Evaluation of the new Voluntary, Community and Social Enterprise Health and Wellbeing Programme

Health and Wellbeing Project Fund – final report

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1.0 Introduction

In July 2017, Ecorys was commissioned by the department of Health and Social Care (DHSC) to undertake an independent evaluation of the new Voluntary, Community and Social Enterprise Health and Wellbeing programme (the "programme").[1] The programme included 2 separate elements, the Health and Wellbeing Alliance (the "alliance") and the Health and Wellbeing Project Fund (the "fund"). The evaluation was designed to include process and impact evaluations of both these elements, with this report focusing on the fund. A separate report has been produced for the alliance element.

1.1 Policy background

DHSC has an extensive history of providing grant funding support for Voluntary, Community and Social Enterprise (VCSE) organisations across England. The Voluntary Sector Investment Programme (VSIP) was launched in 2008 and provided thematically cross-cutting VCSE grants across the sector. It was run by DHSC (then the department of Health) until 2013, when NHS England and Public Health England (PHE) joined as system partners. The VSIP sought to fund VCSE organisations to realise their potential; build capacity within as well as across the sector; develop their own services and provide new solutions that were scalable. There were 3 main funding schemes within the programme:

- the Innovation, Excellence and Strategic Development Fund (IESD)
- the Health and Social Care Volunteering Fund (HSCVF)
- the Strategic Partner Programme (SPP)

The May 2016 Investment Review of the VCSE sector (department of Health, Public Health England, NHS England 2016) recommended a reshaping of VSIP, with the 3 funding schemes being merged into a single Health and Wellbeing Programme, consisting of project funding and partnership elements. These became the fund and alliance elements. Development of this merged programme was supported by an oversight group comprising representatives from the 3 system partners and VCSE organisations.

This development process took place at a time of change, both in terms of the commissioning landscape and wider health sector and how it worked with statutory agencies. It also took into consideration the 2014 launch of the Five Year Forward View NHS. This outlined a consensus on the need for change and a shared ambition for the future of national health, stressing the importance of building new relationships with people

[1] Including Dr Richard Kimberlee University of the West of England, Bristol as academic adviser on elements relating to social prescribing.

and communities. The later 2016 publication of the PHE Strategic Plan set out a complementary vision of the organisation's role in protecting and improving the public's health and reducing inequalities.

1.1.1 The VCSE Health and Wellbeing Programme

Following this development process, the VCSE Health and Wellbeing Programme ("the HW programme") launched in December 2016. DHSC, NHS England and Public Health England established the programme to work with VCSE organisations, in order to 'drive transformation of health and care systems to promote equality and address health inequalities and help people, families and communities to achieve and maintain wellbeing'.

The objectives of the programme were to:

- encourage co-production in the creation of person-centred, community-based health and care which promotes equality for all
- enable the voice of people with lived experience and those experiencing health inequalities to inform national policy making and shape the delivery of services
- build evidence of sustainable, scalable solutions to mitigate and prevent inequalities impacting on health and wellbeing of communities

The HW programme established two interdependent strands to meet its objectives:

- a national partnership arrangement: the VCSE Health and Wellbeing Alliance (HW alliance)
- funding for bespoke social prescribing schemes, embedded in and influenced by the communities they serve: the VCSE Health and Wellbeing Project Fund (HW fund)

The HW fund strand was designed to have separate rounds of funding over time, each based upon a separate theme. The first HW fund theme introduced in 2018 was social prescribing, with schemes receiving funding over 3 years, with new funds being launched alongside any existing themes on an on-going basis (a second theme on children and young people's mental health was launched in 2019). The HW fund sought applications from VCSE organisations to either establish new social prescribing services or build on the work of existing social prescribing schemes.

1.1.2 Social prescribing

Social prescribing is an intervention by which people are supported to access community assets and other non-clinical/non-medical services that seek to increase levels of health

and wellbeing. Typically, a community navigator or link worker works through an assessment of need with the recipient and works with them to co-produce a plan that is bespoke to their wants and needs. Plans range from providing advice or support on issues such as debt or benefits to helping people engage with arts-based, physical activity or befriending groups that interest them. Progress is usually reviewed on a regular basis and amended where required. The overall approach fits with a needs-based model of community care that seeks to link individuals and communities, thereby improving and sustaining health and wellbeing[2].

1.2 Evaluation of the programme

The evaluation of the VCSE Health and Wellbeing Programme consists of overall programme objectives as well as specific objectives for both the alliance and fund elements of the work. The evaluation objectives are set out below.

[2] The social prescribing network use the definition of it as: “Enabling healthcare professionals to refer patients to a link worker, to co-design a nonclinical social prescription to improve their health and wellbeing”

Evaluation objectives of the programme

1. Assess outcomes and impact against the three overall programme objectives
2. Design evaluation metrics to be included into interim reports every 6 months and evaluation report
3. Assess programme management, representation, split of work across members and overall experience for members
4. Reflect the programme focus on protecting equalities and reducing inequalities
5. Measure/assess the social value of the programme
6. Incorporate lessons learned into ongoing monitoring
7. Deliver systems of outcome/impact evaluation that can be adopted going forwards

Evaluation objectives of the project fund

1. Design a straightforward, sustainable process for evaluating outcomes for project grants (including a report in Spring 2019)
2. Build evaluation measures into monitoring and assessment processes for fund applicants
3. Assess the value for money of the fund and its projects
4. Report on impact of project fund topic (social prescribing)

Evaluation objectives of the alliance

1. Assess effectiveness of integrated work and co-production between voluntary and statutory sectors

A mixed methodology evaluation framework was adopted, incorporating feedback from stakeholders via interviews supplemented with quantitative data from a Common Measurement Framework (CMF). The evaluation took a light-touch approach to make the most of a limited budget (resultant data limitation are noted later in this section). Data collection included the following elements:

- Eighteen telephone interviews with successful scheme leads: 4 taking place in 2018 to provide initial feedback on project development, and 14 in 2019 and early 2020 to provide a longer-term perspective

- Two ‘deep dive’ case studies. 2 schemes were visited for a day each to collect the data. This consisted of semi-structured interviews with a range of stakeholders, including those receiving social prescription (clients), the scheme staff and wider community partners. Desk-based research was also incorporated to review relevant documents, specific to the local scheme. Included in Appendix 1, are case-studies detailing 4 client journeys (see page 43 of this report)

- Six telephone interviews with policy stakeholders. These included stakeholders from the system partners and experts from local and regional bodies (across 5 different organisations in total)

- CMF data requested from all schemes providing demographic and outcome information for participants across their involvement in the project

As the fund developed, the focus of the evaluation developed to include an increased focus on how schemes were able to gather data; using the evaluation as an opportunity to test the CMF content as opposed to a sole focus on the outcomes themselves (which were still collected). This reflected the growing interest across the health sector in examining approaches to measuring social prescribing outcomes.

1.2.2 Theory of change

An initial theory of change (ToC) was developed by Ecorys in November 2017 to outline the different elements that made up both the fund and alliance strands of the programme. This was based on initial programme documentation and later supplemented with feedback from both alliance and fund members, and the wider programme steering group.

1.2.3 Common measurement framework

A CMF was designed to record and collate key data. An initial list of possible measures was developed by Ecorys in conjunction with external experts. HW fund staff then provided feedback in an initial evaluation workshop resulting in a list of final measures being developed as part of an iterative process. Individual participant-level data included demographics (for example, ethnicity and gender), whether an NHS number could be accessed (to link to administrative data if required) and outcomes data.

The final version of the CMF was a spreadsheet requiring respondent level data to be provided at three stages:

- baseline stage: when clients first engaged with the project
- end stage: when clients finished engagement with the project
- long-term follow-up: where possible, a final set of data from 3 to 6 months after the end stage

1.3 Data limitations

This section outlines in brief limitations with the data provided in this report, with these being particularly important given the relatively small-scale of the evaluation for this project. While the evaluation provides considerable information and detail on the fund, the following should be taken into consideration:

- the report relies primarily on qualitative interviews with scheme leads and, to a lesser extent, policy stakeholders and therefore represents the perspectives of these stakeholders. Feedback from these interviews is used to show the range of different viewpoints held and should not be taken as indicative of the prevalence of particular opinions. Themes are referred to as “major” or “minor”, to provide a broad indication of the general strength of opinion or experience that emerged through the content analysis, across the whole dataset
- the data in the report was gathered up to May 2020, with funding ending in 2021. As a result, longer-term elements of the ToC, primarily the “outcomes” and “impact” sections, do not form a core part of the evaluation
- interviews with scheme leads provide valuable feedback from across the range of organisations involved in the fund but should not be taken as representing the view of all scheme staff

- the policy stakeholder interviews reflect the views of 6 individuals in total, 3 of the 6 were directly involved with the fund, either by working locally with a scheme, or as part of the design and implementation for social prescribing. This helps provide an overview of the considerations of this group and contextualises findings.

- collection of CMF data varied by organisation depending on their existing systems and capacity. The absence of consistent follow-up data meant that analysis of change in outcomes at a fund level was not possible

- the views of those who were unsuccessful in applying for funding were not included in the scope of the evaluation

1.4 Report structure

Chapter 2 of this report examines the application and set-up process of the fund and reviews the range and focus of activities undertaken by the member organisations. Chapter 3 explores delivery models and practice examples taken from the evaluation learning. Chapter 4 explores the intermediate outcomes and the evidence base for social prescribing with key policy stakeholder input. Chapter 5 explores opportunities and threats for sustainability and future development, and chapter 6 presents conclusions and recommendations.

2.0 Application and set-up

This chapter reviews the application process and how social prescribing approaches were designed, developed and implemented.

2.1 Application requirements

Applications were requested from organisations that were either registered or incorporated charities and applicants were required to provide evidence of a commitment from local statutory partners for project resourcing. The government grant would fully fund the scheme costs in year one and reduce in subsequent years as local statutory funding increased. For local statutory organisations this meant they paid 0% in year 1, 50% in year 2 and 80% in year 3, with a view to realising full funding from statutory partners for the scheme as the government grant came to end after the third year. Applications were invited from both new and existing social prescribing schemes. Potential schemes were also asked to show that they:

- included the community navigator role within their social prescribing scheme model
- were able to demonstrate strong established links with local partners and had a partnership agreement signed by the relevant CCG/s, local authority/authorities, and general practices
- were committed to input experience and share learning with NHS England about measuring the impact of social prescribing
- were committed to share learning and contribute evidence towards evaluation of the fund
- were committed to joining the national social prescribing network and, if relevant, their local regional social prescribing network

All applications were required to demonstrate how their scheme would embed and support a community navigator or link worker role. Schemes were encouraged to design models that would meet the needs of their respective areas of working and draw on existing community assets. There was no requirement to focus on particular patient groups, but applications were required to outline how the scheme would contribute to reducing health inequalities.

The application process involved initial applicants being shortlisted and then a review prior to final selection.

2.2 Overview of successful organisations

The 23 schemes that received funding were a mix of established, or, piloted/new services. Established services were those that had been delivering models of social prescribing for 2 or more years, with piloted/new services those that were entirely new or that had run a short-term trial of a model (usually for the maximum of 1 year).

For both established and piloted/new services the HW fund was seen as an opportunity to extend, grow and embed their work on social prescribing, rather than simply maintaining what was existing through a new funding stream. A lead of a piloted scheme mentioned that their initial work encouraged them to get involved in the Fund:

> "…we had shown the potential and the success that we could have. We wanted to be part of the development gaining knowledge of how infrastructures would work. We thought it would enable us to take the next step required whilst monitoring outputs and outcomes - to see what next direction of travel should be with it. Whether it would be investment in infrastructure and how mature IT systems are, or staff training and development."

