number of PCNs in the area.

DATABASE DEVELOPMENT

When the project began, the VCS commissioned an IT company to develop an independent online database for keeping records of clients and their activities. This is still in operation, and allows access to patient demographics, referrals to be remotely viewed and managed, and levels of engagement with the service to be ascertained.

Link workers do not currently have access to NHS or social care systems that provide information on client's histories, such as medical record systems like System One or Cadre. However, the VCS are in communication with local healthcare providers and are hoping that these systems will become available to them in the future.

EVALUATION AND OUTCOME

The VCS conduct their own evaluation of the social prescribing service. They collect data regarding the number of clients who find employment and whether GP appointments are reduced, and in addition to this have also conducted a social value analysis.

During the five-month period that the pilot ran for 54 individuals were supported by the social prescribing teams, and 38 of these received one-to-one guidance. The majority of clients were older adults, with 85% of people who accessed the scheme aged over 65. Since the pilot the scheme has taken referrals from a wider age range and dealt with individuals ranging from 15 to 95 years old, however adults over 65 are still the most common age group accessing the service.

During the piloting period the majority of referrals (61%) came from the Gainsborough neighbourhood team, whilst a further 13% were through non-health organisations such as adult social care services and JobCentre Plus. There were no direct referrals from GPs, however a report by the project leaders stated that the scheme had increased understanding among healthcare professionals of the potential benefits of additional non-clinical interventions for patients. Since the pilot ended and the scheme has started to receive funding from local PCNs, referrals have been made from GP practices. However, this has brought challenges around inappropriate referrals and there is a need to raise awareness within PCNs about what social prescribing is and who it is most beneficial for:

'… (when) we get referrals through the PCNs directly, if they're coming through the (GP) practices, there's definitely a tone of, 'I just don't know what else to do with these people, could you just have a go?' Whereas… through neighbourhood working and through the wider sector, we're getting more genuinely good referrals because people have a better understanding of what we do.'

FUTURE DEVELOPMENTS: COMMUNITY SURGERIES

Future plans are being developed to deliver community surgeries at GP practices. This would forge closer links with the health sector and provide access to frequent GP attendees who would significantly benefit from social prescribing.

COMMUNITY CAFES CASE STUDY: JOSHUA[2]

Joshua, a young man with complex health and care needs, attended a community cafe that took place at a hospital in Gainsborough after seeing a poster advertising the event whilst visiting another part of the hospital. His carers wished to find out about events and organisations in the local community that could enhance his social life, and in particular connect him with other people of a similar age. The staff gave Joshua's carers information about how to access other community cafes in Gainsborough and scheduled a follow-up meeting with them to discuss other projects that may be suitable.

[2] **Joshua is a pseudonym.*

KEY LESSONS/LEARNING POINTS

- The delivery of social prescribing from a specialised hub that is housed within a building containing various other social services is a particular strength of the Gainsborough model. It allows easy referral to a range of other organisations, and link workers can physically accompany clients in order to ensure that they access a recommended service.
- The hot-desking system at a local hospital is an excellent and novel method of raising awareness of social prescribing among practitioners who frequently work with potential clients. This is very important in increasing referrals from a variety of healthcare settings other than GPs and accessing a broader range of clients who would strongly benefit from social prescribing.
- During appointments with clients, link workers use a variety of techniques including motivational interviewing and reflective questioning. This quasi-counselling component of the service increases its beneficial effect upon clients because it encourages contemplation of life goals that may accelerate positive psychological and behavioural change.
- The development of a new social prescribing hub at an acute mental health setting offers access to a population that have not traditionally received social prescribing but may significantly benefit from it.

NOTTINGHAMSHIRE: SPRIING

BACKGROUND

Gedling is a local government district and borough in Nottinghamshire with a population of 117,100 residents (Gedling Borough Council, n.d.). The borough has an aging population, with the most common age group in the area being 45-59 years and 20.9% of the population aged 65 and over (Nottinghamshire Insight, 2019). Residents across the borough are generally healthy, with 5.3% of the population reporting being in bad or very bad health (Gedling Borough Council, n.d.).

The SPRIING (Social Prescribing Reducing Isolation in Gedling) initiative was developed to reduce isolation and loneliness within the local community. The 'Gedling Plan' 2019/20 is the council's strategic document that outlines its vision for the area and key areas of focus over the next 12 months, and reducing isolation and loneliness is one of its key priorities (Gedling Borough Council, 2019). Gedling Homes, a local housing provider with an interest in reducing isolation and loneliness, joined with the council to assist in developing and delivering the service. The first year of the scheme was funded by the Greater Neighbourhoods Fund following a successful application. In April 2019, Gedling borough council and Gedling Homes decided to fund the project until March 2020.

SOCIAL PRESCRIBING SCHEME

The population that Gedling council serves is increasingly aging. Isolation and loneliness are a significant problem for this group (NHS England, 2018) and can have a serious detrimental effect on health. Chronic loneliness has been estimated to be as damaging to health as smoking 15 cigarettes per day (The Mental Health Foundation Scotland and Age Scotland, 2017), and is associated with higher rates of depression, high blood pressure and dementia (The Local Government Association, 2018). It also has a large financial cost for the NHS as lonely individuals are more likely to visit their GP (Van Woerden, 2016), whilst loneliness also predicts use of accident and emergency services (Geller, Janson, McGovern & Valdini, 1999). Because of this and in order to meet the needs of the aging population, the social prescribing service is targeted towards residents over the age of 60.

Following referral to the service, clients have a telephone appointment with one of the project coordinators in which they provide some history about themselves and discuss their likes and dislikes and the sorts of groups they are interested in attending. The coordinator identifies possible groups or activities specific to the client's needs, and then a follow up telephone appointment is arranged to discuss these. From these discussions the client decides which groups and activities they would like to try. If a client is concerned about attending alone, a community navigator (volunteers who help to deliver the project) offers to go with them initially. There are no formal protocols in place to follow-up with people if they don't access any services, however attempts are made at continuing contact with non-attenders whilst also being conscious to ensure that the clients do not feel obliged to engage:

'…We try and keep that conversation (with non-attenders) going… I wouldn't say we were pushy, but we let people know that we're here when they're ready.'

Up until July 2019 there were two part-time coordinators employed by the service who conducted social prescribing appointments with clients over the telephone, as well as volunteer community navigators who assist with the practical delivery of the service. One of the coordinators was based at Gedling borough council, whilst the other was at Gedling

Homes. In July 2019 this structure changed, with the project moving from having two part-time coordinators to one full-time coordinator based at the borough council. This has been beneficial for the project, as all referrals and clients are now managed by a single point of contact.

Further developments to the service have been made in response to feedback from clients. This found that users wanted more face to face contact and so in July 2019, SPRIING LINK sessions began, which are face-to-face meetings attended by clients, volunteers and the project coordinator. The initial aim of these sessions was to improve relationships between project staff and clients:

'…we're hoping that with (the sessions), we might have more (positive relationships) … I think the relationships have been positive with clients, but I still think that, because you don't have that face-to-face interaction, we're hoping that this might… improve some of the relationships.'

The sessions take place on a monthly basis at a range of community locations (i.e. community centres, libraries and leisure centres) in order to maximise accessibility, particularly for hard to reach groups. Some of the sessions have been in run in partnership with local social groups to offer clients 'taster sessions' of what it's like to take part, whilst others have been themed around common health and social issues. One of the themed sessions was held at a fire station, and attendees were provided with lunch and spoke to fire fighters who gave advice regarding fire safety. The sessions have proven popular so far, attracting up to 25 attendees.
In terms of promoting the project, Gedling borough council advertise the scheme to local residents in their newsletter that is sent to every household in the borough. A steering group was also set up to raise awareness of the scheme within local organisations and healthcare providers. This group contained representatives from agencies including Public Health England, Age UK Nottinghamshire, Gedling Seniors Council and the Gedling Borough Hospital Discharge Scheme. Representatives also came from the local CCG, and these played an important role in endorsing and embedding the project within GP practices. The scheme is aiming to compliment the social prescribing link workers currently being introduced in local PCNs and the SPRIING project manager has participated in discussions with South Nottinghamshire integrated care partnerships around the development of social prescribing in the area.

REFERRALS

Referrals come from a wide variety of sources. These include healthcare professionals such as GPs, social workers, and care staff, but also the fire service, police, and friends and family members of people who are socially isolated. This highlights that the project is not just for individuals with medical needs:

'For us (in terms of referrals) it's about working with local partners… the police (for example), they go out and… see a lot of vulnerable people and, actually, they've identified a few people that could probably get something out of the SPRIING project… we are about connecting people, people that are perhaps a little more independent, into community activities.'

Individuals can also refer themselves by completing an online form or calling Gedling borough council.

SPRIING GRASS ROOTS GROWTH FUND FOR COMMUNITY GROUPS

As well as connecting people with services, the scheme aims to support local groups to become better equipped in order to support individuals who are referred to them. The Grass Roots Growth Fund offers grants of up to £250 to local groups in order to become more accessible to older and vulnerable adults, as well as people with mental health problems and those in regular contact with primary or secondary healthcare services. This is deemed to be vital in ensuring that the social prescribing service can serve clients properly:

'If we are signposting to these community services, we can't just flood them with all these clients, we have to help them to be able to… receive and manage that. I think that's a challenge (in delivering social prescribing).'

EVALUATION AND OUTCOME

Since its introduction in April 2018, approximately 80 clients have accessed the service. Gedling Borough Council commissioned Nottingham Trent University to develop a client questionnaire through which to evaluate the project. This assesses changes in levels of loneliness, wellbeing, and dependency on NHS services. Clients complete the survey twice, once at the end of their initial appointment with the coordinator and three months after this. Responses are currently being collected, and so no analysis of the feedback has been undertaken yet. A social return on investment will also be conducted to estimate the savings made by reduced contact with healthcare services alongside measuring improvements in health and wellbeing.

CHALLENGES/KEY LESSONS

- Offering funding to the local organisations and community groups that take social prescribing referrals means that high quality support is actually delivered to clients, and that such organisations do not become overwhelmed by increases in the number of referrals.

- As with many social prescribing schemes there is difficulty in securing long term funding, particularly with the national roll out of link workers in PCNs. This means that social prescribing is increasingly being seen as something that is delivered and funded by healthcare providers as opposed to external organisations like local authorities and housing organisations. This is despite the fact that community cohesion and supporting local services in order to reduce social isolation in residents is a key priority for most councils and housing associations.

- The scheme sometimes has challenges meeting demand, and referrals can take longer than clients are happy to wait. This can cause people to leave the service before consulting with a coordinator. Because a key area of development for the project is to increase the number of clients accessing and benefitting from the service, it is hoped that the external evaluation will provide evidence regarding the economic benefits of the scheme and help secure further funding to ensure expansion and sustainability.

NORTHAMPTONSHIRE: LAKESIDE SURGERY, CORBY

BACKGROUND

Corby is both a town and borough in Northamptonshire. It has one of the fastest rates of population growth in England (Northamptonshire County Council, 2015), and at the last census recording in 2011 had 61,000 residents (Office for National Statistics, n.d.).

Deprivation in Corby is higher than the national average, and in 2015 62% of households in Corby were classed as deprived compared to the national average of 57.6% (Northamptonshire County Council, 2015). 66.2% of adults living in Corby are overweight, whilst only 56.7% of the population are considered physically active, which is 10% less than the national average (Northamptonshire County Council, 2019). As deprivation, obesity and lack of physical activity are key contributors to ill health, the support and lifestyle changes such as those promoted by social prescribing are particularly important for a community like Corby.

The social prescribing scheme emerged as the result of an idea by one of the GP partners at Lakeside Surgery in Corby, Dr Lynette Patino. The concept was to set up a social prescribing clinic that would be run by medical students from UoL as part of their 12-week placement at the practice. Dr Andy Ward, a partner and GP at Lakeside Surgery and Senior GP Specialist Educator at UoL, strongly advocated and helped to develop the service. He and his colleagues feel that many of their patients would benefit more from social prescribing than medication:

'…one of my partners approached me and said we needed to try and get the students involved in social prescribing because so many of the patients we see here are lonely and yet (we) medicalise it.'

Without an explicit social prescribing service to refer to many non-medical conditions, such as loneliness, are medicalised due to no other forms of treatment being available. In addition to this, accurate information about voluntary organisations is often difficult for people to obtain:

'*It is actually quite hard to find that (information about voluntary services that are available) because although there are online resources and sort of registers of these things, they're nearly always out of date and actually a lot of charities have either gone out of business or have stopped taking referrals…'*

The social prescribing scheme benefits patients by offering up-to-date and accurate information about local groups and services and is delivered by medical students on placement at the practice.

SOCIAL PRESCRIBING SCHEME

Prior to offering patient appointments, the medical students who initially created the service contacted local organisations in Northamptonshire and visited them to see if they had the capacity and capability to take referrals. Following this, they created a social prescribing directory. This directory contains information and contact details of a wide range of services

that may be helpful to patients, and is split into nine categories: finance, family, health and wellbeing, gambling, disability, dementia, home, substance misuse, and volunteering.

APPOINTMENTS

In February 2019 social prescribing appointments were introduced at Lakeside Surgery. During the consultations, patients meet with a medical student who takes a detailed history and identifies with them the organisations that they can access from the social prescribing directory; for example, a patient experiencing financial difficulties would be referred to organisations that support debt management. The student and patient then use the relevant section of the directory to identify and discuss possible services that patients could access and the type of support or activities that might be available. If necessary, the student contacts the organisation on behalf of the patient. As extra support, the students also offer to accompany the patient on their first visit.

Follow-up phone calls are scheduled once the patient has attended an appointment or session with the organisation of their choice. At this point, if the patient feels that their issues have been resolved by accessing their chosen organisation they are discharged. If there are ongoing issues still to work with, a further face-to-face appointment is made in order to explore other support options. Patients are able to return to the social prescribing service at any time after being discharged. With regards to non-attendance, if a patient does not attend their appointment, one of the students calls them and the consultation takes place over the phone.

SOCIAL PRESCRIBING LINK WORKER

On 1 July 2019, primary care networks came into existence across Northamptonshire. These included funding for social prescribing link workers, and in early September 2019 a link worker commenced employment at Lakeside Surgery. As the delivery of appointments by the medical students is proving very effective, the link worker role is not focused upon delivering social prescriptions to patients but instead takes a more strategic approach by working on increasing referrals to the service and evaluating outcomes.

REFERRAL PROCESS

All members of the practice team including GPs are able to refer to the social prescribing scheme. Administrative staff can refer patients who they think would benefit, whilst there are also posters in the surgery waiting room encouraging patients to book appointments themselves. Details of the appointments and follow-ups are kept on the practice's IT system alongside the patient notes.

PATIENT DEMOGRAPHICS

The majority of patients referred to the service are overweight. Social prescribing supports these individuals by offering reduced gym membership, which allows them to increase their physical activity and be more active in managing their own health. There are also a number of referrals for individuals with mental health issues. In terms of age demographics, the scheme is not limited to a particular age group with a broad age range of people accessing the service.

EVALUATION AND OUTCOME

Plans are underway to conduct a formal evaluation of the social prescribing service at Lakeside Surgery. Patients stories have been collected and used in teaching at UoL, as social prescribing and public health have recently been integrated into the medical education curriculum. The trainees have also presented the patent stories at conferences and dissemination events.

PATIENT STORY: MRS X

Mrs X is a patient at Lakeside Surgery who suffers from fibromyalgia and depression. She visited the GP and revealed that she was mostly housebound and struggling to cope with her conditions, and he referred her to the social prescribing service. During this appointment, the student asked Mrs X about her history and discovered that during a previous period of financial difficulty she and her family had received help from a local soup kitchen. The student suggested that Mrs X may enjoy volunteering at the soup kitchen in order to 'give back' for the support that she and her family had received, and Mrs X agreed to try this. Volunteering at the soup kitchen had a profound effect on Mrs X, and she continues to volunteer there. In addition to this, she also set up a local dog walking group and undertook training to handle crisis phone calls, for which she now volunteers for 6 hours a week. Mrs X felt so much better after beginning to volunteer that she no longer required medication and is now medication-free.

KEY LESSONS/LEARNING POINTS

- The social prescribing model uses a proactive referral approach, firstly by identifying the third sector and statutory organisations the patient may access and secondly by contacting the organisations to ensure they have the capacity to accept and support referrals. Patients are also offered the option to be accompanied to the first appointment. This is particularly important during the early stages of introducing social prescribing, as people may initially struggle to understand what it can offer them or struggle to access the services.

- The model requires little financial backing because it utilises the existing placements that medical students undertake as part of their training.

- The creation of the social prescribing directory allows services to be identified quickly and easily, and to ensure that all patients have equal access to all organisations irrespective of the social prescriber's knowledge of local services.

LEICESTERSHIRE: AGE UK LEICESTER, SHIRE AND RUTLAND

BACKGROUND

Leicester is a large city in the East Midlands with a population of 342,000 people (Leicester City Council, n.d.). Deprivation is high in Leicester with one quarter of all residents, and one third of older residents, living in areas of high deprivation (Leicester City Council, 2016). Furthermore, 1 in 6 residents in the city live in areas of high health deprivation with increased rates of illness and disability (Leicester City Council, 2016). Mental illness is also a significant problem in Leicester, with more people receiving incapacity benefit due to mental illness than other locations in England (Leicester City Clinical Commissioning Group, 2020). Individuals in areas of high deprivation and with high levels of mental illness and psychosocial issues are ideal candidates to receive social prescribing, which highlights the particular need for an explicit social prescribing programme in Leicester.

Age UK are a large national charity with an active branch working across Leicester, Leicestershire and Rutland. The majority of their work focuses upon older adults, and they offer a wealth of projects and services aimed at improving wellbeing and independence as well as offering advice and support. Whilst the organisation's traditional client base has been older adults, this has recently changed, and they now offer services for people of all ages:

'…a lot of what we do now is across a much broader age range. I mean, we do the Care Act Advocacy Service across city and county and that (is for) 16 plus…'

Because much of their work is based within the local community and interested in increasing social engagement, as an organisation Age UK is well suited to social prescribing. In late 2019, they began a collaborative project with local PCNs to develop a social prescribing service based within GP practices across the city.

SOCIAL PRESCRIBING SCHEME

The social prescribing scheme (part of the NHS England national roll out) is currently being set up, commissioned by Leicester City West PCN. In order to offer the new service, Age UK are currently in the process of recruiting three link workers who will deliver social prescribing to patients from GP practices. The service will be available to people of all ages, and the link workers will meet with patients during one-to-one appointments. In addition to this and in order to reduce the number of inappropriate referrals, there are also plans to set up needs-based clinics within GP surgeries. The format and content of these clinics will be developed in line with the requirements of local residents, such as dealing with immigration issues or advice about benefits.

AGE UK FURTHER SERVICES

Age UK have a long history of supporting local citizens and have been running projects similar to social prescribing for a number of years. For example, since 2015 there have been four projects run by the organisation and funded by the Leicester Aging Together incentive, which aims to reduce social isolation and loneliness among residents in the city. These are a loneliness prescription service, 'Men in Sheds', 'Anything Goes', which is focused upon developing social groups, and a befriending service. All four projects are still operating.

The befriending service consists of 19 volunteers. It is extremely popular, runs five days per week, and has over 120 clients. In addition to this, it also has an ongoing stream of referrals. Clients are allocated a volunteer via a matching process based upon a variety of factors

including personality characteristics, hobbies, and where they are from. This ensures that the befriending service is as beneficial as possible to the service user. Befriending takes place either over the phone or in person. When befriending takes place in person, volunteers visit clients in their homes and either have a cup of tea and a chat or assist them with various activities. Much like social prescribing, the ultimate aim of the befriending service is to increase confidence in individuals so that they are able to become independent, and importantly is not suitable for individuals with high-level needs:

'…it's really about getting that confidence to get out and reconnect back into the community… our volunteers, they are volunteers, they're not carers.'

REFERRALS

The majority of referrals to the services offered by Age UK currently come from care navigators. However, because the social prescribing project is being funded by the NHS, moving forward GPs are expected to be the largest provider of referrals to the new service. Whilst strong links with GPs are expected to provide many suitable referrals of people who would strongly benefit from social prescribing, staff at Age UK are also aware of the possibility that social prescribing services will be misunderstood and that there is a need to integrate with the current services on offer:

'I think there's going to be an expectation from the GPs that (the social prescribing service) offers some help with completing forms and accessing benefits, (so) we've got to be careful that we don't turn these people (the link workers) into information advice and benefit workers as well.'

Age UK aims to reduce inappropriate referrals through strong working relationships with GPs and education about the relevant services on offer, as well as the themed clinics built around patient needs.

FUNDING

There is currently two years of funding in place. This is being provided by local PCNs via the national roll out from NHS England.

EVALUATION

In terms of evaluation, the loneliness prescription service undertakes wellbeing assessments of clients at the first point of access and three months following this. This wellbeing assessment includes the UCLA loneliness scale. The exact nature of how patient outcomes will be measured within the social prescribing service is yet to be confirmed, however there are plans to gather data regarding whether social prescribing leads to a reduction in the number of GP appointments an individual requires:

'…if we can measure it, we can evidence it and (if) they (GPs) are seeing that they haven't got people coming to them with so many issues that are non-clinical, then I think we'll be doing our job.'

It is also hoped that the social prescribing link workers will have access to System One, which contains information about an individual's medical history and prescriptions. If this is the case more detailed analysis of the effects of social prescribing will be able to be conducted, such as whether the need for medication is reduced following social prescribing.

KEY LEARNING POINTS

- As an organisation, Age UK have significant experience in delivering programmes similar to social prescribing. This means that they have been able to quickly and competently set up the new social prescribing scheme by utilising the skills and resources already in place. In addition to this, the organisation has long-standing relationships with many older residents across the city who may be interested in accessing the social prescribing service.

- If it is possible, the use of System One by link workers to record client appointments and progress will position social prescribing as something delivered in tandem with medical treatment. In addition to this, it will also allow more sophisticated evaluation of outcomes to be undertaken.

- By introducing regular needs-based clinics within GP practices, the risk of inappropriate referrals to the social prescribing service is minimised. Such clinics may also act as a form of social prescribing by engaging and strengthening relationships with the local community.

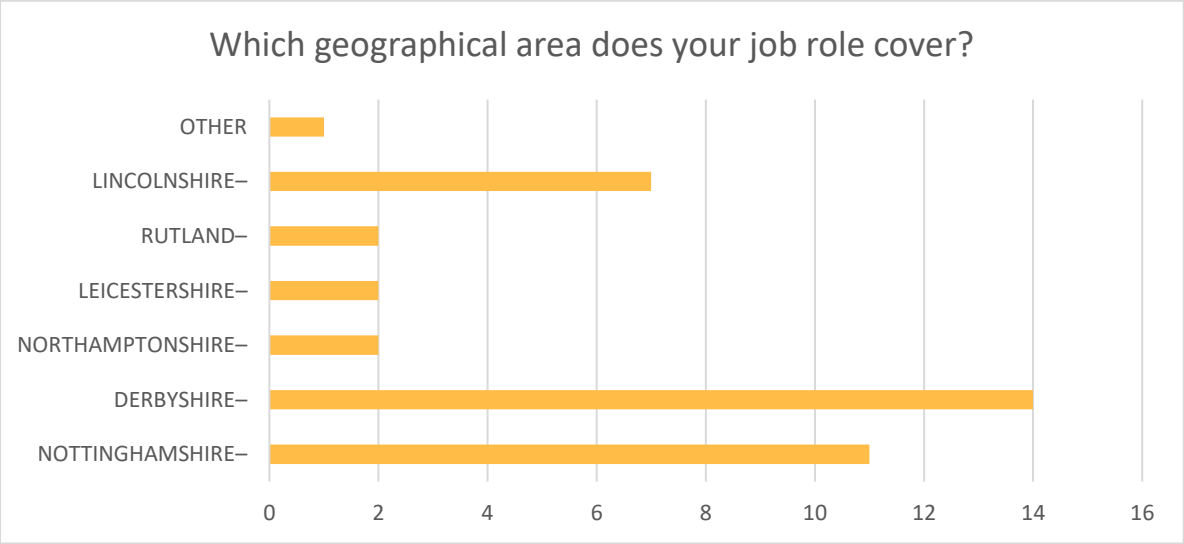
TABLE 1: CORE COMPONENTS OF THE SOCIAL PRESCRIBING CASE STUDIES

Case Study	Key Features									
	County	**Date started**	**Number of Referrals**	**Referred by**	**Patients/ Users**	**Link workers**	**Lead Agency**	**Funding**	**IT System**	**Evaluation**
Erewash Community Voluntary Service	Derbyshire	October 2016	25 (number of one-to-one appointments booked) by end of September 2019. 4493 social connections made (signposts to services)	Medical staff, social care professionals, housing organisations, local authorities, job centres & self-referral	All ages, however most clients aged over 65	Yes – one based within GP setting & one working within the CVS	Erewash CVS	PCNs	Paper based	Yes – external evaluation including return on investment assessment
West Lindsey Voluntary Centre Services	Lincolnshire	June 2016	225 in 2019	Neighbourhood team, job centre, victim support, social care staff, GPs & other medical staff via hot desking system	15-95 years, however majority of users aged 65+	Yes – employed by & based within the VCS	West Lindsey VCS	Various – currently CCG & local PCNs	Yes – internal database with information about clients and activities	Not yet
SPRIING	Nottinghamshire	2018	Approximately 80	Healthcare professionals (including GPs), social workers, fire & police service, friends/family	Adults aged 60+	No – project coordinator based at the borough council	Gedling Borough Council	Various – Greater Neighbour hoods Fund, Gedling borough council &	Data is recorded and stored on a secure spreadsheet	Yes – evaluation being completed by Nottingham Trent University,

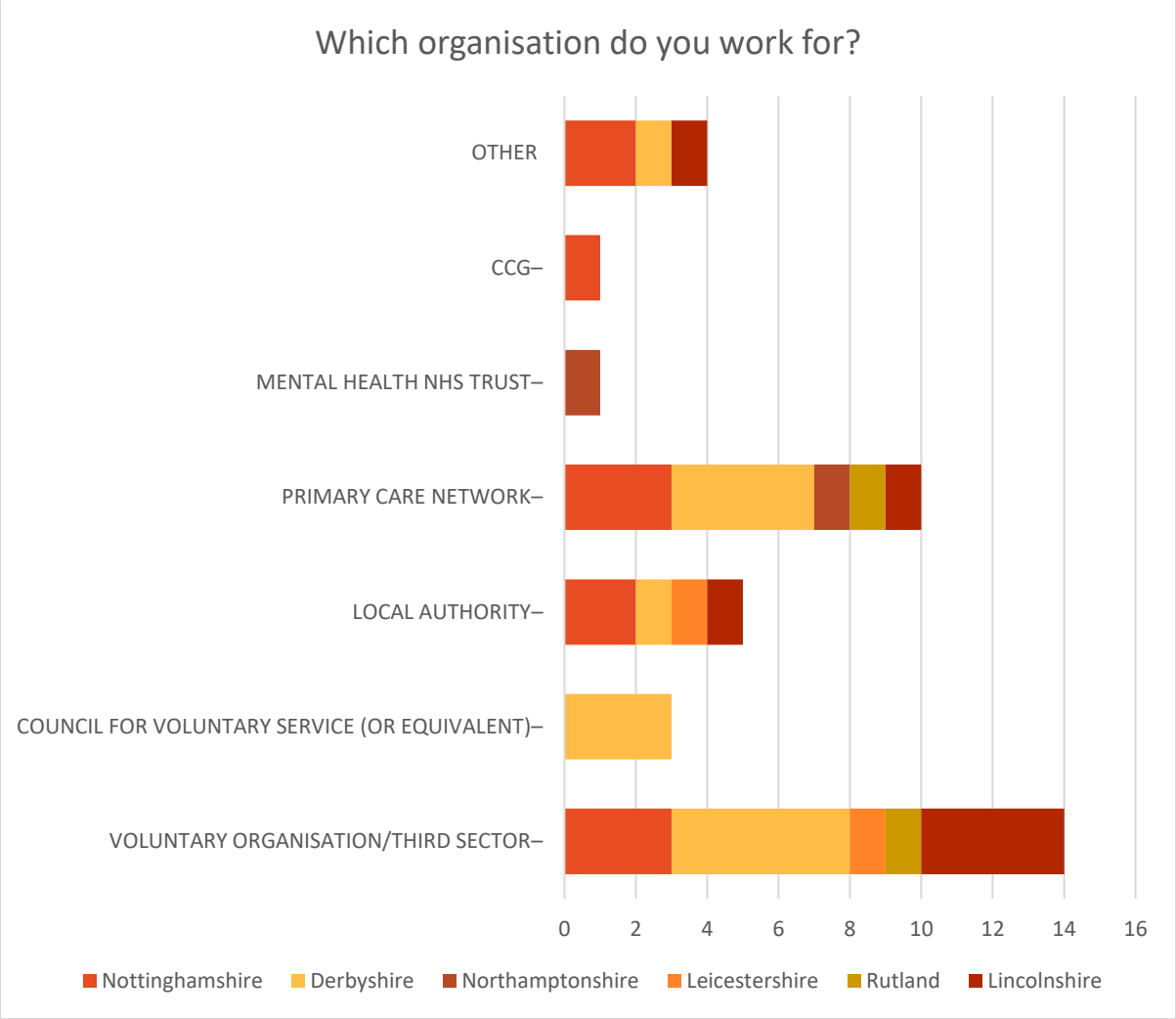
				members & self-referral				Gedling Homes.		including social return on investment
Lakeside Surgery, Corby	Northamptonshire	February 2019	216 since the introduction of a link worker (approx. September 2019)	All GP staff & self-referral	All ages	Yes – one based within GP practice	University of Leicester	None required	Details of appointments are kept on the GP practice's IT system alongside patient medical notes	Not yet
AGE UK	Leicester, Shire and Rutland	2015	Befriending service: 120 current clients. Social prescribing has not yet started so number of referrals not available	Care navigators & GPs	All ages, however most clients are older adults	Yes – three link workers based within GP practices	AGE UK Leicester, Shire and Rutland	PCNs	Currently unknown, however hopefully System One	Not yet

4. SURVEY RESULTS BY REGION

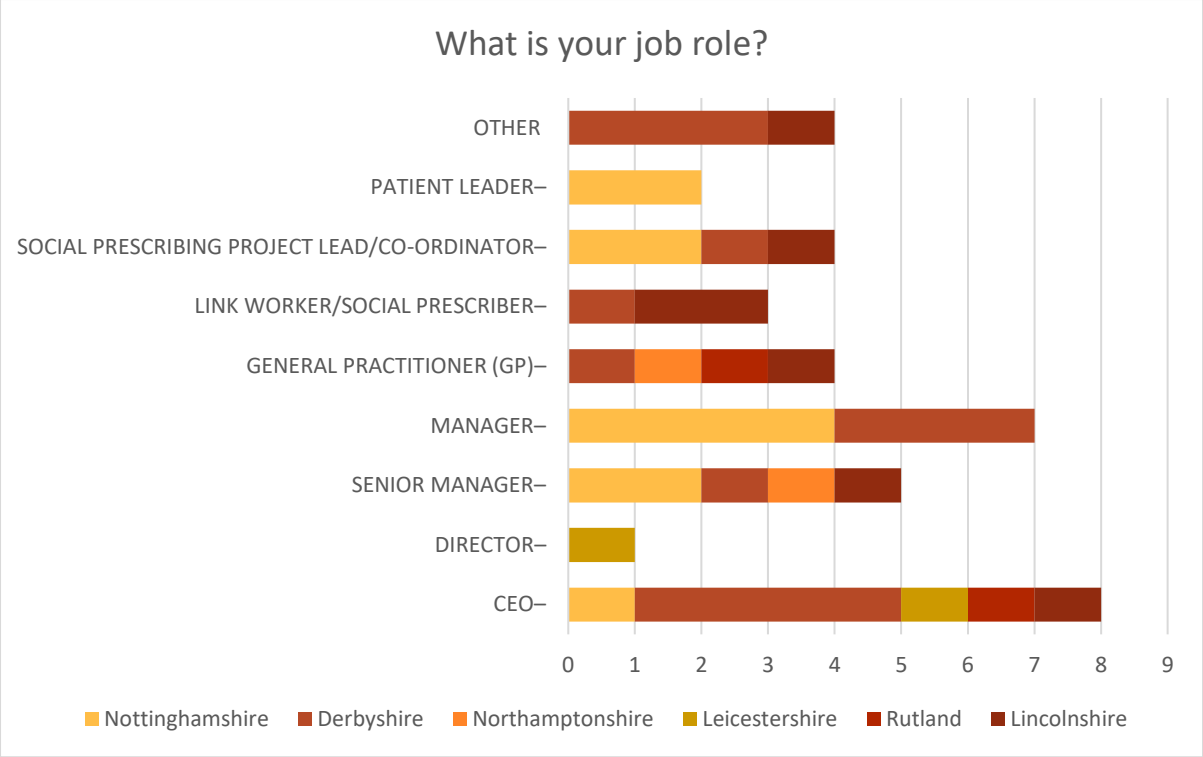
The survey responses (*n*=57) to each question were compared by East Midlands region (Derbyshire, Northamptonshire, Nottinghamshire, Leicestershire, Lincolnshire and Rutland) and are presented below. The survey used question logic, meaning that for some of the questions only those who responded yes were directed onto the following set of questions. In addition to this, some questions encouraged participants to tick all answers that applied; these are marked with an asterisk. In total, only 18 respondents indicated that they were currently running social prescribing schemes in their region.