This example illustrated how schemes saw the programme not only as an opportunity for delivery, but also for the further development of systems and processes, as well as capacity building and development amongst staff.

Some funded organisations intended to deliver the scheme on their own. Others planned to deliver in partnership with other local VCSE organisations. Where they took the latter approach, the approach was usually to split cases across organisations, based on level of patient need (for example low or moderate).

Certain schemes had a demographic focus, for example to work with older people, or, children and adolescents. Others had a more thematic focus, based on supporting those who were lonely or socially isolated. Within that, some schemes had specialist delivery partners that were using their specialist skills and knowledge to work effectively with people from marginalised communities, such as transgender clients, or Roma, Gypsy and Traveller clients.

A full list of successful grantee organisations is available in the annex, section 7.5.

2.3 Aims and objectives of the project fund

All stakeholders saw efficient and effective delivery of social prescribing as a core element of the project fund, with the specific role of the VCSE sector being particularly welcomed. One scheme lead said:

> "A strength [of the programme] is that it's aimed at VCSEs, and our job is to build resilience into the community and the people who keep going to primary care when they are able to get that care in the community."

This was linked to a recognition of the demands faced at national and local levels, relating to the need to 'alleviate the pressure on primary care', to provide community-based support and to help people to have the knowledge, confidence and resilience to access this as required. The importance of generating an evidence-base for social prescribing was noted by some, but not all, organisations. 2 complementary themes were stressed by stakeholders:

- creating an evidence-base to show the results of social prescribing as a means of accessing further funding

- creating an evidence-base to examine how social prescribing works and the strengths and weaknesses as a means of developing social prescribing

One scheme lead summed up the latter as involving a range of different data collection approaches as follows:

> "Part of it is to try to collect evidence, data and information on social prescribing and different approaches… what works and what doesn't… to inform future development."

Staff who recognised the need to collect evidence were generally positive about the opportunities this could provide, particularly in terms of being able to share learning throughout the course of their involvement. A scheme lead said:

> "I think it would be really good to get the learning from different models and different mixes, commonalities and differences - strengths and weaknesses behind each one so we can keep developing."

The extent that schemes felt they achieved these aims is covered in later sections of this report.

2.4 Reflections on the application process

2.4.1 Sources of awareness: initial perceptions and motivations

Scheme leads reported that they found out about the fund through a variety of different sources, primarily through external colleagues from clinical commissioning groups (CCGs) or VCSE partners, organisational research or networks and newsletters.

Those who had not delivered social prescribing previously saw it as an exciting opportunity to move into a new area, supplementing other types of delivery, and providing an opportunity to be part of a nationally recognised programme. Those who had already been delivering social prescribing viewed it as an opportunity to build upon what they already had in place, largely by expanding existing social prescribing schemes to new areas or demographics. A scheme lead said:

> "There was additional work we wanted to do, we knew that we were seeing an increasing number of complex cases and some specialist social prescribing work was needed but didn't have capacity to do that and CCG had maxed out grant giving us. This was the perfect opportunity to gather partners and bring the capacity together to bid for specialist link working."

Scheme leads saw the fund as a positive opportunity to meet unmet need in their area, both in terms of the breadth of support required across communities and, to a lesser extent at the application stage, the depth of support required to meet the increasing prevalence of more complex needs. One scheme lead said:

> "We've known for a long time that if you provide opportunities for people to be engaged with each other in a range of places and ways and activities you can create health and, as an organisation, we have done that for a very long time. Applying [for the Fund] was a way of us codifying what we were doing in a form that health colleagues and professionals would understand around social prescription."

In other areas, the programme enabled them to embed preventative early intervention models and improve quality of life. A strategic scheme lead said:

> "We wanted to extend our preventative work through social prescribing. So rather than [clients] being isolated and suffering and gradually moving into specialist [clinical or social] services as a result, it's about getting in early with them, so they can look at solutions. That really is key in keeping them independent."

Where schemes wanted to extend existing schemes or pilots of services this was generally as data to examine the potential for local replication or micro-scaling to a wider locality or different demographic cohort.

In one area the focus was on establishing a streamlined network of social prescribing schemes across a 'saturated' region of social prescribing and link working schemes, rather than on the delivery of social prescribing. A scheme lead said:

> "…There was an animosity growing in the [local] system because people were being bounced from support to support. We saw the need to get a

> handle on the nature of the different kinds of link workers, social prescribers, or… based on levels of need of the people coming through, some very different kinds of link work. It wasn't building social prescription activities, it was about becoming more transparent, better together, partnership building: having a system of social prescribing activity and better idea about activities available and gaps within activities."

Staff saw the opportunity for increased partnership working as a potential benefit of the fund. They viewed it as a chance to raise awareness of their scheme within or across organisations and to be accountable to a wider network of partners such as CCGs and LAs and even local universities. The increased funding was also welcomed as a way of developing specialisms across staff as they could recruit to specific social prescribing roles and enable link workers to be dedicated to this stream of work.

Being part of a central government funded programme was a source of pride for schemes, as reported by scheme leads. They felt they were part of a collective effort that was raising the profile of social prescribing from the VCSE sector, as demonstrated by this quote from a scheme lead:

> "We feel privileged to be part of it and part of a nationally recognised funding stream for social prescribing. We believe social prescribing works and is now getting more recognised on that level and with primary care network and NHS money coming in, that's even more so."

2.4.2 The application process

Views on the application requirements were positive overall, with the information requested being seen as fair and in-line with applications from similar funding sources - something that VCSE organisations had 'become used to'. On the limited occasions where leads felt that the application documents were not completely sufficient, the information provided in supporting webinars was seen to fill any gaps. A scheme lead said:

> "The guidance wasn't really there, it became a lot more clear what they were looking for and what the fund aimed to achieve when took part in the webinars. That helped steer us into what they were actually looking for."

While the information requirements were seen as sensible, a further observation, was that the process was not seen by everyone as completely transparent. This sometimes made it difficult for applicants to assess the level and nature of responses required. They felt that there could have been more detailed assessment criteria as a further guide to their applications. A scheme lead said:

> "I think to improve it needed clarity on new or existing schemes and whether there was a weighting there. A set of criteria [was missing] –

> usually you know the criteria for most funders and it did feel like we were taking a stab in the dark… [we were] taking a punt on whatever criteria might be."

The timelines for applications were considered appropriate, although some felt it was challenging to identify and secure the additional funding required from other partners, particularly where new schemes were being established or inter-organisational relationships were not yet mature. Leads reported that the need to fully secure funding from a partner after year three was ambitious and may have deterred participation from some organisations, although this was not a requirement of the application. Some leads were not aware of the intricacies of the department's assessment process for submitted applications (shortlisting, followed by a further review), saying they would have benefitted from understanding this from the outset.

2.5 Set-up and initial development

All scheme leads reported that there was a notable delay from confirmations of successful applications to receiving the funding. This reportedly led to challenges in developing and implementing their schemes. This was a particular challenge where organisations were new and did not have considerable alternative sources of funding in place. 1 scheme lead said:

> "…without the money in the bank for us it [the scheme] was a total non-starter until the day it hit the ground."

Where this was the case, networking, recruitment, community engagement and project mobilisation were behind original schedule, in some cases for several months. Overall, this made setting up workstreams a challenge, largely due to the need to shift resources. A scheme lead said:

> "Set-up was the most difficult bit, we planned to have resources available for a certain time period, and it caused us a bit of a problem where [receiving the funding] slipped as our resources were different than we expected to have – mobilisation has been much longer because of that."

The ability of schemes to deal with this situation was felt by some to be compounded by a lack of clear information on when funding would arrive, making it difficult both to plan and to manage expectations. An operations lead said:

> "On the timelines from DHSC… originally we got word [of successful application] in December the previous year. Then we got to January and February. And then it was August and we didn't actually get the funding dropped until the November. It was quite stressful as I couldn't escalate

> anything - even though they said you have got funding I couldn't risk and recruit a huge team for the front door team [as funds were not received]."

Once funding arrived, schemes implemented plans as soon as possible. Albeit some schemes found that elements of the set-up phase were more resource-intensive than originally anticipated. A scheme lead added:

> "When we got the money, other parts of mobilisation had slipped… we needed to establish an inter-organisation agreement with our resourcing partners and that took several iterations until all sides thought it was fit to go ahead."

Yet the intense need for resource at the mobilisation stage was discussed as largely down to the cross-organisational partnership work. A scheme lead said:

> "It's because we are working in partnership with three orgs including the CCG. So, every time we have to change something or steering or organisation groups together, you have three or four different organisations speeds. Because we are presenting options papers to them, can you imagine how slow that becomes?"

3.0 Delivery models

3.1 Overall model approach

Except for one scheme, which was uniquely funded to operate a social prescribing organisation network, the HW fund organisations tended to adopt either a light-touch approach and/or a more bespoke support offering, as outlined in the following figure:

3.1.1.1 Figure of delivery models

Light-touch community support

- Approach: Needs understanding and direct signposting to other services or activities
- Need: Lower-level need
- Length: Short-term, often facilitating key referral route only
- Requirements: Rapid rapport building, quick decision-making, up-to-date networks for forwards referral

Bespoke social prescribing and support

- Approach: In-depth needs assessment focused 1-2-1 or group support on specific need(s)
- Need: Moderate levels of need
- Length: Medium-term, multiple sessions
- Requirements: Supporting complex needs, person-centred planning, regularity of support, motivational and coaching methods

The approaches taken (regardless of whether adopting a light-touch and/or bespoke support) tended to be based upon the nature and needs of the client group. Schemes offered either open services or had more focussed services based around client demographics or experiences, alternatively some were thematically focussed as aforementioned.

Where organisations were faced with a variety of levels of need, they tended to adopt a tiered approach which would enable quick triage decisions to be made based on key criteria, such as mental health conditions, housing status and further indicators of adverse experiences. This was established at the beginning of the client journey, usually at the initial conversation, or gained from any information that came through with the referral.

For example, some people's needs could be met by a one-off meeting, either face-to-face or by phone. In these instances, every effort would be made to follow-up with the recipient of the social prescription. This acted as both a check-in to see how far they got with their one-off prescription, for example, to seek benefits advice, and, to complete the follow-up evaluation questions.

On the other hand, feedback suggested that in some cases it was apparent that levels of need were too high to be dealt with in the service and needed to be referred back into statutory services. When this occurred, schemes made efforts to 'hand-hold' the recipient throughout. Feedback from leads suggested this was linked to perceived gaps in commissioning services for acute mental health concerns that do not meet thresholds of higher-level services. Project funded schemes found that these few individuals would 'bounce' between their services and statutory services regularly. Schemes were being proactive in engaging their resourcing partners, CCGs and local authorities, to raise the awareness of provision gaps, so that services could seek to meet the needs of these people with prominent challenges.

Triaging demand and more complex needs

Dealing with a range of clients with different levels of need was a key element of the social prescribing approach at one organisation. They applied for funding they already had for an existing service in the area working with clients who used services frequently and worked with their local CCG to establish a cross-organisational offer that would provide both preventative work to stop clients becoming high service users and to support those with varying levels of need.

Core to the delivery model was implementing a triage system so that clients could have their specific needs met quickly and effectively. Initial assessment would establish whether clients had low or moderate level needs. Those in the former group would either be supported to access other organisations or receive direct support lasting up to four weeks provided via a sub-contracted local charity. Those with more complex needs would be given longer and more direct work lasting up to eight weeks.