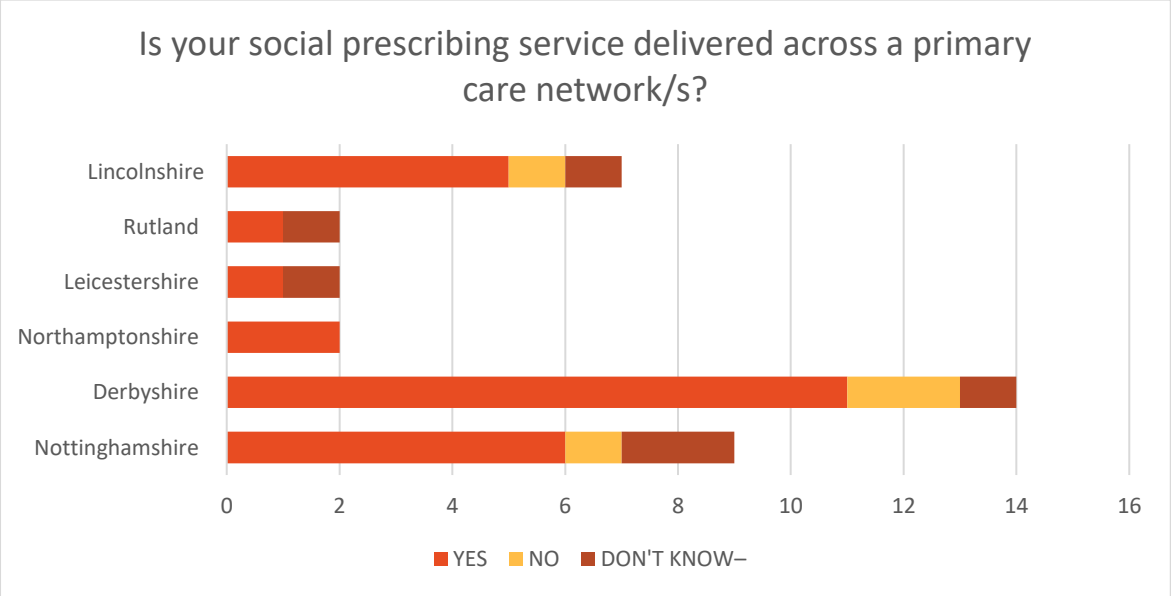
Thirty-nine individuals responded to the question 'Which geographical area does your job role cover?' Of these, 14 were from Derbyshire, 11 were from Nottinghamshire, 7 were from Lincolnshire, 2 from Northamptonshire, 2 from Leicestershire, and 2 from Rutland. One respondent indicated that they were from a region outside the East Midlands.



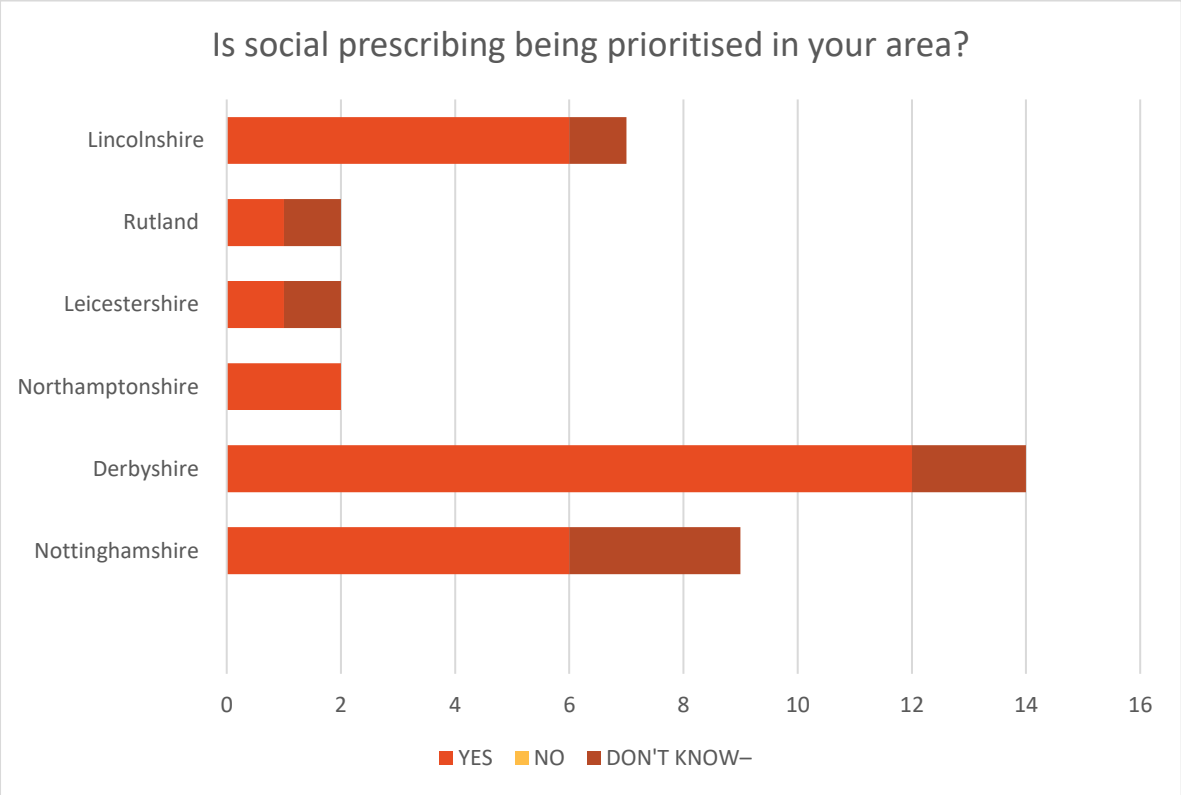
Thirty-eight respondents answered the question 'Which organisation do you work for?' Of these 14 worked in Derbyshire, with 4 from PCNs, 1 from the local authority, 5 from the voluntary sector, 3 from CVS' and 1 from another organisation. A further 11 of the respondents worked in Nottinghamshire, with 3 employed by PCNs, 3 working within the voluntary sector, 2 from the local authority, 1 from a CCG, and 2 from other organisations. Seven responses were from Lincolnshire; 1 from a PCN, 1 from a local authority, 4 from the voluntary sector, and 1 from another organisation. 2 of the responses came from workers in Northamptonshire, one of whom was employed by a mental health trust and the other by a PCN. 2 of the respondents were from Leicestershire, 1 of whom worked at a local authority and the other based within the voluntary sector. Finally, 2 of the responses also came from Rutland. One of these respondents worked for a PCN, whilst the other was from a voluntary/third sector organisation.



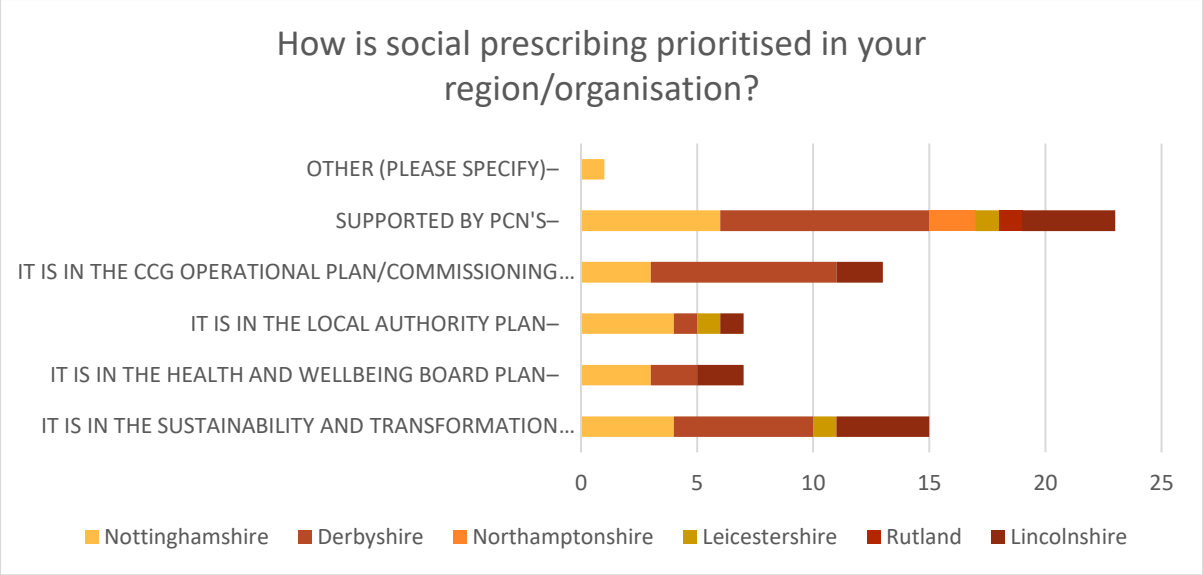
There were 38 respondents for the question 'What is your job role?' Fourteen of the responses came from Derbyshire. Of these, 2 of the respondents were directly involved in social prescribing (link worker/social prescriber or social prescribing lead/co-ordinator), 1 was a GP, 3 were managers, 1 was a senior manager, 4 were CEO's, and 3 had another role. A further 11 respondents were from Nottinghamshire, and of these, 1 was a CEO, 2 were senior managers, 4 were managers, 2 were social prescribing leads/co-ordinators and 2 were patient leaders. 7 of the respondents worked in Lincolnshire; 3 of these were directly involved in social prescribing, whilst 1 was a GP, 1 a senior manager, and 1 a CEO. Two responses came from Northamptonshire, 1 from a GP and 1 from a senior manager, whilst another 2 of the respondents were from Leicestershire, 1 of whom was a director and the other a CEO. Finally, a total of 2 of the responses were from Rutland. One of these came from a GP, and the other a CEO.



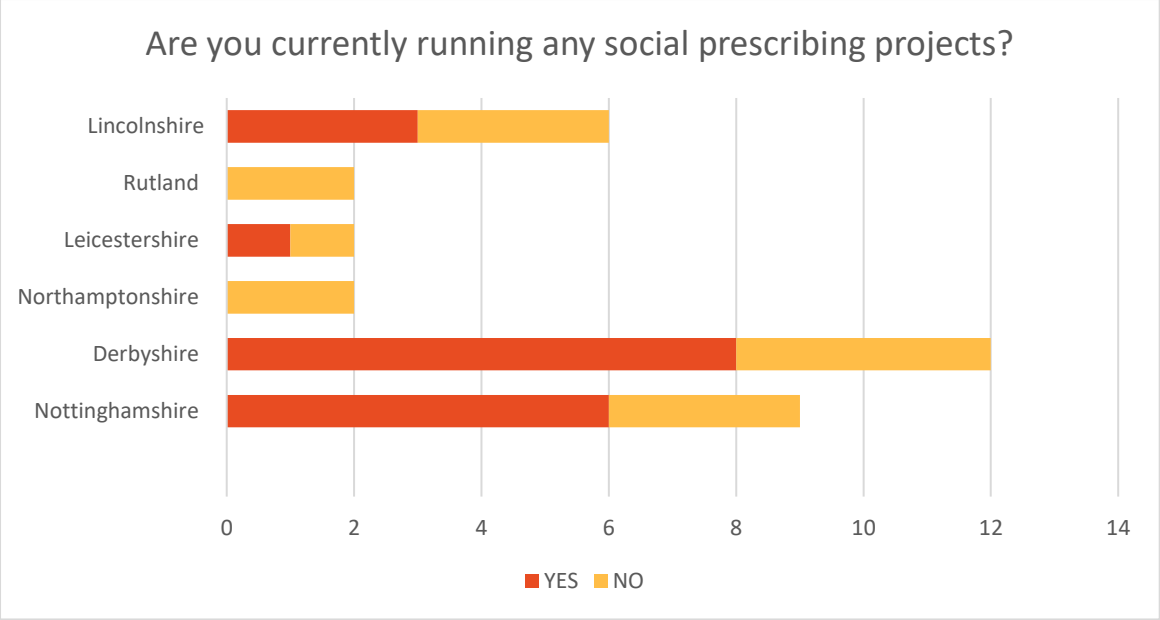
Thirty-six of the respondents answered the question ‘Is your social prescribing service delivered across a primary care network/s?’ The majority said yes (26), 4 said no, and 6 didn’t know. A total of 14 of the responses were from Derbyshire; of these, 11 responded yes, 2 responded no, and 1 answered don’t know. A further 9 of the responses were from Nottinghamshire; 6 yes, 1 no and 2 don’t know. Seven responded from Lincolnshire, with 5 answering yes, 1 answering no, and 1 answering don’t know. Two responded from Northamptonshire, both of whom answered yes. Finally, there were 2 responses each from Leicestershire and Rutland, 1 yes and 1 don’t know.



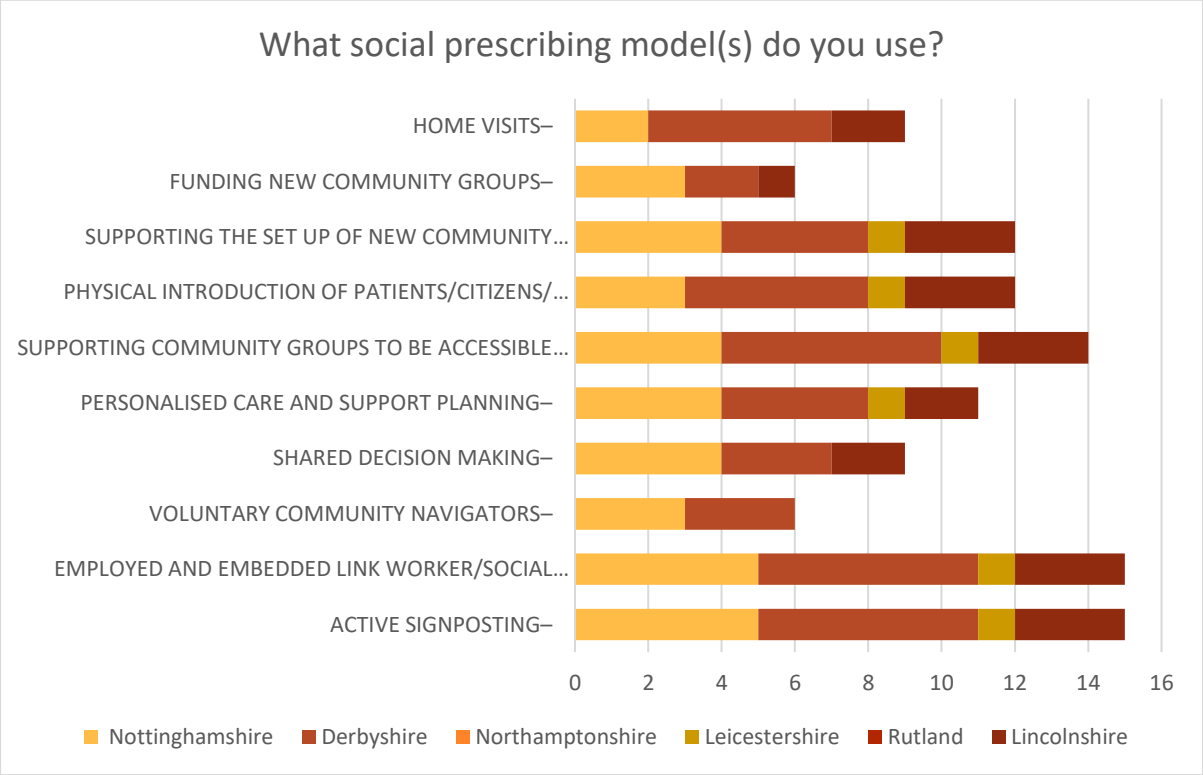
Thirty-eight of the respondents answered the question ‘Is social prescribing prioritised in your area?’ All of the respondents answered either yes (28) or don’t know (8). There were 14 responses from Derbyshire, with 12 stating that it was prioritised and 2 responding that they didn’t know. For Nottinghamshire there were 9 responses, 6 answering that it was prioritised and 3 who didn’t know. For Lincolnshire there were a total of 7 respondents, 6 of whom stated that was prioritised and 1 who didn’t know. In Northamptonshire, all of the respondents (2) said that it was prioritised. Finally, in Leicestershire and Rutland 2 respondents said it was prioritised and 2 didn’t know.



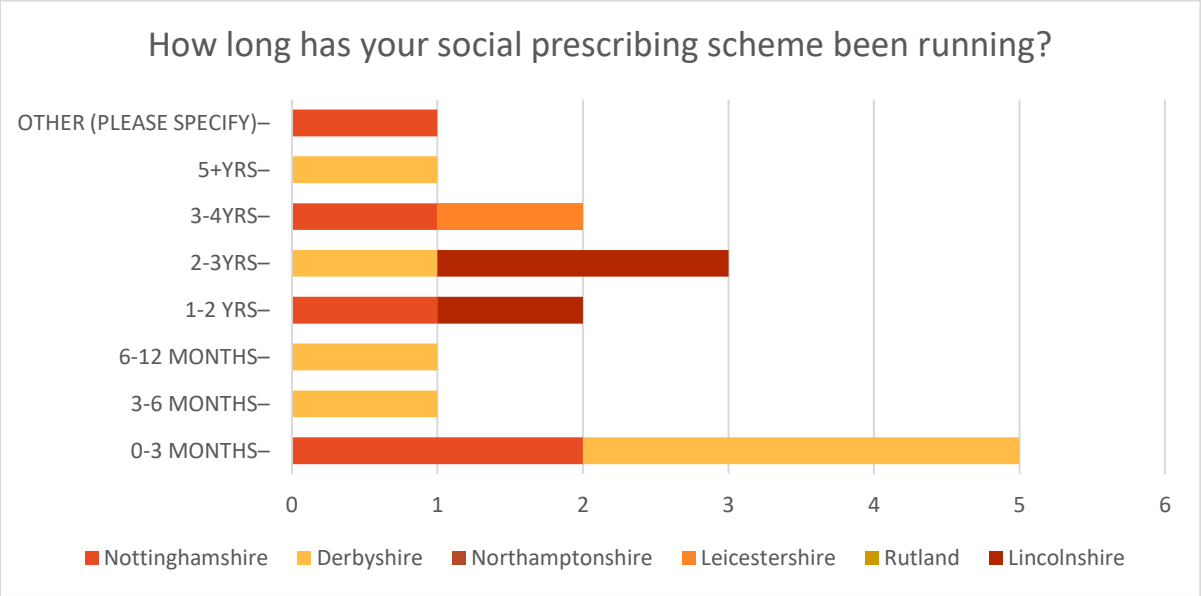
*There were 66 responses to the question 'How is social prescribing prioritised in your region/organisation?' The majority of responses indicated that it was prioritised by PCNs (23), followed by sustainability and transformation partnership (STP) priorities (15), in the CCG Plan (13), in the health and wellbeing board plan (7), in the local authority plan (7), and other (1). For Derbyshire, there were 26 responses. Six of these indicated that social prescribing is an STP priority, 2 reported that it's in the health and wellbeing board plan, 8 stated that it is in the CCG plan, 9 answered that it is being prioritised by the PCNs, and 1 reported that it is in the local authority plan. There were 21 responses from Nottinghamshire. Four of these indicated that social prescribing is in the STP priorities, 3 responded that it is included in the health and wellbeing board plan, 4 said that it is included in the local authority plan, 3 answered that it is in the CCG plan, 6 reported that it is prioritised by PCNs, and 1 responded other. In Lincolnshire there were 13 responses. Four of these indicated that social prescribing is a STP priority, 2 stated that it's in the health and wellbeing board plan, 1 said that it's in the local authority plan, 2 responded it's in the CCG plan and 4 indicated that it is supported by the PCNs. There were only 2 responses from Northamptonshire, both of which indicated that social prescribing is supported by PCNs. In Leicestershire there were 3 responses, one of which reported that social prescribing is in the STP priorities, one that it is in the local authority plan, and another that it is supported by the PCNs. Finally, the single response from Rutland indicated that it is supported by PCNs.



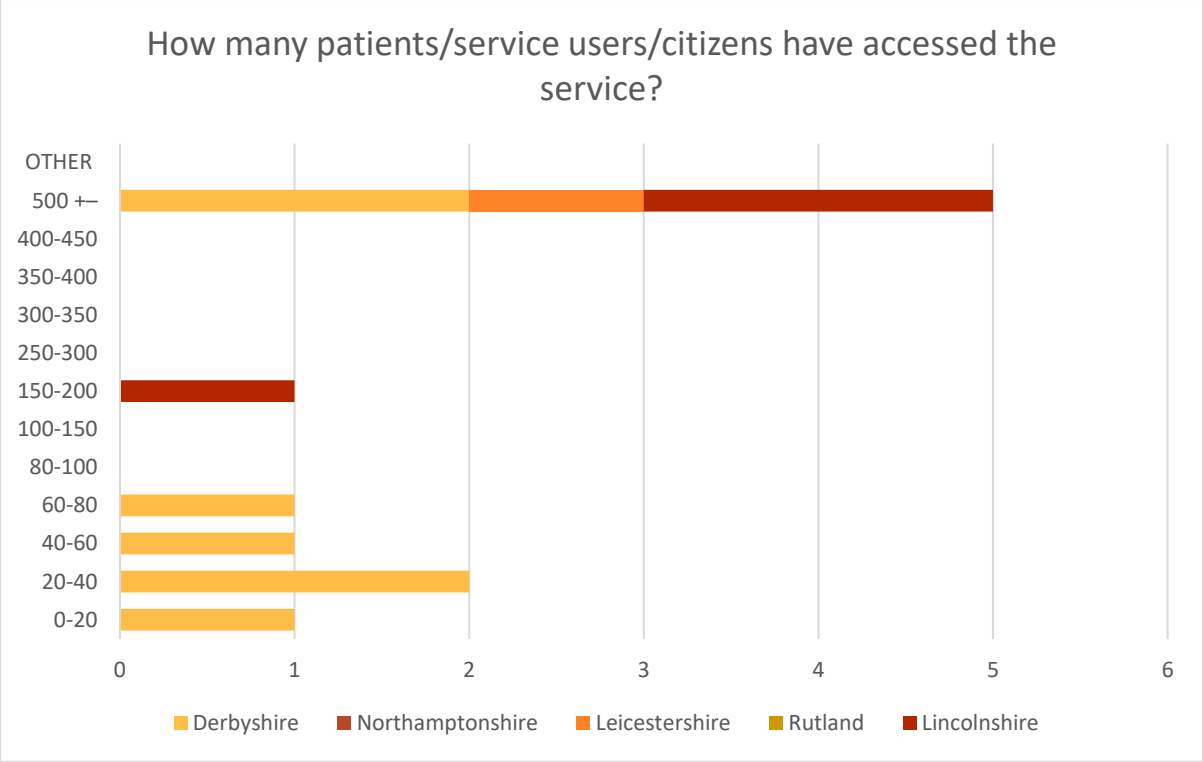
Thirty-three respondents answered the question 'Are you currently running any social prescribing projects?' The majority answered yes (18) and 15 responded no. In Nottinghamshire, of the 9 respondents 6 indicated that they were currently running projects, whilst 3 were not. In Derbyshire there were 12 respondents, 8 of whom indicated that they were currently running projects and 4 who responded that they were not. In Lincolnshire there were a total of 6 respondents; 3 indicated that they were currently running projects and 3 answered that they were not. In Leicestershire there were 2 respondents, one of whom answered that they were currently running a social prescribing project and the other answering that they were not. There were 2 responses each from Rutland and Northamptonshire, all of which indicated that there were not any current social prescribing projects.



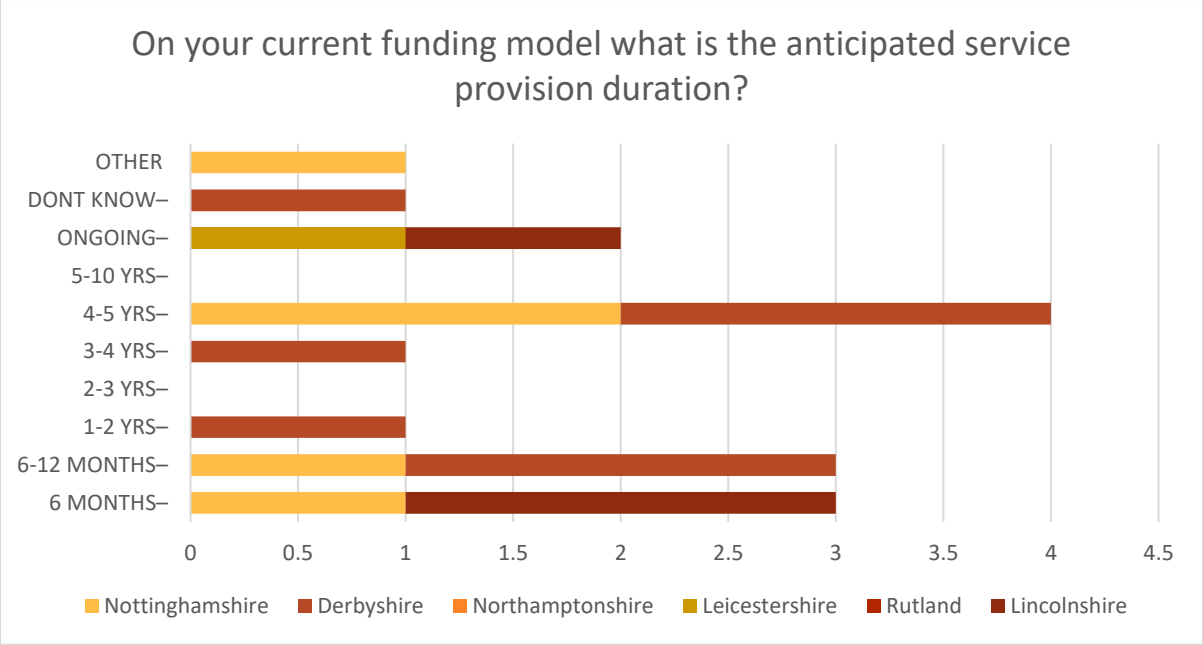
*There were 109 responses to the question ‘What social prescribing model(s) do you use?’ from Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire only. Forty-four of the responses came from Derbyshire, and these indicated that 6 schemes use active signposting, 6 use a link worker, 3 use community navigators, 3 use shared decision making, 4 use personalised care planning, 6 support the community to be sustainable, 5 introduce patients to community groups, 4 support the set-up of new groups, 2 fund community groups and 5 use home visits. A further 37 responses were from Nottinghamshire, and these revealed that 5 organisations use active signposting, 5 use a link worker, 3 use community navigators, 4 use shared decision making, 4 use personalised care planning, 4 support the community to be sustainable, 3 introduce patients to community groups, 4 support the set-up of new groups, 3 fund community groups and 2 use home visits. Twenty-two of the responses were from Lincolnshire. These demonstrated that 3 of the schemes use active signposting, 3 use a link worker, 2 use shared decision making, 2 use personalised care planning, 3 support the community to be sustainable, 3 introduce patients to community groups, 3 support the set-up of new groups, 1 funds community groups and 2 use home visits. The final 6 responses were from Leicestershire. These indicated that 1 organisation uses active signposting, 1 uses a link worker, 1 uses personalised care planning, 1 supports the community to be sustainable, 1 introduces patients to community groups and 1 supports the set-up of new groups.



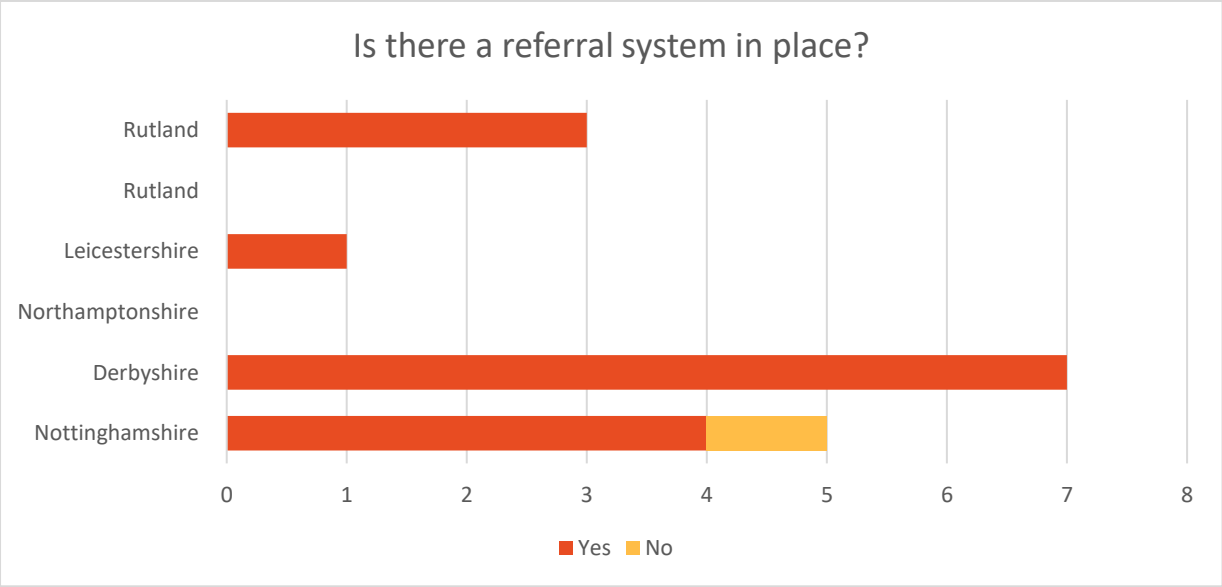
There were 16 responses to the question ‘How long has your social prescribing scheme been running?’ Responses were received from Nottinghamshire, Derbyshire Leicestershire and Lincolnshire only. Responses from Derbyshire revealed that 3 schemes had been running for 3 months or less, 1 scheme had been active for 3 to 6 months, 1 for 6 to 12 months, 1 for 2 to 3 years, and one for over 5 years. Responses from Nottinghamshire indicated that 2 schemes had been running for 3 months or less, whilst one had been running for 1-2yrs, one for 3-4yrs, and one ‘other’. Only 1 respondent from Leicester answered the question, and this indicated that their scheme had been running for 3 to 4 years. Finally, there were 3 responses from Lincolnshire, which revealed that 1 scheme had been running for 1 to 2 years whilst 2 had existed for 2 to 3 years.



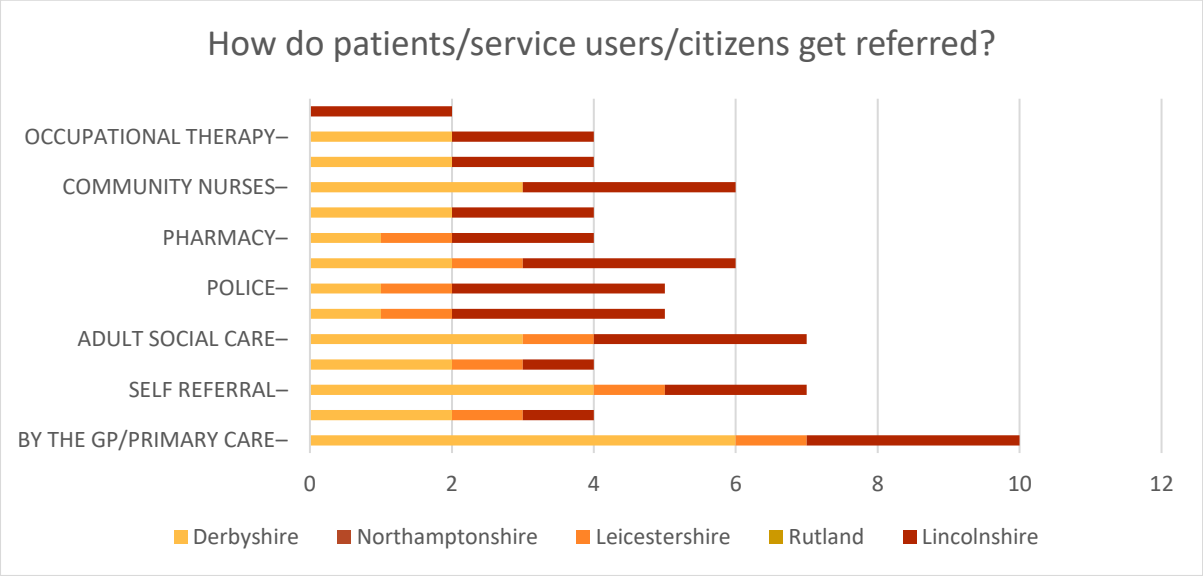
Sixteen of the respondents answered the question ‘How many patients/service users/citizens have accessed the service?’ Responses were received from Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire only. Of the 7 responses from Derbyshire, 1 scheme reported that less that 20 patients had accessed them, 2 answered that 20 to 40 clients had accessed them, 1 had 40 to 60 service users, 1 had 60 to 80, and 2 had had 500+ individuals access them. There were 5 responses from Nottinghamshire. Two of these schemes reported that less than 20 people had accessed their scheme, 1 had had 40 to 60 access it, 1 had 100 to 150, and 1 answered ‘other’. In Leicestershire there was one response, and this scheme reported that over 500 people had accessed it. Finally, 3 respondents were from Lincolnshire. One of these reported that their scheme had had 150 to 200 access it, whilst the other 2 stated that 500+ individuals had accessed them.