A key factor enabling success was ensuring that systems and approaches were in place to ensure that decisions could be made quickly and communicated to clients. Simple decisions to access advice or activities would be made in an initial discussion where possible, with follow-up calls on decisions made to clients where relevant within two working days. Everyone received a follow-up call within 28 days to check on progress.

This process was felt to work well by the Scheme lead. Referrals were received from all the GP practices in the area (over twenty in total) and a broad range of clients were engaged. Demand was higher than expected, with particularly high levels of those with more moderate needs. This was felt to be due to commissioning gaps across the area,

with more clients having acute mental health needs than were anticipated. The triage approach allowed decisions to be made as quickly as possible with, due to increased demand, this being supplemented with a waiting list approach, providing clear expectations around timelines.

While these processes were seen as successful, the model was felt to work well because these were underpinned by clear values which were especially important when dealing with those with more complex needs, ensuring that assessment techniques and communication were non-judgemental, client-focused and client-led.

3.1.2 Ensuring referrals

3.1.2.1 Engaging referral partners

The success of the social prescribing approaches was felt to largely depend on embedding a referral process across appropriate referral organisations. A very common approach was working closely with GP practices, although some schemes also linked with other organisations, including housing, social care, VCSE organisations and job centres. Self-referrals were an option in several, but not all, schemes.

A major theme was that engagement levels varied across referral settings, with the ability to engage GPs being particularly vital to the success of certain schemes given the centrality of this referral route. Considerable work was required where relationships with GPs needed to be set up and where GPs wanted clarity as to the details of the exact social prescribing model being adopted. A scheme lead said:

> “The time it took to engage with GP practices was a concern. A lot of work has been done with [the] VCSE sector in terms of what was a good model [of social prescribing] to provide but until you have that GPs won’t talk to you. Proposing particular practices that we would work with without doing full engagement led to some areas being much better engaged than others”

Where there were similar barriers to engagement there was not an easy solution beyond taking the time to build up relations, speaking to individuals face-to-face and providing relevant information. One scheme lead highlighted the importance of not just being able to attend specific meetings with GPs, but having time set-aside in these meetings to contribute in a formal way:

> “[We had] induction sessions with all referees, [it] works really well and I would advise anyone who is doing social prescribing to do that… Going into a GP surgery to clinical meeting… doing a talk and a Q&A about how

referrals works, what social prescribing is and what kind of patient do or don't need."

3.1.2.2 Referral approaches

A range of different approaches were used by schemes to ensure that referral organisations could make referrals as easily as possible. Direct telephone referrals were commonplace in many schemes, with other referral mechanisms including postcards provided by GPs to allow clients to self-refer, e-mail systems and, online referral portals.

Participants completing the CMF were asked to state how they found out about the social prescribing service, as detailed in the following table:

3.1.2.3 Table: How clients first found out about the social prescribing service

Finding out about the service	Percentage
General Practice	30%
Signposting – Friends or family, Leaflet or poster, Website	13%
Voluntary and Community Sector Organisations	12%
Adult social care or social services/social worker	4%
Community Services (not Intensive Community Treatment Services)	4%
Hospital	2%
Police	Below 1%
Sheltered accommodation/residential care home	Below 1%
Department for Work and Pensions or the JobCentre	Below 1%
Pharmacist	Below 1%
Prefer not to say	Below 1%
Other	34%

(Base = 1794)

Results show that participants first heard about the service from a wide variety of sources, with the main named sources being from the GP (30%), signposting (13%) or from voluntary organisations (12%). Just over a third (34%) noted that they heard from an

“other” source which was mostly recorded as ‘self’ referrals or through other local organisations.

Providing a variety of different approaches was felt to work well in practice, allowing individual referral organisations to choose the method that best met their needs. This helped increase the number of referrals, reducing any initial concerns among any scheme leads that accessing sufficient referrals may be difficult. The downside of using multiple referral mechanisms was that it could be difficult to manage and reconcile information from different sources, as outlined in the following example:

Dealing with information from multiple referral sources

One organisation ran their social prescribing based on having a social prescriber specifically allocated to GP practices in their area to ensure that they were fully embedded in the locality, could work as part of the practice team and build positive relationships. This would also ensure that they could fully understand and work with the exact referral routes in each GP practice.

This required a lengthy set-up process to work across practices and to make decisions as to which practices would or would not be able to access social prescribing staff. Clarity was required as to the decision-making process to ensure that each practice had a fair chance and that practices that were unsuccessful in applying for a social prescriber were comfortable with the reasons for that decision.

The project lead felt the basic approach worked well. The social prescriber was allocated their own room at each practice, accessed referrals from primary care, booked in clients for up to six sessions and supported them as required. This included a wide range of support activities, from linking people to local choirs or welfare rights organisations to helping individuals with autism gain meaningful employment.

The use of technology was a key factor in the practical implementation of this approach. Many clients were receiving support from multiple organisations and having a shared IT system which was regularly updated ensured cross-organisational clarity. Every relevant organisation could log into a portal and access information on the organisations involved in any relevant case and the progress that was being made.

A challenge was that referrals were received from a variety of organisations which tended to have their own different and bespoke systems:

“Every GP practice wants to do it [referrals] in a different way. We want to work with them so we have tried as many different referral ways in as they would like to use. From our point of view, we would prefer it if they all did [it] the same way, but they don’t want to”

As a result, it was difficult to standardise and easily record information across practices. Some provided electronic referral forms themselves, others used different systems or asked clients to refer via telephone. This meant that the organisation spent considerable time “constantly looking at technological fixes” to deal with this issue.

Scheme staff felt that the overall referral processes worked well, when the information required from any initial referral was kept to a minimum. This reduced the requirements for referral organisations and clients. Link workers would often gather additional information as part of initial discussions with the client, thereby providing a person-centred and in-person approach. Using a link worker to get this information helped mitigate against any perception from clients that decisions were based solely on standard referral information.

The referral process was helped by having link workers located in GP surgeries, allowing them to take referrals directly as part of any GP appointment. This ‘warm handover’ approach was seen as most beneficial for vulnerable or nervous people as it reduced the number of stages that were required and allowed trust to be built quickly. This also helped consolidate relationships with GPs as 1 scheme lead said:

> “It took a long time for GPs [to engage]… Now our wellbeing advisors are spending one day or two days in GP practices. Not always seeing clients there all the time but being there, so GPs know they are available.”

Having link workers directly present in surgeries also meant that these staff developed an ‘on the ground’ understanding of specific GP needs, feeding these back to project staff so that any challenges could be dealt with promptly and a supportive relationship established:

Supporting GPs in client discussions

One organisation had been involved in social prescribing for a number of years, scaling this up from a small part of their remit to a major element of their delivery. The project fund provided an opportunity for further scale-up and delivery, working closely with their council to ensure consistency and clarity.

Having staff working close to the ground meant that bespoke marketing approaches could be developed and designed to meet specific needs. Feedback from GPs was that getting consent from clients to take part in social prescribing was sometimes difficult as it was hard to explain social prescribing. As a result, a short “crib sheet” was developed to summarise key information so that GPs would be confident in explaining the aims and processes. Publicity leaflets and posters were also developed and disseminated as required across the area.

While some schemes reported that their referral processes worked smoothly, others faced challenges in making sure that suitable clients were being referred. This was anecdotally linked to increasing prevalence of mental health issues by scheme leads. They reported that they were almost being asked to ‘fill gaps’ by taking on clients that had higher levels of need than was appropriate for social prescribing support. A scheme lead said:

> “[We have had] challenges with the suitability of referrals [relating to] accessing clinical mental health service... [There is a] gap in the middle for people who are too unwell for IAPT [Improving Access to Psychological Therapies] but not enough for CMHT [Community Mental Health Team]. Many referred onto us. Some people have really needed clinical support and we have not been right and [had to] refer them back to their GP directly.”

Schemes had set processes and systems in place to deal with unsuitable referrals or those where more information was required before a decision could be made. One scheme lead said that they had a target to recontact any referral organisation within 3 working days of the initial referral when further information was required. 2 separate schemes were concerned that their service could be used as a “dumping ground”, one relating how they learned to be willing to turn down referrals. The scheme lead said:

> “We need to be better at saying this person is not appropriate for our service. Difficult as they are a very caring bunch, but danger is that we could be dumping ground for all other services that aren’t as caring. Danger is you become ‘try-to-be-everything-for-all-people’.”

Although, a scheme reported that they aimed to accommodate clients with a greater than expected level of need. This required additional resources and having implications for the number of clients that they could realistically cover. A scheme lead said:

> “[The] biggest difference from model to reality… [is] people who are self-referring or particularly referred through other orgs like social workers, [the] level of complexity [is] much higher than our model might deal with. [We] expected most to go in for the universal offer of 6 weeks to 2 months. Even people initially displaying as low-level need, there are a number of other issues that unfold. They have therefore required much more intensive work from staff colleagues rather than befrienders and volunteers. So, [what] we haven’t been able to do is support volume number, but I am sure that the quality is much better.”

3.2 Client engagement approaches

Schemes took a person-centred approach to client engagement, seeing this as a way to achieve sustainable outcomes for clients. Taking a holistic and listening approach to understanding the client and respecting their requests reportedly empowered clients to engage in a way that was right for them. By encouraging clients to be involved in making their own plans and taking responsibility it was hoped that outcomes could be sustained over a longer period than might otherwise have been the case.

Individual schemes took different approaches to contacting and working with clients, with this largely being driven by the level of client need and the overall social prescribing model adopted. Positive engagement was felt by some to be more likely when clients had self-referred. A scheme lead said:

> "Personally, I think [self-referral] is good as person has buy in and recognises the need for some kind of support. And that is sometime half the battle with social prescribing if someone isn't ready to make that change or engage - lots of missed appointments and chasing up. We still have some of that but encouraging [them] is helpful."

3.2.1 Telephone

There was a level of initial concern among some project staff in using the telephone to contact and engage clients. Staff questioned whether clients would be willing to engage over the phone and, if they did, whether it would be more difficult to build up a relationship and work with them due to it being seeing as impersonal.

However, once implemented, schemes reported that clients were generally forthcoming when spoken to over the phone and that a telephone approach worked across different client groups. It allowed an additional element of flexibility for both the worker and the client, enabling bespoke and ad-hoc contact. It was also seen as cost-effective, reducing logistical requirements relating to travel, venues or physical materials.

Adopting a phone-based approach was seen to potentially work well to engage people with conditions such as anxiety or low-mood, reducing the possibility that these clients would be put off by having to meet their link worker in a 'professional' environment. It was also felt that telephone conversations were less of an immediate challenge than a face-to-face meeting if clients needed to report that they were making less progress than expected.

3.2.2 Home visits

Home visits were largely used where clients had levels of need, issues with mobility or mental health conditions, with schemes therefore tending to rely on this approach depending on their overall target client group. Home visits were thought to be less flexible than telephone approaches as they included travel time.

The main benefit of a home visit was that link workers could meet with clients in a setting where the latter felt comfortable. It also showed a willingness of staff to take client needs into account and begin the process of building a personal relationship.