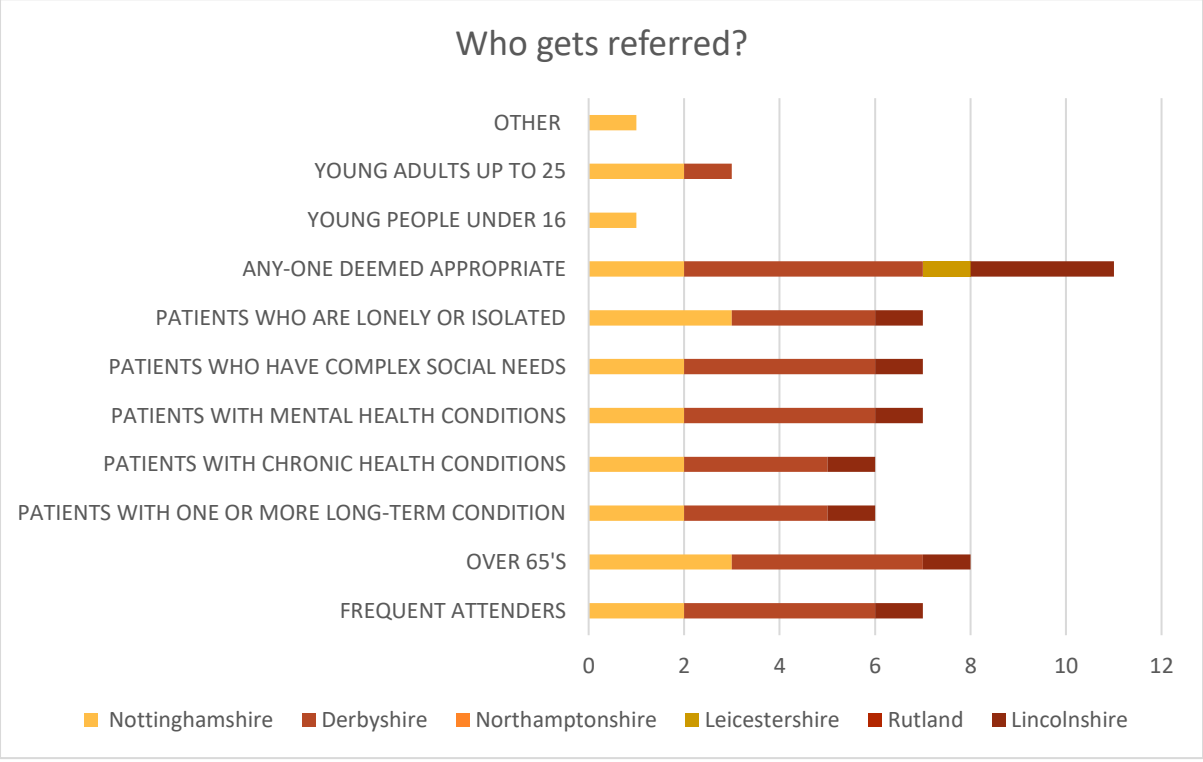
Sixteen respondents answered the question 'On your current funding model what is the anticipated service provision duration?' Responses were from Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire only. There was a total of 7 responses from Derbyshire. Two of these anticipated running for 6 to 12 months, 1 anticipated running for 1 to 2 years, 1 anticipated running for 3 to 4 years, 2 anticipated running for 4 to 5 years, and 1 didn't know. Five of the responses came from Nottinghamshire, and of these 1 anticipated running for 6 months, 1 anticipated running for 6-12 months, 2 anticipated running for 4 to 5 years, and 1 respondent answered 'other'. There were 3 responses from Lincolnshire; 2 of these anticipated running for 6 months or less, and 1 was ongoing. Finally, the only response from Leicestershire indicated that funding was ongoing.



There were 16 responses to the question 'Is there a referral system in place?' Responses were received from Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire only. Apart from one in Nottinghamshire, all of the respondents indicated that there was a referral system in place.

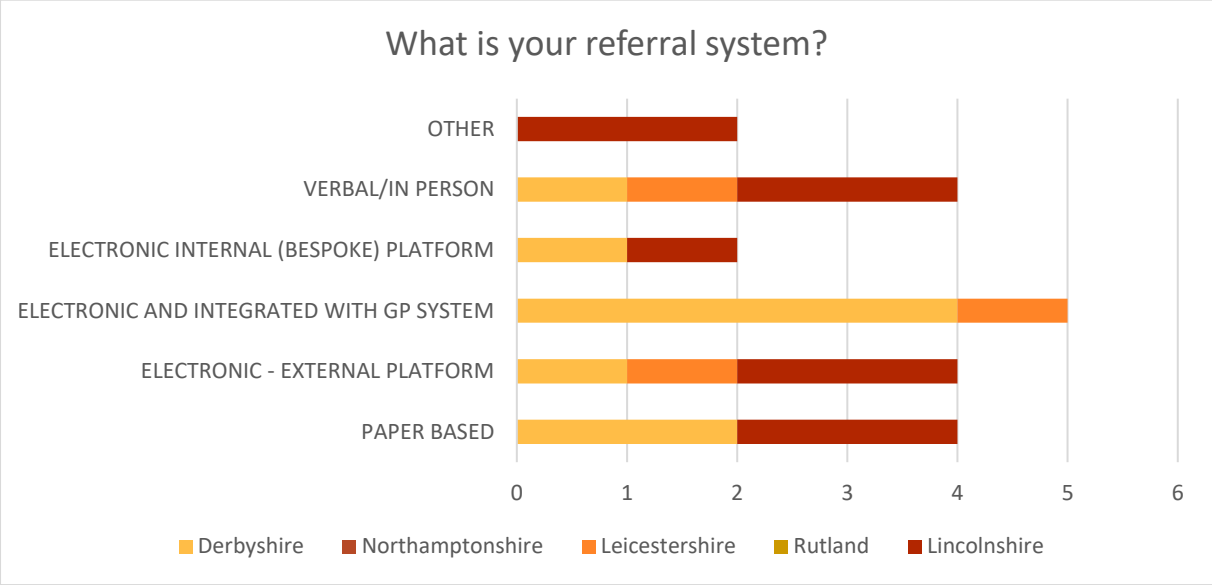


*There were 97 responses to the question 'How do patients/service users/citizens get referred?' Responses came from Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire only. Across the 4 counties the majority of referrals came from GPs (12), followed by self-referral (9) and adult social care (9), community nurses (8) and the fire service (8), housing services (7) and the police (7), hospital discharge teams (6), family members (6) and pharmacists (6), and finally the job centre (5), occupational therapy services (5), and other (3).



*There were 77 responses to the question 'Who gets referred?' Responses were from Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire only. The majority of referrals across the 4 counties were for anybody deemed appropriate (11), followed by the over 65s (8), then frequent attenders (7), patients with mental health conditions (7), patients with

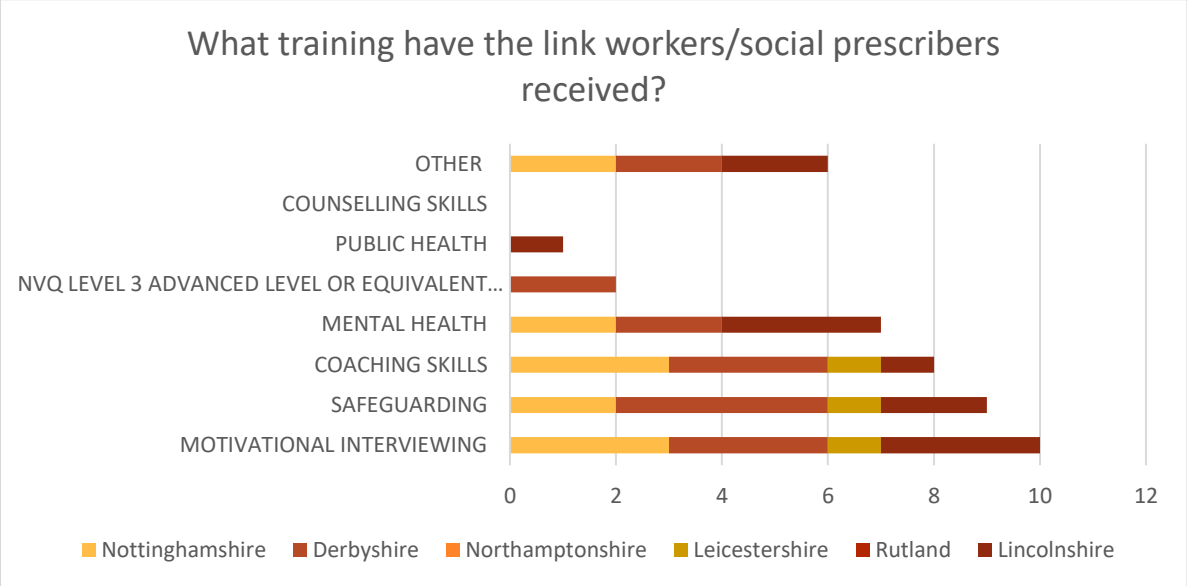
complex social needs (7) and patients who are lonely and isolated (7), and finally patients with complex and/or one or more long term conditions (6) and patients with chronic health conditions (6). Three schemes took referrals for young people up to 25 years old, and only one service accepted referrals for under 16s.



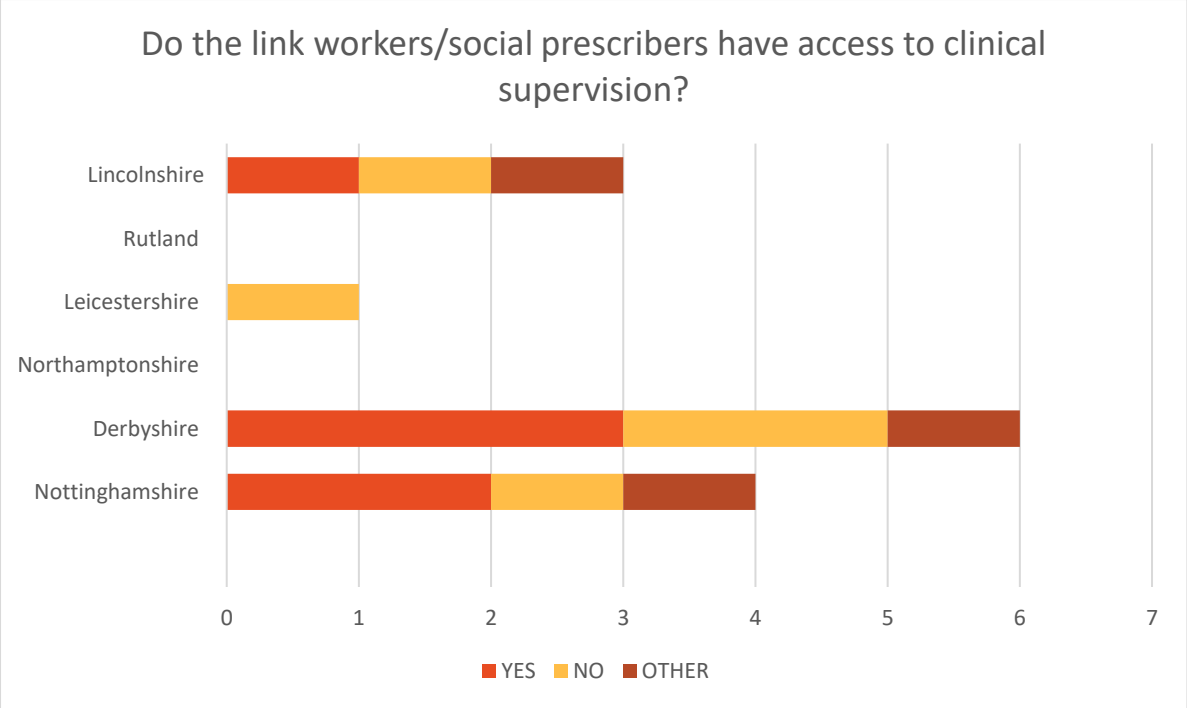
Twenty-seven respondents answered the question 'What is your referral system?' Responses came from Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire only. Across the 4 counties the majority had an electronic system that was integrated with the GP system (7), followed by verbal/in person (5) and paper based (5), then an externally developed platform (4), bespoke platform (3), or other (3).

Thirteen respondents answered the question 'Do you have a voluntary partnership agreement in place with your referral partners?' Responses were from Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire only. Only 3 organisations had a voluntary partnership in place, and these were all in Derbyshire. Across all of the counties there were some schemes that did not have voluntary partnerships in place, with 1 in Derbyshire, 2 in Nottinghamshire, 1 in Leicestershire, and 1 in Lincolnshire. In addition to this a number of

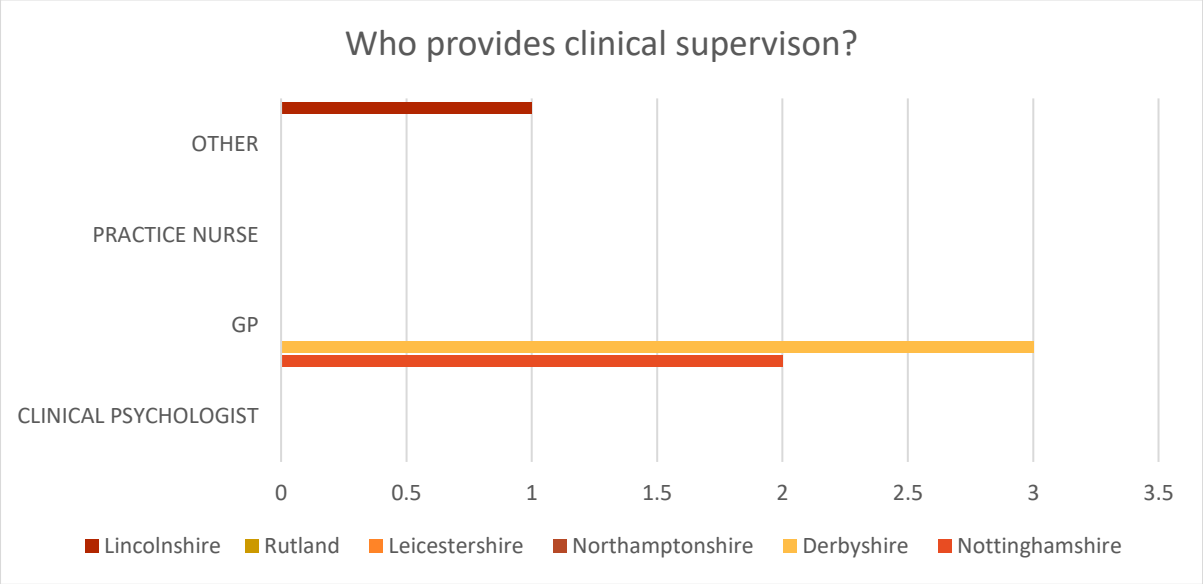
organisations in Derbyshire (2) and Lincolnshire (2) had not set agreements up yet, whilst Nottinghamshire and Lincolnshire both had one respondent who answered ‘other’.



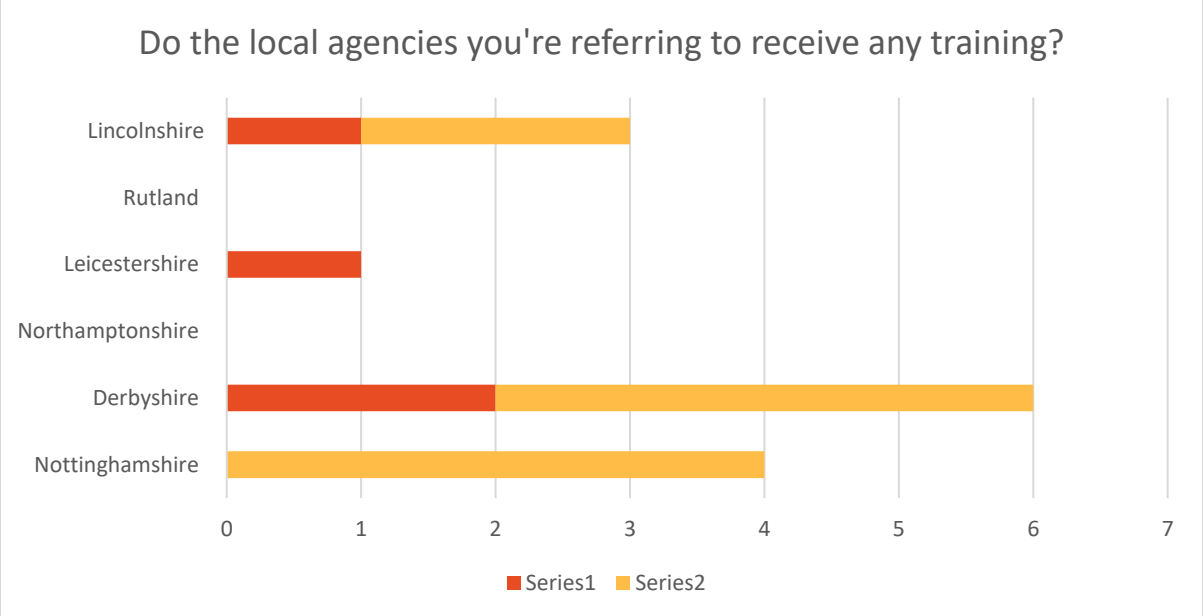
*There were 43 responses to the question ‘What training have the link workers/social prescribers received?’ Responses came from Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire only. The majority of training across the 4 counties was motivational interviewing (10), followed by safeguarding (9), then coaching skills (8), mental health (7) and other (6). Two organisations reported that social prescribers received NVQ Level 3 training or equivalent, and only 1 reported that social prescribers received public health training.



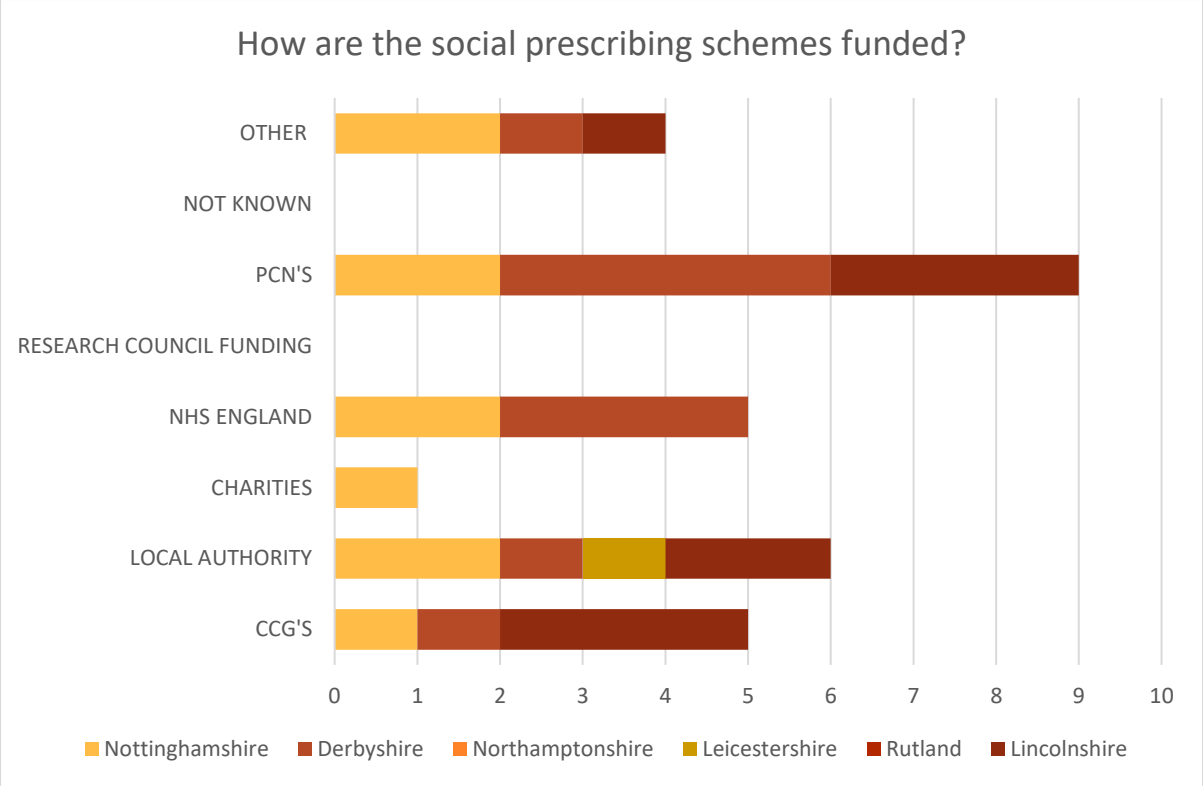
Fourteen respondents answered the question ‘Do the link workers/social prescribers have access to clinical supervision?’ These came from Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire only. The responses indicated that across the 4 counties 6 organisations do offer clinical supervision to link workers/social prescribers, whilst 5 do not. In addition to this, 3 respondents answered the question as ‘other’.



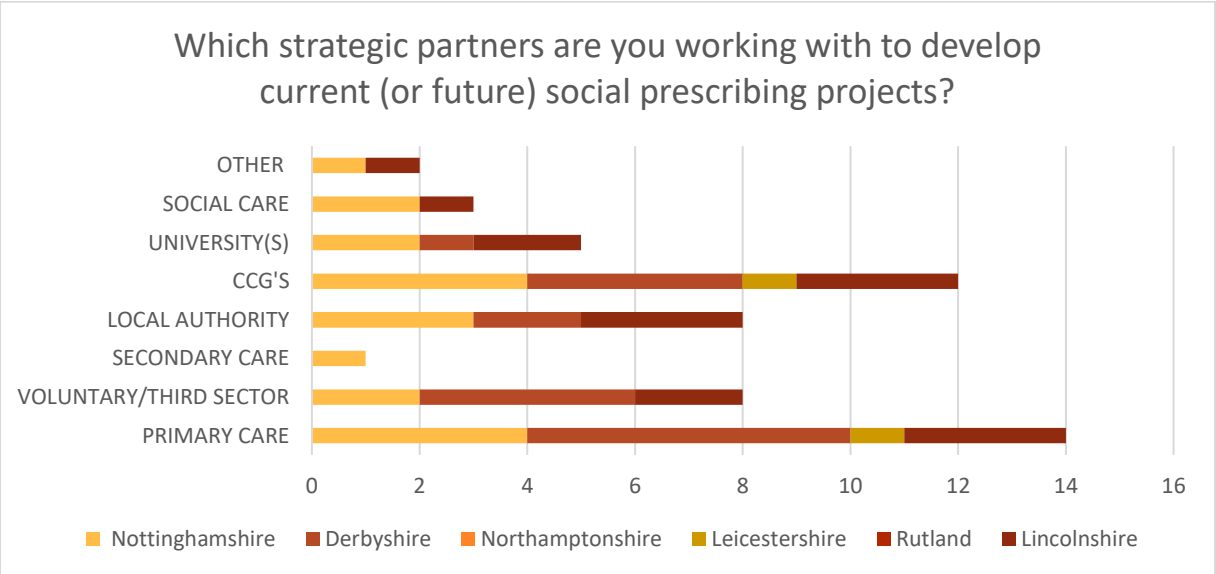
There were 6 responses to the question ‘Who provides clinical supervision?’ These were received from Lincolnshire, Derbyshire and Nottinghamshire only, and indicated that GPs provide clinical supervision in Derbyshire and Nottinghamshire but not Lincolnshire. The 1 respondent from Lincolnshire answered ‘other’.



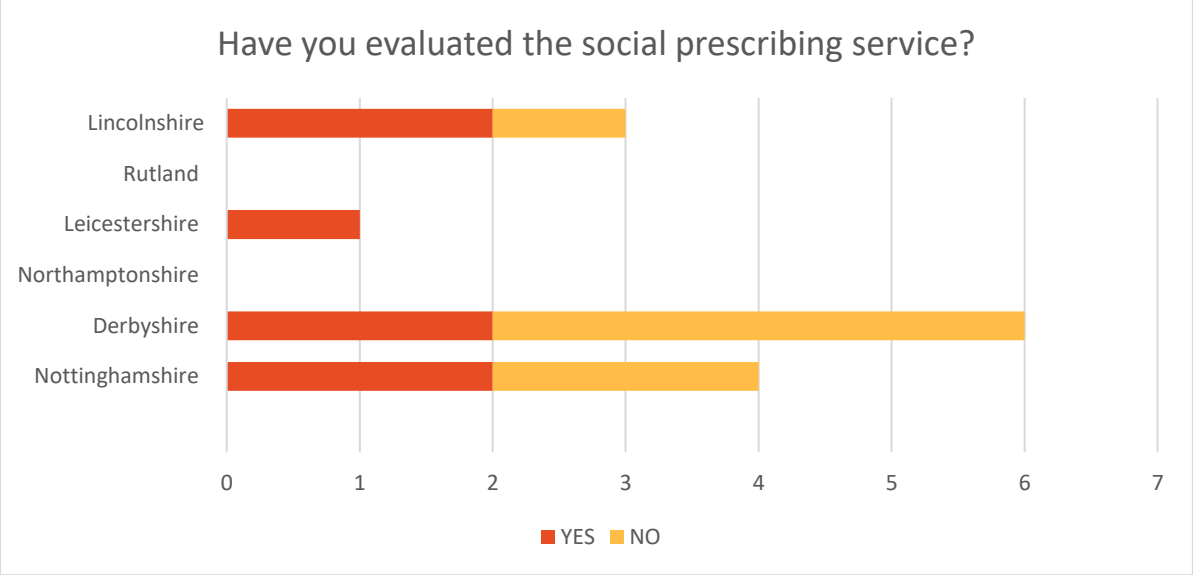
Fourteen respondents answered the question ‘Do the local referral agencies you’re referring to receive any training?’ Responses came from Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire. Only a small number of agencies across Derbyshire (2), Lincolnshire (1), and Leicestershire (1) provided training to local agencies. Ten organisations did not provide any training at all, including 4 in Derbyshire, 4 in Nottinghamshire and 2 in Lincolnshire.



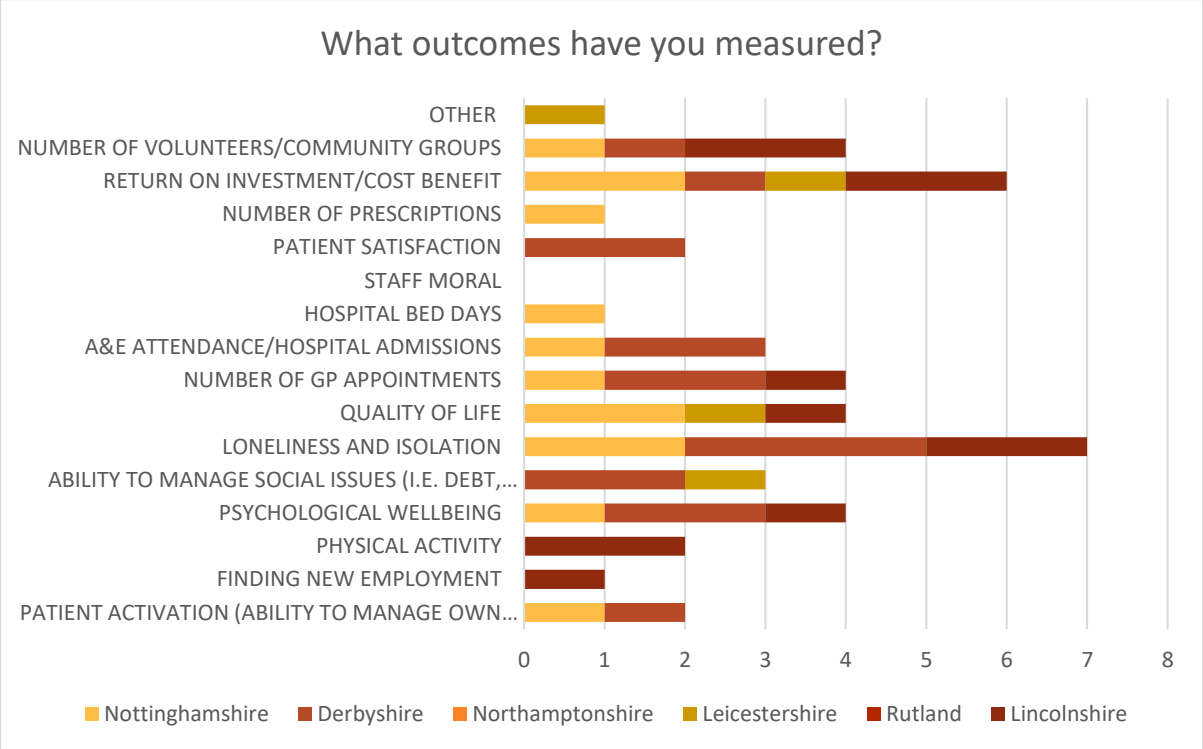
*There were 30 responses to the question 'How are the social prescribing schemes funded?' Responses came from Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire only. The majority of schemes across the counties were funded by PCNs (9), followed by local authorities (6) CCGs (5), NHS England (5), other (4) and charities (1).



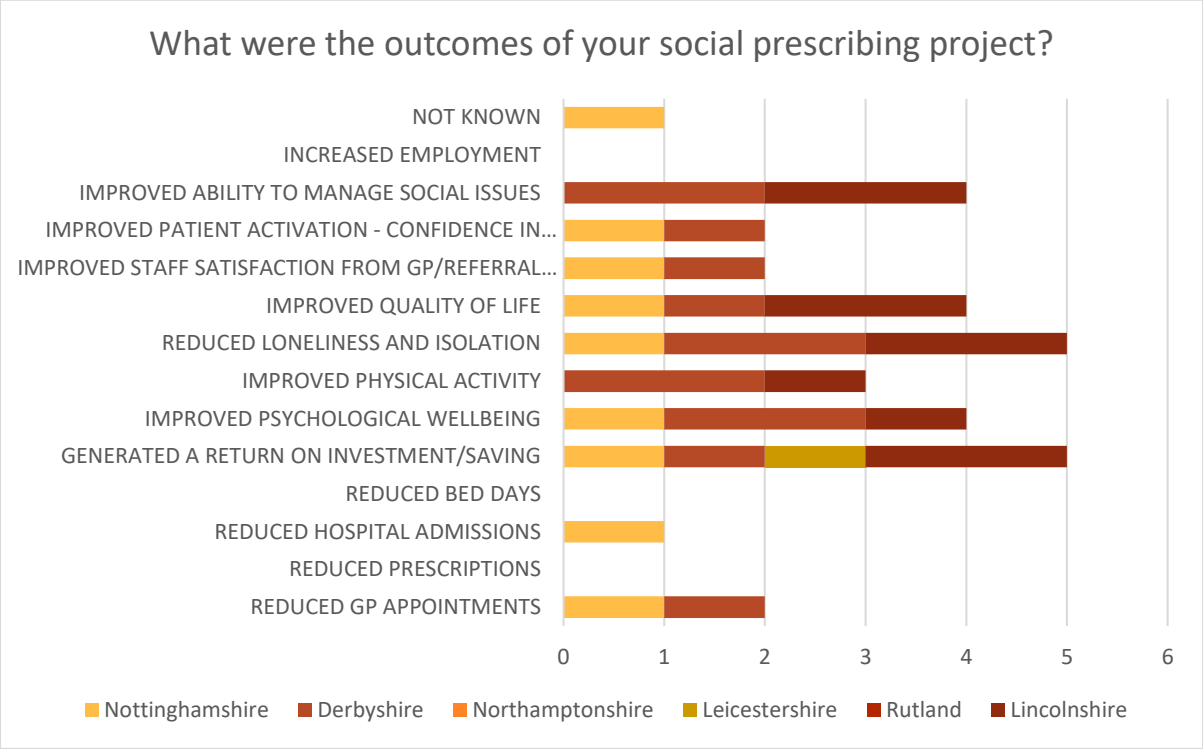
*There were 53 responses to the question 'Which strategic partners are you working with to develop current (or future) social prescribing projects?' Responses came from Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire only. The majority of respondents indicated they had strategic partnerships with primary care (14), followed by CCGs (12), the voluntary sector (8) and local authorities (8), universities (5), social care (3), and other (2).