Adding value through home visits

An example of the added value of home visits was that they could provide project staff with an insight into other factors that might be impacting upon their client, leading to specific issues being identified that might not have otherwise been apparent. A link worker said in a case-study:

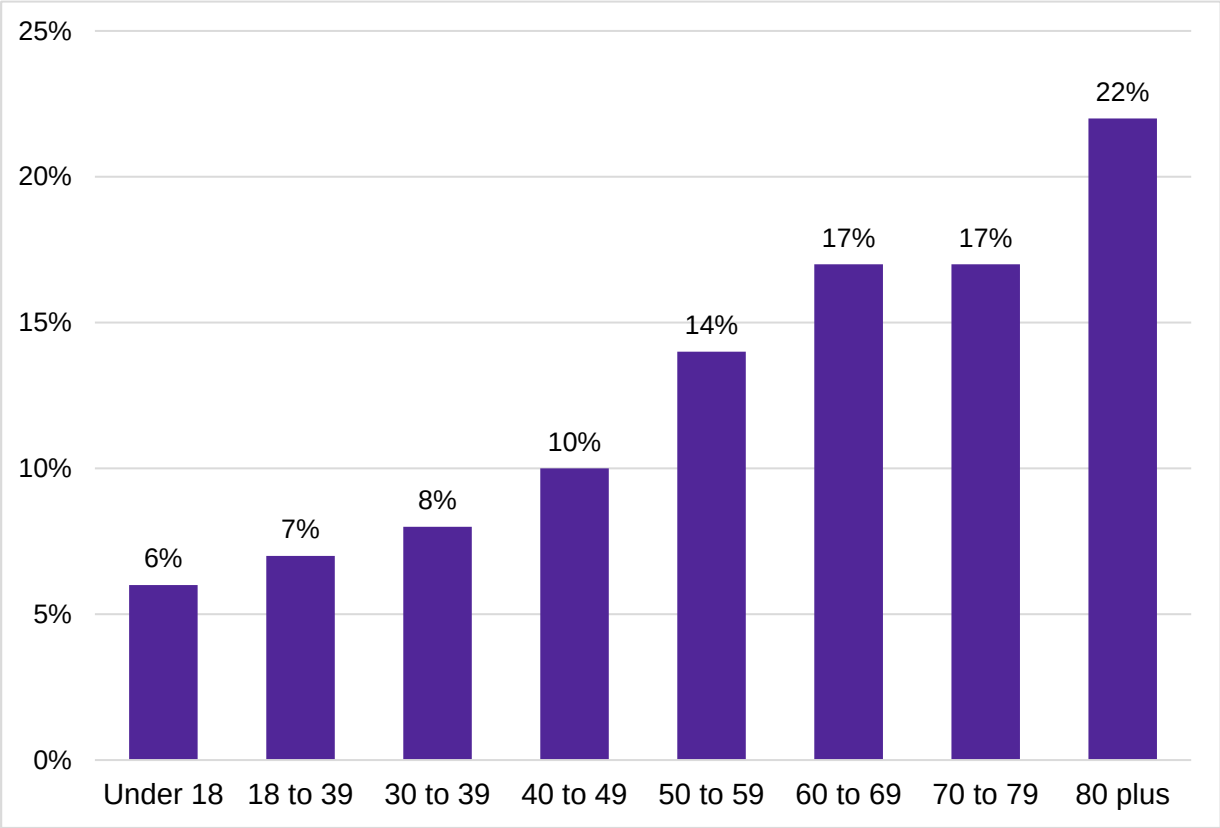
“You’re able to see the person in the place they might, spend a lot of time in, or not spend a lot of time in… and that’s the important bit. There are so many factors in someone’s home that might be causing them discomfort or distress and if someone is caught up on something else, they aren’t going to tell you that, so how would you find out.”

This link worker reflected on a particular situation where a client had initially requested their support with benefits advice, but where a home visit made clear that they also had substandard housing conditions. Visiting them at home helped the link worker start a conversation in an empathetic way, asking if the client had noticed the mould and deteriorating interior. As a result, the client was later rehoused in a refurbished property in the same area.

3.3 Client attendance

In total, CMF data was received from 18 of 23 Schemes, containing individual records for 2,437 participants. These numbers are not an estimate of overall participation given that individual client responses were voluntary, data was provided by some but not all schemes and feedback from others that records were partial. Of the 5 schemes remaining, 1's KPIs were altogether different and not client-facing, 2 were recording data in entirely different formats that could not be amalgamated and 2 did not return any data. The following figure shows the age of the fund clients who had details recorded in the CMF.

3.3.1.1 Figure: Age of social prescribing clients

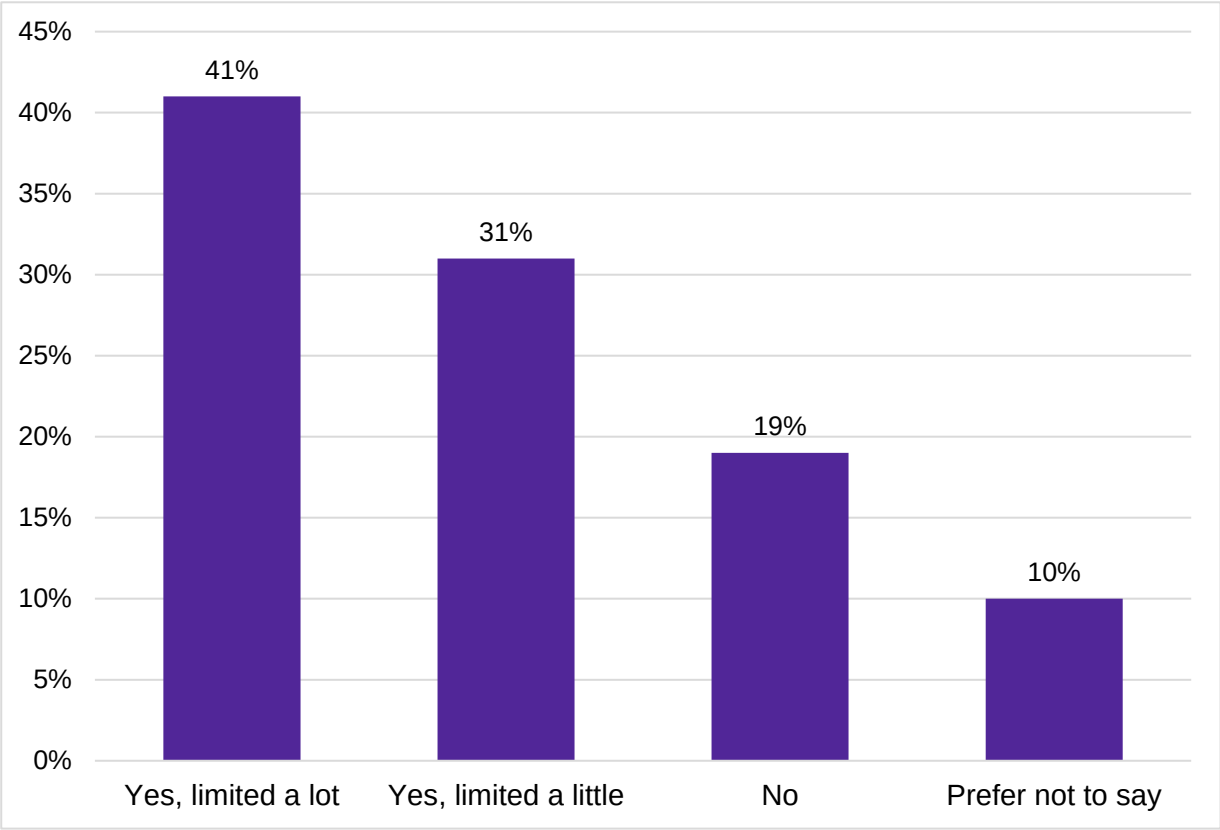


(Base = 2364)

The mean average age of those supported was 59, with data showing that participation was patterned by age with more older than younger participants among those completing CMF details. The programme's youngest client of social prescribing was 8 years old and the oldest was 104. Exactly one-third (33%) of the clients accessing the schemes were men and almost two-thirds women (66%), under one percent of clients identified as non-binary. Approximately, 15% of clients were Black, Asian or Minority Ethnic, under 3% reported to be of "other" ethnicity, such as Gypsy, Roma and Traveller, with the remainder self-categorising as "white". Overall, 14% of clients reported having caring responsibilities.

The following figure shows CMF data on the extent that HW Fund clients reported having limitations affecting the extent that they could take part in regular day-to-day activities.

3.3.1.2 Figure: Limited to day to day activities



(Base = 2133)

Most clients (82%) reported some limitations in their day to day activities. Of these, 41% self-defined as their day-to-day activities being “limited a lot” with 31% being “limited a little”. Just under a fifth (19%) indicated they were not limited in day to day activities and a tenth (10%) preferred not to say.

3.4 Grant management and support

Scheme leads generally felt that grant management requirements were appropriate and did not cause burden. Monitoring requirements were straightforward and easy to implement, with no concerns over the nature or amount of information that was required.

Views varied on the support and contact that was in place from system partners. Some scheme leads were happy with the support provided, noting that ‘everyone has been very helpful’ or that it met their needs. Others felt that there were not as many opportunities as with other funders to speak directly with grant managers, get feedback on progress and exchange learning. At the time of interview, schemes said that it would have been valuable to have a named contact on the grant management team who could be accessed for support by both email and telephone. One scheme lead said:

> “We have struggled not having someone from the system partners [of the programme] who we can pick up the phone and talk to.”

Another scheme lead said:

> “In terms of management it would be good to be able to contact someone to ask questions about things or get feedback on quarterly information - we don’t tend to get a lot from that.”

Although there is a contact available at the time of this report, this was not available from the start, where schemes would have valued more input. This was due to a change in personnel at the system partner level, which sometimes made direct communication with grant management staff more difficult.

4.0 Intermediate outcomes

This section covers the intermediate outcomes identified in the original ToC, examining social prescribing outcomes for clients and organisations, and then the extent that evidence was generated and disseminated.

4.1.1 Social prescribing outcomes

The following section provides an overview of social prescribing outcomes associated by project staff with direct delivery, focusing separately on clients and organisations.

As noted in the data limitations section, although delivering outcomes was a key element of the work of each project, the evaluation primarily focused on the ability of the project fund to establish an evidence-base, as opposed to reporting on the extent that positive or negative outcomes were achieved.

4.1.2 Clients

Project staff tended to feel that clients benefitted from their involvement in social prescribing Schemes. These feelings were largely based on qualitative feedback, the fact that demand for the service was often seen to increase and the assumption that by filling clear gaps in provision that clients would be in a position to have their needs met. A scheme lead said:

> “I do know people are benefitting and being supported how they wouldn’t have been in the past.”

Some organisations did report quantitative outcomes data to show positive change for clients in important outcome variables, such as mental health and loneliness. The following table shows self-reported data on the Office for National Statistics (ONS) Wellbeing Measure, as reported in the CMF from baseline to the first follow-up stage. Data should be taken as indicative as responses are from 10.6% of total CMF records and may be affected by non-response and selection bias.

4.1.2.1 Figure: Distance travelled in wellbeing

ONS wellbeing measures	Baseline average	Short-term follow-up average	Percentage point change	Base
Life satisfaction	4.8	6.3	+1.5	(263)
Worthwhile	4.7	6.4	+1.7	(250)

ONS wellbeing measures	Baseline average	Short-term follow-up average	Percentage point change	Base
Happiness	4.6	6.3	+1.7	(251)
Anxiety	7.0	5.6	-1.5	(246)

This data suggests positive changes for clients in terms of wellbeing across all the four elements of the wellbeing measure, namely increases in clients feeling worthwhile (an increase of 1.7 percentage points), happiness (1.7) and life satisfaction (1.5), with a corresponding decline in reported anxiety (-1.5).