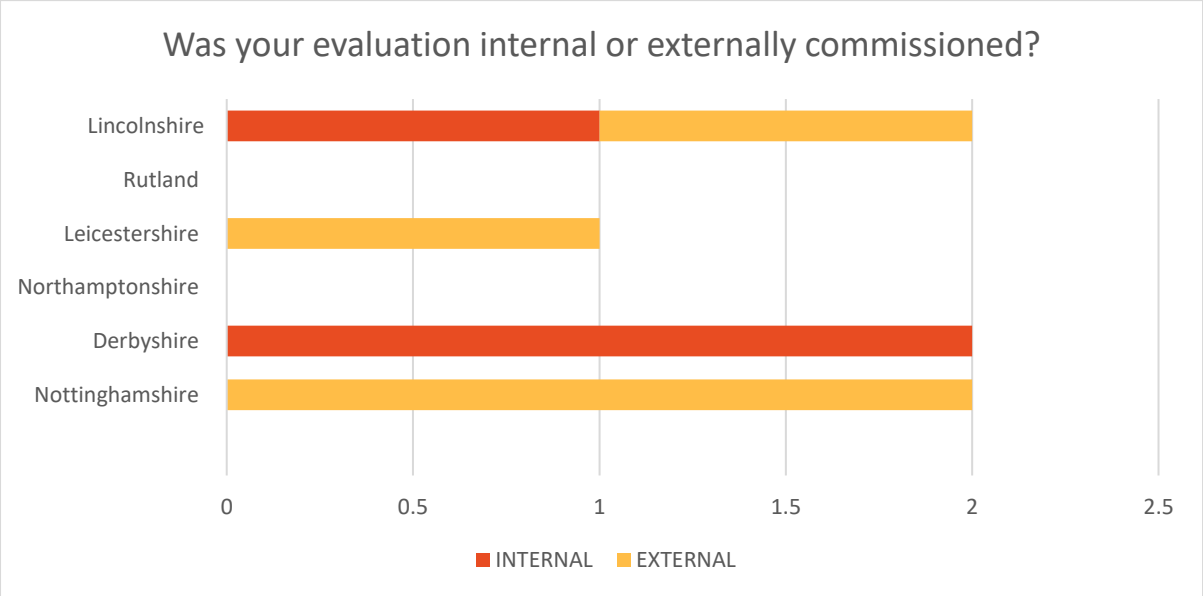
Fourteen of the respondents answered the question 'Have you evaluated the social prescribing service?' These responses came from Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire only. Half of the respondents across the counties had evaluated the schemes (7), and half had not (7).



*There were 45 responses to the question 'What outcomes have you measured?' Responses came from Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire only. In order of popularity, reported outcome measures were loneliness and isolation (7), return on investment (6), psychological wellbeing (4), quality of life (4), number of GP appointments (4), number of volunteers (4) A&E attendance and hospital appointments (3), ability to manage social issues (3), physical activity (2), patient satisfaction (2), number of prescriptions (1), finding new employment (1), and other (1).

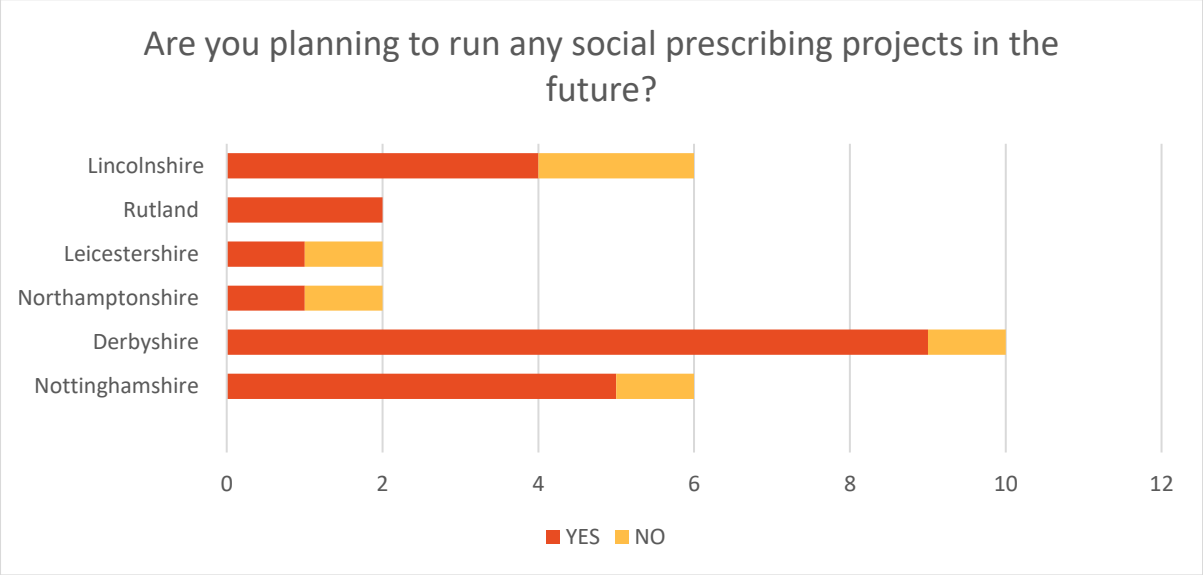


*There were 33 responses to the question 'What were the outcomes of your social prescribing project?' These were from Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire only. The most frequent findings reported were a return on investment (5) and reduction in loneliness and isolation (5). In addition to this, respondents stated that evaluations had found that social prescribing lead to improvements in psychological wellbeing (4), ability to manage social issues (4), quality of life (4), physical activity (3), staff satisfaction (2), patient activation (2) and reduced GP appointments (2), and hospital admissions (1). One respondent indicated that the results of their evaluation were not known.



Seven respondents answered the question 'Was your evaluation internal or externally commissioned?' These were from Nottinghamshire, Derbyshire, Leicestershire and

Lincolnshire only. Responses showed that 3 of the social prescribing schemes were internally evaluated and 4 were underwent external evaluation.



Twenty-eight respondents answered the question ‘Are you planning to run any social prescribing projects in the future?’ Respondents from all 6 counties indicated that they were planning social prescribing projects in the future (22), and only 6 of the respondents reported that they had no future social prescribing plans. Of these, 1 was in Nottinghamshire, 1 in Derbyshire, 1 in Northamptonshire, 1 in Leicestershire, and 2 were from Lincolnshire.

5. QUALITATIVE SURVEY RESPONSES

At the co-production engagement event in May 2019, participants were asked to complete an initial version of the survey and provide feedback on the questions. This copy of the survey contained three open-ended questions, which were as follows:

1. What are the main drivers/enablers to implementing social prescribing in your organisation/region?
2. What are the main barriers/challenges to implementing social prescribing in your organisation/region?
3. What are the three key lessons you would like to share with others across the East Midlands?

In total there were137 responses from the 80 participants who completed the survey.

The feedback from these respondents was incorporated into the survey and the final online version was administered electronically between 1st of November 2019 the 16th of December 2019 and circulated via the EMAHSN network. In total there were 29 responses from 57 participants. This version of the survey included two open ended questions:

1. Do you have any further comments or feedback you would like to add that would give a better understanding of the services or projects you are delivering?
2. What do you feel are your biggest challenges/barriers to delivering a good social prescribing service?

All of the responses from both surveys 166 were thematically analysed (Braun & Clark, 2012) to identify the salient themes for barriers, enablers, and key lessons. These are presented below.

BARRIERS

Significant barriers were expressed by the respondents. These included a lack of funding and financial instability, poor relationships and a lack of trust between GPs and social prescribing providers, the ability of the third sector to cope with and manage referrals, and a lack of awareness about the existence and benefits of social prescribing among the public.

1. Funding.

Approximately one third of respondents cited funding as a barrier to delivering good social prescribing schemes within their organisation or region, and there was a common experience of instability with regards to funding leaving the longevity and sustainability of services uncertain:

'The biggest challenge in delivering a good social prescribing service is financial stability…'

'(the biggest barrier is) securing sustainable funding. There are CCG funding challenges…'

In addition to this, other respondents expressed difficulties due to insufficient funding:

'There is no support or budget to fully implement a great service…'

'One of the biggest barriers is a lack of funding…'

2. **Relationships with GPs, primary care networks and clinical commissioning groups.**

A challenge described by a number of respondents was proving the value of social prescribing to GPs. Among some respondents there was a perception that GPs are suspicious of social prescribing, and that one of the biggest barriers is a lack of belief in its benefits:

'One of the biggest barriers is engaging GPs and getting across the message about social isolation and loneliness.'

'(One of the biggest challenges is that there is a lack of) realisation by practitioners that others can contribute.'

'Engagement with GPs and primary care networks (is) invariably difficult and building an evidence case that is meaningful and impactful for GPs is difficult.'

A lack of strong working relationships between social prescribing providers and GPs, primary care networks and clinical commissioning groups also emerged as a challenge for a number of delivery organisations in the third sector. In particular, a lack of trust was highlighted:

'(There needs to be) increased knowledge and trust between parties.'

'(One of the biggest challenges is a lack of) trust in partnerships.'

3. **Ability of the third sector to cope with referrals.**

Another perceived challenge that emerged from the responses was concern about the capacity and resilience of third sector organisations to cope with a sudden increase in referrals:

'A big challenge is the volume of traffic that will come through the service and therefore the capacity of the community to respond to referrals.'

'One of the largest barriers is the number of (social prescribing) providers.'

4. **Public perception of social prescribing.**

A final challenge that was mentioned by a number of the respondents was the lack of public knowledge about social prescribing. For some of the individuals who completed the survey, the biggest barrier to delivering good social prescribing was either an absence of knowledge or faith in social prescribing among potential recipients:

'The biggest challenge is people's lack of knowledge on social prescribing and its impact.'

'(There needs to be) relevant information available locally for people to learn more about and use the services available.'

Conversely, one respondent suggested that difficulties around public trust of social prescribing could be alleviated by having schemes delivered within the voluntary sector because of its already well-established relationships with the local community:

'(We need to) acknowledge and fund VCSs… their role is pivotal because they already have local knowledge, community relationships and trust of their communities.'

ENABLERS

Three key enablers were cited by the respondents. These were funding for the third sector and organisations providing social prescribing, good partnership working, and social prescribing's ability to reduce the demand on primary and secondary healthcare services.

1. **Funding.**

One of the key enablers cited by respondents was funding. This highlights the need for sufficient and consistent financing in order for social prescribing schemes to be successfully delivered to patients/service users.

'One of the key enablers for the implementation of social prescribing is funding and… commitment to long-term funding.'

'(the biggest enabler is) NHSE money for PCNs!'

One respondent also emphasised the importance of funding for the charities and small organisations that receive a significant increase in clients once social prescribing is implemented:

'Funding for charities (is very important) – social prescribing relies heavily on utilisation of these services.'

2. **Strong partnership working.**

Almost one quarter of respondents reported that the biggest enabler in establishing social prescribing within their region was successful partnerships between different sectors and organisations:

'(The biggest enabler has been) a working group at the integrated care systems level including representatives from healthcare, social services, local authority and the CVS.'

'Links between the voluntary sector and GPs… partnerships at a local level…'

'(What has enabled the development of social prescribing has been) strong partnership working within and across the 8 'places' in Derbyshire.'

3. **Reducing the burden on healthcare services.**

Another factor that emerged as a driver of introducing social prescribing was a need to reduce demand for primary and secondary care healthcare services. These are under continually increasing strain, and patients frequently utilise them despite other services (such as social prescribing) being more appropriate for their needs. For a number of respondents social prescribing was enabled by a need to address this problem:

'(Social prescribing has been driven by a need for better) management of patient presentations at primary and secondary care providers.'

'Social prescribing has been enabled by the need to reduce the number of patients accessing specialist healthcare in the long-term.'

‘(Social prescribing has been enabled because we need to) reduce GP, A&E, and hospital service use.’

KEY LESSONS

In terms of key lessons, three themes emerged from the responses. These were the importance of the voluntary/third sector in the delivery of social prescribing, positive relationships between the NHS and voluntary sector, and the need for clear and robust referral criteria.

1. **Importance of voluntary organisations.**

When sharing key lessons about successful delivery of social prescribing, a number of respondents commented on the importance of voluntary organisations. In order for social prescribing to run effectively, a robust and well supported voluntary sector was seen as key:

‘(There) needs to be… partnership with voluntary sector infrastructure in order that expertise is utilised…’

‘VCSs need to be embedded in social prescribing.’

One respondent also shared their belief that social prescribing should be primarily delivered within voluntary networks:

‘(Social prescribing) needs to sit within the VCS, not the NHS.’

2. **Positive relationships between sectors/organisations.**

A theme that was common among many of the respondents was the need for positive relationships between different organisations and sectors. One third of responses referred to relationships, with strong partnerships and trust being seen as vital to successfully delivering social prescribing:

‘Relationships and trust are vital.’

‘(There needs to be a) joined up approach.’

‘(We must) develop and maintain strong and trusted partnerships (in order to deliver social prescribing successfully).’

3. **Robust criteria.**

Finally, having robust criteria regarding what social prescribing is, and who is it for, was another key lesson that a number of respondents highlighted:

‘Clarity is required regarding criteria.’

‘Robust referral criteria (is) needed.’

6. DISCUSSION AND RECOMMENDATIONS

The in-depth case studies demonstrate the breadth of social prescribing models currently in place in the East Midlands. These are driven and lead by the voluntary sectors, primary care networks and local authorities in their respective localities, each bringing their own unique strengths to the scheme. Different projects are currently utilising key resources and staff such as medical students and community volunteers in order to link service users with beneficial resources and groups in their local community. Integration across the different sectors appears to be a key factor in such projects being successful, as well as continued engagement with and support of the voluntary organisations who receive referrals.

The survey responses offer a broader picture of who is doing what where across the East Midlands. The majority of respondents were from Derbyshire, Nottinghamshire and Lincolnshire, and most worked in the voluntary sector, followed by primary care and local authorities. Most of the respondents said that social prescribing was delivered across the PCNs, and all agreed that social prescribing was prioritised. However, whilst there appears to be good support for social prescribing across the PCNs, it is also clear from the responses that some regions are more developed than others. Three quarters of respondents said that they were running social prescribing projects, however only respondents from Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire indicated that they were currently delivering schemes.

The survey responses also indicated that there are a broad range of models, however embedded link workers and active signposting were the most prevalent. Many of the current schemes have only recently begun, with just under a third being set up within the last three months and just under half in the last year. Of the schemes that have been set up, just under a third have taken less that 40 referrals and half have taken less than 80. Furthermore, just over a third anticipate running less than a year on their current funding model. These responses demonstrate that there are a significant number of recently established social prescribing schemes and that a number of these have limited capacity and resources to take referrals, particularly on current funding models that are short to medium term. This could impact on sustainability and limit the potential benefits and positive outcomes for patients. However, despite the limitations surrounding the duration of funding there appears to be a broad range of financing predominantly from PCNs but also local authorities, CCGs, NHS England and charities.

For well-established social prescribing schemes there are a broad range of referral pathways into the service. Referrals were primarily from GPs, but also the police, community pharmacists, the fire service and social care. The majority of schemes accepted any patients deemed appropriate, which included the over 65s, frequent attenders, patients with complex social needs, individuals who are lonely and isolated, and patients with mental and physical health problems including long term and chronic conditions. Notably, very few schemes took referrals for young people, particularly those under 16. This could be an area of development or focus for schemes in the future.