4.1.3 Integrated working and organisational outcomes

As noted in Section 2.4.1, many schemes saw their involvement in the fund as a way of increasing their profile and creating wider organisational links. Grantees felt that the fund had generally contributed in part to better integrated working or cross-organisational links, either as a result of partnerships set up to deliver project fund elements and/or the wider organisational links establishing during the funding period.

A few schemes operated in partnership for delivering social prescribing with other local VCSE organisations. Where this happened, specialist organisations were able to use their expertise to work with marginalised communities such as the Gypsy, Roma and Traveller communities, as well as those facing disproportionate health inequalities such as transgender people. This was seen to help deliver a better service as well as potentially leading to improved organisational outcomes through joint-working and capacity building.

Where Schemes worked in partnership, scheme leads were often positive about their experience, welcoming the opportunity to work with other organisations and develop a joined-up approach to social prescribing. One project lead saw the fund as the ‘perfect opportunity’ to work with relevant partners. Schemes saw the value of partnership work mainly in terms of direct delivery, leveraging different organisational strengths to provide a fuller service to clients and enabling demand to be met.

Many schemes worked with partners that they already knew well and had often worked with before, with some establishing new relationships. In the main, leads reported that partnership work was progressing smoothly. 1 scheme lead said:

> “[Our model has worked] brilliantly so, all partners fully on board, we all get on really well - from the beginning in developing partnership agreement together, transparent about what money was [available], what they would get out of it, how it was broken down…”

Some schemes did note challenges to partnership working. These included ensuring there was a shared vision and plan across organisations, setting up partnership agreements and dealing with changing organisational perspectives and priorities over the funding period. Establishing shared values was important, with one project lead noting that it took considerably longer than expected to build up the levels of trust that were required to facilitate joint-working. Different organisational processes sometimes required careful consideration. One project also noted that their ability to react quickly and amend delivery or processes was constrained as a result of working with different schemes. The scheme lead said:

> "Every time we have to change something or [get] steering or organisation groups together, you have three or four different organisation speeds. Because we are presenting options papers to them, can you imagine how slow that becomes?"

While these challenges needed to be dealt with appropriately, scheme leads generally felt that this had been achieved, and that they had established a good basis for further partnership working as a result.

Scheme leads reported having established or created deeper relationships with other organisations that they were not previously closely linked with, such as clinical commissioning groups (CCGs), primary care networks (PCNs) and local authorities. They felt this allowed them to raise awareness of their organisation and the capabilities of VCSE organisations in general to develop social prescribing schemes. This was particularly important given the need to ensure that delivery was approached consistently across local areas. A scheme lead said:

> "[The] plan is to find out what is going on in PCNs that are developing… - trying to make sure there isn't two or three models running in the borough. [We've] written an options paper to the CCG and primary care [network]."

Some schemes reported that they had accessed additional funding during the course of the project fund grant to date, albeit that this could not be directly attributed to their involvement in the fund. Some were hoping to work more closely with PCNs, with these often being the best source of local funding. While one project reported difficulties in being able to engage with their PCN, others were more involved in on-going discussions. A scheme lead said:

> "[We are] working towards PCN funding to continue part of the project, gives us a little more freedom to change things in line with the PCN intentions and based on our learning."

Another scheme lead said:

> “PCNs are all considering [spending plans] at the minute as they get additional funding in the next few years.”

4.2 Social prescribing evidence base

This section covers the extent that the project fund contributed towards the development of an evidence base on social prescribing, focusing primarily on feedback from scheme leads and information on CMF completion.

4.2.1 Scheme leads

4.2.1.1 Evidence base needs

Several schemes reported that prior to the project fund their existing data collection mainly consisted of monitoring information to record project reach supplemented with more qualitative feedback from clients, the latter being used to develop case studies and narrative reports.

While less of a distinct theme, some schemes reported they previously collected quantitative data on participant outcomes. Where this was the case, a variety of different tools were being used, including various outcome stars, the ONS4 personal wellbeing measure and the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS). These tended to be implemented among larger funders that either had an interest in proving outcomes were achieved and/or were required to collect this information by other funders.

The perception among both project staff and policy stakeholders was that information on social prescribing had historically been ‘dominated by qualitative data’. Schemes very much valued this data as it helped illustrate the difference that schemes could make in the lives of individual participants. One project lead reported that it ‘is the personal stories that make the most impact’, with another scheme lead stating that:

> “The thing we collect the most that I really value is the qual[itative] and the stories because they really demonstrate how sitting down with someone for an hour and being heard and someone helping you [can make a difference].”

Leads generally felt that there was a gap as a result of the lack of quantitative evidence to show participant outcomes. This gap was particularly important given the increased interest in social prescribing. A scheme lead said:

> “Case studies [are] great but time is coming where we will be asked for more evidence of impact and we need to work out how trying to do that.”

4.2.1.2 Developing evidence

As the project fund grant was still in progress, Schemes had not yet finished accessing data and evidence at the time of interviews. As a result, staff tended to feel it was ‘really early days’ in considering the extent that they had generated and disseminated evidence. Leads did anticipate that they would have a solid set of evidence at the end of the fund, with many being optimistic about sharing learning in future. One scheme lead said:

> “We’re looking forward to sharing our report which has got a lot of detail about what achieved who worked with and outcomes.”

Most schemes continued with the data collection approaches they had used previously, namely collecting monitoring data with this being supplemented by additional qualitative research as felt necessary and CMF completion as part of funding requirements.

4.2.1.3 Common Measurement Framework

At the set-up stage, some schemes welcomed the opportunity to collect data via the Common Measurement Framework, seeing it as a potential way to generate evidence across the Fund as a whole and to influence broader discussions. The ability to have clear and separate outcomes on key areas was observed. Some schemes were more hesitant around the CMF requirements, mainly in terms of logistical requirements and the amount of data collection involved.

Schemes described various challenges in providing CMF data. Some struggled to find capacity to enter data, with one or two cases where they relied on managers inputting information as an additional element of their roles, taking-up important operational resources. Where social prescribing sessions were very time limited, for example taking the form of a 15-minute telephone conversation, staff reported that some clients found CMF requirements disproportionate.

Scheme leads across the board conveyed that it was challenging to contact clients for follow-up data collection, especially where they were no longer engaged with the service and were non-responsive to calls or messages. Some reported that data collection was complex as they had to manage multiple requirements across different funders. For example one local authority required data to show changes in client financial wellbeing. A minor theme from the research with scheme leads, was the observation that a more iterative process of piloting and developing the CMF may have been beneficial.

Schemes that were used to conducting surveys among participants tended to be most comfortable with CMF requirements and able to provide consistent data. One theme was certain leads reflecting that the CMF had built their capacity to provide more detailed information on the full client journey. One project reported quantifiable improvements in specific measures such as wellbeing and another scheme lead said more generally that:

> "We can demonstrate positive progression for people supported through that [our various services]."

Despite these challenges, as noted previously, 18 of the 23 schemes provided CMF data during the evaluation, with this ranging from 30 to 400 participants. In total, data for 2,437 participants was provided, albeit that information for some participants was not sufficient to be included in analysis (for example where there were substantial gaps in baseline data). As was expected, the proportion of clients who were able to source an NHS number was relatively low, particularly where schemes had high proportion of young clients or those with higher levels of need.

4.2.1.4 Potential future challenges

Scheme leads were asked to reflect on potential challenges for social prescribing data collection in the future, with responses suggesting three main issues.

Firstly, difficulties defining social prescribing and the breadth of approaches were felt to provide practical challenges to collecting evidence. One policy stakeholder said:

> "The questions is… social prescribing… for what purpose – to reduce burden on primary care? To change lives of individuals in need? To offer social and non-clinical solutions to raise and sustain levels of health and wellbeing? To use community assets to equalise health chances?"

Another policy stakeholder said:

> "Why, when we are offering non-clinical interventions, are we looking at pretty clinical measures?"

Scheme leads felt that the variety of delivery models and aims made it difficult to develop a framework that could accurately record the variety of approaches. One felt that the preventative nature of much social prescribing work made it difficult to predefine outcomes and, in particular, to show a positive impact on wider health systems, for example reduced A&E admissions. Another worried that schemes would end up concentrating on the specific outcomes that were required in any framework and amend their delivery approaches to meet these requirements rather than concentrating on their own strengths.

Schemes had different views as to which specific outcomes would be important to measure in the future depending on the focus of their project, although mental health and wellbeing outcomes were generally seen as important. They also felt that administrative data could be used to prove the wider impact of social prescribing, most notably as to whether it reduced the burden on the wider health sector. A scheme lead said:

> “I’m hoping it will show less pressure on the GPs to be facing individuals when they could be sitting with one of our… coaches instead.”

Another scheme lead said:

> “Being able to demonstrate that it relieves the burden on primary care and perhaps adult social care and helps to improve wellbeing is kind of a main thing.”

Another policy stakeholder felt that value for money would be particularly important although they acknowledged that this was not necessarily straightforward:

> “What's challenging about the social prescribing element is measuring outcomes from a ROI [Return on Investment] point of view. If you were being quite corporate you could say ‘Yes, in last 6 months 227 people been through the service and all received benefit, but does that provide an evidence base for future commissioning?’”

Scheme leads also felt that measuring impact in the future would be complicated by the multi-faceted nature of social prescribing; whether data collection would be better focused on initial referrals, navigating individuals to activities, and/or the results of activities to which people were ‘prescribed’. Whereas the former may require only a single telephone call, the latter could include pre and post analysis over a 12-week support programme and data from destination activities, e.g. benefits advice service or community gardening groups. The latter may provide challenges in terms of working across organisations to access data and, as noted by both scheme leads and policy stakeholders, extrapolating the associations between certain process and impacts.

A final challenge was that the social prescribing landscape was changing rapidly, possibly making it difficult to ensure the evidence base dovetailed with existing and future needs. 1 lead reflected on their involvement in the fund and the extent that an original ‘test and learn’ approach looking at different approaches to delivery was as relevant as originally anticipated:

> “The idea was to develop some evidence base around the benefit and impact of social prescribing to look at different [models]… this is what these pilot Schemes are said to do. But I think we have been overtaken by events somewhat, with new primary care network and employment social prescribing link workers.”

4.2.2 Policy stakeholders

A major theme from policy stakeholder interviews was that the overall context for social prescribing evidence is not straightforward and is best seen as ‘an immensely complex

and messy and quite piecemeal panorama'. Stakeholders highlighted that there was rapid change in the social prescribing landscape, particularly due to the development of primary care networks and the potential that they may contract out link workers to VCSE sector organisations. Moreover, there was a perceived lack of stability within VCSE organisations, with difficulties accessing funding leading to changes in delivery making the situation 'very destabilising' for social prescribing as schemes that were well tailored to their local contexts may be financially insecure or have to fold without being replaced.

As with scheme leads, policy interviewees felt that policy had developed more rapidly than the evidence base, with one stakeholder stating that was 'maybe to put it slightly mildly'. Although there was a need for the evidence base to develop quickly but a recognition that the nature of social prescribing meant developing an overarching approach was complicated.

Stakeholders felt that standardisation of measures was a sensible aim and would help move away from an over-reliance on an 'anecdotal' case study approach. However, developing a set framework of measures was potentially difficult in practice due to the 'huge complexities around what one might want to measure or understand about social prescribing' and also the practical issues in implementing data collection. A policy stakeholder said:

> "You can end up using a sledgehammer to crack a nut, and about rapport… if you are using lots of validated tools and questions you end up eroding the rapport with the client and the link worker."

A common theme to ensure relevant measures could be collected in practice was being able to use administrative data, embedding this as an automatic part of GP management systems so that information on health, employment, benefits uptake and so on could be accessed relatively easily. This would then provide a wide view of the possible impact of social prescribing across a broad range of different areas. While this was generally seen as a sensible approach, 1 policy stakeholder noted that interpretation of these results would need to be undertaken carefully based on the detailed understanding of the role of social prescribing at a total or project level:

> "I sometimes suggest while demand reduction might be an outcome it is probably the least important quite frankly. Whilst you might want some patients to come less you might want others to come more who aren't engaging with health sufficiently or have such pressing social issues they are unable to engage with their health so by no means is demand reduction a universal measure of success."

A range of different possible outcome measures were considered valuable by stakeholders. Mental health outcomes were frequently mentioned, with validated measures such as SWEMWBS or ONS4 being most easily linked to value-for-money

measurements and service cost-effectiveness. Physical health outcomes were also noted, with leads noting the increasing interest in the Patient Activation Measure (PAM) as a measure. Including an overall measure of client satisfaction was also felt to be important.

The ability to construct a counterfactual for what would have happened without the intervention was mentioned in some interviews, with this being valuable to help prove outcomes and an economic case for funding social prescribing on an on-going basis. One stakeholder referred to a frequent discussion around whether clients who were referred to an activity by a GP would have ended up at a similar destination anyway. In this case, the policy stakeholder used client self-reported data to construct a case that social prescribing navigated clients to activities they would not otherwise have accessed.

A further suggestion was to involve feedback from others involved in social prescribing, not just clients. Conducting GP surveys to examine their perceptions of the approach in relation to primary care, their role as clinicians, and their clients was one approach that was felt to have worked well.

As with scheme leads (see previous section), a recurring theme was the breadth of data collection, namely whether the focus should be on the actual social prescribing or also take into account the service or activity to which clients were ‘prescribed’ or linked to. It was acknowledged that the latter would present practical challenges in collecting data, particularly for VCSE organisations, although this was felt to potentially provide a fuller picture of social prescribing outcomes. A policy stakeholder said:

> “Why are we measuring outcomes for patients rather than outcomes for citizens… in terms of the benefits from the onward referral to the services which the patient or client then gets referred onto. Benefits [such as] learning English, digital inclusion, gardening group on local allotments. Those are the hardest outcomes to track.”

A final challenge related to the broad scope of approaches considered to be part of social prescribing. The variety of approaches not only made it difficult to develop an overall framework but meant it would be valuable to have a greater understanding of where and why certain approaches worked or did not work across different contexts.

4.3 Two-way flow of information and sharing learning

Intermediate HW fund outcomes (see ToC in section 1.2) included both ensuring a flow of information between the VCSE sector, communities and policy stakeholders; and developing and sharing learning across VCSE organisations.

Schemes felt that they were in the process of generating relevant learning that would be of wider interest and could be shared, mainly focusing on issues relating to set-up,

implementation and initial outputs as opposed to a focus on outcomes. The feedback from leads was that it was too early to provide definitive information and hence learning had not generally been shared. This dovetailed with feedback from policy stakeholders, who were generally aware of the HW fund and had a basic understanding of what it involved but could not recall seeing any specific evidence or relevant findings to date.

While there was a widespread willingness to share this type of information (examples given included around delivery model development and use of volunteers), scheme leads tended to feel that the HW fund lacked formal mechanisms to share this learning and that they missed the opportunity to share learning face-to-face with other project fund grantees. 1 scheme lead said:

> “It would have been good to meet up with others, maybe who have the same challenges and say great that’s an opportunity to talk about this.”

System partners reported that plans are in place for developing future opportunities to collaborate, as scheme interviewees said that they would value opportunities to share learning formally in the future, for example, via digital forums or annual events. These were seen as cost-effective and scalable methods of engagement by schemes. A scheme lead said:

> “You could meet first altogether, like we did for the CMF workshop, and then following that have remote calls, you only need to meet other leads for a day face to face to get that familiarity, then you can take it all to telephone or online.”

An operations lead said:

> “Networks are important but the lack of a forum to discuss was really felt in this piece of work, and definitely through the mobilisation phase when you have all those initial hurdles and you want to share that with your peers.”

Whilst formal opportunities to share practice and learning had not taken place thus far in the programme, scheme leads initiated an informal space online to communicate privately among themselves. This functioned as a peer support forum and was seen as one way to fill the gap in the absence of formalised workshop or learning events. Schemes also engaged in local dissemination, 1 lead speaking positively as to how they attended regional meetings and had been able to:

> “Hear what is going on in comparator boroughs and see how it's different across the UK. Learning from everybody and getting that injection of passion - that was really good. Plenary sessions and workshops giving you all the evidence during the day. Evidence of what wasn’t working, where it did work.”

Other schemes were involved in broader dissemination activities, including running workshops and producing posters for conferences, and providing publicity or reports on websites or other platforms. 1 project lead reported that they had an academic paper accepted for publication, with another stating that the social prescribing network provided good opportunities for sharing learning.

An original objective, reflected in the programme ToC (see section 1.2) was for the project fund to work with the alliance, possibly using alliance member links to the wider VCSE sector as a way to share learning. Only 1 project lead reported having heard of the alliance but they had not had any formal contact to date. This potentially reduced the support available to fund members on this issue.

5.0 Sustainability and future development

Scheme leads were confident that being part of the VCSE sector and rooted in local communities meant that outcomes would be sustainable over time. This more ‘grassroots’ approach was seen as important for clients with a lower-level of need and potentially more effective than more reactive or medicalised approaches. Working alongside clients to co-produce plans and potential solutions was seen to encourage individual ownership of issues and solutions, thereby embedding longer-lasting change.

While outcomes were perceived as sustainable, there were concerns over the sustainability of social prescribing schemes in general, with a lack of funding being the main perceived barrier. While the 3 year time period of project fund grants helped with sustainability in the medium term, scheme leads reported uncertainty around future funding beyond the final year, due both to the rising levels of demand and concerns over the current economic situation, including the long-term financial repercussions of the COVID-19 pandemic. A scheme lead said:

> “Just today we were speaking to local churches and other groups in response to COVID-19. How do we support vulnerable and older [people] – in terms of isolation and mental health? Really important as we go forwards, we need to complement what [the] health service is seeking to do.”

Meeting future demand challenges

A common challenge reported by leads was dealing successfully with a future where client demand was likely to rise, the need for social prescribing would increase yet funding constraints may limit the ability to actually deliver to the extent requited.

One scheme lead reflected positively on their experience to date, noting that social prescribing was becoming the ‘buzzword’ both nationally and at a local level. An opportunity was developing to build upon their success, continuing to relieve the pressure on health services, GPs, hospitals while helping people to improve their wellbeing.

Their council was fully on-board with the approach but were lacking budget to cover adequately, particularly as face-to-face social prescribing approaches were more costly than other options. Where local funding was available, the perception was that this tended to be taken up by specific health providers who “keep money to themselves” and that the VCSE sector would be squeezed out as a result. This ran the risk of losing the specific skillsets of the VCSE sector and resulting in general wellbeing needs being lost as a result of over-emphasis on clinical health.

Scheme leads also felt that future sustainability would partly depend on maintaining and developing connections and networks in a rapidly changing health sector. Some schemes were already acting quickly to work across multiple PCNs or renegotiating contacts with local authorities. An ongoing challenge was retaining staff with experience working on social prescribing. As noted in the prior example, the rising number and potentially complex nature of cases was seen as providing a further challenge to future sustainability. A scheme lead said:

> “I’m not the only person that would say cases are so complex, peoples’ mental health issues are needing specialist [clinical] support - or they have learning disabilities or high social care needs, that’s a worry that the future of social prescribing is filling a gap for that lack of resource available for people.”

6.0 Conclusions and recommendations

6.1 Conclusions

Schemes leads were positive about the level of funding available from the project fund and understood that it had set out to achieve necessary and valuable work that put the VCSE sector at the heart of social prescribing. Schemes reported being proud or pleased to be part of national funding for social prescribing that was rooted in the VCSE sector. It was felt that this raised the local profile of social prescribing from VCSE organisations that they had been doing for many years, in offering people non-clinical interventions to holistically improve their health and wellbeing.

While all scheme leads saw their work as requiring a clear focus on delivery, not all necessarily viewed this as a means of improving the social prescribing evidence base. While many schemes worked hard to complete the Common Measurement Framework on an on-going basis, there were a small number of schemes where data was not provided or could not be amalgamated into the required format.

Leads reported that their models worked well and that they were benefitting clients, although there was insufficient data at this stage to prove or disprove this view. Different models were felt to work well in different local contexts, with co-location in surgeries, operating from VCSE organisations and telephone social prescribing all being reported as successful in meeting the diverse needs of clients. Various schemes reported that their ability to deliver in the initial stages was affected by a delay in sign-off for the fund, with some feeling that grant management processes could have provided better on-going support throughout their funding.

They also felt that the fund had helped them develop wider organisational links, primarily through encouraging partnership approaches, requiring additional funding and through increased connections with referral organisations and wider social prescribing networks.

Scheme leads were interested in the learning from the breadth of the different models being used and the different target cohorts across schemes. A range of various approaches had been used to disseminate learning, including face-to-face approaches, often at a more local level involving existing networks. With social prescribing schemes still delivering services and collecting further evidence there was felt to be time to facilitate more opportunities to share learnings and experiences across schemes and more widely to the health sector. Schemes did report a lack of formal opportunities to share information across themselves as part of the fund.

There were concerns around ongoing project sustainability among leads. They felt that a social prescribing approach that was based on the VCSE sector provided the opportunity

to embed delivery in local communities and take an asset-based approach that empowered clients to make long-lasting change. They felt that they were well-placed to meet potentially growing levels of demand, particularly where this focused on preventative or non-clinical levels. However, a key risk was a lack of funding due to national economic conditions and the potential need to provide clear evidence of impact.

6.2 Recommendations

Specific learning points and recommendations to help develop the work of the Health and Wellbeing project fund are:

- develop and communicate a clear vision, mission statement and/or other information that clarifies the focus and priorities of the fund, clarifying the relative importance of delivery as an end in itself and as a means to generating an evidence-base

- where generation of an evidence-base is important, this should be embedded in organisational requirements (for example, project KPIs) with support provided to ensure compliance

- scope the potential value of shared outcome measures, taking into account the amount of funding received by organisations, their existing capacity and other data collection requirements, and ongoing sectoral work to develop appropriate measures

- develop systems to encourage interaction and sharing of learning across schemes. To include simple approaches, including face-to-face meetings and online platforms

- implement support for developing summative learning at the end of the project fund both at an individual project and overall fund level and for this to be shared more widely. Provide support and guidance on how learning can be used to help leverage future funding

- ensure clear feedback and support processes for all schemes (including contact details for system partner staff as required)

- clarify the nature and extent of links across alliance members and project fund grantees, if this would help to disseminate learning and only where there is an obvious benefit to do so.

7.0 Appendix 1: individual case studies

These case-studies illustrate the client journeys of four separate individuals from two different social prescribing schemes, focusing on the actual lived experience of clients in their own words. Case-study participants Alex and Beatrice were referred through a telephone social prescribing service based on community navigation. Case-study participants Claire and Derek were clients of a scheme providing bespoke support with up to eight sessions of 1-1 support with a link worker with the option of assistance to attend the destination services/activities where there was a need. All research participants, including linkworking staff, have been anonymised. These case-studies are sourced from qualitative semi-structured interviews that took place as part of the case-study visits to two projects.