Whilst a number of schemes were integrated with the GP system or had either internally or externally developed their own bespoke platforms, some still relied on in-person and paper-based referral systems. An area of focus for future schemes could be to look at how they might be able to integrate with the GP systems in order to track and monitor referrals more effectively. The majority of schemes delivered training in motivational interviewing, safeguarding and coaching to their link workers/social prescribers. Only one scheme offered public health training. Given that the social prescribing agenda sits across primary and secondary care and public health, an increase in public health training could be beneficial in the future training and development of social prescribers.

NHS England guidance (2019a) indicates that all link workers should have access to regular clinical supervision. The survey results show that just over half of those that responded do have access to clinical supervision, and that this is predominantly delivered by GPs. Existing and future schemes should consider how they can embed regular clinical supervision for link workers to ensure they feel supported and have a safe space to discuss difficult cases. This is particularly important when working with users who have experienced trauma, as link workers (like other professionals such as social workers) may be at risk of vicarious traumatisation.

All of the survey respondents indicated that they had partnerships. Most of these were with PCNs, followed by CCGs, the voluntary sector and local authorities. Relatively few schemes (just over a quarter) provided training for local agencies. Given the integrated nature of social prescribing across referral agencies it appears that this could be another area for future development.

Only half of the schemes from the survey responses had been evaluated. However, as half of them had also only begun in last 12 months there may not have been a sufficient timeframe for evaluation. Of those that had been evaluated, there were a range of outcome measures. Reduced loneliness and isolation and return on investment were the most frequent, whilst other measures included psychological wellbeing, quality of life, number of GP appointments, number of volunteers, A&E attendance and hospital appointments, ability to manage social issues, physical activity levels, patient satisfaction, number of prescriptions and finding new employment. Of those that had evaluated the schemes these factors were also reported as achieved improvements with the notable exception of improved staff satisfaction. Whether evaluations were internally or externally undertaken was almost evenly split. All respondents indicated that they were planning to deliver social prescribing in the future.

The qualitative responses indicated that there are a number of barriers that social prescribing schemes face. These are lack of long-term funding, relationships with GPs and other key funders (as many providers feel that there is still a lack of trust in social prescribing), the ability of the voluntary sector to cope with the volume of referrals and overcoming public perceptions of social prescribing. Long-term funding and ensuring that social prescribing is utilised suitably and to achieve the maximum impact appears key to its success alongside positive partnership working with primary care, commissioning bodies and the voluntary sector, as well as maintaining public and service user confidence. Recognising the key role of the voluntary sector as a core delivery partner was also cited as a key enabler, as well as demonstrating the return on investment of social prescribing schemes in terms of their ability to reduce burden on the health service.

7. RECOMENDATIONS

Identify key respondents: There are some notable limitations of this study. The responses to the survey may not be representative or have captured all of the social prescribing activity in the East Midlands. The survey was distributed to the EMAHSN contacts and networks and via social media (Twitter). For future surveys that wish to capture social prescribing activities across geographical regions, it is important to identify key contacts who are involved with or leading social prescribing projects before distributing the survey and targeting them specifically. It may have been that the respondents in this study were simply unaware of the social prescribing activity in their region or specific details of the schemes, hence the drop off in responses at the start and end of the survey.

Identify changes over time: The survey only captures responses and social prescribing activity at a specific point in time. During the study period of May to November 2019 there were specific policy and structural changes such as the formation of primary care networks and the introduction of NHS England funding to recruit link workers via the new PCNs. As a consequence, there was increased activity and focus on social prescribing across the East Midlands. Some areas may have had plans to implement social prescribing schemes that had not yet been realised at the time of the survey, meaning that some respondents were unable to answer questions specifically related to social prescribing programmes. Because of this, it may be useful for EMAHSN to run the survey on annual basis in order to benchmark and identify the spread of social prescribing over time.

Reporting metrics: The survey used NHS England guidance as well as co-production methods to design the questions. If EMAHSN and other Academic Health Science Networks (AHSNs) are able to share the responses with the organisations completing the surveys, this will allow them to benchmark their progress against others and capture key metrics which could be useful to report back to funders and commissioners such as NHS England and other key stakeholders. These metrics may have some regional variations, so it is recommended that other AHSN's review and adapt the questions by engaging with organisations involved in social prescribing so that the survey suits their specific requirements. Supplementing the surveys with in-depth case studies and patient stories gives a broad picture of the activities undertaken and illustrates the benefits of the social prescribing service(s).

Share best practice: In addition to identifying what social prescribing activity was happening where, one of the aims of this study was to enable the sharing of best practice in terms of social prescribing across the region. A key facet of this was the initial engagement event in May 2019. This enabled those involved in social prescribing to come together and share current social prescribing projects, and through this an EMAHSN social prescribing network was established. The in-depth case studies are also useful as they allow exemplar social prescribing projects to be shared and illustrate the breadth of successful delivery models.

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APPENDIX 1

East Midlands
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East Midlands Social Prescribing Scoping Protocol

1. Introduction

The East Midlands Academic Health Science Network (EMAHSN) has commissioned the University of Leicester (UoL) to develop a protocol (or tool) to help organisations across the East Midlands to scope where they are in implementing social prescribing in their area.

This survey will ask questions about what models of social prescribing you and your colleagues/team are implementing in the East Midlands and how you are implementing them. This data will be used to identify the variety and breadth of social prescribing models and allow benchmarking of progress and sharing of best practice across the region.

All information gathered will be used for the purposes of the study and any personal information provided will be kept confidential. Data will be accessed by the EMAHSN and the UoL research team. Taking part is voluntary, you can withdraw at anytime.

For further information please contact Dr Ceri Jones on crj10@leicester.ac.uk

* 1. I understand the purpose of the project in which I am participating and have been given the contact details of an individual to contact if I have questions.

I understand that all information will be kept securely in accordance Data Protection Act (2018) and GDPR Regulations.

I understand that participation is voluntary and that I can withdraw at any time until the study is completed.

I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis.

I give permission for the EMAHSN and UoL research team to have access to the data and information that I provide, and to store, analyse and publish information obtained by my participation in this study.

I understand that my personal details will be kept confidential.

I understand that the findings and service/project details may be shared with relevant parties for spread and dissemination through the AHSN network and relevant NHS organisations, and utilised in academic publications and conference presentations.

I consent to take part in the study.

- [ ] Yes
- [ ] No

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2. Demographic Information

* 2. In order to maintain your anonymity, we need to devise a unique code to collate and match your responses over time. Please answer the following questions to generate a unique 3 item identifier.

What is the second letter of your surname?	
What is the third letter of the street where you live?	
What is the month you were born?	

3. Which organisation do you work for?

- ◯ Voluntary Organisation/Third Sector
- ◯ Council for Voluntary Service (or equivalent)
- ◯ Local Authority
- ◯ Primary Care Network
- ◯ Other (please specify)
- ◯ Mental Health NHS Trust
- ◯ Acute Hospital NHS Trust
- ◯ Community Health Services NHS Trust
- ◯ CCG

4. What is your job title?

5. Which geographical area does your job role cover?

- ☐ Nottinghamshire
- ☐ Derbyshire
- ☐ Northamptonshire
- ☐ Leicestershire
- ☐ Rutland
- ☐ Lincolnshire
- ☐ Other (please specify)

6. What is your job role?

- ◯ CEO
- ◯ Director
- ◯ Senior Manager
- ◯ Manager
- ◯ Pharmacist
- ◯ Nurse
- ◯ General Practitioner (GP)
- ◯ Clinical Psychologist
- ◯ Link worker/Social Prescriber
- ◯ Social Prescribing Project lead/co-ordinator
- ◯ Other (please specify)
- ◯ Practice Manager
- ◯ Practice Receptionist
- ◯ Academic/Researcher
- ◯ Patient Leader
- ◯ Health Coach
- ◯ Counsellor
- ◯ Occupational Therapist
- ◯ Care Navigator
- ◯ Public Health Consultant

7. What was your Clinical Commissioning Group prior to April 2019?

- [ ] East Leicestershire and Rutland CCG
- [ ] Leicester City CCG
- [ ] West Leicestershire CCG
- [ ] Lincolnshire South CCG
- [ ] Lincolnshire East CCG
- [ ] Lincolnshire West CCG
- [ ] South West Lincolnshire CCG
- [ ] Corby CCG
- [ ] Nene CCG
- [ ] Erewash CCG
- [ ] Hardwick CCG
- [ ] North Derbyshire CCG
- [ ] Southern Derbyshire CCG
- [ ] Mansfield and Ashfield CCG
- [ ] Newark and Sherwood CCG
- [ ] Nottingham City CCG
- [ ] Nottingham North and East CCG
- [ ] Nottingham West CCG
- [ ] Rushcliffe CCG
- [ ] Bassetlaw CCG
- [ ] Other (please specify)

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3. Primary Care Network?

8. Is your social prescribing service delivered across a Primary Care Network/s (PCN)?

- Yes
- No
- Don't know

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4. Primary Care Networks

9. How many PCNs are included?

0 — 50

10. What are the names of PCN's (if known)

11. Of those PCN's how many have a link worker(s) in post?

0 — 50

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5. Social Prescribing is it prioritised?

12. Are Social Prescribing services a priority in your area?

- ◯ Yes
- ◯ No
- ◯ Don't know

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6. Social Prescribing Priorities

13. How is social prescribing prioritised in your region/organisation (tick all that apply)?

- ☐ It is in the Sustainability and Transformation Partnership (STP) Priorities
- ☐ It is in the Health and Wellbeing Board Plan
- ☐ It is in the Local Authority Plan
- ☐ Other (please specify)
- ☐ It is in the CCG operational plan/commissioning intentions
- ☐ Supported by PCN's

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7. Current Social Prescribing Services

14. Are you or your organisation currently running any Social Prescribing services?

◯ Yes

◯ No

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8. Social Prescribing Services

15. What is the name of your social prescribing service and website link if known?

16. What social prescribing model(s) does it use? (Please tick all that apply)

- [ ] Active signposting
- [ ] Employed and embedded link worker/social prescriber
- [ ] Voluntary community navigators
- [ ] Shared decision making
- [ ] Personalised care and support planning
- [ ] Supporting community groups to be accessible and sustainable
- [ ] Physical introduction of patients/citizens/ service users to community groups
- [ ] Supporting the set up of new community groups
- [ ] Funding new community groups
- [ ] Home visits
- [ ] Other (please specify)

17. How long has your social prescribing scheme/service been running for?

- ( ) 0-3 months
- ( ) 3-6 months
- ( ) 6-12 months
- ( ) 1-2 yrs
- ( ) 2-3yrs
- ( ) 3-4yrs
- ( ) 5+yrs
- ( ) Not known
- ( ) Other (please specify)

18. How many patients/service users/citizens have accessed the scheme?

- ( ) 0-20
- ( ) 20-40
- ( ) 40-60
- ( ) 60-80
- ( ) 80-100
- ( ) 100-150
- ( ) 150-200
- ( ) 250-300
- ( ) 300-350
- ( ) 350-400
- ( ) 400-450
- ( ) 500 +
- ( ) Other (please specify)

19. On your current funding model what is the anticipated service provision duration?

- ◯ 6 months
- ☐ 6-12 months
- ☐ 1-2 yrs
- ☐ 2-3 yrs
- ◯ 3-4 yrs
- ◯ 4-5 yrs
- ☐ 5-10 yrs
- ☐ Ongoing
- ☐ Dont know
- ◯ Other (please specify)

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9. Referral system?

20. Is there a referral system in place?

- ☐ Yes
- ◯ No

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10. Referrals

21. How patients/citizens they get referred (tick all that apply)?

- [ ] By the GP/Primary care
- [ ] Local authority
- [ ] Self referral
- [ ] Referral by family member
- [ ] Adult social care
- [ ] Housing provider
- [ ] Police
- [ ] Other (please specify)
- [ ] Fire service
- [ ] Pharmacy
- [ ] Hospital discharge teams
- [ ] Community nurses
- [ ] Job centre
- [ ] Occupational therapy

22. Who gets referred (who gets referred)?

- [ ] Frequent attenders
- [ ] Over 65's
- [ ] Patients with one or more long-term condition
- [ ] Patients with chronic health conditions
- [ ] Patients with mental health conditions
- [ ] Patients who have complex social needs
- [ ] Patients who are lonely or isolated
- [ ] Any-one deemed appropriate
- [ ] Young people under 16
- [ ] Young Adults up to 25
- [ ] Other (please specify)

23. What is your referral system?

- [ ] Paper based
- [ ] Electronic - external platform
- [ ] Electronic and integrated with GP system
- [ ] Electronic internal (bespoke) platform
- [ ] Verbal/in person
- [ ] Other (please specify)

24. Please provide name/details of your referral system?

25. Do you have a voluntary partnership agreement in place your referral partners

- ◯ Yes
- ◯ No
- ◯ Not yet
- ◯ Other (please specify)

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11. Work Force Development

26. What training have the link workers/social prescribers received (tick all that apply)?

- [ ] Motivational Interviewing
- [ ] Safeguarding
- [ ] Coaching skills
- [ ] Mental health
- [ ] NVQ Level 3 advanced level or equivalent qualification
- [ ] Public health
- [ ] Counselling skills
- [ ] Other (please specify)

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12. Clinical Supervision?

27. Does the link-worker/social prescriber have access to clinical supervision?

- [ ] Yes
- [ ] No
- [ ] Other (please specify)

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13. Clinical Supervision

28. Who provides clinical supervision to the social prescriber/link worker?

- [ ] Clinical psychologist
- [ ] GP
- [ ] Practice Nurse
- [ ] Other (please specify)

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14. Agency Training?

29. Do the local referral agencies your referring to receive any training?

- [ ] Yes
- [ ] No

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15. Agency training

30. Which organisation provides the training?

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16. Strategic Partnerships

31. How are the social prescribing schemes funded (tick all that apply)?

- [ ] CCG's
- [ ] Local Authority
- [ ] Charities
- [ ] NHS England
- [ ] Research Council funding
- [ ] PCN's
- [ ] Not known
- [ ] Other (please specify)

32. Which strategic partners are you working with to develop current (or future) social prescribing projects (tick all that apply)?

- [ ] Primary Care
- [ ] Voluntary/Third Sector
- [ ] Secondary Care
- [ ] Local Authority
- [ ] CCG's
- [ ] University(s)
- [ ] Social Care
- [ ] Other (please specify)

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17. Evaluation

33. Have you evaluated the social prescribing service?

- ◯ Yes
- ◯ No

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18. Evaluation and Outcomes

34. What outcomes have you measured (tick all that apply)?

- [ ] Patient activation (ability to manage own condition)
- [ ] Finding new employment
- [ ] physical activity
- [ ] Psychological wellbeing
- [ ] Ability to manage social issues (i.e. debt, housing, mobility)
- [ ] Loneliness and isolation
- [ ] Quality of life
- [ ] Number of GP appointments
- [ ] A&E attendance/Hospital Admissions
- [ ] Hospital bed days
- [ ] Staff moral
- [ ] Patient satisfaction
- [ ] Number of prescriptions
- [ ] Return on Investment/Cost benefit
- [ ] Number of volunteers/community groups
- [ ] Other (please specify)

35. What scales/measures/surveys did you use?

36. What were the outcomes of your social prescribing project (tick all that apply)?

- [ ] Reduced GP appointments
- [ ] Reduced prescriptions
- [ ] Reduced hospital admissions
- [ ] Reduced bed days
- [ ] Generated a return on investment/saving
- [ ] Improved psychological wellbeing
- [ ] Improved physical activity
- [ ] Reduced loneliness and isolation
- [ ] Improved quality of life
- [ ] Improved staff satisfaction from GP/referral agencies
- [ ] Improved patient activation - confidence in managing health conditions and own wellbeing
- [ ] Improved ability to manage social issues
- [ ] Increased employment
- [ ] Not known
- [ ] Other (please specify)

37. Was your evaluation internal or externally commissioned?

- ◯ Internal
- ◯ External
- ◯ Other (please specify)

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19. Future Activity

38. Are you planning to run any Social Prescribing projects in the future?

- ◯ Yes
- ◯ No

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20. Future Social Prescribing Projects

39. What is the anticipated start date of your future social prescribing service?

40. Can you provide a name and brief details?

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21. Comments and Feedback

41. Do you have any further comments or feedback you would like to add that would give a better understanding of the services or projects you are delivering?

42. What do you feel are you biggest challenges/barriers to delivering a good social prescribing service?

43. Any further comments on questionnaire?

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22. Thank-you!

We appreciate your time taking part in this survey. The feedback you have provided has been very valuable. Thank-you!

For further information please contact Dr Ceri Jones at the University of Leicester on crj10@leicester.ac.uk