7.1 Alex

Alex struggled with literacy and was finding it hard to navigate the benefits system. He was living without adequate housing with his daughter, and they were staying temporarily with family in a small flat. Alex had some physical health challenges meaning that he was not very mobile and the burden of both these issues was negatively affecting his mental wellbeing:

> "I was given the time of day, [from the social prescribing link worker] I was given questions nicely and clearly. It was made kind of really easy for me. It was as if I wasn't doing it. I am over the moon with the service really. Everything I have applied for I have had help with and it has all gone well. It's never enough money to be honest but I am getting what I really I'm allowed to get [entitled to].
>
> Now I am kind of talking but I am not really a talker, I'm more of a listener, maybe that's because we are not actually face to face, so I feel a bit more confident than speaking in person. The [phone service] for me it is fine, Faye* has been great for me, she has helped. I feel like I have got someone next to me if I need something because I can't read… [even] a book, I read one line of a book and once I've read the second line I forgot what the first is. Now I feel like I have had someone next to me.
>
> I definitely [would access the service again] if I needed to. I don't know [what other activities or services] I would be interested in. If someone else wanted advice I would definitely say go to [the social prescribing scheme].
>
> If I hadn't [got the social prescription] I don't know… we would either living on my sister's sofa and be getting in their way. My daughter would be

sleeping on a sofa as well. It would have been a very difficult life to be honest. Sharing a 2-bed apartment with my sister and my mother we were putting two sofas together and making a bed. It was a comfortable sofa [laughs] but it's not easy every night trying to put the sofas together, move the furniture and do it all up again in the morning. It is not kind of nice you know. If my daughter has been at school, she has to go to bed at 7.30pm where my mum and my sister would be sitting in the living room watching a film. It's not fair on them. As I said I had lots of help we are much happier much more comfortable where we are in our new home, it's nice and clean so I can only say a big, big thanks."

7.2 Beatrice

This case study illustrates that for some people, a single referral to the appropriate service with a skilled professional receiving the referral, can result in changes that are seen as 'life-changing'. Social prescription helped Beatrice get the outcome she wanted, particularly as she did not feel she would have accessed Citizens Advice of her own volition.

"I was pensioned from my job on medical grounds. I worked hard to keep my job because I enjoyed it. But I was getting so ill I had lots of illnesses. My health deteriorated and I had to get help not just from my salary because it decreased. So I got some form social services and I was doing well. But I have [had my] kidney and ribs removed and a series of other illness, with that my mobility got really bad. I was OK until the letter said I had to go for some examination for my Personal Independence Payment (PIP). They wrote to say they couldn't give me back what I was getting from social services or DSS because I was OK at that time… my health in fact was worse than it was initially. I was so distressed because they suddenly took the security away that I had, to live life normally. I didn't know what to do.

I was referred to the social prescribing service following writing a letter to my Member of Parliament. The service then referred me to Citizens Advice to help me with my claim for PIP. I got a date which was really promptly done. I was between four hospitals each wanting to do major surgery on my body the hip, the knees and fifteen bones to be broken in my toes... I didn't know what to do, I couldn't understand - I'm not stupid but at that particular time nothing meant and made sense.

When I met Lynne she was so warm, her patience and her aura, put you at your ease and free in whatever you were saying what to say. There is no way I could've handled anything at that point as I was dealing with lots

of medical issues… and the reality that I could end up in a wheelchair. The only freedom of getting out I had, I was losing. And Lynne* listened. And there and then she started addressing the issues and I was thinking “Wow, she is fast and she is putting the appeal in”… She told me the issue and what angle she was taking, she also made me aware of what can happen. The negative side as well as the positive which is very, very important. She made me fully understand where we were at, where we were going, and what the next step would be. You don’t get that much these days. People don’t have the time.

When I got the news about my appeal being successful I was elated I was ecstatic, I was on cloud-9, it changed my life: I could get out and about with support again and keep some of my freedom whilst I was suffering with my physical health."

7.3 Claire

This case study shows how home visits allowed the social prescribing link workers to see that there were other wider factors that were contributing negatively to health and wellbeing.

"My doctor sent me through to see Caroline and we had a chat at the centre where she was asking me about all sorts like. I told her about worries and we wrote down some things I wanted to change. The first step was to be having her come round my house as well and I did think it was a bit different way to do things but I am thrilled to bits that she did in the end.

I hadn’t been honest about everything at home like as it was a bit of a source of shame if I am honest with you. I am known for collecting things but I guess it was bordering on sort of hoarding really and there was some issues with the boiler in my house that wasn’t helped by the fact I was always struggling for money to have and keep it on.

I’d say that I met up with Caroline about 5 times after that [face-to-face] and then we would sometimes have a catch up on the phone if I couldn’t make the appointment at the centre… she even would text me on days where I needed reminding things were happening, my memory isn’t great and when there is lots on it is hard for me to remember and organise [things].

So basically she sorted it all, sat next to me like, so I had my benefits reassessed, got to the doctor again and really knew what I was there for

> and the cherry on the cake was getting a new boiler. I wanted to tell all me friends about it and I have done! I am chuffed to bits."

7.4 Derek

Derek was referred into the scheme through another linkworking service that did not feel his needs could be met by their service. This journey represents how attending the first destination service/activity alongside the social prescribing link worker was helpful for an individual who was experiencing social isolation and wanted to branch out more into the community.

> "I just wanted to get a bit more mobile after I had retired and had a bad time of it. It was simple for me [the SP process] but I didn't feel too good about turning up to something new on my own and given my age a lot of my friends have passed away or are living in a home so I don't see a lot of people other than my family.
>
> They helped me in many ways really but we got to the bottom the ideas I had in my head [that would help to make positive change] and then we got sorted with them coming to the first group… after that I went back [to the activity] myself and have loved the gardening as I don't have much of a garden myself."

8.0 Appendix 2: successful organisations

The below provides a summary of the schemes based on initial application information, illustrating the range of different organisations and approaches being funded.

Age UK Sunderland Covering the Sunderland Local Authority Area

The scheme worked alongside Sunderland City Council to build on the success on Age UK Sunderland's Living Well Link LWL service that was introduced in 2015. The service offered a single point of contact and extended access to information, early interventions and flexible low-level community-based support to adults who do not require intensive or specialised support interventions from statutory services.

Brighton and Hove Impetus Covering South East, Brighton and Hove

This expanded scheme strongly focused on providing support for those impacted by health inequalities with attention on the following navigation types: general community navigation for those with complex needs, transgender community navigation, BAME and language needs community navigation, and gypsy and traveller community navigation.

Charlton Athletic Community Trust Covering London, Greenwich

The scheme expanded an existing pilot scheme based in Greenwich from 7 GP surgeries into a further ten localities. The primary target was adults aged 18+ who have visited their GP on 12 or more occasions over the previous year, seeking to engage and empower individuals to better manage their health.

Citizens Advice North Oxfordshire and South Northamptonshire Covering Cherwell and West Oxfordshire District Councils

This scheme focused on supporting those who are lonely or socially isolated; including people with long-term conditions, carers, and disabled people. This model intended to provide patients with an initial one-hour assessment then a further two hours of support over a number of months, as appropriate.

Citizens Advice Waltham Forest Covering Waltham Forest

This scheme built on year-long pilot that focused primarily on the activities available in the voluntary sector for vulnerable patients and residents with high levels of need. It aimed to address the gaps and challenges linked to the social determinants of health inequalities.

Citizen's Advice Bureau Wirral Covering the Wirral

Citizens Advice and Age UK jointly aimed to support the local population of the Wirral. Social prescribing link workers worked across three GP localities and undertook a targeted programme looking to support those with low to moderate mental health needs.

Dudley Council for Voluntary Service Covering Dudley

Through collaborative working with their local CCG, it was recognised that there was a lack in additional support for those who are very dependent on emergency services. The proposed expansion to existing work was to implement 'A&E High Intensity Social Prescribing'. It sought to enhance the current model by offering the voluntary sector collaborative model to the some of the most vulnerable in the community.

Health Exchange Covering Birmingham

This new social prescribing scheme covered the city of Birmingham and involved a large number of GP practices across the city, providing access to a social prescribing system to around 400,000 residents. The model included both access to Community Link workers as well as a digital hub and wellbeing plan to support engagement with the community to address health and wellbeing issues.

Imago Community Covering Dartford and Gravesham

This model expanded an existing scheme which covers both the integrated discharge team at Darent Valley Hospital and a local GP practice to align with the new Sustainability and Transformation Partnership model for Local Care across the Dartford, Gravesham and Swanley clinical commissioning group area. The expansion aimed to reach 36 GP practices and used risk stratification to identify patients with multiple conditions and complex care needs and provide additional support.

Involve Kent Covering West Kent

This new social prescribing scheme targeted five GP surgeries within the West Kent CCG area. The scheme aimed at providing a strong evidence base for the use of social prescribing to demonstrate its effectiveness in improving health outcomes and reducing demand on NHS services. It was intended that each GP practice had a dedicated 'Involve Coordinator' IC, a skilled professional who would build around them a team of local volunteers to provide holistic support, advice and information to enable patients to access activities to improve their health and wellbeing.

Mental Health Concern Covering Newcastle and East Gateshead

This expansion scheme sought to align with processes from 6 GP clusters, utilising existing recourses, to standardise and improve services whilst providing additional capacity. The model aimed to support the development of social prescribing activity by providing funding for physical activity, access to the green spaces, social inclusion, access and transport and events publicity. The key focus of the social prescriptions were: long term conditions; persistent physical symptoms, and; tackling low-mood and depression.

Nova Wakefield District Ltd Covering Wakefield CCG and West Yorkshire STP

Through the experience of running an existing scheme Nova expanded to meet the needs of young adults living with mental health or learning difficulties who require supported, guided and mentored approach to living life well. The expansion provided a further 5 link workers to this group.

People Potential Possibilities P3 Covering Milton Keynes

PPP sought to build on an existing service for high intensity users of NHS and Emergency Health medical services, as well as Police Custody Suites. The new part of the scheme aimed to reduce demand from GPs by actively engaging individuals of medium to lower needs. The project offered support tailored to peoples' needs, ranging from very regular, intensive, support to single-contact interventions.

Redbridge Council for Voluntary Service Covering Redbridge CCG

This scheme was an extension to the prior Redbridge scheme, which is integrated into nine GP surgeries, to cover all 44 general practices in the borough. The scheme employed people from a wide range of backgrounds in to encourage engagement from all communities regardless of language or culture. The key focus was adults who were identified with any of the following conditions: low level mental health concerns; social isolation; and type 2 diabetes.

South Liverpool Citizen's Advice Bureau Covering Liverpool

This expansion of an existing programme provided interventions for people with a combination of long-term conditions, mental health problems and social hardships. The changes to the scheme were intended to support more people and will include a more holistic and diverse health and wellbeing offer than is currently on offer. It included the expansion of the current one-stop connector gateway, navigation workers and supported

access to wellbeing activities as well as pathways to volunteering, employment, enterprise, education and learning.

South Yorkshire Housing Association Covering Barnsley

South Yorkshire Housing Association previously delivered a social prescribing scheme across Barnsley, with project fund funding allowing them to expand into secondary care settings. This was proposed to provide holistic services to support those who are frequent attendees at A&E, at risk of admission to hospital or those who are medically fit but experiencing delays at discharge due to social issues. This secondary care model aimed to both prevent hospital admission as well as accelerate hospital discharge, using motivational interviewing to help people take control of their wellbeing.

Street Games Covering Sheffield, Southampton, Luton, Brighton and Hove

Each scheme was made available across an entire CCG or local authority areas. Processes were established to ensure those who traditionally find hardest to access health services, and who are most vulnerable to inequalities, will receive extra support. The scheme reached children, young people and families, to ensure that they could access the same benefits from social prescribing as adults. The focus of the scheme was to engage with socially excluded young people aged 5 to 25 from the following protected characteristic groups: female, disability, BAME and LGBTQ+, linking them to various community-based services.

The YOU Trust Covering Portsmouth

This new scheme sought to support people with a wide range of social, emotional or practical needs, with a focus on improving mental health and physical well-being. This scheme focused on supporting those who were socially isolated and frequently attended primary or secondary care health care provision. The scheme linked service users to a range of voluntary and community organisations activities or groups.

Voluntary Support North Surrey Covering Surrey Heath

The existing scheme was rolled out across Surrey Heath CCG and aimed at those with chronic conditions. The expansion intended to be inclusive of those who may have barriers to living an active life but were not yet at a crisis stage. The project opened to all adults 18+, with a key focus on people with long-term health conditions and disabilities, people with mental health issues, the elderly and single parents. It also sought to reach those for whom English is a second language and who may have been new to the local community.

The scheme sought to proactively tackle health inequalities in the area by targeting their most vulnerable residents.

Volunteer Cornwall Covering Cornwall and Isles of Scilly

This scheme operated across the STP footprint of Cornwall and the Isles of Scilly, encompassing one local authority, one CCG, 62 GP practices, one community trust and one hospital trust. The scheme focused on benefits and employment, housing, social isolation, arts and culture, natural environment, and lifestyles. The scheme sought to ensure volunteers could contribute to social prescribing by supporting those on the scheme to access activities and develop new activities.

Witton Lodge Community Association Covering North Birmingham

Witton Lodge Community Association had been delivering wellbeing activities since 2011 as part of its mission to deliver community led and based services. It had become integral within Birmingham's body of social prescribing and patient centred programmes. The scheme consisted of an expansion into the constituency of Erdington which had high levels of deprivation. The social prescription aspect of the service included creative activities, talking therapies, physical therapies or 'out & about', which includes walking or gardening groups.

Wolseley Community and Economic Trust Covering Plymouth

The Wolseley Trust provided a complex 'social prescribing and community referral' programme for 5 years and planned to replicate that model across further neighbourhoods in the City of Plymouth. A holistic model of social prescribing was adopted and rolled out across areas of the highest deprivation. This expansion sought to reduce health inequalities in these areas through the provision of tailored support.

Wolverhampton Voluntary Sector Council Covering Wolverhampton

Wolverhampton Voluntary Sector Council looked to expand an existing pilot scheme. Wolverhampton City faced high levels of deprivation with high levels of poverty and poor health outcomes when compared to national figures. The expansion aimed to replicate the current model and processes, implementing a new approach to ensure securing referrals from these most deprived areas whilst focusing on early intervention to improve outcomes.

9.0 Appendix 3: Discussion guides

The below text are excerpts of the semi-structured interview questions (sometimes termed ‘discussion guides’ or ‘topic guides’) that were used in the research with scheme leads, and separately, policy stakeholders.

9.1 Discussion guide used with scheme leads

Context

- What are your roles and responsibilities within your organisation?
- If you could put it in one sentence, what does your organisation do in relation to social prescribing?

Applying for Health and Wellbeing Programme

- When did you first hear about the Health and Wellbeing fund programme?
- Why did you decide to apply? What were the motivations for getting involved? Cover: reasons (for example whether new/existing fund, perceptions of local need etc); concerns
- How was the application process as a whole? What set-up was required once you were successful? How was this managed (and by who and why – for example if different lead partner)?

Social prescribing model and work

- Please can you describe the social prescribing service/activities at your organisation?
- In your opinion, how has work at your organisation (related to the project fund) gone to date?
- What have been the strengths of your approach?
- What have been the weaknesses?
- What are your initial lessons learned?
- What do you think your organisation/approach to social prescribing adds to the project fund as a whole?

- Have you made any changes to your social prescribing approach or model since starting delivery? If so, what?

- How are you planning to develop/amend your social prescribing work in future?

- Are you linked in to any social prescribing schemes elsewhere, either formally or informally (for example the social prescribing network)?

Project fund model and work

- How would you describe the overall model for the project fund? What are the key objectives (of fund – for example probe if understand rationale)?

- Thinking about the project fund as a whole (probe in relation to overall model as in ToC, include reference to key stakeholders, e.g. system partners, as well as for them and service users) …

- What are the strengths?

- What are the weaknesses?

- What are the initial lessons learned?

- How are you in contact with other system partners (DHSC, NHS England, PHE)? Cover: how they meet - formal, informal.

- What are your thoughts around the overall management of the programme? Cover: particular thoughts or suggestions as to the role of the DHSC, PHE or NHS England?

- Have you been in contact with other project funds? Cover: which ones, how.

- What do you think about the range of organisations involved? How do you think they will help meet the overall aims of the project fund?

- Have you had any contact with any VCSE programme alliance members? If so, was this before you applied or after?

- What was the contact in relation to?

- What impact has it had? Did it encourage you to apply?

Developing an evidence

- Please could you tell me about any new tools, services or products that you have developed through the fund? Cover: how this differs to before their fund involvement. Probe to ensure full details where possible (for example quantifying exact details of additional provision)

- Please could you tell me about your monitoring/evaluation plans? Cover: internal monitoring; overall fund level.

- How do you think the evidence that you are collecting will push forward policy change?

- What are your plans for dissemination/sharing learning of social prescribing schemes and why? Cover: local, regional, national.

- What do you think of the current evidence base for social prescribing as a whole? Probe: whether meets policy needs, implications for data collection, cost-effectiveness

- What evidence do you think will make a difference in terms of policy change in relation to social prescribing? Cover: how it should be collected; how it should be disseminated; how can they help to provide/share this evidence?

The future

- How can the fund help your organisation to further progress social prescribing?

- What, in particular, should your organisation, other organisations involved in the fund or the fund in general be doing to push forward policy change? What evidence should be getting collected, on what type of social prescribing and who/how should it be provided to? What should the fund be looking to amend or change either now or in the future during the course of the fund? Can outcomes be delivered by the same mechanism in a more effective/efficient way? If so, cover how.

- Thinking about the future sustainability of the fund, what are the main opportunities and threats?

- What else might be needed to sustain the impact, and how might this be actioned?

- Thinking about the future sustainability of your social prescribing, what are the main opportunities and threats?

- What else might be needed to sustain the impact, and how might this be actioned?

- How might wider strategic developments (for example long-term plan, local strategies, additional link workers and so on) impact upon future sustainability and why)? Probe: whether are aware/have considered these issues and concrete steps taken

9.2 Discussion guide used with policy stakeholders

Background/context

- Role and responsibilities as policy lead (including specific thematic focus)
    - As policy lead
    - Specifically, in relation to social prescribing

Awareness of the project fund

- Have you heard of the project fund?
- How/when did you hear?
- What were your initial thoughts?
    - Strengths and weaknesses
- How would you describe the project fund model? What do you think it is trying to achieve? Probe to examine:
    - Whether seen in terms of social prescribing and/or other themes
    - Whether seen as project delivery or providing evidence base
    - Understanding of time scales
    - Links to policy
- **Ask all. Read out explanation of project fund.** What are your initial thoughts now about the project fund as a model?
    - Strengths and weaknesses

Process of working with the fund

Ask if worked with/received evidence from project fund

- What was your actual involvement with the project fund? What outputs/evidence (if any) have you received?
- Can you describe the process of working with the fund? Probe in detail – ensure we have a clear track of the different stages and processes involved
    - Was it easy to engage fund members?
    - Were systems/structures in place to facilitate your work?
        - How did these work – what worked well or less well? What could have been done differently?
    - How easy or difficult was this process from the start to the end?
        - What worked particularly well or didn't work so well?

Social prescribing and the VCSE sector

- How has social prescribing developed over the last few years in general?
- What do you think the strengths/weaknesses of social prescribing are?
- How do you think it is likely to develop in the future?
    - What are the key factors that might impact on future development?
    - What is the realistic potential for growth and why?
- What role do you think the VCSE sector has to play in social prescribing in general?
- What are the sectors strengths and weaknesses?
    - In terms of delivering social prescribing
    - In terms of linking up with the wider health sector
    - In providing additional value
- How could VCSEs be looking to develop their work in this area?

Social prescribing evidence

- What is the current evidence base for social prescribing and how has this changed over the last few years?

- What are the current gaps in the evidence base? What is needed to prove/disprove the case for social prescribing?
    - Specific thematic areas? Probe on whether self-reported data, admin data etc
    - Information/evidence from certain groups?
- Who requires this evidence (national, regional, local organisations etc)?
- What are the likely gaps in the future?
    - What difference will filling these gaps realistically make?
- What is required to fill these gaps?
    - Evidence
    - Data collection approaches
    - Stakeholder involvement
- To what extent do you feel the project fund is currently in a position to fill evidence gaps? To what extent will it make a difference in filling the evidence gaps? Probe to ascertain concrete details on specific data that it could provide and why this will make an actual difference in the social prescribing agenda.
- To what extent do you think the project fund is in a position to:
    - Intermediate outcome 1. Increase system partners evidence on sustainable and scalable social prescribing interventions to inform health inequalities
    - Intermediate outcome 2. Provide new evidence and findings from supported social prescribing schemes to inform and influence system partners by being available and disseminated to key audiences across the system
    - Intermediate outcome 3. Evaluation results in increased capability for VCSE sector organisations to capture and evaluate the impact of their work
    - Outcome 1. Build evidence of sustainable, scalable solutions to mitigate and prevent inequalities, impacting on health and wellbeing of communities (including financial impact)
- What is the additionality of the project fund in terms of evidence? If the fund did not exist, would organisations be likely to provide this data anyway?

Future of social prescribing and the project fund

- What do you think the strengths and weaknesses are of the project fund moving forwards?
- Do you think the approach of having different themes coming on board will work? Why/why not?
    - What criteria should be used to select themes?
    - What themes do you think might be most suitable?
- Are there any other thoughts around the future of social prescribing?
    - In general?
    - The evidence-base required
    - The extent that the project fund can fill evidence gaps
- From your perspective, what are the main opportunities and threats in terms of the future sustainability of the fund?
- Pre-mortem analysis – make sure this takes place. Imagine an entirely hypothetical situation where in two years' time the project fund has failed from your perspective.
    - What do you think might have caused this failure? What are the reasons why things might not have worked?
    - Which are the most important options/possible failures that people might raise?
    - What solutions are there to dealing with these potential failures? What concrete actions could be taken to stop these happening? Probe: include preventative and reactive actions.

Interviewer note: Please consider sustainability across full range of possible issues as far as time allows. Refer to additional sustainability guide document below for details. Prompt as relevant on:

- Processes and structures
- Incentives and accountability systems
- Organisation, staffing and skills

- Adaptability/flexibility
- Cost/finance

In addition, we need to be as clear as possible about the mechanisms by which sustainability is being addressed, for example, whether no mechanisms are being used, informal mechanisms (meetings, general organisational culture) or formal mechanisms (for example incorporation into protocols, transformation plans, other strategic and official documents).

Final considerations

- If you were to find yourself in overall responsibility for developing the project fund, what would you put in place?
    - What changes would you realistically make?
    - What model would you implement?
    - Probe to ensure moves beyond funding
- Is there anything that you would like to add, or that I have not asked about that you think would be useful to know?

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